Fairness in Health Care: Who Pays? Who Benefits?

Clark C Havighurst, *Duke University School of Law*
Abstract: Lower- and middle-income Americans with private health coverage pay not
only to protect their own families’ health but also to support a vast health care enterprise
that primarily benefits others. The system is able to finance itself in part because U.S.-
style health insurance greatly amplifies price-gouging opportunities for health care firms
with true market power; even though the resulting excess profits often cross-subsidize
seemingly desirable activities, the substantial cost burden falls ultimately on premium
payers like a severely regressive (i.e., unfair) “head tax.” Lower-income premium payers
also bear excessive costs for their own health care. For one thing, they appear to get less
out of their employers’ health plans than their higher-income coworkers, despite paying
similar premiums. Most importantly, however, the coverage they enjoy is designed
according to the economic interests and values of others, not their own. Because of the
tax subsidy for health insurance, consumers do not see with any clarity the costs they bear
for the coverage they enjoy. Employers, industry interests, and politicians therefore can
(and do) make choices on their behalf that systematically neglect economizing
possibilities. The distribution of the cost burden and benefits of Americans’ health care
has not been sufficiently recognized as the fundamental issue of social justice it
undeniably is.

As if the United States needed another reason (besides limited access, high costs, and
uneven quality) to embark on fundamental reform of its health care system, here is one: By any
standard of social justice, far too much of the extraordinarily high cost of U.S. health care falls
on lower- and middle-income payers of private health insurance premiums.1 The problem is not
simply, as some have suggested,2 that health care prices are too high – although they do greatly
exceed competitive prices in many instances. An equally serious matter is that monopoly pricing
has become an accepted method of public finance in the health sector. Thus, much of what
insured Americans pay for their personal health coverage goes, like an inequitable tax, to pay for
goods and services that benefit others far more than themselves. Moreover, not only do these
less-than-affluent workers have no alternative – short of going without health coverage altogether
– to paying this regressive “tax,” but virtually no health plans available to them in the
marketplace are designed with their specific interests in mind. Instead, pursuant to law and
custom, America’s health plans embody the particular values, and serve the particular interests,
of the health care industry and its most affluent customers. Especially in a time of widening
income disparities in American society, it should be unacceptable for insured Americans with

1 See C.C.Havighurst and B.D. Richman, “Foreword: Health Policy’s Fourth Dimension,” Law and Contemporary
Problems 64, no. 4 (2006): 1-6 (suggesting that equity in the distribution of costs and benefits should be permanently
added to the short list of subtopics – i.e., access, cost, and quality – under which health policy is conventionally
discussed).
2 G.F. Anderson et al., “It’s the Prices, Stupid! Why the United States Is So Different from Other Countries,” Health
moderate incomes to bear a disproportionate share of the system’s costs while also being denied health coverage suitable for their specific circumstances.

While commentators on health policy rarely focus on the special burdens that the health care system imposes on less-than-affluent insureds, the status of uninsured Americans is regularly and widely deplored. Yet the problems of the insured and the uninsured are two sides of the same coin, for it is only the high and constantly rising cost of conventional health coverage that causes more and more working people to lose it. Indeed, given the options available, it is easy to understand why large numbers of middle-class Americans are tempted to reject the extortion-like demand that they either pay the industry’s high asking price for coverage (currently equivalent to nineteen percent of median family income\(^3\)) or put their family’s health at risk. Yet industry interests and most commentators still focus their sympathy only on the uninsured, in the apparent hope that government will bring the uninsured and the lost revenues they represent back into the system. Easy financial access to health care is not, however, the only indicium of fairness.\(^4\) There is certainly nothing fair about the Hobson’s choice that working Americans are forced to make between paying for overly costly health coverage and having no coverage at all. Whatever form health reform may take, equity demands that the health care system be financed in a fairer way than it is today.

The purpose of this Article is to call specific attention to the many, cumulatively important regressive features of the financing and regulatory regime that governs the private side of American health care.\(^5\) Some of its observations are not fully documented here but are supported and more fully explained elsewhere.\(^6\) Other points, however, lack extensive empirical support because researchers have not focused nearly enough attention on distributional issues. Some matters touched upon may seem old hat to many readers, but revisiting these features of health policy, both individually and collectively, to determine their cumulative distributional implications should be a sobering experience. Everyone associated with the health care industry

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\(^5\) There are important distributional issues on the public side as well. For example, the bulk of Medicare’s funding comes from a 2.9 percent payroll tax on all current workers (very many of whom lack health coverage of their own); because this tax applies to earned income only and not to unearned income (and, unlike deferred income taxes, is not recouped when distributions from tax-sheltered retirement plans occur), it is significantly less equitable than (even a) true flat tax would be. Moreover, while all Medicare beneficiaries have the same nominal entitlements, the program’s benefits flow disproportionately to high-income users of the system. See note 39 infra. For differing assessments of the overall distributional effects of Medicare, see M. McClellan and J. Skinner, “The Incidence of Medicare,” *Journal of Public Economics* 90, no. __ (2006): 257- (finding net effect regressive); J. Bhattacharya and D. Lakdawalla, “Does Medicare Benefit the Poor?”, *Journal of Public Economics* 90, no. __ (2006): 277- (finding net effect progressive).

is accustomed to thinking about where its next dollars will come from. It is time to think about where all its dollars come from and whether both the cost burden and any offsetting benefits are fairly distributed.

**Excessive Prices: Overpaying Providers and Suppliers**

Evidence that Americans pay excessive prices for health care goods and services comes from comparisons with prices paid to suppliers and providers in other developed nations and with comparable payments under the Medicare and Medicaid programs. Although the explanation for these differentials may be simply that government-controlled health systems regularly use their monopsony (buying) power to set prices below competitive levels (that is, marginal cost), the substantially higher prices observed in the U.S. private sector also result from weak competition and unchecked monopoly or market power. Most importantly, private health insurance, at least as it operates in the United States, greatly enhances the ability of firms with market power to raise prices at the expense of consumers – specifically, payers of health insurance premiums.

**Monopoly and health insurance – a corrosive combination.** The economics textbook objection to monopoly is that the high price a monopolist naturally charges tends to discourage consumption of the monopolized good, thus diverting productive resources to other sectors and away from their best use. Interestingly, this general misallocative effect of monopoly is not a significant problem in health care because health insurance enables most consumers to pay inflated prices, which therefore do not have their usual consumption-discouraging effect. By the same token, however, health insurance enables monopolists to set prices far above what consumers would pay if they faced those prices themselves, rather than paying only deductibles, coinsurance, or copayments; in other words, with health insurance in the picture, a monopolist can charge far more than the theoretical “monopoly price.” Because insured consumers ultimately pay these higher prices in their health insurance premiums, insurance has the effect of seriously aggravating monopoly’s second objectionable effect – the redistribution of wealth from consumers to producers. Although economic theory cannot prove that one distribution of wealth is preferable to another, the public has long objected to unjustified monopolies because of their regressive redistributive effects.

In some ways, to be sure, private health insurers have made price competition in many U.S. health care markets more effective by acting as knowledgeable, aggressive purchasing agents for their insureds and by rewarding with increased patient flow those providers willing to grant substantial discounts from their list prices. But U.S. insurers have little ability to confront true monopolists for the simple reason that they are not in a position (as individuals are, if only by necessity) to forgo purchasing a monopolized service or product simply because its price is too high. In the absence of a near-perfect substitute for a monopolized service or product as a treatment for certain health problems, health plan enrollees facing those problems could be expected to protest, even bring a lawsuit, if the plan would not purchase it for them. Although it

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7 See Anderson et al., cited note 2.
8 See Medicare Payment Advisory Commission, Medicare Payment Policy 85 (Report to Congress, March 2002) (fig. 2B-1).
9 See, for example, G. Anand, “The Most Expensive Drugs” (pt. 1), Wall Street Journal, Nov. 15, 2005, at A1 (quoting one drug company executive as saying, with reference to the profitability of a monopoly conferred under the Orphan Drug Act, “I never dreamed we could charge that much”).
is theoretically possible for a health plan to obtain contractual authority to make benefit/cost trade-offs in purchasing for the group, U.S. health insurers have never sought such authority, perhaps fearing that neither their subscribers nor the legal system would respect any economizing judgments they might make.  Instead, health plans compete mainly to give consumers easy access to all “medically necessary” care, not optimal value for their health care dollars.  U.S.-style health insurance therefore enables providers and suppliers to parlay even marginally advantageous market positions into extraordinary monopoly profits earned at consumers’ expense.

Few analysts have expressly recognized how health insurance aggravates the redistributive effects of monopoly.  For example, antitrust lawyers, courts, and economists have puzzled at length over whether nonprofit firms with market power are any less apt to charge monopoly prices than their for-profit counterparts.  Yet this question fades to insignificance once one appreciates the extraordinary pricing freedom enjoyed by any firm that sells a unique and desirable good or service covered by U.S.-style health insurance.

It is difficult to identify all the health care markets and submarkets in which U.S.-style health insurance facilitates extraordinary price gouging by monopoly sellers.  Antitrust enforcement has been relatively ineffective, however.  Largely because judges view nonprofit monopolies as relatively benign, they have not prevented hospital mergers that increase already high levels of market concentration.  Similarly, the antitrust agencies, while suppressing most naked price fixing, have not been able to prevent the formation of large physician groups with substantial pricing freedom in local markets.

There are also many markets, including significant submarkets for highly specialized services, that feature significant market power that is uncontestable legally because it arises from regulation, patents, technological causes, natural-monopoly conditions, or other market circumstances.  Where a seller exercises pricing power, private health insurance – at least the kind currently found in the United States – positively facilitates its translation into a major redistribution of income to providers and suppliers.  The

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12 The difficulty arises in part because hospitals do not exercise their monopoly power by raising the price of each individual service for which there is no close substitute (geographically or otherwise).  Instead, they use their power over these unique services to resist insurers’ demands for steep discounts from arbitrarily set list prices for numerous services the hospital provides.  See generally C. P. Tompkins, S. H. Altman & E. Eilat, *The Precarious Pricing System for Hospital Services, Health Affairs* 25, no. 1 (2006): 46- (describing how hospitals usually negotiate prices, not service-by-service but by agreeing to an across-the-board discount for large bundles of services).  Although hard data on hospitals’ monopoly profits are lacking, hospitals’ revenues from private sources tend to exceed allocations of their fully distributed costs (which themselves usually exceed marginal cost, the competitive price) by substantially greater margins than their revenues from public sources (which generally use arbitrary fee schedules).  See id. at 47.


14 See T.L. Greaney, “Whither Antitrust? The Uncertain Future of Competition Law in Health Care,” *Health Affairs* 21, no. 2 (2002): 185- (“the federal enforcement agencies have been slow to challenge physician or other provider networks”).
renewal of health care cost escalation in the early 2000s, after several years of relative stability in
the 1990s, resulted in part from increasing supply-side market power.\textsuperscript{15} Prescription drugs and
medical devices, both areas where patents and trade names confer valuable monopoly power,
have also been important contributors to recent cost increases.

\textbf{Monopoly as an instrument of public finance.} One explanation for public toleration of
widespread monopoly in the hospital sector is that most of the extraordinary profits that health
insurance enables nonprofit hospitals to earn in particular lines of business appear to be put to
good uses in cross-subsidizing activities that the market would not otherwise support. Indeed,
such institutions usually do not appear to be earning excess profits at all because their revenues
are so promptly diverted to other uses. Yet much of the high cost of health care in the United
States reflects activities that industry members are able to undertake only because of the way in
which monopoly and health insurance interact.

One set of costs that hospitals regularly cover out of surpluses earned on other lines of
business arise when the institution’s costs of providing services under Medicare or a state
Medicaid program exceed its revenue from that program. In addition, some legal and regulatory
requirements force providers to incur costs (for example, in emergency departments) that cannot
be charged directly to (or recovered in full from) some payer. Moreover, virtually all major
medical centers voluntarily engage extensively in professional education or medical research,
much of it not remunerative. Finally, despite subventions from various levels of government,
hospitals bear substantial uncompensated costs in caring for patients without health coverage.\textsuperscript{16}
Bruce Vladeck has estimated that hospitals incurred “community service costs” totaling $80-95
billion in 2003.\textsuperscript{17}

Many find it easy to approve nonprofit monopolies because, even though the surpluses
they generate may be substantial, they go to defray other health-related costs. Presumably,
however, there is a limit to the amount of resources that should be entrusted to wealthy
institutions that are essentially unaccountable to the public, either politically or in the
marketplace. There is no assurance, after all, that easily-gained revenues will not be squandered
in low-priority activities, in overpaying for inputs, or simply through managerial slack. To be
sure, tax-exempt monopolists in health care markets are committed by their corporate charters,
state law, and the tax code to pursuing only “charitable” purposes (generously defined) and
precluded from conferring any but incidental benefits (broadly defined) on private interests.
Among other things, however, this means that the large surpluses they generate in their profitable
lines of business are trapped in the health sector and unavailable for use elsewhere in the
economy. Indeed, tax exemption and the conditions therefor, combined with the profit-
enhancing effects of U.S.-style health insurance, have permitted hospitals over time to suck very
large amounts of cash out of the economy either to support ongoing health-related activities or to

\textsuperscript{15} MedPAC, \textit{Medicare Payment Policy} 57 (2005) (noting that insurers’ use of selective contracting “has been
limited by both hospital consolidation and consumers’ reluctance to accept limitations on their choice of providers”).
\textsuperscript{16} See S. Altman, D. Schactman and E. Eilat, “Could U.S. Hospitals Go the Way of U.S. Airlines?,” \textit{Health Affairs}
25, no. 1 (2006): 11, 14 (“general hospitals provide a sizable amount of uncompensated care—an average of 5.5
percent of total general hospital costs, or about $25 billion, in 2003”).
\textsuperscript{17} B. Vladeck, “Paying for Hospitals’ Community Service,” \textit{Health Affairs} 25, no. 1 (2006): 34–. To the extent
that some of these costs are recompensed through the Medicare program (and thus do not have to be financed out of
monopoly profits earned at premium payers’ expense), the burden still falls excessively on working Americans
through a somewhat regressive payroll tax. See note 5.
create new health facilities or new health-sector monopolies. This one-way flow of capital into
the health sector has built enormous enterprises that can legally use their untaxed income and
assets only for health-related activities, whatever the economy’s (or premium-paying
individuals’) other needs.

All of this points to the wisdom of thinking of nonprofit monopoly in the health care
sector as an instrument of public finance, administered by private institutions that are
accountable to the public in only limited ways. Although community-based governing boards,
state attorneys general, and the Internal Revenue Service provide some oversight, none of these is
likely to constrain nonprofit hospitals’ use of their power to charge profit-maximizing prices to
health insurers. Nor can they provide much assurance that hospitals’ money is well spent.

**Financing by a regressive “head tax.”** Although U.S. health insurers make it possible
for health care monopolists to earn extraordinary monopoly profits, the resulting heavy costs do
not fall finally on the insurers themselves. Instead, they are reflected in higher premiums, which,
although paid in the first instance by employers, come ultimately from the wages of the subset of
working Americans who enjoy employer-provided health coverage. In this way, a myriad of
health-related activities, many of uncertain value as objects of public finance, are paid for
through what amounts to a hidden “head tax.” True to the regressive nature of such a tax, the
burden is distributed more or less equally across all premium payers, irrespective of their income,
wealth, or ability to pay. Few methods of taxation are as regressive as this. Because the burden
thus imposed on lower- and middle-income premium payers is so large, this regressivity should
be a matter of explicit public concern.

Viewing the extraordinary profits that health care monopolists can earn at the expense of
premium payers as a kind of tax is helpful in appreciating not only the distributive injustice, but
also the potential for resource misallocation, inherent in this method of financing projects for the
public good. In particular, the analogy invites consideration of the accountability of those
imposing the burden and spending the resulting revenue. Unlike public taxing authorities, health
industry monopolists are relatively free to set their own prices and to decide how to use the
surpluses they generate. The ironic result is that, while U.S.-style health insurance obviates the
usual concern that monopoly will misallocate resources by causing monopolized goods or
services to be underproduced, it combines with the peculiar incentives and circumstances of
nonprofit, tax-exempt monopolists to generate allocative inefficiency of precisely the opposite
kind – too much of a good thing.

**Who bears the costs (enjoys the benefits) of innovation?** Opportunities for regressive
redistribution and resource misallocation also arise from the interaction of for-profit monopoly
and U.S.-style private health insurance. Once again, insurance puts health industry monopolists
in a position to capture more than ordinary monopoly profits. Particularly (though not
exclusively) in the case of for-profit firms, the prospect of such extraordinary profits may induce
equally extraordinary efforts to gain and keep such monopolies. Obviously, some efforts to gain
monopoly power are socially beneficial, particularly those yielding technological or other
innovations. But the prospect of earning very large economic rents can also induce a great deal
of spending having little or no social value. For example, firms can pursue or enhance market
power by uninformative advertising, meaningless product differentiation, lobbying for restrictive

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18 Economic theory predicts, and evidence confirms, that employees ultimately bear the cost of their employer-
purchased insurance, mostly in the form of reduced wages. See J. Gruber, *Health Insurance and the Labor Market*
legislation, erecting entry barriers of other kinds, and engaging in preemptive, duplicative, or inconsequential R&D. Indeed, it has been persuasively argued that, even as a general matter, monopoly’s most serious misallocative effect is likely to be, not underproduction induced by monopoly prices, but excessive investments in seeking, gaining, holding, and increasing market power.\textsuperscript{19} And in fact there is no assurance that would-be and actual monopolists will not dissipate a high proportion of (and perhaps even more than) their prospective rents in such endeavors. The likelihood of wasteful expenditures in pursuit or defense of market power is even greater in the health sector, where health insurance dramatically increases the lure of monopoly profits.

To be sure, one can argue that strong incentives for health care R&D are bound to pay large social dividends. Indeed, such analysts as David Cutler and Frank Lichtenberg have shown that the aggregate benefits of innovation in health care far outweigh its aggregate costs,\textsuperscript{20} and it is generally agreed that incentives for innovation tend to be substantially suboptimal in virtually all markets. Moreover, Darius Lakdawalla and Neeraj Sood have shown that, at least in theory, health insurance can create near-optimal incentives for R&D.\textsuperscript{21} On the other hand, Alan Garber and coauthors have suggested that health insurance, because it permits monopolists to earn profits actually in excess of the marginal social value of the monopolized good, service, or technology, may encourage excessive investments in innovation.\textsuperscript{22} Another important body of literature argues that the lure of patent monopolies induces wasteful patent races and other unproductive spending on getting, attacking, defending, and inventing around patents, both valid and invalid.\textsuperscript{23}

Given these complexities, this is clearly not the place to opine on the net allocative consequences of innovation incentives in health care and particularly in the pharmaceutical and medical device sectors. It is far from obvious, however, that prospects for technological innovations of even very great value to the general public (or, say, to populations of the third

\textsuperscript{23} See, for example, M.F. Grady & J.I. Alexander, “Patent Law and Rent Dissipation,” \textit{Virginia Law Review} 78, no. (1992): 305- (“The defect of the system is that if multiple inventors expend resources in competition for the patent monopoly, the benefit to society of having the invention will be dissipated by the cost of numerous, redundant, development efforts.”). In the health care sector, one sees extensive efforts to create and heavily promote relatively modest product improvements and to differentiate brand-name products from nearly equivalent generics by heavy investment in direct-to-consumer advertising.
world) can justify forcing lower- and middle-income U.S. premium payers to fund the incentives needed to realize them. A fortiori, because serious questions can be raised about the net effect of U.S.-style health insurance on incentives to monopolize segments of the health care market, it is unfair to make the high costs of inducing innovation part of the price that working Americans must pay if they are to have any health coverage.

**Reprise.** The foregoing discussion makes several important observations: First, U.S.-style private health insurance, by greatly weakening price elasticity of demand as a constraint on monopoly pricing by health care providers and suppliers, facilitates the latter’s exercise of market power, producing profits substantially exceeding (the word *obscene* comes to mind) the usual returns to lawful monopoly. Second, such monopoly profits both fuel and prospectively induce a great deal of health-sector spending, by both nonprofit and for-profit firms, that society has neither directly nor indirectly validated as appropriate uses of its scarce resources. And, third, the burden of overpaying providers and suppliers is imposed more or less equally, like a head tax, on all Americans with private health coverage, thus regressively impacting all premium payers below the high end of the income spectrum. These observations should inspire more research and political attention to how the burden of financing American health care is distributed.

**Excessive Costs: Undercompensating for Moral Hazard**

A much more widely noted effect of health insurance, more familiar by far than its facilitation of providers’ and suppliers’ exercise of market power, results from its general unleashing of moral hazard – that is, the tendency of patients and providers to spend insurers’ money more freely than the patient’s own. To be sure, some higher costs are unavoidable in any pooling of financial risks and are therefore, in themselves, not a sign of inefficiency. But third-party-financed spending on health care could be seriously welfare-reducing if payers are artificially inhibited or precluded from taking cost-effective administrative and other steps to counter moral hazard or if health coverage is not carefully designed to strike an appropriate balance between financial protection and moral hazard’s potentially heavy costs. Unfortunately, health insurance in the United States generates inefficiency on both scores because custom, law, and regulation are all systematically rigged to give moral hazard nearly full sway. Indeed, U.S. health policy appears to be premised on the notion that health coverage, where it exists, must entitle each insured, subject only to cost-sharing requirements, to unlimited access to any arguably beneficial health service that a physician is willing to prescribe. Thus, working Americans, if they are to have any health coverage at all, must buy a variety of it that, having been designed according the values and interests of the health care industry and other elite groups, allows no serious consideration of benefit/cost trade-offs.

The total cost burden on premium payers resulting from overly rich entitlements is no doubt substantially larger than the burden they bear by virtue of the regressive “head tax” described above. Here, however, an insured consumer receives services and goods of some value in return for his extra outlay, making the exploitation of premium payers less obvious. Moreover, trust in the health care system and admiration for all the good it does make it hard for many people to imagine that a systematic rip-off may be in progress. Yet if one can accept that individuals might be better off taking modest statistical risks with their family’s health in order to pay energy bills, educate their children, or save for an uncertain retirement, then forcing working people to pay for health care of debatable or only marginal value can reasonably be
viewed as unfair. The actual magnitude of the unfairness depends, of course, on valuations that only individuals can make. But ordinary Americans are currently forced to sacrifice far too much for the privilege of having health coverage.

**Conceding the benefit/cost no man’s land.** This is not the place to explore the complex reasons why U.S. health plans have never had, nor even seriously sought, the de facto and de jure authority necessary to efficiently counteract moral hazard. But their resulting inability to withhold coverage of any prescribed service on benefit/cost grounds explains not only the special power that private monopolists can exercise in health care markets (itself a consequence of unchecked moral hazard) but also the general overutilization of health services and the proliferation of extremely costly technologies, many of only slight marginal value. Even during the ascendancy of managed health care, health plans were not truly in the business of administering coverage to give subsets of premium payers good value for what they wanted to spend. Whereas that endeavor would have required establishing and administering mutually agreed-upon, cost-sensitive limits on individuals’ freedom to draw on the common pool of premiums, U.S. health plans have generally adhered to the convention requiring them to finance all care that medical professionals deem “medically necessary.” Thus, the only issues in most coverage disputes were efficacy and cost-effectiveness (in comparison with other measures of equal efficacy). Any rationing of arguably beneficial care occurred behind the scenes without the insureds’ consent, usually as a consequence of insurers’ use of financial incentives to induce providers to economize. Particularly since managed health care suddenly fell out of political and consumer favor in the late 1990s, U.S. health plans have conceded virtually the entire no man’s land of benefit/cost tradeoffs to the moral-hazard enemy.

It is impossible to know the actual extent of inefficient utilization resulting from uncontrolled moral hazard in American health plans. It has been suggested that the United States does not greatly overuse resources because its utilization rates for many services are comparable to those in other nations. That comparison means little, however, without some reason to believe that foreign systems handle the moral-hazard problem well. (In any event, the

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26 Recent work by Amy Finkelstein estimates that the spread of health insurance from 1950 to 1990 (including the implementation of Medicare and Medicaid) accounted for at least 40 percent of the dramatic increase in per capita health spending during that period. A. Finkelstein, The Aggregate Effects of Health Insurance (Nat’l Bureau of Econ. Research, Working Paper No. 11610, 2005). Not all of this added spending was inefficient, of course, because public and private insurance provided both valuable financial security and subsidized access to essential health services. Nevertheless, the moral-hazard effect detected by Finkelstein appears substantially greater than economists had previously detected in studies of individual behavior under various insurance arrangements (for example, the RAND Health Insurance Experiment). In contrast to the earlier studies, Finkelstein’s long time horizon enables her to detect long-term market-wide effects induced by the substantially reduced price resistance (i.e., steeper demand curves) that sellers increasingly faced as generous health insurance spread. These effects include greatly altered styles of medical practice and strong incentives to create and use technologies that would fail most people’s benefit/cost test.

27 E.g., Anderson et al., “It’s the Prices Stupid!”
only relevant comparison, for present purposes at least, would be between foreign utilization rates and consumption by insured Americans alone.) On the other hand, numerous studies reveal heavy spending that is wasteful even by professional standards. To be sure, such studies arguably constitute only anecdotal evidence of inefficiency because they take no account of administrative costs that would have to be incurred to achieve a more efficient result. But one widely noted feature of the American system provides a rock-solid basis for believing that current U.S. spending on health care, at least for the insured population, is seriously inefficient: the federal tax subsidy for employer-purchased health coverage.

**How the tax subsidy helps the rich (it’s not how you may think).** By excluding premiums for employer-sponsored health coverage from employee income subject to federal and state income and payroll taxes, the tax subsidy has long induced employers not to worry about efficiency in designing their employees’ health coverage. Instead, their principal goal has been to exploit a large tax loophole by making as many health care bills as possible payable with untaxed dollars. Thus, they bought generous, comprehensive coverage with minimal cost sharing. This overinsurance, amplified by uncontrolled moral hazard, could only result in a severe misallocation of the economy’s resources.

Among the tax subsidy’s many critics, a common objection is its greater apparent value to higher-bracket taxpayers. The regressivity these critics discern is only apparent, not real, however, because government must replace the revenues it loses through such tax expenditures; this presumably requires taxing other income at higher progressive rates, thus making the net tax effect on high-bracket taxpayers negligible. There are, however, some indirect ways in which the tax subsidy does substantially benefit economic elites, usually at some cost to the less affluent. A particularly important effect has been to make employers – rather than individual consumers or other, more homogeneous groups – responsible for designing or selecting most private health coverage. Although employers serve usefully as sophisticated purchasing agents for their employees, they have interests of their own and will inevitably make choices that benefit some employees (usually higher-income ones) more than others. One way in which the greater value of the tax subsidy to higher-income workers has regressive distributional consequences is by inducing employers to prefer coverage costlier than the average subsidized worker would choose for himself.

An even more subtle and pernicious effect of the tax subsidy is to make employees with health coverage far less cost-conscious, both as consumers and as voters, than they would be if they paid for their coverage directly. Believing that their employers bear any cost of coverage that is not visibly deducted from their wages, employees are inclined to demand generous

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28 See C.E. Phelps, *Health Economics* (New York, Addison Wesley, 2003): 354-55 (estimating, based on empirical estimates of demand for insurance, that “employer-group health insurance premiums would be only about 55 percent as large today if the tax subsidy were not in effect”; “it seems possible that the health sector would be at least 10 to 20 percent smaller without the tax subsidy for health insurance”).

29 Recent legislation extending favorable tax treatment to the funding of health savings accounts (if coupled with high-deductible coverage) has significantly leveled the playing field of health insurance choices and may in due course cause a shift toward more efficient coverage. See M.A. Hall and C.C. Havighurst, “Reviving Managed Health Care with Health Savings Accounts,” *Health Affairs* 24, no. 6 (2005): 1490-1500.

30 See, for example, Powers & Faden, cited note 4, at 132-33.

coverage even when their true interest would be served by economizing.\textsuperscript{32} Similarly, the inability of consumers to see the connection between their own pocketbooks and the macro health care choices that others make on their behalf also has consequences in political arenas. Thus, those who make legislative and regulatory policies for health care are free to take political credit for measures ensuring seemingly higher-quality care or coverage without having to give much weight to their cost consequences for consumer-voters.

The tax subsidy thus provides a solid foundation both for the health care sector’s dominant ideology and for a political economy that works systematically against the interests of lower- and middle-income premium payers. Ideologically, both industry practice and regulatory policy are governed by a strong preference for more and better health care with little or no regard for how much it costs or who bears the cost burden. Consumers of health care, seeing no reason to question this preference, have generally embraced it in the marketplace. Likewise in the political process, hiding the true cost of health coverage and health services from the consumer-voters who ultimately bear them has made it relatively easy for elite interests to have their preferences honored by government. Although special interests flex their political muscles here as elsewhere, they are less likely to meet resistance from consumer-voters when the regulatory choices affect only private costs. Thus, for example, the public generally applauded regulatory limits on the freedom of managed-care plans to ration financing even though such regulation was destined to allow costs to rise. Whereas government regulation is regularly justified on the ground that consumers are too ignorant to be good choosers, few have acknowledged the consequences for political choices when the electorate, having been kept in ignorance about the costs they pay, fails to recognize that health care is an economic good.

The principal beneficiaries of policies and practices that err consistently on the side of costlier care and uncontrolled moral hazard are, of course, the health care industry and the twelve million individuals it employs.\textsuperscript{33} Less obvious beneficiaries are higher-income Americans, who especially prefer, even at high cost, both the highest quality of medical care and virtually unlimited health coverage. The result is a system rigged systematically against the true interests of the political majority. Although the amount of excessive spending cannot be estimated with any precision, it is certain to be substantial. U.S.-style health coverage thus contributes once again to a serious misallocation of resources – too much a good thing.

\textbf{Who Consume What All Have Paid For?}

However one may feel about affluent Americans’ enjoying somewhat more and better health care than everyone else, it would certainly be unfair if consumption patterns varied significantly and positively with income (rather than with health needs alone) in situations where everyone pays the same premium for the same health coverage. Although evidence is scarce,\textsuperscript{34} there are reasons to believe that, in American health plans, higher-income employees make greater use of their coverage, demanding and receiving more and costlier services at plan expense

\textsuperscript{32} Only nineteen percent of employers that offer a choice health plan require the employee to pay the full amount by which the cost of the choice made exceeds the lowest-cost option. Kaiser Family Foundation & Health Research and Educational Trust, \textit{Employer Health Benefits: 2004 Annual Survey} 63, exh. 4.7 (2004).

\textsuperscript{33} \textit{See Uwe E. Reinhardt, “Resource Allocation in Health Care: The Allocation of Lifestyles to Providers,” Milbank Quarterly} 65, no. 1 (1987): 153- (emphasizing extent to which consumer savings from enhanced price competition would come at the direct expense of industry stakeholders).

\textsuperscript{34} But see Richman, “[title to come],” \textit{Health Affairs} (in press).
than their lower-income coworkers. Even if things more or less even out because lower-income persons have generally poorer health and greater health care needs, there is good reason to question the general assumption that, in employee health plans, the healthy wealthy subsidize the less fortunate. In fact, the subsidies may run in the opposite direction.35

One factor that could cause consumption patterns to be correlated positively with income within the same health plan is cost sharing. Most studies of cost sharing focus only on whether it discourages consumption of vital health services by less affluent patients.36 A different question is the extent to which conditioning eligibility for insurance coverage on patients’ willingness to make out-of-pocket payments causes lower-income participants in employee health plans to get disproportionately fewer benefits for the premiums they pay. Intuitively, it seems likely that the winners, once again, are those who are better able to pay up-front fees.37 Time, transportation costs, and child-care needs are additionally greater barriers to care seeking by lower-income insureds.

Income-correlated disparities in the volume and quality of health services received by participants in a single health plan might also result if there are class differences in patient attitudes toward certain kinds of care38 or if physicians take different attitudes or approaches in treating different patients. For example, perceiving that more educated patients have especially high expectations concerning their health care, physicians might strive to accommodate those expectations, providing somewhat more or better services without regard to the patient’s nominal entitlement. Likewise, insured individuals who are more articulate, demanding, or adept at searching the Internet may frequently get their physicians to prescribe more or better services for them than other patients normally receive.

Although equity in employer-sponsored health plans has received little attention from researchers, the vast body of evidence on racial and income disparities in the overall distribution of health care is at least consistent with, and sometimes appears to support, the hypothesis that lower-income workers tend to get less out of their health plans than they pay for. Similarly, socioeconomic status appears to correlate positively with consumption of many plan-covered services in nations with national health programs under which everyone has the same nominal entitlement.39

35 Some economists’ faith in market forces is such that they might expect income-correlated differences in utilization of the same health benefits to be compensated for in other benefits or take-home pay. See, e.g., M.V. Pauly, “The Tax Subsidy to Employment-based Insurance and the Distribution of Well-Being,” Law and Contemporary Problems 69, no. 4 (2006): 83-101. But no one has shown the labor market to be this efficient.
36 For example, Joseph Newhouse et al., Free for All: Lessons from the RAND Health Insurance Experiment (Publ?? 1993).
37 See id. at 46 (table showing that, in a controlled setting, cost sharing had noticeably greater effects on middle-income consumers than on higher-income ones).
38 See Richman, cited note 34.
The potential for regressive redistribution in employer-sponsored health plans could be minimized, it would seem, if employers generally offered their employees different plans each designed for a specific income group – so that each subgroup would bear only costs reflecting its own consumption, priorities, and circumstances. It does not appear that this regularly occurs. Indeed, employers may pool their nonunionized employees for purposes of health coverage precisely because the unwitting contributions of lower-income workers make it cheaper for the employer to provide the costly benefits that high-income employees particularly desire. If employee health plans do indeed operate regressively, the tax subsidy is ultimately to blame, since it both empowers employers to make the crucial choices and hides the true cost of coverage from the rank and file.

Ordinary Americans’ Stake in Health Reform

Comparisons with other developed nations suggest that excessive spending on health care in the United States amounts to several whole percentage points of gross domestic product (GDP), probably more than half a trillion dollars a year. Even if overstated by a hundred billion or so, this cost would still be a very heavy burden to impose by stealth principally on those working families lucky enough to have employer-provided health coverage. Although much questionable spending yields offsetting benefits to individuals in the form of improved health status, reassurance, and security, many of these benefits might be seen as an extravagance by families forced to pay for them in order to have any coverage at all. In addition, much of the money working Americans contribute in premiums is spent on industry-favored projects that, even if socially worthwhile, should not be financed by the equivalent of a regressive head tax on premium payers. It is hoped that this Article’s observation of systematic and cumulatively significant unfairnesses in the American way of financing, regulating, and dispensing health care will stimulate further research on such distributional issues. Even without definitive evidence on each regressive effect, however, the issues raised here need to be front and center in health policy debates.

This Article takes no final position on the policies that should replace the ones that currently serve working Americans so badly. Certainly some of its observations about the consequences of combining monopoly and U.S.-style private health insurance could be cited in support of either a shift to a single-payer health system or extensive administrative control of the prices of hospital services, prescription drugs, and medical devices. But other policy conclusions might be drawn as well. Private health insurance, after all, does not inevitably produce all the adverse consequences for consumers observed herein. Indeed, virtually all the problems we have identified in U.S.-style health coverage have roots in public policies (most obviously, the tax subsidy) and private practices that could, with a little effort, be adjusted to enable lower-income consumers of health care finally to get no less, as well as no more, than they pay for – with the help of whatever new public subsidies are made available to them.

The Bush administration has recently, though belatedly, proposed to change the tax treatment of health coverage in a way that would finally make health care costs visible to insured

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41 For observations on how over-regulation of the health sector, both by legislative and administrative measures and by the tort liability system, exacerbates distributional unfairness, see Havighurst and Richman, cited note 6, pp. 50-71.
The proposal is, first, to include the value of each taxpayer’s health coverage (how determined is not clear) in his income subject to income and payroll taxes. To offset this new tax burden, every taxpayer purchasing acceptable health coverage would be allowed an automatic $15,000 deduction from his taxable income and wages. Although a fixed, refundable tax credit would be a fairer form of subsidy than a new standard deduction, the proposal would simultaneously provide a strong new inducement for some uninsureds to purchase coverage and heighten consumers’ cost-consciousness, thus inviting competing insurers to design coverage giving consumers good value for whatever they or their employers chose to spend. Such a tax regime should also induce more voters to favor relaxation of regulatory and other restrictions limiting their ability, as consumers, to economize. To be sure, the Democratic Congress has ignored the Bush proposal in order that candidates could continue to discuss health care as a noneconomic good in 2008 election campaigns. But responsible reform would be more likely if insured Americans understood that their own welfare, as well as that of the uninsured, might be improved by fundamental changes in the way health care is financed.

No task could be much harder, of course, than to persuade stakeholders in American health care to acknowledge that the health care system, as currently financed and administered, is imposing a very large, unjustifiable cost burden disproportionately on ordinary Americans. Industry interests, like many other observers, profess concern principally for the uninsured. Much of this concern is inspired, however, only by the latter’s failure in increasing numbers to contribute their share of system finances. As to the burden on those who do pay premiums, elite observers usually acknowledge only that the industry has a duty to act responsibly in incurring costs – by practicing only “evidence-based” medicine, for example. But even sincere promises by industry elites to do better on this front – and also to improve quality and eliminate racial and class disparities in the way care is delivered – are not enough. The cumulatively large inequity that results from the many discrete unfairnesses observed in this Article should be the dominant concern of health policy makers today, to be addressed either before or in conjunction with the closely related problem of the uninsured.

It is by no means clear that the American political system is capable of designing – or that public opinion and the legal system would ever finally embrace – an arrangement in which consumers’ ability and willingness to pay explicitly play even a marginal role – a crucially important marginal role, to be sure – in determining the quality and quantity of health care that individuals enjoy. If such a rational and efficient system is impossible either to establish or to maintain in the face of strong egalitarian impulses, then a more radical, government-dominated reform may be the only viable alternative. But whatever kind of system one hopes or expects will emerge from a new reform movement, a good way to launch that movement would be to make consumer-voters currently enjoying private health coverage finally aware of the huge, unfair cost burden they bear.

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42 [cite]

43 See Clark C. Havighurst, “Why Preserve Private Health Care Financing?,” in American Health Policy: Critical Issues for Reform (Washington, AEI Press, 1993): 87- (arguing that private health plans are hard to defend unless they are allowed to offer, and do offer, consumers a full range of health care options, including economizing opportunities).