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MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE? By *Richard A. Epstein.* Addison-Wesley Publishing Company, Inc. 1997. Pp. xvi, 503. $27.50.

There's an old joke about a Southern preacher who is asked whether he believes in the sacrament of infant baptism. "Believe in it?" thunders the preacher. "Hell, son, I've *seen it done.*" In *Mortal Peril: Our Inalienable Right to Health Care?,* Richard Epstein[1] gives testimony that markets should be left unfettered to distribute health care services. Arguing from first principles, he aims to persuade that the messy, confusing business of health care is best dealt with by simple legal rules: permit free contracting, countenance no government-induced subsidies, recognize no positive rights. One leaves this particular revival tent feeling he has heard a good sermon on the wages of sin (failed government regulation), but has not been given much reason to believe in the preacher's promised land (libertarian capitalism).

The book's skeptically phrased subtitle, "Our Inalienable Right to Health Care?" cleverly captures the two principle themes of the book. Used in a positive sense, as in the Declaration of Independence, an "inalienable" right to health care connotes a fundamental right — an interpretation that might be derived from regarding health care as a prerequisite to the pursuit of happiness. From this, Epstein warns, it is "but a short leap to the proposition of universal access to health care" (p. xiv), which is the *bête noire* that he seeks to slay in the first half of the book. He marches the reader through the difficulties in limiting futile care, the problems of defining and providing necessary indigent care, the paradoxes of community rating and mandatory insurance, and finally the failure of two comprehensive access programs, Medicare and the proposed Clinton administration health reforms. The second meaning of "inalienable" is negative: legal rules impose restraints on alienation in health care by restricting freedom of contract in matters such as organ transplantation, euthanasia and assisted suicide, and tort lia-

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1. James Parker Hall Distinguished Service Professor of Law, University of Chicago.

bility. The second half of the book investigates the law's pervasive interference with autonomy in health care matters from an individual rights perspective that Epstein asserts is "closer to the sense of the original Declaration of Independence than the modern gloss that has been placed on it" (p. xv).

Why Epstein believes his two targets (government-sponsored access and legal restrictions on contracting) place us in "mortal peril," however, is less clear. True, a free market for organs might save lives by expanding the supply of a scarce resource. But euthanasia, assisted suicide, and contracting for lower thresholds of tort liability? Though these practices might save resources, they might well increase the aggregate mortal peril of the citizenry. Likewise, removing entitlements to health care services hardly seems calculated to improve the nation's health. Wasteful as government entitlements may be, their eradication can scarcely be said to avoid mortal peril for those who rely on them to obtain health services. Epstein's apparent answer lies in the alchemy of the market. Free markets improve the flow of resources and increase aggregate social welfare. Ultimately this rising tide will lift even the health care boat: "[T]he size of the resource base does more for the creation of good health than any political interventions designed to skew its use" (p. 219). I say apparent answer because Epstein is uncharacteristically vague about explaining just how things will work themselves out. And despite the asserted power of Epsteinian economics, he looks to the *deus ex machina* of charitable care to assure adequate health to all.

In this review, I argue that the history, economics, and politics of health markets belie Epstein's abstract reasoning. Though much of the argument in *Mortal Peril* is written in the language of economics and cost-benefit analysis, Epstein's core faith is libertarianism. I attempt to show below that he eschews careful analysis of the economic complexities of health care markets in favor of simple principles that focus almost entirely on autonomy. It should be understood, especially by policymakers, that the resulting harsh policy prescriptions are not compelled by economic reasoning but by a set of arbitrarily chosen first principles.

Because of the constraints of time and my own predilection, this review focuses on the portions of the book of greatest importance to the health care reform debate that has been going on in Washington and most state capitals over the last five years. Part I discusses the principles and methodology Epstein brings to the task of analyzing health law and policy and Part II expressly takes up the author's challenge to test his analysis with empirical evidence. The remainder of the review focuses on the three principal market reform issues addressed in *Mortal Peril:* Part III takes on Epstein's

critique of programs providing care to the poor or cross-subsidizing such care; Part IV analyzes his approach to regulations affecting insurance and managed care; and Part V focuses on the discussion of Medicare and the Clinton administration's health reform proposals.

I. METHODOLOGY AND MESSAGE

Mortal Peril can be seen as Epstein's effort to deploy many of the themes and principles developed over an uncommonly prolific academic career to see how they might work in practice. His influential and widely discussed writings on takings, tort law, individual rights, and regulation form a body of scholarship that rivals Richard Posner's in sweep and renown among legal academics. An important feature of his recent scholarship is an attempt to develop simplified, common-law-based principles to address complex legal issues.[2] Epstein is also justly acclaimed for his willingness to confront the most difficult challenges to his positions. In choosing to paint on the canvas of the health care sector, he has characteristically taken on a daunting challenge. Health care markets are notorious for their peculiarity and complexity, as well as the emotional rhetoric they inspire. One would be hard pressed to think of an area less hospitable to consensus on simple solutions that rely on first principles. Epstein at least deserves credit for choosing to test drive his theories on such a difficult terrain.

In the end, however, *Mortal Peril* does not meet this ambitious goal. Measured against his promise that the book's arguments are "not advanced as deductive certainties, but as empirical propositions, capable of being tested in particular contexts" (p. 20), Epstein utterly fails to meet his own standard of proof. Indeed, he hardly tries. Instead of marshaling evidence and proposing policies that would persuade the reader that simple rules based on first principles can and do work in health care, Epstein contents himself with tracing out the implications of his philosophy and selectively criticizing deficiencies in existing regulation.[3] Part II of this review

2. *See generally* RICHARD A. EPSTEIN, SIMPLE RULES FOR A COMPLEX WORLD (1995). Epstein identifies six basic rules: "self-ownership, or autonomy; first possession; voluntary exchange; protection against aggression; limited privilege for cases of necessity; and takings of property for public use on payment of just compensation." *Id.* at 53. He also suggests a somewhat qualified and orphaned seventh rule that if there is to be redistribution to the poor it must be financed by flat taxes. *See id.* at 148.

3. Similar problems plague Epstein's defense of his seven simple rules. Though asserting "the most powerful justification for the rule [of self-ownership] is empirical," he offers no such evidence. EPSTEIN, *supra* note 2, at 59; *see also* Jill Elaine Hasday, Book Note, *Preaching to the Choir*, 105 YALE L.J. 1153, 1157-58 (1997) (reviewing EPSTEIN, SIMPLE RULES FOR A COMPLEX WORLD (1995)) ("Rather than cite specific empirical evidence, Epstein analyzes the theoretical disadvantages of alternatives to self-ownership based on the assumption of rational maximizing behavior (pp. 55-58). On that basis, he concludes that his rule maximizes

takes up the author's challenge, offering some empirical observations that raise serious questions about the economic efficiency of the libertarian health care market Epstein envisions. Ultimately, Epstein comprehensively documents the failure of health law and policy to heed his advice, but neglects to offer convincing proof that society would be better off if that advice were followed. As the author acknowledges, in understatement, his book "is not rich in quick fixes for intractable problems" (p. xii). Indeed, one might go further: the reader is only given a glimpse of what the Epsteinian health market would look like.

A second problem involves Epstein's methodological inconsistencies. A social scientist would probably find it surprising that a law professor professing a strong kinship with economists and economics-oriented policy analysts would disregard their research in the health care field. The works of thoughtful health economists like Pauly, Fuchs, Dranove, Newhouse, and Reinhart are ignored and the voluminous health services literature is not consulted. Likewise, Epstein does not discuss the important writings on risk, preference shaping, and psychological analyses of market behavior. These omissions are particularly glaring because throughout *Mortal Peril* the author purports to champion a welfare-maximizing approach consistent with sound microeconomic principles. Indeed, notwithstanding Epstein's libertarian philosophy, his argument is distinctly deontological and utilitarian. Throughout *Mortal Peril* he deploys the language and methodology of economics and cost-benefit analysis, principally to deride the current state of regulation in health care.[4] Yet, as discussed in this review, he pays no attention to the subtleties and imperfections of the market that have caused even the most ardent market enthusiasts to endorse some forms of governmental intervention.

Never far from the surface is the tension between Epstein's strongly held libertarian views, which reject most forms of state coercion, and his invocation of economic/utilitarian modes of analysis, which sometimes require governmental meddling to assure efficient outcomes. The sources of this tension are several. First, as Martha Nussbaum has noted, the libertarian preference for liberty over

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efficiency and asserts that people would choose such a regime if placed behind 'a veil of ignorance' (pp. 57-58).").

4. For example, Epstein describes the role of law in fundamentally utilitarian terms ("The grand task for all legal and social institutions is to try to find some way to arrange for human affairs to secure the largest net benefit to the public at large," p. 417); faults proponents of laws mandating emergency treatments for not asking "whether over time [the laws] will increase the number of lives saved, or more properly, raise them to a level that justifies the public expenditures," p. 104; criticizes laws promoting community rating as prohibiting the market from reaching a "stable equilibrium" and fostering inefficiency, pp. 121-31; and assails Medicare and the Clinton Health Security Acts for their "hidden subsidies and the massive dislocations they cause," p. 146.

other values is "on a collision course" with utilitarianism, which is at bottom committed to pursuing the greatest total (or average) utility.[5] Infringements upon liberty and property may produce greater social welfare; categorically assuming that such infringements inexorably decrease utility is nothing more than a sleight of the invisible hand.[6] Second, under Sen's paradox, libertarianism comes into inevitable conflict with utilitarianism employing the Pareto optimality criterion whenever one recognizes other-regarding preferences.[7] Dismissing all such preferences cannot withstand close economic and efficiency scrutiny. Finally, adoption of a social welfare criterion that aggregates welfare across persons runs squarely into traditional libertarianism. Hence, Epstein's avowed acceptance of utilitarianism as the "justificatory apparatus for demarcating the scope of state power from the area of individual choice"[8] is a move away from libertarian orthodoxy.[9] However, as discussed below, this move may be a feint because Epstein's utilitarian analysis is skewed to yield libertarian outcomes.

An example of how this tension between libertarianism and utilitarianism plays out is found in Epstein's treatment of charity care. A critical juncture in utilitarian analysis is the choice of a measure of what law and policy should seek to maximize. Strict utilitarianism seeks to maximize individuals' happiness by using some metric of utility. For many, including most economists, wealth maximization supplies a convenient, albeit imperfect, proxy for utility. It is imperfect because it fails to account for differences in distributions of wealth and is particularly suspect, as Epstein admits, "when certain transactions do *not* get completed because the prospective buyer lacks necessary funds" (p. 34). Nonetheless, Posner and others rely on the impossibility of making interpersonal comparisons of utility as a grounds for sticking to the wealth maximization criterion.[10] Epstein acknowledges that the "wedge between maximizing social wealth and maximizing utility" provides the strongest

5. Martha C. Nussbaum, *Flawed Foundations: The Philosophical Critique of (a Particular Type of) Economics*, 64 U. CHI. L. REV. 1197, 1206-07 (1997).

6. *See id.* at 1207 ("[I]f one tries dogmatically to rig things so that restrictions on liberty always result in more utility losses than gains, one is simply robbing the idea of utility-maximizing of any predictive value.").

7. *See* Amartya Sen, *The Impossibility of a Paretian Liberal*, 78 J. POL. ECON. 152 (1970); *see also* Jason Scott Johnston, *Not So Cold an Eye: Richard Posner's Pragmatism*, 44 VAND. L. REV. 741, 750 (1991) (reviewing RICHARD A. POSNER, THE PROBLEMS OF JURISPRUDENCE (1990)) (criticizing Epstein because he "misses the logical conflict between libertarianism and efficiency").

8. EPSTEIN, *supra* note 2, at 30.

9. *See* Heidi Li Feldman, *Libertarianism with a Twist*, 94 MICH. L. REV. 1883, 1891 (1996) (reviewing EPSTEIN, SIMPLE RULES FOR A COMPLEX WORLD (1995)); *see also* RICHARD A. POSNER, ECONOMIC ANALYSIS OF LAW 12-13 (4th ed. 1992) (distinguishing value and utility).

10. *See* POSNER, *supra* note 9, at 13.

theoretical support to the claim for a right to health care (p. 31). By this he acknowledges that aggregate welfare-improving transactions may not occur when individuals are unable to afford to pay and that strict adherence to the wealth maximization norm would neglect these improvements. However theoretically or empirically valid this concern might be, the problems raised are "only instrumental and not moral" (p. 32) and can be tolerated because voluntary transactions in the form of charitable giving provide a more reliable means of making accurate interpersonal utility comparisons (pp. 35-37). As to the argument advanced by some, including libertarians,[11] that charitable provision of health care is a public good that will be under-provided in the marketplace due to free-rider problems and related market imperfections, Epstein questions (without providing evidence or anecdote) whether such a problem exists. If it does, he would allow for state intervention only to the extent of subsidizing charity through tax incentives. Here, libertarian principles trump despite the purported commitment to a social welfare standard described above. A utilitarian examination of the costs and benefits of the alternatives may well reveal that market imperfections are significant and that tax policy is an inefficient means of correcting market failure.

II. Will Laissez-Faire Policies Produce Efficient Health Care Markets?: Some Empirical Counterpoints

The competitive revolution in health care is approximately twenty years old — an ample period within which to gauge its performance.[12] While market forces have undoubtedly fostered cost savings and efficiency-enhancing improvements, there is abundant evidence suggesting that health care markets perform less optimally than others. Those who would resist regulatory efforts to improve competition in the health care sector (or would withdraw from government all regulatory functions) might be expected to address these documented failures of the private market. Astonishingly, Epstein says almost nothing about how the competitive market in health care has developed so far. The following empirical observations underscore the point that persistent market imperfections un-

11. *See, e.g.*, Allen E. Buchanan, *The Right to A Decent Minimum of Health Care*, 13 Phil. & Pub. Aff. 55, 68-72 (1984).

12. Passage of the HMO Act during the Nixon administration in 1975 signaled Congress's active encouragement of competition in the health care sector and began a series of steps that ultimately undermined various legal and professional norms that supported a professional paradigm in health care delivery and financing. Health Maintenance Organization Act of 1973, 42 U.S.C. §§ 300(e)-(e)(9) (1994). *See* Clark C. Havighurst, *The Professional Paradigm of Medical Care: Obstacle to Decentralization*, 30 Jurimetrics J. 415, 416 n.2 (1990) (identifying 1979 as a "the watershed year" for acceptance of competition in health care when Congress rejected the Carter administration's proposal to regulate hospital rates and encouraged competition in health care in amendments to federal health planning legislation).

dermine the efficient functioning of health care markets. Together they support the contention that government intervention to promote an infrastructure conducive to competition could produce superior economic outcomes.[13]

Fraud, Abuse, and Waste

The health care sector countenances enormous losses due to fraud, waste, and abuse in paying for provider services that are unnecessary, fraudulently billed, or otherwise improperly provided. By some accounts, fraud and abuse contribute ten percent or eighty billion dollars to annual health care spending.[14] While much of the looting unquestionably can be traced to the door of governmental programs that lack competitive rigor and arguably are not well-monitored, the problem is shared by payers in the highly competitive private sector.[15] Indeed, the practice of provider "self referrals," which studies indicate raised costs of care, was tolerated for many years until federal enforcement stepped in.[16] The magnitude and persistence of these practices lend support to the argument that health care markets are uniquely plagued by informational deficits owing to the nature of health care services and the reliance of both patients and payers on provider judgments.

Demographics and Local Market Structures

Many parts of the country lack a population base sufficient to support workable competition, as envisioned by managed competition advocates. Demographic evidence suggests that as much as thirty or forty percent of the country resides in markets that have natural monopoly or natural oligopoly characteristics because fewer than three integrated systems are likely to form at efficiently configured network levels.[17] Antitrust law, which intervenes to pro-

13. The themes set forth in this section update and confirm views expressed ten years ago about the need for regulation to permit effective competition. *See* Thomas L. Greaney, *Competitive Reform in Health Care: The Vulnerable Revolution*, 5 YALE J. ON REG. 179 (1988).

14. *See* Jerry L. Mashaw & Theodore R. Marmor, *Conceptualizing, Estimating, and Reforming Fraud, Waste, and Abuse in Healthcare Spending*, 11 YALE J. ON REG. 455, 488, 489 tbl.2 (1994).

15. *See id.* (discussing prevalence and estimates of straightforward fraud and abuse); Kurt Eichenwald, *Unwitting Doctors and Patients Exploited in a Vast Billing Fraud*, N.Y. TIMES, Feb. 6, 1998, at A1 (citing estimates of more than one billion dollars in losses by private health insurance companies from false claims).

16. *See* RICHARD P. KUSSEROW, U.S. DEPT. OF HEALTH & HUMAN SERVS., FINANCIAL ARRANGEMENTS BETWEEN PHYSICIANS AND HEALTH CARE BUSINESSES: REPORT TO CONGRESS 18 (1989) (documenting higher incidence of treatment for patients referred to clinical laboratories in which referring physician had investment interest).

17. *See* Richard Kronick et al., *The Marketplace in Health Care Reform — The Demographic Limitations of Managed Competition*, 328 NEW ENG. J. MED. 148, 150 (1993).

hibit inefficient consolidations or private agreements, has little to say about markets that are structurally uncompetitive owing to scale economies.[18] Conventional economic theory posits that regulatory interventions are appropriate unless the threat of entry makes such markets perform competitively. A further consequence of unconstrained market forces may be to permit consolidations and closings of facilities in rural markets so that residents will be deprived of adequate access to health care. Whether these problems call for regulatory interventions to control price, encourage development of buyer cooperatives large enough to impose "yardstick" pricing on rural markets, subsidize rural health care services, or establish other mechanisms is open to question. Nevertheless, the data indicate that an unchecked market may produce results that are economically inefficient or unacceptable to policymakers.[19]

Adverse Selection and Risk Adjustment

It has long been recognized that health insurance markets are particularly vulnerable to adverse selection, which ultimately interferes with the market obtaining equilibrium.[20] The strong tendency of adverse selection to affect the behavior of health insurers is driven in part by the skewed distribution of health expenditures in the United States. One percent of the population accounts for thirty percent of all health spending while fifty percent of the population account for only one percent of health spending.[21] Adverse selection causes many distortions in health care markets: it deters small business from offering insurance, discourages an efficient offering of certain kinds of coverage (for example, mental health services), and has fostered many ill-advised government corrective measures such as mandated benefits and other insurance laws.[22] Selection problems might be dealt with in the market by buyers' developing counter-measures. However, the evidence suggests that employers offering multiple plans rarely risk-adjust for enrollees' health characteristics. In the absence of such adjusted payments,

18. *See* Michael S. Jacobs, *Rural Health Care and State Antitrust Reform*, 47 MERCER L. REV. 1045, 1060-61 (1996).

19. *See* Thomas L. Greaney, *Managed Competition, Integrated Delivery Systems and Antitrust*, 79 CORNELL L. REV. 1507, 1521 (1994).

20. *See* CONGRESSIONAL RES. SERV., 101ST CONG., 1ST SESS., INSURING THE UNINSURED: OPTIONS AND ANALYSIS (Comm. Print 1988); WHITE HOUSE TASK FORCE ON HEALTH RISK POOLING, HEALTH RISK POOLING FOR SMALL-GROUP HEALTH INSURANCE 15-16 (1993); Michael Rothschild & Joseph Stiglitz, *Equilibrium in Competitive Insurance Markets*, 90 Q.J. ECON. 629 (1976).

21. *See* M.L. Berk & A.C. Monheit, *The Concentration of Health Expenditures: An Update*, HEALTH AFF., Winter 1992, at 145, 146.

22. *See* Joseph P. Newhouse, *Economists, Policy Entrepreneurs, and Health Care Reform*, HEALTH AFF., Spring 1995, at 182, 184.

plans have strong incentives to engage in "cherry picking." Moreover, the phenomenon may create disincentives to compete on quality because, perversely, having a good reputation for quality can lead to unfavorable selection. Difficulties in developing adequate mechanisms for risk adjustment have plagued Medicare and private insurance pools seeking to reduce adverse selection.[23]

Variations in Medical Practice, Outcomes Research

Numerous studies have documented that wide variations exist among providers in the nature and intensities of treatments and that these differences in medical interventions cannot be explained by scientific evidence.[24] Likewise, it is widely recognized that the medical profession lacks adequate outcomes research to assist consumers and insurers in selecting providers or pay plans based on demonstrable evidence of quality and cost effectiveness. As a result, though there has been vigorous competition among plans based on price and nonprice variables (for example, choice of physician, style of care, and breadth of network), there is very little evidence of rivalry based on outcomes or quality of care indicators.[25] Economic analysis, of course, stresses the importance of the production of information as a prerequisite to effective competition.[26] Experience suggests that transaction cost and public good problems may prevent the market from producing optimal levels of information.

Employers as Imperfect Agents

As a result of tax policies and historical developments, the employment relationship dominates the choice of health plans: nearly three-fourths of privately insured consumers buy health insurance through their employers. In theory, this relationship might improve the functioning of the market by counteracting information deficits.

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23. *See* Joseph P. Newhouse, *Patients at Risk: Health Reform and Risk Adjustment*, HEALTH AFF., Spring 1994, at 132, 139 ("[T]he good news . . . is that there is a substantial literature on risk adjustment. The bad news is that the literature could be summarized as: We don't know how to do it very well despite several years of trying.").

24. *See* THE DARTMOUTH ATLAS OF HEALTH CARE IN THE UNITED STATES (John E. Wennberg & Megan McAndrew Cooper eds., 1996); John Wennberg, *Dealing with Medical Practice Variations: A Proposal for Action*, HEALTH AFF., Summer 1984, at 6.

25. *See* Robert H. Miller, *Competition in the Health Care System: Good News and Bad News*, HEALTH AFF., Summer 1996, at 107, 117.

26. *See* Mark V. Pauly, *The Public Policy Implications of Using Outcome Statistics*, 58 BROOK. L. REV. 35, 50 (1992) ("The ideal of competition involves much more than multiple producers of care trying to attract patients. Decades of evidence proves that competition alone, in the face of distorted incentives and imperfect information, will not produce an outcome that will make people happy. The ideal of a competitive market, as outlined by Enthoven, involves more than just many sellers. Such a market also involves *knowledgeable* buyers facing proper *financial* incentives." (citation omitted)).

Employers might act as savvy purchasers, gathering information and negotiating insurance contracts on behalf of employees. However, dependence on employers for purchasing insurance has produced highly idiosyncratic results. Both the choices and affordability of insurance vary significantly among employers. Large employers almost uniformly offer health insurance to employees; more than half of small employers do not.[27] Eighty percent of small employers offer only one health plan to their employees,[28] and these employees pay higher co-pays and deductibles and a higher percentage of premiums than employees of larger firms.[29] Contrary to the managed care model for competition, few small employers have joined small business purchasing coalitions.[30] Finally, employer-dominated coverage has created certain well-recognized problems: distortion of individuals' choices in the labor market and "job lock," that is, creating artificial incentives for people to stay in their jobs because of fear losing of health insurance coverage.[31]

Individuals as Informed Purchasers

Competition-based reforms that require consumers to participate in care-limiting decisions under the shadow of financial incentives implicitly assume that consumers are capable of making rational decisions. Studies indicate, however, that individuals are — perhaps inevitably — poorly equipped to be informed consumers of health care. They lack medical training to evaluate the need for alternative courses of treatments; they do not have adequate data to weigh the costs and benefits of care; and they are unlikely to act as rational, detached consumers at the time of illness.[32] The results of the well-known RAND Health Insurance Experiment, which closely examined the behavior of patients with insurance coverage requiring cost-sharing, suggest, for example, that patients are

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27. *See* Paul B. Ginsburg et al., *Tracking Small-Firm Coverage, 1989-1996*, HEALTH AFF., Jan.–Feb. 1998, at 167, 168 (stating that 99% of firms with more than 200 employees offered health benefits to employees in 1996 compared to only 49% of smaller firms).

28. *See* Jon R. Gabel et al., *Small Employers and their Health Benefits, 1988-1996: An Awkward Adolescence; Limited Choice and High Out-of-pocket Costs for Employees May Help to Explain the Managed Care Backlash*, HEALTH AFF., Sept.–Oct. 1997, at 103, 105.

29. *See id.* at 107-08.

30. *See* Miller, *supra* note 25, at 118.

31. Though the recently enacted Health Insurance Portability and Accountability Act addresses the problems of portability and renewability of private insurance, the legislative remedy is of limited scope. *See* BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS, AND PROBLEMS 824-34 (3d ed. 1997).

32. For an excellent elaboration of this argument and summary of the literature on patient spending decisions, see MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING MECHANISMS 43-50 (1997); *see* sources cited *infra* note 33 and accompanying text.

unable to make medically sound decisions as to whether to seek treatment.[33] Other studies question whether consumers can or will choose providers based on quality preferences even when information is available. One notable study suggests that even those patients most expected to engage in quality-based searches in choosing providers rarely do so.[34] The ability of consumers or their employers to monitor effectively the quality of health care services is open to serious question.[35]

Recent Legislative Reform

Health care reform did not end with the defeat of the Clinton administration's proposal in 1994. State legislatures have adopted a large number of statutes regulating managed care organizations;[36] insuring portability and placing restrictions on variations and increases in premium rates;[37] restricting the use of genetic information in health insurance;[38] and improving the market for small-group insurance by promoting health purchasing cooperatives, imposing risk adjustment mechanisms and instituting other reforms.[39]

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33. *See* HALL, *supra* note 32, at 49 (RAND study confirms that "patients are both not capable of making good individual treatments on their own and that they rely heavily on their physicians' recommendations even when they are paying out of pocket"); JOSEPH NEWHOUSE, FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT (1993). On the broad implications of the RAND study for demand theory in health services, see Thomas Rice, *An Alternative Framework for Evaluating Welfare Losses in the Health Care Market*, 11 J. HEALTH ECON. 85 (1992); *see also* Feldman & Dowd, *What Does the Demand Curve for Medical Care Measure?*, 12 J. HEALTH ECON. 193 (1993); Martin Gaynor & William B. Vogt, *What Does Economics Have to Say About Health Policy Anyway? A Comment and Correction on Evans and Rice*, 22 J. HEALTH POL. POLY. & L. 475, 485-86 (1998) (critical responses); *see generally* Kathleen Lohr et al., *Effect of Cost-sharing on Use of Medically Effective and Less Effective Care*, 24 MED. CARE S-31 (1986) (in Supplement: *Use of Medical Care in the RAND Health Insurance Experiment: Diagnosis- and Service-Specific Analyses in a Randomized Controlled Trial*).

34. *See* T.J. Hoerger & Howard, *Search Behavior and Choice of Physician in the Market for Prenatal Care*, 33 MED. CARE 332 (1995).

35. *See* Timothy S. Jost, *Oversight of the Quality of Medical Care: Regulation, Management, or the Market?*, 37 ARIZ. L. REV. 825, 855 (1995) ("[I]t takes a mighty leap of faith to believe that consumers will in fact choose the plan or institution that is in some absolute sense either the highest quality or the most appropriate for their needs."); Haya R. Rubin, *Can Patients Evaluate the Quality of Hospital Care?*, 47 MED. CARE REV. 267 (1990).

36. Forty states have passed a variety of such laws, including statutes requiring managed care plans to provide information to enrollees and prospective members; setting standards for mandatory length of stays for maternity care; regulating utilization review criteria; ensuring access to emergency care; mandating provision of direct access to obstetricians/gynecologists. *See Surveys and Studies: Managed Care*, 14 Health Care Poly. Rep. (BNA) 568 (Apr. 7, 1997).

37. *See* U.S. GEN. ACCOUNTING OFFICE, HEALTH INSURANCE REGULATION: VARIATION IN STATE SMALL EMPLOYER HEALTH INSURANCE REFORMS, GAO/HEHS-95-161 FS, at 20 (1995).

38. *See* John Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311, 330-31 (1997).

39. *See* MARK A. HALL, REFORMING PRIVATE HEALTH INSURANCE 3 (1994); Linda J. Blumberg & Len M. Nichols, *First, Do No Harm: Developing Health Insurance Market Re-*

At the federal level, the Health Insurance Portability and Accountability Act of 1996[40] imposed rules assuring greater portability of insurance and requiring guaranteed issue or renewal of insurance in certain circumstances. Congress also greatly expanded health insurance for children by adopting the Children's Health Insurance Program,[41] which will provide up to $24 billion over four years in federal funds to assist state programs to insure ten million children.[42] These laws evidence a strong endorsement of cross-subsidies and assured availability of health insurance. This collective preference, expressed through the political process, provides a powerful counterfactual to Epstein's contention that society prefers an atomized casualty model of health insurance (pp. 124-25).

The foregoing paints a picture of a market beset with problems of inadequate information and imperfect agency. As a result, consumers of health care are in many respects flying blind with respect to the quality of what they are purchasing and often lack the opportunity to make significant choices because of various structural or other impediments in the marketplace. Meanwhile, forces are at work that encourage insurance market participants to avoid risks, thereby segmenting the market in a way that disfavors the unhealthy, or those with large transactions costs. While intermediating agencies such as certifying agents, boards of standards, group purchasing coalitions, and the like may develop naturally in the marketplace, the evidence suggests that they are slow to appear on the scene. In addition, the recent torrent of legislation regulating health insurance and delivery markets suggests a social preference for market alternatives that embody cross-subsidies of various kinds and guaranteed availability of affordable insurance for consumers. Though these points offer only a snapshot of the issues complicating the performance of health care markets, the message should be clear: stripping government of any role in regulating health markets is unlikely to produce more efficient outcomes or satisfy societal preferences.

III. Rationing and Scarcity

Epstein's inquiry into the problem of access to health care (or positive rights, as he frames the issue) begins in the right place. "Legal entitlements must be geared for a world of scarcity, that is,

form Packages, Health Aff., Fall 1996, at 35, 38 (describing various insurance market reforms).

40. Pub. L. No. 104-191, §§ 701-707, 2711-2713, 2741-2747, 110 Stat. 1936, 1939-55, 1962-67, 2741-47.

41. State Children's Health Insurance Program, 42 U.S.C.A. § 1397aa-1397jj (West Supp. 1997).

42. *See* Hilary Stout, *Children's Health Program is an Unlikely Survivor*, Wall St. J., July 30, 1997, at A6.

for a world where some legitimate wants have to remain unsatisfied" (p. 44). Unqualified claims to a right to health care will ultimately impinge on other "legitimate wants," so it is incumbent upon rights advocates to come up with some limiting principles. Scholars and regulators have undeniably struggled in attempting to devise a workable definition and regulatory scheme that would cabin rights to a "decent minimum" of health care.[43] It bears emphasizing — as Epstein certainly does — that any policy promising access to health care needs to deal with a host of controversy-laden questions: What care is to be provided? To whom? Who will ration care? And subject to what procedures and standards?

Epstein himself need not answer any of these questions, however, for his vision is of a society in which price rations health care just as it does most goods and services. Those unable or unwilling to pay will either do without or — if they are lucky — find help through private charities. In the long run, all citizens will benefit from the larger economic pie and the proper alignment of incentives.

For those who do not happen to inhabit the long run, however, the picture is considerably bleaker. As Uwe Reinhardt bluntly put it, "[Epstein's] argument seems to be that poor children in one generation can properly be left to suffer, so that all children of future generations may be made better off than they otherwise would have been."[44] More about the implications of the libertarian prescription later. This section first analyzes Epstein's treatment of the problem of access to care, finding that his account of contemporary positive rights to health care is flawed descriptively and conceptually.

Epstein identifies positive rights to health care in a variety of legal settings: government financing programs like Medicare and Medicaid; common law decisions that require hospitals to provide emergency care to indigent patients; federal laws requiring that hospitals provide certain care to all individuals as a condition of participation in the Medicare program; and various statutes governing private insurance that foster cross-subsidies. His broad critique of positive rights, however, does not fit all these cases. Providing health care services to the poor, for example, scarcely resembles the open-ended right to care that Epstein decries. In this regard, he seems bent on equating all health entitlements to the open checkbook that the Medicare program arguably provides. But such is assuredly not the case with respect to indigent care, which is provided

43. *See* 1 PRESIDENT'S COMMN. FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE & BIOMEDICAL & BEHAVIORAL RESEARCH, SECURING ACCESS TO HEALTH CARE: A REPORT ON THE ETHICAL IMPLICATIONS OF DIFFERENCES IN THE AVAILABILITY OF HEALTH SERVICES (1983).

44. Uwe E. Reinhardt, *Wanted: A Clearly Articulated Social Ethic for American Health Care*, 278 JAMA 1446, 1447 (1997).

through public health programs and Medicaid. These programs have long distinguished among the needy by various categories — specifically favoring women with children, children, the disabled, and the elderly. Nor do the other means of providing health care to the poor — emergency care at hospitals, free care in clinics, and charitable care from private physicians — constitute an open-ended entitlement. The poor receive only sixty percent of the services of comparable insured citizens.[45] Further, even those legally entitled to parity with the private sector find their care rationed: studies show that Medicaid beneficiaries receive fewer services, have less access to physicians, and are subject to considerably more delay and inconvenience than the insured population.[46] Far from ignoring the problem of scarcity, then, American policymakers have summoned the political courage to ration health care to the poor.

Epstein next embarks on a muddled and confusing argument contending that the problem of medical futility illustrates how "the theory of positive rights runs awry" (p. 81). End-of-life situations pose intractable problems because of the uncertainty in identifying situations of futility and in securing legal enforcement of rules requiring cessation of treatment (pp. 69-71). In these circumstances, the problems of demanded care arise: individuals who can obtain care at other people's expense often do so and impose severe costs on the public sector. Yet Epstein goes on to acknowledge that all measures for dealing with the problem are problematic. As a result of medical ethics, human nature, humanitarian impulses, and the uncertain state of science, the available solutions — advance directives, contracting, and global budgets — are of questionable efficacy in addressing the problem. Thus, instead of demonstrating that the regime of positive rights is to blame for demanded care, Epstein has shown that a web of other social and institutional circumstances contributes to the difficulty we have "saying no" in end-of-life cases. Exploring on utilitarian grounds the competing merits of rationing through consumer choice, bureaucratic mechanisms, and physician direction would seem to be a necessary predicate to reaching conclusions about the proper scope of positive rights in these circumstances. What we are given instead is an account that decries government's unwillingness to confront the scarcity problem, but that affords no new insights as to how society should perform the rationing that scarcity analysis mandates.[47]

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45. *See id.* at 1446.

46. *See id.*

47. An extraordinarily thorough and thoughtful examination of these issues may be found in a recent book by Mark Hall. *See* HALL, *supra* note 32, at 43-50; *see also* Gail Agrawal, *Chicago Hope Meets the Chicago School*, 96 MICH. L. REV. 1793 (1998) (reviewing HALL, MAKING MEDICAL SPENDING DECISIONS).

Dumping on EMTALA

Concluding his analysis of scarcity and indigent care, Epstein homes in on the Emergency Medical Treatment and Labor Act (EMTALA),[48] which he regards as a particularly good example of the pitfalls of governmental policies that create a positive right to health care. EMTALA obligates hospitals that accept Medicare or Medicaid and operate emergency rooms to screen (examine) all persons presenting in the emergency room and to provide treatment sufficient to stabilize those patients who are in labor or in an emergency condition. Hospitals must provide these services to all comers regardless of ability to pay. The right created by EMTALA is positive, but limited: EMTALA does not prohibit transfers after stabilization and permits hospitals to divert individuals coming to their emergency department.[49] For Epstein, EMTALA is "an institutional mistake whose intended benefits are more than offset by its hidden costs" (p. 94). Among the hidden costs are closing and downsizing of emergency rooms; excessive demand and long queues for service; disincentives for new firms to enter the emergency services market; increased risky behavior due to moral hazard; and unequal burdens across hospitals. This is one of the few instances in which the author delves into the empirical and policy studies of health markets and thus his treatment merits closer analysis.

The thrust of Epstein's argument is that EMTALA has prompted closings of trauma and emergency centers where they are most needed and has interfered with the ability of managers of hospitals to triage patients efficiently and perhaps save lives in the long run. There may be a kernel of truth to this argument, but it is hardly established by the sources cited. Moreover, the author's failure to place EMTALA in context with other laws and developments in the health care industry leads him to draw overblown conclusions that conveniently suit his preference for autonomy.

First, Epstein relies almost exclusively on a 1991 General Accounting Office study that documents the closure of trauma centers owing to financial losses.[50] While this study does note the phenom-

48. 42 U.S.C.A. § 1395dd (West 1992).

49. *See* Johnson v. University of Chicago Hosps., 982 F.2d 230 (7th Cir. 1993) (per curiam) (diverting ambulances via telemetry does not violate EMTALA).

50. *See* U.S. GEN. ACCOUNTING OFFICE, TRAUMA CARE: LIFE SAVING SYSTEM THREATENED BY UNREIMBURSED COSTS AND OTHER FACTORS, GAO/HRD-91-57 (1991). Epstein also offers some anecdotal evidence about the University of Chicago's withdrawal from a cooperative protocol with other hospitals for directing emergency care, but that experience is unpersuasive particularly in view of the fact that its emergency room did not close and is still subject to EMTALA. *See* Troyen A. Brennan, *Moral Imperatives Versus Market Solutions: Is Health Care a Right?*, 65 U. CHI. L. REV. 345, 355 (1998) (reviewing MORTAL PERIL).

enon, it does not attribute the closings to EMTALA in the simplified, post hoc ergo propter hoc fashion that Epstein does. Indeed, empirical evidence recently gathered by Troyen Brennan indicates, contrary to Epstein's causal model, that hospital closures correlate positively with the *absence* of emergency departments.[51] The reasons that not-for-profit hospitals shift away from the unprofitable business of emergency care are certainly economic, but they are also multifaceted. As a general matter, the pressures of managed care and tightened provider payments from Medicare and Medicaid have significantly shrunk the margins hospitals formerly used to cross-subsidize charity care.[52] Moreover, the unquestioned oversupply of acute care hospital capacity has spurred downsizings, reorganizations, and closures of many hospitals. HMOs and other managed care entities have placed strong pressures on providers and patients to reduce overutilization of inpatient facilities and particularly to curb unnecessary use of the emergency room.[53] Physicians and hospitals have responded by altering patterns of care and establishing stand-alone care centers and other means of substituting for treatment in an emergency room. Nor does the presence of an emergency room work exclusively to the hospitals' detriment. In some instances, managed care entities have accused hospitals of taking advantage of their emergency facilities by over-treating and over-admitting privately insured patients.[54] Further, other factors such as increased liability risks for malpractice and regulatory pressures may have contributed to hospitals' unwillingness to continue to operate emergency rooms.[55] Thus the impulse to close emergency units or reduce indigent patient care is a systemic issue, and not traceable to EMTALA alone.

Finally, hospitals' obligations to provide free care arise from a variety of sources: state laws requiring emergency treatment or open access, tax-exempt status, community pressures, and charter obligations, to mention a few. The extent to which EMTALA's requirements of screening and stabilizing patients create significant additional obligations is far from clear. Moreover, EMTALA can be seen as effectively reinforcing other public policies, like the charitable obligations of tax-exempt institutions, that may not otherwise be efficiently policed.

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51. *See* Brennan, *supra* note 50, at 354 n.10.

52. *See* Erik J. Olson, Note, *No Room at the Inn: A Snapshot of an American Emergency Room*, 46 STAN. L. REV. 449, 468-70 (1994).

53. *See* Diane Hoffmann, *Emergency Care and Managed Care — A Dangerous Combination*, 72 WASH. L. REV. 315 (1997).

54. *See* Loren A. Johnson & Robert W. Derlet, *Conflicts Between Managed Care Organizations and Emergency Departments in California*, 164 W. J. MED. 137 (1996).

55. *See* Mark Hall, *The Unlikely Case in Favor of Patient Dumping*, 38 JURIMETRICS J. 389, 393-94 (1998).

Epstein also argues that EMTALA increases demand for emergency room services. One hardly knows whether to take seriously his claim that EMTALA gives rise to a serious moral hazard problem — that is, it encourages risky activities that individuals would otherwise not undertake. The bulk of behaviors that produce true emergencies requiring emergency room services — automobile accidents, gunshots, and labor and delivery complications — are hardly the kind of activities involving much deliberation. Positing that individuals undertaking such risky behavior are influenced by the availability of health insurance is, well, absurd. Epstein takes the point even further: Hospitals should be left unfettered in ordering the affairs of their emergency departments, even to the extent of refusing care because of the self-inflicted nature of an illness.[56] Epstein's defense of such denials on utilitarian grounds rings hollow. Can one really expect that triage determinations made in emergency departments will effectively balance the costs and benefits of individual treatment? Is it not more likely that moral judgments about drugs or sexual orientation or other factors such as race or class will predominate?

Make no mistake. EMTALA is a poorly drafted, band-aid statute that has undoubtedly produced unintended consequences.[57] But it does respond to the well-documented[58] problem of financially motivated, health-threatening transfers — a phenomenon that Epstein does not refute. Indeed, today's competitive environment is undeniably more prone to patient dumping than the situation that prevailed at the time of the enactment of EMTALA.

Simple Rules, Preposterous Prescriptions

Ultimately Epstein argues against the government's assuring *any* minimum level of health care. Indeed, he would reject most transfers to supply indigent care, including seemingly high benefit/

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56. Epstein pulls no punches on this issue and apparently would grant hospitals wide discretion in choosing their emergency care patients:

> Unfortunately the current law makes it impossible for a hospital to treat drug addicts or alcoholics just once, or even twice, with this stern warning: there is no treatment next time, period — no matter what their personal consequences, including death. To the question, "you cannot let them die, can you?" we have to avoid the reflexive answer, no. To restore long-term stability to the system of emergency care, the answer has to be "yes, we can sometimes."

P. 103.

57. *See* Hoffmann, *supra* note 53; David A. Hyman, *Patient Dumping and EMTALA: Past Imperfect/Future Shock*, 8 HEALTH MATRIX 29 (1998); Lawrence E. Singer, *Look What They've Done to My Law, Ma: COBRA's Implosion*, 33 HOUS. L. REV. 113, 117-18 (1996); Thomas L. Stricker, Jr., Note, *The Emergency Medical Treatment & Active Labor Act: Denial of Emergency Medical Care Because of Improper Economic Motives*, 67 NOTRE DAME L. REV. 1121 (1992).

58. *See* Robert L. Schiff et al., *Transfers to Public Hospitals*, 314 NEW ENG. J. MED. 552, 552 (1986).

low cost programs such as the recently enacted expansion of Medicaid to cover poor children.[59] Though ostensibly relying on a utilitarian balancing of alternative means of satisfying social needs,[60] his account is singularly unpersuasive and lacking even the gloss of anecdote, let alone an empirical basis. Ultimately his position must be understood as resting on a libertarian preference for avoiding government coercion rather than on any careful assessment of impact on social welfare.

Epstein begins by taking on the common perception that society would realize a gain in net utility by redistributing some modest quantum of health services to the poor. Repeating the familiar rationale that comparisons of utility are "conceptually impossible," he asserts that "[t]o make utility the coin of the political realm is to invite piteous tales of woe, exaggerated for the partisan purpose for which they are made" (p. 35). This position is vastly overstated. Herbert Hovenkamp has persuasively argued that it is possible to make objective welfare judgments that do not require highly individuated comparisons of utility. One may assume realistically that similarities among individuals occur over a small range of their utility functions, particularly those that involve primary goods.[61] Objective welfare judgments are commonplace in economics and in law and economics and they certainly drive the judgments of policymakers and social scientists.[62]

In any event, Epstein goes on to acknowledge that it is precisely the ability to make interpersonal utility comparisons that drives charitable giving, not to mention many other exchanges in everyday life. While accepting the notion that individuals perform utility

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59. Arguing against expanding Medicaid to cover ten million children, Epstein wrote in a letter to the New York Times:

> [E]xpanding subsidized care will drive private insurers from the market, thereby turning a larger fraction of working citizens into wards of the state . . . [T]he new plan introduces large deadweight administrative costs, invites the overuse of medical care and reduces parental incentives to prevent accident or illness.
>
> By providing free public care, we further undercut charitable institutions and blunt efforts to slim down the vast licensing and regulatory apparatus that makes medical care unaffordable to so many. Mrs. Clinton's implicit premise is that Federal subsidies can offset Federal regulation. Mine is that we could do better with less regulation and less subsidy. Scarcity matters, even in health care.

Richard A. Epstein, Letter to the Editor, N.Y. TIMES, Aug. 10, 1997, at 14.

60. *See id.*

61.

> [O]bjective welfare criteria can be used to make judgments that for most people the marginal utility of food or housing is greater, up to some point, than the marginal utility of jewelry or fast cars. Most people value such primary goods more highly, until they are supplied in some minimum sufficient quantity, than they value other goods further up the chain.

Herbert Hovenkamp, *The Limits of Preference-Based Legal Policy*, 89 NW. U. L. REV. 4, 78 (1994).

62. *See id.* at 81-83 (describing use of objective welfare judgments in economics and in law and economics).

comparisons when making charitable donations, Epstein argues that this does not open the barn door for permitting the government to make similar determinations. He contends that the state is poorly equipped to make reliable comparisons for other people because of "[i]ts lumbering structure," "bureaucratic incentives," and the influence of "fierce and partisan politics" (p. 37). Moreover, charitable arrangements permit donors to "compare their own welfare with the welfare of unidentified strangers in need and to resolve their internal conflicts *against* some narrow conception of their own economic self-interest" (p. 36). Hence, some form of objective welfare comparison is indeed possible and probably done in a manner quite similar to that proposed above. The key difference lies in Epstein's unwillingness to substitute assessments of aggregate utility of citizens for individualized assessments by donors. At bottom, this position flows more from the author's antipathy to coercion than from a comparison of the efficiency of the two alternatives, for Epstein makes no attempt to evaluate the merits of the two institutions in this respect. There are certainly many efficiency questions that can be raised about the mechanics of private charity. For example, how effectively can donors monitor and police charities to overcome information, collective action, and monitoring problems? The notorious and scandalous conduct of directors and managers of not-for-profit hospitals and Blue Cross plans in recent years should surely give pause to anyone asserting that the not-for-profit sector is an efficient substitute for government.[63]

One of the more surprising aspects of *Mortal Peril* is that the author does not attempt to defend systematically his contention that charity will emerge to at least alleviate the suffering that would be caused by the wholesale elimination of government-supplied care and subsidies. For example, he offers no support for the implicit contention that charitable impulse is thwarted or suppressed by the existence of large government programs. Is one to believe that potential suppliers of charity care are fooled into thinking that Medicare and Medicaid satisfy all the needs of the poor? Likewise, there is no attempt to give assurance that society can realistically count on new charitable sources to supply indigent care in the staggering amounts required even partially to replace government programs. There is ample basis for skepticism: government program outlays for Medicaid alone in fiscal year 1996 totaled $160 billion,[64]

63. *See* Lawrence E. Singer, *The Conversion Conundrum: The State and Federal Response to Hospitals' Changes in Charitable Status*, 23 AM. J.L. & MED. 221, 231-32 (1997).

64. *See* U.S. Dept. of Health & Human Servs., Health Care Financing Administration, *HCFA Statistics: Expenditures* (visited June 2, 1998) <http://www.hcfa.gov/stats/hstats96/blustat2.htm>.

while aggregate charitable giving in the United States was only $150 billion.[65]

IV. Insurance and the Private Sector

Epstein's concept of private health insurance is a bold one. That is a polite way of saying that his model of insurance would be totally unrecognizable to the vast majority of consumers and policymakers in this (or any other) country. Of course, Epstein's self-described "contrarian" thinking should not disqualify his ideas from serious consideration; perhaps he has unearthed a better way to organize the market for private health insurance. Unfortunately, he has not. This Part argues that Epstein's analysis is fatally flawed by its inattention to the economics of health insurance. Because his vision is strongly refracted by a libertarian lens, he ignores the imperfections that plague the market for health insurance. Consequently, his account cannot be said to offer greater market efficiency, however that term is defined. Moreover, the libertarian focus presumes an atomistic conception of insurance that is at odds with the prevailing societal conception of that product, expressed in numerous legislative choices. Changing that conception is certainly possible, but why should we assume that a market exists for a product that the American society has collectively rejected?

Epstein's approach dichotomizes broadly between casualty insurance, in which each person's premium is calibrated as closely as possible to the individual risk she transfers to the carrier, and social insurance, in which government interventions of various kinds enhance risk redistribution. Laws supporting community rating, prohibiting genetic discrimination, or barring pre-existing conditions terms in insurance contracts are unacceptable to Epstein for their redistributional tendencies. In addition, Epstein argues that efforts to promote broader risk sharing or risk redistribution destabilize markets as insurers vie for better risk pools. "Correct risk classification allows the insurance market to reach a stable equilibrium" (p. 121), while interference with that process blocks efficient resource allocation.

Note that this account does not recognize the pooling function of insurance. Pooling entails spreading variations in medical spending across a group. To be sure, cross-subsidies occur in heterogeneous groups as premiums paid by those with better-than-average risks help cover the costs of those with worse-than-average risks. Low-risk individuals accept this arrangement because they want to be able to enjoy the benefits of pooling when they become worse-

65. *See* Adam Bryant, *Companies Oppose Idea of Disclosing Charitable Giving*, N.Y. Times, Apr. 3, 1998, at A1.

than-average risks, as most people do over their lifetime. Unfortunately, market forces attack pooling as insurers that have strong financial incentives seek out better risks.[66] The consequence of this process, called risk segmentation, is that high-risk individuals find insurance unavailable or prohibitively expensive.[67] Likewise, the benefits to low-risk individuals may prove to be short-lived, as aging and unexpected illness (their own or that of members of their families) turn the tables on them.[68] The market might be expected to solve this problem through multi-year or lifetime insurance contracts. No such contracts exist, however, probably owing in part to the risks of adverse selection and other market imperfections.[69] Ultimately policymakers confront a trade-off between risk segmentation and risk pooling. Unfortunately, economics cannot answer the question of which imposes higher social costs. Proponents of insurance market reform point out, however, that reducing risk segmentation comes at a relatively small cost and that the advantages of assurances of affordable insurance over time suggest broad popular support for such implicit taxes.[70]

Insurance law and policy in the United States, consisting of legal interpretations, legislation, and administrative rulings, have never been guided by a single overriding principle. Economic, distributional, and equitable goals have all influenced the nature of insurance products.[71] There is no question, of course, about the fact that economic goals have been predominant. Indeed, many legal interventions seek to assure that the market can function properly, such as by dealing with transactions costs, adverse selection, and information gaps.[72] Other regulations are designed to redistribute risk and have the effect of sacrificing efficiency for the sake of redistributing wealth. Thus, laws regulating community rating promote redistributional ends, while others, such as those governing sol-

66. *See* Alan C. Enthoven & Sara J. Singer, *Market-Based Reform: What to Regulate and By Whom*, HEALTH AFF., Spring 1995, at 105, 107.

67. Considerations of justice and social cohesion, not addressed in this review, are also raised by risk segmentation. *See, e.g.*, Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POLY. & L. 285, 290 (1993) ("Actuarial fairness — each person paying for his own risk — is . . . a method of organizing mutual aid by fragmenting communities into ever-smaller, more homogeneous groups and a method that leads ultimately to the destruction of mutual aid."). For an excellent analysis of Epstein's treatment of insurance regulation issues from a Rawlsian perspective, see Russell Korobkin, *Determining Health Care Rights from Behind a Veil of Ignorance*, ILL. L. REV. (forthcoming 1998).

68. *See* Linda J. Blumberg & Len M. Nichols, *Health Insurance Market Reforms: What They Can and Cannot Do* (visited May 8, 1998) <http://www.urban.org/pubs/hinsure/insure.htm>.

69. *See* Blumberg & Nichols, *supra* note 39, at 38.

70. *See id.* at 38-39.

71. *See* KENNETH S. ABRAHAM, DISTRIBUTING RISK: INSURANCE, LEGAL THEORY, AND PUBLIC POLICY 9-10 (1986).

72. *See id.* at 210.

vency and mandating simplicity in contracts, standardized benefits, and greater information for consumers help improve market efficiency. The law governing health insurance has vacillated between encouraging greater pooling or sharing of risk and requiring a closer relation between health status and premiums. The trend in recent years has been unmistakably toward encouraging risk sharing or pooling.[73]

My principal concern with Epstein's approach to regulation of insurance is his failure to acknowledge that some laws may improve the performance of health care markets. As noted above, controlling risk segmentation is at the heart of market reform efforts designed to improve efficiency.[74] An enormous policy literature has developed concerning the steps necessary to avoid risk selection, to promote the gathering and use of information, and to prevent abuses of market power. Although details and policy prescriptions vary, legislation to support risk pooling, minimize variations in benefit packages, eliminate tax subsidies, promote joint purchasing of insurance, guarantee issue and renewal of policies, and implement other steps has been proposed by economists of all political stripes to deal with these issues.[75] Finding the appropriate mix of policies is indeed a daunting challenge, but that does not excuse overlooking the complexities of the various proposals, as Epstein does. Simple solutions here are possible only if one chooses to define away the core economic problem.

V. Medicare and the Clinton Health Reforms

Part I of *Mortal Peril* concludes with two extended chapters analyzing Medicare (unoriginally subtitled "The Third Rail of American Politics") and the Clinton administration's Health Security Act (HSA) (aptly subtitled "The Shipwreck"). For Epstein, these programs epitomize all that is bad in positive rights to health care: inefficiency, coercion, bureaucracy, unintended consequences, and

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73. *See* John V. Jacobi, *The Ends of Health Insurance*, 30 U.C. Davis L. Rev. 311, 313-14 (1997); *see also supra* notes 37-39.

74. *See* Clark C. Havighurst, Health Care Law and Policy: Readings, Notes, and Questions 1108-10 (1988) ("Adverse selection is potentially the Achilles heel of a health policy relying on consumer choice . . . . [but] an intensely practical problem that may be amenable to practical solutions."); Blumberg & Nichols, *supra* note 68; Alain C. Enthoven, *Effective Management of Competition in the FEHBP*, Health Aff., Fall 1989, at 33, 34 (discussing adverse selection under the Federal Employees Health Benefits Program); Stanley B. Jones, *Can Multiple Choice Be Managed to Constrain Health Care Costs?*, Health Aff., Fall 1989, at 51, 54.

75. *See, e.g.*, Mark V. Pauly et al., Responsible National Health Insurance (1992); Stuart M. Butler, *The Conservative Agenda*, *in* The Problem That Won't Go Away: Reforming U.S. Health Financing 236 (Henry J. Aaron ed., 1996); Paul M. Ellwood, *"Responsible Choices": The Jackson Hole Group Plan for Health Reform*, Health Aff., Summer 1995, at 24, 25; Enthoven & Singer, *supra* note 66, at 105, 107.

excessive cost. His grasp of the mechanics and details of these complex programs is impressive. His careful dissection of the flawed regulatory structures of each is a model of clear economic and policy analysis. The overarching message — that regulating price and quality in a complex industry like health care is a daunting, if not intractable, task for governments — is one that should be carefully observed by policymakers. Unfortunately, Epstein misses the fact that many of these same underlying conditions bedevil private markets and evidence the need for market-improving regulation. In many respects, the HSA, the rival bills before Congress in 1994, and many reforms subsequently considered by the states have been aimed at addressing those problems. As discussed below, these chapters also suffer from a number of problems that undermine the successful technical analysis of the programs.

History, Politics, and Public Choice

Epstein portrays Medicare as a program born in economic naïveté and inaccurate actuarial estimates, with every attempt to confine costs succumbing to incentives built into the program. The lesson? "[N]ever start down a road that promises to give subsidies; but once given, seek to limit them if possible" (p. 182). Epstein's historical account is seriously deficient and his prescription slights the program's purposes and achievements. First, Epstein does not acknowledge that Medicare's original sin — a cost-based provider reimbursement system only loosely policed by private intermediaries — was the product of explicit lobbying and coercion by the provider community.[76] The perverse incentives that fueled Medicare's spiraling costs might just as easily be laid at the door of interest group politics as at the door of positive rights. Epstein's response appears to be that positive rights have inherently expansionist tendencies. But is this true? It can hardly be argued that positive rights to public education, public housing, and food stamps have produced a spiraling growth in those entitlements. One might well look to the marriage of middle class entitlements and nonmarket payments to providers for a more satisfying explanation of Medicare's unbridled growth.

Second, Epstein's utilitarian account is completely one-sided in that it does not mention important items on the benefit side of the cost-benefit ledger. It entirely neglects the fact, for example, that Medicare was designed to reduce poverty among the elderly, and that it has been highly successful in this regard.[77] Moreover, there

76. *See* THEODORE R. MARMOR, THE POLITICS OF MEDICARE 70-73 (1973); Thomas L. Greaney, *Transforming Medicare Through Physician Payment Reform: An Introduction to the Symposium*, 34 ST. LOUIS U. L.J. 749, 750-54 (1990).

77. *See* Bruce Vladeck, *Medicare at 30*, 274 JAMA 259 (1995).

is no mention of Medicare's important ancillary roles — namely, providing enormous subsidies to medical education and scientific research.[78] Here one again finds Epstein's libertarian preferences dressed up as utilitarian analysis. In one astonishing passage, for example, Epstein criticizes judicial decisions upholding Medicare's freezes on prices paid to physicians based on the fact that physician participation in the program is voluntary: "Claims of physician voluntariness myopically ignore the system of taxes and subsidies that make the government the sole primary provider of medical services to persons over age 65 and to disabled persons" (p. 90). Apparently, the six billion dollars in federal funds flowing in the other direction — subsidizing physicians' education — eluded Epstein's clear-eyed calculus.

Epstein also offers a selective reading of the history and politics of the HSA. He correctly identifies a number of factors that undermined public support: the Clinton administration's "[g]affes and intrigues" (p. 192), including its propensity to promise everything to everyone; the plan's complexity; and its disguised but pervasive regulatory apparatus. But he goes on to draw some perplexing and unsupported conclusions about the causes of the plan's demise. The HSA "could have done little to improve the lot of the uninsured" (p. 215); it lost support because it "operated as a wealth transfer from the low-risk uninsureds to the high-risk uninsureds" (p. 197); it was the victim of having "oversold equality" (p. 199); and it ultimately fell victim to its "egalitarian impulse" (p. 215). The influence of massive lobbying and campaign contributions by special interests is only obliquely acknowledged: "The special interests did line up against the plan, and for once they represented just about everyone" (p. 215).

The extensive postmortem literature on the HSA identifies several factors of greater importance than those Epstein highlights. Prominent among the concerns of the public and politicians were the plan's potential cost, the prospect of the rationing of health care, and the possibility that the plan might interfere with patients' choice of providers.[79] Moreover, studies indicate that public support for universal access to insurance and reform of insurance markets remained strong despite the defeat of HSA.[80] The torrent of legislation regulating insurance and managed care and expanding access to health insurance underscores the point that, if any collective preference was expressed in 1994, it was assuredly not what

78. *See id.*

79. *See* DAVID J. ROTHMAN, BEGINNINGS COUNT: THE TECHNOLOGICAL IMPERATIVE IN AMERICAN HEALTH CARE 152-53 (1997); Robert J. Blendon, *What Happened to Americans' Support for the Clinton Health Plan?*, HEALTH AFF., Summer 1995, at 7, 11; James Fallows, *A Triumph of Misinformation*, ATLANTIC MONTHLY, Jan. 26, 1995, at 26.

80. *See, e.g.*, Blendon, *supra* note 79, at 20-21.

Epstein suggests. His conclusion that the episode is a shining example of the democratic process correctly rejecting subsidies and positive rights seems more like wishful thinking than the product of a careful evaluation of the evidence.

What Is to Be Done?

Mortal Peril offers no more concrete analysis of what to do with Medicare or managed care regulation than it does for indigent care programs like Medicaid. At one point Epstein suggests that medical savings accounts might be a move in the right direction but that "the present set of feeble alternatives [increased deductibles and copayments; increased choice of plan; reduced coverage for hospital stays] may be the best that can be enacted" (p. 182). In fact, with the adoption of Medicare+Choice in the Balanced Budget Act of 1997, Congress took a definitive step toward bringing Medicare into the mainstream of managed care. This move, bolder than anything proposed in the Clinton reforms, suggests that the supposed inevitability of fixed or expanding entitlements is incorrect.

While Epstein fails to offer programmatic solutions to problems, there is no shortage of broad-brush assertions about the fundamental principles that should apply. One such principle is the rather protean concept of generational equity. Epstein recounts, for example, an episode in which he was asked to participate in a panel of scholars and experts on a television program concerning the Clinton Health Reform proposal.

> [A]n earnest University of Chicago undergraduate . . . had the temerity to ask . . . why he should have to fund the health insurance costs of his grandparents' generation. A representative of the AARP fumbled with a reply that stated in essence that in the long run the student would benefit from the same system that imposed this short-term dislocation. Consistent with the norms of so much social accounting, no present-value calculations of benefits and cost were offered. It hardly mattered that the over-65 generation were large net recipients, and the under-25 generation large net payers. [p. x]

Net recipients? Net payers? Of what? Epstein seems suddenly to suffer from tunnel vision when advocating inter-generational equity. Consider what a principled and beady-eyed utilitarian's calculus would look like. Surely it would include the present value of the costs incurred by the grandparents' generation in preserving the free market. Therefore it would take into account the lost lives and forgone income during World War II and perhaps the taxes spent on military expenditures during the Cold War. What of the tax-subsidized education and health benefits the undergraduate's generation has received? And the public expenditures through Medicare and other programs on medical education, research, and

public health that have produced an uncommonly healthy (albeit ungrateful) under-twenty-five generation?

Equally unsatisfying is the book's treatment of managed care. In Epstein's view, most regulation of managed care is a bad idea, but his discussion of these issues never confronts those reforms aimed at improving competition and correcting market imperfections. Though the regulatory issues surrounding provider contracting and insurance are among the most important and difficult economic problems faced by policymakers today, Epstein treats the subject as an afterthought. In a Postscript, Epstein sketches the pitfalls of regulatory developments such as "any willing provider" laws, which ensure doctors' ability to offer services within a plan as long as they agree to the plan's terms and conditions, and efforts to regulate HMOs. After correctly identifying the capacity of these laws to undermine the potential benefits of managed care, Epstein fails to draw any connection with the vested provider interests that drive many reforms that are misleadingly billed as "consumer protection" measures.[81] Moreover, many of the landmarks that complicate the issue of regulation in the area are never addressed:

- The Employment Retirement Security Act (ERISA),[82] which prevents states from regulating self-insured employers, is perhaps the most important regulatory complication facing lawmakers.
- The $100 billion federal tax subsidy for private health insurance (a sum greater than the cost of providing coverage for every uninsured person in the country)[83] distorts economic incentives, regressively allocates tax burdens, and encourages inefficient insurance purchasing decisions.[84]
- Employer sponsored insurance, encouraged by tax laws and other regulations, distorts employment market decisions and creates other inefficiencies for certain purchasers of health insurance.[85]

If Epstein endorses legislative repeal of these complications, he should say so and address whatever dislocations that repeal may cause. However, back-benching on managed care regulation without acknowledging the current regulatory context makes for shoddy policy analysis.

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81. *See* Peter T. Kilborn, *Bills Regulating Managed Care Benefit Doctors*, N.Y. TIMES, Feb. 16, 1998, at A1.

82. 29 U.S.C.A. § 1001-1001b (West Supp. 1998).

83. *See* Reinhardt, *supra* note 44, at 1447.

84. *See* SHERRY GLIED, CHRONIC CONDITION: WHY HEALTH REFORM FAILS 80-81 (1997).

85. *See* Michael J. Graetz, *Universal Health Coverage Without an Employer Mandate*, DOMESTIC AFF., Winter, 1993-94, at 83.

Conclusion

Mortal Peril teaches us several lessons. First principles yield few concrete policies. Those policies that do emerge from Epstein's first principles would leave tens of millions more citizens without insurance or health care, may permit insurance markets to unravel, and would block efforts to improve competition. Libertarians' insistence on autonomy will thwart effective market regulation that could produce more efficient economic outcomes. Simple rules are not costless: complex problems may require nuanced solutions. Courageous as it may seem to some to let people die, it may not be all that efficient.

Epstein mentions on several occasions the profound influence that his father, a radiologist, had on his thinking about this subject. He learned valuable lessons about charitable care, the perils of Medicare, and the fundamentals of medical ethics. I, too, learned some valuable lessons from my father, a shipyard worker who lost his pension and medical benefits — *twice* — when the shipyards in which he worked went out of business. Most, but not all, of his enormous end-of-life medical bills were paid for by Medicare. A big, good-natured Irishman, he never displayed any bitterness about his plight. But he did worry a lot about the bills and attempted to forgo expensive treatments whenever possible. Some costs are harder to measure than others.