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Adding Principle to Pragmatism: The Transformative Potential of “Medicare-for-All” in Post-Pandemic Health Reform

William M. Sage*

Abstract:

“Medicare-for-All” should be more than a badge of political identity or opposition. This Article examines the concept’s potential to catalyze policy innovation in the U.S. health care system. After suggesting that the half century of existing Medicare has been as much “Gilded Age” as “Golden Era,” this Article arrays the operational possibilities for a Medicare-for-All initiative. It revisits America’s recent history of pragmatic rather than principled health policy and identifies barriers to more sweeping reform. It then applies to Medicare-for-All four health policy insights not known when “single-payer” reform was debated a generation ago: simultaneous inefficiency and injustice in medical care, neglect of the social determinants of health, inertia resulting from the legal architecture of health care, and the latent power of generational change. It concludes by explaining how applying a Medicare-for-All frame to post-pandemic health reform might prompt ethical re-engagement by the medical profession and help the health care system take specific steps on a path to improvement.

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TABLE OF CONTENTS

INTRODUCTION: ESCAPING MEDICARE’S GILDED AGE	71
I. SIX USEFUL MEANINGS OF “MEDICARE-FOR-ALL” (AND A CAUTIONARY ONE)	76
A. UNIVERSAL COVERAGE	76
1. MEDICARE ELIGIBILITY FOR ALL	76
2. MEDICARE ADVANTAGE FOR ALL	78
B. A STRONGER SAFETY NET	78
1. MEDICARE AS A “PUBLIC OPTION”	78
2. MEDICARE FOR MORE	80
C. CHANGING THE RULES	80
1. MEDICARE PRICING FOR ALL	80
2. MEDICARE (FEDERAL) REGULATIONS FOR ALL	81
D. MEDICARE FOR NONE: PREMIUM SUPPORT	82
II. PRINCIPLE OR PRAGMATISM: THE EBB AND FLOW OF “SINGLE-PAYER” HEALTH REFORM	83
A. NOTHING VENTURED: PRESIDENT CLINTON’S HEALTH SECURITY ACT	84
1. FISCAL POLITICS	86
2. RATIONING CARE	88
3. INTEREST GROUP GRIDLOCK	89
B. COMPROMISES AND DIALECTICS	90
C. THE POORLY RESTRAINED MARKET	92
D. THREADING THE NEEDLE: THE AFFORDABLE CARE ACT	96
III. RE-THINKING THE PROBLEMS WITH U.S. HEALTH CARE	99
A. FROM RATIONING TO IMPROVEMENT	100
B. SOCIAL DETERMINANTS AND UNJUST DISPARITIES	102
C. THE INERTIAL FORCE OF HEALTH LAW	106
D. GENERATIONAL CHANGE	111
IV. INNOVATING THROUGH MEDICARE-FOR-ALL	116

- A. REVISITING PROFESSIONAL ETHICS 116
- B. KEY STRUCTURAL GOALS FOR MEDICARE-LED INNOVATION 120
 - 1. IMPROVING COST DISCIPLINE..... 121
 - 2. REDUCING CLAIMS MIDDLEMEN..... 123
 - 3. DISINTERMEDIATING PHYSICIANS FROM MANY TRANSACTIONS 124
 - 4. MANAGING CONSOLIDATED PROVIDER MARKETS 125
 - 5. REINING IN DRUG COSTS BY RETHINKING INNOVATION FUNDING 126
 - 6. DE-MEDICALIZING SOCIAL PROBLEMS 127
- CONCLUSION 128**

INTRODUCTION: ESCAPING MEDICARE'S GILDED AGE

"The modern era of medicine began in the 1960s," opens a pre-pandemic commentary by Dr. Howard Bauchner, editor-in-chief of the *Journal of the American Medical Association (JAMA)*.¹ What the commentary fails to mention is that the "modern era" resulted mainly from one watershed event: the passage of Medicare in 1965.²

Medicare guaranteed government health insurance to elderly Americans and moved the country significantly closer to completing the New Deal's promise of a comprehensive social safety net.³ There were other, contemporaneous national biomedical initiatives, such as expansions of the National Institutes of Health (NIH) and the U.S. Food and Drug Administration (FDA). The simultaneous passage of Medicaid, along with support for community health centers and medical volunteerism through Great Society programming, also significantly boosted access to care for the poor. But only Medicare offered an assurance of operating revenue for nearly all health care providers and suppliers, with additional payments to boost capital investment and generous subsidies for the physician workforce—all with minimal controls beyond the ethical self-restraint of the American medical profession.

As the COVID-19 pandemic begins to recede, the United States finds itself in another "Medicare moment": an opportunity to combine principle with pragmatism in national health system design. What was denoted "single-payer" health reform in the 1990s is now called Medicare-for-All. Although "Medicare-for-All" admits a variety of meanings and interpretations,⁴ the essence of the idea is to convert health coverage in the United States from a patchwork largely associated with private employment into a universal, national insurance entitlement. Proponents of Medicare-for-All offer an idealistic, ambitious vision—describing health care as a right, not a privilege, and invoking by verbal association that mid-1960s moment in U.S. health policy when solidarity seemingly triumphed over division.⁵

1 Howard Bauchner, *Rationing of Health Care in the United States: An Inevitable Consequence of Increasing Health Care Costs*, 321 *JAMA* 751, 751-52 (2019). The author goes on to assert that an imminent "postmodern era of medicine" will generate even more dramatic yet expensive innovations in diagnosis and treatment. *Id.* at 751.

2 See Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965).

3 Theodore R. Marmor & Jerry L. Mashaw, *Understanding Social Insurance: Fairness, Affordability, and the 'Modernization' of Social Security and Medicare*, 25 *HEALTH AFF.* w114, w117 (2006).

4 See *infra* text accompanying notes 25-46.

5 A few Democratic candidates for president in 2020 endorsed Medicare-for-All in concept, and some offered moderately detailed plans. Medicare-for-All bills were introduced in the previous Congress, but never advanced through committee. See, e.g., Medicare for All Act of 2019, H.R. 1384,

Revisiting Medicare as a principled program is important. In many ways, post-Medicare American medicine is a Gilded Age, not a Golden Era. The conventional assertion of American medicine’s technological superiority tells only part of the story. The *JAMA* commentary offered above goes on to describe current forms of health care rationing as “linked to poverty, race, and ethnicity,” and connects those disparities to public neglect of the “social determinants of health.”⁶ Concluding that “[g]reater rationing of care is inevitable if health care costs continue to increase,” its author not only proclaims a right to health care and urges a more just distribution of medical advances, but he also calls for a public balancing of medical spending with investment in other social needs.⁷ Failing to do so “in the richest country in the world,” the *JAMA* editor-in-chief declares, “is a blight on the [U.S.] soul.”⁸

The clearest health policy lesson from the COVID-19 pandemic year is that there remains a gulf between the health care system we have and the health care system we thought we had. There is much to celebrate about America’s capacity to treat and prevent disease, as dramatic improvements in intensive care for COVID-induced respiratory failure and the rapid development and deployment of mRNA vaccines make clear. But the problems have become starker and harder to ignore, if still challenging to solve. Inadequate public health investment. Critical infrastructure funded mainly by revenue from elective procedures. Disparities that increase vulnerability in both exposure and prognosis arising from racism and injustice. Legal authorities straining for rationality in making care accessible and responsive. Cumulatively, we have learned that our much-vaunted health care system is unethical in both design and operation.

Medicare sent the United States down this path by writing a blank check for traditional medical transactions between one physician and one patient. We think

116th Cong. (2019); Medicare Buy-In and Health Care Stabilization Act of 2019, H.R. 1346, 116th Cong. (2019) (“To amend title XVIII of the Social Security Act to provide for an option for individuals who are ages 50 to 64 to buy into Medicare, to provide for health insurance market stabilization, and for other purposes.”); Medicare at 50 Act, S. 470, 116th Cong. (2019) (“A bill to amend title XVIII of the Social Security Act to provide for an option for any citizen or permanent resident of the United States age 50 to 64 to buy into Medicare.”).

Comprehensive “single-payer” plans have been pursued in several states as well, creating microcosms of potential federal reform. Erin Fuse Brown and Elizabeth McCuskey identify sixty-six single-payer bills introduced at the state level between 2010 and 2019, although only Vermont’s plan (later repealed) was enacted. See Erin C. Fuse Brown & Elizabeth Y. McCuskey, *Federalism, ERISA, and State Single-Payer Health Care*, 169 U. PA. L. REV. 389, 396-97 (2020). In addition, Massachusetts and Oregon have comprehensive multi-payer systems of coverage. See *id.* at 407, 423-28. Along with budgetary challenges, the preemptive effect of federal employee benefits law (Employee Retirement Income Security Act) constitutes a major barrier to state single-payer plans. *Id.* at 415-42.

⁶ Bauchner, *supra* note 1, at 751.

⁷ *Id.* at 752.

⁸ *Id.*

of Medicare as innovative because of the technical improvements it has funded over the years, and the vast medical-industrial complex it begat. In its original form, however, Medicare renounced innovation in physician practice and payment, becoming law only because it made itself unthreatening to the medical establishment.⁹ Over time, Medicare's structural straitjacket distorted health system growth and bred considerable deformity in public policy.¹⁰

As the critical congressional vote on Medicare approached in the summer of 1965, President Lyndon Johnson capitulated to the political demands of the American Medical Association (AMA), which at the time spoke for the great majority of American physicians. Johnson's advisors estimated a price tag of \$50 million a year for these concessions, beyond the previously projected cost.¹¹ The incremental cost of deferring to medical professional judgment on what should be funded and—at least originally—at what prices turned out to be orders of magnitudes larger. In 1975, the Medicare program cost federal taxpayers \$16.3 billion.¹² By 2018, Medicare cost taxpayers \$740.6 billion.¹³ From 1970 to 2016,

9 For an eyewitness account, see JOSEPH A. CALIFANO, *AMERICA'S HEALTH CARE REVOLUTION: WHO LIVES? WHO DIES? WHO PAYS?* (1986). In exchange for the American Medical Association (AMA) withdrawing its opposition to the program as "socialized medicine," the original Medicare legislation pledged non-interference with medical practice, paid customary fees, and replicated the familiar features of the private health insurance sector (which, at the time, was merely a passive conduit for provider payment). 42 U.S.C. § 1395, titled "Prohibition against any Federal interference," reads:

"Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person."

§ 1395.

10 Medicaid, by contrast, has had to be innovative in order to survive. Medicaid was paired with Medicare on the Johnson administration's legislative agenda not by progressive reformers, but by opponents of "socialized medicine" who thought that the public would not support social insurance to provide health care for the elderly if it were conditioned on also embracing medical welfare for the poor. For general analysis of Medicare and Medicaid politics, respectively, see LAURA KATZ OLSON, *THE POLITICS OF MEDICAID* (2014); and Bruce C. Vladeck, *The Political Economy of Medicare*, 18 *HEALTH AFF.* 22, 22-24 (1999). Threatened repeatedly with extinction in the decades since its enactment, Medicaid fought back and adapted, and now serves a larger population than Medicare at a lower annual cost. Medicaid, according to leading scholars, has become the truly "irreplaceable" federal health program. See Sara Rosenbaum & Elizabeth Taylor, *The Irreplaceable Program in an Era of Uncertainty*, 46 *J.L. MED. ETHICS* 883, 885 (2018).

11 CALIFANO, *supra* note 9, at 50-52.

12 BDS. OF TRS. OF THE FED. HOSP. INS. AND FED. SUPPLEMENTARY MED. INS. TR. FUNDS, 2019 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS 168 (2019).

13 *Id.*

total national health expenditures grew from 6.9% to 18% of Gross Domestic Product.¹⁴

Because of Medicare—plus Medicaid and tax subsidies for private health coverage—descriptions of America’s supposedly free market for health care as an international outlier in health policy tell a misleading story. Indeed, the United States stands alone among developed nations in lacking a true national health system. And, correspondingly, the United States spends far more private money per person on health care than any other nation. But the United States also typically spends more *public* money per person on health care than any other nation.¹⁵

Unlike Johnson’s landslide victory in 1964—which made the original Medicare legislation politically achievable—President Joe Biden took office in 2021 with razor-thin majorities in both houses of Congress. Biden was the only candidate in the 2020 presidential field to celebrate “Obamacare,” echoing the locker-room praise he had offered as Vice President when it was signed into law.¹⁶ Given the plausible link between Biden’s temperate positions and his narrow victory, it would be easy to criticize the progressive wing of the Democratic party as opening itself to accusations of confiscatory taxation and socialized medicine by endorsing Medicare-for-All while dismissing such a major legislative achievement in U.S. health policy as the Patient Protection and Affordable Care Act of 2010 (ACA).

This would be misguided. If anything, the outcome of the 2020 election gives Medicare-for-All heightened relevance as an analytical frame, beyond any utility it may have as a political rallying-cry. The conventional rhetoric of capitalism and socialism as opposing forces implies that highly efficient health care systems will be distributionally unfair, while equitable health care systems will be inefficient. This is a serious misreading of today’s policy moment, in which common causes place inefficiency and inequity side-by-side.¹⁷ The U.S. health care system has

14 *U.S. National Health Expenditure As Percent of GDP from 1960 to 2020*, STATISTA (June 8, 2020), <https://www.statista.com/statistics/184968/us-health-expenditure-as-percent-of-gdp-since-1960/>.

15 For specific comparisons among Organisation for Economic Cooperation and Development countries based on 2010 data, see *Health Care Spending Per Capita by Source of Funding, Adjusted by Cost of Living*, COMMONWEALTH FUND (2012), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_in_the_literature_2012_nov_pdf_2012_oecd_chartpack.pdf. Whether the United States is at the top in per capita public funding of health care, or just near the top, has varied in recent years.

16 John Bowden, *Biden Campaign Starts Selling ObamaCare ‘BFD’ Stickers*, HILL, (July 31, 2019), <https://thehill.com/homenews/campaign/455678-biden-campaign-starts-selling-obamacare-bfd-stickers>.

17 This is literally if accidentally illustrated by a PowerPoint slide commonly used in presentations regarding “health equity.” The slide shows an adult, teen, and child attempting to watch a baseball game over a solid fence, with one panel depicting an equal amount of assistance in the form of one wooden box for each to stand upon, which is excessive height for the adult and still

shown itself to be both grossly wasteful and profoundly unjust, with the COVID-19 pandemic experience inviting a serious ethical re-equilibration.

This Article's discussion of the transformative potential of Medicare-for-All proceeds as follows. Part I discusses how "Medicare-for-All" might be translated from a slogan to a program. Paired possibilities involve universal coverage, safety net reinforcement, and legal change. Part II describes the recent history of federal health reform, culminating in the passage of the Patient Protection and Affordable Care Act of 2010.¹⁸ This policy history distinguishes principled moments from pragmatic ones, and explains what "single-payer" approaches traditionally sought to accomplish and why they were disfavored – primarily contestable perceptions of cost and fears of rationing. The events this Article describes parallel my own professional journey in health law and policy.¹⁹ Part III outlines what researchers and policymakers have learned since the last "Medicare moment" in the early 1990s, when comprehensive federal reform failed. Concepts such as disparities, social determinants, non-medical investments, and value that are prominent in Dr. Bauchner's 2019 editorial but had been absent from earlier, similar ones.²⁰ Finally, Part IV discusses how a Medicare-for-All frame might take account of these new policy perspectives and promote critical improvements to U.S. health care. This Article's conclusion emphasizes ethical reengagement by physicians and other health professionals as essential to renegotiating the interplay of professional self-regulation, market processes, and the state, and therefore to defining a productive path forward.

I. SIX USEFUL MEANINGS OF "MEDICARE-FOR-ALL" (AND A CAUTIONARY

insufficient for the child. A second panel depicts no box for the adult, one for the teen, and two for the child, with all able to see. *See, e.g.*, Illustrating Equality VS Equity, INTERACTION INST. FOR SOC. CHANGE (Jan. 13, 2016), <http://interactioninstitute.org/illustrating-equality-vs-equity/>. The latter, equally costly but more effective approach is labeled "equity" in the graphic but is in fact efficiency. Also unaddressed in the graphic is why the three individuals, depicted as dark-skinned, must stand outside the ballpark at all.

¹⁸ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of the U.S.C.).

¹⁹ After completing a joint degree program in law and medicine and spending two years in graduate medical training and two years in corporate law practice, I had the opportunity to serve in the White House in early 1993, during the intense push to develop a national health reform proposal shortly after President Clinton took office. I returned briefly to California to resume health law practice and provide health policy advice to a gubernatorial candidate, then joined the faculty of Columbia Law School in 1995.

²⁰ *New England Journal of Medicine* editors-in-chief Arnold Relman and Jerome Kassirer, for example, had focused their attention on access to medical services and to health insurance coverage. *See, e.g.*, Jerome P. Kassirer, *Managing Care – Should We Adopt a New Ethic*, 339 *NEW ENG. J. MED.* 397 (1998); Arnold S. Relman, *The Trouble With Rationing*, 323 *NEW ENG. J. MED.* 911 (1990).

ONE)

At the risk of stating the obvious, one should not invoke a policy concept without defining it, and “Medicare-for-All” admits a diversity of possible interpretations. Accordingly, advocates for “Medicare-for-All” might adopt a range of policy approaches to operationalizing the phrase. Leaving partisan litmus tests aside—proving one’s progressive bona fides for Democrats, opposing socialism for Republicans—what forms might Medicare-for-All take, and what conditions might be conducive to a proposal that emphasizes each form?

This Section offers six possible ways to implement Medicare-for-All reform: two committing the United States to universal coverage, two strengthening the medical safety net through incremental coverage improvements, and two federalizing health care regulation without an explicit expansion of coverage. A seventh potential change to Medicare—offered by Medicare’s skeptics—is also described briefly.

A. *Universal Coverage*

1. *Medicare Eligibility for All*

The most straightforward interpretation of the phrase “Medicare-for-All” is that all Americans would be automatically enrolled in Medicare, whether or not those individuals are among today’s eligible population of (mainly) those age sixty-five and over.²¹ This would include persons currently covered by employment-based insurance, those purchasing individual coverage (most on ACA insurance exchanges), and those who remain uninsured notwithstanding the ACA—in each case on the same terms they would be covered by Medicare at age sixty-five today. All current Medicaid recipients would become “dually eligible” for Medicare, rather than only certain subgroups as is the case now. The newly Medicare eligible would choose, as do current Medicare beneficiaries, between traditional Medicare (Parts A and B, with providers paid by the government) and Medicare Advantage (MA) plans (Part C, with providers paid by managed care

21 A bill introduced in the previous Congress by Rep. Pramila Jayapal (D-WA) and Sen. Bernie Sanders (I-VT) came closest to taking this approach. See H.R. 1384, 116th Cong. (2019) (“To establish an improved Medicare for All national health insurance program”); S. 1129, 116th Cong. (2019) (“To establish a Medicare-for-all national health insurance program”). Neither exactly replicates Medicare’s financing and benefits structure. Both would significantly expand benefits to include Long-Term Services and Supports and other benefits more typical of Medicaid, and both would strictly limit beneficiaries’ out-of-pocket costs for covered services. Both plans also rely almost exclusively on fee-for-service Medicare, essentially eliminating today’s Part C governing MA plans. With respect to Part D, both of these proposals – as well as bills creating a partial expansion or public option – authorize the Secretary of Health and Human Services to negotiate prescription drug prices.

organizations in which beneficiaries enroll).²² New Medicare members would be eligible for outpatient drug coverage from private plans operating under Part D, and could access the established, highly regulated "Medigap" market for voluntary supplemental coverage.²³

Most Medicare financing would be borne by taxpayers, though the tax burden would be shared more broadly than in the current system as insurance coverage now paid from workers' earnings would be covered using tax dollars instead. Payroll-based income taxes would undoubtedly increase (as would equivalent taxes on non-wage income), but most compensation now paid by employers as untaxed insurance premiums likely would be retained by workers as taxable wages. States likely would remain financially responsible only for the Medicaid portion of the dually eligible, reducing their costs. Except for beneficiaries enrolled in MA plans, health care providers would be paid administered prices (i.e., Medicare-style reimbursement) for all patients in the form and amount they are currently paid for treating the elderly, although some physician specialties (e.g., pediatrics, obstetrics) would need to gain experience with Medicare.

Medicare-for-All payment would need to offer a fair return to health care providers, as the possibility for cross-subsidizing Medicare patients with funds from other payers would no longer exist (nor would private insurance be available to cross-subsidize Medicaid). Medicare's ongoing experiments with "alternative payment methods," such as accountable care organizations, bundled payments, and health homes, would adapt to the new enrollment.²⁴ Part D drug plans would serve a much larger population, with additional bargaining power to reduce prescription drug costs through market processes or using new authority conferred by government. The market for MA plans would grow substantially as well, with the potential for greater competition among them.

This outcome is unlikely during the Biden Administration given the President's preference for compromise, our polarized populace, and an evenly balanced Congress that would be unable to end a Senate filibuster and pass comprehensive legislation, even if recovering from the health and economic effects of the pandemic relaxed the expected fiscal constraints on entitlement legislation.

²² See PETER R. KONGSTVEDT, *ESSENTIALS OF MANAGED HEALTH CARE* 499-525 (6th ed. 2012) (explaining managed Medicare coverage).

²³ *What's Medicare Supplement Insurance (Medigap)?*, MEDICARE.GOV, <https://www.medicare.gov/supplements-other-insurance/whats-medicare-supplement-insurance-medigap> (last visited Aug. 1, 2021).

²⁴ See, e.g., Dawn E. Alley et al., *Accountable Health Communities—Addressing Social Needs through Medicare and Medicaid*, 374 *NEW ENG. J. MED.* 8 (2016) (describing demonstration and pilot programs to use Medicare and Medicaid funds for health-improving social services).

2. *Medicare Advantage for All*

A second possible meaning of Medicare-for-All would greatly simplify implementation and administration of an expanded Medicare program. The U.S. population not currently enrolled in Medicare would become eligible, but it would be required to enroll in MA plans where geographically available rather than in traditional, fee-for-service Medicare. This condition would not necessarily seem restrictive to new beneficiaries: most of the potential conversion population is already enrolled in employer-sponsored health plans that more closely resemble MA than traditional Medicare. Traditional Medicare would remain in place, but it would no longer be the dominant form of Medicare except perhaps in rural areas, and it would very likely fade in significance over time. Many health plans currently serving other market segments would pursue MA business (or, in large payer organizations, cede enrollment to that organization's MA product line). Individuals eligible for both Medicare and Medicaid would be served by health plans that comply with both programs' rules, as occurs today. Health care providers would negotiate with MA plans regarding network inclusion and fees, while continuing to provide residual service to fee-for-service Medicare beneficiaries. Taxpayer financing would replace premiums paid directly or through employers.

The presidential campaign proposal for universal coverage circulated by now-Vice President Kamala Harris made similar use of MA plans, enabling private insurers who currently offer employer-based and other coverage to convert those products into Medicare-regulated health insurance.²⁵ That proposal contemplated a ten-year transition to a system of universal, Medicare-based health plan coverage.²⁶ Still, this outcome remains unlikely during the Biden presidency: although it retains the structure of private insurance, it would still require a suspension or major relaxation of fiscal constraints on health care legislation.

B. *A Stronger Safety Net*

1. *Medicare as a "Public Option"*

"Medicare-for-All" need not denote immediate universalization of a Medicare entitlement. A more modest but still morally significant proposal would be to allow individuals not currently enrolled in Medicare to buy into the program as a "public option." This outcome is more likely given the political equipoise and impulse to moderation that seem to characterize the Biden presidency, as it could be

²⁵ See Alexandra Hutzler, *Kamala Harris Finally Unveils Her 2020 Health Care Plan but Experts Are Skeptical About How She'll Pay For It*, NEWSWEEK (July 30, 2019), <https://www.newsweek.com/kamala-harris-health-care-plan-2020-experts-skeptical-cost-1451633>.

²⁶ *Id.*

accommodated using current fiscal practices, including passage by a simple Senate majority through budget reconciliation. Following a playbook outlined by the Center for American Progress, President Biden supported a robust public option during his campaign, as did Secretary of Transportation Pete Buttigieg.²⁷

To minimize its fiscal demands, a public option could be limited to purchasers of individual coverage (whether or not on ACA insurance exchanges), while those receiving employer-sponsored coverage and Medicaid beneficiaries could be ineligible. Traditional Medicare would remain important because the public option might be most attractive in geographic areas where few ACA exchange plans operate. Pricing the buy-in premium for traditional Medicare might be challenging. MA plans and Medicaid managed care plans might compete with ACA exchange plans if the public option permitted Medicare buy-in through those health plans. Health care providers would continue to work with multiple payers with varying benefit packages and payment methods.

Various public option proposals have been described or introduced. Most, including the Biden and Buttigieg campaign proposals, make public coverage voluntarily available to all Americans, not just those currently in individual health insurance. In the last Congress, Rep. Rosa DeLauro (D-CT) authored the Medicare for America Act, a public option supported by presidential candidate Beto O'Rourke.²⁸ The Urban Institute has described a plan that emphasizes a "Medicare-style marketplace," including a public plan option.²⁹ Several other proposals have offered a limited public option, not directly linked to Medicare, in connection with ACA marketplace coverage.³⁰ In May 2019, Washington became the first state to enact a public option for its state ACA marketplace; Colorado has authorized the development of a similar plan.³¹

²⁷ *Medicare Extra for All: A Plan to Guarantee Universal Health Coverage in the United States*, CTR. FOR AM. PROGRESS (Feb. 22, 2018), <https://www.americanprogress.org/issues/healthcare/reports/2018/02/22/447095/medicare-extra-for-all/>. Mayor Buttigieg describes his plan as "Medicare for All Who Want It." Dan Merica & Tami Luhby, *Buttigieg Outlines Middle-of-the-Road Approach to Health Care in New Plan*, CNN (Sept. 19, 2019), <https://www.cnn.com/2019/09/19/politics/pete-buttigieg-health-care-plan/index.html>.

²⁸ H.R. 2452, 116th Cong. (2019).

²⁹ Linda J. Blumberg, John Holahan & Steven Zuckerman, *The Healthy America Program Building on the Best of Medicare and the Affordable Care Act*, URBAN INST. (May 14, 2018), <https://www.urban.org/research/publication/healthy-america-program>.

³⁰ These resemble the public option in an early version of the ACA. *See, e.g.*, S. 3, 116th Cong. (2019); S. 1261/H.R. 2463, 116th Cong. (2019); Medicare X Choice Act, S. 981/H.R. 2000, 116th Cong. (2019); H.R. 2085/S. 1033, 116th Cong. (2019).

³¹ *See* Austin Jenkins, *Will Washington State's New 'Public Option' Plan Reduce Health Care Costs?*, NPR: SHOTS (May 16, 2019), <https://www.npr.org/sections/health-shots/2019/05/16/723843559/will-washington-states-new-public-option-plan-reduce-health-care-costs>.

2. *Medicare for More*

In another incremental interpretation of Medicare-for-All principles, subsets of the population might be given either a Medicare entitlement or the opportunity to buy into Medicare (or Medicaid).³² Rather than segmenting the population by age, “Medicare-for-More” proposals might provide Medicare coverage in rural areas, or in health professional shortage areas generally, or to low-income individuals, to persons with particular conditions (as with end-stage renal disease now), or to states that agree to make particular financial commitments (as with Medicaid today).

A proposal of this sort might, for example, lower the eligibility age for Medicare to fifty-five or permit buy-in at that age. Buy-in proposals for Medicaid coverage are also possible, most likely through managed care plans.³³ Medicare (or Medicaid) standards would apply to more of the population, but most parts of the country and most health care providers would experience few changes.

C. *Changing the Rules*

1. *Medicare Pricing for All*

There is a lot more to Medicare than eligibility for coverage, a point that the current debate over Medicare-for-All seldom acknowledges. To the extent that the Biden Administration applies moral pressure to overcome the inertia bred of interest group influence, Medicare-for-All has the potential to change the health care system by altering the rules of payment and practice.

A proposal with potentially universal application but less ideological baggage would require (or enable) all buyers of health care to pay as Medicare would pay for all or some products or services. The pernicious effects of “payer mix”—that hospitals and physicians expect greater remuneration for treating privately insured patients than Medicare or Medicaid beneficiaries—was immediately evident in the initial surge of the COVID-19 pandemic. Patients’ fears of contracting COVID-

32 Two bills in the current Congress would expand Medicare to individuals age fifty and over: one introduced by Sen. Debbie Stabenow (D-MI), and one introduced by Rep. Brian Higgins (D-NY). At the federal level, a Medicaid buy-in bill has been introduced by Sen. Brian Schatz (D-HI) and Rep. Ben Ray Lujan (D-NM). Several state legislators have introduced bills to permit buy-in to Medicaid; the Nevada legislature passed such as bill in 2017, but it was vetoed by the governor. See Heather Howard, *Map: State Efforts to Develop Medicaid Buy-in Programs*, STATE HEALTH AND VALUE STRATEGIES (June 4, 2019), <https://www.shvs.org/state-efforts-to-develop-medicare-buy-in-programs/>; David Montero, *Nevada Governor Vetoes Medicaid-for-All Bill*, L.A. TIMES (June 17, 2017), <https://www.latimes.com/nation/la-na-nevada-medicare-2017-story.html>.

33 See Michelle Andrews, *Progressives Tout ‘Medicare-For-All’ But States Eye ‘Medicaid Buy-In’*, KAISER HEALTH NEWS (Feb. 26, 2019), <https://khn.org/news/progressives-tout-medicare-for-all-but-states-eye-medicare-buy-in/>.

19, followed by state-mandated moratoria on elective procedures to prevent spread and preserve scarce supplies, led to a precipitous drop in demand for privately financed medical care. The Medicare and Medicaid patients most likely to need intensive treatment for COVID-19, seniors and poorer individuals with greater occupational or residential exposure and pre-existing health problems, were significantly less lucrative and put many hospitals in financial jeopardy just when they were most needed.³⁴

In a payment-based interpretation of Medicare-for-All, provider or supplier prices not considered reasonable by Medicare, including high prices resulting from the exercise of market power, would be discouraged or reduced. Additional authority to negotiate or set prescription drug prices might be enacted. Uniform pricing would require standardized measurement, with attendant advantages (e.g., technical interoperability, reduction of conflict or duplication) and disadvantages (e.g., lock-in of particular delivery models or performance metrics). Cross-subsidization and “cost-shifting” among payers by hospitals and physicians would be more difficult to maintain. The effect of this change on privately negotiated health care is uncertain. As with the safety net proposals above, however, Medicare pricing for more rather than for all is possible as well, and could be targeted to specific market conditions, services, providers, or recipients.³⁵

No current federal proposal takes this approach to payment without also adopting a comprehensive single-payer plan, but some state-level public option plans peg provider payment to Medicare rates. The State of Washington public option plan on the ACA marketplace pays providers at 160% of Medicare rates; Colorado’s plans would be more broadly available and would pay at 175-225% of Medicare.³⁶

2. *Medicare (Federal) Regulations for All*

It is possible to interpret “Medicare-for-All” as reversing current preferences for federalism and state authority in favor of uniform federal rules. The ACA took this approach with respect to prohibiting medical underwriting and making other changes to the rules governing the individual insurance market (which previously was subject primarily to state oversight). The ACA also standardized insurance benefits, although in practice the “essential health benefits” required by the ACA

34 The adverse financial effects on hospitals of payer mix differentials may be long-lasting if job recovery is slow and significantly more patients remain on Medicaid after the pandemic recedes than were previously enrolled. Glenn Melnick & Susan Maerki, *The Financial Impact of COVID-19 on California Hospitals*, CAL. HEALTH CARE FOUND. REPORT (June 3, 2020), <https://www.chcf.org/publication/financial-impact-covid-19-california-hospitals/>.

35 See *infra* notes 200-204 and accompanying text.

36 Jenkins, *supra* note 31.

reflect state norms rather than a true national consensus.

Among the laws that could be made nationally uniform are professional licensing laws, laws conferring authority to write prescriptions, laws governing the “corporate practice of medicine,” health planning laws such as certificates of need, medical malpractice laws, telemedicine laws, and survey and certification practices for health facilities (many of which are already uniform because of the Joint Commission).³⁷ Patients, providers, and payers across the country would vary considerably in how they were affected by the nationalization of particular legal standards.

Again, the COVID-19 experience is instructive and adds to the appeal of this approach. Rapidly redeploying health professionals from lower-need to higher-need locations as infections spiked around the country was inhibited by protectionist state licensing laws and geographically limited processes for granting medical staff privileges at hospitals.³⁸ Provincial regulatory restrictions on populations, presentation, and payment hindered the expansion of telehealth services, as did scope of practice laws in limiting the ability of advanced practice nurses and others with demonstrably valuable skills to step up and serve to the full extent of their education and training. Although most states adopted emergency regulations to facilitate an effective pandemic response, there is already evidence of backsliding under pressure from interest groups. There is no federal constitutional obstacle to taking a more national approach to commerce in medical services, and it may well be time to do so as the nation emerges from the pandemic.

The Veterans Health Administration has adopted rules enabling its health care providers to treat patients across state lines without being limited by state laws on scope of practice or telemedicine.³⁹ Beyond addressing discrete problems such as “surprise medical bills,” however, no federal legislative proposal takes this approach at present.

D. Medicare for None: Premium Support

Although current Democratic control of Congress and the White House provides temporary inoculation against the possibility, no compendium of potential approaches to Medicare reform would be complete without noting the longstanding desire in some conservative circles to reduce the threat that Medicare poses to their preference for a smaller national government that maintains low

37 See *infra* notes 143-162 and accompanying text.

38 See, e.g., Donnie L. Bell & Mitchell H. Katz, *Modernize Medical Licensing, and Credentialing, Too—Lessons from the COVID-19 Pandemic*, 181 JAMA INTERNAL MED. 312, 312-15 (2021).

39 See Press Release, U.S. Dep’t of Veterans Affairs, Office of Public and Intergovernmental Affairs, VA Expands Telehealth by Allowing Health Care Providers to Treat Patients Across State Lines (May 11, 2018), <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=4054>.

taxes while avoiding fiscal catastrophe. Advocates for fiscal prudence, traditionally though not presently a hallmark of the Republican party, have long sought to shift the risk of continued increases in health care costs from the federal government by changing Medicare from a defined benefit to a defined contribution model. This is typically referred to as “premium support.”

Sherry Glied has observed that Medicare premium support proposals run exactly counter to economic logic: individuals are poorly positioned to bear the additional risk, the government is well-positioned to bear that risk, and the government has far greater ability than individuals to control and limit that risk.⁴⁰ Still, conservatives whose preoccupation with moral hazard originally motivated the “consumer-directed” health care movement,⁴¹ and who continue to endorse “high-deductible” private health plans and “block grants” as a replacement for the existing Medicaid entitlement, have never abandoned the idea of premium support in Medicare.

In the aggregate, these alternative formulations of Medicare-for-All reveal the phrase’s potential to capture a variety of values and pursue a number of goals beyond the assertion of an enforceable “right” to health care and the expression of mistrust in commercial purveyors of health insurance. Principles that might be advanced include greater social solidarity around health, diversified public investment in non-medical as well as medical services, non-discriminatory access and consistent administrative oversight from person to person and place to place throughout the nation, and respect for dignity and personhood associated with illness or incapacity. Unfortunately, many of these ideals have been caricatured or short-changed by a generation of health policy pragmatism, which the next section describes in detail.

II. PRINCIPLE OR PRAGMATISM: THE EBB AND FLOW OF “SINGLE-PAYER” HEALTH REFORM

The seemingly inexorable growth of U.S. health care spending from the 1970s onward constitutes a background condition for all post-Medicare federal reform efforts. As is often observed about the 1970s, the temporal proximity of adverse economic circumstances (oil shocks, recession, and inflation) to adverse political circumstances (Vietnam and Watergate) reduced confidence in government and limited its ambition.⁴² These pressures are evident in federal health policy.

Although Medicare’s direct effects on overall health care spending were not

⁴⁰ See Sherry A. Glied, *Financing Medicare Into the Future: Premium Support Fails the Risk-Bearing Test*, 37 HEALTH AFF. 1073, 1073 (2018).

⁴¹ See *infra* notes 95-97 and accompanying text.

⁴² See generally DAVID FRUM, *HOW WE GOT HERE: THE 1970S: THE DECADE THAT BROUGHT YOU MODERN LIFE (FOR BETTER OR WORSE)* (2000) (describing a decline of national ambition).

widely noted in the 1970s and 1980s, the uncapped financial exposure that Medicare created for taxpayers as those expenditures increased was a constant concern. As a country no longer at war turned against big government and the taxation that supported it, what had been understood as the social price of medical progress in the world's wealthiest nation came to be seen as a bottomless pit of potential public spending. Beginning with the Budget Control Act of 1974,⁴³ a series of disciplinary measures were adopted on a bipartisan basis to define and enforce fiscal prudence. Every substantial change in federal health policy from that point forward would either be motivated by cost reduction or have to justify (and typically offset) any costs it imposed. In health policy, principle would repeatedly yield to pragmatism.

A. Nothing Ventured: President Clinton's Health Security Act

The best example is the 1993-94 failure of national health reform, when centrist pragmatism won the policy battle but lost the political war. By 1990, Medicare expenditures were a known peril to the nation's fiscal health. The program had reconfigured its methods for paying both hospitals and physicians, but a broader reform called the Medicare Catastrophic Coverage Act (MCCA) had failed catastrophically, labelling Medicare the "third rail" of American politics.⁴⁴

As the Democrats reclaimed the White House in 1993 after twelve years of Republican control, it was widely expected that a single-payer plan for universal health coverage would follow. As previous Democratic administrations had passed Medicare and a National Health Planning Act, there appeared to be a public mandate for health reform, and the individual charged with leading the health reform effort—First Lady Hillary Clinton—was said to be sympathetic to liberal, big-government solutions for what was labeled "health insecurity."⁴⁵

What might a single-payer plan have achieved in 1993, had one been enacted? First, it very likely would have reduced the portion of U.S. health care spending that goes to administration rather than the delivery of care—a goal that Dr.

43 The Congressional Budget and Impoundment Control Act of 1974, Pub. L. No. 93-344, 88 Stat. 297 (codified as amended in scattered sections of 2 and 31 U.S.C.).

44 Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, 102 Stat. 683. The Medicare Catastrophic Coverage Act (MCCA) expanded Medicare's covered benefits to include prescription drugs and to reduce residual cost exposure for serious illness. Unlike conventional Medicare, however, the MCCA was financed by a tax on beneficiaries, which prompted a backlash and, ultimately, repeal of the law before it ever took effect.

45 The Clinton Administration's proposal was introduced in Congress as the "Health Security Act," mock "Health Security" cards were distributed to the public in order to build political support, and the tag line associated with the campaign was "Health care that is always there." See *Clinton's Health Plan; Transcript of President's Address to Congress on Health Care*, N.Y. TIMES (Sept. 23, 1993), <https://www.nytimes.com/1993/09/23/us/clinton-s-health-plan-transcript-president-s-address-congress-health-care.html>.

Bauchner, writing in 2019, still strongly endorses.⁴⁶ Leaving aside the critical question of how large the denominator for medical spending *should* be, Medicare disburses a much smaller fraction of its funds on administration than do multiple private insurers who must market their policies, pay commissions to brokers, determine eligibility, and (pre-ACA) price their policies based on risk of loss—tasks typically done annually in private markets and only somewhat simplified by offering group coverage through employers.⁴⁷

Second, a single-payer approach would have attached moral primacy to universal access to care, an expression of social solidarity that is uncontroversial abroad but seldom voiced in the United States. Third, it would have regularized the evaluation of new technologies, while potentially creating a closer connection between public funding of biomedical research and access to the resulting therapies.⁴⁸ Fourth, drawing together these strands, it would have created a collective defense of health care affordability that could function as a political counterweight to the self-interest of smaller but more motivated stakeholder groups.⁴⁹ In the United Kingdom, where health care spending remains roughly half that of the United States, citizens bind themselves collectively through the rules of the National Health Service to restrictions on high-cost care that they otherwise might resist as individuals if they became medical patients with specific desires regarding their own treatment.

When President Clinton instructed the leaders of his health care reform working group to explore options, however, single-payer reform was already off the table.⁵⁰ Instead, the favored strategy was declared to be “managed competition.” A structured system of constrained choice among private health

⁴⁶ Bauchner, *supra* note 1, at 752.

⁴⁷ According to the Kaiser Family Foundation, traditional Medicare’s cost of administration in 2018 was only 1.8% of program spending. Juliette Cubanski et al., *The Facts on Medicare Spending and Financing*, KAISER FAMILY FOUND. (Aug. 20, 2019), <https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/>.

⁴⁸ The federal Office of Technology Assessment (OTA) was established in 1977, when federal health planning and single-payer health reform were being actively considered by Congress, and was defunded in 1995, after the failure of the Clinton health reform effort. Although OTA assessed a wide range of technologies in order to improve governmental processes, its health care evaluations were among its most important and its most controversial. See *The OTA Legacy*, OFFICE OF TECHNOLOGY ASSESSMENT, <http://www.princeton.edu/~ota/> (last visited Aug. 1, 2021).

⁴⁹ See Lawrence R. Jacobs, *Politics of America’s Supply State: Health Reform and Technology*, 14 HEALTH AFF. 143, 143 (1995) (noting that, unlike nations with formal commitments to universal coverage, U.S. politics prioritize expanding the supply of health care products and services over assuring broad access to those benefits).

⁵⁰ I served as a “cluster leader” in the Clinton Administration’s health reform effort, with responsibility for groups of experts making recommendations regarding health care quality, information systems, medical malpractice liability, the health care workforce, and academic health centers. The anecdotes related in the section are personal recollections.

plans accessed through employers that would compete on price and quality rather than avoidance of risk, managed competition was a formulation associated with a small group of moderate economists and policy experts, several from California.⁵¹ One irony was that, in many respects, managed competition was similar to the never-introduced Nixon Administration's health plan, which had been drafted following the passage of the managed care-sympathetic Health Maintenance Organization Act of 1973.⁵² A second irony was that the Clinton Administration's "health czar," a quirky management consultant named Ira Magaziner who had been a Rhodes Scholar with the President, believed fervently that reducing administrative costs was the key to successful health reform.⁵³ This assumption, if warranted, argued for a single-payer approach; the complexities of managed competition necessitated more rather than less administrative investment. A third irony was that Medicare, a single-payer construct, would be preserved intact rather than restructured—the federal government's largest existing system of health insurance having been rendered politically untouchable by fear of triggering the same "gray panther" uprising that had brought down the MCCA only a few years earlier.⁵⁴

1. *Fiscal Politics*

What killed single-payer health reform in 1993? Several factors, all of which bridge health reform approaches but have special salience for systems of national insurance, including the Medicare-for-All proposals circulating in 2020. Foremost among these was what Lawrence Jacobs at the time called the "fiscalization of access," which has become such a formidable barrier to health system change that it is more accurately described today as the "tyranny of the budget."⁵⁵

In 1993, as the country began its fragile recovery from a mercifully brief recession, budgetary discipline had unusual public salience because it had been the

51 See Alain C. Enthoven, *The History and Principles of Managed Competition*, 12 HEALTH AFF. 24, 24, 46 (1993); see also Alain Enthoven & Richard Kronick, *A Consumer-Choice Health Plan for the 1990s*, 320 NEW ENG. J. MED. 29 (1989) (proposing a competitive health care system that would improve both accessibility and affordability).

52 See President Richard Nixon, President Richard Nixon's Special Message to the Congress: Proposing a Comprehensive Health Insurance Plan (Feb. 6, 1974) (transcript available at <https://www.nixonfoundation.org/2015/11/the-nixon-comprehensive-health-insurance-plan/>).

53 Magaziner repeatedly asserted that his work as a management consultant on nursing homes in Rhode Island had revealed profound inefficiencies associated with, in his phrasing, "checkers checking checkers."

54 See *supra* text accompanying note 48.

55 See Jacobs, *supra* note 49, at 149; see also William M. Sage, *No, the ACA Isn't Unconstitutional: Ends and Means in a Dysfunctional Democracy*, HEALTH AFF. BLOG (Dec. 19, 2018), https://www.healthaffairs.org/doi/10.1377/hblog20181219.912615/full/?fbclid=IwAR3PCLAqwDw6i94qWwkgXwGMuoHRjxeoVCTI_CVfaSb52812m2EWWdjky3E, (explaining why budgetary policy and politics have repeatedly subjected the ACA to litigation).

primary focus of Texas businessman Ross Perot in his third-party candidacy for president one year earlier. Given other budgetary needs, the Clinton Administration found itself having to demonstrate that insuring an additional 15% of the U.S. population without cutting Medicare would end up costing the government *less* money than it was already spending.⁵⁶ In factual terms, this was simply impossible, but the Administration's budgeting wizards did everything they could to situate their proposal favorably within the Congressional Budget Office's (CBO) arcane "scorekeeping" rules.⁵⁷

The need for a benign budgetary evaluation was an absolute bar to the Clintons pursuing a single-payer program.⁵⁸ CBO scoring remains a major consideration to this day: if one follows current fiscal accounting practices, converting private, employer-sponsored coverage into a Medicare benefit would constitute an immediate nearly \$1.5 trillion annual tax increase on the American people accompanied by a reciprocal annual increase in federal government expenditures, even though the money would start and end in the same places (individuals and their health plans) and be spent on the same thing (health insurance).⁵⁹

56 George Stephanopoulos (personal communication as a guest lecturer at Columbia Law School, May 1998).

57 "Health alliances" (previously called "health insurance purchasing cooperatives") were nonprofit bodies that would have structured regional health insurance markets, receiving contributions from employers and paying risk-adjusted premiums to the health plans in which beneficiaries had enrolled. "Global budgets" would have limited, as a matter of law, the aggregate amount that could be paid for the statutory package of health benefits, imposing various correctives that (if not revised by a subsequent Congress) would be triggered should the limits be exceeded. For insight into the role of the Congressional Budget Office, as well as its struggle to maintain impartiality, see Viveca Novak, *By the Numbers*, NAT'L J., Feb. 12, 1994, at 348.

58 See *Health Care Reform (Part 10): Joint Hearing Before the Subcomm. on Health and the Env't and the Subcomm. on Com., Consumer Prot. and Competitiveness of the H. Comm. on Energy and Com.*, 103d Cong. 10-13 (1994) (statement of Robert D. Reischauer, Director, CBO) (citing data that the limits placed on premiums and Medicare savings are sufficient to reduce national health expenditures by some \$30 billion below baseline levels by 2000 and \$150 billion below baseline levels by 2004, but also concluding that mandatory payments from private employers to health alliances constitute "an exercise of sovereign power" and therefore a tax).

59 Private health insurance premiums were over \$1.35 trillion in 2020. Sean P. Keenan et al., *National Health Expenditure Projections, 2019–28: Expected Rebound in Prices Drives Rising Spending Growth*, HEALTH AFF. Mar. 24, 2020, at 704-05 (2020). For a superb account of how fiscal politics drives health care policy, see Timothy Westmoreland, *Invisible Forces at Work: Health Legislation and the Budget Process*, in OXFORD HANDBOOK OF U.S. HEALTHCARE LAW 873 (I. Glenn Cohen et al. eds., 2016). In addition to the failed Health Security Act and the ACA's individual mandate, tobacco control, physician payment, and the ACA's Medicaid expansion were all largely the product of fiscal compromise.

2. Rationing Care

A second problem was the accusation of rationing.⁶⁰ Evaluating the health reform landscape in 1990, during a period of general economic uncertainty, the editor-in-chief of the *New England Journal of Medicine* observed: “Suddenly everyone is talking about rationing.”⁶¹ After weighing arguments for and against, however—including the “discomfort” of physicians—he concluded that “a public rationing plan would not be ethically or politically acceptable at this time,” and called for “improv[ing] the system rather than rationing its services.”⁶²

The possibility of improvement without rationing was not intuitive to the public, however. In 1993, commentators universally proclaimed American health care to be “the best in the world,” and any suggestion of centralized limits on access to new therapies was both frightening to voters and an admission of weakness for leaders. This was bipartisan: neither George H.W. Bush, when evaluating (and rejecting) a Medicaid waiver for a novel system that the state of Oregon proposed for prioritizing treatments according to cost-effectiveness,⁶³ nor Bill Clinton, when considering the direction of his comprehensive health reform effort, was willing to echo Jimmy Carter’s defeatism by becoming the first American president to concede the need to ration potentially life-saving medical care. Leading bioethicists invited to participate in the policy development phase of the Clinton reform, who imagined their role as helping craft an ethically defensible system of rationing, were unceremoniously informed that they were welcome to work on advance directives for end-of-life care, but that the “R-word” could not be uttered.⁶⁴

The more easily a health reform proposal can be portrayed as a “government takeover,” the more vulnerable it is to accusations of rationing.⁶⁵ Single-payer

60 For early, influential work on rationing health care, see GUIDO CALABRESI & PHILIP BOBBITT, *TRAGIC CHOICES* (1978); and VICTOR R. FUCHS, *WHO SHALL LIVE?: HEALTH, ECONOMICS, AND SOCIAL CHOICE* (1975).

61 Arnold S. Relman, *supra* note 20. Known to his friends as “Bud,” Dr. Relman was a passionate defender of Harvard-quality academic medicine, and a strident critic of the skewed incentives and casual profligacy he observed beyond the Longwood campus and its peer institutions.

62 *Id.* at 912.

63 For perceptive analyses of the Oregon Health Plan, see James F. Blumstein, *The Oregon Experiment: The Role of Cost-Benefit Analysis in the Allocation of Medicaid Funds*, 45 *SOC. SCI. & MED.* 545 (1997); and Jonathan Oberlander et al., *Rationing Medical Care: Rhetoric and Reality in the Oregon Health Plan*, 164 *CANADIAN MED. ASS’N J.* 1583 (2001).

64 See, e.g., NORMAN DANIELS & JAMES E. SABIN, *SETTING LIMITS FAIRLY: CAN WE LEARN TO SHARE MEDICAL RESOURCES?* (2002) (describing sources of ethical legitimacy that might be applied to rationing in connection with national health reform). Ethicists participating in the Clinton reform effort were also discouraged from using the word “right” in connection with health care, as that connoted a European-style single-payer system with its attendant fiscal-political risks.

65 See Frank Luntz, *The Language of Healthcare 2009: The 10 Rules for Stopping the “Washington Takeover” of Healthcare*, *THINKPROGRESS* 1 (2009), <http://thinkprogress.org/wp->

approaches are squarely in the crosshairs for these attacks. This remained true for the ACA during the Obama administration, when Alaska Governor Sarah Palin and other opponents of health reform cited the nascent law's supposed "death panels" as evidence of extreme social control.⁶⁶ These wholly unfounded allegations forced health reform proponents not only to defend a mild provision that would have permitted Medicare to reimburse end-of-life conversations between patients and their physicians as covered services,⁶⁷ but also to explicitly prohibit any application of newly funded (and much-needed) research regarding comparative clinical effectiveness to actual coverage determinations.⁶⁸

3. *Interest Group Gridlock*

The third problem was extreme risk aversion among organized interest groups. Fearmongering about "socialized medicine" had been an obstacle to a national health system in the United States since the 1940s, and it constituted the AMA's drumbeat against Medicare in the 1960s.⁶⁹ Those fears reinforced the Clinton Administration's budgetary preference for tax-subsidized private coverage rather than single-payer public insurance in 1993, but it was the overhang of the 1988 MCCA debacle that made the political climate even less hospitable to any dramatic

content/uploads/2009/05/frank-luntz-the-language-ofhealthcare- 20091.pdf (contending that "[n]othing else turns people against the government takeover of healthcare than the realistic expectation that it will result in delayed and potentially even denied treatment, procedures and/or medications").

66 See Jim Rutenberg & Jackie Calmes, *False "Death Panel" Rumor Has Some Familiar Roots*, N.Y. TIMES (Aug. 13, 2009), <https://www.nytimes.com/2009/08/14/health/policy/14panel.html> (linking conservative criticism of government "death panels" that would purportedly be created by enacting proposed health care reform to similar conservative attacks against Clinton's health care reform efforts in the 1990s).

67 See Benjamin W. Corn, *Ending End-of-Life Phobia—A Prescription for Enlightened Health Care Reform*, NEW ENG. J. MED., Dec. 31, 2009, at e63(1)-(2); Peter Ubel, *Why It Is So Difficult to Kill the Death Panel Myth*, FORBES (Jan. 9, 2013, 12:00 PM), <http://www.forbes.com/sites/peterubel/2013/01/09/why-it-is-so-difficult-to-kill-the-deathpanel-myth/>.

68 The ACA funds "patient-centered outcomes research," but eschews any use of that research to dictate health care financing decisions unless narrowly limited to clinical effectiveness. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6301(c), 124 Stat. 119, 740 (2010) ("The Secretary shall not use evidence or findings from comparative clinical effectiveness research conducted under section 1181 in determining coverage, reimbursement, or incentive programs under title XVIII in a manner that treats extending the life of an elderly, disabled, or terminally ill individual as of lower value than extending the life of an individual who is younger, nondisabled, or not terminally ill.").

69 Ronald Reagan, then best known as an actor, was hired by the AMA in 1961 to explain his opposition to Medicare on a 45-RPM record called "Ronald Reagan Speaks Out Against Socialized Medicine." Physicians' wives hosted social gatherings to listen to the LP and spread the word. See DAVID HYMAN, *MEDICARE MEETS MEPHISTOPHELES* 27-30 (2006).

reconceptualization of health care.

The MCCA had been negotiated within the Beltway by interest group staffers who regarded it as necessary and uncontroversial, and who were shocked when strident grassroots opposition among the elderly forced an immediate congressional retraction.⁷⁰ The result was a sharp decrease in risk-taking among stakeholder groups. Rather than offer concessions in backroom negotiations, many stakeholder organizations waited for direction from their grassroots membership, or went directly to the public to mobilize opposition and halt reform in its tracks. The “Harry and Louise” campaign by the Health Insurance Association of America to preserve “free choice of health insurer” was the best-known and most successful example.⁷¹

B. *Compromises and Dialectics*

From 1994 until the passage of the ACA in 2010, U.S. health reform legislation remained pragmatic. To put it more accurately, ideology hedged its bets. Repeatedly during this period, laws were enacted that included rival principles, with each side hoping that its assumptions would prove accurate, and its favored direction of reform would prevail.

The Clinton reform, though unsuccessful, offers a compelling example. With nary a Republican in sight, staffers at the Department of Health and Human Services pushed to include structures and safeguards familiar to them from Medicare, while advisors from beyond the Beltway, particularly California, argued for a more market-based scheme. Drawing concepts from both camps, the compromise framework for reform became “competition under a budget.” Although the Clinton Administration’s policy gurus tried mightily to rationalize the bifurcation,⁷² one group of internal advocates believed that competitive processes would maintain quality at affordable cost while the other assumed that

⁷⁰ *Id.* at 41-46.

⁷¹ See generally Raymond L. Goldstein et al., *Harry and Louise and Health Care Reform: Romancing Public Opinion*, 26 J. HEALTH POL., POL’Y & L. 1325 (2001) (analyzing the Health Insurance Association of America’s campaign against the Clinton Administration’s health care reform proposal). A White House Correspondents’ dinner video, with President Clinton playing “Harry” and the First Lady portraying “Louise,” offers a fitting response. Clintonlibrary42, *A Message from Harry & Louise*, YOUTUBE (May 10, 2012), https://www.youtube.com/watch?v=1-7A8d2wptI&ab_channel=clintonlibrary42.

⁷² See, e.g., Paul Starr & Walter A. Zelman, *A Bridge to Compromise: Competition Under a Budget*, 12 HEALTH AFF. 7 (Supp. 1993). Starr and Zelman, who were among the principal architects of the Clinton health plan, likened the dual approach to “belt and suspenders.” Once it became clear that CBO would credit a statutory budget cap as limiting the fiscal profligacy of health reform, global budgeting became a political necessity. To be fair, no nation had controlled health care spending through competitive processes no matter how appealing the theoretical case might be for a market-based approach.

budgetary limits would quickly be exceeded, triggering a single-payer substitute. This dialectic persisted throughout the policy development period and was retained in the final bill because an explicit “global budget”—whether or not realistic—carried with it the strong secondary advantage of assuring that the CBO’s estimate of the legislation’s cost would be capped at a politically manageable amount in a plan that otherwise depended mainly on private actors whose behavior was difficult for the CBO to assess.⁷³

Although it would take another fifteen years for comprehensive health reform to regain a place on the national political agenda, many of the changes that were enacted in the interim had a similar duality. In the Medicare Modernization Act of 2003, for example, a Republican administration and a Democratic Congress reached agreement on adding a Part D benefit for outpatient pharmaceuticals to the Medicare statute.⁷⁴ The Democrats drew public attention to the ends: a substantial new entitlement program that could be a step toward full universal coverage. The Republicans drew public attention to the means: competing private drug plans that could be a step toward full privatization of Medicare.⁷⁵ Apposition of principles also characterized the Health Insurance Portability and Accountability Act of 1996 (HIPAA).⁷⁶ The first health care legislation following the 1994 Republican sweep of both the House and Senate, HIPAA combined novel federal restrictions on health insurance underwriting (i.e., partially managed competition) with a federal charter for high-deductible insurance and health savings accounts. The latter approach advanced a wholly different principle: reducing rather than increasing health insurance coverage so as to combat “moral hazard” when generously insured individuals choose to utilize medical services.⁷⁷ The following year, the Balanced Budget Act of 1997 paired the preservation of Medicaid and fee-for-service Medicare, as well as restrictions on managed care (part of the national backlash described below), with an expanded and reinvigorated managed care

⁷³ See *supra* notes 55-59 and accompanying text.

⁷⁴ Medicare Prescription Drug, Improvement, and Modernization Act, Pub. L. No. 108-173, § 101, 117 Stat. 2066, 2071–2152 (2003) (setting forth Medicare prescription drug benefits).

⁷⁵ See generally Thomas R. Oliver et al., *A Political History of Medicare and Prescription Drug Coverage*, 82 MILBANK Q. 283 (2004) (explaining why Medicare omitted outpatient drug coverage until 2003).

⁷⁶ Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, § 264(c)(1), 110 Stat. 1936, 2033 (1996).

⁷⁷ An allegorical account of the theory of moral hazard in health insurance is presented in Gerald L. Musgrave et al., *Lunch Insurance*, CATO INST. (1992), <https://www.cato.org/sites/cato.org/files/serials/files/regulation/1992/10/reg15n4a.html> (postulating a “lunch system” with subsidies similar to the current health care system). For a contrary take, see John A. Nyman, *Is “Moral Hazard” Inefficient? The Policy Implications of a New Theory*, 23 HEALTH AFF. 194 (2004) (arguing that when an individual becomes seriously ill, that individual has no higher use for funds than to pay the cost of treatment).

program for Medicare.⁷⁸ Denominated Part C and named Medicare+Choice (later rebranded as Medicare Advantage), it changed Medicare managed care from a niche enterprise to a rapidly growing, partially privatized form of national health insurance for the elderly.⁷⁹

C. *The Poorly Restrained Market*

The Clinton Administration's centrist approach to health reform in the early 1990s marked a distinct turn toward market signals as the basis for federal health policy, extending both the Nixon Administration's belief in "good" HMOs such as Kaiser Permanente in California,⁸⁰ and the Reagan-Bush Administrations' savings-minded reconfiguration of Medicare payment incentives for hospitals and physicians, as well as their solicitude toward HMO participation and selective provider contracting in state Medicaid programs.⁸¹

Although "managed competition" was never synonymous with "managed care," it seemed sufficiently aligned with corporate incursion into the physician-patient relationship that fears over the latter were readily transferred to the former.⁸² Perhaps the most widely read condemnation of the Clinton Health Plan was an essay titled "No Exit," written by a well-connected conservative polemicist and minor academic who would later serve as the lieutenant governor of New

78 Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251.

79 According to the Kaiser Family Foundation, as of late 2018 approximately 20 million Americans were enrolled in Medicare Advantage plans, constituting 34% of total Medicare beneficiaries. See Gretchen Jacobson et al., *A Dozen Facts About Medicare Advantage*, KAISER FAM. FOUND. (Nov. 13, 2018), <https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage/>.

80 For a history of the Kaiser-Permanente organization, see RICKEY HENDRICKS, *A MODEL FOR NATIONAL HEALTH CARE: THE HISTORY OF KAISER PERMANENTE (HEALTH AND MEDICINE IN AMERICAN SOCIETY)* (1993).

81 According to the Medicaid and CHIP Payment and Access Commission (MACPAC), the principal federal advisory body on Medicaid and CHIP policy: "Section 1915(b) of the Social Security Act, enacted in 1981 as part of the Omnibus Budget Reconciliation Act (P.L. 97-35), provides states with the flexibility to modify their delivery systems by allowing CMS to waive statutory requirements for comparability, statewideness, and freedom of choice. States typically use two provisions in the law to implement managed care delivery systems." *1915(b) waivers*, MACPAC, <https://www.macpac.gov/subtopic/1915b-waivers/> (last visited Aug. 1, 2021).

82 "Managed care" has never been cleanly defined or popular as a term, but in the aftermath of debate over the Clinton plan and then its demise, it became shorthand for private sector efforts to reduce health insurance costs, mainly in the employment-based health plans that cover a plurality of Americans but also by serving Medicaid and, more slowly, Medicare beneficiaries. There were three principal tools of managed care: (i) pre-approval of coverage through "utilization review" of high-cost services and through "primary care gatekeeping" of access to specialists likely to provide those services; (ii) selective contracting with hospitals and physicians, which permitted per-service price negotiation with the promise of patient volume (and under the threat of exclusion); and (iii) financial incentives such as capitation payments or percentage "withholds" from aggregate fees to induce physician cost-consciousness in clinical recommendations.

York.⁸³ Most of the accusations it hurled at the Administration's proposal—some foreshadowing the ACA's apocryphal "death panels"—were really about the aggressiveness of private managed care, not overreach by government.

Similar objections were raised to "enterprise liability" for medical malpractice, an academic construct that the Clinton Administration unexpectedly cast into the national spotlight as an operational proposal.⁸⁴ The core idea was that, in order to maintain incentives for quality and safety, liability in the event of negligent injury should fall not on individual physicians, but on the health plans that were no longer to be merely passive funders of care.⁸⁵ At a time when doctors hated and feared malpractice suits with unrivaled intensity, one might think the proposal would have triggered a celebration within organized medicine. Not so. Physicians recoiled at the thought of HMOs as defendants in malpractice suits—seeing in the transfer of legal accountability a harbinger of physicians' loss of control over clinical decisions.⁸⁶ One physician leader went so far as to proclaim his "constitutional right to be sued!"⁸⁷

The Clinton reform effort collapsed, however, and when the dust cleared private managed care had a much freer rein than would have been the case under the detailed regulatory safeguards necessary for managed competition. Employers embraced HMOs to combat double-digit annual percentage increases in insurance premiums, sleepy Blue Cross and Blue Shield (BCBS) plans converted to aggressive for-profit enterprises, and a dizzying set of acronyms (EPO, PPO, IPA, POS) and associated restrictions on patient choice emerged in parts of the country that had known only fee-for-service medicine.⁸⁸ The public—already on edge—

⁸³ Elizabeth McCaughey, *No Exit*, NEW REPUBLIC (Feb. 7, 1994), <https://newrepublic.com/article/69935/no-exit> (equating rationing under the Clinton reform with private managed care).

⁸⁴ See Robert Pear, *Clinton Advisors Outline Big Shift for Malpractice*, N.Y. TIMES, May 21, 1993, at A1.

⁸⁵ See Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 415-19 (1994); William M. Sage et al., *Enterprise Liability for Medical Malpractice and Health Care Quality Improvement*, 20 AM. J.L. & MED. 1, 162-66 (1994).

⁸⁶ See *The Sinking of Enterprise Liability*, AM. MED. NEWS, July 5, 1993, at 17; cf. Arnold S. Relman, *Medical Practice Under the Clinton Reforms—Avoiding Domination By Business*, 329 NEW ENG. J. MED. 1574, 1575-76 (1993) (expressing concern about combining clinical with cost management in large organizations).

⁸⁷ This information comes from a contemporaneous conversation with Dr. Robert A. Berenson, who had been assigned the duty of explaining the Clinton malpractice proposal at a 1993 meeting of the Physician Insurers Association of America (now called the Medical Professional Liability Association). This Alice-in-Wonderland rights discourse was presumably based on the old management axiom "no responsibility without control." At the same time, of course, the managed care industry protested against enterprise liability on the ground that it could *not* control physicians' behavior.

⁸⁸ See Jonathan P. Weiner & Gregory de Lissovoy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. HEALTH POL., POL'Y & L. 75, 83 (1993) (offering

reacted with alarm. Urged on by organized medicine and the hospital industry, politicians at both the state and federal levels passed “patient protection acts” that swung the balance of negotiating power back toward health care providers.⁸⁹ This fierce backlash against managed care was not seriously challenged by large employers, who feared losing valuable workers during a widening economic boom.⁹⁰

The result was the emasculation of payers and the re-empowerment of health care providers in local markets across the country.⁹¹ Without changing their behavior at all, hospitals and physicians were transformed in the public’s imagination into heroic bulwarks against the predations of managed care. Courts, which (like physicians) tend to focus on the individual case more than the aggregate policy, were swept along by the same narrative.⁹² Federal antitrust enforcers lost seven consecutive challenges to hospital mergers, an unprecedented rejection of competitive processes.⁹³ Hospitals that had begun to consolidate

a taxonomy of managed care organizations).

89 See David A. Hyman, *Regulating Managed Care: What’s Wrong with a Patient Bill of Rights*, 73 S. CAL. L. REV. 221, 223 (2000).

90 See Robert J. Blendon et al., *Understanding the Managed Care Backlash*, 17 HEALTH AFF. 80, 94 (1998) (examining the depth and breadth of the public backlash against managed care and the underlying causes).

91 Why even large private employers – including America’s most powerful and innovative companies – have been such ineffectual health care purchasers is an enduring mystery. See David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL’Y, L. & ETHICS 23, 26-30 (2001). Some contributing factors are fairly obvious: government subsidy through non-taxability of coverage offered as a fringe benefit, competition for upper-echelon workers given legal prohibitions on benefits-related discrimination, insulation of human resources departments from senior financial management, and general reluctance among high-profile companies to being seen as intruding on access to care. But these companies, which self-insure their benefit costs, seem unable to obtain fair, transparent pricing from the insurance companies they pay generously to negotiate on their behalf with providers.

92 The battle among insurers, policymakers, and courts over coverage of high-dose chemotherapy with autologous bone marrow transplantation (HDC-ABMT) for advanced breast cancer is archetypal of this period in health policy. HDC-ABMT was promoted as lifesaving by prominent cancer centers without proof of benefit, and insurers’ efforts to deny coverage as experimental were reversed by courts and even some legislatures. When research studies were finally performed, the treatment was found to be both useless and harmful. See Michelle M. Mello & Troyen A. Brennan, *The Controversy over High-Dose Chemotherapy with Autologous Bone Marrow Transplantation for Breast Cancer*, 20 HEALTH AFF. 101, 101-02 (2001).

93 See *FTC v. Tenet Healthcare Corp.*, 186 F.3d 1045 (8th Cir. 1999) (FTC and state of Missouri unsuccessfully sought to enjoin merger of two hospitals); *California v. Sutter Health Sys.*, 84 F. Supp. 2d 1057 (N.D. Cal. 2000), *aff’d*, 217 F.3d 846 (9th Cir. 2000) (state of California unsuccessfully brought suit against two hospitals, claiming that proposed merger would have anticompetitive effect); *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121 (E.D.N.Y. 1997) (government unsuccessfully sought to enjoin merger of two not-for-profit “anchor hospitals”); *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285 (W.D. Mich. 1996) (FTC unsuccessfully sought preliminary injunction to prevent merger of two hospitals); *United States v. Mercy Health Servs.*, 902 F. Supp. 968 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632 (8th Cir. 1997) (government

mainly to reduce excess capacity and achieve economies of scale suddenly found themselves with nearly unlimited pricing power.⁹⁴

Faced with rising health insurance premiums but unwilling to risk their recent political gains by revisiting managed care, conservative policymakers instead embraced health savings accounts and other “consumer-directed” care models that blamed costs on wastefulness by fully insured consumers (i.e., moral hazard)—a framing not unlike the dependency and fraud narrative the same policymakers applied to welfare recipients.⁹⁵ However, shifting substantial financial responsibility to consumers through high-deductible coverage, but not really assessing the functionality of the markets in which self-funded care was purchased, served mainly to conceal continued cost growth by taking it out of the visible premium.⁹⁶ Similar dynamics affected markets for prescription drugs, medical devices, and biologics, with seemingly competitive improvements such as rebates negotiated by prescription benefit management companies ultimately being co-opted by existing stakeholders to augment rather than reduce their financial returns.⁹⁷

unsuccessfully brought antitrust action against two hospitals to enjoin proposed merger); *FTC v. Freeman Hosp.*, 911 F. Supp. 1213 (W.D. Mo. 1995), *aff'd*, 69 F.3d 260 (8th Cir. 1995) (FTC unsuccessfully filed motion for preliminary injunction seeking to prohibit consolidation of hospitals pending resolution of administrative proceedings as to legality of consolidation); *FTC v. Hosp. Bd. of*

Dir. of Lee County, No. 94–137–CIV–FTM–25D, 1994 U.S. Dist. LEXIS 19770 (M.D. Fla. May 16, 1994), *aff'd*, 38 F.3d 1184 (11th Cir. 1994) (FTC unsuccessfully filed complaint to prevent county hospital board’s proposed purchase of private hospital in county, alleging that purchase would be anticompetitive in violation of Clayton Act).

94 Research on hospital consolidation was collected and analyzed by a Robert Wood Johnson Foundation initiative called the Synthesis Project, which published a report in 2006 and an update in 2012. See WILLIAM B. VOGT & ROBERT TOWN, ROBERT WOOD JOHNSON FOUND., *HOW HAS HOSPITAL CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HOSPITAL CARE?* 11–12 (2006); MARTIN GAYNOR & ROBERT TOWN, ROBERT WOOD JOHNSON FOUND., *THE IMPACT OF HOSPITAL CONSOLIDATION—UPDATE 2* (2012). The Synthesis Project concluded that less competitive hospital markets have higher prices and may have lower quality. Moreover, both nonprofit and for-profit hospitals acquired and exercised market power to the detriment of consumers.

95 See Phil Gramm, *Why We Need Medical Savings Accounts*, 330 *NEW ENG. J. MED.* 1752, 1752–53 (1994) (claiming that waste in health care is primarily attributable spending “other people’s money” at the point of service); see also James C. Robinson, *Consumer-Directed Health Insurance: The Next Generation*, 24 *HEALTH AFF. WEB EXCLUSIVE* W5-583 (2005) (interviewing then-Aetna CEO Jack Rowe, MD, about high cost-sharing models of coverage), https://www.healthaffairs.org/doi/10.1377/hlthaff.w5.583?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%20pubmed.

96 See Sherry A. Glied & Benjamin Zhu, *Catastrophic Out-of-Pocket Spending: A Problem Mainly for Middle-Income Americans with Employer Coverage*, COMMONWEALTH FUND (Apr. 17, 2020), <https://www.commonwealthfund.org/publications/issue-briefs/2020/apr/catastrophic-out-of-pocket-costs-problem-middle-income>.

97 See NAT’L ACADS. OF SCI., ENG’G, AND MED., *MAKING MEDICINES AFFORDABLE: A*

This poorly restrained market lasted until the Great Recession of 2007-08, which ended what one might describe as a “lost decade” in U.S. health policy. What had begun as inadequate restraint of managed care ended as inadequate restraint of an increasingly consolidated, profit-oriented, and costly health care delivery system in which private interests massively benefited from public subsidies and regulatory protection. Buyers had retreated; sellers again were in charge. Health insurers, which also had consolidated over the course of the decade, refrained from managing care lest consumers recoil, and focused on claims processing and provider network administration. This was possible because few insurers bore significant financial risk—instead passing care costs along to self-insured employers and government programs while skimming off as profit a comfortable percentage of the enormous revenues flowing through the system.⁹⁸ Calls for comprehensive national health insurance were rare, “single-payer” advocates marginalized. Although the market rhetoric of incentives, transparency, and “skin in the game” had become pervasive, actual market discipline in the U.S. health care system was seldom to be found.

D. *Threading the Needle: The Affordable Care Act*

Although the ACA is often portrayed as a radical reform, it also fits the pattern of subordinating principle to pragmatism. A highly significant piece of social legislation with ambitions to simultaneously improve health insurance, health care service delivery, and population health, the ACA nonetheless represents a cautious, incremental approach to coverage expansion.⁹⁹ Even so, that it achieved passage is nothing short of miraculous.

The ACA reinvigorated a nearly moribund market for individual (as opposed to group) health insurance, expanded Medicaid coverage, and built infrastructure within Medicare to pursue improvements to both provider payment and health care

NATIONAL IMPERATIVE 89-95 (2018) (describing pharmaceutical product promotion and distribution). The corruption of medical ethics associated with these phenomena did not go unnoticed by traditionalists within the medical profession. See, e.g., JEROME P. KASSIRER, *ON THE TAKE: HOW MEDICINE’S COMPLICITY WITH BIG BUSINESS CAN ENDANGER YOUR HEALTH* (2004) (criticizing the profit incentives in health care).

⁹⁸ See, e.g., Scott Allen & Marcella Bombardieri, *A Handshake that Made Healthcare History*, BOS. GLOBE (Dec. 28, 2008), <https://www.bostonglobe.com/specials/2008/12/28/handshake-that-made-healthcare-history/QiWbywqb8oJJsA3IZ11o1H/story.html> (describing the decision by Blue Cross Blue Shield of Massachusetts to pay very high prices to Partners Healthcare). Insurer-provider “cahoots” from the late 1990s onwards recalls the origins of Blue Cross and Blue Shield plans as provider-controlled organizations, and is at odds with the image of hard-hearted managed care companies compromising quality or access by strong-arming physicians and hospitals. See, e.g., *W. Pa. Allegheny Health Sys., Inc. v. UPMC*, 627 F.3d 85, 91–92 (3d Cir. 2010) (describing insurer-provider cooperation in Pennsylvania).

⁹⁹ See William Sage, *Putting Insurance Reform in the ACA’s Rear-View Mirror*, 51 HOUS. L. REV. 1082, 1100-11 (2014).

delivery.¹⁰⁰ Unfortunately, as Dr. Arnold Relman's 1990 essay foreshadowed,¹⁰¹ it left significant conceptual gaps and ambiguities with respect to the relationships between health care and health, and between health and citizenship.

As in 1993, the necessary compromises involved fiscal palatability, stakeholder appeasement, and renunciation of rationing.¹⁰² Again, fiscal maneuvering had the greatest immediacy, as members of Congress seldom will vote to raise taxes or substantially increase the deficit, effects that federal budgetary procedures make all too visible. In that respect, the global financial crisis was a necessary precursor to health reform. Even with a newly elected Democratic president and Democratic control of both House and Senate, there would have been no ACA had the economy not been sufficiently threatened to justify federal stimulus spending (nearly \$150 billion of which was spent directly on health). Between 1993 and the present, the only other time that an investment in universal coverage seemed possible was briefly in 2000 when the "dot-com bubble" burst but CBO's projected budget surpluses had not yet been revised

100 With respect to private insurance, the ACA mandates the establishment of public health insurance exchanges across the country to broker coverage for individuals and small employers. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1311, 124 Stat. 119, 173 (2010). Insurers participating in these exchanges operate under very different rules from traditional health plans, including offering standardized benefits and complying with a blanket prohibition on medical underwriting. *Id.* § 1201 (prohibiting underwriting based on preexisting conditions); *id.* § 1302 (outlining essential health benefits). The ACA also creates significant incentives to create or expand "private exchanges" not limited to a single employer, which are subject to slightly different rules. *Id.* §§ 1311-12. Among the ACA's reforms intended to improve health care services, many of which operate through the Center for Medicare and Medicaid Services (CMS), are the following: i) Essential Health Benefits Requirements, *id.* § 1302; (ii) zero cost sharing for U.S. Preventive Services Task Force A- or B-rated services, *id.* § 4003; (iii) the Patient-Centered Outcomes Research Institute (PCORI) (comparative effectiveness research), *id.* § 6301; (iv) the Independent Payment Advisory Board [later repealed], *id.* §§ 3403, 10320; (v) Accountable Care Organizations (Medicare Shared Savings Program), *id.* § 3022, (vi) Patient-Centered Health Homes (Medicaid), *id.* § 2703; (vii) bundled (episodic) payment pilot program for acute and post-acute care, *id.* § 3023; (viii) the Center for Medicare and Medicaid Innovation (CMI) to test new, budget-neutral models for care delivery and provider payment, *id.* § 3141, (ix) the hospital value-based purchasing program (Medicare pay-for-performance), *id.* § 10326, (x) an expanded Medicare hospital quality reporting system, *id.* § 3001; (xi) an expanded Medicare physician quality reporting system, *id.* § 3002; and (xii) the Independence at Home Demonstration Program to avoid hospitalization (Medicare), *id.* § 3024.

101 Relman, *supra* note 20.

102 Proposals based on managed competition are less threatening than single-payer reforms to health insurers as an organized interest. Indeed, health insurers saw the ACA's expansion of both private coverage and Medicaid managed care as a source of new business, a dynamic that might be repeated in a Medicare-for-All system based on Medicare Advantage plans. More generally, the Obama Administration followed the political playbook devised by "Romneycare" proponents in Massachusetts, with at least some sacrifice from each stakeholder group. See Christie L. Hager, *Massachusetts Health Reform: A Social Compact and a Bold Experiment*, 55 U. KAN. L. REV. 1313, 1313-29 (2007) (providing an insider's summary of and context for the Massachusetts health reform law).

downward—creating the unusual situation in which the public felt poor enough to want “health security” and the government was rich enough on paper to fund it.

Still, the Obama Administration followed the managed competition playbook rather than making an ideologically explicit commitment to universal public coverage. By building on the prevailing system of private health insurance, the ACA not only made itself as unthreatening as possible to existing stakeholders but also sidestepped the apparent, if basically illusory, budgetary cataclysm noted above that single-payer reform would trigger.¹⁰³

The Obama Administration’s decision to rely primarily on an individual mandate, rather than requiring private employers to provide coverage, was also made with budget scoring foremost in mind. Far more Americans receive health insurance through employment than purchase it individually. Even at maximum capacity, the Obamacare “marketplaces” for individual insurance purchases (so-named to project a private, voluntary character) would operate at the margins of private health coverage, which would limit their adverse fiscal impact even if the CBO were to consider them “on-budget.” By contrast, putting employers at the center of government-regulated exchanges would have risked a much larger flow of annual funds being characterized by the CBO as a tax—a finding that had driven the final nail into the coffin of the Clinton Administration’s reform plan two decades earlier.¹⁰⁴

There was a downside to the ACA’s incrementalism and fiscal prudence. Even so limited, mandating the private purchase of insurance, obligating private insurers to cover contraception, establishing state-based marketplaces, and changing Medicaid into a nationally uniform entitlement for the poor and near-poor (with some of the cost forced on the states) all proved toxic in the prevailing, hyper-partisan political environment.¹⁰⁵ Many of the parties affected by these provisions took their grievances to court, and because of the ACA’s convoluted design had legal standing to do so.¹⁰⁶ In other words, the ACA’s drafters accepted litigation risk in exchange for fiscal palatability. It has proved a steep price to pay.

Moreover, by adopting managed competition as its framework, the ACA

103 William M. Sage & Timothy M. Westmoreland, *Following the Money: The ACA’s Fiscal-Political Economy and Lessons for Future Health Care Reform*, 48 J.L. MED. ETHICS 434, 434 (2020); see also *supra* notes 55-59 and accompanying text.

104 See Novak, *supra* note 57.

105 See generally Sage & Westmoreland, *supra* note 103 (explaining the fiscal implications of each of these sources of political controversy).

106 See *id.* at 440-41 (discussing the *California v. Texas*, No. 19-840, slip op. (June 17, 2021), litigation, which at the time had yet to be scheduled for oral argument); see also Abbe R. Gluck, *Imperfect Statutes, Imperfect Courts: Understanding Congress’s Plan in the Era of Unorthodox Lawmaking*, 129 HARV. L. REV. 62 (2015) (analyzing the Supreme Court’s decision in *King v. Burwell*, 576 U.S. 473 (2015)). In 2021, the Supreme Court dismissed the *Texas v. United States* litigation for lack of standing. *California v. Texas*, No. 19-840, slip op. 1 (June 17, 2021).

asserted at most a consumerist vision of national health reform. As President Obama declared in celebration of his signature reform surviving a major court challenge in 2015:

And unlike Social Security or Medicare, a lot of Americans still don't know what Obamacare is beyond all the political noise in Washington. Across the country, there remain people who are directly benefitting from the law but don't even know it. And that's okay. There's no card that says "Obamacare" when you enroll. But that's by design, for this has never been a government takeover of health care, despite cries to the contrary. This reform remains what it's always been: a set of fairer rules and tougher protections that have made health care in America more affordable, more attainable, and more about you—the consumer, the American people.¹⁰⁷

Put simply, President Obama did not demand social solidarity around health or health care, and none emerged organically. The ACA regarded the citizen as coterminous with the consumer. There was no aspiration to "Americare."¹⁰⁸

III. RE-THINKING THE PROBLEMS WITH U.S. HEALTH CARE

As interest in some form of Medicare-for-All builds on the political left, a question presents itself: What do we know now about improving the U.S. health care system that we did not know when single-payer proposals were last debated a generation ago? In fact, quite a lot. Four insights seem relevant to the evaluation of any new health policy proposal. The first two constitute a revised health policy consensus that is supported by extensive research and analysis, and confirm the core ethical challenge of simultaneous wastefulness and injustice in the existing

107 President Barack Obama, Remarks in the Rose Garden of the White House on the Supreme Court's Decision in *King v. Burwell* (June 25, 2015). The occasion was to celebrate the Court's 6-3 ruling that insurance exchanges operated by the federal government as well as those operated by state governments were eligible for tax subsidies under the ACA. *King v. Burwell*, 135 S. Ct. 2480 (2015).

108 It is only occasionally noted that the Obama Administration made virtually no attempt to associate the ACA with patriotism, democracy, or collective self-interest. See William M. Sage, *Brand New Law! The Need to Market Health Care Reform*, 159 U. PA. L. REV. 2121, 2138-46 (2011) (proposing a social marketing campaign for the ACA); William M. Sage, *Solidarity*, in *CONNECTING AMERICAN VALUES WITH AMERICAN HEALTH CARE REFORM* 10, 11 (Thomas H. Murray & Mary Crowley eds., 2009); William M. Sage, *Why the Affordable Care Act Needs a Better Name: "Americare,"* 29 HEALTH AFF. 1496, 1496-97 (2010). To be fair, Medicare itself appears to have been named fortuitously rather than strategically. See PETER A. CORNING, *THE EVOLUTION OF MEDICARE: FROM IDEA TO LAW* 75 n.3 (1969) (explaining that "Medicare" was "coined by some unknown newspaper headline writer").

health care system. The pair that follows—emphasizing structural and generational change—is less often discussed but, in my view, equally compelling. The COVID-19 pandemic experience has only enhanced these insights.

Developments in understanding are critical considerations not only for single-payer advocates, but also for proponents of other health reform models such as managed competition and consumer-directed care. Because facts should matter to policymaking whatever one’s principles, it is important to revisit from time to time the assumptions underlying even well-established health policy “brands.” This rather obvious point is often missed in health reform debates, where labels routinely outlast the conditions that created them, counterexamples drawn from emotionally compelling anecdotes are used to refute clearly demonstrable aggregate trends, and interest groups are assigned positions that long outlive the people who initially asserted them.

A. *From Rationing to Improvement*

Universal health insurance is controversial in the United States in large part because it seems to invite rationing of necessary care.¹⁰⁹ Conventional wisdom in the 1980s and 1990s, after Medicare’s inflationary effects had become apparent, was that advances in medical technology would continually and inexorably push costs even higher.¹¹⁰ Although reducing “waste, fraud, and abuse” was admittedly desirable, experts agreed that any one-time savings would do little to alter the long-term upward trend.

Health policy in the United States is typically taught as a “three-legged stool,” with the legs representing access to medical care, quality of care, and cost. Inherent in the “chair” metaphor is the idea that the legs must be of roughly equal length to keep the system in balance. As costs rose, the uncomfortable implication of this analytic frame was that any effort to expand access would necessarily require a reduction in quality – almost certainly by denying individuals potentially lifesaving but very expensive treatment. Dr. William Kissick captured this belief in a 1994 book titled *Medicine’s Dilemmas: Infinite Needs Versus Finite Resources*: “No society in the world,” he wrote, “has ever been—or will ever be—able to afford providing all the health services its population is capable of utilizing.”¹¹¹

Technology as a driver of health spending remains a critical consideration in a few domains, such as biopharmaceuticals, and generates important tensions between futurists and skeptics in a few others, such as “precision” or

109 See *supra* notes 59-67 and accompanying text.

110 See, e.g., SHERRY GLIED, *WHY HEALTH REFORM FAILS* (1997).

111 WILLIAM KISSICK, *MEDICINE’S DILEMMAS: INFINITE NEEDS VERSUS FINITE RESOURCES* 48 (1994).

“personalized” medicine powered by genetic sequencing and cellular targeting.¹¹² At the macro level, however, a new three-part framework arguably has superseded “cost, access, and quality” in health policy analysis. It is called the “Triple Aim.”

Developed by the Institute for Healthcare Improvement (IHI), the Triple Aim consists of (1) improving the patient experience of care (including quality and satisfaction), (2) improving the health of populations, and (3) reducing the per capita cost of health care.¹¹³ Two novel aspects of the Triple Aim are immediately evident: examining care from the patient’s perspective and becoming accountable for populations as well as individuals. But a third is far more important: whereas cost, access, and quality exist in perpetual tension with one another in the traditional paradigm, the three parts of the Triple Aim are simultaneously achievable.

This is the case because the U.S. health care system is now known to be massively, recurrently wasteful.¹¹⁴ Much medical practice is habitual rather than scientific. Prices are high and seemingly arbitrary. Where scientifically optimal care exists, even affluent, educated, insured patients often fail to receive it. Poorer, less educated patients and members of racial and ethnic minorities fare far worse, even if their care is publicly subsidized.¹¹⁵ Many new technologies layer themselves atop flawed processes of care, adding expense but not yielding better results.

In a report titled *Best Care at Lower Cost*, the National Academy of Medicine (NAM) attributed over \$750,000,000,000 annually to waste in 2010,¹¹⁶ a

112 For a concise argument in favor of personalized medicine, see Margaret A. Hamburg and Francis S. Collins, *The Path to Personalized Medicine*, 353 *NEW ENG. J. MED.* 301 (2010).

113 *IHI Triple Aim Initiative*, INST. FOR HEALTHCARE IMPROVEMENT (2015), <http://www.ihio.org/Engage/Initiatives/TripleAim/pages/default.aspx> (last visited Aug. 1, 2021). IHI’s founder, pediatrician Don Berwick, served briefly as acting director of the Centers for Medicare and Medicaid Services in the Obama Administration.

114 Work begun by Dr. John Wennberg at Dartmouth in the 1970s is most often credited for identifying the magnitude of waste in U.S. health care. JOHN E. WENNBURG, *THE DARTMOUTH ATLAS OF HEALTH CARE IN THE UNITED STATES 2* (1996). “Small-area variation” studies revealed substantial, unexpected geographic differences in medical treatment that are neither the result of greater health care needs nor associated with superior clinical outcomes. See *FAQ*, DARTMOUTH ATLAS PROJECT, <https://www.dartmouthatlas.org/faq> (last visited Aug. 1, 2021). This work revealed that “best practices” were seldom available, outcomes of care were typically unmeasurable, and clear advances in medical knowledge often took years to diffuse into communities and alter the habits of local physicians.

115 See *infra* notes 123-143 and accompanying text.

116 INST. OF MED., *BEST CARE AT LOWER COST: THE PATH TO CONTINUOUSLY LEARNING HEALTH CARE IN AMERICA* 102 (2012); see also Alan M. Garber & Jonathan Skinner, *Is American Health Care Uniquely Inefficient?*, 22 *J. ECON. PERSP.* 27, 28 (2008) (“The fundamental cause is a combination of high prices for inputs, poorly restrained incentives for overutilization, and a tendency to adopt expensive medical innovations rapidly, even when evidence of effectiveness is weak or absent.”).

staggering sum that almost certainly exceeds \$1,000,000,000,000 annually today. The NAM estimated that \$210 billion reflected unnecessary services, including overuse not justified by scientific evidence, discretionary use beyond established standards, and unnecessary choice of higher-cost services.¹¹⁷ The report identified another \$130 billion in inefficiently delivered services, including medical errors, preventable complications, fragmented care, unnecessary use of higher-cost providers, and operational inefficiency at care delivery sites.¹¹⁸ Excess administrative costs accounted for \$190 billion, missed prevention opportunities for \$55 billion, and fraud for \$75 billion.¹¹⁹ The final category, “Prices That Are Too High,” suggested that \$105 billion reflected prices in the United States that clearly exceed benchmark amounts.¹²⁰

Inefficiency of this magnitude is a damning indictment of post-Medicare public policy and is not merely an economic problem. The NAM’s findings were derived from four decades of research into unjustified practice variation, sub-optimal quality, and poor safety.¹²¹ For single-payer advocates, this body of new knowledge implies that American health policy, in the short to medium term, need concern itself less with developing centralized systems for allocating scarce resources (i.e., rationing), and more with facilitating (including through payment reform) incremental, decentralized improvement in the provision of medical care. It also makes clear that fifty years of deference to the expertise and judgment of individual physicians in a lavishly funded system—Medicare’s Gilded Age—has in important ways proved counter-productive.

B. *Social Determinants and Unjust Disparities*

The opportunity cost of wasting \$1 trillion each year on mispriced, poorly designed, often unnecessary, and sometimes harmful medical care arguably has been greater than the direct effects. There are two harsh realities associated with health policy in the United States: our health care system is extraordinarily expensive, and the health of our population is not particularly good.¹²² In 2018,

117 INST. OF MED., *supra* note 116, at 102.

118 *Id.*

119 *Id.*

120 *Id.*

121 See INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 23-25 (2001) (documenting the U.S. system’s suboptimal performance in making health care safe, effective, patient-centered, timely, efficient, and equitable); INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1 (1999) (documenting up to 100,000 annual deaths due to medical error in the United States).

122 International comparisons of health care system performance generally place the United States at or near the bottom. See, e.g., Eric C. Schneider et al., *Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care*, COMMONWEALTH FUND (2017), <http://www.commonwealthfund.org/~media/files/publications/fund-report/2017/jul/schne>

U.S. per capita health care spending exceeded \$10,000 (16.9% of Gross Domestic Product (GDP)), 25% more in absolute amount than second-highest Switzerland (12.2%) and almost triple average per capita spending among Organisation for Economic Cooperation and Development (OECD) countries.¹²³ However, U.S. life expectancy at birth remained 78.6 years, more than two years lower than the average among OECD countries.¹²⁴ Infant mortality in the United States is the highest in the OECD and is improving more slowly than elsewhere.¹²⁵

One should not be surprised. Research shows clearly that the immediate causes of death may appear medical (cancer, heart disease, kidney failure, etc.) but the underlying causes are predominantly non-medical.¹²⁶ These “social determinants” of health consist of behavioral patterns (roughly estimated as accounting for 40% of premature mortality), social circumstances (15%), and environmental exposures (5%), with 30% attributable to genetics and only 10% having to do with lack of medical care.¹²⁷ For these reasons, most health policy experts—affirming the core governmental commitments made by the ACA—consider policy changes that invest in population health to be at least as important as those that promote value-based care delivery, and recognize that there are important interactions between the two sets of interventions. For example, the ACA requires that health insurers cover the full cost (without imposing deductibles or co-payments) of screening interventions that are rated “A” or “B” by the U.S. Preventive Services Task Force.¹²⁸

That advanced medical care is necessary but not sufficient for longevity

ider_mirror_mirror_2017.pdf; see also Steven H. Woolf & Laudan Y. Aron, *The US Health Disadvantage Relative to Other High-Income Countries*, 309 JAMA 771, 772 (2013) (describing the causes of lower life expectancy in the United States).

¹²³ *OECD Health Statistics 2021*, OECD (2021), <https://stats.oecd.org/Index.aspx?DataSetCode=SHA>.

¹²⁴ *Id.*

¹²⁵ The rate for non-Hispanic African Americans of 11.3 per 1000 live births is comparable to the infant mortality rate in Mexico, a country that spends roughly 10% of what the United States spends on health care. *Compare Infant Mortality Rate by Race/Ethnicity*, KAISER FAMILY FOUND. (2018), <https://www.kff.org/other/state-indicator/infant-mortality-rate-by-race-ethnicity/?currentTImeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D,with%20Infant%20Mortality%20Rates>, OECD (2021), <https://data.oecd.org/healthstat/infant-mortality-rates.htm#indicator-chart>.

¹²⁶ See Rachel Rebouche & Scott Burris, *The Social Determinants of Health*, in OXFORD HANDBOOK OF U.S. HEALTH LAW 1097 (I. Glenn Cohen et al. eds., 2016).

¹²⁷ J.M. McGinnis et al., *The Case for More Active Policy Attention to Health Promotion*, 21 HEALTH AFF. 78, 83 (2002). These numbers are admittedly imprecise. For a comprehensive discussion, see Laura McGovern, George Miller & Paul Hughes-Cromwick, *Health Policy Brief: Contribution of Multiple Determinants to Health Outcomes*, HEALTH AFF. (2014), https://www.healthaffairs.org/doi/10.1377/hpb20140821.404487/full/healthpolicybrief_123.pdf.

¹²⁸ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 4008, 124 Stat. 173 (2010).

becomes even clearer when one examines the comparative performance now and over time of the United States and other developed countries in avoiding mortality from cancer, on one hand, and cardiovascular diseases, on the other. Heart disease deaths have plummeted in nearly all countries, but deaths from other circulatory conditions and cerebrovascular disease are still strikingly high in the United States.¹²⁹ By contrast, the United States has had the greatest success among developed countries at reducing deaths from cancer, and cancer mortality in the United States is on the low end in absolute terms.¹³⁰ This is not because America's considerable innovation in cancer treatment is so much better than our innovation in drugs and surgery for heart disease but because the United States has been highly successful at reducing tobacco use, which has dropped by 80% over the past 40 years.¹³¹ However, we have been fighting a losing battle against the obesity epidemic, even as the cardiovascular consequences of smoking declined. In 1990, not a single U.S. state had more than 15% of its adult population obese; in 2010, not a single U.S. state had less than 20% of its adult population obese.¹³²

Moreover, resources to help avoid and address social determinants of ill health have skewed sharply toward medical uses in recent decades—another consequence of Medicare's Gilded Age. Non-defense federal spending is dominated by Medicare, Medicaid, and Social Security (plus interest on the national debt), leaving relatively little for all other national needs. From 1970 to the present, the federal government's financial commitment to health care programs has grown from 5% to over 10% of GDP, with a proportionate reduction in public dollars available for other uses.¹³³ In state budgets, rising medical spending in particular crowds out funding for education, adding an element of tragic competition to two essential building blocks for human capital.¹³⁴ The United States seems to be a negative outlier in this respect as well: it not only devotes a much higher share of GDP to medical care than do other developed countries, but also dedicates less of

129 Ellen Nolte & C. Martin McKee, *In Amenable Mortality—Deaths Avoidable Through Health Care—Progress in the US Lags That of Three European Countries*, 31 HEALTH AFF., 2114, 2118 (2012).

130 Warren Stevens et al., *Cancer Mortality Reductions Were Greatest Among Countries Where Cancer Care Spending Rose the Most, 1995–2007*, 34 HEALTH AFFS, 562, 564 (2015).

131 See generally U.S. DEPT. OF HEALTH & HUMAN SERVS., *THE HEALTH CONSEQUENCES OF SMOKING—50 YEARS OF PROGRESS: A REPORT OF THE SURGEON GENERAL* (2014) (describing the successful public health campaign against smoking).

132 *Adult Obesity Prevalence Maps*, CTRS. FOR DISEASE CONTROL & PREVENTION (2019), <https://www.cdc.gov/obesity/data/prevalence-maps.html>.

133 See *American Health Care: Health Spending and the Federal Budget*, COMM. FOR A RESPONSIBLE FED. BUDGET (May 16, 2018), <https://www.crfb.org/papers/american-health-care-health-spending-and-federal-budget>.

134 See *State and Local Expenditures*, URBAN INST. (2021), <https://www.urban.org/policy-centers/cross-center-initiatives/state-and-local-finance-initiative/state-and-local-backgrounders/state-and-local-expenditures>.

its national output to non-medical social services that improve health.¹³⁵ One-half to two-thirds of health-improving spending in other countries is non-medical compared to only one-fourth in the United States.¹³⁶ Medicalizing the governmental response to poverty and other social ills may be superficially appealing, but it has not proved effective.¹³⁷

The injustice of these circumstances goes beyond denying a universal human right to medical care. It encompasses the systematic diversion of resources away from individuals and communities that suffer persistent, compound disadvantage. Profound inequalities at the community level in wealth and education, endemic violence, concentrated environmental hazards, and other resources exert negative effects on health that cannot be overcome by medical care alone. Capturing the personal, often purposeful actions that created and now perpetuate these conditions is one reason why "unjust disparities" in health and health care are a powerful descriptor that supplements the more sterile and potentially immutable phrasing of "social determinant." Disparities exist at the community as well as the family level, which further conveys the importance of place to engaging and improving health.¹³⁸

America's shameful experience with race is a significant contributor to lack of health justice (though perhaps with less independent effect than poverty). Many studies have shown that persons of color are comprehensively disadvantaged in access to high-quality medical care, although attention to specific contexts presenting risks of clinical discrimination has helped narrow the gap.¹³⁹ Most shockingly, African-American women suffer maternal complications and infant

135 See generally ELIZABETH H. BRADLEY & LAUREN A. TAYLOR, *THE AMERICAN HEALTH CARE PARADOX: WHY SPENDING MORE IS GETTING US LESS* (2015) (discussing relative lack of social investment in the US); RICHARD COOPER, *POVERTY AND THE MYTHS OF HEALTH CARE REFORM* (2016) (arguing that poverty, not clinical uncertainty, explains geographic variation in health care spending); Raj Chetty et al., *The Association Between Income and Life Expectancy in the United States, 2001-2014*, 315 *JAMA* 1750 (2016) (examining the geography and socioeconomics of longevity).

136 BRADLEY & TAYLOR, *supra* note 135, at 14-15. These estimates are not definitive; subsequent research asserts a generally positive relationship between health and social spending, with U.S. social spending only slightly below international averages. See Irene Papanicolas et al., *The Relationship Between Health Spending and Social Spending in High-Income Countries: How Does the US Compare?*, 38 *HEALTH AFF.* 1567, 1567 (2019).

137 See, e.g., William M. Sage & Jennifer E. Laurin, *If You Would Not Criminalize Poverty, Do Not Medicalize It*, 46 *J.L. MED. & ETHICS* 573 (2018) (using the application of criminal justice to poverty as a cautionary tale for medicine).

138 In doing so, however, one should guard against biases that may incorrectly attribute disadvantage to failures of individual character rather than long-term patterns of denial and discrimination by society at large. See *id.* at 574-76.

139 See generally DAYNA B. MATTHEW, *JUST MEDICINE: A CURE FOR RACIAL INEQUALITY IN AMERICAN HEALTH CARE* (2015) (examining causes, consequences, and treatments of race-based health disparities.); RACE, ETHNICITY AND HEALTH (Thomas A. LaVeist ed., 2002) (same); DAVID B. SMITH, *HEALTH CARE DIVIDED: RACE AND HEALING A NATION* (1999) (detailing racial disparities).

mortality more than double that among non-Hispanic white families—accounting for nearly all of the excess mortality compared to other OECD countries.¹⁴⁰ Studies strongly suggest that these mothers’ exposure to toxic levels of stress is the principal cause, with explicit racism, implicit bias, and structural racism all contributing.¹⁴¹ An explicit goal of health policy can be to reduce discrimination and promote justice. The original Medicare program, for example, integrated America’s highly segregated acute care hospitals virtually overnight.¹⁴²

C. *The Inertial Force of Health Law*

The preceding insights into wasteful care delivery, inattention to population health, and discrimination based on race, ethnicity, and socioeconomic status have been gained steadily over the past twenty-five years, and were incorporated into the ACA through its attempted Medicaid expansion, its Medicare payment and care delivery reforms (e.g., ACOs, PCMHs), and its dramatically increased (but never fully appropriated) funding for public and community health.¹⁴³ Similarly, experts in health systems management and care redesign have developed clear, evidence-based paths to improvement for hospitals and medical practices.¹⁴⁴

Still, consensus objectives for the health care system—becoming safe, effective, patient-centered, timely, efficient, and equitable—largely remain unachieved. If we have known for so long where we wish to go, and how to get

140 *Infant Mortality*, CTNS. FOR DISEASE CONTROL & PREVENTION (2020), <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm>.

141 See Linda Villarosa, *Why America’s Black Babies and Mothers Are in a Life-or-Death Crisis*, N.Y. TIMES MAG. (Apr. 11, 2018), <https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html>.

142 See DAVID BLUMENTHAL AND JAMES A. MORONE, *THE HEART OF POWER: HEALTH AND POLITICS IN THE OVAL OFFICE 195-98* (2010) (detailing President Lyndon Johnson’s personal commitment to hospital desegregation); see also Peter Ubel, *Medicare and the Desegregation of American Hospitals*, FORBES (Jan. 30, 2014), <https://www.forbes.com/sites/peterubel/2014/01/30/medicare-and-the-desegregation-of-american-hospitals/#4889c59a2e1b> (explaining how segregated hospitals changed their practices in order to receive federal funding). Functional segregation has persisted, of course, often through the proxy of socioeconomic status. When I was an anesthesiology resident at Johns Hopkins Hospital in the early 1990s, for example, the ward patients cared for by physicians-in-training in the older buildings were nearly all African American, while predominantly white, private-pay patients were admitted to a separate, recently constructed pavilion.

143 See *supra* notes 98-107 and accompanying text.

144 See, e.g., CLAYTON M. CHRISTENSEN, *THE INNOVATOR’S PRESCRIPTION: A DISRUPTIVE SOLUTION FOR HEALTHCARE* (2008); MICHAEL E. PORTER & ELIZABETH O. TEISBERG, *REDEFINING HEALTH CARE: CREATING VALUE-BASED COMPETITION ON RESULTS* (2006); Michael E. Porter & Thomas H. Lee, *The Strategy That Will Fix Health Care*, 91 HARV. BUS. REV. 50 (2013). Quality and safety improvements have been around even longer. See, e.g., DONALD M. BERWICK ET AL., *CURING HEALTH CARE: NEW STRATEGIES FOR QUALITY IMPROVEMENT* (1990).

there, why are we not there yet?¹⁴⁵ One explanation lies in the tendency among observers and analysts to ignore the principal mechanism used to impose and maintain constraints on how the health care system operates, which is the law.¹⁴⁶

Put simply, governance of U.S. health care is based on an idealized image of an individual physician caring for a single patient in a private transaction.¹⁴⁷ The physician possesses all the characteristics one most wishes for in a caregiver: wisdom, skill, compassion, and incorruptibility. The patient possesses all the characteristics one most sympathizes with in a recipient of care: serious illness, vulnerability, and dependence. In the mind's eye, each party looks and sounds like a character in a television medical drama. The law fosters and protects these hypothesized therapeutic relationships by empowering the American medical profession to set its standards, by insulating it from direct corporate or governmental control, and by generously subsidizing its costs.¹⁴⁸

Governance of the overall U.S. health care system is essentially the same fragmented legal and financial environment scaled to the population level.¹⁴⁹

145 See, e.g., Nikhil Sahni et al., *How the U.S. Can Reduce Waste in Health Care Spending by \$1 Trillion*, HARV. BUS. REV. (Oct. 13, 2015), <https://hbr.org/2015/10/how-the-u-s-can-reduce-waste-in-health-care-spending-by-1-trillion>.

146 See generally William M. Sage, *Relating Health Law to Health Policy: A Frictional Account*, in OXFORD HANDBOOK OF U.S. HEALTH LAW 3–28 (I. Glenn Cohen et al. eds., 2016) (explaining how health law sometimes works at cross-purposes with consensus health policy goals). The medical profession often feigns ignorance of its legal privilege. See, e.g., William M. Sage, *Over Under or Through: Physicians, Law, and Health Care Reform*, 53 ST. LOUIS UNIV. L.J. 1033, 1033–34 (2009) (“For a physician to want regulation out of medical licensing is as absurd as the oft-quoted saw about a senior citizen telling his congressman to ‘keep the government out of my Medicare.’”). For a comprehensive review of health law following the enactment of the ACA, see OXFORD HANDBOOK OF U.S. HEALTH LAW, *supra*.

147 See William M. Sage, *Assembled Products: The Key to More Effective Competition and Antitrust Oversight in Health Care*, 101 CORNELL L. REV. 609, 613–14 (2016) (explaining the constitutive role of regulation in health care delivery); see also ROBERT I. FIELD, *MOTHER OF INVENTION: HOW THE GOVERNMENT CREATED FREEMARKET HEALTH CARE* 24 (2014) (discussing the crucial role of public initiatives in private health care). For an early analysis of how professional control blunts competition, see Charles D. Weller, *Free Choice as a Restraint of Trade in American Health Care Delivery and Insurance*, 69 IOWA L. REV. 1351, 1392 (1984) (noting the potential for market power from unconstrained choice of physician). Some commentators have assigned traction to alternative views of health law, for example, Rand E. Rosenblatt, *The Four Ages of Health Law*, 14 HEALTH MATRIX 155 (2004), but the “professional paradigm” has proved extremely difficult to dislodge.

148 For the definitive historical overview, see PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (2d ed. 2017) (exploring the American medical profession’s centuries-long interactions with government).

149 For a comprehensive look at care fragmentation, see Einer Elhauge, *Why We Should Care About Health Care Fragmentation and How to Fix It*, in *THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS* 1–20 (E. Elhauge ed., 2010). For an overview of associated legal issues, see William M. Sage & Robert F. Leibenluft, *Overcoming Barriers to Collaboration and Alignment: Legal and Regulatory Issues*, in *PHYSICIAN-HOSPITAL INTEGRATION* 110–40 (Francis J. Crosson &

Starting about 100 years ago, state governments have repeatedly conferred legal privileges and protections on the medical profession, often relying on licensing boards and other self-regulatory bodies controlled by physicians for both standards and enforcement. Starting about fifty years ago, the federal government—largely through Medicare—has uncritically financed the system that state law created. Additional layers of essentially mandatory self-regulatory compliance—such as Joint Commission standards for hospitals and Liaison Committee for Medical Education (LCME) or Accreditation Council for Graduate Medical Education (ACGME) standards for medical education—further impede movement away from this physician-centric model of health system governance.¹⁵⁰

State professional licensing laws, echoed in Medicare’s payment policies, are obvious sources of inefficiency and inequity. In 1962, libertarian economist Milton Friedman was “persuaded that [restrictive] licensure has reduced both the quantity and quality of medical practice; . . . that it has forced the public to pay more for less satisfactory medical service, and that it has retarded technological development both in medicine itself and in the organization of medical practice.”¹⁵¹ After half a century of Medicare, this is no longer a fringe view.¹⁵² Another important example is Medicare’s decades-long expansion of civil and criminal penalties for “fraud and abuse,” an epidemic the root causes of which are ultimately traceable to Medicare’s original design choices such as its deference to physician judgment, its fragmented delivery structure, and its poor financial oversight.¹⁵³ Other potentially problematic laws include those governing physician-hospital relations, accountability for quality, private health insurance, and Medicare payment itself.¹⁵⁴ In recent years, both Democratic and Republican administrations have made note of some legal barriers to health system

Laura Tollen eds., 2010).

150 Hospitals accredited by the Joint Commission are deemed to meet the survey and certification requirements necessary to participate in (and be paid by) Medicare and Medicaid. The Liaison Committee for Medical Education (LCME) accredits M.D. degree programs, while the Accreditation Council for Graduate Medical Education (ACGME) accredits programs that train interns and residents in medical specialties. Governance of the Joint Commission, the LCME, the ACGME, and several other influential credentialing bodies in U.S. health care is shared in various ways among medical professional associations and hospital groups. See, e.g., James S. Roberts et al., *A History of the Joint Commission on Accreditation of Hospitals*, 258 JAMA 936, (1987).

151 MILTON FRIEDMAN, CAPITALISM AND FREEDOM 149–59 (1962).

152 See, e.g., Aaron Edlin & Rebecca Haw, *Cartels by Another Name: Should Licensed Occupations Face Antitrust Scrutiny?*, 162 U. PA. L. REV. 1093 (2014).

153 For a history and critique of the inefficiencies embedded in Medicare’s fraud control regime, see James F. Blumstein, *The Fraud and Abuse Statute in an Evolving Health Care Marketplace: Life in the Health Care Speakeasy*, 22 AM. J.L. & MED. 205 (1996); and David A. Hyman, *Health Care Fraud and Abuse: Market Change, Social Norms, and the Trust “Reposed in the Workmen”*, 30 J. LEGAL STUD. 531 (2001).

154 See Sage, *supra* note 146, at 21–27.

improvement.¹⁵⁵ Unfortunately, points of bipartisan agreement often have been obscured by the concurrent emphasis on more narrowly partisan arguments, such as Republican calls for tort reform and for the relaxation of state insurance laws to facilitate cross-border marketing.

Neither party, however, has directly challenged the centrality of the medical profession to the legal architecture of American health care. Throughout the “modern era” that followed Medicare’s enactment in 1965, maintaining the medical profession’s autonomy and influence has been considered a bulwark against injustice. Physicians’ ethics, economist Kenneth Arrow famously asserted in 1963, would help compensate for imbalances in information that might otherwise result in exploitation of the vulnerable and misappropriation of public resources by profiteers.¹⁵⁶ Even when the net inefficiency of physician control became evident—most obviously through critiques of “care fragmentation” that perpetuated idiosyncratic practices and precluded coordination—the ethical argument for professional rather than commercial or governmental control still appeared strong. This pro-physician sentiment and expectation, usually unspoken, occasionally became a focus of public discourse and policy activism. In the expansion of Medicare’s anti-fraud authorities after Barbara Ehrenreich and others cautioned against an emerging “medical-industrial complex,”¹⁵⁷ for example, or in connection with the popular and legislative backlash against private managed care in the late 1990s.¹⁵⁸

With the benefit of hindsight, allowing physician professionalism to dictate health system governance likely has perpetuated injustice, not reduced it. Laws

155 See, e.g., OFFICE OF ECON. POL’Y, U.S. DEP’T OF THE TREASURY ET AL., OCCUPATIONAL LICENSING: A FRAMEWORK FOR POLICYMAKERS 13–14 (July 2015), https://obamawhitehouse.archives.gov/sites/default/files/docs/licensing_report_final_nonembargo.pdf (attributing not only inefficiency but also injustice to states’ over-reliance on occupational licensing in an Obama Administration report); U.S. DEPT. OF HEALTH AND HUM. SERVS. ET AL., REFORMING AMERICA’S HEALTHCARE SYSTEM THROUGH CHOICE AND COMPETITION (2018), <https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf> (reporting on legal barriers to health system efficiency, including restrictive licensing in a Trump Administration report).

156 Kenneth Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 965 (1963). For detailed commentary on Arrow’s analysis, see UNCERTAIN TIMES: KENNETH ARROW AND THE CHANGING ECONOMICS OF HEALTH CARE (Peter J. Hammer et al. eds., 2003).

157 William M. Sage, *Minding Ps and Qs: The Political and Policy Questions Framing Health Care Spending*, 44 J. L. MED. & ETHICS 559, 559–60 (2016) (substituting “health care” for “military” in Eisenhower’s address); see also BARBARA EHRENREICH, *THE AMERICAN HEALTH EMPIRE: POWER, PROFITS, AND POLITICS* (1970) (warning of the “medical-industrial complex”); President Dwight D. Eisenhower, *Farewell Address to the Nation* (Jan. 17, 1961), https://www.eisenhower.archives.gov/All_About_Ike/Speeches/Farewell_Address.pdf.

158 See *supra* notes 80–98 and accompanying text.

maintaining physicians' privileges and protections—conferring market power in the hope of fostering altruism, charity, and collaboration—can have the opposite effect.¹⁵⁹ For example, organized medicine has fought nearly universally to preserve its practice monopoly through restrictive medical licensing laws.¹⁶⁰ This has prevented large numbers of nurses and other trained health professionals from meeting the basic needs of lower-income communities, including many individuals who are more racially and ethnically diverse than the typical American physician and who are more likely to locate their practices in places where prosperous physician specialists seldom choose to work.¹⁶¹

Accreted health law tends to worsen the frictions inherent in transitioning the existing health care system to a universal model. Its relative lack of visibility in policy debate, moreover, enables American physicians to resist a holistic approach to health reform as contrary to the “free-market” ideology which they routinely yet incorrectly credit for the technology-rich environment in which they practice and for their personal financial success. Replying twenty years ago to one such physician, the late Princeton health economist Uwe Reinhardt was blunt in connecting inefficiency to injustice, and in assigning considerable responsibility to laws protecting the medical profession:

[Dr.] Lally writes of “a fierce sense of rugged individualism, independence, and self-reliance that have been and still are the hallmarks of the American ethos.” Where are these rugged individualists? . . . Would I find them in the medical profession, whose members rely so heavily on public subsidies for their education and the science they apply, who now seek a federal tax preference for medical savings accounts, who plead with government to punish managed care organizations that are late in paying bills, to impose on managed care organizations any-willing-provider laws, and to regulate managed care organizations with countless other strictures, and who have never balked at using archaic licensure laws to protect their own economic turf? . . . As

159 For classic if contrasting views of the social benefits of professionalism, compare TALCOTT PARSONS, *THE SOCIAL SYSTEM* (1951), which emphasizes professional altruism and expertise, with ELIOT FREIDSON, *PROFESSIONAL POWERS: A STUDY OF THE INSTITUTIONALIZATION OF FORMAL KNOWLEDGE* (1986), which emphasizes professional self-interest.

160 INST. OF MED., *THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH* 22–23 (Oct. 5, 2011); *Implementation Status Map*, NAT'L COUNCIL OF STATE BDS. OF NURSING (Jan. 25, 2021), <https://www.ncsbn.org/5397.htm> (showing current status of efforts to expand nursing scope of practice) (last visited Aug. 1, 2021); see also Daniel J. Gilman & Julie Fairman, *Antitrust and the Future of Nursing: Federal Competition Policy and the Scope of Practice*, 24 HEALTH MATRIX 143, 149–50 (2014) (connecting licensing laws to competition as well as quality control).

161 See Peter Buerhaus, *Nurse Practitioners: A Solution to America's Primary Care Crisis*, AM. ENTER. INST. (2018), <https://aei.org/wp-content/uploads/2018/09/Nurse-practitioners.pdf>.

all of these self-styled, rugged individualists enlist their government's coercive power to protect their own fiscal health, they might more gracefully countenance the use of that power and also protect the physical health of poor children and, indeed, of all poor people.¹⁶²

Reinhardt's questions remain unanswered.

D. Generational Change

When considering next steps in national health policy, both reform partisans and the broader public often overlook an important truth about physicians—indeed, about all professionals. Professions such as medicine invite us to imagine archetypes with deep historical roots and to assign them fixed preferences. As much as we imbue the doctor, the lawyer, the engineer, or the nurse with timeless qualities, however, professionals are merely people. And those people learn, leave, and are replaced. When one accounts for generational change, the integrated, community-engaged health care system that Medicare-for-All reform might pursue becomes markedly less threatening to medical professionalism.

In part because the political process relies so heavily on labels, looking back at professions rather than looking forward is common in public policy. Politicians seek support from groups, weighing one group's apparent interest and ideology against another's, while media coverage focuses more on the conflicts between groups than the diversity within groups. Moreover, interest groups typically represent the least innovative of their potential constituents, a bias that professional associations accentuate because leadership positions at the national level are earned only after years or decades of lesser service. As a result, the light they cast on the professional world often resembles that reaching earth from nearby stars—formed in the tumult of an earlier time and showing things as they used to be, not as they exist today. And, for the American health professions, certainly not as they will be in years to come.

The challenges of post-ACA medical practice are more tractable and less ethically jarring for younger generations of physicians than for older ones because of who they are, how they are trained, and what they believe about the goals and consequences of the tasks they are undertaking.¹⁶³ Compared to their generational

¹⁶² Uwe E. Reinhardt, Letter to the Editor, *Articulating a Social Ethic for Health Care*, 279 JAMA 745, 746 (1998).

¹⁶³ See Timothy Kelley, *Young Docs: The New Blood that Health Care Needs*, MANAGED CARE (Feb. 19, 2016), <https://www.managedcaremag.com/archives/2016/2/young-docs-new-blood-health-care-needs>. Dr. Robert Wachter, then an associate dean at UCSF School of Medicine, describes offering a sobering message to a recent class of first-year medical students. "You folks are entering

predecessors, “young docs” are gender-diverse, and they want careers that offer work-life balance.¹⁶⁴ They regard information, even professional expertise, as abundant and democratically accessible. Technology is a pervasive aspect of their personal and professional lives. Their social networks do not track traditional groups or hierarchies. They not only respect but expect patient autonomy, and do not find medical consumerism off-putting. They think globally about health.

By contrast, the generation that preceded them—people such as I who entered medical school in the 1980s and 1990s—had been socialized into a narrower professional orientation. We were lectured about the virtues of becoming a primary care physician while every incentive pointed us toward specialization. We were taught to fear control by hospitals and managed care organizations, and we were cautioned that we might never “have” patients but would “rent” them from others. We learned to mistrust any ethical reorientation from individual patients to populations as obligating us to ration care at the bedside. We bristled under accusations of financial conflict of interest, fretted over the effects of quality “report cards” on our professional reputations and opportunities, struggled to computerize our record-keeping, and worried about the economic viability of converting our small private practices from simple cash-flow models to complex payment negotiations.

Emerging generations of physicians see many of the same challenges through a more positive lens. Informed by the IHI’s Triple Aim and supported by an improved pedagogy, they do not insist on independent practice for its own sake, and they are comfortable working in large organizations unless and until they decide to pursue specific entrepreneurial opportunities. They are acclimated to interprofessional teamwork, systems-based practice, and patient-centered care, and regard them as more than mere buzzwords. They expect to have their performance measured and compared, and to be paid for the value they deliver. They do not fear “big data,” and they see the health of populations as part of their clinical and social responsibility.

Generational change enables the creation of new public policy for the medical profession that preserves its ethics and judgment without equating those to absolute decisional, organizational, and financial autonomy. When I was a medical student, I saw professional norms of self-reliance and clinical independence being both challenged by technologic change and perverted by unlimited funding. Instruction never to rely on information about a patient one did not personally *observe* by taking a history and performing a physical examination—sound guidance in a

a profession completely different from the one I entered 30 years ago, because you will be under relentless, unremitting pressure to figure out how to deliver the highest-quality, safest, most satisfying care at the lowest possible cost.” The immediate question from one of the students: “What exactly were you trying to do?” *Id.*

¹⁶⁴ See *id.*

simpler time —was twisted into a peculiar command never to trust the reported results of diagnostic tests one did not personally *order*. Following this advice led to duplication, delay, communication failures, unnecessary expense, and patient harm. Similarly, my cohort of physicians who trained in the 1980s learned to posture and guess when confronted with an unfamiliar situation—admitting one’s inexperience or ignorance being considered a sign of professional weakness. Our successors, thankfully, are expected to seek assistance, and to look things up using evidence-based, reliable, convenient online clinical resources.¹⁶⁵

Practice structure has changed as well. A majority of physicians are now employees. Many are employed by large physician-controlled organizations.¹⁶⁶ The percentage of physicians in solo or small-group practice has plummeted from roughly 90% when Medicare was enacted in 1965 to about 35% today.¹⁶⁷ Nearly 40% of physicians work in settings fully or partially controlled by hospitals, compared to 25% as recently as 2012.¹⁶⁸ Younger generations of physicians tend to prefer these arrangements, which offer stable hours and benefits while freeing them from many managerial responsibilities.

This shift has health policy implications. For example, visceral opposition to malpractice lawsuits is considerably less among physicians who do not write annual checks for liability coverage and need not worry constantly about its price and availability. Physicians working in organized systems of care can also expect a better patient safety infrastructure and more robust resources to support them in the unlikely event they are involved in causing a patient serious harm.¹⁶⁹

Changes in physician professionalism accompany parallel changes among recipients of care. Labelling someone a “patient” implies suffering and dependence. Patients are removed from their usual surroundings and activities, freed of their outside responsibilities, and assigned only the task of recovery (where possible, otherwise they are tasked with acceptance). Once recovery has been accomplished, or is well under way, patients are restored to their everyday lives. Sometimes today’s care recipients can accurately be described as “patients,”

165 See, e.g., *UpToDate: Evidence-Based Clinical Decision Support*, WOLTERS KLUWER, <https://www.wolterskluwer.com/en/solutions/uptodate> (last visited Aug. 1, 2021) (online and mobile clinical information platform operated by Wolters-Kluwers publishing).

166 CAROL K. KANE, AM. MED. ASS’N, UPDATED DATA ON PHYSICIAN PRACTICE ARRANGEMENTS: FOR THE FIRST TIME, FEWER PHYSICIANS ARE OWNERS THAN EMPLOYEES 7, 13-16 (2019), <https://www.ama-assn.org/system/files/2019-07/prp-fewer-owners-benchmark-survey-2018.pdf>.

167 *Id.* at 13.

168 *Id.* at 14.

169 See William M. Sage et al., *A Quiet Revolution: Communicating and Resolving Patient Harm*, in *SURGICAL PATIENT CARE: IMPROVING SAFETY, QUALITY, AND VALUE* 649, 651-54 (Juan A. Sanchez et al. eds., 2017) (describing the growth of “communication and resolution programs” to prevent and respond to medical error in hospitals).

but in many instances the patient construct has become inapt.

Many recipients of care never cease being persons, maintaining their health and dealing with illness or disability while living their lives.¹⁷⁰ If one imagines an educated, insured patient twenty-five years ago diagramming her care, it is likely she would place her family's physician at the center – not only prescribing, ordering, and referring for services but also personally treating, counseling, and coordinating.¹⁷¹ Such a diagram today would be much more likely to place the patient herself at the center, armed with a smartphone and the Internet while connected to a host of health-related products, services, and professionals, including several physician specialists.

Re-orienting health care to be more “patient-centered” has become a consensus goal with respect to assessing satisfaction with care, opening health care records to patient review, developing models for shared decision-making, being honest about medical errors, and relaxing overly restrictive rules governing the hospital environment (e.g., visiting hours). Recent trends are even more dramatic in reconfiguring the patient role. The benefits of care increasingly are assessed using patient-reported outcomes (PROs), and therapeutic approaches are increasingly guided by patient-directed goals whose achievement is subsequently measured.¹⁷² These changes are generally intuitive to, and embraced by, younger generations of health professionals.

Empowerment will not be evenly distributed among care recipients, however. I posed the diagram question to an honors undergraduate health policy class a few years ago, imagining that they would have had insufficient contact with the health care system to answer meaningfully. One young woman, who suffered from a chronic disease, proved me wrong. Poignantly, she drew herself underwater, clutching a shaky ladder to the surface and struggling to climb it rung by rung as she located the services she needed. Things would be even harder for someone who is poor, who is homeless or unemployed, or who lives in a community of color. Widening income inequality and persistent racial discrimination threaten to reduce resilience among care recipients even as generational change promises to increase it among care providers.

170 See generally William M. Sage & Kelley McIlhattan, *Upstream Health Law*, 42 J.L. MED. & ETHICS 535 (2014) (arguing that labeling health system users “patients” who are dependent on their physicians is inconsistent with how most people hope to manage their health and health care).

171 Indeed, experts generally agree that the “physician’s pen” is the world’s most expensive medical technology. Cf. Louis Goodman & Timothy Norbeck, *Who’s to Blame for Our Rising Healthcare Costs?*, FORBES (Apr. 3, 2013), <https://www.forbes.com/sites/realspin/2013/04/03/whos-to-blame-for-our-rising-healthcare-costs/?sh=721dc89b280c> (citing 80% as a “frequently used number” for the percentage of health care costs that is directed by physicians).

172 See, e.g., Neil W. Wagle, *Implementing Patient-Reported Outcome Measures*, NEJM CATALYST (Oct. 12, 2017), <https://catalyst.nejm.org/implementing-proms-patient-reported-outcome-measures/>.

Each of the foregoing developments in understanding U.S. health and health care has been intensified during the COVID-19 pandemic. With respect to the relationship between rationing care and improving it, sudden surges in infection and lack of national and regional preparedness led many communities and the hospitals within them to the brink of rationing.¹⁷³ Facilities and localities considered or adopted “crisis standards of care”—not to save money but to address physical shortages—while the nurses and physicians who found themselves unable to provide their best care suffered profound moral injury.¹⁷⁴ Implicit, structural, and occasional overt racism in imposing risks of severe COVID-19 infection, in providing access to life-saving treatment and then vaccination, and in protecting individuals from harassment and abuse sharpened the moral case for health justice.¹⁷⁵ The need for a robust public health workforce to address social determinants of health also became more apparent during the pandemic, as “trickle-down” service from private health care providers was clearly inadequate to prevent major differentials in disease burden, hospitalization, and death. Suspending or changing obstructionist laws was a priority activity for governors, health departments, and mayors who found themselves struggling to maintain an effective workforce as the disease surged. In terms of generational change, the emotional burden of caring for COVID-19 patients has alerted professional leaders, health care executives, and policymakers to the dangers of widespread burnout and post-traumatic stress disorder (PTSD) in the post-pandemic workforce, necessitating new commitments to self-care and team-based support that challenge and improve on the traditional paradigm of professional stoicism and heroism during periods of emergency service.¹⁷⁶

173 See, e.g., Neil A. Halpern & Kay See Tan, *United States Resource Availability for COVID-19*, SOC’Y CRITICAL CARE MED. (2020), <https://www.sccm.org/Blog/March-2020/United-States-Resource-Availability-for-COVID-19>; Amit Uppal et al., *Critical Care and Emergency Department Response at the Epicenter of the COVID-19 Pandemic*, 39 HEALTH AFF. 1443 (2020).

174 See generally INST. OF MED., *CRISIS STANDARDS OF CARE: A TOOLKIT FOR INDICATORS AND TRIGGERS* (2013), <https://doi.org/10.17226/18338> (recommending procedures for making triage and similar decisions in response to emergency constraints on resources).

175 See, e.g., Leonard E. Egede & Rebekah J. Walker, *Structural Racism, Social Risk Factors, and Covid-19—A Dangerous Convergence for Black Americans*, NEW ENG. J. MED., Sept. 17, 2020, <https://www.nejm.org/doi/full/10.1056/NEJMp2023616>.

176 See generally James G. Adams & Ron M. Walls, *Supporting the Health Care Workforce During the COVID-19 Global Epidemic*, 323 JAMA 1439 (2020) (discussing physical and psychological risks to health care workers from the COVID-19 pandemic); Ari Shechter et al., *Psychological Distress, Coping Behaviors, and Preferences for Support Among New York Healthcare Workers During the COVID-19 Pandemic*, 66 GEN. HOSP. PSYCH. 1 (2020) (urging that health care worker preferences guide programs of COVID-19 psychological support).

IV. INNOVATING THROUGH MEDICARE-FOR-ALL

Will an explicitly national policy design of the sort that Medicare-for-All represents be better equipped than the existing health policy framework—even assuming continuation of the ACA—to make progress toward a more efficient and just health care system? Perhaps, if proponents take account of the changes just described, if they adjust their arguments to align with this new knowledge, and if they choose wisely among available approaches to implementation. To reach that point, however, two related public conversations seem inescapable: one regarding the role of ethics and health professionals, and another regarding the role of the state in influencing the structure of medical care.

A. *Revisiting Professional Ethics*

The U.S. health care system will not change without permission from health professionals, especially America’s physicians.¹⁷⁷ Permission must be built on principle, and it should take the form of reaffirming medical ethics. The need to do so has been evident for over two decades, but COVID-19 has increased its urgency.

Resistance to reform is often rationalized as defending the idealized ethics of an established physician-patient relationship. In 1998, the editor-in-chief of the *New England Journal of Medicine*, Dr. Jerome Kassirer, authored a commentary titled “Managing Care – Should We Adopt a New Ethic?” Dr. Kassirer strongly opposed a group-oriented ethics for physicians that justified applying different medical standards to patients enrolled in particular commercial managed care plans.¹⁷⁸ However, he explicitly left open the question of how American medical ethics might accommodate a national single-payer system:

The fundamental flaw in any universal ethic of medical care in this country is the structure of our health care system A system in which there is no equity is, in fact, already unethical.

¹⁷⁷ Other health professions may play an equally important role in conveying the ethics of health system change, including a stronger commitment to social justice. Nursing is the largest U.S. health profession, counting approximately three million members with a wide range of training, experience, and care delivery functions. See generally INST. OF MED., *THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH* (2011) (making the case for nurse leadership). Social justice lies at the ethical heart of nursing, although the focus on hospital-based services in recent decades has reduced its visibility. See Patricia Pittman, *Rising to the Challenge: Re-Embracing the Wald Model of Nursing*, 119 AM. J. NURSING 46, 47-48 (2019). Multi-disciplinary care teams including social workers, psychologists, pharmacists, and even lawyers to address patients’ health-harming legal needs are increasingly common. See, e.g., JEREMY CANTOR ET AL., *COMMUNITY-CENTERED HEALTH HOMES: BRIDGING THE GAP BETWEEN HEALTH SERVICES AND COMMUNITY PREVENTION* (2011).

¹⁷⁸ Jerome P. Kassirer, *Managing Care – Should We Adopt a New Ethic?*, 339 NEW ENG. J. MED. 397 (1998).

We gave up the idea of having an equitable system when we decided several years ago to give up on a proposed national health system with consistent coverage for the entire population. Although the chance of rekindling such a proposal seems remote now, we should not stop trying.¹⁷⁹

It is time for physician supporters of Medicare-for-All to take up Dr. Kassirer's ethical challenge. A national commitment to health and health care was underplayed by the ACA, for reasons described above.¹⁸⁰ By contrast, all Medicare-for-All proposals convey at least some degree of health-oriented social solidarity, which the medical profession should endorse as sound ethics.¹⁸¹

To that end, President Biden should invite physicians to create an ethical health care system by convening a Presidential Commission on the Ethics of Health. He should demand that physicians take seriously their mission and that they work closely with other health professions and the public, sharing their power and authority. Nearly all recent presidents—Donald Trump being the starkest exception—have convened commissions on bioethics.¹⁸² Typically, these bodies focus on new technologies offering both promise and peril, particularly those that raise dystopian possibilities or provoke religious as well as moral objections. Where U.S. health is concerned, however, a futuristic approach to bioethics is—ironically—short-sighted. The ethical problem is not what is new. The ethical problem is what is now.

Creation of an ethical health care system is the critical, indeed self-critical task. Not defense or protection. America's physicians tend to draw attention only to external threats to what they consider medical professionalism. Obstructionist

¹⁷⁹ *Id.* at 398.

¹⁸⁰ See *supra* notes 105-108 and accompanying text (describing pragmatic constraints on solidarity as a core value in U.S. health reform); see also Donald M. Berwick, *The Moral Determinants of Health*, 324 JAMA 225 (2020) (making the case for social justice and other general principles as part of health reform).

¹⁸¹ During the 2009-2010 health reform debate, the AMA and many physician specialty societies supported the ACA because it expanded insurance coverage for the sick and the poor, notwithstanding the opposition of powerful state medical associations and the generally conservative politics of private practice physicians.

¹⁸² Previous commissions include the following: Presidential Commission for the Study of Bioethical Issues, 2009-2017; President's Council on Bioethics, 2001-2009; National Bioethics Advisory Commission, 1996-2001; Advisory Committee on Human Radiation Experiments, 1994-1995; Biomedical Ethical Advisory Committee, 1988-1990; President's Commission for the Study of Ethical Problems in Medicine and in Biomedical and Behavioral Research, 1978-1983; and National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1974-1978. See Bioethics Rsch. Libr., *U.S. Bioethics Commissions*, <https://bioethics.georgetown.edu/library-materials/digital-collections/us-bioethics-commissions/> (last updated July 11, 2016).

insurance companies. Greedy pharmaceutical manufacturers. Unscrupulous malpractice lawyers. Overbearing government bureaucrats.

The greater ethical failings come from within. Not because many physicians are uncaring or unskilled or self-aggrandizing, but because continuing to do what the existing health care system has been designed to reward is not always right and is seldom enough. Physicians and those who profit off them are wont to suggest that any substantial change to where power sits in U.S. health care will endanger each of us and our parents, children, and partners. But a health care system that fetishizes the relationship between one physician and one patient ignores the degree to which effective twenty-first-century medical care departs from such nostalgic imagery and the fact that many communities lack meaningful therapeutic access and therefore receive no or paltry benefits from the status quo.

Physicians' silence in the face of massive health injustice, inefficiency, and waste must be called out by leaders of the medical profession for what it is: complicity. Defense of an ethically indefensible status quo has made much-needed reform proposals seem morally threatening, rather than representing opportunities for ethical introspection and improvement. All those who profit from the current system – a large group given \$4,000,000,000,000 of annual U.S. health care spending—use physician complacency to justify their own resistance to change.

In part because we medicalize so many social problems, we fail to notice profound racial, ethnic, and economic disparities in health needs and responses—inequities that are more honestly labelled injustices. Our bloated health care system is beset by injustice-in-passing (implicit bias and microaggression) and injustice-by-design (structural racism). Although the scientific objectivity with which we tend to approach policy analysis may obscure it, there is even injustice-on-purpose in U.S. health care. In the aggregate, these moral failures demand an immediate ethical response.

It does not help to overly intellectualize injustice by speaking only the language of science and evidence and process. Where moral outrage is justified, we need to display it. Appealing to self-interest is no substitute for appealing to principle. In health reform, the “business case” for improvement is a semantic repeat offender—much overused and rarely effective. With trillions of dollars flowing so freely, it is hardly a surprise that the health care sector finds it easier to keep making money the established way than to confront deep challenges offering at best speculative savings.

Taking advantage of generational change in the professions, a Presidential Commission on the Ethics of Health might work to reset professional norms in several respects:

- To proclaim clearly that the current system, as Dr. Kassirer observed twenty years ago, is profoundly unethical.

- To refute arguments that care rationing constitutes the principal threat to professional ethics, focusing instead on unjust disparities and inattention to social determinants of health.
- To support social investment in health, even when it favors non-medical over medical approaches.
- To recognize and reverse the biases that create racism and other forms of injustice in the exercise of professional judgment.
- To do “personal justice,” including finding compassionate ways for health professionals, organizations, and systems to say “no” to those whose claims on shared resources are not strong.
- To advocate for benefits to communities and populations as strongly as for the well-being of individual patients, including to address systematic problems such as climate change and mass incarceration that fall outside the usual “lanes” of medical advocacy.
- To articulate a “just science” that is less technocratic and absolute in order to create realistic expectations of medicine and preserve trust in public health.

Some proponents of government-led reform strategies have become so preoccupied with the recent history of market-based approaches to system improvement that they tend to ignore the health care system’s long history of professional control.¹⁸³ This would be a mistake. Reinforced by the legal architecture explained above,¹⁸⁴ physician professionalism remains central to both health system operations and public confidence in health care governance.

Ethical leadership from health professionals in connection with Medicare-for-All can also help recover the humanity that seems to have been eclipsed by commercialized technology in U.S. health care. Trust between patient and caregiver risks being eclipsed by complex incentives, bureaucratic systems of information management, and associated performance metrics – all of which seem

¹⁸³ See, e.g., Allison K. Hoffman, *Health Care’s Market Bureaucracy*, 66 UCLA L. REV. 1926 (2019).

¹⁸⁴ See *supra* notes 143-162 and accompanying text.

remote from the core values of health and few of which have been shown to improve quality or safety.¹⁸⁵ For this reason, some commentators again emphasize caring relationships as the most enduring aspect of health care and therefore as a core goal of policy change. Notably, both Donald Berwick and Avedis Donabedian—two pioneers of quality measurement and safety improvement—returned late in their careers to the central role of humanity in healing.¹⁸⁶

B. Key Structural Goals For Medicare-Led Innovation

With an assertive grounding in professional ethics, the operational approaches to “Medicare-for-All” previously identified could help achieve specific objectives that the next generation of health reformers would be wise to embrace. This Section describes some of the more challenging steps on the path to health system improvement, while offering a thumbnail sketch of whether and how Medicare-for-All could make a difference. The structural changes suggested below are intended to help address root causes of inefficiency and inequity that become apparent only when the health care system is examined from the “middle-distance.” This approach, uncommon in health policy analysis, is sensitive to ground-level conditions of professional and industrial organization as well as to the policy levers available under federal law.

These objectives are all important to pursue, and they need not be approached in any particular order. Still, they share attributes that make them amenable to a Medicare-for-All project of national health reform. They each can be communicated using principles of empowerment, effectiveness, and justice—particularly if younger generations of physicians and other health professionals reject ethical complacency and help draw attention to the failings of the status quo. They do not have an overtly partisan valence, nor do they rely on labelling particular political stakeholders as heroes or as villains. They invite a long-overdue communitarian and collective perspective on health and medical care, as befits the Medicare-for-All frame. And they persist in large part because of outdated or self-interested legal constraints, which the COVID-19 pandemic has helped reveal and in some ways has begun to change.

185 Donald M. Berwick, *Era 3 for Medicine and Health Care*, 315 JAMA 1329, 1329 (2016) (criticizing excessive measurement and performance incentives for individual physicians); *See also* INST. OF MED., VITAL SIGNS: CORE METRICS FOR HEALTH AND HEALTH CARE PROGRESS (2015) (reviewing and critiquing health care performance metrics).

186 Berwick, *supra* note 185, at 1330; Fitzhugh Mullan, *A Founder of Quality Assessment Encounters a Troubled System Firsthand*, 20 HEALTH AFF. 137, 141 (2001) (according to quality pioneer Avedis Donabedian, “The secret of quality is love.”); *cf.* KARL W. GIBERSON & FRANCIS S. COLLINS, THE LANGUAGE OF SCIENCE AND FAITH: STRAIGHT ANSWERS TO GENUINE QUESTIONS (2011) (reconciling expertise with belief).

1. *Improving Cost Discipline*

Health care providers, especially hospitals but also physicians, tend to know more about their revenue flows than about their cost structures, and they manage their enterprises accordingly. This phenomenon has several causes. First, hospital revenues are determined largely by “payer mix” (i.e., disparate revenue streams for insured patients from multiple sources with variable terms of payment). Private health insurers pay more generously than the Medicare program, which in turn pays more generously than state Medicaid programs. Second, physicians make many of the decisions that drive hospital costs without bearing administrative or financial responsibility themselves. Third, services tend to be defined not by direct utility to patients, but instead in terms of disaggregated professional process steps and associated components that can be assigned a billing code.¹⁸⁷ Finally, prices for many inputs are outrageously high—distorted by lack of cost discipline at many points along what is often a needlessly complex supply chain.¹⁸⁸

Information exchange has not much helped, even in the electronic age. The reason is a simple one. Health care enterprises have tended to collect the information they needed to collect in order to get paid, and very little more.¹⁸⁹ Researchers and progressive clinicians frequently note the inadequacies of this “claims data” as a clinical improvement tool, but seldom acknowledge its pervasiveness in the information ecosystem of medical care or its parallel inadequacies as a cost management tool.

Could Medicare-for-All help? Possibly. Under most scenarios, the Medicare program would possess the ability and authority to redefine services and payment so as to better approximate their actual utility to both individual patients and covered populations. Bundled payment programs attempt the former; accountable care organizations attempt the latter. For health care organizations that assume

187 See William M. Sage, *Assembled Products: The Key to More Effective Competition and Antitrust Oversight in Health Care*, 101 CORNELL L. REV. 609, 617-33 (2016) (arguing that “getting the product right” is a precondition to improving health care market outcomes through competition).

188 America’s extremely high health care prices routinely prompt criticism, even outside consolidated markets. See, e.g., Gerard F. Anderson et al., *It’s the Prices, Stupid: Why the United States Is So Different from Other Countries*, 22 HEALTH AFF. 89 (2003); Erin Fuse-Brown, *Irrational Hospital Pricing*, 14 HOUS. J. HEALTH L. & POL’Y 11 (2014); Ezra Klein, *21 Graphs That Show America’s Health-care Prices Are Ludicrous*, WASH. POST (Mar. 26, 2013, 12:40 PM), <https://www.washingtonpost.com/news/wonk/wp/2013/03/26/21-graphs-that-show-americas-health-care-prices-are-ludicrous/>; see also INST. OF MED., BEST CARE AT LOWER COST: THE PATH TO CONTINUOUSLY LEARNING HEALTH CARE IN AMERICA 102 (2012) (attributing \$105 billion of \$750 billion total estimated annual waste to “prices that are too high”).

189 In 2015, U.S. health plans processed 5.4 billion transactions. CAQH EXPLORATIONS, 2016 CAQH INDEX: A REPORT OF HEALTHCARE INDUSTRY ADOPTION OF ELECTRONIC BUSINESS TRANSACTIONS AND COST SAVINGS 3 (2016), https://www.caqh.org/sites/default/files/explorations/index/2016-caqh-index-report.pdf?token=qV_h14H5.

responsibility for serving entire geographic areas, Medicare could impose global budgets that create incentives for non-medical community investment.¹⁹⁰ Both actual expansions of Medicare coverage and proposals that generalize Medicare payment practices to all payers might make this possible. A weakness is that Medicare tends to construct its payment bundles by combining the payments for items that it previously reimbursed individually, rather than by estimating a packaged price from observable markets in assembled services. For this reason, MA plans might be able to restructure payment more flexibly than traditional fee-for-service Medicare, and MA plans can exclude lower performing or less adaptive providers in ways that traditional Medicare by law cannot.

With respect to physician cost discipline, countering “surprise medical bills” from anesthesiologists, assisting surgeons, and other physicians who turn out, unexpectedly, to not have network contracts with insurers become a significant regulatory challenge in recent years. Federal legislation in 2020 first prohibited billing by providers for COVID-19 care.¹⁹¹ Later, broader “No Surprises Act” protections were put in place, holding patients harmless beyond in-network cost-sharing amounts in both emergencies and certain non-emergency situations in which patients are unable to choose an in-network provider, with payment disagreements between providers and insurers resolved by independent dispute resolution.¹⁹² Medicare-based payment reforms could do even more to avoid unexpected balance or surprise billing.¹⁹³ By law, Medicare Advantage plans can cap out-of-network exposure at fee-for-service Medicare rates, including a

190 Medicare and Medicaid recently revised definitions of permissible services to enable MA plans, Medicaid managed care plans, and hospitals to expend government funds on transportation, housing, and similar services that enable the delivery of effective medical care. See NAT. ACADS. OF SCIS., ENG’G, AND MED., INTEGRATING SOCIAL CARE INTO THE DELIVERY OF HEALTH CARE: MOVING UPSTREAM TO IMPROVE THE NATION’S HEALTH 117 (2019) (describing federal legal authorizations for health-related social services). At the state level, Maryland has a federal waiver in place that allows it to pay hospitals based on total cost of care. *Maryland Total Cost of Care Model*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://innovation.cms.gov/initiatives/md-tccm/> (last visited Aug. 1, 2021); see also Jesse M. Pines et al., *Maryland’s Experiment with Capitated Payments for Rural Hospitals: Large Reductions in Hospital-Based Care*, 38 HEALTH AFFS 594 (2019) (measuring effects of Maryland’s initial pilot program).

191 See AM. MED. ASS’N., ISSUE BRIEF: BALANCE BILLING FOR COVID-19 TESTING AND CARE - FEDERAL AND STATE RESTRICTIONS (2020), <https://www.ama-assn.org/system/files/2020-05/issue-brief-balance-billing-covid-19-testing-care.pdf> (explaining CMS position on balance billing in the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. No. 116-136, § 3202, 134 Stat. 281, 367 (2020)).

192 Consolidated Appropriations Act of 2021, H.R. 133, 116th Cong. § 101-118 (2021) (No Surprises Act).

193 See Kevin A. Schulman et al., *Resolving Surprise Medical Bills*, HEALTH AFF.: BLOG (July 10, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20190628.873493/full/>. Private equity firms have selectively invested in specialty physician groups who can maintain non-network status, not only worsening surprise billing practices but also enhancing those groups’ leverage to negotiate higher network contract rates.

prohibition on “balance billing” patients for amounts not reimbursed by insurance.¹⁹⁴

Because traditional Medicare’s convoluted approach to fee-for-service payment is a principal cause of the underlying problem, however, MA plans alone probably have limited ability to engineer a comprehensive solution unless and until they represent the substantial majority of Medicare beneficiaries. Medicare expansion plans based on MA plans could accelerate this trend.

2. *Reducing Claims Middlemen*

Many “health insurers” are merely contract administrators, with true risk of financial loss borne by self-funded employers (for private coverage) or by government programs. Traditional Medicare became a substantial cause of such intermediation when—bowing to the AMA’s demand for unthreatening payment mechanisms—the federal government entered into contractor agreements to perform those functions with established BCBS plans (which were originally called “fiscal intermediaries” for Medicare Part A and “carriers” for Medicare Part B).¹⁹⁵ As mentioned previously, the principal tasks associated with the administrative role in employer-based health plans include verifying eligibility, assembling and maintaining provider networks, negotiating provider payment, and processing claims.

For different reasons, neither governments nor private employers have proved to be demanding customers for most health plans, which in turn are seldom disciplined negotiators with providers or innovators with respect to benefit design. For political reasons, government insurance programs tend to disfavor competitive bidding or other measures that selectively channel enrollees to more cost-conscious organizations. On the private side, even the largest national employers seldom have sufficient geographic concentration to exert meaningful leverage over health care providers and would suffer very high switching costs if they attempted to withdraw business from one giant insurance administrator in favor of another. As a result, the health plan sector essentially takes a percentage of the vast sums of money passing through them from true payers to health care providers, which limits its incentive to pursue innovations that might substantially decrease that flow of funds.¹⁹⁶

194 Robert A. Berenson et al., *Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices*, 34 HEALTH AFF. 1289, 1292 (2015).

195 *Medicare Administrative Contractors*, CTRS. FOR MEDICARE AND MEDICAID SERVICES (2019), <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/MedicareAdministrativeContractors>.

196 There are exceptions, of course. Some employers, typically medium-sized companies with locally concentrated workforces, have greater ability to find or induce insurers to be effective third-

Again, Medicare-for-All might help. An undoubted strength of single-payer programs is to lower administrative costs. Greater transparency associated with the Medicare Administrative Contractor process could avoid overpayment for ministerial tasks, while changes in Medicare benefits that rationalize services and reduce claims volume could further streamline administration. For approaches centering on managed care, MA plans seem to do better than commercial health plans at keeping members healthier and costs down, partly because Medicare beneficiaries who choose MA plans tend not to switch plans in subsequent years, and partly because a higher percentage of elderly patients are at risk of serious illness.¹⁹⁷ Whether this would hold true for a universal MA entitlement is unclear.

3. *Disintermediating Physicians from Many Transactions*

The U.S. health care system still conceptualizes its products and services—no matter how expensive, technologically advanced, physically substantial, or dependent on a broader workforce—as extensions of the “black bag” that accompanied physicians on house calls a century ago. Often by law, physicians retain exclusive decisional authority over most health care services through prescription, order, or referral. Similarly, health insurance payment is generally limited to services that physicians request, which helps insurers demarcate the boundary between covered medical benefits and excluded non-medical services. Physician intermediation also permits certification of necessity, both for processing coverage and for deterring fraud.

However, continual physician intermediation imposes expense and delay, restricts other health professionals (and non-professionals) from practicing at the top of their training, and discourages self-care even for straightforward conditions. It is only a slight exaggeration to say that the U.S. health care system is perfectly crafted to prevent people from taking care of their own health-related needs. Bringing physicians into so many transactions also adds complexity to addressing social determinants of health, which is generally a non-medical endeavor.¹⁹⁸

Because the drivers of physician control and intermediation are often state laws and federal payment policies, one might welcome a Medicare-for-All approach that emphasizes nationally uniform practice regulations, coverage, and reimbursement categories less tethered to the traditional professional hierarchy, and facilitation of self-care (including remote or asynchronous services delivery

party administrators of their coverage. Some health plans operate disease-management programs that successfully reduce emergency department visits and hospitalizations.

¹⁹⁷ See Gretchen Jacobson et al., *Medicare Advantage Plan Switching: Exception or Norm?*, KAISER FAM. FOUND. (Sept. 20, 2016), <https://www.kff.org/report-section/medicare-advantage-plan-switching-exception-or-norm-issue-brief/> (describing how about 10% of MA plan members switch each year).

¹⁹⁸ See *supra* notes 122-142 and accompanying text.

through telehealth). This would be a major change from existing Medicare practices, however, which often cede authority to physician-led advisory bodies (e.g., the Relative Value Scale Update Committee for Medicare physician payment) and which continue to rely on physicians as gatekeepers for non-fraudulent federal expenditures.¹⁹⁹ As a result, progress on workforce flexibility and patient direction likely would depend on the degree to which those advocating for policy change could resist the political influence of established interest groups when crafting rules and guidelines for a Medicare expansion.

4. *Managing Consolidated Provider Markets*

When competition is threatened in the private economy, one expects a response from the U.S. Department of Justice or the Federal Trade Commission, the two public enforcers of the federal antitrust laws. In health care, this expectation is frustrated by (at least) two facts. First, competition is constrained more by other laws governing the health care system than by purely private conduct, and federal antitrust laws have limited purchase over that regulatory architecture.²⁰⁰ Second, U.S. antitrust law is better suited to preventing corporate mergers and acquisitions that might confer market power than to restoring competition in markets that have already consolidated, which has become the case for the majority of American hospitals, many physician specialists, and many health insurers.²⁰¹ This is because antitrust enforcers and reviewing courts prefer structural remedies that promote actual competition to conduct remedies that simulate competitive outcomes – and structural remedies are difficult to impose on an existing monopolist.²⁰² COVID-19 appears to be further consolidating health

199 The Relative Value Scale Update Committee (RUC) is composed of thirty-two physician members approved by the AMA, with twenty-two nominated by major national medical specialty societies. *Composition of the RVS Update Committee*, AM. MED. ASS'N, <https://www.ama-assn.org/about/rvs-update-committee-ruc/composition-rvs-update-committee-ruc> (last visited Aug. 1, 2021) (providing an overview of RUC composition). For a detailed analysis of the RUC's anticompetitive effects, see MIRIAM J. LAUGESSEN, *FIXING MEDICAL PRICES: HOW PHYSICIANS ARE PAID* 3-5, 23-46 (2016).

200 See William M. Sage & David A. Hyman, *Antitrust as Disruptive Innovation in Health Care: Can Limiting State Action Immunity Help Save a Trillion Dollars?*, 48 *LOY. U. CHI. L.J.* 724, 730-34 (2017) (examining the potential effects of recent Supreme Court rulings on reducing anti-competitive professional regulation in health care).

201 See HEALTHCARE FINANCIAL MANAGEMENT ASS'N, *HEALTH CARE 2020: CONSOLIDATION* (2016), <https://www.hfma.org/industry-initiatives/health-care-2020.html>.

202 See Thomas L. Greaney, *Commentary, Competition Policy After Health Care Reform: Mending Holes in Antitrust Law's Protective Net*, 40 *J. HEALTH POL., POL'Y & L.* 897, 900 (2015) (describing the problem of extant market power); see also William M. Sage, *Antitrust Enforcement and the Future of Healthcare Competition*, in *OXFORD HANDBOOK OF U.S. HEALTHCARE LAW* 606 (I. Glenn Cohen et al. eds., 2016) (examining the limited power of competition law in health care). The Herfindahl-Hirschman Index (HHI) is calculated by summing the squares of the percentage of the

care markets, as smaller competitors who were more vulnerable to the financial volatility produced by the pandemic are bought out by their larger, better capitalized rivals.²⁰³

Medicare-for-All approaches could be beneficial for three reasons. Most obviously, a true single-payer plan creates a regulatory counterweight to anti-competitive behavior in consolidated markets. Whether Medicare could play this role effectively depends on political factors, notably the ability to overcome interest-group favoritism and act in the broader public interest. Second, approaches that would apply Medicare pricing throughout a market could blunt the pricing power associated with consolidation. Along these lines, a novel bill was introduced in Congress in early 2019 that offered health care providers in consolidated markets a choice: reduce concentration to below a prescribed threshold (using the Herfindahl-Hirschman Index), or accept Medicare pricing.²⁰⁴ Third, many of the state laws that Medicare could supersede on a nationally uniform basis, such as professional licensing laws and certificate-of-need requirements for capital investments, constitute barriers to entry for new competitors. Consolidation is less likely to have anti-competitive effects in markets where entry barriers are low.

5. *Reining in Drug Costs by Rethinking Innovation Funding*

Extremely high prices for innovative prescription drugs and other biopharmaceuticals are common motivators for further health care reform. Novel therapies to ameliorate serious chronic conditions routinely generate charges exceeding \$100,000 annually, while prices for established drugs have increased rapidly in recent years.²⁰⁵ One problem is that supply chains for drug distribution and purchasing have become bizarrely complex—often involving non-transparent cash flows in both directions—and can be simplified by federal regulation. Examples include recent proposals by FDA to require price transparency in direct-to-consumer drug advertising and to repeal exceptions to fraud and abuse laws that had allowed a system of hidden but sizeable “rebates” to flourish.²⁰⁶ The core

market served by each competitor. The HHI for five firms each with 20% of the market is 2,000; the HHI for two firms each with 50% of the market is 5,000.

203 See Reed Abelson, *Buoyed by Federal COVID Aid, Big Hospital Chains Buy Up Competitors*, N.Y. TIMES (May 21, 2021), <https://www.nytimes.com/2021/05/21/health/covid-bailout-hospital-merger.html?searchResultPosition=1>.

204 Hospital Competition Act of 2019, H.R. 506, 116th Cong. (2019).

205 NAT’L ACADS. OF SCI., ENG’G, AND MED., MAKING MEDICINES AFFORDABLE: A NATIONAL IMPERATIVE 11-17 (2018).

206 See Alex M. Azar, Sec’y, U.S. Dep’t Health & Hum. Servs. Remarks on Drug Pricing to the National Academy of Medicine (Oct. 15, 2018). The Trump Administration formulated a rule to make drug rebates unlawful, but then withdrew the rule after push-back from industry. See Peter Sullivan, *White House Withdraws Controversial Rule to Eliminate Drug Rebates*, HILL (July 11, 2019), <https://thehill.com/policy/healthcare/452561-white-house-withdraws-controversial-rule-to->

challenge of prescription drug policy, however, remains unsolved. It is to reconcile the trivial marginal cost of producing additional doses of most drugs with the staggering initial investment necessary to invent those therapies and to demonstrate their safety and effectiveness.

The solution, simply put, is to begin to decouple the costs of drug development from the price paid at the point of care for an individual patient. Medicare-for-All creates a significant opportunity to do so. Those seeking to lower drug prices often focus on using the government's greater negotiating power, backstopped by the threat of imposing direct price controls or altering intellectual property rights. Purchasing at the population level makes it possible to pursue truly radical approaches to making lifesaving therapies widely available. Australia, for example, recently negotiated a fixed-fee license for curative Hepatitis C medication.²⁰⁷

Moreover, FDA regulation of biopharmaceuticals is the most extensive health-related gatekeeping function that operates through federal rather than state law. The federal government also acts as the principal funder of biomedical research through the NIH, National Science Foundation, and other entities. These synergies would enable a Medicare-for-All system to pursue comprehensive reform—combining better technology assessment, fully aligned coverage standards, novel purchasing strategies, streamlined FDA regulation, and enhanced direct research funding—that substantially lessens the perceived tension between present pricing and future innovation.

6. *De-Medicalizing Social Problems*

The apparent imbalance in government expenditures between medical care and non-medical social services is one of the most damning consequences of Medicare's Gilded Age. As the social determinants and disparities literatures demonstrate, the easiest way to improve health is to increase wealth, education, and community cohesiveness.²⁰⁸ Instead, the United States often treats poverty and other social problems as medical ones.²⁰⁹ This has increased expense, widened injustice, distorted community support, and—because of the dependency inherent in the patient role—arguably diminished individual initiative far more than would have resulted from providing substantially greater cash assistance to the poor.

eliminate-drug-rebates.

²⁰⁷ See Suerie Moon & Elise Erickson, *Universal Medicine Access through Lump-Sum Remuneration—Australia's Approach to Hepatitis C*, 380 NEW ENG. J. MED. 607, 607 (2019). This subscription approach, sometimes called the "Netflix model," is being pursued domestically at the state level, notably in Washington State and Louisiana.

²⁰⁸ See *supra* notes 127-147 and accompanying text.

²⁰⁹ BRADLEY & TAYLOR, *supra* note 136, at 78; Sage & Laurin, *supra* note 138, at 575-76.

With sufficient political will, Medicare-for-All could help public policy turn the corner toward substantially greater non-medical social investment. Small steps are already being taken, such as authorizing MA plans and some Medicare providers to use federal funds for housing, transportation, and other social needs that benefit health.²¹⁰ Much greater change—achievable only if still-daunting fiscal barriers are overcome—would be possible if Medicare-for-All were fully “on-budget,” forcing taxpayers to compare directly the costs and benefits of medical versus non-medical expenditures. The risk is that, in the short term, further enhancing the percentage of the federal budget devoted to health will make entrenched interest groups stronger rather than weaker in their pursuit of privileges and subsidies. Over the longer term, however, one would hope it would become difficult for those groups to justify maintaining the status quo.

CONCLUSION

If one looks closely at medicine’s “modern era” of technological progress—funded largely by the original Medicare program—several gilded aspects become apparent. Scratching the surface of the American health care system reveals far less impressive characteristics: waste, injustice, and neglect.²¹¹ Many of the services the health care system funds and provides are simultaneously inefficient and inequitable, while medicalizing the social safety net crowds out fairer and more cost-effective investments in health-related but non-medical support for individuals and communities.

As the Biden Administration explores options for post-pandemic health reform, Medicare-for-All offers a test of both discourse and decision-making in liberal democracy, which increasingly seems under siege in the United States and abroad. Because over a trillion dollars of annual medical spending currently languishes less productively than it might, rebalancing the nation’s health-related policy priorities presents substantial opportunities to both address disparities and enhance welfare.²¹² Partisan sniping over single-payer proposals as “socialized medicine” is counter-productive. Instead, the political conversation around Medicare-for-All might deepen, both morally and in response to what has been

210 See NAT. ACADS. OF SCI., ENG’G, AND MED., *supra* note 190, at 109-36 (discussing how to finance social care); Maria Castellucci, *Insurers Want to Lead if CMS Pilots Payments for Housing, Social Determinants of Health*, MOD. HEALTHCARE (Dec. 15, 2018), <https://www.modernhealthcare.com/article/20181215/NEWS/181219967/insurers-want-to-lead-if-cms-pilots-payments-for-housing-social-determinants-of-health>.

211 For a perceptive and entertaining examination of Medicare’s arguable flaws, see DAVID A. HYMAN, *MEDICARE MEETS MEPHISTOPHELES* 27–39 (2006) (providing a C.S. Lewis-style epistolary analysis of Medicare as the devil’s handiwork).

212 See generally William M. Sage, *Fracking Health Care: The Need to Safely De-Medicalize America and Recover Trapped Value for Its People*, 11 N.Y.U. J.L. & LIBERTY 635 (2017) (noting the potential for wasteful health care expenditures to be captured and repurposed).

learned about deficiencies and opportunities in the current system.

Politics may be the art of the possible, but pragmatism that renders principle invisible is not something to be celebrated. For the Biden Presidency to be transformational in health policy, it must keep progressive principles at the forefront. The Biden Administration will get things done by being strategic in priority-setting, procedure, and messaging—not by retreating to an incrementalism that discards principle out of misperceived necessity. Considering its substantial collective responsibility for current conditions, moreover, the American medical profession cannot sit on the sidelines during this effort. It must help lead.

A principled re-evaluation of post-pandemic health policy through a Medicare-for-All lens enables diverse democratic values to be considered: welfare, justice, freedom, and civic republicanism among them. Justice and self-governance were clear elements of the original Medicare program, which redistributed resources toward an aging generation that had forgone earnings during the Great Depression and World War, as well as connecting the patriotism of that generation to democratic renewal, including racial desegregation, in a country that had benefited from its sacrifices. Tensions among these values can be explored as well, such as the unexpected distance that America's prolific but distorted medical marketplace often inserts between entering into seemingly voluntary medical transactions and actually experiencing improvements in subjective welfare.²¹³

Can the United States build social solidarity around health as a collective obligation even if not as an individual right? Without such a commitment, it is difficult to counter both special interests and the constraints of fiscal politics. What guardrails should be placed around market processes in medical care in order to generate better social outcomes? Original Medicare's blank-check approach sent many medical industries into overdrive, with unpredictable and ultimately hazardous consequences. Medicare-for-All might facilitate developing a channeled competitive framework closer to the National Health Service's "internal market" in Great Britain.²¹⁴ Universalizing Medicare might also generate a different dialogue about the "Nanny State." The language of opportunity almost universally resonates with the American public. In some situations, however, direct investments in health may be necessary to overcome community characteristics that render individual choice illusory. In other situations, providing cash assistance

213 Legal theorists have periodically engaged these issues, but sometimes have posited a dichotomy between free markets and government control that, while intellectually engaging, does not capture the range of possibilities for actual health system governance. *See, e.g.,* RICHARD A. EPSTEIN, *MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE* (1997) (arguing both liberty and efficiency).

214 In terms drawn from popular culture, regularizing how government helps structure medical markets might bring the U.S. health care system a bit closer to *The Truman Show*, instead of today's *Jurassic Park*-like environment.

outside of the medical frame may enhance both liberty and welfare.

America is a decade into the Affordable Care Act, a law that ascribed considerable importance to care delivery and population health. Despite the deadliest pandemic in over a century, the political process has yet to move past the ACA's relatively straightforward provisions regarding insurance expansion.²¹⁵ As a result, the nation has barely begun to confront the deeper shortcomings of U.S. medicine and health discussed in this Article.

A critical first step for the Biden Administration is demanding ethical leadership from the American medical profession, which U.S. law continues to charge with substantial responsibility for health system design and operation. This requires a forward-looking commitment to innovation in justice as well as effectiveness, not misguided nostalgia for a golden age that never was.

²¹⁵ See generally William M. Sage, *Putting Insurance Reform in the ACA's Rear-View Mirror*, 51 HOUS. L. REV. 1082 (2014) (noting that the ACA's most significant reforms go beyond health insurance to encompass health care delivery and underlying health).