CHAPTER SEVEN

After the ACA

Freeing the Market for Healthcare

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Introduction

Most health-economics policy discussion takes the bulk of our current legal and regulatory structure for granted, in particular that the government will have a heavy hand in providing, paying for, and directing the private provision of and payment for healthcare. Opponents of the optimistically named Affordable Care Act (ACA) delight in pointing out its unintended consequences, mangled incentives, and exploding budgets.[1] Fans work to patch it up with new layers of regulation or "reforms." Neither takes a ground-up, first-principles approach to understand why our current system is such a mess and how a better system might emerge. That is my goal.

I survey the supply, demand, and market for healthcare and health insurance, to think about how those markets should work to provide quality care, low cost, and technical innovation. A market-based alternative does exist, and it is realistic.

Healthy markets do not emerge because our current web of healthcare laws and regulations forbids them from doing so, not because of intractable market failures. But deregulation is not easy. The impediments to well-functioning healthcare and insurance markets go deep into federal, state, and local law, regulation, and practice. And the pieces are linked; greater competition, innovation, and entry by suppliers, greater control by consumers, and insurance innovations that cure the current mess each need the others in order to function.

This analysis is obviously aimed at the long run. Thinking through how a freer and more competitive healthcare and insurance market can work and how most of the regulatory apparatus is doomed will not get anyone hired as a consultant, lobbyist, or adviser, nor will it generate bundles of government- or industry-provided research funding. It will not lead to immediate policy impact.

But such long-run thinking is important nonetheless. Opponents of the ACA who would see it repealed need a detailed, coherent alternative, and even if the alternative is "leave it to the market," they need to understand and explain how that alternative can realistically address the cost, "access," and other evident pathologies of contemporary healthcare and insurance markets. The status quo was a mess, and the concerns that motivated the ACA were real. If the ACA remains, as is likely, but stumbles from one crisis to another and eventually falls apart of its own weight, it will be equally important to have that detailed coherent alternative in our back pockets.

I focus on the supply and demand for health *care*, which gives this essay a bit of novelty. Curiously, most of the current policy debate, and most of our regulation, focuses on health *insurance*, the question of who will pay the bill, as if the market for health *care* were functioning normally. The market for health *care,* which is if anything even more dysfunctional, and which underlies any health insurance scheme, is relatively neglected.

Healthcare Supply

We all agree what we would like to see: healthcare needs to become efficient and innovative and to provide high-quality care at reasonable cost.

A. Cost Reduction and Innovation: Some Examples

How will this happen? Well, we have before us many good examples. Wal-Mart and Home Depot revolutionized retail. Airlines are dramatically cheaper than in the 1970s. Consumer electronics, telecommunications, computers, and even cars are much better and cheaper, for what you get, than ten or twenty years ago.

These revolutions are not just about technology. In most of these cases, we see *process* innovation, reorganizing activities to deliver com-

plex services at lower cost and with better and more uniform quality. This process efficiency is most glaringly absent in healthcare.[2]

Southwest Airlines turns a plane around in twenty minutes, and has finally figured out how to get people on it without the chaos at United and American. Wal-Mart's and Home Depot's success is as much about organizing and standardizing the motion of people and inventory as it is about adopting technology, outsourcing supply, or negotiating lower prices. Toyota assembles a car with thirty hours of labor. As Atul Gawande asked in the *New Yorker,*[3] the Cheesecake Factory delivers a complex service-oriented product with remarkable quality, efficiency, and cost—why can't hospitals do the same?

Beyond stories, Amitabh Chandra and Jonathan Skinner summarize the academic literature, writing that "there is increasing evidence of the potential for cost-saving technologies (with equivalent or better outcomes) in the management and organization of healthcare to yield substantial productivity gains. But these types of innovations are unlikely to diffuse widely through the healthcare system until there are much stronger incentives to do so."[4]

But our hopes for healthcare go beyond the obvious need to streamline process and delivery and to adopt cost-saving technology. We do not want 1950s care at 1920s prices. Technical innovation is, fundamentally, why we can be so much healthier than our grandparents. Healthcare markets need to bring that innovation as fast as possible—and then diffuse it quickly down to the mass market.

My example industries are also great at this sort of technology innovation and diffusion. Healthcare is a paradox in that innovation is widely reviled as a cause of increased costs.

The standard economists' answer is that we are mistaking "cost" for "price" and "introduction of new goods." A new $500,000 treatment represents a reduction in cost—widening of the budget constraint—over a less effective but still available $50,000 older treatment. But though economically correct, this answer is unsatisfying—especially to those needing the care and those paying the bills—because we all see the monstrous inefficiencies in healthcare. That $500,000 could be $100,000. We know we could get more and faster technical innovation and lower prices.

Why does Moore's law not apply to medical devices? Why has the price of cell phones, GPS devices, and computers come down so fast relative to the prices of medical technology? Where is the home MRI? There is nothing deeply different about medical and other technology.

The answer is that supply and demand—in the current highly regulated system—is not producing the Moore's law incentives.

In my example industries, innovation also does not always mean lower cost. I paid $1500 in 1982 for an IBM PC with 16K of RAM and one floppy disk drive. I paid about the same (nominal) for my most recent laptop, with vastly more power. Nissan plans to sell $3,000 cars in China and India[5]—with no airbags. We have chosen much better cars for higher prices. But my example industries did a good job of pushing the cost/innovation/quality frontier out to its limits, and then discovering where people really want to be. If we "spend more" today, we know we're getting a good deal, and simply choosing a different point on a far better frontier than we faced twenty years ago. We know a better healthcare frontier is possible.

My example industries do not cut costs by selling shoddy products or service. Instead, they provide consistent quality on the dimensions people turn out to really care about, and save on those that people do not really care about. Southwest gets you where you want to go at convenient times, with a good on-time record and admirable safety. And seats twenty-seven inches apart, while feeding you peanuts. People are not willing to pay the extra $20 that slightly more legroom would cost. The iPhone error rate is a lot lower than the medical error rate. Wal-Mart shirts use inexpensive materials, and they are sold in environments far less sexy than Michigan Avenue boutiques, but it is rare to find one torn, or missing buttons.

The theory that unregulated competitive suppliers will pawn off shoddy merchandise on consumers, so often expressed in medical contexts, is exactly false in every other industry. Restaurants and hotels tremble at a poor Yelp.com review. The corporatization and standardization of my example industries, which many people bemoan, is a good part of their ability to deliver consistent quality. If each airplane and pilot were a different practice, quality would vary a lot more.

B. Competition and Entry

How can healthcare emulate the quality improvement and cost reductions of these successful service-oriented industries? My examples share a common thread: *intense competition*—in particular, competition from *new entrants,* who put old companies out of business or force unwelcome and disruptive changes. Microsoft displaced IBM, and Google is displacing Microsoft. Wal-Mart displaced Sears, and Amazon may displace

Wal-Mart. Typewriter companies did not invent the word processor; word-processing companies did not invent the PC. The post office did not invent FedEx or email. Kodak is out of business, famously hobbling its digital cameras to protect a dying film business. Toyota, not competition between Ford, GM, and Chrysler, brought us cheaper and better cars. When the older businesses survive, it is only the pressure from new entrants that forces them to adapt.

I will not dwell on just how uncompetitive healthcare is, as I do not think the point needs belaboring. The simple fact that hospitals will not tell you a price ahead of time makes it blatantly obvious. No competitive industry would dream of getting away with this. As one good academic study of this phenomenon, Jaime Rosenthal, Xin Lu, and Peter Cram posed as an elderly patient seeking a hip replacement and wishing to pay cash[6]. Few hospitals could even quote a price, and the price quotes the authors finally received varied from $11,100 to an amazingly precise $125,798.

My examples share another common thread. They remind us how painful the cost control, efficiency, and innovation processes are. When airlines were regulated, artificially high prices did not primarily go to stockholders. They went to unionized pilots, flight attendants, and mechanics. They produced an easy life more than financial reward. Protection for domestic car makers supported generous union contracts and inefficient work rules more than outsize profits.

"Bending down cost curves" in these examples required cleaning out these rents, through offshoring, elimination of union contracts and work rules, mechanization, pressure on suppliers, internal restructurings, and painful bankruptcies and mergers in which lots of people—both workers and well-paid managers—lost their jobs to others.

The fact that so much cost reduction comes from new entrants, not reform at the old companies, is testament to how painful this process is and the ability of incumbents to protect the status quo. The Big Three still take forty hours to build a car as opposed to Toyota's thirty. And two of them went bankrupt, while Toyota sits on a cash reserve. American and United are still struggling to match Southwest's efficiencies, after thirty years. The parts of Kodak invested in film simply could not let the company exploit its technical knowledge in optics and electronics. Chicago's teacher unions are fighting charter schools tooth and nail.

A quick look at a modern hospital and its suppliers reveals many similar ossified structures. It suggests just how wrenching the same transformations

will be. And it suggests just how hard healthcare incumbents will fight to stop it, if they can.

C. Competition and Regulation

So, where are the Wal-Marts and Southwest Airlines of healthcare? They are missing, and for a rather obvious reason: regulation and legal impediments.

A small example: in Illinois as in 35 other states,[7] every new hospital or even major purchase requires a "certificate of need." This certificate is issued by our "hospital equalization board," appointed by the governor and, like much of Illinois politics, regularly in the newspapers for various scandals. The board has an explicit mandate to defend the profitability of existing hospitals. It holds hearings at which they can complain that a new entrant would hurt their bottom line.

Specialized practices that deliver single kinds of service or targeted groups of customers cheaply face additional hurdles, because they undermine the cross-subsidization provided by "full service" hospitals. For example, the Institute for Justice is bringing a major suit on behalf of a specialty colonoscopy practice in Virginia, which local full service hospitals managed to ban.[8]

This is exactly the form of regulation put in place by the Civil Aeronautics Board until the late 1970s, which produced airline prices much higher than they are today. Airlines had to show need for a new route, and incumbents defended monopoly rents on the grounds that they cross-subsidized service to small airports. This one deregulation is pretty much what brought us cheap airline flights now.

Revealingly, certificate of need laws were part of an earlier round of "cost containment" and were federally mandated for a while. The theory sounds sensible enough, and you can easily imagine it echoing through academic conferences to gentle approval. In a fee-for-service system, there can be an incentive to buy too many MRI machines and then prescribe "needless" scans, which insurance companies and the government would be forced to pay for. "Well," said an earlier round of health-policy experts, "we'll patch that up by having a regulatory board review the 'need' for major investments or hospital expansion to avoid 'overinvestment.'" It is a story worth remembering; how a regulatory cost-containment patch to one broken system (poor incentives in fee-for-service reimbursement)

turned swiftly into a well-captured barrier to competition and wound up increasing costs.

How occupational licensing is captured to restrict supply and push up prices should be obvious by now—Milton Friedman wrote his PhD dissertation on it, and a chapter in *Capitalism and Freedom* in 1962. Little has changed. For example, Uwe Reinhart recently covered the AMA's opposition to a California measure that would have allowed nurse practitioners to perform some simple primary care services.[9] He particularly savaged the usual argument that consumers have a right to the quality of a licensed doctor, noting that half of California's physicians do not take new Medicare patients.

If you are a parent, you have been there. It is 2:00 a.m. in a strange city. The kid has an ear infection. She needs amoxicillin, now. Getting it is going to be a three-hour trip to an emergency room, hundreds of dollars, so a "real doctor" can peer in her ear, then off to the pharmacy to fill the prescription. A nurse practitioner at the Wal-clinic could handle this in five minutes for $15.

I am not arguing that we have to get rid of licensing. But licensing for quality does not have to mean restriction of supply to keep wages up—including state-by-state licensing, restriction of residency slots, restrictions on the number of new medical schools, and restrictions that encourage overuse of doctors where they are not needed.

Restrictions on immigration of doctors and nurses keep prices up here, as they keep out high-skilled workers in many fields. Here our immigration law dovetails with occupational licensing restrictions. Immigration law is explicitly designed to keep American wages up. We forget that we pay those wages, or kid ourselves that we can drive wages up and costs down.

Einer Elhauge examines "fragmentation" of medical care in detail,[10] that is, the fact that care is bought essentially from different doctors and specialists, even in hospital settings, rather than in an integrated manner—as, say airline travel is, where you do not separately purchase pilot, flight attendant, fuel, and baggage services. My examples suggest a consolidation, integration, and corporatization of overall health service provision, in the same way restaurant chains displace individual stores. What stops this defragmentation? Elhauge surveys research concluding that nothing in the nature of healthcare seems to require this fragmented structure, since hospitals in other countries have salaried

doctors. He concludes instead: "The dominant cause of fragmentation instead appears to be the law, which dictates many of the fragmented features described above and thus precludes alterative organizational structures."[11] He lists a long string of legal impediments, including Medicare reimbursement rules, laws against corporate practice of medicine, and tort doctrines. Referring to private insurance:

> State laws generally make it illegal for physicians to split their fees with anyone other than physicians with which a physician is in a partnership. More important, alternative payment systems, such as paying a hospital (or other firm) to produce some health outcome or set of treatments, would make sense only if it has some control over the physicians and other contributors to that outcome and treatments. And other laws preclude such control. . . . The corporate practice of medicine doctrine provides that firms—whether hospitals or HMOs—cannot direct how physicians practice medicine because the firms do not have medical licenses, only the physicians do. Although some states allow hospitals to hire physicians as employees, that change in formal status does not help much if the employer cannot tell the employee what to do. Even if the law did not prohibit such interference, tort law generally penalizes firm decisions to interfere with the medical judgments of individual physicians, making it unprofitable to try. . . . Further, hospital bylaws usually require leaving the medical staff in charge of medical decisions, and those bylaws are in turn required by hospital accreditation standards and often by licensing laws. . . .
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> Private insurer efforts to directly manage care have likewise been curbed by the ban on corporate practices of medicine and the threat of tort liability. In addition, states have adopted laws requiring insurers to pay for any care (within covered categories) that a physician deemed medically necessary, banning insurers from selectively contracting with particular providers, and restricting the financial incentives that insurers can offer providers.[12]

Laws against the "corporate practice of medicine" are another example of restrictions that end up limiting competition and innovation. The American Health Lawyers Association explains:[13]

> The CPM doctrine generally prohibits a business corporation from practicing medicine or employing a physician to provide professional medical services.
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> Corporate employment of a licensed professional has been prohibited on the grounds that such a relationship "tends to the commercialization and debasement of those professions."

Commercialization is what competition is all about.

My cost-cutting examples are all for-profit companies. About 70 percent of hospitals and 85 percent of healthcare employment is in nonprofits,[14] whose legal and regulatory treatment protects much inefficiency from competition. If United did not have to pay taxes, Southwest's job would have been that much harder.

Maybe for-profit companies pay too much attention to stock prices. But nonprofits can go on inefficiently forever, with no stockholders to complain. The whole point of a nonprofit is to pursue goals other than economic efficiency.

More importantly, if a for-profit company is inefficiently run, another company or a private-equity firm can buy up the stock cheaply, replace management, and force reorganization. Nonprofits (especially their management) are protected from this "market for corporate control."[15]

Many nonprofit hospitals are too small, cannot merge, and, unable to issue stock by definition of "nonprofit," are undercapitalized.

Recognizing some of these pathologies, there is a wave of mergers and transfers between for-profit and not-for-profit status. But there is lots of gum in the works. When a nonprofit is sold or converts to for-profit, the state attorney general and courts can weigh in on the sale; legally to ensure that the proceeds benefit a charitable cause related to the nonprofit's original mission. This is a great opportunity for competitors to block the change.[16]

The FTC is ramping up antitrust action against hospital mergers.[17] Hospitals need economies of scale for expensive, specialized modern medicine and to comply with the avalanche of regulation and insurance paperwork. The FTC worries about local monopolies able to raise prices, especially given the inelastic demand by insurers and government reimbursement. So here we have the government forcing small size in order, it hopes, to boost competition with one hand; stopping entry, explicitly to protect hospitals from competition, with another; trying to force larger "networks" through "affordable care organizations" to obtain the needed economies of scale with the third; and preserving doctor independence from competitive pressure by law with the fourth.

The schizophrenic attitude of our regulatory regime to size and competition comes partly down to its desire to enforce cross-subsidies and mandates.

For example, the Emergency Medical Treatment and Active Labor Act (EMTALA) requires pretty much all acute-care hospitals to provide care

for emergencies and active labor patients, without any provisions for reimbursement. And Medicare reimbursement rates are notoriously lower than costs. So hospitals have to make up the difference by overcharging other patients, both those with insurance and the few cash customers.

But you cannot have cross-subsidies with competition—those being overcharged will quickly leave. Thus, the hospitals providing EMTALA service and the insurance companies cross-subsidizing Medicare have to be protected from competition, or they will not be able to stay in business. That is fine for a while, but businesses protected from competition and able to cross-subsidize money-losing operations soon become complacent and sclerotic and find other ways to lose money. They also find ways to lobby regulators for even more protection from competition, so as to continue to provide the regulators' desired cross-subsidy.

Regulation, mandated cross-subsidies, and protection from competition also help to hide the size of the government's interventions from a skeptical electorate. If the government taxed corporations and used the revenue to provide health-insurance subsidies, that action would count on the budget as "taxing and spending." The government instead mandates that employers shall provide health insurance, and then neither the tax nor the spending show up in the government's budget. The economic effect is exactly the same, and the distortions are exactly the same. (Witness the number of jobs suddenly cut down to 29.5 hours a week once the ACA required health insurance for jobs over 30 hours a week.) We are just kidding ourselves in many ways.

It is amazing that computerizing medical records was part of the ACA and stimulus bills. Why in the world do we need a subsidy for this? My bank computerized records twenty years ago. So did my car repair shop. Why, in fact, do doctors not answer emails? And do they still send you letters by the post office, probably the last business to do so? Or maybe grudgingly by fax, only 20 years obsolete? Why, when you go to the doctor, do you answer the same twenty questions over and over again, and what the heck are they doing trusting your memory to know what your medical history and list of medications are? Part of the answer: they're afraid of being sued. Confidentiality regulations, apparently more stringent than those for your money in the bank. They can't bill email time.

So medical records offer a good parable; rather than look at an obvious pathology, rather than ask what features of current law and regulation are causing hospitals to avoid the computer revolution that swept

banks and airlines twenty years ago, and rather than remove those roadblocks, the government adds a new layer of subsidies and contradictory legal pressure. One regulation says move right, the other says move left.

The impediments to supply-side competition go far beyond formal legal restrictions. Our regulatory system has now evolved past laws, past simple, explicit, and legally challengeable regulations, to hand vast discretionary power to officials and their administrative bureaucracy—either directly ("the Secretary shall determine" is the chorus of the ACA) or through regulations so lengthy, vague, and contradictory that administrative discretion is the effect. Witness the wave of waivers to ACA that HHS handed out to friendly companies. Those administrators can easily be persuaded to take actions that block a disruptive new entrant, with little recourse for the potential entrant. And criticizing a regulator with such power is a dangerous business. (Lobbying government to adopt rules or take actions to block entrants is legal, even if those actions taken directly would violate antitrust laws, under the *Noerr-Pennington* doctrine.)

Forget about Wal-clinics; Chicago and New York have kept Wal-Mart from selling *food and clothes* to their residents for years, at the behest of unions and competitors, by denying Wal-Mart all the necessary permits and approvals. So many citizens, especially our poor and vulnerable, continue to live in employment and retail deserts.

The increasing spread of medical tourism to cash-only offshore hospitals is a revealing trend. Why does this have to occur offshore? What's different about the hospital location? Answer: the regulatory regime.

So, what's the biggest thing we could do to "bend the cost curve," as well as finally tackle the ridiculous inefficiency and consequent low quality of healthcare delivery? Look for every limit on *supply* of healthcare services, especially entry by new companies, and get rid of it.

D. The Reregulation Path

Now, this is of course not the way of current policy. The ACA and the health-policy industry are betting that additional layers of new regulation, price controls, effectiveness panels, "accountable care" organizations, and so on will force efficiency from the top down. And they plan to do this while maintaining the current regulatory structure and its protection for incumbent businesses, management, and employees.

Well, let us look at the historical record of *this* approach, the great examples in which industries, especially ones combining mass-market

personal service and technology, have been led to dramatic cost reductions, painful reorganizations towards efficiency, improvements in quality, and quick dissemination of technical innovation by regulatory pressure.

In other words, let's have a moment of silence.

No, we did not get cheap and amazing cell phones by government ramping up the pressure on the 1960s AT&T. Southwest Airlines did not come about from effectiveness panels or an advisory board telling United and American (or TWA and Pan Am) how to reorganize operations. The mass of auto regulation did nothing to lower costs or induce efficient production by the Big Three.

When has this approach ever worked? The Postal Service? Amtrak? The Department of Motor Vehicles? Road construction? Military procurement? The TSA? Regulated utilities? European state-run industries? The last twenty or so medical cost control ideas? The best example and worst performer of all . . . wait for it . . . public schools?

It simply has not happened. Government-imposed efficiency is, to put it charitably, a hope without historical precedent. And for good reasons.

Regulators are notoriously captured by industries, especially when those industries feature large and politically powerful businesses with large and politically powerful constituencies, as in health insurance or as in most cities' hospitals. In turn, regulated industries quickly become dominated by large and politically powerful businesses. See "Banks, comma, too big to fail." (Several insurance companies were also bailed out in the financial crisis, on the theory that failure of their retirement contracts was somehow a "systemic" danger. Many states now have only a few health insurers left. Too-big-to-fail protection for health insurers is not an abstract and distant worry.)

This is not to say that regulators are not well-meaning and do not put great pressure on many industries. But the deal, "You do what we want, we'll protect you from competition" is too good for both sides to resist. The addendum "And support us and our administration politically or else" is emerging fast.

Needless to say, price controls have been a disaster in every case they have been tried. Long lines for gas in the 1970s are only the most salient reminder. Price controls' predictable result is vanishing supply, abundant demand, and low quality. Try finding a doctor who will take new Medicare or Medicaid patients. The over-the-counter additional payments many providers now require will predictably become the under-the-counter payments or personal connections you need to get treated in many countries.

The current regulatory approach is not really well described as simple price controls—for example "Thou shalt not charge more than $3 per gallon of gas"—but rather as fiddling with a payment system of mind-numbing complexity and endlessly discovered unintended consequences. The past record of cost control and "incentive" efforts should warn us of how likely adding more complex rules is to work. There are already conferences for doctors to teach them how to maximize Medicare billing codes (there are sixty-eight thousand) for each visit,[18] and there are 2.2 people doing medical billing for every doctor who actually sees patients, costing $360 billion.[19] This regulatory failure seems instead to be a challenge to the next generation of planners.[20]

But capture and the failure of price controls are only the beginning. Real cost reduction is a painful process, as my examples remind us, and our political system is allergic to pain.

Can a regulator, appointee, or politician in a democracy really become a union buster, forcing painful concessions on workers, managers, suppliers, and other "stakeholder" beneficiaries of rents? Can a regulator realistically demand that jobs be outsourced or replaced by software? Can a regulator really preside over a wave of bankruptcies, mergers, and mergers, in which new businesses send old ones to the dustbin? They can stand back and let the market do it, but can they possibly take direct responsibility for these events?

Consider a small example now in the news. Hospitals are starting to outsource the reading of X-rays, even to India. This activity is still heavily regulated—the radiologists must still be US-trained and certified, and also state certified. But already it is a cause célèbre for its potential to cost jobs. When the obvious happens—"Hmm, we have some good Indian doctors who can read the X-rays just as well"—you can imagine the scandal. And doesn't every American deserve the best—a US radiologist on staff and present twenty-four hours a day, ready to consult with the doctor? Personal-injury law firms are already lining up to sue based on the "inferior quality" of outsourced readings, with requisite horror stories.[21] How could a regulator not just allow but *demand* outsourcing radiology and using Indian doctors?

A big stated point of regulation is to ensure quality. It is interesting how bad a job it does. Regulators can impose minimum standards, requiring degrees, certification, inspections, and the like, and keep out really dangerous quacks. But beyond that they are terrible at pushing for higher quality, especially when quality means so much in the experience of a cus-

tomer in a service-oriented business. Restaurant regulation keeps restaurants reasonably safe, but there is no regulatory pressure for Joe's Tacos to use better cuts of beef, let alone to adopt molecular gastronomy, seat you quickly, or be polite. Yelp.com ratings do that in a way no regulator can hope to. Yet mind-numbing and competition-destroying regulation is routinely instituted on the argument that quality must be forced on businesses that are for some reason unwilling to provide it. Well, of course they are unwilling to provide it if they are not competitive. And they are not competitive when the regulator protects them from competition.

My examples also do a remarkable job of getting rich people to pay through the nose voluntarily, covering fixed costs for medium-income consumers. Two words: business class. But a politician who proposed taxing people this way to provide air travel would be hanged as a socialist. And a regulator who consigned middle-income patients to seat 25D while wealthier patrons got business class would be hanged as a fascist.

E. Realism

Now by being concrete and therefore realistic, I invite obvious complaints. What, I like airlines and Wal-Mart? Have I flown Southwest or shopped at Wal-Mart? (Yes to both, incidentally.) But I think the examples are good to remind us what efficiency looks like in the real world and how it is achieved, and to keep us from fantasies about what healthcare can look like and what outcomes regulators are likely to be able to achieve.

We love to complain about airlines. But aside from the TSA's security theater and air traffic control—both run by the government—what we really want is 1970s service at 2010 prices. Sorry, we can't afford private-jet medicine for everyone. Southwest medicine has to be the goal—safe, effective, and just as comfortable as people are willing to pay for.

Shop at Wal-Mart? Wal-Mart is putting all those cute mom-and-pop stores out of business. It is putting pressure on union jobs, the main reason Chicago kept it out all these years. It pushes suppliers relentlessly. It buys from China. Am I not being heartless? No. I am being realistic. The lesson from all our experience with other industries is that cost control and innovation are hard and brutal processes. Not just the businesses, but their suppliers and employees clamor for protection.

Many of you are probably still squirming in your seats. You want some other way. You want to keep unionized jobs, "living wages," "worker

protections," or to "keep our community hospitals going." Perhaps you mourn the bank tellers replaced by ATM machines and jobs sent to China. More deeply, you are probably squirming in your seats at my observation that quality varies enormously in efficient industries; some fly economy middle seat, and some fly in private jets. Some get shirts from Wal-Mart and some get shirts from Macy's. Surely, does not every American deserve the best when it comes to healthcare?

If so, you are not serious about reducing costs—that is, finding the efficient point on the quality-cost curve. This is simply a fact: you are adding other goals to the mix, so you are accepting rising costs to fund those other goals. Or you are fantasizing that you can have it both ways.

And if *you* are having trouble putting those other considerations aside and accepting a consumer-focused Wal-Mart / Southwest Airlines model for healthcare, imagine how unlikely it is that the Department of Health and Human Services will force that model to emerge through its regulatory power.

Healthcare Demand

The demand side of the healthcare market is just as severely distorted.

A. Payment Plans and "Need"

Most basically, with either government provision or private insurance, healthcare is bought in "payment plan" form. You pay a tax or a premium, then your expenses are "covered."

We all understand that when somebody else is paying, people do not economize on expensive services, shop for better deals, or accept less convenient but cheaper alternatives. More importantly, I think, demand affects supply, and demand distortions inhibit needed supply competition; it is a lot harder for new entrants to attract business when people are paying with someone else's money.

Is there something about the nature of healthcare, as an economic good, that necessitates payment-plan provision? Thinking about it, I think the opposite is true; healthcare, as an economic good, is a particularly poor candidate for payment-plan provision.

I think people have in mind examples such as a simple wound or a broken arm. Even if it is free, nobody is going to overuse broken-arm

treatment. Nobody will have a good arm put in a cast or have stitches just for fun. Pretty much any qualified doctor can handle such procedures; you do not need to find one who is "really good at setting bones" (or so people think) but charges a higher price. So the "good" is well defined, it is a pretty generic commodity, the demand curve is steep, and what you "need" is clearly observable.

But these are misleading examples. The actual demand curve for healthcare is incredibly elastic. When healthcare is provided at low cost, people consume prodigious amounts of healthcare services. Every cost estimate for government provision or subsidy, from the U.K. NHS to Medicare, Medicaid, and beyond has missed its mark by orders of magnitude.

Furthermore, though it is common to disparage "overuse" in health policy circles, the elastic demand curve is real. These are real people, with painful and debilitating illnesses, and the "extra" test or visit to the specialist, the one more last-ditch treatment, might just be the one to finally help them. Conversely, when asked to pay more, consumers economize rapidly, refusing "too much" care in the judgment of the medical community.

So we have attempted payment plans with limits—insurance rules, managed care, HMOs, effectiveness panels, affordable care organizations, and so on—to cut off the flat demand curve. Ezekiel Emanuel, Neera Tanden, and Donald Berwick, writing in the *Wall Street Journal,*[22] explained the idea behind affordable care organizations: "Instead of paying a fee for each service, providers should receive a fixed amount for a bundle of services or for all the care a patient needs."

Hmm. "Need." "From each according to his ability, to each according to his need." It has a nice ring to it. Why do I feel a certain foreboding? "Need" is not an economic concept.

Would this setup work for clothes? Your employer gives you "access" to clothes by including a "clothes plan" in your benefits. Then your appointed "primary style consultant" will determine how many shirts you need, which you can pick from the preferred shirt-provider network (Kmart). (And if you show up at Kmart saying "I'd rather pay cash," they charge $1,000 for a shirt.) Home repair? The home-repair effectiveness board will conduct peer-reviewed research on appropriate materials for kitchen counters. Sorry, granite is off the approved list, you don't need it.

Healthcare? For many patients, just getting through the diagnosis to decide what treatment they might try is an expensive and inconclusive nightmare, with trip after trip to various specialists. How much *diagnosis* do you really need in these circumstances?

Many diseases are chronic, requiring widely varying and individual-specific treatment plans. Nothing really works, and we are trading off different options with different bad side effects, and needing different levels of commitment from the patient.

End-of-life care, care for the elderly, infirm, handicapped, and mentally ill are very expensive, and all lie on a long string of quality versus quantity choices. Does grandma really need a five-star nursing home, a helper (a highly personal service!—Could insurance or government "provide" needed housecleaning services successfully?), or just support from family? Does need without considering cost, that is, willingness to pay, really even begin to describe the economics of this decision? Should a family that decides to provide care, saving the nation hundreds of thousands of dollars, receive no benefit?

I had a back pain episode recently. (Somehow health policy always ends up with here's-where-it-hurts anecdotes!) Did I need an MRI to really see the structural problem? Cortisone shots? Surgery? Physical therapy, or just a photocopy of recommended exercise? Physical therapy at the University of Chicago hospital, or at the specialty sports-rehab clinic that patches up the Bears? Or just a handful of ibuprofen and time to let it heal? Did my planned trip to Europe matter in this medical need?

And why not speak the dirty little secrets? For most patients, "Stop smoking, exercise and lose some weight" is the best advice they could take. Patients' awful compliance is an open secret. How much drugs and treatment do patients need who won't stop smoking, lose weight, exercise, do the physical therapy, or comply with drug regimes?

Another dirty little secret: quality, both actual and perceived, varies enormously. Rates of medical errors, infection rates, rates of success in difficult procedures, just getting basic diagnoses right, or even washing hands often enough vary widely. The quality of service provided, including everything from waiting times to convenience of making an appointment to whether the doctor answers emails, varies as well. Do you need an MRI this afternoon at 5:00 p.m. near your work, or on the other side of town two weeks from now? Conversely on supply: Yelp.com ratings have a huge effect on spurring this sort of attention to detail in restaurant services. Can bureaucratic rules really substitute in medical services?

And medicine is not perfect. For a range of conditions, we have imperfect treatments, with varying side effects, and scientific knowledge of what works or does not is changing fast. What does need mean then?

If only it were so simple to determine need. If only people like me went away quickly when told we do not need an MRI to find out why our backs hurt. Or if people with hard-to-diagnose but debilitating illnesses like food allergies quietly went away rather than hold out hope that the next specialist will figure out the problem.

B. Need and Willingness to Pay or Forego

So what does "need" really mean? The only sensible economic definition I can think of is that "need" is the bundle of services you would choose if you were paying with your own money at the margin. You need that MRI to make sure your back pain will not just heal after six weeks of ibuprofen if you would be willing to shell out $1,000 of your own money to get it. And you need it delivered at a convenient hour, tomorrow, rather than next week, across town, if you are willing to pay that extra cost.

"At the margin" is an important qualifier, because intuitive thinking soon mixes up "what you'd rather spend money on" with "what you can 'afford.' "

As economists, we are expected to avoid that confusion. A good way to do so is to pose the question in the positive rather than the negative: suppose we offered each patient the choice, "Your doctor prescribed this MRI. You can have the MRI or you can have $1,000 in cash." The patient "needs" the MRI if he or she foregoes the cash and goes through with the MRI.

This is an important and unsettling conceptual experiment. If the patient chooses to forego treatment, or to find a cheaper alternative and keep half the cash, you can not argue the patient "cannot afford" treatment. It's unsettling, because I think we suspect lots and lots of people would take the cash, especially at current inflated prices. So there is a lot of paternalism in healthcare policy, which we might be more upfront about.

In any case, once defined, it's pretty clear that this need is essentially impossible to measure externally for a personal service with so much variety and imperfection as healthcare. Moreover, many more people would need MRIs, by any definition of "need," if competition and innovation drove the price down to $50. So we are just arguing about *who makes* the cost/benefit decision. What you "want" is where you make the cost/benefit decision. What you need is what I—or some panel of bureaucrats—think you should get.

I think the word "need" also has a moral tone, implying "what society owes you." This seems even harder to define or measure. How much back treatment did society owe me?

Now economists might quibble with my definition of "need" as willingness to pay or forego because I left out income effects. My patient taking the cash instead of an MRI might have wanted to pay for food and rent. Perhaps "need" should mean "what you would be willing to pay or forego if you earned $1 million a year." Alas, we don't have the resources to pay for that definition of "need." We simply cannot all fly on private jets at public expense.

So while private jet stories are fun, given the social budget constraint the relevant question is whether someone earning $50,000 a year would give a much different answer than someone earning $80,000 per year. Care for the very poor and indigent is a separate question, which I discuss below.

Now it is not so obvious that income is a large source of variation in "willingness to pay," in this relevant range. For every other good and complex service, variation of demand across people within income categories is far greater than variation of demand with income by the average person. At Denny's and at Alinea, some eat steak and some eat chicken. This pattern is likely to hold for healthcare as well. So, while it is a relevant quibble, in the end I think an argument based on income effects in the definition of "need" is distraction.

C. Healthcare Demand, Bottom Line

In sum, healthcare is a complex, highly varied personal service, not a simple well-defined commodity. The demand curve is as elastic as any in economics. When, where, how, how much, by whom are vital components of that service. Objective and subjective quality and corresponding cost vary tremendously, and many dimensions of that quality are not easily measurable. The distinction between "need" and "want" is at best unmeasurable and at worst simply meaningless. The broken arm is a horrendously misleading example.

But healthcare *is* an economic good. Healthcare is not that different from the services provided by lawyers, auto mechanics, home remodelers, tax accountants, financial planners, restaurants, airlines, or college professors.

Payment-plan provision, with rationing by some bureaucratic determination of need, is based on the opposite and false assumptions and

thus is pretty hopeless for healthcare. No planner can mimic the market outcome in which what you need is what you are willing to pay for at the margin.

To some extent, private insurers offer high-quality versus generic plans to sort patients *ex ante* by quality versus willingness to pay. But regulation makes that sorting much harder; once we force guaranteed issue at the same price, it is next to impossible for insurers to maintain bare-bones versus Cadillac plans. The minute a bare-bones customer gets sick, that customer will demand to be issued a Cadillac plan at the same cost as everyone else. And health insurers will respond by tailoring plans to attract healthy consumers—for example, by offering free health club benefits—and discourage sick ones.

The whole guaranteed issue plus mandate arrangement assumes that health insurance is a generic good, not one with good-better-best quality and price points. If not generic already, health insurance will soon be forced to be generic by this regulation. And regulatory rationing cannot say that anyone must shop at Wal-Mart.

I conclude that at the margin, the consumer needs to be paying a lot closer to full marginal cost of healthcare, or, equivalently, receiving the full financial benefits of any economies that consumer is willing to accept.

The Healthcare Market—Supply and Demand

The obvious problem with my demand analysis is that the cash market is dead. Making people pay, and shop, is unrealistic.

If you walk in to the University of Chicago Hospitals and say, "I don't have insurance. I have a bank account. I'll be paying cash," their eyes will light up (after they figure out you actually have the cash). "We'll pay for a hundred Medicare patients with this guy." That is like walking up to United Airlines and saying "I want to go to Paris, first class. Sell me a ticket." Actually, it is worse—at least United will quote you a price up front and on its website, and let you compare with American. It will not usher you into a back room for a one-on-one negotiation over what you will pay.

Nobody reading this essay really needs health insurance—income protection—for anything less than catastrophes. We pay for transmis-

sion repairs, leaking roofs, and vet bills out of pocket. We could easily "afford" most of our routine medical expenses, and even pretty big unplanned expenses, especially if we were paying commensurately lower health-insurance premiums.

But we all have health insurance, and we deal with the paperwork nightmare. Why? Because we know we cannot simply pay for healthcare when we need it. Insurance companies now function as purchasing agents, negotiating complex deals on our behalf.

But why, again? You do not need an insurance company to negotiate your cell phone contract, home repair and rehab, mortgage, airline fare, legal bills, or clothes, as we do for health.

Moreover, why do we mix this negotiation with "insurance," and a payment plan? Dr. Jones is in Humana's network, Dr. Smith is in Blue Cross's. What economic principle means I should not see Dr. Jones, just because some arcane negotiation took place behind the scenes? And what about the new low-cost specialty clinic that Dr. Thomas is setting up, which cannot get into either network?

Part of the answer is the tax-deductibility of employer-provided group insurance. The 10 percent who really do not need health insurance pay high marginal income-tax rates, so a great deal of inefficiency is worth a tax dodge.

But the bigger answer is that the market is missing robust supply-side competition. Hospitals would never get away with obscure pricing, hidden rebates, or massive cross-subsidies if they were facing serious competition from new entrants who could peel you away—and peel you away from your expensive "price negotiator" as well.

The cash market is also dead because of the demand-side distortion: too *many* people have insurance, that is, highly regulated "payment plans." Competing for cash customers just does not make enough money to keep a hospital going, and the pool of cash customers is a lot sicker.

A hospital must choose, basically, to be all insurance or all cash. If it offers clear transparent prices to cash consumers, it cannot also play the game with insurance companies.

(The spread of "concierge medicine," the equivalent of private schools for people so fed up they just throw away health insurance, is an interesting phenomenon. But it is still too small to affect the overall market. There are no concierge, cash-only hospitals. That business seems to have to move offshore.)

In a vicious circle, the absence of a functional cash market lies at the heart of many insurance pathologies and government cost-control problems. Insurance functions best when it is a small part of a market, in which prices are set by marginal consumers paying cash and competitive businesses supplying them. With little price discovery left in healthcare, health *insurers* have to do all the price negotiation in a vacuum.

Airlines, restaurants, and car repair work reasonably well even though in each case a large fraction of consumers are not paying with their own money—instead using expense accounts in the first two cases, insurance in the third. Each has competitive supply and a remaining fraction of consumers who feel marginal decisions, enough to allow price discovery and competitive pressure for efficiency. Healthcare is so far gone that it is missing the price discoverers.

Many pricing decisions are based on Medicare reimbursement rates. But from where does Medicare get its rates? With no supply-equals-demand pricing going on anywhere, how does price discovery happen? Ed Lazear reported that in the Soviet Union, which had no price discovery mechanism, central planners used the Sears Catalog to set relative prices.[23] But what happens when there is no Sears catalog left?

I suspect this is the reason that we cannot even separate negotiator and insurance functions. It has long puzzled me why insurance companies do not offer the very sickest patients or rich people who do not want "insurance" the following deal: "You need our negotiating power. But we do not want to take you on as a risk. So you get access to all our negotiating power, but you have to pay all your bills." Alas, hospitals and insurance companies have negotiated contracts with lump-sum rebates, so the cost of a particular patient is not really measured. The phony-baloney bills you see really are phony-baloney bills. Perhaps the companies also fear that insurance regulators would quickly put a stop to the practice and force the company to pay for the sick person's care rather than just pass on huge bills.

Part of the reason for phony pricing is that hospitals know most "cash" customers will not end up paying, so they will end up negotiating charity care. Then they can report the discount as a contribution to charity care. Nicholas Kristof's story in the *New York Times* of the travails of an uninsured friend who got cancer unwittingly but beautifully illustrates my point.[24] Kristof cites completely ridiculous prices, then explains how his friend applied for charity care and had a $550,000 bill knocked down to

$1,339. But just to reiterate how ridiculous the cash pricing is, the hospital still wanted to charge $1,400 for an ambulance ride.

Freeing up either supply or demand without freeing up the other will do little good. Increasing co-pays can help to ration expensive or overpriced services, but co-pays do not stimulate supply or efficiency as long as new entrants cannot come in and compete for business. Allowing new entrants to compete for business does not do any good as long as few consumers are able to vote with their money.

Health Insurance

I have written a lot about how to fix health insurance, so I will not repeat all that here.[25] To summarize briefly, health insurance should be individual, portable, lifelong, guaranteed renewable, transferrable, competitive, and lightly regulated, mostly to ensure that companies keep their contractual promises. "Guaranteed renewable" means that your premiums do not increase and you cannot be dropped if you get sick. "Transferable" gives you the right to change insurance companies, increasing competition.

Insurance should be insurance, not a negotiator and payment plan for routine expenses. It should protect overall wealth from large shocks, leaving as many marginal decisions unaltered as possible. "Access" should mean a checkbook and a willing supplier, not a federally regulated payment plan. Such insurance would, of course, be a lot cheaper. And insurance can be all these things, in a free or lightly regulated market.

Preexisting conditions, failure by the young and healthy to obtain insurance, and spiraling insurance costs—the main problems motivating the ACA—are neatly addressed by this alternative, as I and others have explained at length elsewhere.

Why do we not have a system? First, because law and regulation prevent it from emerging. Before the ACA, the tax deduction and regulatory pressure for employer-based group plans were the elephants in the room. This distortion killed the long-term individual insurance market, and thus directly caused the preexisting conditions mess. Anyone who might get a job in the future will not buy long-term individual insurance. Mandated coverage, tax deductibility of regular expenses if cloaked as

"insurance," prohibition of full rating, barriers to insurance across state lines—why buy long-term insurance if you might move and are forbidden to take it with you?—and a string of other regulations did the rest. Now, the ACA is the whale in the room; the kind of private health insurance I described is simply and explicitly illegal.

The second reason we do not have a system is that functional so-called insurance requires a functioning underlying market, which law and regulation have also prevented from emerging. We cannot reasonably write contracts about who pays the bill when the bill itself is so meaningless.

If there were functional cash markets, health savings accounts could also substitute for much of the necessarily cumbersome functions of insurance. Health borrowing accounts, that is, health savings accounts with a preapproved line of credit that you can tap for unexpected expenses, are not insurance in the sense of transferring overall wealth but would help even more. But without functional (competitive) cash markets, health savings accounts are not that helpful either.

Unfortunately, individual long-term policies were one of the first casualties of Obamacare. In fall 2013, a large number of insurers canceled individual policies, most of which were guaranteed renewable under ACA requirements. Many customers faced large premium increases and more restrictive new policies under the exchanges, and may choose to go without insurance instead. Here was a population that did the right thing and bought insurance, even if badly overpriced, precisely for the right to keep it if they should get sick in later years. And the first act of the ACA, just before the disastrous healthcare.gov rollout, was to cancel that insurance. The only silver lining is the number of voters who began to find out what is really in the system, epitomized by a young woman writing a letter to Pam Kehaly, president of Anthem Blue Cross in California, on receiving a 50 percent rate hike: "I was all for Obamacare until I found out I was paying for it."[26]

Objections

The idea that healthcare and insurance can and should be provided by deregulated markets and that existing regulations are the main source of our problems is fairly radical within the current policy debate. Let me deal with a few of the standard objections.

A. The Poor

"What about the homeless guy with a heart attack?"

Let us not confuse the issue with charity. The goal here is to fix health insurance for the vast majority of Americans—people who have jobs, people who buy houses, cars, and cell phones, people who buy insurance for their houses and life insurance for their families.

Yes, we will also need charity care for those who fall through the cracks, the victims of awful disasters, the very poor, and the mentally ill. This will be provided by government and by private charity. It has to be good enough to fulfill the responsibilities of a compassionate society, and just bad enough that few will choose it if they are capable of making choices. I wish it could be better, but that is the best that is possible. For people who are simply poor, but competent, vouchers to buy health insurance or to refill health savings accounts make plenty of sense.

But supplying decent charity care does not require a vast "middle class" entitlement and regulation of health insurance and healthcare for everyone in the country, any more than providing decent homeless shelters (which we are pretty scandalously bad at) or Section 8 housing subsidies for the poor requires that we apply ACA-style payment and regulation to your house and mine, to Holiday Inn or to the Four Seasons. To take care of homeless people with heart attacks, where does it follow that your health insurance and mine must cover first-dollar payment for wellness visits and acupuncture? The ACA is hardly a regulation minimally crafted to solve the problems of homeless people with heart attacks.

B. The Straw Man

There is a more general point here, which will appear time and again as I answer criticisms. Critics adduce a hypothetical situation in which one person might be ill served by a straw-man completely unregulated market, with no charity or other care (which we have had for over eight hundred years,[27] long before any government involvement at all), which nobody is advocating. They conclude that the hypothetical justifies the thousands of pages of the ACA, tens of thousands of pages of subsidiary regulation, and the mass of additional federal, state, and local regulation applying to every single person in the country.

How is it that we accept this deeply illogical argument, or that anyone making it expects it to be taken seriously?

Will not one person fall through the cracks or be ill served by the highly regulated system? If I find one Canadian grandma denied a hip replacement or one elderly person who cannot get a doctor to take her as a Medicare patient, why do I not get to conclude that all regulation is hopeless and that only an absolutely free market can function?

Both straw men are ludicrous, but somehow smart people make the first one, in print, and everyone nods wisely.

C. Adverse Selection

We all took that economics course in which the professor shows how asymmetric information makes insurance markets impossible due to adverse selection. Sick people sign up in greater numbers, so premiums rise and the healthy go without. George Akerlof's justly famous "The Market for Lemons"[28] proved that used cars cannot be sold because sellers know more than buyers.

Yet CarMax thrives. Life, property, and auto insurance markets at least exist, and function reasonably well despite the similar theoretical possibility of asymmetric information. Life insurance is also "guaranteed renewable," meaning you are not dropped if you get sick.

Is the story even true? Do most people, with knowledge of aches and pains, really know so much more about likely cost than an insurance company armed with a full set of computerized health records, actuaries, health economists, and whatever battery of tests it wants to run? Or is asymmetric information market failure in health insurance just a myth passed from generation to generation, despite functioning markets in front of our eyes?

Now the real world does see a big "adverse selection" phenomenon. Sick people are more likely to buy insurance, and healthy people forego it. But the insurance company does not charge people the same rate because it *can't tell* who is sick or likely to cost more—the fundamental, technological, and intractable information asymmetry posited in your economics class. The insurance company charges the same rate because law and regulation *force* it to do so. The insurance company is barred from using all the information it has.

Regulation seems to feel that we have the opposite information problem; insurers know *too much*. The centerpiece of the ACA, after all, is *banning* the use of information, that is, preexisting conditions, not a

great regret that insurers cannot tell who has preexisting conditions in order to charge them more.

This source of adverse selection is the legal and regulatory problem, not the information problem of economic theory, and easily solved. If insurance were freely rated, nobody would be denied. Sick people would pay more, but "health status" insurance or guaranteed renewability solve that problem and eliminate the preexisting conditions problem. (See note 21 for references.)

Adverse selection due to fundamental information asymmetry in an unregulated market is, as far as I can tell, a cocktail-party market failure. It is a nice story, but does not quantitatively account for the real world.

Furthermore, the ACA is not a minimally crafted regulation to solve the problem that people know more than their insurance companies can know about their health. Once again we are subject to the logical fallacy of accepting the entire regulatory structure because of one alleged failure of a hypothetical free market.

D. Shopping Paternalism

Defenders of regulation reiterate the view that markets can't possibly work for health decisions:[29]

> "A guy on his way to the hospital with a heart attack is in no position to negotiate the bill."

> "One point I cannot agree with is that competition can work in healthcare, at least as it does in other markets. I cannot fathom how people faced with serious illness will ever make cost-based decisions."

> "What about those who currently don't have the background and/or the economic circumstances to consume healthcare, (e.g. take anti-hypertensive medicine instead of [buying] an iPhone)?"

Ezra Klein trying to understand why healthcare prices are so high and so obscure, writes:[30]

> Health care is an unusual product in that it is difficult, and sometimes impossible, for the customer to say "no." In certain cases, the customer is passed

> out, or otherwise incapable of making decisions about her care, and the decisions are made by providers whose mandate is, correctly, to save lives rather than money.
>
> In other cases, there is more time for loved ones to consider costs, but little emotional space to do so—no one wants to think there was something more they could have done to save their parent or child. It is not like buying a television, where you can easily comparison shop and walk out of the store, and even forgo the purchase if it's too expensive. And imagine what you would pay for a television if the salesmen at Best Buy knew that you couldn't leave without making a purchase.

New York Times columnist Bill Keller put it clearly, in "Five Obamacare Myths:"[31]

> [Myth:] The unfettered marketplace is a better solution. To the extent there is a profound difference of principle anywhere in this debate, it lies here. Conservatives contend that if you give consumers a voucher or a tax credit and set them loose in the marketplace they will do a better job than government at finding the services—schools, retirement portfolios, or in this case health insurance policies—that fit their needs.
>
> I'm a pretty devout capitalist, and I see that in some cases individual responsibility helps contain wasteful spending on health care. If you have to share the cost of that extra M.R.I. or elective surgery, you'll think hard about whether you really need it. But I'm deeply suspicious of the claim that a health care system dominated by powerful vested interests and mystifying in its complexity can be tamed by consumers who are strapped for time, often poor, sometimes uneducated, confused and afraid.
>
> "Ten percent of the population accounts for 60 percent of the health outlays," said Davis [Karen Davis, president of the Commonwealth Fund]. "They are the very sick, and they are not really in a position to make cost-conscious choices."

Now, "dominated by powerful vested interests and mystifying in its complexity" is a good point, which I also just made. But why is it so? Answer: because law and regulation have created that complexity and protected

powerful interests from competition. And is the ACA really creating a simple clear system that will not be "dominated by powerful vested interests?" Or is it creating an absurdly complex system that will be, completely and intentionally, dominated by powerful vested interests?

But the core issue is these consumers who are "passed out, or otherwise incapable of making decisions about [their] care," "strapped for time, often poor, sometimes uneducated, confused and afraid," and "not really in a position to make cost-conscious choices."

Yes, a guy in the ambulance on his way to the hospital with a heart attack is not in a good position to negotiate. But what fraction of healthcare and its expense is caused by people with sudden, unexpected, debilitating conditions requiring immediate treatment? How many patients are literally passed out? Answer: next to none.

What does this story mean about treatment for, say, an obese person with diabetes and multiple complications, needing decades of treatment? For a cancer patient, facing years of choices over multiple experimental treatments? For a family, choosing long-term care options for a grandmother with dementia?

Most of the expense and problem in our healthcare system involves treatment of chronic conditions or (what turns out to be) end-of-life care, and involve many difficult decisions involving course of treatment, extent of treatment, method of delivery, and so on. These people can shop. Our healthcare system actually does a pretty decent job with heart attacks.

And even then . . . have they no families? If I'm on the way to the hospital, I call my wife. She is a heck of a negotiator.

Moreover, healthcare is not a spot market, which people think about once, at fifty-five, when they get a heart attack. It is a long-term relationship. When your car breaks down at the side of the road, you're in a poor position to negotiate with the tow-truck driver. That is why you join AAA. If you, by virtue of being human, might someday need treatment for a heart attack, might you not purchase health insurance, or at least shop ahead of time for a long-term relationship to your doctor, who will help to arrange hospital care?

And what choices really need to be made here? Why are we even talking about "negotiation?" Look at any functional, competitive business. As a matter of fact, roadside car repair and gas stations on interstates are remarkably honest, even though most of their customers meet them once. In a competitive, transparent market, a hospital that routinely overcharged

cash customers with heart attacks would be creamed by Yelp.com reviews, to say nothing of lawsuits from angry patients. Life is not a one-shot game. Competition leads to clear posted prices, and businesses anxious to give a reputation for honest and efficient service.

So this is not even a realistic situation.

To be sure, some conditions really are unexpected and incapacitating. Not everyone has a family. There will be people who are so obtuse they would not get around to thinking about these things even if we were a society that let people die in the gutter, which we are not, and maybe some hospital somewhere would pad someone's bill a bit. (As if they do not now!) But now we are back to the straw man fallacy. Once again, the idea that ACA is a thoughtful, minimally designed intervention to solve the remaining problem of poor negotiating ability by people with sudden unexpected and debilitating health crises is ludicrous. As is the argument that we should accept the entire ACA because of this issue.

Take a closer look at Keller and Davis's statement: "strapped for time, often poor, sometimes uneducated, confused and afraid," and "not really in a position to make cost-conscious choices."

We are talking about average Joe and Jane here, sorting through the forms on the insurance offerings to see which one offers better treatment for their multiple sclerosis or diabetes-related complications. If Joe and Jane cannot be trusted to sort through this, how in the world can they be trusted to figure out whether they want a fixed or variable mortgage? Which cell phone or cable plan to buy? To deal with auto mechanics, contractors, lawyers, and financial planners? How can they be trusted to sign marriage or divorce documents, drive, or . . . vote?

We have a name for this state of mind: legal incompetence. Keller, Davis, and company are saying that the majority of Americans, together with their families, are legally incompetent to manage the purchase of health insurance or healthcare. And, by implication, much of anything else.

Yes, there are some people who are legally incompetent. But—straw man again—Keller and Davis are not advocating social services for the incompetent. They are defending the ACA, which applies to all of us. So they must think the vast majority of us are incompetent.

If not blatant illogic, this is a breathtaking aristocratic paternalism. Noblesse oblige. The poor little peasants cannot possibly be trusted to take care of themselves. We, the *bien-pensants* who administer the state, must make these decisions for them.

Let me ask any of you who still agree, does this mean you? When you are faced with cancer, do you really want to place your trust in the government health panel, because they will make better decisions than you, with your doctor and family? Or is this just for the benighted lower classes, and you and I, of course, know how to find a good doctor and work the system?

Choice is always between alternatives. Sure, some people make awful decisions. The question is, can the ACA bureaucracy and insurance companies really do better? Yet you would not trust them to buy your shirts?

And once again does the entire gargantuan bureaucratic apparatus of the ACA follow, not from the proposition that there is some fundamental economic market failure, but because . . . *Americans are no good at shopping?*

No. Health is not too important to be left to the market. Health is so important—and so varied, so personal, and so subjective—that it must be left to the market. If you do not trust the vast majority of people to make the most important decisions of their lives, and a government bureaucracy can make better decisions on their behalf, you are a devout patrician, not a devout capitalist.

E. Theory and Experience

I'm often told, "Well, fine, but this is just theory. Free-market healthcare has not been tried in a modern economy. All countries regulate healthcare or governments provide it."

That is the point of my extensive examples of other industries. As an economic good, there really is not much difference between healthcare and other complex personal services such as auto repair, legal services, home repair and remodeling, or college education. Yet these markets do not require payment plans styled as "insurance" for "access," nor must bureaucracies decide what every American "needs." In all these other industries, the providers also have considerably more expertise than the customer.

One hundred fifty years ago, the United States looked across the ocean and nearly all the governments of the time were monarchies. That observation did not prove that monarchy was a better system.

Over and over again, from the guilds against which Adam Smith railed to the telecommunications, trucking, and airlines industries

deregulated in our time, people have told us that industries cannot possibly be left to market forces. And time and time again they have been wrong. No country in the world let private markets operate telephones and television stations when we deregulated them, either.

The pockets of healthcare that are allowed relatively competitive free entry operate reasonably well. Plastic surgery and dentistry are not disasters. Radial keratotomy (corrective eye surgery) is a good example, as specialization and competition have led to both lower costs and increased quality. I am not the first dog owner to notice how easy and relatively inexpensive cash-and-carry veterinary medicine is compared to the same treatment for humans. Concierge medicine is taking off. So is cash-and-carry medical tourism.

If anyone is guilty of theorizing in the face of experience, it would seem to be those who hold the faith that the next round of brilliant ideas for layering on ACA-style regulation will lead finally to successful cost control that is not simply rationing, or will induce the radical quality improvement and innovation that we need, whereas the past ones have all failed, over and over again.

Realistic Freedom, Help, and Vouchers

I do not require that you follow me to some unrealistic libertarian nirvana. "The unfettered free market" where the improvident die in the gutter is another ridiculous straw man. Southwest's pilots have FAA licenses. Wal-Mart's products meet the standards set by the Consumer Product Safety Commission. True-blue libertarians argue about this last 5 percent of deregulation, but we do not have to. A little freedom will go a long way.

A. Better Regulation through Transfers and Vouchers

In addition to the need for genuine charity care, there can stlll be lots of government help in various places. But a central principle of economics is "don't transfer income by distorting prices, mandating transfers, or via government-provided services." The vast majority of any help and transition smoothing can and should be given in the form of on-budget, lump-sum subsidies or vouchers, leaving marginal incentives intact, and avoiding programs, protections, and incentives that last forever.

When we transition to freely rated lifelong individual insurance, individuals who are already sick face high premiums. That problem is easily solved with a voucher, or a lump-sum payment to their health savings accounts.

The same principle applies to genetic diseases. Economics has long recognized the principle that insurance cannot insure events that have already happened, so lump-sum transfers are appropriate. But one-time lump-sum transfers based on clearly defined events over which no one has control, such as a DNA marker, are much less distorting, or subject to abuse, than perpetual regulation and intervention in a market, to "provide care" as "needed."

If we want to subsidize healthcare or insurance for old people, poor people, or veterans, give them a voucher. There is no reason the government should try to run an insurance company or run hospitals in order to provide financial assistance to people it wants to help. Insurance is about money, after all, period. There is no reason for government to pass an implicit tax by mandating that businesses "provide" insurance.

If we want to subsidize emergency rooms, let us just do it, on budget. That will be much more efficient than forcing a big cross-subsidy scheme and blocking competition to keep that scheme afloat. Subsidies do not require the competition-smothering protective regulation needed to prop up mandated cross-subsidies. Letting Wal-Mart set up more clinics would be a lot cheaper too.

If you think people do not get enough checkups when paying with their own money, give them a voucher. That is much easier than passing a mandate that every company must provide first-dollar health payments with a long range of mandated benefits.

More generally, there is an income-based paternalism at work in healthcare policy, somewhat more reasonable than the "they cannot shop" paternalism I decried above, worth making explicit. Most people, when spending their own money at the margin, are likely to choose less healthcare than we, the self-appointed advisers to "policy makers," would like. Already, they exhibit trade-offs that imply less health than we would like—they drink sugared sodas, eat fast foods, and do not exercise enough. In my example in which patients were offered an MRI or $1,000 in cash, I think we suspect that a lot of patients would choose the cash, and we would prefer that they did not.

A true libertarian would say, "Well, let people choose more iPhones and less health if that is what they want." But we do not have to have

this argument. If you think people will spend too little on health overall, give them vouchers in a health-savings account that can only be used for healthcare expenses or insurance. This system maintains the efficiency of patient-driven choice. It distorts the overall health versus nonhealth price so they will choose health-related expenses, but without distorting relative healthcare prices, destroying healthcare competition, or writing ten thousand pages of regulations and supply-side restrictions that gum up the entire system.

Now you might object that all these subsidies and vouchers will raise "costs" on the budget. But this happens simply because of phony accounting. If the government mandates that cardiac patients cross-subsidize emergency rooms, this is exactly the same as a tax on cardiac services and an expenditure on emergency rooms. Actually, it is a lot worse because the distortion of the current system is much greater. So any economically relevant accounting would recognize that we save money overall. Fixing the accounting is a much better and cheaper project than keeping our ridiculously inefficient healthcare system.

B. "Politically Feasible"

"Well," my typical critic concludes, "maybe you're right about all this as a matter of economics, but it's not 'politically feasible.'"

No, not now. But the alternative is not economically feasible, and economics is a sterner taskmaster. The ACA is becoming less and less politically feasible by the day as well, and inevitable scandals will not help it. What was not feasible today can quickly become feasible tomorrow if it is correct—once people understand it, once people see the alternative fall apart, and once people realize there is no option. Our job as economists is to figure out what works and explain it, not to bend reality to some notion of what today's politicians are willing to say in public, or to hire us as advisers to defend for them.

The "politically feasible" conversation is truly lunatic. It is taken for granted in policy discussion that no American can be asked to "pay" (directly, rather than through taxes or cross-subsidies) for one cent of health cost risk, while they routinely pay for broken and crashed cars and destroyed houses, suffer huge risks in the job market, and shoulder housing, transport, and other expenses much greater than the cost of healthcare. Yet while we are pretending nobody should pay for things, unfortunates

who fall through the cracks can be handed ridiculous $550,000 bills for cancer treatment.

We can start by saying, out loud, that healthcare is an economic good like any other. It is okay to ask Americans to pay for it, and to allow American companies to competitively supply it, just like all the other goods and services we routinely purchase. It is okay for insurance to retreat to its proper role, that of protecting people from large shocks to wealth, rather than that of a hugely inefficient payment plan. Car insurance does not pay your oil changes after you fax in the forms in quintuplicate, obtain permission from your mechanic, go to the in-network mechanic, wait six weeks, and answer a twenty-page questionnaire about your repair history and driving habits. It is okay for Americans to bear small risks of expenditure in healthcare as they do in everything else.

Conclusion

Healthcare is a complex personal service, with wide variation in quality, both along measures of health outcomes and along more subjective dimensions of satisfaction. Its demand curve is very elastic—people will consume a lot at subsidized prices. The distinction between "want" and "need" is conceptually fuzzy, and nearly impossible to measure.

The big improvements in healthcare come from better technology. But big improvements in healthcare delivery, average quality, and cost are also attainable. The latter come from much better human organization, as has happened recently in many other industries that have witnessed revolutionary supply competition. Achieving those improvements requires that newcomers can sell products at a profit and enter new markets, while displacing lots of entrenched interests before facing competition themselves.

From these observations, simple conclusions follow.

Health *care* markets need a big *supply*-side revolution, in which the healthcare equivalents of Southwest Airlines, Wal-Mart, and Apple enter, improving business practices, increasing quality and transparency, and spurring innovation. And disrupting the many entrenched interests and cross-subsidies of the current system.

I outlined a long string of restrictions on competition that must be repealed or modified to allow competition. At a minimum, every new

regulation should be evaluated by its effect on competition by new entrants or protection of incumbents, a consideration not even spoken of in policy discussion today. (Even when regulatory cost-benefit calculations are made, they do not consider the effects of regulation on competition, capture, and cronyism.)

Healthcare is singularly ill suited to payment-plan provision, either by government directly or by heavily regulated insurance issued by a few large well-protected businesses. A functional cash market must exist in which patients can realistically feel the marginal dollar cost of their treatment or (equivalently) enjoy the full financial benefits of any economies of treatment they are willing to accept, and are not patsies for huge cross-subsidization and rent seeking by an obscure system negotiated behind the scenes between big insurance companies, hospitals, and government.

Both supply and demand must be freed, along with insurance. Without supply competition, asking consumers to pay more will do little to spur efficiency. Without demand competition, new suppliers will not be able to succeed.

So the alternative to the current healthcare and health insurance mess (both pre- and post-ACA) is clear. Getting there will be a long hard road. It is not a simple matter of "deregulation," given how deep and widespread the offending restrictions are, and the many legitimate purposes they purport to serve, and sometimes do. We need to construct a different but wiser legal and regulatory regime. I know an interest group when I see one: do not worry, there will be lots of jobs for health economists, policy analysts, and lawyers.

The alternative, doubling down regulations on an already highly regulated system, full of protected and politically connected incumbents and rent seekers, has little chance of achieving these goals. Whether in the post-office model (government provision) or the 1950s-style regulated airline, utility, or bank model (the ACA), this effort will just produce less efficiency, more costs, and another generation of bright ideas dashed. Reformers, remember that the last twenty bright ideas did not fail simply because the people in charge were not as smart as you are, or as well meaning.

There are some bright spots. As Uber has undermined taxi regulation by swiftly implementing a better system and creating a large enough interest group of consumers unwilling to be taken advantage of by taxi

regulations, so Internet-based startups are undermining many aspects of healthcare, including obscure hospital and pharmacy pricing and obscure quality. Many ACA exchange policies have large co-payments, and as more workers are thrown on to exchanges, a critical mass of price-sensitive consumers who are also voters may demand change as it is being supplied.

Notes

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1. An excellent example: Richard A.Epstein and David A. Hyman, "Fixing Obamacare: The Virtues of Choice, Competition and Deregulation," Annual Survey of American Law 68 (2013): 493, http://ssrn.com/abstract=1158547. Epstein and Hyman end up calling for a much more free-market system, as I do, but build their case from the failures of the ACA and current regulation.

2. If personal experience is not enough to remind you how inefficient the current system is, I recommend Jonathan Rauch's YouTube video, "If Air Travel Worked Like Health Care," YouTube video, 7:00, uploaded by TheNewAltons, January 4, 2010, http://www.youtube.com/watch?v=5J67xJKpB6c. Hat tip to Einer Elhauge, who showed it at the conference.

3. Atul Gawande, "Big Med: Restaurant Chains Have Managed to Combine Quality Control, Cost Control, and Innovation. Can Health Care?" *New Yorker,* August 13, 2012, http://www.newyorker.com/reporting/2012/08/13/120813fa_fact_gawande.

4. Amitabh Chandra and Jonathan Skinner, "Technology Growth and Expenditure Growth in Health Care," *Journal of Economic Literature* 50 (September 2012): 643 –80.

5. Chester Dawson, "For Datsun revival, Nissan Gambles on $3,000 Model, *Wall Street Journal,* October 1, 2012, http://online.wsj.com/article/SB10000872396390443890304578009284279919750.html.

6. Jaime A. Rosenthal, Xin Lu, and Peter Cram, "Availability of Consumer Prices From US Hospitals for a Common Surgical Procedure," *JAMA Internal Medicine* 173, no. 6 (2013): 427–32 doi:10.1001/jamainternmed.2013.460.

In a hilarious follow-up, Jillian Bernstein and Joseph Bernstein called twenty Philadelphia hospitals to inquire about the cost of a simple ECG and the cost to park at the hospital to obtain the ECG. Only three hospitals were able to provide the cost of an ECG, while nineteen were able to provide the cost of parking. Of these, ten offered free or discounted parking. "This demonstrates not only that hospitals are able to provide cost information by telephone but, we infer, that

they can respond to consumers' concern about cost." And "hospitals seem able to provide prices when they want to." Jillian R. H. Bernstein and Joseph Bernstein, "Availability of Consumer Prices From Philadelphia Area Hospitals for Common Services: Electrocardiograms vs Parking," 292 *JAMA Internal Medicine* 174 (2) (2014): 292. http://jamanetwork.com/data/Journals/INTEMED/929736/ild130153.pdf.

7. In a literature review, the Civitas Institute writes: "One hospital industry respondent to a National Institute for Healthcare Reform Study reported "member hospitals initially had mixed views about the benefits of CON but banded together to support the process after realizing it was a valuable tool to block new physician-owned facilities." "Certificate of Need: Does It Actually Control Healthcare Costs?" http://www.nccivitas.org/2011/certificate-of-need-does-it-actually-control-healthcare-costs/. Innovation and competition are thus stifled in order to continue the profitability of existing healthcare providers. Physicians and multiphysician groups find it harder to open and operate ambulatory surgery centers, freestanding radiology practices, and other facilities that would allow consumers to enjoy healthcare that is potentially both lower cost and higher quality.

The Washington State Certificate of Need website, http://www.doh.wa.gov/LicensesPermitsandCertificates/FacilitiesNewReneworUpdate/CertificateofNeed.aspx, makes fun browsing. The "methodology" sets out numerical targets for facilities in "planning areas." Thus, the idea of building an "unneeded" facility simply because you can do it better and cheaper than an incumbent is explicitly prohibited.

In North Carolina, "All new hospitals, psychiatric facilities, chemical dependency treatment facilities, nursing home facilities, adult care homes, kidney disease treatment centers, intermediate care facilities for mentally retarded, rehabilitation facilities, home health agencies, hospices, diagnostic centers, and ambulatory surgical facilities must first obtain a CON before initiating development. In addition, a CON is required before any upgrading or expansion of existing health service facilities or services, which involves a capital expenditure above specified minimums." "Certificate of Need," North Carolina Division of Health Service Regulation, http://www.ncdhhs.gov/dhsr/coneed/index.html,

8. Institute for Justice, "CON JOB: How A Virginia Law Enriches Established Businesses by Limiting Your Medical Options, and How IJ Is Going to Stop It" 2012, http://www.ij.org/vacon; Michael Tennant, "The Big Health Care Con," June 28, 2102, http://fff.org/explore-freedom/article/the-big-health-care-con/gives a short CON review and covers the Virginia case.

9. Uwe E. Reinhardt, "The Dubious Case for Professional Licensing," *Economix: Explaining the Science of Everyday Life,* October 11, 2013, http://economix.blogs.nytimes.com/2013/10/11/the-dubious-case-for-professional-licensing.

10. Einer Elhauge, ed., *The Fragmentation of U.S. Health Care—Causes and Solutions* (Oxford: Oxford University Press, 2010). These quotes from the introductory chapter are available at http://www.law.harvard.edu/faculty/elhauge/pdf/Elhauge%20The%20Fragmentation%20of%20US%20Health%20Care%20--%20Introductory%20Chpt.pdf.

11. Einer Elhauge, ed., *The Fragmentation of U.S. Health Care—Causes and Solutions* (Oxford: Oxford University Press, 2010), 11.

12. Ibid., 12.

13. American Health Lawyers Association, "Corporate Practice of Medicine," www.healthlawyers.org/hlresources/Health%20Law%20Wiki/Corporate%20Practice%20of%20Medicine.aspx.

14. Darius Lakdawalla and Tomas Philipson, "Non-Profit Production and Industry Performance," *Journal of Public Economics* 90, no. 9 (2006), 1681–98.

15. Eugene F. Fama and Michael Jensen, "Agency Problems and Residual Claims," *Journal of Law and Economics* 26 (1983), 327–49. Fama and Jensen also view the presence of donors on boards of directors as an imperfect substitute for knowledgeable insiders and corporate-control market discipline.

16. For a description of the process, with a view, however, that it needs more not less regulation, see Jill R. Horwitz, "State Oversight of Hospital Conversions: Preserving Trust or Protecting Health?" (working paper, Hauser Center for Nonprofit Organizations, Kennedy School of Government, Harvard University, 2012), http://www.hks.harvard.edu/hauser/PDF_XLS/workingpapers/workingpaper_10.pdf.

17. For an example of recent news coverage see "Regulators Seek to Cool Hospital-Deal Fever," *Wall Street Journal,* March 18, 2012.

18. Gregory Warner, "The Battle over Billing Codes," *Marketplace,* April 10, 2012, http://www.marketplace.org/topics/life/health-care/battle-over-billing-codes.

19. David M. Cutler and Dan P. Ly, "The (Paper)Work of Medicine: Understanding International Medical Costs," *Journal of Economic Perspectives* 25, no. 2 (2011): 8, http://pubs.aeaweb.org/doi/pdfplus/10.1257/jep.25.2.3.

20. At the conference, Meredith Rosenthal gave a wonderful presentation highlighting a wide range of complex payment schemes and how they didn't work out, a wider range of bright new ideas, and how little we know about how they work. Her conclusion was that lots more research will lead to something workable to patch up each leak. Mine was that jiggering health payment systems is the best modern example of the hopelessness of central planning. You can get some idea from Meredith B. Rosenthal, "What Works in Market-Oriented Health Policy?" *New England Journal of Medicine* 360 (May 21, 2009):,2157–60. http://www.nejm.org/doi/full/10.1056/NEJMp0903166. See especially the table in Meredith B. Rosenthal, "Beyond Pay for Performance—Emerging Models of Provider-Payment Reform,"

New England Journal of Medicine 359 (September 18, 2008): 1197–1200, http://www.nejm.org/doi/full/10.1056/NEJMp0804658.

21. For example, http://www.personalinjurylawupdate.com/damorelaw/2012/04/what-is-outsourced-radiology.html complete with a link, "Read the tragic story of a now brain-damaged young woman who had 2 sets of x-rays - yet no one diagnosed her brain abscess," and "Outsourcing radiology abdicates 3 of 4 of the core responsibilities of radiologists."

22. Ezekiel J. Emanuel, Neera Tanden, and Donald Berwick, "The Democrats' Market-Friendly Health-Care Alternative," *Wall Street Journal,* September 25, 2102, http://online.wsj.com/article/SB10000872396390444401750457764519 3107383610.html.

23. Edward P. Lazear, *Prices and Wages in Transition Economies*" (Stanford: Hoover Institution Press, 1992), 16.

24. Nicholas D. Krist of, "A Possibly Fatal Mistake," *New York Times,* October 12, 2012, http://www.nytimes.com/2012/10/14/opinion/sunday/kristof-a-possibly-fatal-mistake.html?ref=healthcare.

25. "Health-Status Insurance," Cato Institute, *Policy Analysis* No 633 (2009); "Time-Consistent Health Insurance," *Journal of Political Economy* 103, no. 3 (1995): 445–73; "What to Do about Pre-Existing Conditions," *Wall Street Journal,* August 14, 2009; "Forget about the Mandate," *Bloomberg View,* July 12, 2012; "What to Do on the Day after Obamacare," *Wall Street Journal,* April 2, 2012; "The Real Trouble with the Birth-Control Mandate," *Wall Street Journal,* February 9, 2012; all available at http://faculty.chicagobooth.edu/john.cochrane/research/news.htm#health, except for "Time-Consistent Health Insurance," available at http://faculty.chicagobooth.edu/john.cochrane/research/index.htm#health.

26. Terhune, Chad, "Some Health Insurance Gets Pricier as Obamacare Rolls Out," *Los Angeles Times,* October 26, 2013, http://www.latimes.com/business/la-fi-health-sticker-shock-20131027-story.html. The article also states, "All these cancellations were prompted by a requirement from Covered California, the state's new insurance exchange. The state didn't want to give insurance companies the opportunity to hold on to the healthiest patients for up to a year, keeping them out of the larger risk pool that will influence future rates."

27. The Misericordia charitable hospital was founded in Florence, Italy, in 1244, http://www.misericordia.firenze.it/Home/ChiSiamo.

28. Akerlof, George A., "The Market for 'Lemons': Quality Uncertainty and the Market Mechanism," *Quarterly Journal of Economics* 84, no. 3 (1970): 488-500.

29. These quotes are from commenters on my blog, not a very authoritative source, but they put the view so clearly I couldn't resist. *Grumpy Economist, The*. http://johnhcochrane.blogspot.com/search/label/Health%20economics.

30. Ezra Klein, "Why an MRI Costs $1,080 in American and $280 in France," *Washington Post,* March 3, 2012, http://www.washingtonpost.com/blogs/ezra-klein/post/why-an-mri-costs-1080-in-america-and-280-in-france/2011/08/25/gIQAVHztoR_blog.html.

31. Bill Keller, "Five Obamacare Myths," *New York Times*, July 15 2012, http://www.nytimes.com/2012/07/16/opinion/keller-five-obamacare-myths.html.