

HEALTH CARE REFORM: PERSPECTIVES FROM THE ECONOMIC THEORY OF REGULATION AND THE ECONOMIC THEORY OF STATUTORY INTERPRETATION

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INTRODUCTION

Health care currently consumes more than fourteen percent of the United States' gross domestic product.¹ President Clinton has proposed radically changing this entire segment of the economy by offering a government-run system of universal health insurance.² As originally conceived, the Clinton plan would have provided certain standard benefits—including hospital care, visits to physicians, and prescription drugs—to all Americans through a system of regional health care purchasing alliances, which were to have received their funding through government subsidies and mandatory contributions from employers and employees.³ Indeed, with the exception of employers of over 5000 people, all employers would have been *required* to procure health insurance from their regional alliance, as well as to pay for eighty percent of the costs of health insurance for their employees—up to 7.9% of payroll.⁴ Furthermore, with few exceptions,⁵ the Clinton plan would have *required* all Americans to enroll in a health plan offered by their regional alliance.⁶ Those who failed to enroll would be assigned to plans automatically and made to pay premiums to their assigned plan.⁷ Never before has a politician proposed bring-

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¹ Theodore R. Marmor & Jonathan Oberlander, *A Citizen's Guide to the Health Care Reform Debate*, 11 *YALE J. ON REG.* 495, 496 (1994).

² Health Security Act, H.R. 3600, 103d Cong., 1st Sess. (1993) [hereinafter HSA].

³ HSA §§ 1101 (benefit package), 1341-1375 (funding).

⁴ HSA § 6123; NFIB/HEAL, *Study Criticizes Mandates, Business Subsidies in Clinton Health Plan*, 21 *Pens. & Benefits Rep. (BNA)* No. 16, at 785, 786 (Apr. 18, 1994).

⁵ The exceptions are persons receiving Medicare, veterans benefits, or military benefits or working for corporations employing more than 5000 people. HSA §§ 1002(a)(1) (Medicare), 1004(a) (large corporations), 1004(b) (veterans, persons receiving military benefits).

⁶ HSA § 1001.

⁷ HSA § 1002.

ing such a large part of the American economy under government control outside of war time.⁸

In order to administer the new system, the Clinton plan would have created 105 new government bureaucracies and enlarged 47 others.⁹ Because one of the primary objectives of this superstructure would be to contain costs, a National Health Board, comprised of the President's political appointees, would have to decide how much to spend on health care, and would dictate what the average health plan in each region could cost.¹⁰ The bill sought to forbid plans that cost more than 120% of the average plan, thus limiting the amount that people could spend on health care.¹¹ As Elizabeth McCaughey observed in her comprehensive analysis of the Clinton plan, "[t]he goal [of the Clinton health care plan] is to curb spending by limiting what every American is allowed to pay for health insurance."¹² Predictably, such radical proposals for change generated opposition. Largely in response to concerns over the restrictive and mandatory nature of the proposed system, the President's plan lost momentum and stalled out in Congress.¹³

This Article employs the economic, or "interest group," theory of regulation to explore the current debate about reform and regulation of the health care industry. It will focus on the Health Security Act (HSA), the work product of the Health Care Task Force which was organized by President Bill Clinton and directed by Ms. Hillary Rodham Clinton. Part I of the Article briefly contrasts the economic theory of regulation with public-interest theory, and then proceeds to discuss aspects of the economic theory that are of particular importance in understanding the health care debate. Part II provides a brief discussion of the critical features of health care reform, and then explores the interest-group aspects of those features.

Descriptively, this analysis will show that the critical features of President Clinton's proposal were inconsistent with the traditional public-interest approach to regulation, but were entirely consistent with the economic theory of regulation. Through consideration of the HSA, this analysis will cast doubts on the *possibility* of achieving net improvements in social welfare through legislative reform of any sort.

⁸ *American Survey: Kill or Cure?*, ECONOMIST, Sept. 25, 1993, at 31.

⁹ *All Things Considered*, (National Public Radio broadcast Jan. 26, 1994) (interview with Arlen Spectre), available in LEXIS, News Library, Transcript # 1374-20.

¹⁰ See HSA § 6001.

¹¹ Elizabeth McCaughey, *No Exit: What the Clinton Plan Will Do For You*, NEW REPUBLIC, Feb. 7, 1994, at 21.

¹² *Id.*

¹³ J. Jennings Moss, *Clinton Prescription Rejected by Body Politic*, WASH. POST, Sept. 22, 1994, at A10.

I

THE ECONOMIC THEORY OF REGULATION

A. Public-Interest Theory vs. Economic Theory of Regulation

Two competing theories have been offered to explain the role of government in regulating society: the public-interest theory and the interest-group (economic) theory. This section sets out the basic frameworks of these two approaches.

Developed by A. C. Pigou, the public-interest theory of regulation holds that regulation is designed to benefit the public by solving collective action problems and intervening when the private market fails to allocate resources properly.¹⁴ Public-interest theory maintains that government should correct these failures through regulation, for example, through taxes or subsidies designed to push markets toward a "socially optimal" equilibrium.¹⁵

To reach this conclusion about the role of government, public-interest theory indulges some curious assumptions about the nature of government. For example, public-interest advocates assume that the government has the ability both to identify and to correct market failures without cost.¹⁶ As McCormick and Tollison note, "the Pigovian approach assumes an all-knowing, benevolent government."¹⁷ Such presumptions have spawned the general criticism that public-interest theory "is not a very *believable* theory of government action."¹⁸

The economic, or "interest group," theory of regulation derives from a starkly different view of government and the legislative processes. To borrow Judge Richard Posner's description, the economic theory of regulation "asserts that legislation is a good demanded and supplied much as other goods, so that legislative protection flows to those groups that derive the greatest value from it, regardless of overall social welfare."¹⁹ The theory further holds that political actors behave just like private-sector consumers and businesses—they attempt to maximize their own self-interest.²⁰ Thus, the economic theory of regulation analyzes decisions made by politicians,

¹⁴ A. C. PIGOU, *THE ECONOMICS OF WELFARE* (4th ed. 1932).

¹⁵ For a description of the public-interest model, see ROBERT E. MCCORMICK & ROBERT D. TOLLISON, *POLITICIANS, LEGISLATION, AND THE ECONOMY: AN INQUIRY INTO THE INTEREST GROUP THEORY OF GOVERNMENT* 3 (1981).

¹⁶ *Id.* at 3-4.

¹⁷ *Id.* at 4.

¹⁸ *Id.* at 3.

¹⁹ Richard A. Posner, *Economics, Politics, and the Reading of Statutes and the Constitution*, 49 U. CHI. L. REV. 263, 265 (1982).

²⁰ MCCORMICK & TOLLISON, *supra* note 15, at 5.

bureaucrats, and interest-groups in accordance with generally accepted principles of rational economic behavior.²¹

It will be useful to examine the market for legislation in some detail. On the demand side of the equation, interested parties form distributional coalitions in order to pool resources and trade them in exchange for legislation that provides private benefits to members of the distributional coalition.²² Interest groups or coalitions of interest groups that outbid their rivals obtain favorable legislation from the politicians who populate the supply side of the equation. The currency used in the bidding takes "the form of campaign contributions, votes, implicit promises of future favors, and sometimes outright bribes."²³ Legislation flows to interest groups because politicians need the resources these groups can provide in order to remain in office.

The economic theory of regulation does not suggest that politicians are necessarily evil, greedy, or venal. Rather, democracy by its very nature places politicians in a Darwinian struggle for survival. To win that struggle, politicians must receive more votes than their rivals. Hence, they will compete with their rivals to demonstrate their superior ability and willingness to supply the legislation demanded by those constituents who can best support their vote-getting efforts.

This process naturally focuses the attentions of politicians on interest groups rather than on the mass of average citizens, because interest groups are better able to provide the competitive political resources that politicians need for survival than are highly diffuse, disorganized citizens. Unlike interest groups, citizens face high organizational costs that act as barriers to forming effective political coalitions. Therefore, the economic theory of regulation focuses on the differing organizational costs that rival political coalitions face.²⁴

Efficiency considerations indicate that a group forms into an effective political coalition when the benefits from achieving wealth transferred from the legislature outweigh the costs of organizing. For a number of reasons, some groups will be able to organize into distributional coalitions more cheaply than others.²⁵ In particular, groups that have already formed into coalitions for exogenous reasons, such as mutual professional interests (e.g., lawyers, doctors, and bankers), will find that the marginal costs of diverting their activities to the political arena are far outweighed by the benefits from the favorable legis-

²¹ See *id.*

²² William M. Landes & Richard A. Posner, *The Independent Judiciary in an Interest-Group Perspective*, 18 J. L. & ECON. 875, 877 (1975).

²³ *Id.*

²⁴ McCORMICK & TOLLISON, *supra* note 15, at 16-18.

²⁵ *Id.*; MANCUR OLSON, *THE RISE AND DECLINE OF NATIONS: ECONOMIC GROWTH, STAGFLATION, AND SOCIAL RIGIDITIES* 18 (1982).

lation such activities can procure. Thus, focusing on the factors that influence the costs of forming an effective political coalition can enable economists, political scientists, and lawyers to predict the contours of future legislation.²⁶

To take a simple example, suppose a proposed piece of legislation will transfer \$250 million to a particular interest group. Suppose further that the legislation imposes direct costs (such as taxes) and indirect costs (such as reductions in the efficiency of the economy) totalling \$20 on every man, woman, and child in America. Clearly, passage of the legislation results in a net reduction of social welfare. Nevertheless, the economic theory of regulation suggests that it will pass. While the interest group will expend resources up to the full amount of the prospective gain to ensure passage of the legislation, no individual will be willing to spend more than \$20 to ensure its defeat. However, by the time any individual spends the resources to (1) learn about the existence of the proposal, (2) understand its merits and implications, (3) search for and discover others willing to oppose the legislation, (4) mobilize like-minded individuals to voice their opposition, and (5) signal legislators that defeating the legislation is the price of their support, the costs to the individual probably far outweigh the expected savings (\$20) of defeating the legislation. Consequently, the rational course of action of an individual citizen under such circumstances is not only to refrain from organizing to oppose the legislation, but also to remain ignorant of its effects and possibly even ignorant of its existence. Hence, an interest group seeking to obtain legislation with highly concentrated benefits and diffuse costs can generally count on little popular opposition.

Thus, while qualifications sometimes are in order, the economic theory of regulation generally predicts that legislation will be characterized by concentrated benefits for discrete groups and widely disbursed costs. Legislatures pass laws to benefit groups that can trade political support in exchange for their passage, while the costs of such legislation are shifted onto those in the worst position to object—the amorphous and desegregated public. Moreover, the realities of the political marketplace provide strong incentives for politicians themselves to search actively for issues where the winners are easily identified and vote their gratitude, while the losers are poorly identified and unable to object effectively.²⁷ The losers pay for legislation that bene-

²⁶ See McCORMICK & TOLLISON, *supra* note 15, at 18-22, 123-27.

²⁷ Jonathan R. Macey, *Promoting Public-Regarding Legislation Through Statutory Interpretation: An Interest Group Model*, 86 COLUM. L. REV. 223, 224 (1986) (“[M]arket forces provide strong incentives for politicians to enact laws that serve private rather than public interests, and hence statutes are supplied by lawmakers to the political groups or coalitions that outbid competing groups.”).

fits interest groups through higher taxes, increased regulatory burdens at all levels, and higher prices for goods and services.²⁸

Within the economic theory of regulation, marginal conditions still hold. By this we mean that politicians will continue to supply legislation to favored groups until the benefits in the form of increased political support are outweighed by the costs, which take the form of opposition to such legislation from rival groups.²⁹ After all, while politicians would like to pass uncontroversial legislation (i.e. legislation that only harms scattered and unorganized individuals), that will not always be possible. Virtually all interest groups have rivals, and individual citizens can overcome rational ignorance through newspapers, magazines, and television news accounts, and by organizing into interest groups. Thus, at the margin, passing legislation that benefits special interest groups is not without costs for politicians. Certain individuals and groups are likely to oppose any new legislation, particularly the legislation that obviously serves no legitimate public purpose, or that plainly benefits one special interest group at the expense of another. In other words, politicians face an opportunity cost when they pass laws. The benefits they receive in the form of increased political support from certain groups are offset by the opposition that the passage of such laws brings from other groups.³⁰ Operating under these constraints, the politicians' goal is to maximize net political support.³¹

B. Aspects of the Economic Theory of Regulation That Illuminate the Health Care Debate

Several aspects of the economic theory of regulation which are particularly important to understanding the health care debate will be considered below.

²⁸ Jonathan R. Macey, *Transaction Costs and the Normative Elements of the Public Choice Model: An Application to Constitutional Theory*, 74 VA. L. REV. 471, 478-80 (1988).

²⁹ For example, the National Association of Manufacturers can be expected to galvanize into an effective political coalition to resist legislation proposed by trial lawyers attempting to make it easier for plaintiffs to succeed in products liability suits.

³⁰ A recent development in the Canadian health care system provides an interesting example of a situation where politicians were able to incur relatively small political opportunity costs in passing legislation that was favorable to politically important groups. In order to deal with rising health care costs and increasing budget deficits, the Canadian government in April canceled the health insurance coverage of over 66,000 tax-paying Canadian residents who are in the country on temporary work visas. The decision saves the Canadian government over \$21 million and postpones the need for more unpopular fiscal measures. According to Jane Fulton, a health care expert at the University of Ottawa, "[t]he bureaucrats have targeted a vulnerable and less skilled group because they are least likely to make a fuss." Anne Swardson, *Canada's Vaunted Health Care System Limiting Coverage, Reducing Services*, WASH. POST, April 19, 1994, at 12.

³¹ See Sam Peltzman, *Toward a More General Theory of Regulation*, 19 J. L. & ECON. 211, 214 (1976).

1. *Exploitation of Asymmetric Control of Information by Politicians and Interest Groups*

As illustrated in the previous section, members of the general public have little or no incentive, let alone ability, to promote generally beneficial laws or to oppose those contrary to the public interest. The public remains rationally ignorant because the benefits of being informed on social issues do not justify the costs of finding the information.

This is not to say, however, that information will not find them. Both interest groups and entrepreneurial politicians have a significant stake in supplying voters with information. On the one hand, entrepreneurial politicians may seek out and identify issues and concerns relevant to their constituents. Such politicians can move the public to adopt the politician's point of view.³² In the process, entrepreneurial politicians may find it possible and convenient to form their own interest groups around the issues they have chosen. Indeed, Mancur Olson has observed that entrepreneurial politicians can use "indoctrination and selective recruitment" to increase the homogeneity of the groups they organize,³³ and to ensure that the groups will have strong preferences for the laws they propose. To the extent that the politician controls the supply of information to such groups or to his constituents at large, he can control the formation of their preferences.

On the other hand, independent interest groups may control the generation and dissemination of information that goes to politicians themselves.³⁴ When, in turn, the politicians try to monopolize (or at least dominate) the flow of information to the general public, they end up presenting the issue in the light most favorable to the interest group which supplied them with their information in the first place. Indeed, because interest groups play a crucial role in supplying information, particularly on technically complex subjects,³⁵ even well-intentioned politicians, presented with one-sided information, may honestly believe they are acting in the public interest when they are in fact subject to partisan influence.

Ultimately, then, the information that reaches the rationally ignorant voter has passed through partisan filters. Thus, the superior ability of interest groups and entrepreneurial politicians to control the

³² OLSON, *supra* note 25, at 25.

³³ *Id.*

³⁴ GRAHAM K. WILSON, *INTEREST GROUPS IN THE UNITED STATES* 113-14 (1981) (quoting Senator Metcalf remarking on the essential function of lobbying groups in supplying information, particularly on technical subjects); NORMAN J. ORNSTEIN & SHIRLEY ELDER, *INTEREST GROUPS, LOBBYING AND POLICYMAKING* 75-76 (1978).

³⁵ See *supra* note 34.

flow of information to the public has a profound effect on public opinion about important issues.³⁶ The man on the street may find himself aligned in his opinions with an interest group, even when it is not in *his* interest to be. That is not to say that the man on the street is a fool; rather, politicians and/or interest groups contrive to deceive him in ways that are difficult to recognize.

Politicians shape issues so that it is costly for the losers to learn about their effects. One way to accomplish this is to couch special interest oriented legislation in public interest terms. By doing this, politicians may avoid some of "the political fallout associated with blatant special interest statutes."³⁷ Another strategy is to maximize the ambiguity or complexity of legislation, thus making it difficult for the public to discern its true ramifications.

2. *Exploitation of Market Power by Politicians in the Market for Legislation*

Politicians have incentives to pass statutes that artificially increase the demands for their services. This can be done in two ways. One way is known as rent extraction.³⁸ Rent extraction refers to the phenomenon by which entrepreneurial politicians use the threat of imposing new regulation to extract political support from interest groups who wish to remain free of regulatory interference.³⁹ This tactic is particularly useful where a group has made specific capital investments that can be expropriated in the political process.⁴⁰

In addition, politicians can increase demand for their services by lowering the political costs to interest groups of petitioning for regulatory assistance. Whereas a particular group may lack the organizational capacity to form an effective coalition to press for a particular regulatory outcome, it may have sufficient organizational skills to petition for assistance if a program is already in place. By creating a system of government benefits, and then inviting or requiring groups to *apply* for assistance, politicians can artificially expand the demand for their services. For example, social security programs currently in place have spawned an entire cottage industry consisting of Congressional aides who specialize in making sure that Congressional constituents receive the social security benefits to which they are ostensibly entitled.⁴¹

³⁶ ORNSTEIN & ELDER, *supra* note 34, at 33-34.

³⁷ Macey, *supra* note 27, at 233.

³⁸ Fred S. McChesney, *Rent Extraction and Rent Creation in the Economic Theory of Regulation*, 16 J. LEGAL STUD. 101, 102-03 (1987).

³⁹ *Id.*

⁴⁰ *See id.*

⁴¹ ROGER H. DAVIDSON & WALTER J. OLESZEK, CONGRESS AND ITS MEMBERS, 146 (1994).

The following section will consider each of these aspects of the economic theory of regulation within the context of the current debate about reform of the health care industry.

II

HEALTH CARE REFORM

A. The Crisis in Health Care: Political Salience and Rational Ignorance

One of the most interesting aspects of health care reform concerns the debate over whether or not a genuine health care "crisis" already exists in the United States.⁴² The very fact that the question is being debated in earnest is inconsistent with a public-interest theory of regulation. It is, however, highly consistent with the economic theory of regulation presented in this Article.

If the debate over health care reform were proceeding along a path consistent with the public-interest theory of regulation, then the presence or absence of a crisis would be irrelevant. After all, if politicians and regulators were exclusively interested in furthering the public interest, the only issue would be whether the public would benefit from the passage of sweeping reform.

By contrast, the economic theory of regulation understands politicians to concern themselves primarily with estimating the demand for new regulation relative to the strength of political opposition to that regulation, and care only incidentally about the merits. The health care "crisis" and plans for reform seem to conform to *this* model of political behavior for two reasons.

First, the "crisis" characterization is important because of the high-profile nature of the health care debate. Unlike other debates such as those on the reauthorization of Superfund, or the determination of precise numeric quotas for certain Japanese products, everyone has a clear and "immediate stake in the direction of health care reform."⁴³ Moreover, the health care issues have been the subject of much public scrutiny. Consequently, with the stakes higher and informational barriers to organization lower, it will be easier than usual to organize opposition by the general public. However, if proponents of health care reform can characterize the health care industry as being in a state of crisis, they can prevent public opposition from coalescing. The presence of a crisis enables interest groups and entrepreneurial politicians to neutralize opposition to radical reform by the eighty percent of Americans who report themselves as being either "very" or

⁴² Irwin M. Stelzer, *There is No Health Care Crisis*, WALL ST. J., Jan. 25, 1994, at A12.

⁴³ *Id.*

“somewhat” satisfied with their own health care.⁴⁴ It also permits “reformers” to surmount obstacles presented by deep and abiding public skepticism of the government’s ability to manage large segments of the economy effectively.⁴⁵ In short, only a crisis can overcome the objections of an overwhelming majority of Americans to a regulatory scheme they do not want.

Second, successfully characterizing the health care issue as a crisis will enable politicians to *create* demand for health care reform, thus turning a potential political liability into a political asset. As noted above, entrepreneurial politicians will attempt to educate their (rationally ignorant) constituents about why they should invest resources to support the issues that the politician has identified as important. If politicians supporting health care can convince the general public that there is a genuine crisis in health care, they will be able not only to neutralize potential opposition to reform, but also to use “indoctrination and selective recruitment” to add new support to the special interests already committed to health care reform. If successful, such indoctrination and selective recruitment can ensure that not only relevant interest groups, but large segments of the general public as well, will have strong preferences for the laws that entrepreneurial politicians propose—even if those preferences are based on incomplete or erroneous information.

The existence of a crisis facilitates indoctrination and selective recruitment because people will be more likely to form opinions about health care reform for consumption reasons—i.e., for the same reasons that they follow professional sports, or international relations. Even under ordinary circumstances, people enjoy the satisfaction that comes from participation and expression. This is also a significant reason why people vote.⁴⁶ Forming an opinion on health care is even more enjoyable if health care can be considered a crisis. It provides cheap entertainment, and it is also a virtually costless vehicle for self-definition.

However, it is important to distinguish between forming an opinion on health care reform and truly mastering the intricacies of the problem. Although the initial cost of ideological expression through opinion formation is very low, the costs of overseeing implementation of technically complicated statutes such as the HSA are extremely high. Therefore, once the public has demanded regulation, interest

⁴⁴ KARLYN H. BOWMAN, AMERICAN ENTERPRISE INSTITUTE, PUBLIC ATTITUDES ON HEALTH CARE REFORM, ARE THE POLLS MISLEADING THE POLICY MAKERS? 21 (1994).

⁴⁵ Robert J. Blendon et al., *The American Public and the Critical Choices for Health System Reform*, 271 JAMA 1539, 1543 (1994) (footnotes omitted).

⁴⁶ Dwight R. Lee, *Politics, Ideology, and the Power of Public Choice*, 74 VA. L. REV. 191, 193 (1988).

groups, with their superior resources, can be expected to completely dominate the details of the political process that ultimately formulate policy.⁴⁷ It is simply too costly for individual voters to (1) become informed about precisely what sorts of health care legislation would be best, (2) lobby for the implementation of this legislation rather than a rival sort of legislation, and (3) monitor those who implement the legislation even if it ultimately is enacted.⁴⁸ The point Dwight Lee has made about environmental programs therefore applies to health care as well:

Predictably, there is little genuine public surveillance of environmental protection programs, and organized groups have significant latitude to influence (such) programs in ways that serve their private interests. This means of course that these programs are far less effective . . . than they could be.⁴⁹

Thus, the successful characterization of the state of American health care as a crisis will permit entrepreneurial politicians to "have their cake and eat it too." They will pick up votes for supporting major legislation that promises change, safe in the knowledge that the rational ignorance of the public will prevent it from understanding that interest groups will control the details and implementation of the program in exchange for their political support. Indeed, the special interest groups' influence over the legislation will inevitably undermine any positive benefits of the ideological expression of the public in support of the legislation.⁵⁰

Thus, characterizing the issues as being of crisis proportions clearly serves the purposes of interest groups and entrepreneurial politicians.

B. Rent Extraction

A second way in which the current debate reflects the economic theory of regulation can be found in the existence of rent extraction from certain market participants. The Clinton plan accomplishes this in several ways, but the common theme is that by making credible threats to impose significant costs on certain market participants, politicians can extract political support from these market participants in exchange for an agreement by politicians to forbear from regulating or to oppose regulatory initiatives proposed by others. This so-called

⁴⁷ *Id.*

⁴⁸ *Id.* at 196-97.

⁴⁹ *Id.* at 197 (footnote omitted).

⁵⁰ For this reason, even organized interest groups often appear to support laws that contain provisions that seem adverse to their interests.

rent-extraction⁵¹ aspect of the economic theory of regulation predicts that, even if there is no major reform of the health care system, the debate about health care reform should benefit politicians.

Certain core aspects of the current debate about health care reform correspond with classic efforts at rent extraction. First of all, empirical observation suggests that the health care debate has already succeeded in accomplishing a result which is the object of rent extraction. As the Associated Press reported recently:

Members of Congress considering proposals for reforming the health care system are reaping a windfall in election-year contributions from industry groups most affected by the legislation, campaign records show.

Health care and insurance lobbies have contributed \$579,352 to members of the House Ways and Means Health Subcommittee during the 1994 election cycle, according to a review by The Associated Press of campaign reports on file with the Federal Election Commission through March 31.

That represents nearly a threefold increase over the like period in the last election cycle, when the same 11 lawmakers got \$206,135 from health and insurance political action committees.⁵²

Thus, politicians have already been able to use the threat of health care to augment their campaign war chests.

The vicious attacks on the pharmaceutical industry represent another clear example of rent extraction in the current health care debate.⁵³ While much of President Clinton's rhetoric reflects a New Democrat's embrace of economic logic and the effects of global economic forces, his rhetoric about health care reform typifies a "populist demonization" of the pharmaceutical industry.⁵⁴ Because the pharmaceutical industry accounts for only seven percent of health care costs in the United States,⁵⁵ it would seem an unlikely target for the excoriation that it has received from the Clinton Administration. Moreover, for an Administration almost obsessively concerned about foreign trade (as evidenced by the intense personal lobbying of for-

⁵¹ By contrast, rent-seeking refers to the attempt to obtain economic rents (i.e. rates of return on the use of an economic asset in excess of the market rate) through governmental intervention in the market. An example of rent-seeking is a firm's attempt to secure government-granted monopolies or tariff protection. Such government-sanctioned restraints on trade allow firms to increase their prices above competitive levels. The resulting profits represent economic rents from government regulation. Rent-seeking differs from rent-extraction in that the latter term refers to efforts by private sector actors to resist regulation that imposes costs upon them, rather than to attract regulation that provides protection from competition.

⁵² *Congressional Contributions Increase Considerably From Health Care Lobbies*, CHRISTIAN SCI. MONITOR, May 12, 1994, at 2.

⁵³ See J.D. Kleinke, *Killing Drug Research Kills People*, WALL ST. J., Feb. 16, 1994, at A18.

⁵⁴ *Id.*

⁵⁵ *Id.*

eign governments to obtain orders for the U.S. aerospace industry),⁵⁶ it seems odd that the Administration is not supporting a “net exporting industry that turns basic research into marketable products while creating and sustaining high-skill jobs.”⁵⁷

The Clinton Administration’s attacks on the pharmaceutical industry appear quite perplexing if one adopts a public-interest theory of governmental regulation. If anything, the Administration should be encouraging high drug prices as an incentive to the pharmaceutical industry to develop new drug treatments that would replace more expensive surgical procedures.

However, instead of encouraging increased revenue for research and development, the Clinton plan would saddle drug manufacturers with additional burdensome regulation. Under the Administration’s plan, The Secretary of Health and Human Services (HHS) would be given extensive power over drug manufacturers. As McCaughey describes,

[The HHS Secretary] has the power to set a controlled price for every new drug, and to require the drug manufacturer to pay a rebate to the federal government on each unit sold to Medicare patients at market price instead of the controlled price. If a producer balks at paying the rebate, the secretary can “blacklist” the drug, striking it from the list of medications eligible for Medicare reimbursement. The proposed regulation [thus] threatens to keep a new drug such as Tacrine (a treatment for Alzheimer’s) from older patients.

Under the bill, the secretary weighs the development costs and profit margin for the single drug, rather than the overall profitability of investing in new cures.⁵⁸

This would clearly stifle innovation. Because price controls look only at the cost and profit margins on single drugs, rather than development costs for the pharmaceutical firm as a whole, the impact of price controls on incentives in research and development can be devastating.⁵⁹ The mere proposal of price setting in the pharmaceutical industry “has already scared off investment capital, and scuttled the plans of the American drug and biotech companies. Internal and external risk capital has dried up, forcing companies to shelve new products, cut [research and development], cancel waves of recruitment, and issue tens of thousands of pink slips.”⁶⁰ Approximately \$520.8 million in stock offerings were canceled in 1993 under the threat of drug price controls, and 35,000 people have been laid off by pharma-

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ McCaughey, *supra* note 11, at 25 (citations omitted).

⁵⁹ *Id.* at 25 (discussing the impact of price controls on research into new cures).

⁶⁰ Kleinke, *supra* note 53.

ceutical manufacturers since the introduction of the Clinton health care plan.⁶¹

Additionally, the Administration is undoubtedly aware of solid economic explanations for the high prices that exist for certain drugs. For every drug that reaches the market, more than 1000 others do not, resulting in complete losses for investors in those drugs.⁶² Thus, “[l]imiting the price and profitability of the one drug in a thousand that succeeds will halt research into new cures, including drugs for ovarian and breast cancers now in the pipeline.”⁶³

Politicians in the Clinton Administration excoriating the pharmaceuticals industry for price gouging also probably are aware that expensive drug research can actually lower, rather than raise, health care costs. Even very expensive drugs are cost effective if they can eliminate the need for surgery, which is virtually always more expensive. Research by HCIA, a health care data analysis and research firm, has found that

[e]very study of hospital clinical patterns conducted by our firm indicates that the cumulative differences between the least efficient medical pathway and the best approach represent multibillion-dollar potential savings for the health care economy. Hospitals are actively pursuing such savings: their continued progress, the most profound “reform” of all, will require continual development of even better, if premium priced, medicines.⁶⁴

While price controls make little sense from a public-interest standpoint, the economic theory of regulation suggests two perfectly sensible reasons for them. First, the economic theory of regulation predicts that rent extraction is particularly likely to occur in an industry which is characterized by fixed capital investments that cannot easily be shifted to other uses.⁶⁵ The following example illustrates the point. Imagine two industries, each earning the same risk-adjusted rate of return on assets, say fourteen percent. One industry requires only highly mobile, interchangeable capital investment, while the other requires fixed capital investments that have no alternative uses. If the government threatens to impose a dramatic regulatory burden on the first industry, it will have little incentive to pay significant amounts of political support to gain regulatory forbearance. If the threat of regulation materializes, the industry will respond by simply redeploying its assets to another use.

61 *Id.*

62 McCaughey, *supra* note 11, at 25.

63 *Id.*

64 Kleinke, *supra* note 53.

65 McChesney, *supra* note 38, at 102-03.

The second industry, by contrast, has much greater incentives to purchase regulatory forbearance, because by definition the immobile nature of its assets makes impossible shifts to alternative uses. Thus, for example, if the next best alternative use for the assets of the pharmaceutical industry will yield only an eight percent rate of return, rather than a fourteen percent rate of return, it will be in the interests of the industry to pay politicians sums equivalent to the capitalized value of six percent of its assets in exchange for regulatory forbearance. In other words, the high cost of redeploying assets to alternative uses leaves an industry vulnerable to rent extraction.

The pharmaceutical industry is characterized by its dedication to and reliance upon product innovation.⁶⁶ This endeavor requires large amounts of highly specialized scientific research,⁶⁷ which is highly capital-intensive.⁶⁸ In addition to some amounts of specialized machinery, this research is characterized by a fixed, and thus expropriable, nature.⁶⁹ The greater and more important portion of the research investment is in human and other intangible manifestations of capital. So much can be seen by the large concentration of pharmaceutical research facilities in New Jersey.⁷⁰ While some types of capital may escape regulation by foreign relocation,⁷¹ pharmaceutical companies cannot avoid the effects of price control on their locale-specific investments in research capital by relocation offshore. Even if price controls could be avoided by relocation, their effect on the value of the product of the research investment, at least to the extent it is realized in the U.S. market, would be a marked reduction and is not avoidable.⁷² Firms will readily expend resources to provide political

⁶⁶ James Driscoll, *The Moral Battle Plan*, WALL ST. J., Feb. 16, 1994, at A18; Richard J. Kogan, *Clinton Rations Future Cures*, WALL ST. J., Feb. 16, 1994, at A18.

⁶⁷ Kogan, *supra* note 66, at A18.

⁶⁸ See *supra* note 53.

⁶⁹ Appropriation of a firm-specific (or, in this case, industry/locale-specific) capital investment stems from the existence of an appropriable quasi-rent. Klein et al., *Vertical Integration, Appropriable Rents, and the Competitive Contracting Process*, 21 J. L. & ECON. 297, 299-310 (1978). Appropriable quasi-rents arise when an asset is so specialized to a particular user [or industry/locale] that barrier costs prevent transfer of the asset to another application without substantial loss of investment return. *Id.* at 299.

⁷⁰ Thomas J. Lueck, *Pharmaceuticals' Blue Chip May Be Fading*, N.Y. TIMES, Feb. 15, 1993, at B1. New Jersey has become the nexus for world-wide pharmaceutical research. Ten of the 18 largest pharmaceutical concerns in the world have their major operations, especially research, located there. Perhaps explainable in terms of access to academic facilities, to the complementary facilities of other firms, or the like, research in the pharmaceutical industry is not so much firm-specific as locale-specific. The peculiar attractiveness of this region may be demonstrated by the existing siting of foreign pharmaceutical firms, and by their continuing relocation within the area. *Id.*

⁷¹ See Jonathan R. Macey, *Externalities, Firm-Specific Capital Investments, and the Legal Treatment of Fundamental Corporate Changes*, 1989 DUKE L.J. 173 (1989).

⁷² There must also be a consideration not only of investments presently made, but also of the large sums expended in the past on research which has not yet come to fruition. Considering the sometimes decades-long development process for new drugs, the value of

support in order to avoid price controls and salvage the value of these investments.

The locale-specific capital investment of the pharmaceutical industry presents a ripe target for rent extraction in another way. Unlike doctors or hospitals, which are widely dispersed throughout the nation, the concentration of the pharmaceutical industry in New Jersey makes politicians' threat to regulate the industry more credible, because the economic costs of such regulation will be borne by the people of this state and the political costs by the state's representatives alone. Furthermore, this geographic concentration increases the likelihood that the industry will be able to organize itself to make political payoffs. In other words, even an industry characterized by fixed, and thus expropriable, capital investments would not present a particularly attractive target for rent extraction unless it were also capable of organizing sufficiently to pay for regulatory forbearance.

Further, because the pharmaceutical industry accounts for a relatively small percentage of U.S. health care costs,⁷³ politicians' threats to impose costs on the industry in the form of price controls are credible because the effects of these inefficient regulations may escape public notice. Such inefficiencies will result largely from a reduction in the flow of new drugs being developed and marketed.⁷⁴ But because members of the general public will have no way of knowing what life-saving cures would have been developed in the absence of price controls, threats to regulate the pharmaceutical industry will impose few, if any, political costs on politicians. Finally, unlike doctors, who see patients, the pharmaceutical industry has no direct access to the public. It cannot launch a cheap and effective grass roots campaign to counter politicians' populist rhetoric against it.

The pharmaceutical industry then is a paradigm candidate for rent extraction under the economic theory of regulation because of its locale-specific capital investments, its capacity to organize political

considerable sums may be appropriable through the specter of regulation. See Kogan, *supra* note 66, at A18.

⁷³ The pharmaceutical industry accounts for seven percent of health care costs and is a net exporter. Kleinke, *supra* note 53.

⁷⁴ In Germany, similar inefficiencies have developed in response to governmental regulation. The German government has enacted a drug budget which must be met by doctors and pharmaceutical companies. If the amount spent on drugs exceeds the budgeted allotment, doctors will be held responsible for the first DM280 million of the excess and pharmaceutical companies the next DM280 million. Naturally, doctors have responded to this measure by decreasing the amount of drugs they prescribe—especially the more expensive and innovative drugs. As a result, pharmaceutical companies are finding it less profitable to invest in research and development, potentially stalling the discovery of new life-saving drugs. Annette Tuffs, *Germany: Reaction to New Health Care Law*, 341 THE LANCET 427 (Feb. 13, 1993).

payoffs in response to threats, and its inability to directly inform the public of the costs of regulation.

C. Creating Future Demand for Regulation

By far the most important aspect of the economic theory of regulation reflected in the current debate about health care concerns the extent to which the debate has prompted interest groups to lobby for new, artificial protection from competitive forces.⁷⁵ In other words, from the perspective of the economic theory of regulation, at the heart of the debate about health care reform lies significant efforts at rent creation by well-organized special interest groups.

1. *The Shift From Core to Comprehensive Benefits*

The shift from a "core" services concept to a "comprehensive" benefits approach during the course of the policy debate about health care reflects a major victory for interest groups trying to profit from health care reform.⁷⁶ Under a core approach, the government would assure that those qualified to receive a public subsidy would get certain essential services.⁷⁷ Other services could be purchased in the private marketplace.⁷⁸ Access to these services would be allocated by the price-setting mechanism of the marketplace. By contrast, under a comprehensive approach the government guarantees all citizens a package of medical services beyond what is merely necessary.⁷⁹

Clearly, health care providers will derive major advantages from having their services included in the list of comprehensive benefits to be provided by the government. Such inclusion would protect health care providers from the vagaries of market forces by reducing the marginal costs of their offered services to zero.⁸⁰ Consequently, health care providers will be willing to pay to have their particular product or service included in the list of products or services that all insurance programs must require.⁸¹ Indeed, in Germany, which has long had a

⁷⁵ In fact, according to Charles Lewis of the Center for Public Integrity, "[h]ealth care reform has become the most heavily lobbied legislative initiative in United States history." Neil A. Lewis, *Vast Sum Spent to Sway Health Plan*, N.Y. TIMES, July 22, 1994, at A20.

⁷⁶ James F. Blumstein, *Health Care Reform: The Policy Context*, 29 WAKE FOREST L. REV. 15, 35 (1994) (describing the shift in the Clinton plan from a core services concept to a comprehensive benefits concept).

⁷⁷ *Id.* at 34-35.

⁷⁸ *Id.* at 35.

⁷⁹ *Id.* at 35-37.

⁸⁰ This reduction is a function of the zero-cost availability of additional service. Empirically, people with free access to health care services used about 50% more health care services than those who had to pay, with no discernible difference in health outcomes. Bulter, *infra* note 89, at 115.

⁸¹ The proliferation of state mandates on health insurance coverage demonstrates the proficiency of health care providers at effecting the inclusion of various services. Jensen, *infra* note 88, at 167-93.

health care plan similar to that proposed by President Clinton,⁸² the issues of which medical services are included on the list of benefits “are so important that they can affect elections: coverage of abortions, for example, will play a role in [German] elections this year. The net result, Germany shows, is that the list simply grows over the years.”⁸³

Already in the United States there have been intense debates about inclusion of treatment for alcoholism and drug abuse in the comprehensive package.⁸⁴ Of course, the very shift to a comprehensive package of benefits from a core package of benefits represents a major political victory for a host of health care providers.

The Comprehensive Benefits Package presented in President Clinton’s Health Security Act is extremely appealing to Congress. As professed congressional concern about the federal deficit rises, it becomes more difficult to buy votes with traditional pork-barrel government spending programs. Given this restriction, members of Congress have considerable incentives to try to buy political support through rent creation, thereby shifting the costs of providing benefits away from the federal government. Naturally, politicians prefer this over direct government spending, since they may avoid the high visibility, and associated political costs, of on-budget spending while reaping the same political rewards.

The Health Security Act presented Congress with a significant opportunity to obtain political support in exchange for regulatory action whose costs would be kept off the balance sheet of the federal government. In this respect, future reform efforts will be no different. Congress is, and will inevitably be, the focus of the demands of health care providers and certain consumers for generously mandated benefits. Even with safeguards such as those in the HSA which specify that the National Health Board is to determine the content of the comprehensive benefit package,⁸⁵ the economic theory of regulation predicts that Congress would ultimately come to dominate the process, for example by dictating the guidelines under which such a Board would operate.⁸⁶ In considering the initial enabling legislation, Congress will always be positioned to extract substantial payments from every

⁸² Wilfried Prewo, *Germany Is Not a Model*, WALL ST. J., Feb. 1, 1994, at A14.

⁸³ *Id.*

⁸⁴ See, e.g., *Small Market Health Insurance Reform: Hearings Before the House Ways and Means Committee*, 103d Cong., 1st Sess. 219-33 (1993) (statement of Ellen M. Weber, Co-Director of National Policy Legal Action Center before the House Ways and Means Committee).

⁸⁵ HSA §§ 1101, 1151-1154; Butler, *infra* note 89, at 116.

⁸⁶ This is seen in the specification of minimum benefits by the HSA. HSA § 1101. The power of the National Health Board to affect those specified benefits is limited. HSA § 1152(a).

provider group not obviously included in or excluded from the benefits package. Psychologists, chiropractors, optometrists, dentists, podiatrists, and allergists, for example, will be willing to invest substantial sums to ensure their services are included. Moreover, the issue of inclusion in or exclusion from the package will be a continual rent-seeking battle as circumstances change, new interest groups or coalitions emerge, and budgets come up for renewal.

To put it prosaically, the economic theory of regulation predicts that the deliberative process over the content of the comprehensive benefits package will evolve into a congressional rent-seeking frenzy, as politicians and interest groups jockey to include more and more elaborate benefits in the mandated package. Indeed, the administration's failed plan illustrates this precisely. Patricia M. Danzon, Professor of Health Care Systems at the Wharton School of the University of Pennsylvania and perhaps America's foremost authority on the economics of health care, noted that the Clinton plan's package of benefits was "comparable to at least the median of plans offered by the Fortune 500 companies [and] is more comprehensive than the average person appears willing to pay for voluntarily, even with the current tax subsidy, which, on average, reduces the cost of coverage by at least one-third."⁸⁷

The magnitude of the distributional effects flowing from the definition of the comprehensive benefits package will be enormous. As noted above, Germany's experience indicates that the determination of what is included in the basic package will become highly politicized. Closer to home, the states' experience with interest-group domination of the bargaining process for determining the content of basic health insurance policies highlights the potential role of interest groups in defining the comprehensive benefits package on the federal level. Specifically, there has been an explosion of state mandates on health insurance coverage.⁸⁸ Such mandates represent little more than concessions to special interests to force consumers to buy coverage for specific diseases or medical practices that are not needed or wanted. John Goodman of the National Center for Policy Analysis estimates that there are "more than 1,000 state mandates today, up from forty-eight in 1970."⁸⁹ Mandated services include chiropractic care, psychological services, optometry, podiatry, nurse-midwife services, social work, and acupuncture. Other mandates require consumers to purchase coverage for alcoholism, drug addiction, mental illness, and

⁸⁷ PATRICIA M. DANZON, AMERICAN ENTERPRISE INSTITUTE, GLOBAL BUDGETS VERSUS COMPETITIVE COST-CONTROL STRATEGIES 10 (1994).

⁸⁸ Gail A. Jensen, *Regulating the Content of Health Plans, in AMERICAN HEALTH POLICY: CRITICAL ISSUES FOR REFORM 167-93* (Robert B. Helms ed., 1993).

⁸⁹ Henry N. Butler, *The Political Market for Mandated Health Care Benefits Under the Proposed National Security Act*, 3 KANSAS J. LAW & PUB. POL'Y 113, 115 (Winter 1993-94).

even “accidental ingestion” of cocaine, marijuana, morphine, hallucinatory drugs, and other controlled substances.⁹⁰ The escalation of state mandates has been disastrous to health care policy. Goodman estimates that one-quarter of persons currently uninsured could afford basic, no-frills health coverage if some or all of these state mandates were repealed.⁹¹ Even Paul Starr, one of the leading proponents of the Clinton health care plan, has observed that “past experience suggests caution because of the dominant influence of provider interests in state health policy.”⁹²

Similarly, the experiences with congressionally mandated increases in Medicaid benefits suggest that members of Congress will eagerly meet the demands of consumers and interest groups, since most of the costs of additions to the comprehensive benefit package are to be paid by employers, employees, and state governments.⁹³ During the 1980s Congress placed additional burdens on states by expanding Medicaid coverage for the poor without voting for the funds to pay for the expansion.⁹⁴ Under Medicaid, Congress pays about fifty-seven percent of the cost of new benefits.⁹⁵ Because Congress can win votes by expanding Medicaid coverage without voting for full funding for the new benefits (i.e., by requiring the states and private individuals to pay for coverage), Medicaid has become the fastest-growing item in state budgets, ahead of schools, roads, and prisons.⁹⁶ To reduce Medicaid outlays, states are cutting reimbursement rates to doctors and hospitals.⁹⁷ Thus, the political costs of congressional action are effectively shifted onto state politicians. Furthermore, because of lower reimbursement rates, many doctors refuse to treat Medicaid patients—effectively denying the poor the very health care promised to them by politicians.⁹⁸

Under the HSA, Congress would have paid an even lower percentage of the cost of new health care benefits than under Medicaid. Consequently, the perverse incentives Congress faces under Medicaid

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² Paul Starr, *Design of Health Insurance Purchasing Cooperatives*, 12 HEALTH AFF. 58, 62 (Supp. 1993).

⁹³ See Don Colburn, *Medicaid: A Safety Net With Some Holes*, WASH. POST, July 28, 1992, (Health Magazine), at 19. A further consideration is the hidden effects of cost-shifting, where health care providers are not fully reimbursed by government payments and must recoup the outstanding costs by adjusting upwards the bills of private providers and individuals paying out of pocket. Charles T. Carlstrom, *The Government's Role in the Health Care Industry: Past, Present, and Future*, ECON. COMMENTARY (Fed. Reserve Bank of Cleveland, OH), June 1, 1994.

⁹⁴ Colburn, *supra* note 93.

⁹⁵ *Id.*

⁹⁶ See *id.*

⁹⁷ *Id.*

⁹⁸ *Id.*

would have been exacerbated under the HSA. This issue would arise in the initial debate about how to expand the basic benefits package, and would continue as politicians, consumers, and interest groups began to demand more health care benefits. Like Medicaid, reform legislation such as the HSA would present Congress with an unavoidable moral hazard: Congress could sell interest-group legislation, satisfy constituent calls for more benefits, and not have to worry about most of the cost.

The political moral hazard was compounded under the HSA by the fact that it would have limited the current tax deductibility of employers' expenditures for medical benefits as an ordinary and necessary business expense⁹⁹ to the level of the comprehensive benefit package mandated in the proposal.¹⁰⁰ This would have induced employers to join the lobbying effort to expand the basic benefits package: By including all of the benefits being offered in the comprehensive benefits package, employers would have received what is, in essence, a public subsidy in the form of a tax deduction, for the benefits they offered employees.

One aspect of the HSA's financing proposal, however, could have provided positive political incentives for cost containment by Congress. The Clinton plan would have capped employers' and employees' contributions for health insurance at a certain percentage of total payroll costs. This would have, in theory, required Congress to finance additional benefits that were to be included in the basic benefits package in the future. Even under Medicaid, however, Congress has not proven itself capable of resisting the urge to impose tremendous new costs on the states when it imposes new federal mandates. Thus, if experience is a guide, Congress will not be able to stop itself from buying votes with other people's money simply by increasing the caps on the amounts of employers' contributions to pay for health care or by elasticizing whatever self-restraint mechanisms may exist.

The German experience corroborates this analysis. The German health care payroll tax rose from an average of 6% in 1950 to 8.4% in 1960, to 11.4% in 1980.¹⁰¹ It currently stands at 13.4%.¹⁰² In Germany, the 13.4% payroll tax is needed to finance health care expenditures that amount to 10.6% of GDP.¹⁰³ Meanwhile, under the Clinton plan a maximum payroll premium of about 10% is intended to pay for health costs that account for 14% of current GDP today,¹⁰⁴ and will

99 I.R.C. § 162(a) (1988).

100 HSA § 7201(a).

101 Prewo, *supra* note 82.

102 *Id.*

103 *Id.*

104 *Id.*

account for 17.3% of GDP by the year 2000.¹⁰⁵ As Wilfried Prewo, the head of the Hanover, Germany, Chamber of Commerce noted in analyzing the Clinton health care plan, it is unclear how a payroll tax of 10% will finance health care expenditures that amount to between 14 to 17% of GDP, when a 13.4% payroll tax in Germany is unable to finance only 10.6% of GDP in that country.¹⁰⁶ Thus, the financial gimmickry has already begun. When the program is fully operational, one should only expect more of the same as politicians face escalating health care costs and insufficient payroll tax revenue.¹⁰⁷

2. *The Requirement of Universal Coverage*

In addition to the extremely comprehensive guaranteed benefits package, the Clinton plan would also require that everybody receive coverage. Indeed, President Clinton has described this promise of universal coverage as the one non-negotiable demand in his legislative package.¹⁰⁸ Under the plan, all Americans must enroll in one of the regional health care alliances in their communities, unless they receive Medicare, military benefits, or veteran's benefits, or work for a company with more than 5000 employees.¹⁰⁹ The analysis of this requirement under the economic theory of regulation is straightforward. By requiring that everybody receive health insurance, whether they want it or not, the administration artificially inflates the demand for insurance. Reports on the precise number of uninsured vary greatly, ranging from 5.5 million to 37 million,¹¹⁰ depending upon whether one is trying to determine the number of chronically uninsured or simply the number of people who are uninsured at any particular time.¹¹¹ Some of this number represents people whose health profiles cause them to present great risk to insurance companies. However, a significant number is comprised of people who are in excellent health, and therefore do not consider health insurance to be a good "buy." Such risk taking is not irrational for the young and

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ The British system of universal health care coverage provides a disturbing example of such financial gimmickry. Though the British system is able to boast the second-lowest proportion of national income spent on health care (6.5% in 1993) and only a 1% increase in 12 years, such impressive figures have come at the expense of health care availability to British citizens. Though the British government has no official rationing policy, there is de facto rationing as budget restrictions force doctors to control costs "by putting patients on waiting lists, by denying some services or procedures to certain patients, and by denying other treatments altogether." Timothy Harper, *What We Can Learn From Europe*, 70 *MED. ECON.* 138, 143-44 (1993).

¹⁰⁸ Dana Priest & David S. Broder, *Veto Threat Cleaves Congress*, *WASH. POST*, Jan. 27, 1994, at A1.

¹⁰⁹ HSA §§ 1001-1006.

¹¹⁰ Stelzer, *supra* note 42.

¹¹¹ *Id.*

healthy, for whom the probability of illness is low, and for whom paying health insurance premiums simply involves transferring wealth from themselves to the least healthy members of the insured cohort. Forcing healthy and uninsured people to pay health care premiums transfers income from such people to insurance companies as well as to the unhealthy people their premiums subsidize. In addition, these premiums will have been diverted from other presumably more efficient uses. In regard to unhealthy, uninsured people, it must be remembered that eighty-eight percent of the hospitals in the United States are not-for-profit institutions. The emergency rooms of such hospitals cannot legally deny medical care to any patient who needs it.¹¹² Similarly, such hospitals cannot unreasonably deny access to the hospitals' health maintenance technology for the duration of the course of treatment; contrary to popular belief, access to treatment is not limited to the duration of the emergency.¹¹³ Indeed, per-capita health care spending on the uninsured, pre-Medicare population constitutes fully sixty percent of per-capita expenditures by the insured population.¹¹⁴

The inclusion of this latter group, the presently healthy and uninsured, provides a windfall to the insurance companies because these people pay premiums to insurance companies and receive few medical services in return. That the former group is also included under the HSA poses no problem to the insurance companies, however, so long as the insurance companies can fully price the associated risks.

3. *Cartelization and Affirmative Action in Health Care*

The Clinton health care initiative reflects yet another basic tenet of the economic theory of regulation. Its requirement that by 1998 no more than forty-five percent of new doctors be permitted to go on to advanced training in a specialty is consistent with textbook rent-seeking theory.¹¹⁵ Return on human capital for practitioners of lucrative specialties will increase dramatically under the Clinton health care plan because the plan artificially restricts entry into those specialties. As noted above, the classic example of rent seeking is the effort to obtain economic rents on the use of an economic asset (including human capital) through governmental intervention in the marketplace.

These new quotas for medical specialties follow the classic pattern predicted by the economic theory of regulation in which the govern-

¹¹² *Id.*

¹¹³ *Id.*

¹¹⁴ *Id.*

¹¹⁵ HSA §§ 3011-3013; McCaughey, *supra* note 11, at 24; doctors in training will be assigned to specialties based partly on race and ethnicity.

ment creates an artificial cartel in order to benefit some favored group at the expense of the public at large. Typical of this pattern, the regulations are embedded deep within some ancillary regulatory scheme of extreme complexity, in order to maximize the information costs the general public will incur.

CONCLUSION

This Article has analyzed health care reform from the perspective of the economic theory of regulation. The Clinton health care plan reflected all of the classic features of rent-seeking legislation. First, the public was manipulated by loud and frequent cries that the health care system is in a state of extreme crisis. This enabled the Administration to quiet those who wonder why fourteen percent of the nation's GDP should be brought under a new regulatory system characterized by bureaucratic command and control. Next, the proposed regulations were of such sweeping complexity that few in the general public could be expected to read them, much less understand their implications. Finally, by defining a system of universal coverage more generous than that received by the average American, and then promising people that such coverage will come at lower cost than the coverage they currently receive, the Administration has created in the public the false hope of a universal free lunch. The Administration has never tried to explain how it can reconcile its promises to massively expand the quantity and quality of coverage with its equally loud promises of lower total spending on health care. Consistent with the economic theory of regulation, the Administration is relying on the fact that the rational ignorance of the average citizen ensures that these pie-in-the-sky promises will go unchallenged.

Beneath the superficial debate taking place in public is the real health care controversy, which consists of the life and death struggle among interest groups to avoid the costs and obtain the benefits available in this massive restructuring of the American economy. The Administration has utilized both rent-extraction and rent-creation techniques in its health care reform proposal. The results of this strategy are already apparent, as interest groups dramatically increase their political involvement and their expenditures on lobbying.

Not since Franklin Roosevelt's War Production Board has government proposed to bring such a large part of the economy under its own control.¹¹⁶ The economic theory of regulation provides the tools with which better to understand the public presentation and marketing of health care reform proposals and to discover not only the precise nature of the plans themselves, but the likely course of their

¹¹⁶ ECONOMIST, *supra* note 8, at 31.

future evolution. No matter the shape future attempts at health care reformation take, the principles outlined here allow a basis for evaluating the likely political and economic consequences of future legislative initiatives.