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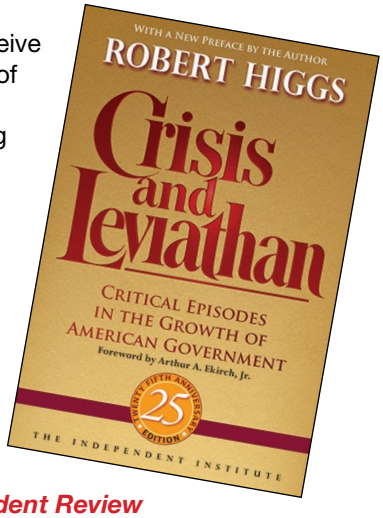

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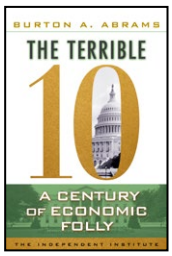
❑ 

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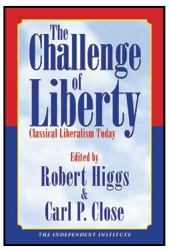
❑ 

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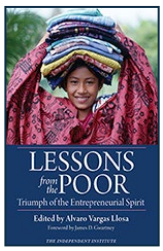
❑ 

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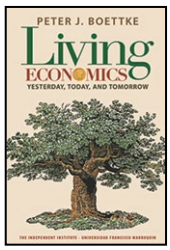
❑ 

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The Modern Health Care Maze

Development and Effects of the Four-Party System

CHARLES KRONCKE AND RONALD F. WHITE

Our national health care system is so dauntingly complex that reform efforts seem hopelessly adrift. How should we proceed in reforming that system? As a rule, any "realistic" reform project must begin with a survey of its principal stakeholders. A stakeholder, by definition, is any party who has a "stake" in the outcome—that is, anyone who stands to benefit or to suffer from either maintaining or changing the status quo. Our health care system today comprises many and often competing stakeholder groups. The four most visible ones are *first-party patients,* who seek access to an imponderable variety of health care products and services; *second-party providers* of these products and services, including hospitals, physicians, nurses, physical therapists, dentists, and pharmaceutical companies; *third-party payers,* including private insurance companies, government programs such as Medicaid and Medicare, and their employees; and *fourth-party employers,* who purchase health insurance for their employees and thereby obtain a deductible expense in calculating their federal income-tax liability.

Other stakeholder groups are less visible, but nonetheless salient. There are scientists engaged in research and development of medical products and services.

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Some are employed by research laboratories affiliated with private corporations, and others are employed by government labs. Most are funded by government research grants. Many scientists teach at tuition-driven public and private educational institutions that train future researchers, providers, and institutional administrators. There are also financial institutions that lend tuition money to ambitious college students in the health care professions and provide capital to hospitals, laboratories, and other facilities. And we must not forget the vast number of lawyers and law firms that specialize in medical malpractice litigation and the insurance companies that sell malpractice insurance. Many stakeholders directly or indirectly earn paychecks by building, maintaining, and managing the aforementioned institutions and programs, and many of these people are affiliated with labor unions or professional societies. Many of us invest in mutual funds that hold stock in the health care sector. The most ephemeral of all stakeholder groups are those that lack favorable tax status and therefore indirectly finance our health care system.

In the United States, politics—that is, each stakeholder group's capacity to influence powerful legislators—drives health care reform. Some groups stand to benefit from maintaining the status quo, whereas others stand to benefit from reform. Therefore, politically sensitive presidential candidates and lawmakers tend to "nibble around the edges" for fear of alienating a stakeholder group. Revolutionary change therefore is highly unlikely.

Health care is, indeed, much more complex than the traditional doctor-patient relationship suggests. The health care industry in the United States accounts for at least 14 percent of the gross domestic product (GDP), with approximately $5,267 spent per person annually (Cannon and Tanner 2007). Between 2007 and 2017, growth in health care spending is expected to remain steady at about 6.7 percent per year, but by 2017 health care will account for about one-fifth of the U.S. economy (Keehan et al. 2008, w145), which greatly exceeds its proportion in other nations. Moreover, the government's role in financing health care is expanding. Prior to Medicare's creation in 1965, the public sector accounted for approximately 25 percent of health care expenditures; today its portion is 45 percent (Sharp, Register, and Grimes 2008, 446). The U.S. government funds the lion's share of the medical research done in this country, from which the entire world benefits. The National Institutes of Health alone spend about $28 billion annually.

Prevailing discourse on health care reform aims at the simultaneous realization of three extraordinarily idealistic goals: *universal access* to *high-quality* health care at a *reasonable cost*. However, all three of these goals mask hidden complexities. When we say "universal access," exactly what products and services do we want everyone to have access to? What do we mean by "high-quality health care," and how do we know it when we see it? Finally, what do we mean by "reasonable cost?"

It is also important to acknowledge that throughout the world, health care has always been shaped by cultural, economic, and political forces. In the United States, it has been influenced not only by our own unique historical gravitas, but also by

earlier European precedents, especially in Germany, England, and France (Dutton 2007). Although most reformers tend to reduce European health care traditions to pejorative, simplistic terms, such as *socialized medicine,* these national systems differ greatly among themselves, and none of them approaches the ideal of providing universal access to high-quality health care at reasonable cost.

All governments influence access, quality, and cost of health care by means of enabling legislation, which invariably benefits some stakeholder groups at the expense of others. This kind of legislation takes many different forms, ranging from outright subsidies to licensure requirements and favorable tax status. The current state of the health care industry in the United States has been shaped by an accumulation of enabling legislation that began in the early twentieth century and continues unabated today.

In this article, we argue that much of the daunting complexity of health care reform can be reduced if we focus more critically on the four-party payment system. Sustained by a mountain of ill-advised enabling legislation, this system has become a public-policy juggernaut. Yet most contemporary reform packages seek to build on this maladapted tradition despite its obvious deficiencies.

Many critics of the U.S. health care system argue that our practice of "free-market" medicine has been a failure, and we ought to follow the Europeans and embrace "socialized medicine." We maintain, however, that this country's "awkward flirtation with the marketplace" (Whalen 2003) more closely resembles corporate welfare than an experiment in free-market medicine. Therefore, we suggest that before Americans abandon the free market, they ought at least to try it.

Third-Party Payment

Third-party payment systems traditionally involve the interaction of three self-interested stakeholder groups: a *first party* who is in need (or may be in need in the near future), a *second party* who is willing to sell or give products or services that might meet those needs, and a *third party* who is willing and able to pay the second party on behalf of the first party. Third parties act sometimes out of charitable motives, sometimes with the prospect of future reciprocity in mind, and sometimes simply for immediate profit. The history of third-party payment in the United States chronicles how our current insurance-based system evolved from arrangements based on charity and reciprocity to arrangements based on profit.

The rise of third-party payment in the distribution of health care is attributable to incremental sociopolitical construction around the original concept of "insurance." That concept is rooted in our psychological response to risk taking, whereby self-interested, rational agents seek to avoid potentially devastating harms, and other self-interested rational agents respond to this quest.

In the eighteenth century, third-party payment in the United States was based on charity. Individuals living in cooperative (often rural) communities eased the

impact of catastrophic events by sharing risks through pooling their time, effort, and resources. If a neighbor's home was ravaged by fire, family and friends voluntarily helped rebuild it. These helpers may or may not have had an underlying expectation of reciprocity or profit. "Insurance," in this sense, was often couched in idealized religious or moral terms, such as "Christian charity" or a "sense of duty." Later, as communities became more urbanized and impersonal, voluntary helping associations, such as mutual aid societies and fraternal organizations (for example, the Loyal Order of Moose), gradually took root in many urban areas (Beito 2000, Chalupníček and Dvořák 2009).

The modern era has been marked by the collateral rise of corporate (private) and governmental (public) third-party payers, which has gradually transformed informal, personal, and community-based reciprocity into a vast industry and a complex system of social welfare. In recent years, the role of third parties in health care has become larger. Today, only 12.6 percent of health care payments are paid out of the pockets of the patients receiving the care (Sharp, Register, and Grimes 2008, 446).

All third-party payment systems are constrained by the availability of economic resources. Hence, cooperative communities, informal voluntary associations, and (eventually) private and public third-party payers ration their assistance based on four broad harm-related parameters: *specificity* (conceptual clarity regarding the harm to be remedied), *frequency* (how often this harm may occur), *magnitude* (the degree of pain or suffering associated with the harm), and *predictability* (insurers' capacity to predict the harm's magnitude and frequency). Third-party payers, therefore, limit their assistance to providing security against relatively well-defined, infrequent, and costly harms that are "beyond the control of the insured" (Starr 1982, 290).

The first private insurance policies issued in the United States, which covered property in case of fires and floods, gradually displaced localized, informal, cooperative, charity-based solutions. These early third-party payers earned a profit by investing premiums in other profitable business ventures or by underwriting. They soon discovered that profitable underwriting required a two-pronged approach: controlling "risk" and controlling the prices demanded by second-party providers. Risk management entailed setting premium rates in ways that minimized risk and maximized profit. Two alternative pricing strategies emerged: *community rating systems* and *experience rating systems*.

Community Rating Systems

One risk-management strategy was to adopt a *community rating system,* which charged all members of a specified "group" the same premium. These groups were invariably composed of both low-risk and high-risk buyers. In order to earn a profit, insurance companies preferred large risk pools that included a sufficient number of low-risk buyers to cover the costs of insuring high-risk buyers. Although community rating systems dovetailed nicely with Judeo-Christian charitable traditions and

egalitarian political ideals, these strategies gave rise to a host of unanticipated consequences. The most nettlesome were the problems of *adverse selection* and *moral hazard*.

Adverse Selection and Moral Hazard

All community-rated systems tend to attract high-risk buyers seeking protection from highly probable and costly events. When community-rated insurance policies became available in the United States, the first buyers were homeowners living in picturesque settings near west coast forest areas, on floodplains, along the Gulf Coast, or in urban areas near concentrations of wooden structures. The basic problem was that low-risk homeowners had no incentive to purchase fire and flood insurance. The fledgling insurance industry obviously could not survive long by serving a clientele of only high-risk buyers. Economists call this phenomenon *adverse selection*. It was not the only quandary confronting the industry, however.

Another, closely related problem that arose in the context of the community rating system was *moral hazard*. From the outset, community-rated insurance policies tended to alter the buyers' normal risk-taking behavior. Once third-party payers insulated policyholders from the consequences of their choices, people bought more homes in the fire and flood-prone areas, which in turn increased the potential for expensive insurance payoffs.

As the number of high-risk insurance buyers grew, the cost of providing fire and flood insurance naturally increased. Community-rated systems typically responded by raising premiums for all insurance buyers. This idealistic strategy assumed that low-risk buyers would willingly subsidize high-risk buyers, but where buyers could freely enter or exit the insurance market, this strategy gave low-risk buyers an incentive to withdraw from the risk pool. Insurance companies were eventually left with an ever-expanding pool of high-risk buyers, often living in expensive homes in risk-prone areas near forests, floodplains, and earthquake zones. As companies raised premiums to cover costs, the risk pool became smaller and riskier. In short, adverse selection and moral hazard rendered the community-rated, third-party payment system financially unsustainable. As we discuss later, this reality resurfaced when the insurance paradigm was extended into the domain of health care.

Over time, insurance companies developed market-based business strategies to manage adverse selection and moral hazard. These strategies involved offering incentives for low-risk buyers, offering disincentives for high-risk buyers, lowering the reimbursement costs to second-party providers, or some combination of all three. Other strategies included requiring buyers to cover "deductibles," make "copayments," or submit to "lifetime limits." The fire and flood insurance market would remain unsustainable, however, as long as the following conditions continued: private third-party payers charged all buyers the same premium; low-risk buyers could freely exit the market, and high-risk buyers could freely enter it; and third-party

payers had no control over reimbursement rates paid to second-party providers. Enabling legislation ultimately stepped in to salvage the insurance industry by protecting it from the free market.

Legislation took many different forms, ranging from regulations (such as building codes) to outright government subsidies. Today, because of federally subsidized fire and flood insurance, more Americans can afford to build (and rebuild) homes in high-risk areas (Florida and California) with relative impunity (Pompe and Rinehart 2008). Of course, with or without federally subsidized insurance, the more affluent homeowners can afford to rebuild their homes in high-risk areas. But when government "enabled" insurance companies to remain in these high-risk domains by offering risk-sharing subsidies, middle-class homeowners were also able to move into these places. Therefore, enabling legislation began to look much like public assistance for middle- and upper-class homeowners.

Over time, local, state, and federal governments introduced increasingly convoluted enabling legislation, including favorable tax status, regulations that limited entry into the insurance market, and impediments to interstate competition between insurance companies. Moreover, the cost of rebuilding homes was increased dramatically by local building codes and licensure requirements for builders, electricians, and plumbers. This legislation also contributed to the decline of personal rebuilding assistance by relatives and friends. Therefore, although enabling legislation was often touted as a means of advancing the public good, it invariably did so by rewarding second-party providers with noncompetitive, monopolistic pricing. Spiraling reimbursement rates for second-party providers also later proved to be a problem for the health insurance industry itself.

In fire and flood insurance markets, adverse selection and moral hazard were at least temporarily manageable by means of market-based strategies and enabling legislation. However, as the insurance industry expanded into new risk domains, such as life, automotive, and health insurance, it became increasing reliant on legislative assistance.

Although community-rated insurance systems proved to be unsustainable in free markets, egalitarian-minded legislators were especially fond of them. The most obvious way for legislators to increase these systems' viability was to prevent low-risk buyers from exiting the risk pools. Compulsory (or mandatory) insurance laws now dominate homeowner, automotive, unemployment, and disability insurance markets. These laws artificially extend the sustainability of community-rated systems insurance systems by facilitating economies of scale. Over the long run, however, without third-party control over second-party reimbursement rates, compulsory insurance produced windfall profits for providers and fueled spiraling costs.

As costs increased, third-party payers sought to gain control of the reimbursement rates being paid to providers, but in a free market "price controls" enforced by third parties also led to adverse selection. If third-party payers set reimbursement rates too low, the most competent providers exited the system, and less-competent, lower-quality providers remained. If they set reimbursement rates too high, their

costs became unmanageable. Unfortunately, free-market negotiation between third-party payers and providers was difficult to manage and was frequently impeded by enabling legislation—such as governmentally enforced licensure laws limiting competition among second-party providers—that undermined competition. This pattern would be repeated when private insurance companies entered into the health care market.

Experience Rating Systems

As the community rating system proved unsustainable apart from compulsory insurance laws, other pricing strategies came to the forefront. The most obvious alternative was to set premiums relative to known risk exposure. In an experience rating system, the strategy is to charge higher premiums to known high-risk buyers and lower premiums to known low-risk buyers. In managing the risk of fires, floods, and earthquakes, experience-rated systems partially resolved the problem of moral hazard by providing homeowners with a financial incentive to adopt risk-aversive behavior. In the case of homeowner insurance, experience rating systems earned profits for insurance companies by giving homeowners incentives to place their homes in lower-risk areas and to construct them of fire-resistant, water-resistant, or earthquake-resistant materials. Although this strategy lowered the insurance risk, it also led to adverse selection as low-risk homeowners chose to forgo the insurance.

Over time, insurance companies adapted to the changing market by "bundling" the number of risks their policies covered, which gave rise to today's so-called comprehensive insurance. This insurance was never truly comprehensive because homeowner policies in various states covered (and excluded) a variety of specific, infrequent, disastrous, and unpredictable potential natural disasters and liabilities. Private insurance companies eventually bundled disparate risk domains such as homeowners, life, automotive, and health insurance. Between bundling and compulsory insurance laws, private insurance companies were eventually able to attract and maintain a sufficient number of low-risk buyers to forge a highly profitable industry.

Yet experience-rated systems were plagued by their own unanticipated consequences, the most serious of which were *information asymmetry* and *outright insurance fraud*.

Information Asymmetry and Fraud

All rational economic transactions require relevant information on both the buyer's side and the seller's side. Our basic intuitions of fairness support information symmetry and therefore prescribe transparency in contracts. Information asymmetry on either side, however, may lead to either good deals for buyers or windfall profits for sellers. Hence, both buyers and sellers prefer information asymmetry as long as it works in their own favor.

In order to manage fire and flood risks in an experience rating system, the exchange of reliable information between insurance buyers and sellers is essential. Information relating to fires and floods is fairly objective and equally accessible to both buyers and sellers. Clusters of wooden structures in congested, fire-prone areas and homes located on floodplains were obviously at high risk, but before experience-rated systems could be expanded into other risk domains, insurance companies had to contend with the fact that insurance buyers often possess risk-related information that they deliberately withhold from their insurance carriers. Information asymmetry in favor of the buyer also makes it easier for the insured to defraud insurance companies, often by surreptitiously destroying unwanted insured property or by filing false claims. Life insurance policies were similarly plagued with mysterious disappearances, suicides, and murders involving their insured clients.

As risk pools expanded, the opportunity for fraudulent insurance claims increased, and companies found it increasingly more difficult to monitor and enforce their policies' terms. Hence, diseconomies of scale made it difficult for companies to expand into new risk domains without legislative assistance. The U.S. Government Accountability Office (GAO) has long identified large-scale public programs, such as Medicare and Medicaid, as notoriously rife with provider-based fraud. Recent enabling legislation has provided the GAO and the Department of Justice with new tools for ferreting out these abuses (U.S. GAO 2002).

Information asymmetry on the seller's side benefits sellers. It usually involves deliberately withholding or disguising information insurance buyers need in order to decide rationally between competing policies or companies. Seller-side information asymmetry leads directly to increasing reliance on insurance "agents" to serve as intermediaries between buyers and sellers. As we discuss later, the relative absence of transparency relating to access, quality, and cost was especially problematic when third-party payment was extended to health care.

Although legislation often targeted information asymmetry, business-friendly state legislatures tended to tolerate seller-side asymmetry. Indeed, as the insurance industry matured, the language employed in its contracts became increasingly opaque and varied between companies and states. This complexity made it difficult, if not impossible, for insurance buyers to make informed decisions based on quality and cost. In recent years, thanks to the Internet, auto insurance and life insurance have become more transparent, less reliant on agents, and therefore more competitive. But homeowner's insurance (recall the indiscernible distinction between wind and water damage in the aftermath of Hurricane Katrina), disability insurance, unemployment insurance, and health insurance remain steeped in legalized opacity and continue to be veritable crapshoots for most buyers. Even when buyers can decipher these policies, competition between companies has been hindered by state regulations, which limit the kinds of policies available and the number of insurance companies that can operate in any given state. State regulations impede the formation of

nationwide risk pools, which would facilitate economies of scale and increase insurance buyers' bargaining power. Again, this problem resurfaced when insurance companies entered the health care market.

In sum, much of the exponential growth of the insurance industry as a whole can be attributed to enabling legislation, which generously helped private insurance companies overcome adverse selection, moral hazard, and information asymmetry. Owing to this increasingly complex maze of legislation, the number of risks that could be profitably covered by commercial insurance policies expanded to include disability, life, unemployment, automotive, and health insurance. In yet another twist in the insurance maze, however, other forms of enabling legislature such as licensure, accreditation, and patent protection tended to increase the largess of second-party providers at the expense of third-party payers.

Rise of the Health Insurance Industry

From the beginning, private insurance companies were wary of extending the third-party payment paradigm into the domain of health care. At the individual level, human illness and injury seemed more ambiguous, more common, less predictable, and less manageable than fires, floods, and accidental death on a steamboat trip. It was also evident that an individual's health varied with age, sex, lifestyle, family history, and employment. This variability presented the industry with daunting problems for both community-based and experience-based rating systems. The most serious impediment to the initial rise of third-party payment systems in the health care industry, however, was the public's longstanding antipathy toward the traditional providers of health care: hospitals and physicians. In the end, the financial incentives provided by third-party payment systems were instrumental in elevating medicine's overall cultural status and thereby in sowing the seeds of the subsequent rise of the health care industry.

Traditional second-party providers' cultural acceptance of thirty-party payment was not attained easily, however, and it required a great deal of marketing savvy, organizational cajoling, and enabling legislation. At the turn of the twentieth century, health care was not only highly decentralized, but also laden with longstanding tradition. While the economic feasibility of extending the private insurance paradigm into health care was being debated, local hospitals and physicians gradually warmed up to the idea for different reasons.

Hospitals, Physicians, and Third-Party Payment

The first hospitals in the Western world were nontherapeutic custodial institutions for the unwanted segments of society: criminals, the poor, the elderly, and the mentally ill (Foucault 1965, 1973). Most health care was provided at home by family members or by local physicians. Many of the early hospitals were charitable

institutions operated by religious organizations or local governments, but eventually most became state-funded repositories. In short, until well into the twentieth century, hospitals really did not provide much therapy and were widely regarded as institutions of last resort. They certainly were not very promising as private business ventures.

It was hospitals that eventually spearheaded the health care industry's movement toward third-party payment. By the 1920s, spurred by urbanization and the rise of scientific medicine, the demand for hospital care gradually increased, and the idea of third-party payment of hospital expenses seemed promising. The fledgling American Hospital Association (AHA) won over local hospitals to third-party payment in the form of "prepaid hospital plans." These locally issued Blue Cross policies appealed to individual local hospitals because they generated income even when patients were not hospitalized. Because the Blue Cross guidelines required patient choice of hospitals and physicians, plans issued by individual hospitals were gradually crowded out by group plans, which tended to undermine cost-based competition between hospitals.

From the beginning, Blue Cross plans benefited from more than their fair share of enabling legislation. Because of a longstanding tradition of state regulation of the insurance industry, most legislation occurred at the state level. The most important legislation allowed these companies to operate as nonprofit corporations, a privilege that enabled Blue Cross companies to enjoy tax-exempt status and to operate free from the regulatory mechanisms that constrained other types of insurance (Thomasson 2002, 238).

The most generous federal enabling legislation was the Hill-Burton Act of 1946, which provided direct federal subsidies for the construction of nonprofit community hospitals. This gift led to exponential growth in the number of hospitals. Buoyed by generous subsidies supplemented by a lucrative tax advantage, hospitals soon became the primary locus of health care in the United States.

By the 1950s, hospitals had become the heart of our health care system, and relatively low-risk procedures, such as childbirth management, were transferred to the hospital setting under the vigilance of highly educated, licensed gynecologists and obstetricians. Mothers were typically hospitalized for about a week even for normal deliveries. Baby boomers were introduced at a young age to hospitals and surgeons with a barrage of routine circumcisions and tonsillectomies. But long before hospitals became profitable, they first had to elicit physicians' cooperation.

Throughout most of human history, physicians had also endured a less than stellar reputation. Before the discovery of opiates near the end of the nineteenth century, physicians were manifestly ineffective at alleviating pain and suffering, and before the advent of germ theory and antibiotics, they were equally ineffective in curing infectious diseases. To make things worse, their unsavory reputation was perpetuated by a dogged adherence to tradition, which stymied their acceptance of the growing European movement toward "scientific medicine."

Before third-party payment could be fully embraced, American physicians had to abandon some longstanding traditions. They preferred to practice medicine as independent, self-employed contractors, which implied one-to-one relationships with patients in both therapeutic and financial matters. Indeed, throughout the twentieth century, the American Medical Association (AMA) and a critical mass of its membership regarded the so-called doctor-patient relationship as sacrosanct and therefore resisted all forms of third-party interference. Hence, most physicians were wary of becoming employed by either a private insurance company or a European-style national health care system. As market conditions changed, however, a growing number of them broke with tradition and willingly accepted hospital employment. For physicians, third-party payment was deeply problematic. It not only threatened their coveted independence and newfound cultural authority, but also endangered two other highly valued medical traditions: fee-for-service pricing and price discrimination.

Fee-for-Service Pricing and Price Discrimination

Physicians traditionally preferred payment on a fee-for-service basis: patients were expected to pay them directly for each individual product or service provided. As medicine became more scientific, the number of services that physicians could sell increased, and fee-for-service pricing became even more lucrative. As information asymmetry in favor of the providers increased, physicians' cultural authority and economic clout grew, and the medical profession became increasingly paternalistic. Trusted physicians were empowered not only to prescribe the products and services their patients needed, but also to provide those same products and services. Hence, conflict of interest became culturally accepted and institutionalized.

Paternalism, in concert with fee-for-service pricing, generated perverse incentives for physicians, encouraging them to prescribe unnecessarily drawn-out and expensive treatment regimens. As scientific researchers generated more diagnostic tests, pharmaceutical products, surgical techniques, and other technological innovations, both physicians and researchers benefited from the fee-for-service arrangement (as did the educational institutions that trained the researchers and physicians). The most influential and highly successful physicians, researchers, and educational institutions were thus understandably not eager to accept any compensation arrangement that undermined fee-for-service pricing. Today, one of the lingering effects of fee-for-service pricing in medicine has been the migration of physicians into service-intensive specialties, such as surgery and reproductive medicine, and away from primary care.

This provider-friendly and researcher-friendly business environment could be sustained only in a culture steeped in a web of paternalism. By the 1990s, there was a growing realization that many physicians were less than altruistic guardians of Hippocratic idealism. As physicians' cultural authority declined, managed-care

organizations usurped their responsibility as gatekeepers, and many of the most egregious forms of conflict of interest by physicians were moderated.

Physicians were also intensely protective of another practice that complemented fee-for-service pricing. In its purest form, price discrimination (or market segmentation) set fees based on the buyer's ability to pay. In theory, this practice seemed to dovetail nicely with Hippocratic, Judeo-Christian, and egalitarian moral traditions by implying that physicians ought to provide their service to all patients regardless of their ability to pay for it. In practice, however, price discrimination was plagued by information asymmetry because it assumed that physicians could acquire information relating to a patient's "ability to pay." Even when the self-interested physician could ascertain that information, he obviously could not earn a decent living by serving only the poorest patients, so price discrimination gave him an incentive to treat at least a critical mass of financially well-off patients.

As physicians naturally gravitated toward affluent urban neighborhoods, competition between older, established doctors and younger doctors threatened to drive down monopolistic fee-for-service compensation. Therefore, physicians' support for third-party-payment was often contingent on the financial viability of their medical practice. Younger physicians, with less-lucrative practices, tended to be less resistant to third-party payment than were older physicians, who served more affluent patients.

Both the AHA and the AMA sought more enabling legislation that reduced competition. The AMA sought to shield physicians from internecine competition by lobbying for higher educational and licensure requirements. Between 1904 and 1920, medical education reform inspired by the 1910 Flexner Report, which called for stricter admission and graduation standards as well as adherence to mainstream science, reduced the number of medical schools from 160 to 85 and the number of graduates by one-half (Mangu-Ward 2008, 40). State legislatures eventually took control of the accreditation of medical schools. However, as the number of urban physicians increased throughout the first half of the century, unwanted competition began to seep surreptitiously into the system.

Although third-party-payment threatened both fee-for-service pricing and price discrimination, it promised to solve other longstanding business-related problems for physicians. In the centuries before third-party payment, if a patient was not cured as promised or died during treatment, patients or grieving families often withheld payment. Hence, the fees that physicians (and later hospitals) charged were naturally limited to what price-sensitive and quality-sensitive buyers were actually willing and able to pay. Uncertainty of payment gave many physicians an incentive to avoid treating both seriously ill patients (with poor prognoses) and low-income patients. Third-party payment promised to ease the age-old burden of collecting fees directly from poor, bereaved, and often disgruntled patients. In other words, it guaranteed reimbursement for services rendered regardless of quality or cost—an attractive feature for a profession with a less-than-stellar reputation. More important, it also made the care and treatment of seriously ill patients more economically feasible, which laid

the foundation for heroic medicine's triumph over preventative medicine in the United States.

By the 1930s, a critical mass of physicians had rallied behind their own nonprofit third-party payment systems. These Blue Shield policies preserved the venerable doctor-patient relationship along with their lucrative fee-for-service pricing. But price discrimination in its traditional form was sacrificed. In 1934, the hospital-based and physician-based third-party systems were combined to form Blue Cross and Blue Shield, which became the model for nonprofit, private health insurance.

As a whole, the third-party payment system enjoyed widespread support as long as individual community hospitals could attract enough patients to earn a profit, physicians could negotiate directly with their patients over their course of treatment and charge insurance companies whatever they wanted, and Americans were willing to purchase private health insurance voluntarily. However, legions of other highly educated providers were soon attracted to the third-party payment system's noncompetitive pricing structure. Best of all, regardless of therapeutic outcome, they could collect their fees from deep-pocket, private insurance companies without directly inflicting economic hardship on individual patients. The most visible of these new highly paid stakeholders were pharmaceutical companies and tort lawyers.

Pharmaceutical companies were the next major class of providers to board the third-party gravy train. Before their industry could enjoy the feast, however, it had to overcome its own reputation for producing unsafe and ineffective products. Beginning in 1906, the Pure Food and Drug Act destroyed the competing patent medicine industry. The few major corporations that were eventually left standing feasted on generous patent protection and unimpeded access to primary research paid for or provided by government agencies such as the National Institutes of Health and the National Science Foundation. Once again, enabling legislation invariably contributed to imperfect competition and windfall profits for providers, but it also raised costs for the insurance industry.

Tort lawyers and malpractice insurance carriers were the next major stakeholder groups to enjoy the benefits of third-party payment. Throughout the twentieth century, the AHA and the AMA proved to be less-than-effective guarantors of the safety and effectiveness of health care products and services. Unsafe or ineffective medical treatment combined with an overabundance of tort lawyers led to an epidemic of malpractice lawsuits. The invasion of tort lawyers led directly to yet another highly profitable risk domain for the insurance industry: medical malpractice insurance (Budetti and Walters 2005).

The meteoric rise of the insurance industry during the twentieth century reshaped our cultural attitudes toward risk taking by instilling incentives for providers to insure policyholders against low-magnitude and low-probability risks. This change expanded the health care market and led to even higher profit margins. Moreover, the growing intolerance of risk also fueled an insatiable, culturally driven demand for expanded insurance coverage in all aspects of American life. Today, our private and

public lives are extraordinarily constrained by multiple layers of mandatory insurance coverage and insurance-based mandates. For evidence of this constraint, look no further than our current obsession with zero risk at public gatherings, in workplaces, during travel, and at children's playgrounds and schools. As our insurance-conscious society became dominated by tort lawyers and insurance companies, our aversion to risk taking became irrational.

Owing to successive rounds of enabling legislation, third-party payment transformed health care in the United States into a vast and highly profitable coterie of industries, but the seeds of success were sown less by the invisible hand of the free market than by the visible hand of government.

The Four-Party Payment System

Although commercial for-profit insurance companies initially had been reluctant to enter the health care domain, the "Blues" clearly demonstrated that adverse selection could be overcome by insuring groups of relatively young, healthy workers (Thomasson 2004, 316). Therefore, in the 1930s commercial companies entered the market. As long as for-profit and nonprofit health insurance companies could stay in business by investing insurance premiums and managing risks, third-party payment seemed to be a win-win-win proposition. It provided first-party patients with low-cost health care, and it was a cash cow for second-party providers and third-party insurance companies. As a growing number of high-priced providers entered the market, however, health insurance inevitably became more expensive.

In the 1930s, nonprofit and for-profit private health insurance companies competed head to head for health care dollars. In the early years, nonprofit Blue Cross and Blue Shield companies were statutorily required to employ community rating systems, and legal restrictions were placed on what they could do with any leftover profits. By midcentury, for-profit insurance companies began to entice younger, healthier patients into their risk pools by offering lower experience-based premiums. The "Blues" then became dogged by adverse selection as an increasing number of sick or elderly patients were attracted to the community-rated policies and the healthier group members were attracted to private experience-rated policies.

To level the playing field between for-profit and nonprofit insurers, state legislators gradually watered down the community-rating requirement for nonprofit insurance companies. Henceforth, patients with preexisting conditions would be forced to pay higher premiums or go without insurance and pay for care out of pocket or join the growing ranks of free riders.

The Invasion of Free Riders

Any noncompulsory health insurance system must deal with the fact that many patients will be either unwilling or unable to purchase insurance. In other economic

domains, if you are unable or unwilling to pay for the products and services you need, providers simply refuse to provide them. If your home is destroyed by a flood, local builders probably will not gratuitously rebuild your home if you are either unwilling or unable to pay for the work. In the domain of health care, however, longstanding moral tradition made withholding treatment untenable, and therefore free-ridership became endemic.

By the 1970s, the system of voluntary, private health insurance faced a variety of fiscal challenges. Next to inflation, probably the most visible challenge was the invasion of free riders. This puzzle can be traced to the moral and legal constraints imposed on medicine by the Hippocratic, Judeo-Christian, and Western liberal moral traditions. Even today, many Americans believe that they have a positive right to high-quality health care regardless of whether they are able to pay for it. This eighteenth-century rights-based tradition eventually collided with twentieth-century insurance-based economic reality. As the cost of group health insurance increased, providers had to contend with an increasing amount of uncompensated care. State and local governments tried to provide coverage assistance, but the invasion of free riders continued.

For a while, free-ridership was even protected by lenient laws governing personal bankruptcy. Although the bankruptcy rules have now been tightened, in reality if you do not have health insurance, you will never be able to pay off those six- or seven-digit medical bills, especially if you charged them to your multiple credit cards. One study finds that in 2005, approximately 47 million Americans had no health insurance, and half of all bankruptcy filings were partly the result of medical expenses (Himmelstein et al. 2005).

Meanwhile, as the cost of health care spiraled along with free-ridership, many stakeholder groups, especially labor unions, hoped that the United States would solve these problems by adopting the European model of publicly funded, universal health care or socialized medicine. In contrast, politically powerful interest groups such as the AHA and the AMA had a vested interest in preserving voluntary private insurance burnished by generous enabling legislation. By the 1940s, however, the third-party system had begun to falter, and yet another major round of enabling legislation loomed on the horizon.

In 1942, the U.S. government rescued the health insurance industry by means of enabling legislation that spawned the fourth-party payment system. At the time, the government had a freeze on wages and salaries. Most white male workers were employed by large corporations such as General Motors, Ford, and General Electric. A provision in the 1942 Stabilization Act allowed large corporations to offer fringe benefits without violating the freeze on wages. Because these corporations employed large numbers of young, healthy workers, adverse selection could be avoided, and community-rated health insurance plans were relatively inexpensive. A flurry of enabling legislation and Supreme Court decisions made the four-party payment system even more appealing. The most important government intervention was buried in the 1954 Internal Revenue Code. It codified that employer contributions to

employee health plans would be tax exempt for employees. Between 1953 and 1958, health insurance coverage increased from 63 percent to 75 percent of the population (Thomasson 2002, 241). The Employee Retirement Income Security Act of 1974 (sweetened the pot for employers by exempting health care benefits from many state taxes and regulations. Since then, this act has become a magnet for health care–related enabling legislation (U.S. Department of Labor 2008).

In the 1950s, health insurance became more comprehensive as coalitions of patients and providers lobbied state and federal governments to cover not only catastrophic health care, but also basic health care. "Comprehensive" health insurance policies increasingly included office visits for minor illnesses, especially colds and flu. Physicians responded by dutifully performing more expensive diagnostic tests and writing more prescriptions for patent-protected pharmaceutical products. Today, the most comprehensive health care policies include legislatively mandated coverage of annual physicals, a growing number of routine tests (PAP tests, mammograms, and so forth), and childhood vaccinations. Many policies even cover birth-control pills, psychiatric treatment, physical therapy, fertility treatment, and hospice care.

Legislatures were especially politically sensitive to the demands of the elderly, as evidenced by a growing emphasis on the prevention, diagnosis, and treatment of age-related ailments that plague baby boomers, especially cancer, diabetes, glaucoma, arthritis, heart disease, osteoporosis, erectile dysfunction, and acid reflux disease. Mobility-conscious baby boomers now demand insurance coverage for hip- or joint-replacement surgery, physical therapy, and motorized wheelchairs or scooters. Thanks to various forms of enabling legislation, most providers of these products and services also remain protected from unwanted competition.

The gradual expansion of the concept of disease to include potential diseases led directly to cultural changes in our perception of medical risk. As hospitals and medical specialists assumed unquestioned paternalistic authority in the management of these medical risks, the number of potential risks increased exponentially, especially risks associated with childhood diseases (for example, ear infections), colds and flu, premature births, and infertility. In 2000, twenty of the forty-six drugs most often prescribed to the elderly pertained to asymptomatic risk factors, such as osteoporosis and hypertension (Aronowitz 2006, 153).

Much of the expanded health insurance coverage now available includes ambiguous, morally hazardous, self-inflicted "diseases." Many can be readily attributed to overconsumption, most notably obesity, alcoholism, and legal and illegal drug addiction (Szasz 2005). Moreover, we also demand health insurance policies that cover fee-for-service specialists, advanced surgical techniques, and prescription drugs that treat socially constructed conditions, such as depression, obesity, and unruly or slow-learning children. Some of the most recent political pressure to expand health insurance coverage has come from mental health patients, their families, and their providers. These state and federal "parity laws," which increase insurance coverage for mental illnesses, will almost certainly contribute to the continuing cost spiral.

As we continue to eat, drink, and smoke our way into our health care system and use the political system to expand the comprehensiveness of health insurance, the cost of maintaining that system will continue to escalate exponentially (Szasz 2003).

Institutionalized Information Asymmetry

As the economic viability of the four-party system became almost entirely dependent on higher deductibles, copayments, and the exclusion of preexisting conditions, insurance companies institutionalized seller-side information asymmetry. The gradual introduction of a private language that stealthily disguises the comprehensiveness of health insurance policies helped sustain, at least temporarily, the profitability of the health insurance industry, if not that of the insurance industry as a whole.

Although medicine had long been plagued by obscure scientific discourse, the insurance industry added yet another layer of legalized opacity. Obscurantism was institutionalized by means of enabling legislation that allowed insurance companies to write increasingly complex, convoluted, and undecipherable insurance contracts. Even today, both private health insurance programs and government programs (Medicare, Medicaid, and Veterans Health Care) stealthily employ institutionalized, seller-side information asymmetry. Look no further than Medicare's recently expanded coverage of prescription drugs. The inscrutability of insurance contracts was complicated even more by the industry's being regulated primarily by state governments. Indeed, one of the most tragic features of our current system has been the increasing number of unwittingly underinsured patients who are subsequently denied health care coverage for specific products and services that have already been provided and who are left having to pay astronomical medical bills.

A study of 1,771 bankruptcies found that about half were caused by medical expenses. More than 75 percent of the persons who filed bankruptcy had insurance at the onset of the problem but inadequate coverage or a policy cancellation (Himmelstein et al. 2005). Again, information asymmetry in favor of insurance companies has had disastrous consequences, even for those who are willing and able to purchase insurance. Today, catastrophic illness is the most prolific source of individual bankruptcy in the United States.

For a while, employer-provided health insurance was enormously appealing to all major stakeholders. First-party patients employed by major corporations received nontaxable, low-cost (or no-cost) health insurance. Second-party providers continued to earn supercompetitive compensation for their products and services. Third-party private insurance companies (for-profit and nonprofit) sold more policies and therefore could cover provider costs by economies of scale. And fourth-party employers could increase their employees' compensation without having to pay the full cost. Since then, the four-party system has become an entrenched tradition based on an unsustainable win-win-win-win illusion. Indeed, even after the cost of providing health insurance had far outstripped the tax advantages, and employment-based

insurance had become less attractive to employers, powerful unions continued to negotiate lucrative benefit packages that often featured free or low-cost health insurance. The four-party payment maze thus emerged in its full form.

Employment-based health insurance obviously left out many stakeholders, most notably the unemployed, part-time workers, the self-employed, nonunionized African American and Latino workers (usually in agriculture), and a growing number of workers employed by small companies (usually in service industries) unwilling or unable to offer health insurance. In order to manage the growing number of treatable, if not curable, diseases, health insurance companies stealthily reduced their risk exposure by introducing complex policies that relied heavily on deductibles, copayments, and lifetime limits. As for-profit and nonprofit insurance companies gravitated toward experience-based rating systems, large numbers of patients with preexisting conditions were excluded from coverage. The growing number of uninsured patients and free riders eventually threatened the fourth-party payment system, provoking yet another round of enabling legislation.

Medicare and Medicaid

As the second-party providers' charges continued to stoke rising costs, which gradually outran the value of the employers' tax write-offs, two political problems took center stage. First, poor patients who were either unemployed or underemployed were left uninsured, but were still receiving most medical treatment as free riders. Second, elderly patients, who have a tendency to accumulate those dreaded preexisting conditions, were priced out of experience-rated private insurance.

In 1965, in an effort to expand health care coverage for the elderly and the poor, the government created Medicare and Medicaid. These complex bodies of enabling legislation institutionalized private insurance companies' experience-rated cherry picking by removing the two most costly patient populations from the private coverage pools (the elderly and the poor). These publically funded third-party payment systems raised their own set of problems, however, and they merely delayed the eventual collapse of the four-party payment system.

As reimbursements to providers skyrocketed, government programs and employers looked for ways to lower the cost of providing health insurance coverage. In response, new managed-care organizations—including health-maintenance organizations, preferred-provider organizations, and physician-hospital organizations—were erected on mountains of enabling legislation. Between 1996 and 2006, the number of employees covered by traditional fee-for-service insurance plans declined from 27 percent to 3 percent (Shi and Singh 2008, 355). Physicians adapted to this new competitive environment by entering into group practice, and hospitals responded with corporate mergers and acquisitions. Although these new business entities tended to erode many providers' returns, they enriched the new managed-care companies' coffers.

The Collapse of the Four-Party System

By the beginning of the twenty-first century, it was evident that managed care would ultimately fail to control costs. At that point, the most price-sensitive fourth-party payers began to withdraw from the system, leaving behind large numbers of uninsured employees. This exodus was accelerated as global competition intensified, and manufacturing jobs were increasingly outsourced to countries that offered less-costly, nonunionized labor and lax environmental controls. The rapidly contracting workforce in the manufacturing sector also contributed to the declining influence of the once-powerful labor unions that had negotiated those generous benefit packages. Today, even large companies have begun to rethink how they provide health care to their employees (Scandlen 2000).

Chrysler, General Motors, and Ford are (as we write) all teetering on the brink of bankruptcy, saddled with soaring health care costs for both workers and retirees. GM has a retiree health care liability of $73 billion (Labor Research Association 2005), an expense their foreign competitors do not incur. In the United States, the cost of employment-based health care is so far out of line that GM is moving some of its facilities to Canada, where the cost of health care is only 16.6 percent of the wage, relative to 28.8 percent in the United States. Many other large employers are either decreasing the quality of their health care benefits or outsourcing production to other countries that do not saddle stockholders with the duty of providing for employee health care.

The 2007 the United Auto Workers (UAW) contracts reflect the growing realization that globalization has reduced the union's bargaining power. With regard to health care, the UAW has essentially agreed to be the insurance provider for six to seven hundred thousand retired auto workers (Carty 2007). This new health care fund, known as Voluntary Employees Benefit Association, is likely to give strength to lobby organizations pushing for nationalized health care.

The explosive increase in the comprehensiveness of the U.S. health care system—wrought by union demands on fourth-party payers, the high cost of research and development of scientific medicine, and noncompetitive pricing for providers—has fueled spiraling cost increases in the health care industry. Although the fourth-party payers temporarily revived the third-party payment system, this system's long-term sustainability is now in question.

The Juggernaut Marches On

The four-party payment system has infused our health care system with perverse incentives and an intractable cost spiral. Nevertheless, most reformers remain committed to maintaining the juggernaut, and therefore it is highly unlikely that health care reform will stray far from the status quo. The most likely features of reform proposals include health savings accounts (HSAs), a return to catastrophic health

insurance, and "play or pay" government programs. Unfortunately (and perhaps inexplicably), most of these programs preserve the four-party system.

The focal point of health care reform among economic conservatives consists of combining HSAs with catastrophic health insurance. These components have also become the most recent targets of convoluted enabling legislation.

Here, the underlying strategy is to dismantle comprehensive health insurance by segmenting the market. This strategy entails drawing a legislative line between basic health care and catastrophic health care. Basic health care costs are to be paid directly by first-party patients, out of pocket, by means of tax-sheltered HSAs. The more expensive catastrophic illnesses are to be paid by private or public third-party payers. In theory, HSA accounts would reduce moral hazard by restoring price sensitivity among patients and thereby forcing second-party providers to compete for HSA dollars. Less-comprehensive health insurance would theoretically become less expensive and more sustainable over the long run. Major medical policies with high deductibles would cover only the less-common, serious diseases that require expensive, highly specialized treatment.

Unfortunately, the devil is in the details for both the HSA and catastrophic insurance components. The most puzzling detail is how to draw an unambiguous legislative line between basic and catastrophic health care. Our political environment is currently dominated by well-funded special-interest groups, such as patient advocacy groups, health care professional advocacy groups, hospital advocacy groups, and pharmaceutical advocacy groups. Legislators will invariably be subjected to an army of lobbyists seeking catastrophic status for their particular health care interests. Will mammograms, high-tech diagnostic technologies, new drugs, and vaccinations be paid for by patients or by insurance companies? Even if legislators can draw a clear legislative line between basic and catastrophic health care, other problems will come into play.

If historical trends hold true, the enabling legislation intended to promote HSAs and catastrophic insurance will be loaded with obscure provisos, limitations, and exceptions. For example, should HSAs be regulated at the state level or the federal level or by the free market? Should HSAs be voluntary or mandatory? Should legislatively mandated minimum or maximum limits be placed on the size of the accounts? What percentage of one's personal income should be dedicated to health savings in comparison to other goal-directed savings plans, such as for a new house, education for one's children, and retirement? And we still have the central question: What role should fourth-party employers play in any future HSA program? For the catastrophic insurance component, similar legislative decisions will be crucial to the potential success of the whole program.

Should the content of these policies be shaped by politically sensitive legislation? If so, should the new policies be community rated or experience rated? What specific treatments are to be covered by the catastrophic insurance policies? Will insurance companies be forced to pay for extraordinarily expensive new drugs with uncertain or

marginal benefits? Will government continue to regulate the formation of risk pools? Should government act as a single payer in order to maximize economies of scale? If the system is to be funded by tax write-offs, who should receive the tax benefits—individual buyers of health care or their employers? And finally, what role, if any, should employers play in the distribution of catastrophic insurance or HSAs?

Most of the proposed reform programs involving HSAs and catastrophic insurance include mandatory participation, thereby utilizing the government's coercive power to force employers to offer HSAs and catastrophic health insurance to their workers. These play-or-pay programs require employers either to offer these products or to pay into a government-administered program. Such a program will no doubt be burdensome for small businesses, which now dominate our economy.

Other reformers advocate forcing first-party patients to purchase individual policies (Bailey 2004). However, forcing healthy low-income workers to purchase expensive health insurance policies will prove to be not only politically untenable, but also difficult to monitor and enforce. If mandatory automobile insurance is a reliable predictor of the problems with compliance, the economic, political, and social costs of monitoring and enforcing mandatory private health insurance will be prohibitive. Hence, mandatory health insurance will almost certainly lead to political pressure to subsidize costly premiums or to expand access to public programs such as Medicaid and Medicare.

In 2006, Massachusetts enacted the first statewide universal health care system in the United States based on the play-or-pay model. It includes both employer mandates and individual mandates. As one might have expected, the enabling legislation that created the system is extraordinarily convoluted and regulates the interaction between private and public third-party payers. It includes the following components: "(1) a Medicaid expansion for children up to 300 percent of the federal poverty level and adults who are unemployed, are disabled, or have HIV; (2) income-related subsidies for health insurance for households earning up to 300 percent of poverty; (3) the creation of a purchasing pool, the Commonwealth Health Insurance Connector Authority, available to small-group and individual purchasers; and (4) an individual mandate requiring all adults to have health insurance, if they have access to affordable health plans, or else incur a financial penalty" (Gabel, Whitmore, and Pickreign 2007, w13). The law also requires all employers with more than ten full-time-equivalent employees to offer health insurance to workers and allow employees to purchase that insurance with pretax dollars. Employers with fewer than fifty workers may purchase coverage through the Connector (Gabel, Whitmore, and Pickreign 2007, w14).

If universal access to high-quality health care at a reasonable cost is the goal of health care reform, how does the Massachusetts program stack up? Evidence suggests that the program has increased access to health care by successfully reducing the number of uninsured from 600,000 to 260,000 (Sack 2008). Unfortunately, little if any evidence has been gathered regarding an overall improvement in the quality of health care in the state. We know, however, that the program is costly and that most

of its cost is being shifted to the public system. Because it costs about one-tenth as much for small businesses to "pay" as to "play," critics argue that the publically funded program will eventually crowd out private insurance coverage. It appears so far, though, that the crowding-out effect has not yet taken its toll on private insurance (Gabel, Whitmore, and Pickreign 2007), but it is still too early to celebrate. Even if Massachusetts, in fact, has managed to reduce the ranks of the uninsured, the costs incurred by the state-funded system will certainly contribute to the cost spiral. As more middle-class individuals become eligible for Medicaid and more small businesses choose to contribute to the less-expensive state-funded program, the costs to taxpayers will no doubt continue to escalate.

In the absence of competitive pricing structures, mandatory insurance laws will merely force buyers into a market dominated by incomprehensible, high-priced, low-quality private insurance policies or into a low-quality, price-insensitive, state-run system. Either way, health care reform in the United States seems destined to expand access to health care without solving the problems of quality and cost.

As health care reform takes shape, the resulting legislation will almost certainly increase information asymmetry and hence the difficulty Americans have in choosing among competing HSA products, private catastrophic insurance policies, and government programs. The most troubling aspect of play-or-pay programs, however, is that they will further complicate our already incomprehensible tax code.

Conclusion

The current crisis in health care in the United States has been fueled by diminishing access, dubious quality, and spiraling costs. These problems can be directly attributed to employment-based health insurance. Today, only 43 percent of workers covered by employer-sponsored health insurance are satisfied with the quality and price of their health care (Miller 2005, 285). Faced with ever-rising premiums, employers are adapting by choosing increasingly lower-quality insurance products with less coverage or by dropping out of the system altogether. Free-riding, young, healthy employees are adapting by refusing to purchase these increasingly inscrutable, shoddy health insurance products. We have argued that many of these problems can be traced to the government's use of enabling legislation, the crown jewel of which has been the four-party payment system. As Paul Dutton observes, "The legacy of workplace-linked health security must be recognized for what it is—a twentieth-century solution that is failing to solve twenty-first century problems" (2007, 18).

In hindsight, did it ever really make sense to set up a health care system whereby fourth-party corporate employers purchase health care insurance for their first-party employees from third-party corporations, which in turn pay second-party providers for health care products and services? Does any other industry insulate buyers from sellers in this way? Why does this arrangement make sense only for the health care industry? Why not for food, clothing, and shelter? Why not for homeowners, life,

and auto insurance? Despite the seeming irrationality, employment-based schemes continue to dominate the discourse on health care reform.

Since the dawn of the twentieth century, the U.S. government has responded to impending market failure in the health care industry by erecting a mountain of myopic enabling legislation, ranging from outright corporate subsidies to tax breaks, mandated coverage, licensure, and a host of other regulatory mechanisms. Overall, these interventions have contributed to persistent cost increases wrought by a non-competitive pricing structure stacked in favor of providers and insurance companies even though the industry never did figure out how to overcome adverse selection, moral hazard, information asymmetry, and free-ridership. As a result, our health care system has become a self-sustained bastion of corporate welfare for the most politically connected industries.

At bottom, the tax code has provided the primary fulcrum for government intervention in health care markets. Even today, almost all of the proposed insurance reforms revolve around changes in the tax code. As Jason Furman observes, tax reform tends to get bogged down in politics. "For some, the goal is to expand insurance coverage—which requires, inter alia, subsidies to reduce the cost of health insurance to enrollees. For others, the principle focus is on reducing current tax incentives that encourage spending or by creating new tax incentives intended to reduce spending. Some reforms simultaneously try to achieve both mutually reinforcing goals" (2008, 622).

Meaningful health care reform will require rethinking the American tradition of social engineering via the tax code. The basic problem is that health care is not the only "social good" currently funded in this way. Legislators are inundated annually with requests from well-intentioned philanthropists who want to raise or lower taxes to fund their own pet project. As a result, most cities now have a long list of tax levies that provide funding for schools, health clinics, mental health facilities, hospitals, zoos, museums, symphonies, and even sports stadiums. Even if most of these projects really do "serve the public good," where does all this special-interest pleading end?

The federal tax code has become as jargonized as any health insurance policy. In fact, it is now so convoluted and inscrutable that most of us hire tax professionals and purchase computer software programs to decipher the growing morass of tax-related social engineering. Ironically, the more we rely on experts and computer programs to compute our taxes, the easier it is for legislators to add to the tax code with impunity. We already know that politicians are highly skilled in doling out tax breaks to their own constituents and influential lobbyists at the expense of everyone else: look no further than tax deductions for children, mortgages, hybrid automobiles, ethanol, college tuition, and now HSAs and catastrophic health insurance.

The current maze of health care policy wrought by years of accumulated enabling legislation has in effect disabled free-market mechanisms. Throughout the second half of the twentieth century, fourth-party employers and U.S. tax payers have imperceptibly shouldered most of the financial burden. Economic reality is beginning

to creep into the industry, as price-sensitive and quality-sensitive patients pay more out of pocket for their health care (White 2006). However, politicians are once again poised to "fix" the system. In order to advance the goal of providing universal access to high-quality health care at a reasonable cost, legislators will have to resist the collective will of well-funded lobbyists associated with patient advocacy groups, the AMA, the AHA, and the Pharmaceutical Research and Manufacturing Association.

Ultimately, the only way to reform our health care system successfully is to destroy the infrastructure that sustains the four-party system, and the only way to do that is to cut off its food supply: we must "starve the beast" (Bartlett 2007). Until we reduce government's ability to surreptitiously distort the market forces that drive the health care industry, the juggernaut and other dysfunctional arrangements will continue to plague the system.

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