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Money, Solidarity, and Half a Century of Health Reform

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Abstract

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INTRODUCTION

Perhaps everything began to change around 1995, perhaps not. I was new to health law teaching then, and it is always tempting to tell stories that begin in one's youth. There were certainly giants in the field back then — "giants" are probably easiest to notice when they are already full-grown — but something in U.S. health policy has seemed different since the mid-1990s.[2] The difference centers on the role of money in medicine. Put simply, so much money has come into modern American medicine that change is harder rather than easier. Investment in our collective future — the point of spending tax dollars on health, as it is also of spending on education — suffers because we keep paying too much for the present.

Let's start with the numbers. A good way to understand one's colleagues in health law and policy is to ask them the first dollar figure they remember describing annual U.S. health care

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[2] Although I never met Professor Bill Curran, Professors George Annas, Fran Miller, and Wendy Mariner have been inspirations to me throughout my teaching career. The health law faculty who have followed them to BU's Law and Public Health schools are also phenomenal teachers and scholars, and I consider them valued friends.

spending. For me, the number was $200 billion (equal to about three times that in current dollars), learned in a medical school health policy class in the early 1980s.[3] (In terms of general inflation, something costing a dollar in 1960 would cost about $10 today).

Medicare's (and Medicaid's) passage in 1965 at the peak of enthusiasm for building a "Great Society" was the fiscal watershed for health care investment.[4] In 1960, annual expenditures were $26.9 billion, with the governmental contribution only $6.6 billion.[5] A mere ten years later, those figures had grown to $74.7 and $27.3 billion.[6]

In 2024, the United States is projected to have spent just over $5,000,000,000,000 on medical care, roughly $15,000 per person (though much less on healthy people and much, much more on those with serious illnesses, injuries, or disabilities).[7] Even with higher general growth in the U.S. economy compared to other developed countries, a twenty-four percent difference in percent of GDP spent on health in 1980 became a fifty-two percent difference by 2023.[8]

[3] I still own the book assigned for that class, which cites $192.4 billion as total US health expenditures in 1978. STEVEN JONAS, HEALTH CARE DELIVERY IN THE UNITED STATES 273 (2d ed. 1981). The book is now in its 13th edition. *See* JONAS & KOVNER'S HEALTH CARE DELIVERY IN THE UNITED STATES (James R. Knickman & Brian Elbel eds., 13th ed. 2023).

[4] *See generally* Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965); JULIAN E. ZELIZER, THE FIERCE URGENCY OF NOW: LYNDON JOHNSON, CONGRESS, AND THE BATTLE FOR THE GREAT SOCIETY 163–223 (2015) (describing the actions of the Eighty-Ninth Congress during Lyndon Johnson's "Great Society").

[5] *See* JONAS, *supra* note 3, at 273.

[6] *See id.*

[7] Jacqueline A. Fiore et al., *National Health Expenditure Projections, 2023–32: Payer Trends Diverge as Pandemic-Related Policies Fade*, 43 HEALTH AFFS. 910, 911 (2024).

[8] Health spending in the U.S. was 8.2% of GDP in 1980 and 16.7% of GDP in 2023. The "comparable country average" was 6.6% of GDP in 1980 and 11% of GDP in 2023. Emma Wager et al., *How Does Health Spending in the U.S. Compare to Other Countries?*, KFF (Apr. 19, 2025), https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#GDP%20per%20capita%20and%20health%20consumption%20spending%20per%20capita,%20U.S.%20dollars,%202023%20(current%20prices%20and%20PPP%20adjusted)%C2%A0].

An aside: lest this essay seem too self-indulgent of recent history and, by extension, one's own place in it, concerns about high cost and limited accessibility of medical care long predate Medicare. American medicine has always seemed too expensive (though most so in periods of general economic uncertainty), with its cost trajectory a perpetual crisis that is now so baked into health policy that perhaps it is not a crisis at all. In the late 1920s, for example, a physician-led Committee on the Costs of Medical Care convened, deliberated, and opined on rising medical care costs – one of many blue-ribbon bodies to assume and discharge such responsibility in the last century.[9]

Recent warnings about the apparent dangers to patients, physicians, and care relationships from the "financialization" of health care, such as private equity "roll-up" acquisitions of medical practices and other health care businesses,[10] therefore continue a pattern. Prior cycles of post-Medicare professional outrage and defensiveness followed by partial capitulation and incorporation into the prevailing business model occurred in the 1970s (for-profit hospitals), 1980s (home health care, physician self-referral enterprises), 1990s (network HMOs, physician practice management companies), 2000s (hospital consolidation, Pharmacy Benefit Managers, retail medical clinics), and 2010s (Accountable Care Organizations, pharmaceutical-physician financial relationships).

My point is not that ethical professionalism has prevailed, though it manages to survive on the skill and dedication of nurses, physicians, and other health care workers. Rather, my point is that

[9] PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 261–67 (rev. 2d ed. 2017).
[10] *See generally* Erin C. Fuse Brown & Mark A. Hall, *Private Equity and the Corporatization of Health Care*, 76 Stan. L. Rev. 527 (2024) (discussing corporatization and financialization, using the principal example of private equity involvement in medicine).

the U.S. health care system is no less ethical today than it has been in the past. One should not criticize the morality of change without interrogating the morality of the status quo.

In the 1990s, Jerome Kassirer wrote that "a system in which there is no equity is, in fact, already unethical."[11] The same can be said for a system that overfunds medical care and underfunds other essential social investments, including education. Moreover, a system that cannot be justified by the limited morality of competition in the marketplace because it does not — and could not absent radical change — perform as a functioning market would. In terms of robust market competition with its winners and losers, U.S. health care has been, at worst, a sheep in wolf's clothing.

This essay explores central aspects of the relationship between money and national health policy over the past sixty years, from the passage of Medicare in 1965 to the present, with an extended discussion of the two most sweeping attempts at system reinvention during that period – one earning passage into law (the Patient Protection and Affordable Care Act of 2010, or ACA), the other not (the failed Health Security Act of the early 1990s).[12] It focuses on the big picture, as an entire library could be devoted to the details of a high-technology but also labor-intensive sector that constitutes over one-sixth of the U.S. economy.[13]

[11] Jerome P. Kassirer, *Managing Care – Should We Adopt a New Ethic?*, 339 NEW ENG. J. MED. 397, 398 (1998).
[12] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of the U.S.C.). For a contemporaneous public overview of the Clinton reform, see generally DOMESTIC POL'Y COUNCIL, THE PRESIDENT'S HEALTH SECURITY PLAN: THE CLINTON BLUEPRINT (1993).
[13] Matthew McGough et al., *How Has U.S. Spending on Healthcare Changed Over Time?*, KFF (Dec. 20, 2024), https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/ [https://perma.cc/VK2P-PPVC] (showing that in 2023, national health expenditures accounted for 17.6% of the U.S. Gross Domestic Product).

Looking back from 2025, the ACA's passage presaged (I hesitate to say caused) a backsliding from commitments to better clinical performance, better population health, and greater social solidarity that it should have inspired the nation to pursue. This retreat seems to be accelerating under the second Trump administration, in which many longstanding assumptions about America's commitments to the nation's welfare and to global stability have been challenged or upended.

Most of the new policies, implemented mainly through executive-branch actions but also present in early Republican legislative proposals, seem primarily about money for science, education, health, global humanitarian relief, and domestic welfare. The Medicaid program, which was passed as a companion law to Medicare in 1965 to fund health insurance for poor Americans while Medicare supports older Americans, appears to be under more severe political threat now than at any time since its enactment. Even the Social Security system, which since the 1930s has provided income in retirement to Americans who contribute to it during their working years, is being questioned.

This essay is not primarily about the new Trump administration or its potential effects on American health care. Nobody knows what will happen in the next year, or in the next few years. Those of us who are experts in U.S. health policy anticipated that there would be fierce debate over many of the issues that the Trump administration has prioritized, but none of us expected so many decisions to be made so quickly outside the usual channels of law, Congress, and the courts.

SECTION ONE: REASONABLE EXPECTATIONS UNMET

Still, in hindsight at least, the mid-1990s represent an inflection point. Things that were reasonable to predict at the time did not come to pass, such as lower-cost industrialization of medical production, meaningful control by individuals over their own health-related needs and experiences, or reasoned engagement by the citizenry with society-wide health care rights and responsibilities. Failure to achieve these objectives also precluded serious consideration of the opportunity costs, both public and private, consequent to unconstrained medical spending. There has been minimal discussion, for example, of the tradeoffs involved in choosing to spend public dollars on health rather than, say, education or infrastructure.

By the 1990s, rising health care spending was principally attributed by the public to new technology, suggesting a perpetual and widening gap between medical costs and general economic growth that could only be resolved at the national level by rationing beneficial care.[14] From this perspective, cost, access, and quality constituted the core attributes of a system in equipoise, and the only way to achieve more favorable performance along any one dimension was to sacrifice performance along another. Welfare economists would describe this situation as "Pareto optimal"; changes that might benefit one individual or group would harm somebody else.[15] Because it favors the status quo, Pareto optimality conveys nothing about moral superiority; Amartya Sen famously observed that a society "can be Pareto optimal and still be

[14] *See generally* GUIDO CALABRESI & PHILIP BOBBITT, TRAGIC CHOICES (1978) (exploring the efficacy and morality of the strategies different societies employ to allocate "tragically scarce resources"); VICTOR R. FUCHS, WHO SHALL LIVE?: HEALTH, ECONOMICS, AND SOCIAL CHOICE (1975) (analyzing the economic, social, and ethical dimensions of how health care is delivered, financed, and rationed in the United States).
[15] AMARTYA SEN, COLLECTIVE CHOICE AND SOCIAL WELFARE 21 (4th ed. 1995).

perfectly disgusting."[16] As Lawrence Jacobs wrote at the time, the U.S. prioritized supply of new treatments, while European countries prioritized access to established ones.[17] Moreover, as physician-policymaker William Kissick observed, continued progress meant that no society over the long term could afford all the health care that its members would benefit from receiving.[18]

Are we merely seeing the same picture thirty years later? Not really. The myth of optimal medical organization and decision-making has long been exploded. Inexplicable variation in cost from provider to provider and community to community, reflected neither in need nor outcome, made it clear that "best care at lower cost" was indeed a possibility. This was the conclusion in 2012 of the Institute (now National Academy) of Medicine, reinforcing its findings a decade earlier that the health care system it claimed to lead was beset by widespread medical error and a massive "quality chasm."[19] These problems were magnified by persistent inattention to population-level causes and effects of ill health, which specialized physicians and acute-care hospitals had essentially declared "not their problem."

A better system that could be built incrementally, without centralized rationing, has been promoted by a generation of health care reformers, led by the Institute for Healthcare Improvement (IHI). IHI's "Triple Aim," supported amply by research, asserted that the health

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[16] *Id.* at 22.
[17] *See* Lawrence R. Jacobs, *Politics of America's Supply State: Health Reform and Technology*, 14 HEALTH AFFS. 143, 143–45 (1995) (observing that, unlike European nations among others, U.S. politics prioritizes expanding the supply of healthcare products and services over assuring universal access to those benefits).
[18] WILLIAM KISSICK, MEDICINE'S DILEMMAS: INFINITE NEEDS VERSUS FINITE RESOURCES 48 (1994).
[19] COMM. ON THE LEARNING HEALTH CARE SYS. IN AM., INST. OF MED., BEST CARE AT LOWER COST: THE PATH TO CONTINUOUSLY LEARNING HEALTH CARE IN AMERICA 102 (Mark Smith et al. eds., 2012); *see also* COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 23–25 (2001) (concluding that healthcare fails to be safe, effective, patient-centered, timely, efficient, or equitable); COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1 (Linda T. Kohn et al. eds., 2000) (estimating as many as 98,000 annual deaths due to medical error in the United States).

care system should be able to simultaneously (i) improve technical quality and the personal experience of care, (2) improve population health, and (iii) reduce per capita costs.[20] Kissick's pessimism was thus unwarranted, and the ACA's sweeping ambitions in 2010 and beyond to improve health coverage, clinical care, and population health had acquired much stronger scientific and theoretical justification.

Unfortunately, efforts to pursue the Triple Aim were never robust — largely because of entrenched interest groups and limited incentives in U.S. health care's faux marketplace — and did not result in breakthrough improvement. Supplanted by other frameworks and mantras, including those more directly focused on "health equity," the Triple Aim no longer seems central to training either health professionals or policymakers.

"Accountable care organizations" (ACOs), the original darlings of the "value-based care" movement legislatively approved for Medicare in the ACA, are a case in point.[21] ACOs were designed to improve on managed care organizations (MCOs) by being physician-led, quality-driven, primary-care oriented, and risk-limited.[22] It turned out, however, that the requisite managerial and financial expertise resided mainly in hospitals[23] – and they had little incentive to sacrifice high, assured fee-for-service earnings in exchange for a speculative, partial share of "savings" from care not provided. Where ACOs did thrive, it was often by becoming Medicare

[20] Donald M. Berwick, Thomas W. Nolan & John Whittington, *The Triple Aim: Care, Health, And Cost*, 27 HEALTH AFFS. 759, 760 (2008); *Improvement Area: Triple Aim and Population Health*, INST. FOR HEALTHCARE IMPROVEMENT, https://www.ihi.org/improvement-areas/improvement-area-triple-aim-and-population-health [https://perma.cc/V4F2-EC4Q] (last visited Aug. 27, 2024).
[21] Steven B. Spivack, Genevra F. Murray & Valerie A. Lewis, *A Decade of ACOs in Medicare: Have They Delivered on Their Promise?*, 48 J. HEALTH POL. POL'Y & L. 63–64, 74 (2023).
[22] *See id.* at 66–67; Judith Ortiz et al., *Primary Care Clinics and Accountable Care Organizations*, 2 HEALTH SERVS. RSCH. & MANAGERIAL EPIDEMIOLOGY art. no. 2333392815613056, at 1 (2015).
[23] *See* Spivack, Murray & Lewis, *supra* note 20, at 69.

Advantage (MA) plans – assuming full risk but then hedging much of it by gaming the risk classification and quality reporting systems they had originally committed to honor.

What has happened instead? One way to put it is that the relationship between money and technical progress in health care became even further decoupled from the relationship between money and social solidarity.[24] A wealthy society, which we are, can devote resources to both technical achievement and collective welfare. Although money has continued to flow generously in the U.S. health care system, social divisions have intensified. As a result, innovation accelerated but became even less affordable, quality and safety failed to keep pace with innovation, access and equity stalled despite Obamacare's insurance expansion, public health faltered, social solidarity weakened, and trust eroded. And "patients" quietly morphed from individuals to be comforted and cared for into diagnoses to be treated and charged for.

What has endured from the compromises generating the original Medicare legislation is a governmental health care system masquerading as a private one. The majority of the trillions of dollars dedicated to health care in any given year are public dollars[25] and the core purpose of spending them is to benefit public health. Yet they flow almost entirely through private organizations, and the narrative that attaches to how they are spent comes no closer to solidarity than consumerism.[26]

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[24] For the manifestations of this dynamic in health law, see William M. Sage, *Relational Duties, Regulatory Duties, and the Widening Gap Between Individual Health Law and Collective Health Policy*, 96 GEO. L.J. 497 (2008).
[25] McGough et al., *supra* note 12.
[26] Indeed, President Obama rhetorically equated "consumers" with "the American people" in celebrating a Supreme Court ruling upholding a cornerstone of the ACA's insurance expansion. *See* Remarks on the United States Supreme Court Ruling on the Patient Protection and Affordable Care Act, 1 PUB. PAPERS 743, 744 (June 25, 2015) ("This reform remains what it's always been: a set of fairer rules and tougher protections that have made health care in America more affordable, more attainable, and more about you, the consumer, the American people."); King v. Burwell, 576 U.S. 473 (2015). Regarding the ACA's overall inattention to solidarity, see William M. Sage,

If the only certainty in life is change, change indeed happened–just not along predicted paths. Things that were relatively easy to change did so, but those pursuing profit found it simpler to exploit the existing, inefficient system than to force it into a semblance of efficiency that few would recognize and even fewer would appreciate.[27] As explained below, competition as a force promoting efficiency requires two basic attributes that U.S. health care lacks: real buyers and meaningful prices.[28] At the same time, pressure on the political process to resist meaningful reform was accentuated by pressure within the political process to undercut solidarity for partisan advantage. The sudden, seemingly impulsive dismantling of federal financial support for health, biomedical science, and medical care under the Trump administration represents a new high-water mark in this trend.

Where does the money keep coming from? Much represents taxpayer dollars being funneled through private organizations, with the slowness and intermittency of legislative change in the best of times combining with a history of professional control to perpetuate habit and favor innovation that can be financed through existing payment streams. Steady interest group pressure to maintain subsidies, plus occasional large-dollar bailouts justified as "stimulus" for economic downturns and the COVID-19 pandemic, are also contributing factors. Not infrequently, the political influence of these groups led legislators to cut into non-health spending — more of which was subject to annual appropriation — rather than challenge fiercely defended health care

Solidarity: Unfashionable, but Still American, *in* CONNECTING AMERICAN VALUES WITH AMERICAN HEALTH CARE REFORM 10, 10–11 (Thomas H. Murray & Mary Crowley eds., 2009); William M. Sage, *Why the Affordable Care Act Needs a Better Name: "Americare,"* 29 HEALTH AFFS. 1496, 1496–97 (2010).

[27] *See* William M. Sage, *Putting Insurance Reform in the ACA's Rear-View Mirror*, 51 HOUS. L. REV. 1082 (2014).

[28] *See infra* notes 83–84 and accompanying text.

entitlements. Partisan posturing in Congress has replaced what might be a more thoughtful, deliberate budgeting process with multiple, short-term continuing resolutions hastily adopted under threat of default, along with suspensions/non-renewals of PAYGO rules. Until recently, low interest rates for government borrowing have reduced concern about large deficits and accumulating debt.

The same has been true for much private borrowing, especially pre-pandemic when low inflation and low unemployment managed to co-exist,[29] while tight labor markets in those years maintained the attractiveness of generous employer-based coverage for higher-wage workers. Even as provider prices rose under norms that favored broad networks over narrow networks, under-the-radar increases in consumer cost-sharing concealed what would otherwise have been visible as rising monthly premiums. Both the TPAs that administer health benefits for large, self-insured employers but do not themselves bear financial risk, and the PBMs that structure prescription drug formularies are deeply conflicted and seldom motivated to police spending. What little legislation has been enacted to assist them, such as the "No Surprises" Act to combat excessive, arbitrary billing by hospitals and out-of-network physicians, has been cumbersome and minimally effective.[30]

This outcome does not speak well of the policymaking process, nor bode well for the American public. "Stein's Law" – attributed to the Nixon administration economist Herbert Stein, says that

[29] *See United States Inflation Rate*, Trading Econ., https://tradingeconomics.com/united-states/inflation-cpi# (last visited Apr. 3, 2025) (showing that in Feb. 2020, the unemployment rate was 3.5% and the core inflation rate was 2.4%).

[30] *See* Joseph Burns, *How Providers Avoid Complying with the No Surprises Act*, ASS'N OF HEALTH CARE JOURNALISTS (July 16, 2024), http://healthjournalism.org/blog/2024/07/how-providers-avoid-complying-with-the-no-surprises-act/ [https://perma.cc/C6NH-UJY9].

if something cannot go on forever, then it will stop.[31] Health care spending continues to defy that expectation, even though a route by which access and affordability might converge still exists. The sledgehammer-like cost-cutting actions of the new Trump administration may be an exception that proves the rule, but have neither evident logic nor substantial consensus to support them.

This raises a possible paradox: would less money in the health care system at the outset of this period have meant more progress on key challenges over time? Perhaps. We will return to this intriguing question at the end.

SECTION TWO: MONEY-RELATED BARRIERS TO REFORM

My early-career health policy immersion while staffing the Clinton Administration's 1993 Task Force on National Health Reform was a wake-up call about the ways that money affects efforts to improve U.S. health care.[32] The Clinton plan's failure highlighted an enduring aspect of health care interest-group politics that ten years previously had been emphasized by Paul Starr in his prize-winning history of American medicine.[33] Both corporate and government control were equally noxious to the organized, independent medical community, which justified its autonomy

[31] Paul Krugman, Opinion, *This Can't Go On*, N.Y. TIMES (Nov. 4, 2003), https://www.nytimes.com/2003/11/04/opinion/this-can-t-go-on.html [https://perma.cc/8HBY-TJY4].
[32] I worked in the White House for approximately six months, ultimately being put in charge of five of the roughly twenty-five groups of government employees assigned to develop detailed policy recommendations for Congress. The experience was personally transformative, though not without unusual moments such as the evening when I had failed to comply with the formatting requirements for faxing a short list of people requiring clearance to the building the following day, and received a phone call from an officer of the United States Secret Service pointing out my error and offering to "fax [the list] back" to me so that I could correct it.
[33] *See* STARR, *supra* note 9, at 92.

by citing the sanctity of the physician-patient relationship and had grown accustomed to dictating both treatment and billing with minimal attention to cost or pricing.[34]

Rising health care spending — much of it the by-product of Medicare — accentuated these fears. Physicians' earnings had increased substantially over the years, but what might have seemed like a windfall to older physicians was the status quo to their younger colleagues, who had incurred student debt and invested in building their practices with the expectation of high incomes.[35] By 1993, following a worrisome but brief economic downturn with attendant fiscal pressure on government, the rising cost of health care to American businesses, who sponsor coverage as a fringe benefit of employment, became as evident a threat to long-term affordability as the inflationary aspects of Medicare's aging demographics. Unsurprisingly, "cost-containment" for either private coverage (through suddenly-evil "HMOs") or public coverage (through cuts to "reimbursement") provoked vocal opposition from medical associations.[36]

As the Clinton reform proposal took shape, it raised physician hackles on both fronts simultaneously by relying on cost-control on competitive purchasing by employers from HMOs plus a "global budget" that capped annual national spending.[37] This approach, which survived the executive branch drafting process and remained the centerpiece of the bill primarily to gain

[34] *See* MIRIAM J. LAUGESEN, FIXING MEDICAL PRICES: HOW PHYSICIANS ARE PAID 3–5, 23–46 (2016).
[35] *See* S. Ryan Greysen, Candice Chen & Fitzhugh Mullan, *A History of Medical Student Debt: Observations and Implications for the Future of Medical Education*, 86 ACAD. MED. 840, 840 (2011) (describing the shift in student financing of medical education and graduation debt that occurred around the 1980s).
[36] George J. Church, *Backlash Against HMOs: Doctors, Patients, Unions, Legislators Are Fed Up and Say They Won't Take It Anymore*, CNN: ALL POL. (Apr. 14, 1997), https://www.cnn.com/ALLPOLITICS/1997/04/07/time/hmo.html [https://perma.cc/KKR9-LERQ].
[37] *See* Paul Starr & Walter A. Zelman, *A Bridge to Compromise: Competition Under a Budget*, 12 HEALTH AFFS. 7 (Supp. 1993). Because of the political debacle that had caused the repeal before implementation of the aptly named Medicare Catastrophic Coverage Act in the late 1980s, Medicare was not expressly reconceived in the Clinton plan, but Medicaid was folded in and the potential implications of global budgeting were clear. Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, 102 Stat. 683 (1988).

fiscal palatability in Congress, made private health insurance businesses seem complicit with government rationing of care in the health reform enterprise, further worrying the medical profession and the public.[38]

When Medicare was enacted in 1965, concern over rationing of beneficial care had been less salient from the public's perspective than the hope that generous public funding would not only bring advanced health care to America's seniors but also improve incentives to innovate, as exemplified by the special coverage added in the early 1970s for individuals of any age in need of kidney dialysis.[39] In terms of lobbying pressure, there were few medical interest groups at the federal level until there was Medicare funding to attract them. The most important adversary to convert in the Medicare debate was the American Medical Association, which strongly opposed "socialized medicine" on ideological grounds. [40] The most straightforward way to satisfy physicians was to promise them unconstrained clinical authority and self-determined fees, which President Lyndon Johnson did without hesitation.[41]

The modern federal budgeting process and its associated political theater did not yet exist, leaving the fiscal debate only with round-number cost estimates. There was no federal Budget Control Act until 1974;[42] before then, nothing similar to the modern Congressional Budget

[38] *See* Elizabeth McCaughey, *No Exit: What the Clinton Plan Will Do for You*, NEW REPUBLIC (Feb. 7, 1994), https://newrepublic.com/article/69935/no-exit [https://perma.cc/V5WE-4WDQ] (equating the Clinton reform with private managed care as rationing care).
[39] *See generally* Richard Rettig, *Origins of the Medicare Kidney Disease Entitlement: The Societal Security Amendments of 1972*, *in* INST. OF MED., BIOMEDICAL POLITICS 176 (Kathi E. Hanna ed., 1991).
[40] *See* JOSEPH A. CALIFANO, JR., AMERICA'S HEALTH CARE REVOLUTION: WHO LIVES? WHO DIES? WHO PAYS? 49 (1986).
[41] *See id.* at 50–51.
[42] Congressional Budget and Impoundment Control Act of 1974, Pub. L. No. 93-344, 88 Stat. 297, 297–98 (codified as amended in scattered sections of 2 and 31 U.S.C.).

Office (CBO) "scoring" process had to be navigated.[43] The Clinton reform was the first major health legislation to face (and be defeated by) specific fiscal-political barriers, while the Obama Administration's successful navigation of the CBO was achieved only by design features that greatly increased the ACA's vulnerability to litigation in federal court.[44]

By 1994, the health care terrain had shifted along all three dimensions — rationing, fiscal constraint, and interest-group lobbying — rendering the Clinton reform plan unpassable. In a political climate that suddenly favored fiscal prudence, federal "scorekeeping" rules came to dominate assessments of the Clinton proposal, and the CBO was ultimately the Health Security Act's reluctant executioner.[45] For their part, medical interest groups accustomed to generous government payment were more fearful than hopeful regarding massive legal change even if coverage expanded, while corporate America (which seemingly stood to benefit substantially from a truly national health insurance system) quickly learned that when push came to shove in the political process it would be left paying more rather than less.

Because America requires a can-do attitude from its leaders, President Clinton also explicitly instructed his bioethics advisors to avoid endorsing (or even mentioning) government rationing of care even though most of those experts believed that the prevailing system rationed it unethically based on ability to pay.[46] The Clinton proposal further signaled rejection of rationing

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[43] *See* Timothy Westmoreland, *Invisible Forces at Work: Health Legislation and the Budget Process*, *in* THE OXFORD HANDBOOK OF U.S. HEALTHCARE LAW 873, 875 (I. Glenn Cohen et al. eds., 2016).
[44] *See* William M. Sage & Timothy M. Westmoreland, *Following the Money: The ACA's Fiscal-Political Economy and Lessons for Future Health Care Reform*, 48 J.L. MED. & ETHICS 434, 437–38 (2020).
[45] *See Health Care Reform (Part 10)*: *Joint Hearing Before the Subcomm. on Health & the Env't & the Subcomm. on Com., Consumer Prot., & Competitiveness of the Comm. on Energy & Com.*, 103d Cong. 10–14 (Feb. 10, 1994) [hereinafter *Joint Hearing*] (statement of Robert D. Reischauer, Director, Congressional Budget Office).
[46] *See, e.g.*, NORMAN DANIELS & JAMES E. SABIN, SETTING LIMITS FAIRLY: CAN WE LEARN TO SHARE MEDICAL RESOURCES?, at ix (2002) (Dr. Daniels served on the Clinton ethics advisory group). The Clinton administration was

by excluding the existing Medicare program from the rules that would apply elsewhere, even though wasteful care at the end of life was a common explanation at the time for relentlessly rising medical spending (to be replaced a few years later by overuse of high-priced emergency departments). Neither assurance persuaded the public, most of whom were afraid of losing existing benefits more than they were eager to universalize coverage.[47]

In fact, the Clinton plan's architects had vacillated between two views of health care reform, one that implied either rationing or imposing higher taxes to expand insurance coverage, and a second that invoked theoretically attractive but unproven market forces. The first, an established option since the 1930s typically called "single payer," appealed ideologically to Democratic politicians and their allies in organized labor and left-leaning coastal cities, as well as bureaucratically to federal regulators who were used to administering Medicare as a gigantic, if not exclusive, funder of hospital and physician care paid on a fee-for-service basis.[48] The second was newly formulated by academic economists under the moniker "managed competition," and was wholly untested if half-way established in a few parts of the country (e.g., the Kaiser health system in California).[49] Managed competition sought to organize both the purchasing of health insurance and the provision of covered medical services into two sets of large, geographically based organizations — the former quasi-monopsonies and the latter competing enterprises —

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also reconsidering the denial of a Medicaid waiver to the Oregon Health Plan, which had attempted to apply a cost-effectiveness metric to health coverage. *See* Jonathan Oberlander et al., *Rationing Medical Care: Rhetoric and Reality in the Oregon Health Plan*, 164 CAN. MED. ASS'N J. 1583, 1585 (2001).

[47] Bill Schneider, *Health Care Returns as an Issue*, CNN (Oct. 4, 1999, 6:22 PM), https://www.cnn.com/ALLPOLITICS/stories/1999/10/04/schneider.healthcare/? [https://perma.cc/BD8W-FVGG].

[48] Theda Skocpol, *The Time is Never Ripe: The Repeated Defeat of Universal Health Insurance in the 20th Century United States* 9–10 (Econ. & Soc. Rsch. Inst., Geary Lecture No. 26, 1995).

[49] *See* Alain C. Enthoven, *The History and Principles of Managed Competition*, 12 HEALTH AFFS. 24, 24, 46 (1993). For a history of Kaiser, see RICKEY HENDRICKS, A MODEL FOR NATIONAL HEALTH CARE: THE HISTORY OF KAISER PERMANENTE (1993).

rendering government unnecessary as a payer and casting HMOs (soon to be called "managed care organizations" or the more innocuous-sounding "health plans") as the central actors in both managing risk and arranging accessible, high-quality care for their insured populations.

Neither view, it should be said, was particularly palatable to physicians or their professional organizations. The former would have been explicitly public, rather than having public dollars generously subsidize private actors. The latter would have been explicitly corporate, without the primacy of the individual physician-patient dyad and its familiar ethical obligations. A single-payer would, in physicians' opinions, "socialize" medicine in the United States as it had throughout Western Europe, reducing their independence and income.[50] But the latter seemed truly horrific, shifting patient allegiances from them to the HMO, thus creating an adversarial relationship between physicians and HMOs over the necessity of care, and making profit the principal motivator for the shift in control.

Under political pressure to find a centrist solution, the Clinton Administration split the difference. Its 1993 proposal preserved Medicare in its existing fee-for-service form, imposed a coverage mandate on employers, who would purchase HMO-style, largely through new, regional non-profit "alliances," and subjected the entire "system" to a global budget that Congress would monitor and, if need be, enforce.[51] In truth, the primary motivator of this was not so much

[50] *See, e.g.*, Richard A. Culbertson & Philip R. Lee, *Medicare and Physician Autonomy*, HEALTH CARE FIN. REV., Winter 1996, at 115, 116–19; Christopher Cai, *How Would Medicare for All Affect Physician Revenue?*, 37 J. GEN. INTERNAL MED. 671, 671 (2021) (noting widespread opposition of US physicians to single-payer based on concerns about loss of income); *see also* Beatrix Hoffman, *Health Care Reform and Social Movements in the United States*, 93 AM. J. PUB. HEALTH 75, 76 (2003) (noting practitioners' fears in the early 20th century that "compulsory insurance would erode their incomes and independence").

[51] *See* Robert Pear, *Clinton's Health Plan: The Overview; Congress Is Given Clinton Proposal for Health Care*, N.Y. TIMES (Oct. 28, 1993), https://www.nytimes.com/1993/10/28/us/clinton-s-health-plan-overview-congress-given-clinton-proposal-for-health-care.html.

political pragmatism as fiscal politics[52]–the hope that the CBO would not regard money paid by private employers to private alliances as a new federal tax (it did, killing the plan[53]), and that placing an explicit cost cap (which a later Congress could still choose to amend or ignore) into the health reform law would put an upper bound on the overall ten-year budgetary impact notwithstanding the uncertainty of predicting private market outcomes.

An important if inadvertent effect of this design was to accelerate cost growth in health care during the late 1990s and early 2000s. A national political backlash occurred against "managed care" that was not offset by concerns over loss of employment-based health insurance because overall economic conditions remained favorable.[54] That backlash began with partisan opposition to the Clinton plan, which seized on public fears of rationing to cast HMOs as government bureaucrats that would deny Americans their choice of insurance plan and therefore of physicians.[55] In fact, "managed competition" was not "managed care," and had been intended to assure affordability and quality in a national insurance system and not merely to empower managed care plans. Opposition interests made sure that difference was lost on the public.

When the Clinton plan failed, unregulated managed care took hold, albeit briefly–reviewing the necessity of treatments, overseeing hospital length of stay, signing up physicians and hospitals for "preferred" networks, and bargaining fees downward.[56] Within five years, however, reactive

[52] *See* William M. Sage, *Adding Principle to Pragmatism: The Transformative Potential of "Medicare-for-All" in Post-Pandemic Health Reform*, 20 YALE J. HEALTH POL'Y L. & ETHICS 68, 86–87 (2021).
[53] CONG. BUDGET OFF., AN ANALYSIS OF THE ADMINISTRATION'S HEALTH PROPOSAL 44 (1994) (classifying Health Alliances as on-budget). *See also Joint Hearing*, *supra* note 45 (CBO Director's congressional testimony concluding that mandatory payments to health alliances represented an exercise of sovereign authority).
[54] *See* Robert J. Blendon et al., *Understanding the Managed Care Backlash*, 17 HEALTH AFFS. 80, 80 (1998).
[55] Theda Skocpol, *The Rise and Resounding Demise of the Clinton Plan*, 14 HEALTH AFFS. 66, 67 (1995).
[56] *See* Joseph White, *Markets and Medical Care: The United States, 1993-2005*, 85 MILBANK Q. 395, 403, 405, 429 (2007).

legislation at the state and eventually the federal level de-fanged managed care by restricting what is now called pre-authorization, thereby discouraging narrow provider networks, and prohibiting financial incentives to limit treatment. At the same time, hospitals consolidated into larger systems that could bargain for higher reimbursement (as did many physician groups).[57] When mergers that significantly reduced hospital competition in their communities were challenged by federal antitrust regulators, the merging organizations prevailed in seven straight cases between 1994 and 2000,[58] confirming a narrative that cast physicians and hospitals as altruistic and HMOs as profiteering villains who were sacrificing quality and access by denying needed care. This legal, political, and perceptual dynamic set the stage for the spending increases that followed. At the same time, no serious case was being made after the Clinton plan's demise for health care as a collective investment in the public's health or as a valued aspect of shared American identity.

SECTION THREE: MISSED OPPORTUNITIES AND PERHAPS GETTING WORSE

The late 1990s and 2000s were not devoid of national efforts to rationalize health care spending while promoting affordability and expanding access. Among many developments: the Health Insurance Portability and Accountability Act of 1996 made small-group insurance markets more available; Medicare added an outpatient prescription drug benefit[59]; support for Federally

[57] *See id.* at 413.
[58] *See* Cory Capps et al., *The Continuing Saga of Hospital Merger Enforcement*, 82 ANTITRUST L.J. 441, 443 (2019).
[59] *See generally* Michelle M. Megellas, *Medicare Modernization: The New Prescription Drug Benefit and Redesigned Part B And Part C*, 19 BAYLOR U. MED. CTR. PROC. 22 (2006) (discussing the establishment of Medicare Part D, which went into effect January 1, 2006, by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003).

Qualified Health Centers grew[60]; health information technology proliferated; and advances occurred in drug development, quality measurement, and patient safety processes. There were even periods of apparent moderation in the growth of health care spending, especially during and immediately following the "Great Recession" of 2007-08.[61] But it was only in the aftermath of that economic crisis that — as had happened a generation earlier — returning a Democrat to the White House brought national health reform once more to the top of the national policy agenda.[62]

By the time President Obama's Affordable Care Act took shape, a lot had been learned about the sources of both inefficiency and unfairness in U.S. health care, even if the health equity movement with its deeper understanding of structural racism and consequent injustice was still nascent. The potential for much greater clinical cost-effectiveness had been demonstrated by Triple Aim advocates,[63] the importance of upstream "social determinants" (now often called "non-medical drivers") of health had been established,[64] and professional practice restrictions and payment policies that compromised access and increased cost were being reconsidered.[65] At

[60] NAT'L ASS'N OF CMTY. HEALTH CTRS., COMMUNITY HEALTH CENTERS PAST, PRESENT AND FUTURE: BUILDING ON 50 YEARS OF SUCCESS 2–3 (2015) (discussing history of bipartisan federal support for Community Health Centers, including George W. Bush's Health Care Expansion Initiative).
[61] Matthew McGough et al., *How has U.S. spending on healthcare changed over time*?, PETERSON-KFF HEALTH SYS. TRACKER, (Dec. 20, 2024) https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time [https://perma.cc/ZLG5-3RFM].
[62] Lizzy Berryman, *Fixing the Health Care System Tops President's Agenda*, PBS (June 26, 2009, 9:25 PM), https://www.pbs.org/newshour/classroom/posts/2009/06/fixing-the-health-care-system-tops-presidents-agenda [https://perma.cc/7MB8-CCJQ].
[63] *See supra* note 19 and accompanying text.
[64] *See* Rachel Rebouche & Scott Burris, *The Social Determinants of Health*, *in* OXFORD HANDBOOK OF U.S. HEALTH LAW 1102-09 (I. Glenn Cohen et. al. eds., 2016); LAURA MCGOVERN ET. AL., HEATLH AFFS., HEALTH POL'Y BRIEF NO. 2014.17, THE RELATIVE CONTRIBUTION OF MULTIPLE DETERMINANTS TO HEALTH OUTCOMES 2–6 (2014), https://www.healthaffairs.org/do/10.1377/hpb20140821.404487/full/healthpolicybrief_123.pdf [https://perma.cc/7AJJ-M66Z].
[65] *See*, *e.g.*, Hannah L. Crook et al., *A Decade of Value-Based Payment: Lessons Learned And Implications For The Center For Medicare And Medicaid Innovation, Part 1* , HEALTH AFFS., (June 9, 2021) (https://www.healthaffairs.org/do/10.1377/forefront.20210607.656313/; *see also* Hannah L. Crook et al., *A Decade of Value-Based Payment: Lessons Learned And Implications For The Center For Medicare And Medicaid*

the same time, new generations of caregivers and recipients of care were poised to do things differently, with greater patient-centeredness, better communication, more level professional hierarchies, and larger, more team-based organizations.

Partly by design and partly by circumstance, the ACA took advantage of these advances in expert understanding of health system performance. Ambitiously, it enacted major changes to federal law in three distinct though related domains: health insurance (to render all Americans insurable at affordable premiums or under public programs), health care services (by enhancing value), and underlying health (by investing in preventive services and community well-being).[66] The first of these was the easiest to achieve: everyone is insurable if everyone is covered, and affordability of insurance (at least in the short term) simply requires financial subsidy through, in the ACA's case, tax credits and an expanded Medicaid program. Streamlining health care delivery and improving individual and community health are much harder goals to accomplish, and the measures contained in the ACA were more tentative.

The ACA had skirted past the three shoals on which the Clinton plan floundered,[67] but the political navigation necessary to do so took its toll. Fiscal-political blowback from the CBO scorekeeping process was partly avoided by pre-funding aspects of health reform in the HITECH Act and other Great Recession stimulus legislation, then bolstered by limiting scorable mandates to the small subset of individual health insurance policies (leaving more numerous employer-

Innovation, *Part 2*, HEALTH AFFS., (June 10, 2021) https://www.healthaffairs.org/content/forefront/decade-value-based-payment-lessons-learned-and-implications-center-medicare-and (payment reform); Institute of Medicine, The Future of Nursing: Leading Change, Advancing Health. Washington, DC: The National Academies Press (2011) (professional scope of practice expansion).

[66] *See* Sage, *supra* note 26, at 1084–87; Sage, *supra* note 50, at 69–120.

[67] *Id.* at 84–85.

sponsored group plans largely untouched), and budgetary gamesmanship such as favoring lower-priced Medicaid coverage over tax-subsidized private insurance. [68]

This approach avoided a politically unacceptable CBO budget score, but placing obligations on states or private parties that would have otherwise been borne by the federal government conferred standing on many of the ACA's opponents, which they did with enthusiasm and persistence. Nearly all the high-profile lawsuits focused on the insurance piece – the "individual mandate" to have coverage; the expansion of Medicaid to cover all poor Americans regardless of age, gender, disability, or family status; and the inclusion of contraceptive benefits as covered preventive care.[69] The core of the insurance reforms survived multiple trips to the Supreme Court[70] as well as several election cycles, but distracted policymakers' attention from improving health care delivery and community health, which further explains why costs continued to rise and solidarity faltered.

The Clinton plan's refusal to acknowledge any ethical case in favor of rationing also came back to haunt the Obama administration when it was accused without evidence of wanting to create "death panels" to deny medical care to Medicare beneficiaries.[71] A harbinger of conspiracy theories to come (and ironic given later conservative commentary describing high COVID-19

[68] *See* Sage & Westmoreland, *supra* note 42, at 437–39.
[69] *See* Abbe R. Gluck, Mark Regan & Erica Turret, *The Affordable Care Act's Litigation Decade*, 108 GEO. L.J. 1471, 1477–91, 1500–09 (analyzing the "existential challenges" to the ACA, including to the individual mandate and Medicare expansion, and the waves of litigation focusing on the provisions of the ACA that broaden protections for civil rights and preventive services); *see generally id.* (surveying the thousands of federal and state court challenges to the ACA).
[70] California v. Texas, 593 U.S. 659 (2021); Zubik v. Burwell, 578 U.S. 403 (2016); King v. Burwell, 576 U.S. 473 (2015); Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682 (2014); Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012).
[71] *See*, Peter Ubel, *Why It Is So Difficult to Kill the Death Panel Myth*, FORBES (Jan. 19, 2013, 12PM), https://www.forbes.com/sites/peterubel/2013/01/09/why-it-is-so-difficult-to-kill-the-death-panel-myth/ [https://perma.cc/3BZJ-2J6K].

deaths in the elderly as acceptable[72]), death panel rhetoric led the ACA's proponents to avoid using centralized data or expert analysis to determine covered benefits or provider payment.[73] The ACA's new Patient-Centered Outcomes Research Institute (PCORI) was explicitly prohibited from playing a role in defining cost-effective coverage,[74] and its Independent Payment Advisory Board was never even constituted.[75] Perhaps most importantly, the need to deny a "government takeover" of medical care prevented the Obama administration from making health reform via the ACA into a truly collective project.[76]

Finally, interest-group politics cautioned against radically restructuring health care. Opposition from health care industry groups fearing loss of revenue was blunted by the absence of named villains in the Obama administration's framing. To the contrary, key constituencies were courted with assurances of new paying customers, including health insurers (which had opposed the Clinton plan because it would have forced them to alter their core business model), hospitals, pharmaceutical companies, and physicians. Nor did most large corporate employers find the ACA objectionable, as it left nearly all their existing health benefit practices in place.

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[72] *See, e.g.*, Quint Forgey, *'It Affects Virtually Nobody': Trump Downplays Virus Threat to Young People*, Politico (Sept. 22, 2020, 9:27 AM), https://www.politico.com/news/2020/09/22/trump-downplays-coronavirus-threat-young-people-419883; Bess Levin, *Texas Lt. Governor: Old People Should Volunteer to Die to Save the Economy*, VANITY FAIR (Mar. 24, 2020), https://www.vanityfair.com/news/2020/03/dan-patrick-coronavirus-grandparents.

[73] ACA opponents loudly and repeatedly accused the Obama administration of wanting to make life-or-death decisions by fiat. *See* Elizabeth Weeks Leonard, *Death Panels and the Rhetoric of Rationing*, 13 NEV. L.J. 872, 878–86 (2013).

[74] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6301(c), 124 Stat. 119, 740 (2010) (codified at 42 U.S.C. § 1320e–1) ("Limitations on Certain Uses of Comparative Clinical Effectiveness Research").

[75] *See* Bipartisan Budget Act of 2018, Pub. L. No. 115-123, § 52001, 132 Stat. 64, 298 (repealing 42 U.S.C. § 1395kkk (establishing a fifteen-member Independent Payment Advisory Board for the purpose of reducing the per capita rate of growth in Medicare spending)); Ian D. Spatz, *IPAB RIP*, HEALTH AFFS. FOREFRONT (Feb. 22, 2018), https://www.healthaffairs.org/content/forefront/ipab-rip (describing the Advisory Board's "failure to launch" due to never having any members recommended or appointed).

[76] *See* Jonathan Oberlander, *Implementing the Affordable Care Act: The Promise and Limits of Health Care Reform*, 41 J. HEALTH POL. POL'Y & L. 803, 807–11 (2016).

The ACA has largely been successful in its central goal of increasing the percentage of Americans with health coverage,[77] with the consensus need for pandemic-related tax subsidies and entitlement extensions helping counterbalance erosion of the mandates and benefits in Congress and the courts. Nonetheless, the post-ACA period arguably has taken us farther from — not brought us closer to — a more effective and fairer health care system.

Overall, there have been few economic counter-pressures to continued health system underperformance with limited access yet persistent medical inflation, and few political ones either. To the contrary, the angry "othering" that has grown to dominate partisan rhetoric is inconsistent with a better, less costly health care system. The remainder of this section highlights some worrisome trends that have tended to undercut both health system stewardship of what are largely public resources and health system solidarity regarding us all being "in this together." Significantly, "business interests" account for few if any of these trends, apart from the profit potential that inheres in continuing the current healthcare system rather than moving toward a more effective, accessible one.

VALUE/PERFORMANCE

While many constituencies continue to support the idea of private rather than government-controlled health care, few applaud the overall performance of the U.S. health care system[78] This

[77] *See Historic 21.3 Million People Choose ACA Marketplace Coverage*, CTRS. FOR MEDICARE & MEDICAID SERVS. NEWSROOM (Jan. 17, 2025), https://www.cms.gov/newsroom/press-releases/historic-213-million-people-choose-aca-marketplace-coverage (reporting that 21.3 million people selected an Affordable Care Act Health Insurance Marketplace plan during the 2024 Open Enrollment Period); Preeti Vankar, *Number of People Without Health Insurance in the United States from 1997 to 2023*, STATISTA (July 10, 2024), https://www.statista.com/statistics/200955/americans-without-health-insurance/ (showing that the number of people in the United States without health insurance has dropped from 48.6 million in 2010 to 25 million in 2023).

[78] *See* ERIC C. SCHNEIDER ET AL., MIRROR, MIRROR 2017: INTERNATIONAL COMPARISON REFLECTS FLAWS AND OPPORTUNITIES FOR BETTER U.S. HEALTH CARE 4 (2017),

is mainly because the system's background conditions have changed little since Medicare was enacted.[79] These include massive amounts of public money for primarily public purposes "laundered" through private provider organizations and coverage intermediaries,[80] political entrenchment of these financial flows,[81] and professional control over clinical decisions and associated billing that disaggregates medical services and emphasizes revenue over cost in establishing production functions.[82]

Consequently, U.S. health care has the semblance of a market, but little of a market's responsiveness to change. This was poignantly illustrated during the COVID-19 pandemic, when the sudden inability to deliver lucrative in-person, elective procedures "reimbursed" by private insurance intermediaries sent health care organizations into a financial tailspin requiring government bailout.[83] Instead, the pattern of health care operations remains that when dedicated

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http://www.commonwealthfund.org/~/media/files/publications/fund-report/2017/jul/schneider_mirror_mirrEcor_2017.pdf [https://perma.cc/S99E-KQNJ] (explaining why the United States health care system "falls short" through a comparative analysis of the health care system performance of 10 other high-income countries); *see also* COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 23–25 (Rona Briere ed., 2001) (explaining the reasons underlying the current health care system's failure to meet patient needs and establishing the framework for a new health care system).

[79] Economists disagree on the system's degree of "productive inefficiency." *See* Sherry Glied & Adam Sacarny, *Is the U.S. Healthcare System Wasteful and Inefficient? A Review of the Evidence*, 43 J. HEALTH POL. POL'Y & L. 739, 741–45 (2018).

[80] *See, e.g.*, DONALD COHEN & ALLEN MIKAELIAN, THE PRIVATIZATION OF EVERYTHING HOW THE PLUNDER OF PUBLIC GOODS TRANSFORMED AMERICA AND HOW WE CAN FIGHT BACK 167–74 (2023) (discussing the privatization of Medicaid); Stephanie Woolhandler et al., *Public Money, Private Control: A Case Study of Hospital Financing in Oakland and Berkeley, California*, 73 AM. J. PUB. HEALTH 584 (1983).

[81] *See, e.g.*, Steffie Woolhandler & David U. Himmelstein, *Paying for National Health Insurance—And Not Getting It*, HEALTH AFFS., July/Aug. 2002, at 88, 89 exhibit 1 (showing the flow of health care financing funds among individuals/employers, providers, government, and private insurers).

[82] *See, e.g.*, Matthew B. Lawrence, *Operationalizing Power in Health Law: The Hospital Abolition Hypothesis*, 52 J.L. MED. & ETHICS 364, 371 (2024) (discussing the "off-loading [by the medical profession] of many non-clinical responsibilities to hospitals — billing, electronic health records, treatment of staff, overall care management, patient intake, etc.").

[83] *See* Sarah Kliff*, Hospitals Knew How to Make Money. Then Coronavirus Happened.,* N.Y. TIMES (May 20, 2020), https://www.nytimes.com/2020/05/15/us/hospitals-revenue-coronavirus.html [https://perma.cc/CD5F-93Z3]. COVID-19 shifted care away from private reimbursement in the short term and probably in the long term as well. *Id.*; *see also* GLENN MELNICK & SUSAN MAERKI, THE FINANCIAL IMPACT OF COVID-19 ON CALIFORNIA HOSPITALS: JANUARY 2020 THROUGH JUNE 2021, at 12 (2021), https://www.chcf.org/wp-

subsidies for new ideas end, so does the related practice innovation. While catchphrases may abound — from "patient safety" to "patient-centered care" to "value-based care," along with associated metrics — sustained progress is rare.

Competition?

Health law and policy scholars are probably more likely today than at any time in the last thirty years to believe that market competition has failed as a path to health system improvement.[84] A more accurate characterization is that market competition never had a chance to succeed. Efficient production and allocation depend on prices conveying information, and there are few economically "real" prices in the health care system.[85] It is equally difficult for markets to function without actual buyers, and most significant health care purchasers are using OPM ("other people's money"), whether private employers, administrators of self-funded employer plans, or government health programs.[86] What one typically calls an "insurer" is seldom bearing insurance risk, but rather taking a percentage of the revenues flowing through the system. What one might draw as a "supply chain" for pharmaceuticals is more circular than linear, with money poured in from outside, circulating in multiple pathways and directions among manufacturers, pharmacy benefit managers (PBM), and pharmacies– eventually resulting in the transfer of product to a user. Moreover, most transactions are based on reimbursable claims for professional

content/uploads/2021/08/FinancialImpactCOVID19CAHospitalsJan2020June2021.pdf [https://perma.cc/L82J-JCVH].

[84] *See, e.g.*, Allison K. Hoffman, *Health Care's Market Bureaucracy*, 66 UCLA L. REV. 1926 (2019) (arguing that leading market-based policies are inefficient and have created a massive "market bureaucracy" that has failed to enhance consumer choice as promised or deliver effective health care).

[85] *See generally* F.A. Hayek, *The Use of Knowledge in Society*, 35 AM. ECON. REV. 519, 526–28 (1945) (describing the "marvel" of price signals in competitive markets).

[86] *See* D. ANDREW AUSTIN & JANE G. GRAVELLE, CONG. RSCH. SERV., RL34101, DOES PRICE TRANSPARENCY IMPROVE MARKET EFFICIENCY? IMPLICATIONS OF EMPIRICAL EVIDENCE IN OTHER MARKETS FOR THE HEALTH SECTOR 8–9 (2008), https://www.congress.gov/crs-product/RL34101 [https://perma.cc/Y4E5-QH7F].

process steps dictated by physician specialists, plus disorganized inputs into those professional process steps.[87] For much of the health care system, this turns "patients" from living beings with physical and emotional needs into financial fictions to which billing codes can be attached. Nothing has changed this in recent years; to the contrary, pandemic-generated financial distress followed by financial relief from government has only reinforced these dynamics. Whether construed as "volume" or as "value," the core challenge for health care markets is to pay for meaningful products and services that are produced at the lowest cost and sold at a competitive price.[88]

Consolidation

Private equity roll-ups of physician practices and other organizations are only the most recent sector of the health care system to consolidate. Some consolidation, like home health care during the 1980s,[89] has been the result of new Medicare funding streams creating easy profits for start-up businesses, many of which merge (or fail) when financial opportunism causes payment rules to change. Other consolidation, such as among hospitals, health insurers, and physician practices during 1990s-style managed care,[90] happened in anticipation of greater market discipline – either to become market leaders or to defend against competitive threats.

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[87] *See* William M. Sage, *Assembled Products: The Key to More Effective Competition and Antitrust Oversight in Health Care*, 101 CORNELL L. REV. 609, 613–14 (2016).

[88] "From volume to value" became a catchphrase around 2015 among market-based health policymakers. *See, e.g.*, Michael E. Porter & Thomas H. Lee, *From Volume to Value in Health Care: The Work Begins*, 316 J. AM. MED. ASS'N 1047, 1047 (2016). The problem is that increased volume with lower per-unit costs is desirable for many things, such as necessary surgery or effective preventive testing, but not for others, such as unnecessary imaging. *See also* Michael E. Porter & Thomas H. Lee, *The Strategy That Will Fix Health Care*, HARV. BUS. REV., Oct. 2013, at 50.

[89] *See, e.g.*, *The Home Care Evolution: What a Long, Strange Trip It's Been*, HOMECARE MAG., Jan. 2003, at 20, 23–24 (chronicling the many mergers in the 1980s, the "golden age" of home medical equipment); Eliot Z. Fishman, Joan D. Penrod & Bruce C. Vladeck, *Medicare Home Health Utilization in Context*, 38 HEALTH SERVS. RSCH. 107 (2003).

[90] *See, e.g.*, Martin Gaynor & Deborah Haas-Wilson, *Change, Consolidation, and Competition in Health Care Markets*, J. ECON. PERSPS., Winter 1999, at 141, 141–44 (discussing the impacts on the health care industry in the

The political backlash against managed care weakened antitrust enforcement involving hospital mergers while simultaneously reducing, through enhanced regulation, the incentives on the insurer and employer sides to demand cost reductions.[91] Consolidation therefore accelerated into the 2000s, with demonstrable harm to price competition and plausible harm to process improvement,[92] in part because U.S. antitrust law is better equipped to forestall potentially anticompetitive consolidation than to address its aftermath.[93] Nor has productivity measurably improved. Even consolidated health care provider markets remained operationally fragmented because of the enduring regulatory and payment partition between licensed physicians and the facilities in which they deliver professional services.[94] This reinforces the point that the regulatory environment of health care often enhances the anticompetitive potential of private business structures and conduct.[95]

Physicians and Nurses as Employees

1990s of the rise of managed care, horizontal consolidation within markets for insurance, hospital services, and physician services, and vertical integrations in health care markets); David Dranove, Carol J. Simon & William D. White, *Is Managed Care Leading to Consolidation in Health-Care Markets?*, 37 HEALTH SERVS. RSCH. 573, 573–75 (2002) (discussing consolidation trends during the 1980s and 1990s and finding that managed care is "associated with a substantial increase in concentration in hospital markets and a sharp decline in the number of solo physician practices").

[91] *See* Sage, *supra* note 85, at 641–49.

[92] *See* WILLIAM B. VOGT & ROBERT TOWN, ROBERT WOOD JOHNSON FOUND., HOW HAS HOSPITAL CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HOSPITAL CARE? 11–12 (2006); MARTIN GAYNOR & ROBERT TOWN, THE IMPACT OF HOSPITAL CONSOLIDATION—UPDATE 2 (2012).

[93] *See* Thomas L. Greaney, *Coping with Concentration*, 36 HEALTH AFFS. 1564, 1565 (2017) ("Antitrust law has an important, constrained, role to play but is especially inept in dealing with extant market power.").

[94] *See* Einer Elhauge, *Why We Should Care About Health Care Fragmentation and How to Fix It*, *in* THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS 1–20 (Einer Elhauge ed., 2010).

[95] *See* Peter J. Hammer & William M. Sage, *Critical Issues in Hospital Antitrust Law*, 22 HEALTH AFFS. 88 (2003) (attributing greater anticompetitive effect to regulation than to pure market conduct); *see also* ROBERT I. FIELD, MOTHER OF INVENTION: HOW THE GOVERNMENT CREATED "FREE-MARKET" HEALTH CARE 24 (2014) (centrality of public initiatives setting conditions for private health care).

As a result of consolidation, generational change, and to a lesser degree, recent financialization (e.g., private equity investment), hospitals and other health care organizations now and for the first time, have a majority of their clinical workforce (physicians, nurses, and other health professionals) serving as employees rather than as practice owners or independent contractors.[96] This convergence toward teamwork and shared goals has potentially positive implications for patient safety, health equity, professional ethics, and health care payment and regulation. Yet the common meaning of "employer" in health policy discourse is "payer" in the sense of non-health care businesses that sponsor coverage for their workers, and trends toward an employment model for physicians tend to provoke knee-jerk criticism rather than thoughtful consideration of how hospitals and other healthcare organizations can be held to high standards for managing their workers and assuring their welfare and therefore the quality of their services.[97]

Beyond professional nostalgia and consequent inattention to generational change, a major reason for this blind spot is that both physicians and nurses are essentially invisible on even the largest hospital bills. The reasons are opposite: physicians' services are billed separately under professional rather than facility codes,[98] even when they are hospital employees, while skilled nurses are essentially treated as furniture, meaning that they are accounted for as hourly rather

[96] This was first reported in 2019. CAROL K. KANE, AM. MED. ASS'N, UPDATED DATA ON PHYSICIAN PRACTICE ARRANGEMENTS: FOR THE FIRST TIME, FEWER PHYSICIANS ARE OWNERS THAN EMPLOYEES 7, 13–16 (2019), https://www.ama-assn.org/system/files/2019-07/prp-fewer-owners-benchmark-survey-2018.pdf [https://perma.cc/7HX9-JW8H].
[97] *See, e.g.*, Patricia C. Gabow & Matthew K. Wynia, *Oaths, Conscience, Contracts, and Laws—The Gathering Storm Confronting Medical Professionalism*, 332 J. AM. MED. ASS'N 614 (2024) (expressing concern over provider contracts but ignoring employer responsibilities).
[98] Sage, *supra* note 85, at 625.

than salaried labor cost that is folded into the overhead associated with a "hospital bed."[99] As a result, hospitals may not take their responsibilities as employers seriously, and neither government nor the broader public has the context to demand it.

Post-pandemic Backsliding

Such is the strength of self-protective regulation affecting the American medical profession that greater efficiency-enhancing liberalization arguably occurred in the first year of the COVID-19 pandemic than in the half century preceding it.[100] Restrictive state-by-state licensing and the narrow scope of permitted practice for non-physician clinicians, for example, have been criticized for decades by experts of all political persuasions for raising costs, reducing access to care, and limiting educational opportunity.[101] These barriers — including lack of payment parity — fell quickly during the pandemic as disease surges and local staff shortages could only be remedied by interstate mobility of nurses and other skilled personnel, and telehealth services replaced in-person visits for non-emergency treatment.[102] Unfortunately, although predictably,

[99] Sylvia Allegretto & Dave Graham-Squire, *Monopsony in Professional Labor Markets: Hospital System Concentration and Nurse Wages* (Inst. for New Econ. Thinking, Working Paper No. 196, 2023), https://ssrn.com/abstract=4336504 [https://perma.cc/V4JQ-LH35].

[100] *See, e.g.*, Iris Hentze, *COVID-19: Occupational Licensing During Public Emergencies*, NAT'L CONF. OF STATE LEGISLATURES, https://www.ncsl.org/labor-and-employment/covid-19-occupational-licensing-during-public-emergencies (Oct. 30, 2020) (detailing state occupational health licensing regulatory responses to the COVID-19 pandemic); Donnie L. Bell & Mitchell H. Katz, *Modernize Medical Licensing, and Credentialing, Too— Lessons from the COVID-19 Pandemic*, 181 J. AM. MED. ASS'N INTERNAL MED. 312 (2021) (discussing how NYC Health + Hospitals "was able to staff up to meet urgent needs during the pandemic" by waiving credentialing and state licensure requirements); Lusine Poghosyan et al., *State Responses to COVID-19: Potential Benefits of Continuing Full Practice Authority for Primary Care Nurse Practitioners*, 70 NURSING OUTLOOK 28 (2021) (detailing federal and state deregulation of scope of practice restrictions on nurse practitioners during the COVID-19 pandemic).

[101] *See, e.g.*, MILTON FRIEDMAN, CAPITALISM AND FREEDOM 149–59 (1962); OFF. OF ECON. POL'Y, U.S. DEP'T OF THE TREAS. ET AL., OCCUPATIONAL LICENSING: A FRAMEWORK FOR POLICYMAKERS 13–14 (2015), https://obamawhitehouse.archives.gov/sites/default/files/docs/licensing_report_final_nonembargo.pdf [https://perma.cc/PB6T-Q6SB] (Obama Administration report); U.S. DEP'T. OF HEALTH & HUM. SERVS. ET AL., REFORMING AMERICA'S HEALTHCARE SYSTEM THROUGH CHOICE AND COMPETITION 32 (2018), https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf [https://perma.cc/N4BR-LXQT] (Trump Administration report).

[102] *See* sources cited *supra* note 98.

the post-pandemic period has brought significant backsliding, not only because emergency authorizations at both state and federal levels lapsed, but also because it is more lucrative for many provider organizations to return to old workflow patterns and their associated billing privileges. This process has been accompanied by a resurgence of protectionist physician advocacy opposing the restoration or expansion of practice authority for advanced practice nurses and others,[103] which seems to be part of a pattern of physicians "fighting the last war" despite its inconsistency with any forward-looking approach to ethical, cost-effective, and accessible interprofessional practice.

Drug Costs and Innovation Funding

Sharp increases in drug prices — understandable to some degree for cutting-edge biologics but seemingly inexcusable for small molecules that have long been on the market — also illustrate the limits of market competition. Regulatory responses, probably long overdue but still of unproven effectiveness, include federal caps on diabetes patients' monthly expenditures for insulin paid through government programs[104] and a new system of selective price negotiation between drugmakers and government for a rotating list of patented drugs that impose a substantial cost on Medicare.[105] These limited measures reflect tunnel vision regarding both the

[103] *See AMA Successfully Fights Scope of Practice Extensions that Threaten Patient Safety*, AM. MED. ASS'N (May 15, 2023), https://www.ama-assn.org/practice-management/scope-practice/ama-successfully-fights-scope-practice-expansions-threaten [https://perma.cc/H6QG-5P52].
[104] *See* Inflation Reduction Act of 2022, Pub. L. No. 117-169, sec. 11406, § 1860D-2(b)(9), 136 Stat. 1818, 1902–03 (codified as amended at 42 U.S.C. § 1395w–10(b)(9)) (limiting out-of-pocket costs for covered insulin products under Medicare Part D to $35 per month); *id.* sec. 11407(b)(2), § 1833(a), 136 Stat. at 1904–05 (codified as amended at 42 U.S.C. § 1395l(a)) (same for covered insulin products under Medicare Part B).
[105] *See id.* § 11001, 136 Stat. at 1833 (codified as amended at 42 U.S.C. §§ 1320f to 1320f-7) (establishing the "Price Negotiation Program to Lower Prices for Certain High-Priced Single Source Drugs"); *see also* Juliette Cubanski, *FAQs about the Inflation Reduction Act's Medicare Drug Price Negotiation Program*, KFF (Jan. 23, 2025), https://www.kff.org/medicare/issue-brief/faqs-about-the-inflation-reduction-acts-medicare-drug-price-negotiation-program/ [https://perma.cc/P9XK-WYY3] (providing details about the fifteen drugs currently selected for the Medicare Price Negotiation Program).

underlying problem and the range of potential solutions.[106] The problem is seen as an unresolvable tension between the billions of dollars needed to develop a new drug and bring it to market, and the pennies it costs to produce each additional pill once available.[107] The solution is framed as a Goldilocks determination of what price paid per unit at the point of service to a patient is "just right" given the aforementioned tension. These approaches seem incompatible with a market framework, but radical alternatives have yet to emerge even in the aftermath of the COVID-19 pandemic. Instead, efforts to reduce spending have rekindled old animosities (and their typically non-innovative political manifestations) between physicians and insurers over "pre-authorization" and similar administrative burdens on professionals' clinical judgment.[108]

EQUITY/SOLIDARITY

If the 1980s and 1990s were an era when business pressures from international competition, rising health benefit costs, and the awakening of "market forces" were in apparent tension with national health solidarity, the last thirty years have undercut solidarity through partisan divisions centered on regional geography, culture, and allegiances. During this shift, commercial interests were joined and sometimes superseded by partisan or ideological ones. For example, the dynamics of state-local conflicts over health-promoting city or county ordinances ("preemption") shifted from state-level influence by large corporations (e.g., sugar-sweetened beverage

[106] For a realistic assessment, see NAT'L ACADS. OF SCIS., ENG'G & MED., MAKING MEDICINES AFFORDABLE: A NATIONAL IMPERATIVE 11–17 (2018).
[107] *See* Aylin Sertkaya et al., *Costs of Drug Development and Research and Development Intensity in the US, 2000-2018*, 7 J. AM. MED. ASS'N NETWORK OPEN art. no. e2415445 (2024) (estimating the mean cost of developing a new drug as $172.7 million exclusive of cost of failures, and $515.8 million inclusive thereof); Andrew M. Hill et al., *Estimated Costs of Production and Potential Prices for the WHO Essential Medicines List*, 3 BRIT. MED. J. GLOB. HEALTH art. no. e571, at 2 (2018) (estimating a conversion cost from raw active pharmaceutical ingredients to finished pharmaceutical product of one cent).
[108] *See, e.g.*, Kevin B. O'Reilly, *As COVID-19 Peaked, Prior Authorization's Harmful Burdens Continued*, AM. MED. ASS'N (Apr. 13, 2021), https://www.ama-assn.org/practice-management/prior-authorization/covid-19-peaked-prior-authorization-s-harmful-burdens [https://perma.cc/SDS4-FKJ4].

manufacturers or fast food restaurants) to political contests pitting liberal, urban areas against conservative, rural ones.[109] Similarly, consensus following the September 11, 2001 terrorist attacks regarding investment in bio-preparedness and biomedical research generally, and similar consensus during the Great Recession regarding investment in health information technology, reflected a potential for health solidarity that seems to have dissipated shortly after the COVID-19 pandemic, regardless of generous federal subsidies for testing, treatment, and vaccine development.

Disagreements around authority, professional judgment, expertise, and information generally lie at the heart of this shift, which political opportunism both magnifies and exploits. Skepticism regarding elite opinion and conspiratorial thinking has a long history in American society, but the intensity of division today seems unique.[110] Optimizing information exchange has always been challenging in health care, between the public's uneasy reliance on physicians' professional judgment, suspicion of both government and corporate interference, and the inescapable fact that billing and payment rather than quality or safety or health improvement dominate the medical information ecosystem. These tensions have been compounded in recent years by technologic advances in data and communication that have outpaced efforts to monitor them, with massive threats to privacy and cybersecurity, an abundance of misinformation and disinformation, and

[109] *See, e.g.*, Eric Crosbie et al., *State Preemption: An Emerging Threat to Local Sugar-Sweetened Beverage Taxation*, 111 AM. J. PUB. HEALTH 677, 677–79 (2021); James G. Hodge et al., *Public Health 'Preemption Plus*,*'* 45 J.L. MED. & ETHICS 156, 156 (2017).

[110] *See, e.g.*, LEWIS A. GROSSMAN, CHOOSE YOUR MEDICINE: FREEDOM OF THERAPEUTIC CHOICE IN AMERICA 5–6 (2021) (discussing the historical popular distrust of state "medical practice acts," which "threatened the very existence of the unorthodox medical sects that millions of Americans adhered to before the rise of modern scientific medicine," and observing that "the medical freedom rhetoric of alternative medicine movements has always included a strain of thoroughgoing hostility to scientists, experts, bureaucrats, elites, and big business—a hostility sometimes fading over into paranoid conspiracy mongering"); Richard Hofstadter, *The Paranoid Style in American Politics*, HARPER'S MAG., Nov. 1964, at 77, https://harpers.org/archive/1964/11/the-paranoid-style-in-american-politics [https://perma.cc/8YGK-6KW5].

now the uncertainties associated with generative AI. Shifting First Amendment doctrine has also played a role, with the Supreme Court now routinely extending full constitutional protection to commercial as well as political speech, and bootstrapping free speech rights onto equally expansive decisions protecting religious free exercise.[111] The COVID-19 pandemic supercharged many of these risks, aligning the political, commercial, technical, and legal environments to favor misinformation, and subjecting infection-related guidance to conspiratorial thinking and even violence. The new Trump administration has further amplified this informational dysfunction and has given it the imprimatur of federal policy.

"Medicalization"

Recent insights regarding racial and ethnic health disparities and the importance of social (i.e., non-medical) drivers of health could be solidarity-enhancing if the public and the political process were to recognize that investments outside of the conventional medical system often provide cheaper, broader payoffs than investments within it.[112] However, because the health care workforce is so large and the financial flows that support it so generous (and so dependent on organized medical interest groups and their lobbyists), the path of least resistance has often been to "medicalize" health-related social problems by bringing housing, nutrition, and other non-medical drivers inside the medical tent rather than diversifying society's investment in health. Although well-intentioned, many of these efforts have subjected health-enhancing but non-

[111] *See* Nathan Cortez & William M. Sage, *The Disembodied First Amendment*, 100 WASH. U. L. REV. 707, 707–10 (2022).

[112] *See generally* DAYNA BOWEN MATTHEW, JUST MEDICINE: A CURE FOR RACIAL INEQUALITY IN AMERICAN HEALTHCARE (2015) (examining race-based health disparities); Marshall H. Chin et al., *Interventions to Reduce Racial and Ethnic Disparities in Health Care*, *in* RACE, ETHNICITY, AND HEALTH 761 (Thomas A. LaVeist & Lydia A. Isaac eds., 2nd ed. 2012); DAVID BARTON SMITH, HEALTH CARE DIVIDED: RACE AND HEALING A NATION (1999) (chronicling racial discrimination and segregation in the United States health care and tracing the role that race has played in shaping it); ELIZABETH TOBIN-TYLER & JOEL B. TEITELBAUM, ESSENTIALS OF HEALTH JUSTICE: A PRIMER (2019) (defining and exploring health justice).

medical domains to the geographic, insurance claims-driven, professionally hierarchical limitations of hospitals and their payers rather than being deferential to, and financially supportive of, established community organizations.[113] Scholars therefore divide on the desirability of medicalization.[114] More generally, medicalizing social problems tends to reinforce dependency by applying a "patient" construct, as opposed to empowering recipients by providing a targeted financial subsidy or, as economists typically prefer, cash.[115]

Racism and the "Undeserving Poor"

When the ACA expanded the Medicaid program to include essentially all poor Americans on a national basis, its straightforward goal was to reduce the ranks of the uninsured and relieve financial pressure on the hospitals that serve them, often in neighborhoods where poverty is concentrated and privately-insured patients are relatively scarce.[116] For reasons of fiscal politics and an in-retrospect naïve desire to preserve states' autonomy, however, that reduction was to be accomplished through state-by-state cooperation with generous but not complete federal payment, which gave states legal standing to bring suit against the expansion and quickly led the

[113] *See* William M. Sage & Keegan D. Warren, *Why MLP Legal Care Should Be Financed as Health Care*, 26 AM. MED. ASS'N J. ETHICS 640, 641 (2024) (reviewing funding models for medical-legal partnerships).
[114] *Compare* Craig Konnoth, *Medicalization and the New Civil Rights*, 72 STAN. L. REV. 1165 (2020) (defending medical civil rights-seeking), *with* Allison K. Hoffman, *How Medicalization of Civil Rights Could Disappoint*, 72 STAN. L. REV. 165 (2020) (expressing concern about the longer-term consequences of medicalization of civil rights).
[115] *See* William M. Sage & Jennifer E. Laurin, *If You Would Not Criminalize Poverty, Do Not Medicalize It*, 46 J.L. MED. & ETHICS 573, 578 (2018) (noting dependency in both hospitals and prisons).
[116] Poverty is a major correlate of poor health and increased mortality. *See generally* ELIZABETH H. BRADLEY & LAUREN A. TAYLOR, THE AMERICAN HEALTH PARADOX: WHY SPENDING MORE IS GETTING LESS 8–9 (2015) (discussing excessive investment in medical versus social care); RICHARD COOPER, POVERTY AND THE MYTHS OF HEALTH CARE REFORM 9–10 (2016) (arguing that poverty, not clinical uncertainty, explains geographic variation in health care spending); Raj Chetty et al., *The Association Between Income and Life Expectancy in the United States, 2001-2014*, 315 J. AM. MED. ASS'N 1750, 1750–66 (2016) (mapping the socioeconomics of longevity).

Supreme Court to prohibit, as unconstitutionally coercive, any withholding of existing Medicaid funds from states that declined to expand the program.[117]

As liberal states (and many health care philanthropies) embraced health equity, conservative states mobilized against Medicaid expansion as a liberal command to erase a long-standing distinction between aiding those whose need was no fault of their own — the old-fashioned term is the "deserving poor" — and encouraging shirking and risky behavior among seemingly less deserving groups. Arguing that reducing "dependence" was a legitimate goal of Medicaid, conservative states added work requirements and similar measures to their waiver requests and then swiftly moved to disenroll beneficiaries who had remained eligible for Medicaid under pandemic-related emergency authorities.[118] Racism has probably played a significant role in changing the Medicaid expansion from an expression of solidarity into a social flashpoint. According to surveys, whether a state has expanded Medicaid correlates strongly with the perception of Medicaid as welfare for the "deserving" or "undeserving" and racial stereotypes.[119]

Abortion and Reproductive Health

During the 1993-94 health reform debate, abortion rights advocates coined the phrase "medically appropriate" to position abortion for government coverage within general categories of medical benefits, rather than listing it separately in proposed legislation where it could be easily targeted

[117] *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012); *see also* Sage & Westmoreland, *supra* note 42, at 438–39.
[118] *See* Madeline Guth & MaryBeth Musumeci, *An Overview of Medicaid Work Requirements: What Happened Under the Trump and Biden Administrations?*, KFF (May 3, 2022), https://www.kff.org/medicaid/issue-brief/an-overview-of-medicaid-work-requirements-what-happened-under-the-trump-and-biden-administrations/ [https://perma.cc/5Q2T-VE2L].
[119] *See* Lonnie Snowden & Genevieve Graaf, *The "Undeserving Poor," Racial Bias, and Medicaid Coverage of African Americans*, 45 J. BLACK PSYCH. 130, 130–31 (2019).

for elimination by amendment. A similar maneuver in the ACA brought contraception into the category of preventive services that would be covered without cost to the beneficiary, including in employer-based health plans.[120] The reaction from conservatives was swift, with the provision generating litigation that was heard on multiple occasions all the way to the Supreme Court, again sacrificing national uniformity to the "culture wars."[121]

These divisions have only gotten worse after *Roe v. Wade* was overruled by *Dobbs v. Jackson*,[122] magnifying hostility among states and challenging even the limited solidarity in U.S. health care created by the federal EMTALA statute for hospital-based emergency care without regard for immigration or insurance status.[123] Similar divisions have been stoked by state legislation restricting transgender health care, resurrecting a long-standing argument on the political right that expansive federal policies on issues of sexual and gender identity are intended to alienate children from their parents' traditional values[124] (notwithstanding that many policies on the

[120] Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, sec. 1513, § 4980H, 124 Stat. 119, 253–54 (2010) (codified as amended at 26 U.S.C. § 4980H) (establishing fines for large employers that fail to offer employees opportunities to enroll in minimum essential coverage under eligible employer-sponsored plans, which by definition must be group health plans or group health insurance coverage); *id.* sec. 1001, § 2713(a)(4), 124 Stat. at 131 (codified as amended at 42 U.S.C. § 300gg-13(a)(4)) (requiring group health plans and health insurance issuers to provide preventive care coverage for women that complies with comprehensive guidelines supported by HRSA); *Women's Preventive Services Guidelines*, HEALTH RES. & SERVS. ADMIN., https://www.hrsa.gov/womens-guidelines [https://perma.cc/F4XF-L5MG] (describing the Women's Preventive Services guidelines supported by HRSA, which recommend full coverage for FDA-approved contraceptives, based on the 2011 recommendations by COMM. ON PREVENTIVES SERVS. FOR WOMEN, INST. OF MED., CLINICAL PREVENTIVE SERVICES FOR WOMEN CLOSING THE GAPS (2011)).

[121] *See* Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania, 591 U.S. 657 (2020); Zubik v. Burwell, 578 U. S. 403 (2016) (per curiam); Hobby Lobby Stores, Inc. v. Burwell, 573 U.S. 682 (2014).

[122] *See* Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022).

[123] *See* Moyle v. United States, 603 U.S. 324 (2024).

[124] *See, e.g.*, AJ Eckert, *Irreversible Damage to the Trans Community: A Critical Review of Abigail Shrier's* Irreversible Damage: The Transgender Craze Seducing Our Daughters *(Part Two)*, SCI.-BASED MED. (July 18, 2021), https://sciencebasedmedicine.org/irreversible-damage-to-the-trans-community-a-critical-review-of-abigail-shriers-book-irreversible-damage-the-transgender-craze-seducing-our-daughters-part-two/ (describing conservative author Abigail Shrier's beliefs that gender-affirming-care permissive policies lead to indoctrination in liberal gender ideology and work to alienate children from traditional notions of womanhood); SARAH PARSHALL PERRY & THOMAS JIPPING, HERITAGE FOUND., LEGAL MEMORANDUM NO. 355, PUBLIC SCHOOL GENDER POLICIES THAT EXCLUDE PARENTS ARE UNCONSTITUTIONAL 3 (2024) (arguing that school gender policies have "broken the bonds

political right allow government to dictate private family matters and impose majority religious views on non-conforming individuals).

Public Health Prevention and Emergency Response

Public health interventions were exacerbating partisan divisions in the American public well before the COVID-19 pandemic. The ACA had created a federal Prevention and Public Health Fund with projected annual funding of $2 billion, a minuscule fraction of federal Medicare and Medicaid expenditures but a substantial sum in historical terms.[125] These resources were intended to support individual and population health, concentrating on underserved communities and chronic diseases such as obesity-related diabetes that were primarily addressed through behavioral change. Republican opposition to the ACA therefore incorporated objections to what some called the "nanny state" policing nutrition and physical activity not to protect third parties but to protect individuals from themselves (or, as above, to intrude on families).[126]

Somewhat surprisingly, this worsened when COVID-19 struck, despite serious communicable disease long constituting an acceptable justification for proportionately constraining civil liberties,[127] even among libertarian-leaning conservatives. Social distancing, school closures, masking, limitations on gatherings, workplace restrictions and, eventually, vaccination — many imposed despite unavoidable scientific uncertainty regarding a novel pathogen — all became

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of trust between parent and child, relegating parents to uninformed bystanders in the development of their children's very identities").

[125] ACA § 4002, 124 Stat. at 541 (codified as amended at 42 U.S.C. § 300u-11). For comparison, mandatory federal spending on Medicare and Medicaid is about $1.41 trillion ($839 billion on Medicare and $567 billion on Medicaid). *See* Juliette Cubanski, Alice Burns & Cynthia Cox, *What Does the Federal Government Spend on Health Care?*, KFF (Feb. 24, 2025), https://www.kff.org/medicaid/issue-brief/what-does-the-federal-government-spend-on-health-care [https://perma.cc/TC5U-L9SZ].

[126] *Compare* Richard A. Epstein, *Let the Shoemaker Stick to His Last: A Defense of the "Old" Public Health*, 46 PERSPS. BIOLOGY & MED. S138, S139 (Supp. 2003), *with* Lawrence O. Gostin & M. Gregg Bloche, *The Politics of Public Health: A Response to Epstein*, 46 PERSPS. BIOLOGY & MED. S160, S160 (Supp. 2003).

[127] *See, e.g.*, Lawrence O. Gostin, Jacobson v Massachusetts *at 100 Years: Police Power and Civil Liberties in Tension*, 95 AM. J. PUB. HEALTH 576 (2005).

embroiled in partisanship and sectionalism. Related strands of political tribalism; mistrust of expertise (some well-founded); and social media amplification of misinformation, disinformation, and conspiracy theories are also likely responsible. At the extreme, Trump-aligned Republicans have turned the conventional libertarian distinction between communicable and non-communicable diseases as a justification for public health intervention on its head – asserting that public health is overly focused on infections and should instead "make America healthy again" by targeting chronic conditions.

Addiction, Guns, and Mental Health

Rising income and wealth inequality since the 1990s took a toll on poor communities regardless of race, especially in parts of the country, such as Appalachia and its surroundings, where manufacturing and mining jobs had vanished and where few other opportunities for training or employment existed.[128] Increases in addiction-associated harms, mental illness, domestic violence, and the proliferation of guns led to rapid increases in suicide, overdoses, and other so-called "deaths of despair."[129] Prescription opioids and later heroin and fentanyl were particularly pernicious,[130] in part because an opioid prescription was for many years the best way to access monetary benefits for musculoskeletal disability after welfare reform made cash assistance less available.[131] Nor was it lost on the most affected communities that physicians and other so-called

[128] *See* Madeline Brown et al., *Nine Charts About Wealth Inequality in America*, URB. INST. (Apr. 25, 2024), https://apps.urban.org/features/wealth-inequality-charts/; JOHN HISNANICK, INCOME INEQUALITY AND THE APPALACHIAN REGION BEFORE, DURING AND AFTER THE GREAT RECESSION 9–10, 18–19 (2014) (discussing industry and income inequality in Appalachia).

[129] *See generally* ANNE CASE & ANGUS DEATON, DEATHS OF DESPAIR AND THE FUTURE OF CAPITALISM (2020) (popularizing the term "deaths of despair" to refer to death from drug overdose, alcoholic liver disease and cirrhosis, or suicide, and explaining the surge in these deaths among working-class Americans); Gonzalo Martinez-Ales et al., *Why Are Suicide Rates Increasing in the United States? Towards a Multilevel Reimagination of Suicide Prevention*, 46 CURRENT TOPICS BEHAV. NEUROSCI. 1, 4, 12 (2020) (discussing the roles of mental illness, substance abuse, and firearms in suicide).

[130] *See* Nat'l Ctr. for Health Stat., *Provisional Drug Overdose Death Counts*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm (last visited Apr. 12, 2025) (exhibiting data on overdose deaths per year for synthetic and non-nonsynthetic opioids); *see generally* SAM QUINONES, DREAMLAND: THE TRUE TALE OF AMERICA'S OPIATE EPIDEMIC (2015) (chronicling the devastation of the opiate epidemic on American communities).

[131] *See*, *e.g.*, Nicole Maestas & Tisamarie B. Sherry, *Opioid Treatment for Pain and Work and Disability Outcomes:*

"pain experts" had been conned, at best, and more likely complicit in industry schemes to market opioids — and opioid-mediated death — on an unprecedented scale.[132] Trust, which had always been fragile, evaporated. Regional divisions and associated culture wars in legislatures and the courts over gun restrictions combined with persistent underinvestment in effective care for mental illness and substance use disorders made any "coming together" over health impossible, especially at the national level.

CONCLUSION

This essay seeks neither to bury nor to praise the U.S. health care system. Certainly, there have been many successes over the last thirty years, including near-miraculous advances in both diagnostics and therapeutics. From a policy perspective, low-cost generic drugs treat most ailments.[133] Federally qualified health centers provide outstanding care to diverse communities, often in conjunction with social services.[134] Smoking has declined dramatically,[135] although other substance use disorders and mental health have not improved.[136] Outpatient or short-stay

Evidence from Health Care Providers' Prescribing Patterns, NAT'L BUREAU OF ECON. RSCH., (Oct. 15, 2020) (https://www.nber.org/programs-projects/projects-and-centers/retirement-and-disability-research-center/center-papers/nb19-28-2) (finding that opioid prescriptions facilitate disability claims and may lead to permanent separation from the workforce).

[132] *See, e.g.*, Ronald Hirsch, Perspective, *The Opioid Epidemic: It's Time to Place Blame Where It Belongs*, 82 MO. MED. 82, 82 (2017).

[133] *See* Steve Brachmann & Gene Quinn, *95 Percent of WHO's Essential Medicines Are Off-Patent*, IP WATCHDOG (Sept. 12, 2016, 5:15 AM), https://ipwatchdog.com/2016/09/12/essential-medicines-off-patent/id%3D72542/ [https://perma.cc/3R52-G9M6]; ASS'N FOR ACCESSIBLE MEDS., THE U.S. GENERIC & BIOSIMILAR MEDICINES SAVINGS REPORT 2022, at 3 ("In 2021, patients in the United States received 6.4 billion prescriptions, 91% of which were generic and biosimilar medicines.").

[134] *See generally* Celli Horstman et al., *Community Health Centers' Progress and Challenges in Meeting Patients' Essential Primary Care Needs*, COMMONWEALTH FUND (Aug. 8, 2024), https://www.commonwealthfund.org/publications/issue-briefs/2024/aug/community-health-centers-meeting-primary-care-needs-2024-FQHC-survey.

[135] *See Trends in Cigarette Smoking Rates*, AM. LUNG ASS'N (May 30, 2024), https://www.lung.org/research/trends-in-lung-disease/tobacco-trends-brief/overall-smoking-trends [https://perma.cc/R2FZ-LR4B].

[136] *See,* Natalia C. Chacon et al., *Substance Use During COVID-19 Pandemic: Impact on the Underserved Communities*, 9 DISCOVERIES art. no. e141, at 1 (2021).

procedures are common and generally safe. Medical imaging, image processing, and information exchange are much faster and more effective. Biologics and small-molecule drugs can be developed or screened with speed and precision. Gene therapies are becoming a reality. And the health care workforce is skilled, caring, and reliable.

Still, as discussed above, potentially beneficial technological, organizational, and social progress has been delayed or compromised because the United States continues to construe health care as an individual service rather than a shared resource. Our longstanding culture of physician professional control is reflected in law and in payment policy, and the federal funding streams that support it are hard to modify. The ACA made major improvements to health insurance, if we can keep them, but in terms of overall quality both the health care system's efficiency and its equity have languished or backslid since the ACA's enactment. The pandemic experience was revealing, but its lessons elude us.[137]

Which brings us back to the question of money. How many editorials in both medical journals and the popular press have bemoaned the role of money in medicine? How many have criticized financial relationships between physicians and the pharmaceutical industry? Between hospitals, insurance companies, and drug companies and their investors? How many have asserted conflicts of interest, or called out fraud, or lamented greed? And what, really, has changed?

We should resist adding private equity — or whatever might follow it — to our list of existential threats. Private equity might be seriously disruptive, for ill or perhaps for good. At scale, it might

[137] William M. Sage, *What the Pandemic Taught Us: The Health Care System We Have Is Not the System We Hoped We Had*, 82 OHIO ST. L.J. 857, 863 (2021).

remove, rather than recycle capital from the health care system, which is problematic because substantial amounts of what is largely public money should be recaptured for other public purposes rather than being captured by private interests. It might finally focus attention on cost and the production function in health care delivery, in addition to enhancing potential revenue. It might even take its role as employer of health professionals seriously, or be forced to do so, thereby articulating a stronger managerial ethic with a more coherent approach to conflicts of interest or obligation. But likely it will adapt, like many potential pathogens, to a less virulent form that feeds off the current system rather than destroying it, with continued medicalization of social problems and with compromise approaches to governance resembling today's nonprofit but still profitable hospital sector.

But what if Medicare had not written essentially a blank check for medical care? Would things be worse, or might they be better? Is the quality of our health care system constrained only by the limits of our bank accounts? Or is quality constrained because our bank accounts have not been limited?

With so much money flowing to them, we seldom pause to ask "what is" questions about the most basic actors in the health care sector. What is a hospital? A health insurer? A service? Even a patient? We are comfortable with trendy phrases such as "patient safety", "value-based care", and "health equity." We are equally comfortable assigning blame, especially to corporate actors who seem peripheral to actual care delivery. But we are less sure of the principles and ethics that define the system we want.[138]

[138] *See, e.g.*, Donald M. Berwick, *Era 3 for Medicine and Health Care*, 315 J. AM. MED. ASS'N 1329, 1329 (2016); Donald M. Berwick, *The Moral Determinants of Health*, 324 J. AM. MED. ASS'N 225, 225–26 (2020).

In my view, the most urgent lessons from COVID-19 are about defining the collective investment and performance that the American public must demand of its health care system. This urgency is compounded in the present moment by the Trump administration's rapid, wholesale cancellation of contracts and grants for science and education involving medicine and public health, its appropriation of personal and health-related information, its retaliation against state and local governments with which it disagrees, and its alteration of regulations and withholding of additional federal funding without following established legal process. Considering the seeming unwillingness of Congress to assert its constitutional and institutional prerogatives, a substantial reduction in government commitments to Medicaid and perhaps even Medicare seems likely, although there has been little explanation of the purpose of doing so or seeming awareness of its potential adverse effects.

All of this Executive-branch activity has rapidly revealed to many who were unaware of it the U.S. health care system's dependence on public funding – a degree of invisibility that itself makes it harder to mobilize public opinion in its defense than would be the case for an explicitly governmental health care system such as England's National Health Service (NHS) or even a formalized system of publicly structured, employment-based coverage that exists in many developed countries. Nor is there sufficient managerial capacity or flexibility within America's private health care sector to quickly and effectively adjust to the rapid withdrawal of public funding.

For the next few years of health policy, what might we focus on more than money? How about the people who provide care: ethics, opportunity, training, and fair pay for meaningful work? And the people who receive care, and who are ultimately most concerned with, and most responsible for, their health? Physicians still possess considerable public authority and economic influence; nurses enjoy unparalleled community trust. These reputational assets must be strategically deployed in defense of science, compassion, and community before they fall victim to the current political moment.

Health professions also represent the future. We tend to imagine professional archetypes with deep historical roots and assign them fixed preferences, especially when their organized representatives are lobbying for or against legislation. But professionals are merely people, and those people learn, leave, retire, and are followed by others. The challenges of post-ACA medical practice are more tractable and less ethically jarring for younger generations of health professionals than for older ones because of who they are, how they are trained, and what they believe about the goals and consequences of the tasks they are undertaking. As discussed above, practice structure has changed as well: a substantial majority of physicians are now employees rather than business owners or partners.[139]

Changes in physician professionalism accompany parallel changes among recipients of care. If one imagines an educated, insured patient thirty years ago diagramming her care, it is likely she would place her family's physician at the center. Such a diagram today would be much more likely to place the patient herself at the center, armed with a smartphone while connected to a

[139] *See supra* text accompanying notes 96–99.

host of health-related products, services, support groups, and professionals. These technology-driven trends in reconfiguring the patient role are likely to accelerate because of generative AI.

Empowerment will not be evenly distributed among care recipients, however, imposing additional challenges on those who are chronically ill, poor, homeless, unemployed, or who live in underserved communities. Widening income inequality and persistent racial discrimination loom if the social safety net frays in the next few years and threatens to reduce resilience among care recipients even as generational change promises to increase it among care providers.

Therefore, the greatest challenge is to convince Americans, and ideally America's political leaders, that solidarity around health and health care is neither "socialized medicine" nor a commercial scam. In the United States, change will only happen when, echoing what Dr. Kassirer observed more than twenty years ago, the American health professions clearly proclaims that "[a] system in which there is no equity is, in fact, already unethical."[140] In particular, the United States has empowered physicians to oversee its health care system in an ethical fashion. Therefore, physicians must work shoulder-to-shoulder with other professions to defend health solidarity today, and must attach ethical primacy to improving it tomorrow. That, to me, seems the best way forward.

[140] Kassirer, *supra* note 11, at 398.