

THE VIRTUES OF MEDICARE

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MEDICARE MEETS MEPHISTOPHELES. By *David A. Hyman*. Washington, D.C.: Cato Institute. 2006. Pp. xviii, 138. Cloth, \$14.95; paper \$9.95.

Most of us look forward to a heaven where people don't get sick. But if they do, health care would be traded among fully informed patients and providers in perfectly competitive and frictionless markets. In that perfect world, sick citizens simply shop for doctors the way they shop for other consumer goods. The better doctors, like the most elegant hotel rooms and fanciest cars, would cost more than inferior doctors. Patients would consult their utility meters and, with appropriate attention to discounting over an infinite lifetime, choose accordingly. After each treatment, the patients would know the quality of their outcome and would accurately tell their friends in heaven whether they got a good deal on their appendectomy, bypass surgery, or what have you.

Unfortunately, that's not the way it works here in the corporeal world. Illness is messy. Medical treatment is complex. Knowledge is limited. Decisions need to be made quickly. And, therefore, health care markets are a muddle. Enter Professor David Hyman.¹ Posing as Underling Demon 666, Hyman has written a book-length letter to Satan about Medicare, the federal health insurance program for people age sixty-five and older.² In the letter, Hyman explains that only one thing stands in the way of having heaven's health care system here on earth: big government.

The problem with Hyman's view is that even without big government sticking its meddlesome finger into the pot, health care markets don't work well. Health care markets are all about failures and, unfortunately, the stakes are high. That's what makes health care devilish to provide and vexatious to regulate (and, incidentally, interesting to scholars). That's also why I think

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2. Medicare also insures people under age sixty-five who are blind, disabled, or have end-state renal disease. A few percent of the elderly are not eligible for Medicare because they do not qualify as a worker or dependent of a worker with at least forty quarters of Social Security earnings. Medicare is not to be confused with Medicaid, a joint state-federal program that provides health insurance to poor people, particularly children who make up almost half of its enrollees. Medicaid is, however, important for the elderly because "[a]lthough the elderly and people with disabilities make up just one-quarter of all Medicaid enrollees, they account for 70% of Medicaid spending." KAISER COMM'N ON MEDICAID & THE UNINSURED, THE MEDICAID PROGRAM AT A GLANCE 1 (2007), available at <http://www.kff.org/medicaid/upload/7235-02.pdf>.

that Hyman misses his target. Instead of aiming his considerable wit at Beelzebub's bureaucrats, those policy planners whom he charges with designing a system that was "dysfunctional from the get-go" (p. 10), he'd do better to recognize that his problems rest with the nature of health care and proceed from there. After all, sensible reform must be grounded in reality.

That said, there is a lot to recommend *Medicare Meets Mephistopheles*. I'll briefly touch on three of its virtues (and one of its vices) before considering Hyman's argument. First, there is a lot of truth in this book. As with any program of this importance and scale, Medicare is riddled with serious troubles. Yes, Medicare spending is huge and it will shock many readers to learn how fast it is growing. Yes, policymakers, analysts, and all but a few scholars have paid inadequate attention to the program's distributional consequences. Yes, the new prescription drug plan is not sustainable. And the list goes on. Despite Hyman's implication that rampant idiocy, greed, and corruption are behind these problems, many smart, honest, and hard-working people are struggling to fix the problems he identifies. I know, I know, the road to hell is paved with good intentions. Still, one need not abandon all hope before entering the realm of Medicare policy.

Second, Hyman is extraordinarily knowledgeable about health care regulation and his exposition is succinct. The book is filled with informative and accurate summaries of Medicare's complicated program design and related laws. The summaries of fraud and abuse law, for example, make my heart sing. I've seldom seen such an accessible and accurate primer.

Third, the book identifies crucial issues raised by all large social programs, not just Medicare. For any large program, we need to know whether the benefits are worth the costs—both on average and at the margin. We also need to know how those costs are distributed—among young and old, healthy and sick, rich and poor.

But that is not all we need to know. Although the book covers a vast terrain, I wanted more. Hyman's arguments only hint at an equally important matter for social policy. What should we do when such a program is, as it inevitably will be, imperfect? How should we balance various injustices? Hyman focuses on Medicare's financing, oversight, and political problems. Yet his preferred design, one more oriented to the market, would generate plenty of its own injustice. Why is that better?³

A word of warning: The book's clever approach too often crosses into the facile, making Hyman's argument hard to nail down. But if there is a thesis in this book—beyond that Medicare is big government and big government is bad—it is probably best summed up by Hyman's claim that "the very existence of the Medicare program evoked and encouraged gluttony—and the political consequence of that gluttony was a one-way ratchet that shifted the costs of the Medicare program to the working population and away from Medicare beneficiaries" (p. 41). However, Hyman's refrain about

3. I suspect that Hyman's answer would rest on principles of libertarian political theory. Although such a debate is beyond the scope of this review, it may very well lie only slightly below what seem to be technical disagreements about social insurance arrangements.

Medicare's irredeemable sins—it spends too much, for the wrong reasons, on second-rate stuff, and all from the pockets of the poor—tells a partial and partisan story.

In addition to obscuring his insights, Hyman's breezy style too often crosses into insult, mainly against mommy-party Democrats. Although acknowledging that all politicians pander to voters, Hyman gratuitously asserts that "Democrats disproportionately emphasize Medicare in their appeals to the electorate, which is consistent with their basic position that the 'highest purpose of government is to send people checks in the mail.'" ⁴ Typical is the unfounded claim that "many of Medicare's defenders react to even the slightest criticism of their favorite program with a ferocity that demonstrates that their enthusiasm has more to do with ideology than the actuarially sound/goo-goo [that is, good-government] approach they would insist on if we were talking about anything other than Medicare" (p. 103). Beleaguered Republicans are mainly guilty of the sin of anger, a reasonable response to their turncoat members who acted like Democrats in lustfully voting "to expand an out-of-control entitlement" (p. 65). In politics all sides engage in shallow and inconsistent argument. Yet it is principally Democrats and Medicare supporters that Hyman charges with substituting slogan for reason. Despite these distractions, readers should press on.

I. WHAT'S A FEW BILLION AMONG FRIENDS?

Hyman starts with a sketch of Medicare's vastness: "Covering approximately 42 million (primarily elderly) Americans, it funnels almost \$340 billion per year into the pockets of physicians, hospitals, clinical laboratories, home health agencies, physical therapists, social workers, [and] pharmaceutical companies . . ." (p. xvii). (I've heard about the billions lining the pockets of big-pharma execs, but social workers?) Of course, this money is not sent by the federal government to these professionals in the form of birthday gifts, but rather through reimbursement for providing services to sick people.

Predictions and polemics aside, Hyman is right that by any measure the United States spends a lot of money on health care. But Medicare is only part of the picture. Don't forget that Medicaid spending is almost as high, and on top of that there is private insurance and out-of-pocket payments. Hyman is also right that Medicare *massively* exceeded its initial cost projections. As Richard Epstein reports in his introduction, "By 1990, Satan had secured his pound of flesh: total hospital expenditures were more than six times those originally estimated in 1965" (p. xiv). Pretty soon even these dollars might come to look like pocket change. By 2050, Medicare spending alone is projected to increase to 9.2% of GDP from 2.9% today, both be-

4. P. 59. Here Hyman quotes Nicholas Lemann, *America Right and Left*, ATLANTIC MONTHLY, Apr. 1998, at 103, 108. Lemann's article, however, does not attribute the view about government's highest purpose to Democrats, but rather to a book he is reviewing.

cause of medical cost growth and the graying of America.⁵ Not everyone, however, is convinced that Medicare's spending will continue to grow at current rates.⁶

But Hyman didn't even give the Devil his due. Medicare can be blamed for much of *total* U.S. health care spending. People spend more on medical care when they have insurance than when they don't. But the spending growth is much greater when it comes in the form of a public insurance program than through individual insurance coverage. In fact, Amy Finkelstein has estimated that Medicare's effect on hospital spending is over *six times larger* than what the evidence from individual-level changes in health insurance would have predicted. How can this be? Finkelstein explains that insuring a large percentage of the population leads to market-wide changes that go beyond those that would result from the mere aggregation of a bunch of individual decisions to buy insurance.⁷ The idea is that if you insure the elderly in one fell swoop, hospitals will respond to the promise of increased demand by entering new markets and adopting new practices, despite the high fixed costs of these activities. The more Medicare spends, the more we all spend.

Why should we care how much money is spent on health care in the United States? Per capita health spending varies considerably (more than 100 to 1) across nations.⁸ Ironically, spending on medical care is lower in

5. David M. Cutler, *The Potential for Cost Savings in Medicare's Future*, 2005 HEALTH AFF. W5-R77, W5-R78, (web exclusive) <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.r77v1>.

6. Cutler, for example, thinks that spending growth may decline, in large part because the Medicare population is getting healthier (e.g., lower smoking rates and better control of hypertension). See *id.* Growth rates may also go down if current trends in the compression of illness into the later years of life continue; this is because medical spending during the last year of life is twice as high for people who die young (ages sixty-five to sixty-nine) than for those who die very old (over ninety). *Id.* Finally, recent projections do not account for technological innovations, such as laparoscopic surgery, that are cheaper than current interventions. *Id.* at W5-R79. In addition, Medicare managed care will likely continue to grow because new retirees are more accustomed to managed care than past generations of retirees who were familiar only with traditional fee-for-service plans. For managed care enrollment rates, see KAISER FAMILY FOUND., TRENDS AND INDICATORS IN THE CHANGING HEALTH CARE MARKETPLACE § 2 ex.2.17 (2005), <http://www.kff.org/insurance/7031/print-sec2.cfm> (last visited Sept. 28, 2007). Cf. Susan Bartlett Foote & Gwen Wagstrom Halaas, *Defining A Future For Fee-For-Service Medicare*, 25 HEALTH AFF. 864, 864 (2006) (reporting that by 2013 upwards of eighty-four percent of Medicare enrollees are still predicted to choose fee-for-service over managed care, but suggesting ways in which care management can be imported into fee-for-service arrangements).

7. Amy Finkelstein, *The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare* 15 (Nat'l Bureau of Econ. Research, Working Paper No. 11619, 2005). Finkelstein reports as follows:

Data from the National Health Expenditure Accounts indicate that real hospital expenditures grew by 63 percent between 1965 and 1970, compared to only 41 percent over the previous five years The smaller estimates . . . imply that Medicare can account for about one-third of the growth in hospital spending over this five year period or all of the above-average growth relative to the previous five years.

Id.

8. William D. Savedoff, *What Should A Country Spend On Health Care?*, 26 HEALTH AFF. 962, 962 (2007).

countries with public systems than in countries with private systems.⁹ But people (and countries) have to spend their money on something. We spend a larger share of our money on the military (4.06% of GDP in 2005) than do France (2.60%)¹⁰ and Tuvalu (which doesn't have a military to spend money on).¹¹ Both Sweden (7.7% of GDP in 2004) and Swaziland (6.2%) spend more of their money on education than we do (5.7%).¹² Accordingly, how much of GDP goes to health care can be understood as a matter of national choice, not whether the country can afford the bill.¹³

Some economists have argued that our spending hasn't been profligate, but rather shows good investment sense. David Cutler, for example, argues that we have gotten more than our money's worth. Analyzing treatments as varied as neonatal care and anti-depressants, he demonstrates that people are living longer and healthier lives because medical care has gotten so much better.¹⁴ Without health insurance, very few sick people would be able to access this care. Robert Hall and Charles Jones claim that by the middle of the century we *ought* to spend more than thirty percent of GDP on health care.¹⁵ This is because while the marginal utility of consumption falls when we get richer, the marginal utility of spending to live longer does not. More intuitively, Hall and Jones ask, "As we get older and richer, which is more valuable: a third car, yet another television, more clothing—or an extra year of life?"¹⁶ The claim has real bite because the elderly are not only living longer lives, they are increasingly living healthier lives into very old age. So that extra year is increasingly likely to be spent healthily.

There are, however, a few problems with this argument. First, when spending gets high enough—some think high enough will come by 2016 when almost twenty percent of GDP will go to health spending¹⁷—we may start giving up spending money on other things that matter for our quality of life. It's one thing if Americans can't buy the next version of their favorite

9. David M. Cutler, *Health Care and the Public Sector*, in HANDBOOK OF PUBLIC ECONOMICS 2143, 2168 (Alan J. Auerbach & Martin Feldstein eds., 2002).

10. CENT. INTELLIGENCE AGENCY, THE WORLD FACTBOOK 199, 586 (2006), available at <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2034rank.html> (last visited Nov. 23, 2007).

11. *Id.* at 569, available at <https://www.cia.gov/library/publications/the-world-factbook/geos/tv.html> (last visited Sept. 28, 2007).

12. THE WORLD BANK, WORLD DEVELOPMENT INDICATORS § 2 tbl.2.10, at 86 (2006), available at <http://siteresources.worldbank.org/DATASTATISTICS/Resources/table2-10.pdf>.

13. Michael E. Chernew et al., *Increased Spending on Health Care: How Much Can the United States Afford?*, 22 HEALTH AFF. 15 (2003).

14. DAVID M. CUTLER, YOUR MONEY OR YOUR LIFE: STRONG MEDICINE FOR AMERICA'S HEALTH CARE SYSTEM (2004).

15. Robert E. Hall & Charles I. Jones, *The Value of Life and the Rise in Health Spending*, 122 Q.J. ECON. 39, 40 (2007).

16. *Id.*

17. John A. Poisal et al., *Health Spending Projections Through 2016: Modest Changes Obscure Part D's Impact*, 26 HEALTH AFF. W242, W242 (2007) (web exclusive), <http://content.healthaffairs.org/cgi/reprint/26/2/w242>.

video game or the newest model SUV, it is quite another when a country must skimp on education, national defense, or housing to pay its health care bill. Second, all is well and good as long as productivity keeps going up and up and up. But what happens if it doesn't? Third, we aren't getting all we could for the money we are spending on health care.¹⁸ However, because variations in spending patterns are so complex—additional spending in some regions is worth it and in others is not—you don't improve the efficiency of Medicare spending by simply refusing to buy the next dollar of health care.¹⁹ So we shouldn't necessarily spend less; we should spend smarter.

Hyman would also likely respond to the suggestion that Medicare spending is worth it by pointing out that what people do with their own money is their own business. Let them burn it if they want. The problem with Medicare is that it is “overwhelmingly . . . financed by taxpayers who are not receiving benefits from the Medicare program” (p. 17). Even if this is true, why is this so troubling? So what if everyone pays and the sick get treated?

Hyman's answer is that Medicare is insidious because it induces people to spend more money on health care than they otherwise would. People aren't paying for health care out of their own pockets; they are using other people's money, and spending other people's money is fun. His argument blends together two distinct problems that I disentangle below: (1) moral hazard (with, for Hyman, the added insult that all this spending is buying a low-quality product) and (2) inequitable distribution.

II. MORAL HAZARD

Moral hazard is an inevitable cost of insurance. It occurs when an individual consumes more than she otherwise would because she doesn't have to pay all the costs of her consumption. People may be less careful when they are insured, such as driving a little less carefully when their auto insurance includes payments for collision than if they had to pay for the full cost

18. Inefficiency explains some, although not all, of why U.S. health spending is higher than health spending elsewhere. A summary of several studies suggests that relatively intensive medical treatment during hospital visits as well as expensive inputs like highly paid doctors and medical equipment are also to blame. Gerard F. Anderson et al., *It's The Prices, Stupid: Why The United States Is So Different From Other Countries*, HEALTH AFF., May–June 2003, at 89, 98. But there are inefficiencies in the U.S. system. Although this is not evidence of Medicare's inefficiency, the fact that the United States both spends more money per capita and has the highest infant mortality rate and lowest life expectancy among high-income Organization for Economic Cooperation and Development (OECD) countries suggests health spending inefficiency. William C. Hsiao, *Why Is a Systemic View of Health Financing Necessary?*, 26 HEALTH AFF. 950, 950 (2007). For examples of inefficient Medicare spending, see, for example, Jonathan S. Skinner et al., *Is Technological Change In Medicine Always Worth It? The Case Of Acute Myocardial Infarction*, 25 HEALTH AFF. W34 (2006) (web exclusive), <http://content.healthaffairs.org/cgi/reprint/25/2/w34>.

19. E.g., Skinner et al., *supra* note 18, at W41–W43 (showing that while there is considerable waste in spending, the efficiency of treatments vary considerably by location). Skinner and his coauthors suggest that a better bet for increasing efficiency is to identify effective treatments and use education and incentives to increase their use.

of the body work. Similarly, the argument goes, having health insurance may induce insureds to be less careful with their own health.²⁰ More plausibly, health insurance can cause patients to go to the doctor more often than they would otherwise because the additional care is relatively cheap when insurance covers the bill.

Hyman thinks moral hazard is to blame for Medicare's dramatic cost growth. Because they pay so much less than their medical care costs, beneficiaries have become gluttons for medicine. Having insurance has made Medicare patients—not to mention the doctors who both order the care on their patients' behalf and receive the payments—bad shoppers. Like diners who take that extra trip to the all-you-can-eat buffet, Medicare patients consume too much care—more than the patient would have asked for had she paid the full bill. Strictly speaking, this conception of medical care under insurance is absolutely correct. There are some egregious examples of inefficient, not to mention dangerous, care that patients buy and providers sell mainly because people have health insurance. I remember a few years back when MRI providers were targeting the “worried wealthy” by advertising full body scans at Valentine's Day; presumably many of these were paid through insurance.

Moral hazard arguments in the context of health care, however, are not entirely fitting. You don't have to look hard to find evidence that people generally become patients because they are sick, not because they are insured. Medical care isn't very pleasant to consume. Aside from some cosmetic treatments that are generally not covered by insurance, you don't see rich people giving their loved ones gifts of surgery—“Oh, darling, thank you so much for that weeklong stay in intensive care.”

Measuring moral hazard in the health care context is notoriously hard. Doing it the usual way—looking at what people would consume absent insurance and deciding the rest is moral hazard—isn't accurate. People consume more medical care when they are insured because they can't afford it otherwise. If there were no insurance, only a very few of the roughly 225,000 Medicare beneficiaries who have heart attacks each year would write a \$25,000 check for the hospital costs of cardiac bypass surgery alone,²¹ never mind the physician, diagnostic and other related medical treatment, and pharmaceutical costs. Is that because these folks didn't really

20. Dhaval Dave and Robert Kaestner have found some evidence that being insured by Medicare reduces prevention and increases unhealthy behavior among beneficiaries. They also found that these moral hazard effects are smaller than the beneficial preventative effects of physician counseling that come with the increased contact with doctors because of Medicare coverage. Dhaval Dave & Robert Kaestner, *Health Insurance and Ex Ante Moral Hazard: Evidence From Medicare* 33–35 (Nat'l Bureau of Econ. Research, Working Paper No. 12764, 2006). The limits to this line of reasoning are discussed below.

21. Costs based on average Medicare reimbursement estimates for 2006. Guidant Corp., *2006 FY Medicare Hospital Payment Changes Affecting CABG and Microwave Ablation*, available at http://web.archive.org/web/20061029085712/http://www.guidant.com/reimbursement/cs_codes/medicare_ip.shtml (last visited Dec. 4, 2007). For more detailed information for earlier years, see David M. Cutler et al., *Pricing Heart Attack Treatments*, in *MEDICAL CARE OUTPUT AND PRODUCTIVITY* 305 (David M. Cutler & Ernst R. Berndt eds., 2001).

value their treatment at more than \$25,000? Or is it because they *can't* write such a check, even though they actually value the care they receive by much more than its cost? Health insurance induces patients to get the surgery, but in many cases that's good, not bad. And it's not evidence of moral hazard—or gluttony, as Hyman calls it. Insurance lets sick people get access to very expensive medical care when they need it, and that's what it's supposed to do.

Because a patient can't write a check for intensive medical care, therefore, doesn't mean that the patient's purchase of the care with insurance is inefficient.²² (Nor does it necessarily mean that the purchase is efficient. Gee, I really value that new Ferrari at more than its price; perhaps the government should provide insurance for buying sport cars!) Therefore, we should not only ask whether people consume more than they otherwise would because they are insured, but also whether the care being provided is worth the cost. Unfortunately, that's a still harder question to answer. It depends on what patients are getting for all these payments as well as the opportunity costs of public spending. While Hyman is right that Medicare insurance has tempted patients to spend more than they would otherwise, that doesn't mean the temptation is one that patients ought to resist.

III. WHAT ARE WE GETTING FOR OUR MONEY?

Hyman informs us that the Devil is thrilled with all this Medicare spending for two reasons. What we are getting from it is (1) a bunch more spending and (2) some lousy care.

First, Hyman argues that Medicare's reimbursement system is inflationary. The old fee-for-service reimbursement system that paid physicians based on "usual, customary, and reasonable" charges led to skyrocketing payments (p. 20). Advances in reimbursement systems that did a better job of mimicking market prices (now almost twenty-five years old for hospital payments and fifteen years old for physician payments) are so filled with pathologies that they don't work either (p. 21).

What's worse is that beneficiaries of this largess—doctors (who, by the way, are all private actors) and hospitals (the vast majority of which are also private)—deliver their Medicare patients care that is "highly mediocre overall, with some of it absolutely appalling" (p. 23). Hyman, who knows his stuff when it comes to health policy research, knows this because there are so many studies that identify "overuse, underuse, misuse, unexplained variations in treatment patterns, and outright errors" (p. 23).

Jonathan Skinner and colleagues have found examples of "flat of the curve" spending—where more spending doesn't yield more benefit—in some Medicare regions where doctors and hospitals are spending too much on expensive and ineffective care and too little on inexpensive and effective

22. John A. Nyman, *Is 'Moral Hazard' Inefficient? The Policy Implications of a New Theory*, HEALTH AFF., Sept.–Oct. 2004, at 194.

care.²³ Throughout the book, Hyman refers to what can only be described as shocking geographic variation in patterns of hospital use, surgery, and medical spending. All this is true. One look at the Dartmouth Atlas of Health Care,²⁴ which documents treatment variation, is enough to make patients very queasy.

While citing a host of studies by health economists and policy analysts that identify problems in the Medicare program, he rejects their conclusions. Whereas researchers focus on particular examples of “defective incentives, poor information, inadequate monitoring, the state of medical science, non-compliant patients, incompetent providers, and everything else one could imagine” (p. 23), Hyman would prefer that they conclude that the rot of inefficient spending and bad care lies with Medicare itself. In fact, Hyman cites one study to support his claim that Medicare is not only wasteful but also bad for the health of its beneficiaries (p. 25). Unfortunately, it says something quite different; though the study found a negative correlation between Medicare spending and quality, it identified the relatively high proportion of specialists in the area as the root of the quality problem, not Medicare spending per se.²⁵

Based on an unexamined premise, Hyman assumes reducing government involvement in health care provision will lead to more efficiency and higher quality. So how does Medicare compare to its alternatives? It’s very hard to tell. No neat case control study can be done because there is no relevant control group. Almost all of old people who get the illnesses that Medicare pays to treat are covered by Medicare. There are plenty of studies comparing various experiments within Medicare, but none that would allow anyone to conclude that elderly patients would spend less or get higher quality care without it.²⁶ Even so, there is plenty of evidence that there is lots of lousy privately provided medical care.²⁷ There is also some evidence that Medicare is at least as good as private insurers at containing costs, maybe better.²⁸ Admittedly, that’s not good enough.

Some scholars find that all insurance, including Medicare and its private alternatives, has had only a small causal effect on health outcomes; the effects

23. Jonathan Skinner et al., *The Efficiency of Medicare* 3 (Nat’l Bureau of Econ. Research, Working Paper No. 8395, 2001).

24. <http://www.dartmouthatlas.org> (last visited Sept. 28, 2007).

25. Katherine Baicker & Amitabh Chandra, *Medicare Spending, The Physician Workforce, And Beneficiaries’ Quality Of Care*, 2004 HEALTH AFF. W4-184 (web exclusive), <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.184v1>.

26. Although not a sufficient reason to endorse them, large and centralized social insurance programs produce at least one nice externality: a source for consistent and comprehensive data. Basing policy responses on analysis of these data is the best we can hope for to improve insurance arrangements and related health care. The less unified the system, the more difficult it is to study outcomes like quality.

27. Elsewhere Hyman provides a synopsis of recent quality studies indicating widespread quality problems and concluding that “Medicare is not immune to these problems.” David A. Hyman, *Does Medicare Care About Quality?*, 46 PERSP. BIOLOGY & MED. 55, 57 (2003).

28. Cristina Boccuti & Marilyn Moon, *Comparing Medicare And Private Insurers: Growth Rates In Spending Over Three Decades*, HEALTH AFF., Mar.–Apr. 2003, at 230.

of insurance, however, are likely larger for populations insured by public programs such as infants, poor children, and the elderly.²⁹ Amy Finkelstein and Robin McKnight are two of the few scholars who address the question of Medicare's value head on. In their article, *What Did Medicare Do (And Was It Worth It)?*, they find that during the program's first ten years Medicare had no discernable effect on elderly mortality, possibly because elderly patients with life-threatening conditions had found their way to medical care even before Medicare's implementation.³⁰ They concluded, however, that Medicare's value as an *insurance program*, one meant to reduce the risk of high out-of-pocket spending on health care when it is needed, made it a big success. They found that Medicare's effect on risk exposure alone represented the equivalent of between one-half and three-quarters of Medicare's costs.³¹

IV. INCIDENCE AND INEQUALITY

The book's final theme is that Medicare is a reverse-Robin Hood scheme.³² It takes from the young and the working poor and gives to the retired wealthy (pp. 12–13). How is this so? Although Medicare's various programs are funded differently, overall about 40% of its revenue comes from payroll taxes and 41% from general tax revenue (p. 18). Wage taxes are flat, not progressive, and they don't apply to nonwage sources of income. By definition they come from workers, who are younger and poorer than Medicare beneficiaries. Only 11% of the program is funded by premiums paid by the elderly beneficiaries who use it and those premiums are not means tested (p. 18). Attempts to make affluent elderly patients pay more, such as the Catastrophic Coverage Act, have failed miserably (pp. 42–43).

Hyman's discussion of Medicare's distributional effects conflates a few separate questions, discussed in turn below: (1) Does Medicare transfer money from workers who are young to retirees who are old? Yes, it's supposed to. (2) Does Medicare transfer monetary value from the poor to the rich? It depends on how you count. The rich live longer so they are both more likely to become eligible for Medicare at all and to enjoy its benefits for more years. But they also pay more taxes than the poor. (3) Is Medicare

29. Helen Levy & David Meltzer, *What Do We Really Know about Whether Health Insurance Affects Health?*, in *HEALTH POLICY AND THE UNINSURED* 179 (Catherine G. McLaughlin ed., 2004).

30. Amy Finkelstein & Robin McKnight, *What Did Medicare Do (And Was It Worth It)?* 1–2 (Nat'l Bureau of Econ. Research, Working Paper No. 11609, 2005).

31. *Id.* at 2.

32. According to Hyman, "As a group, the elderly received far more from the public trough than they ever paid in (and more than is economically sustainable) even before the MMA, which made things substantially worse for younger taxpayers." P. 41 (citing EUGENE STEUERLE & ADAM CARASSO, *URBAN INST., LIFETIME SOCIAL SECURITY AND MEDICARE BENEFITS* (2003), available at http://urbaninstitute.org/UploadedPDF/310667_Straight36.pdf). Clark Havighurst and Barak Richman have recently argued that it is not just public programs but the private health care system that results in distributive injustice. Clark C. Havighurst & Barak D. Richman, *Distributive Injustice(s) in American Health Care*, 69 *LAW & CONTEMP. PROBS.* 7 (2006).

inequitable among the old? That is, do the rich beneficiaries get more out of the program than do poor beneficiaries? Probably, but the poor show net gains too. And (4), how do rich compare to poor beneficiaries in terms of health outcomes? Probably better. Unfortunately, the book does not consider what are, perhaps, the most important questions for evaluating a social insurance scheme: What are the net insurance benefits for the elderly? For the poor? For the rich? In other words, how valuable is Medicare insurance in terms of risk protection to the elderly, many of whom were uninsured before the program was started?

A. Intergenerational Transfers

Medicare's design was based on temporary intergenerational transfers. Today's working young fund the program for retirees. On its face, this design should not raise distributional concerns because today's workers are tomorrow's beneficiaries. (The first cohort of Medicare beneficiaries received benefits without paying in, but every program needs to start somewhere.) Further, today's workers are paying for today's quality medical care. Given the march of progress, they'll be quite happy to find that they are consuming something much better: tomorrow's medicine.³³ You don't see discount offers on last year's treatments like you see on last year's car model for a reason.³⁴

Regardless, analyzing the financial flows of Medicare in isolation is an odd exercise. Need every individual public program be neutral among generations? The elderly don't benefit much, at least directly, from the Head Start programs. They don't need to go to preschool themselves. (There might be considerable indirect benefit to the old from educating the young. Toting up the costs and benefits is a tricky business.) The elderly need health insurance more than younger workers because, on average, they get sick more. Considering total transfers among generations, at least some estimates suggest that net financial flows go from parents to children rather than vice versa.³⁵

As the U.S. population ages, however, fewer workers will have to support an increasingly elderly population. Hyman predicts that the "intergenerational pyramid scheme" that is Medicare will get worse and will eventually come crashing down (pp. 79–81). This is open to debate. First,

33. Havighurst and Richman doubt whether each generation will do better than the last because the trend depends on continued upward trends in health care costs and life expectancy. Havighurst & Richman, *supra* note 32, at 8 n.1. At this point, I think that we've got bigger worries than whether health care costs will decline. But they are correct that if Medicare loses support and the program is discontinued, today's workers will not get the benefit of their payments.

34. Some think it's a bad reason. Hyman would like to give consumers more ability to trade off cost against quality. See David A. Hyman, *Getting the Haves to Come Out Behind: Fixing the Distributive Injustices of American Health Care*, 69 LAW & CONTEMP. PROBS. 265, 272 & n.43 (2006).

35. Theodore R. Marmor & Jerry L. Mashaw, *Understanding Social Insurance: Fairness, Affordability, and the 'Modernization' of Social Security and Medicare*, 25 HEALTH AFF. W114, W120 (2006) (web exclusive), <http://content.healthaffairs.org/cgi/reprint/25/3/w114.pdf>.

whether transfers will indeed get larger depends on how much medicine changes over time and how much it will cost. For example, we don't know whether genomic developments will make medicine more or less expensive and efficient.³⁶ Second, demographics are not destiny. Whether Medicare, like other large social insurance programs, is sustainable depends on economic growth. Historically, each successive generation is more productive than the last. Even if the next one proves not to be, forecasting fifty years and more into the future is a perilous business; neither pessimism nor optimism is justified.

Hyman advocates restructuring Medicare to avoid these explicit intergenerational transfers. Doing so will not necessarily help. Unless we are willing to let elderly people suffer untreated illness and die without care, they will find some way to get it. Cost-shifting will abound. Some elderly patients would become eligible for Medicaid, which is funded by state and federal taxes that young people also must pay. Others will turn to already overburdened public emergency rooms, both for primary care and the growing number of emergencies that will result. Still others will turn to their children for financial help. Increased cost-sharing will also lead to service reductions that may in turn cause increased disability and morbidity among the elderly. Some children will pay the indirect costs of their parents' increasing dependence on their attention and care. Younger people, particularly taxpayers, will pay one way or another.

B. Does Medicare Help the Rich get Richer?

A more troubling issue than intergenerational transfers is how Medicare distributes across socioeconomic class. Hyman claims the transfers from the poor to the rich are large (pp. 12–13). The evidence is mixed: some find that the program redistributes on a financial basis from the rich and educated to the poor and poorly educated.³⁷ But there is also plenty of evidence that the rich receive more in Medicare benefits than the poor. This is not surprising. No one would be stunned to learn that the rich do better than the poor. They live longer, so they are both more likely than the poor to reach age sixty-five—when they become eligible for Medicare—and then to stick around even longer while Medicare is paying the bill.³⁸ However, Medicare payments are only one side of the equation. Richer beneficiaries consume more but they also pay more in lifetime taxes than do poorer beneficiaries.

36. Medical research and treatments are in the midst of a transformation from anatomy-based science to a focus on biochemical processes. Any well-functioning health care system will have to account for these changes. HARVEY SCHIPPER ET AL., *LOOKING FORWARD, MOVING FORWARD: AN ALTERNATIVE PATH FOR CANADA'S HEALTH CARE SYSTEM* 5–6 (2003), <http://changeofoundation.com/> (follow "Online Library" hyperlink; then follow "Archived Reports" hyperlink).

37. Jay Bhattacharya & Darius Lakdawalla, *Does Medicare Benefit the Poor?*, 90 J. PUB. ECON. 277, 278 (2006).

38. Mark McClellan & Jonathan Skinner, *The Incidence of Medicare*, 90 J. PUB. ECON. 257, 258 (2006).

Even considering all these factors, “the highest income households receive[] net benefits (i.e., lifetime expenditures less lifetime taxes) slightly *higher* than those in lower income groups.”³⁹ So on a financial basis, the rich do better than the poor. There is some evidence that this gap is shrinking.⁴⁰ But we aren’t there yet. Regardless, this conclusion does not provide sufficient reason to tank the program. The poor are receiving net benefits, just not as many as the rich.⁴¹ Medicare is still worth it for the elderly poor, just not as worth it as it could (or should) be. If Hyman is interested in redistributing wealth, I’ve got a lot of methods more direct and efficient than tinkering with the health care system. We should talk.

In any event, the monetary benefits that flow from Medicare—the main concern of *Medicare Meets Mephistopheles*—are not the only distributional issue raised by the Medicare program. As Mark McClellan and Jonathan Skinner explain, “dollar flows of money are not the appropriate way to judge the value of any social insurance program.”⁴² Before Medicare was enacted, many poor people were uninsured or underinsured. Medicare provided risk protection to people who were previously unable to get it. So it’s important to identify what Medicare provided in terms of *insurance* value to its beneficiaries and to identify “the *differential* insurance value between high and low income households.”⁴³ From this perspective, the results look pretty good. Beneficiaries at every level of income show net gains from having access to the insurance provided by Medicare and the poor show bigger gains than the rich.⁴⁴

39. *Id.*

40. Jonathan Skinner & Weiping Zhou, *The Measurement and Evolution of Health Inequality: Evidence from the U.S. Medicare Population 2* (Nat’l Bureau of Econ. Research, Working Paper No. 10842, 2004) (“Between 1987 and 2001, we found a dramatic increase in health care expenditures among the lowest income groups, accounting for a 78 percent increase (\$2,624) in real terms compared to a 34 percent increase (\$1,214) for those in the top income decile.”). As the authors point out, there are problems with this measure. It could reflect preferences, ill health among the poor, access, and spending on things that don’t help. *Id.*

41. At every level of wealth, people pay less in taxes than Medicare spends on their behalf. Further, McClellan and Skinner note:

Medicare effects a modest redistribution from lower income to higher income households The lowest income decile is estimated to receive a net transfer of \$978 (for a total generational transfer of \$27,251), the 3rd decile within-cohort redistribution is -\$1,017 (total transfer of \$25,256), while the highest income decile nets \$1,381 (total transfer of \$27,654).

McClellan & Skinner, *supra* note 38, at 264–65 (internal cross-references omitted).

42. *Id.* at 258.

43. *Id.*

44. *Id.* at 270 (“[O]nce again removing the mean intergenerational transfer (in this case, \$41,254) the intragenerational transfers are tilted toward lower income households. Net intragenerational benefits for the bottom income decile (\$8,210) far exceed the net contributions of the highest decile (-\$4,105).”).

C. Health Outcomes

So far this discussion has been all about whether Medicare transfers money and insurance value. What about health? As discussed above, establishing a causal link between insurance and health outcomes is difficult. However, scholars have found that during the 1990s, higher income beneficiaries had greater gains in life expectancy (0.8 years among the highest income decile) and more effective medical interventions for various conditions than lower income beneficiaries (0.2 years among the lowest income decile).⁴⁵ Further, “better educated patients get access to newer drugs . . . , survive longer following the diagnosis of cancer . . . and comply better with regimens for the treatment of AIDS.”⁴⁶

This is a problem and there are ways to address it. For example, Jonathan Skinner and Weiping Zhou suggest nondiscrimination rules that penalize providers for supplying relatively less effective care to low-income compared to high-income patients.⁴⁷ Yet even if these problems can’t be solved, do you think poor patients want to give up those life years they gained from the program just because someone else got a better deal?

V. THE MARKET: HEAVEN ON EARTH

Medicare Meets Mephistopheles only briefly attempts to tell us what to do about all this. Given Hyman’s anti-government rhetoric, it is surprising he doesn’t suggest that we let the entirety of Medicare burn in hell. Rather, the book concludes with a short outline of a few policy reforms—and here the reader should be warned the Devil has not provided many details—in which Hyman makes clear that large command and control programs don’t hold much truck for him (Chapter Eleven). He sums up the policy proposals under the heading, “Demand Side Conservatism.” The idea is that since it is impossible for Big Government to muster the discipline to control health care supply it’s better to shrink “the demand for government by empowering individual citizens to make their own decisions, and making them more self-reliant and responsible, and less dependent on government” (p. 87).

How can government empower its citizens? With incentives that induce them to voluntarily limit their spending on medical care. The menu mostly consists of familiar fare: replace defined benefits with defined contributions, introduce individual health savings accounts (“HSAs”),⁴⁸ and authorize private contracting between patients and doctors to replace publicly negotiated and regulated contracts. Consider what these reforms mean and “empowerment” begins to look like a bunch of Orwellian doublespeak. To empower

45. Skinner & Zhou, *supra* note 40, at 2.

46. *Id.* at 1 (citations omitted) (citing several studies).

47. *Id.* at 21.

48. HSAs are savings accounts, owned by individuals, filled with pretax dollars for the purpose of buying current or future medical care. They are commonly used in conjunction with catastrophic coverage insurance plans—plans that cover only very high spending.

individuals to function like grownups—that is to make the most of the resources they happen to have in negotiating contracts in a free market—means to unravel insurance markets, make care too expensive for all but the very rich to buy, and let the sick suffer.

Before making these suggestions, Hyman was spot-on when he hinted that insurance should be designed with cost sharing at the front end (pp. 46–47), both to discourage wasteful spending and because the front end is where many people can afford it. Policymakers understand this. This is why Medicare beneficiaries are subject to both deductibles and co-payments, both of which are already pretty high. In 2007, the deductible for Part A, hospital insurance, was \$992 (with co-payments for hospital stays at \$248 per day for days 61–90, \$496 per day for days 91–150, and then, unfortunately, the beneficiary becomes responsible for all costs).⁴⁹

In theory, HSAs coupled with high-deductible insurance plans would make patients even more cost-sensitive. In practice it has proven difficult to design systems that both make patients cost-sensitive and still insure them for big losses.⁵⁰ Medicare spending is concentrated among a very small percentage of beneficiaries. In 2001, 5% of the top spending beneficiaries accounted for 43% of total spending, on average \$63,000 per person, and the top 25% accounted for 85% of annual expenditures.⁵¹ Cost sharing would have to be untenably high to make much of a dent in this. And how, exactly, will that HSA-wielding citizen escape being treated by anything but the style of medical care available in his hometown? Patients have a hard enough time figuring out which treatment is most likely to help their medical problem, how are they supposed to judge which one is the most cost-efficient? Seems like regulation is a better bet. Finally, although the book is too sketchy on the details to know what Hyman has in mind, HSAs are typically inequitable. Because they allow people to spend with pretax money, they benefit the rich more than the poor. So much for distributional concerns.

Insurance is supposed to protect people from the big, unpredictable hits. Yet the defined contribution plans that Hyman advocates might very well cut people off when the big bills began rolling in. HSAs with high deductibles and catastrophic care are great plans for the healthy and the rich, so they would be quite likely to take advantage and opt out of group plans that pool risks and make insurance feasible.⁵² Another of Hyman's proposals is to allow doctors to treat Medicare beneficiaries for covered benefits both through the program and by contracting around it. How fast would you like

49. U.S. Dep't of Health & Human Servs., The Official U.S. Government Site for People with Medicare, <http://www.medicare.gov/Updates.asp> (follow "2007 Medicare premiums and co-insurance rates" hyperlink) (last visited Sept. 28, 2007). Wealthy people, however, tend to purchase supplemental insurance that they use to pay for co-payments and deductibles, creating both inefficiency and inequity.

50. Dahlia K. Remler & Sherry A. Glied, *How Much More Cost Sharing Will Health Savings Accounts Bring?*, 25 HEALTH AFF. 1070, 1074 (2006).

51. CONG. BUDGET OFFICE, HIGH-COST MEDICARE BENEFICIARIES 2 (2005).

52. Marmor & Mashaw, *supra* note 35, at W126.

to see risk pools disintegrate? Economically rational doctors would be thrilled to sign up the low-risk patients and take their money, leaving the actual sick people to get treated elsewhere. The list goes on, but the suggestions add up to risk segmentation and the attendant welfare losses. It is likely that Hyman's proposals will shift the risk from large pools to individual patients, increase the cost of care for the sick, and restrict the access of those who most need treatment.

Of course, I could be underestimating what the elderly would do with their newfound liberation from the nanny state. Unburdened of Medicare's chains, they might start saving. They might analyze insurer, physician, and hospital report cards to choose the best providers. They might vote with their wallets, buying medicine through insurance plans that give them the biggest bang for their buck. They might choose bigger risk pools just to give their neighbors a hand. The medical system would then be streamlined, efficient, and a whole lot cheaper.

This vision may be heavenly, but it is seriously unrealistic. It doesn't take into account how actual human beings behave or how the world of health care works. Young and healthy people have little understanding of what it is like to be sick, and as a result they often don't plan for illness. Meanwhile, old and sick people are often scared and confused. This doesn't mean people are immature or bad or economically irresponsible. It means that they are human. Even those of us with years of specialized training in health policy can find it difficult to choose among insurance plans and negotiate in the world of medicine when we or people we love get sick.

Under the best of circumstances, it is very difficult to evaluate health care. After you've taken your medicine, it is hard to know whether you got better because of the medicine, the skill of the doctor, the passage of time, or the luck of the draw.⁵³ Although there have been some developments in quality improvement such as increasingly sophisticated report cards and pay-for-performance approaches, at least in the short term they have been less successful than Hyman suggests. Leemore Dafny and David Dranove have shown that Medicare patients respond to report cards ranking Medicare

53. When critics of regulation and public health care acknowledge that health care is a merit good, they often advocate for service guarantees. See, e.g., Havighurst & Richman, *supra* note 32, at 51. For example, they suggest guaranteeing a basic package of care and making the rest of health care subject to real markets. *Id.* In principle this is an elegant solution. In real life, how would this work? How do you define essential care? You try it. In these parlor games, cosmetic surgery always comes up first. But remember lots of cosmetic surgery goes to burn victims, fixing congenital defects, or breast reconstruction after a mastectomy. Ok, we're all in agreement: no more using public dollars for cosmetic breast augmentation, no more liposuction, no more hair transplants for bald men. But those were, of course, never on the list. Look what happened when we tried to get serious about deciding on these lists, at least in part, democratically. Oregon tried and what happened? There was widespread controversy, alteration to the proposed rankings of services, and ultimately little in the way of rationing or cost savings. Jonathan Oberlander et al., *Rationing medical care: rhetoric and reality in the Oregon Health Plan*, 164 CAN. MED. ASS'N J. 1583 (2001). People differ regarding what is an important benefit. Hyman and I do. He mocks Massachusetts for mandating infertility treatment as part of insurance plans in Massachusetts. David A. Hyman, *The Massachusetts Health Plan: The Good, the Bad, and the Ugly*, POL'Y ANALYSIS, June 28, 2007, at 1, 6, available at <http://www.cato.org/pubs/pas/pa-595.pdf>. Infertility treatment—frivolous or important—what do you think?

HMOs, but they do so based on the subjective measures of patient satisfaction rather than more objective measures of treatment quality.⁵⁴ Risk adjustment remains hard and the costs of getting it wrong are very high since the best way to produce great outcomes is to avoid sick patients and treat healthy ones. Pay-for-performance systems haven't, at least yet, proved to be very effective.⁵⁵ They also tend to disadvantage poor patients and racial minorities.⁵⁶ These are just a few of the problems with embracing a market model and abandoning regulation.

Yet Hyman wonders why "almost no one has asked why the form of price setting used by the government in other parts of procurement (competitive bidding) is effectively nonexistent in Medicare" (p. 22). States have experimented with competitive bidding with limited success.⁵⁷ But as Hyman explains, federal efforts have had trouble even getting off the ground, in part because interest groups such as private insurers opposed the programs.⁵⁸ On the other hand, competitive bidding has been more successfully used for purchasing durable medical equipment. That's because buying wheelchairs and canes through a competitive process is a lot more straightforward than buying health care.

Even if political opposition could be overcome, it is unclear whether merely increasing competition absent extensive regulation would get what Hyman wants. The most recent efforts to introduce more competition into Medicare have provided beneficiaries with more choices among health insurance plans, but they have also increased Medicare spending and increased the likelihood of fragmenting risk pools.⁵⁹ Further, where quality is hard to measure, even ex post, competition doesn't necessarily improve quality.⁶⁰ There is a small industry of scholarly work that explains all the ways health care markets deviate from ordinary markets, with more detail

54. Leemore S. Dafny & David Dranove, *Do Report Cards Tell Consumers Anything They Don't Already Know? The Case of Medicare HMOs* 28–29 (Nat'l Bureau of Econ. Research, Working Paper No. 11420, 2005).

55. See, e.g., Arnold M. Epstein, *Pay for Performance at the Tipping Point*, 356 *NEW ENG. J. MED.* 515 (2007); Meredith B. Rosenthal & Richard G. Frank, *What Is the Empirical Basis for Paying for Quality in Health Care?*, 63 *MED. CARE RES. & REV.* 135, 151–53 (2006).

56. Lawrence P. Casalino et al., *Will Pay-For-Performance And Quality Reporting Affect Health Care Disparities?*, 26 *HEALTH AFF. W405* (2007) (web exclusive), <http://content.healthaffairs.org/cgi/reprint/26/3/w405>.

57. Several states have experimented with competitive bidding in their Medicaid programs. The results have been mixed and the potential for long-term savings uncertain. See, e.g., Lynn Paringer & Nelda McCall, *How Competitive Is Competitive Bidding?*, *HEALTH AFF.*, Winter 1991, at 220.

58. Pp. 55–56 (citing Bryan Dowd et al., *A Tale Of Four Cities: Medicare Reform And Competitive Pricing*, *HEALTH AFF.*, Sept.–Oct. 2000, at 9); see also Len M. Nichols & Robert D. Reischauer, *Who Really Wants Price Competition In Medicare Managed Care?*, *HEALTH AFF.*, Sept.–Oct. 2000, at 30.

59. Marsha Gold, *Medicare Advantage In 2006-2007: What Congress Intended?*, 26 *HEALTH AFF. W445, W454* (2007) (web exclusive), <http://content.healthaffairs.org/cgi/reprint/26/4/w445>.

60. Cutler, *supra* note 9, at 26.

than I can offer here.⁶¹ Suffice it to say that health care is not a typical commodity and treating it as such would bring dire consequences.

Perhaps *Medicare Meets Mephistopheles*' most disconcerting prescription is its plan to address distributional injustice via means testing. Making the rich elderly pay more for their care than they now do seems compelling in a world with limited resources. But Hyman is nothing if not politically astute. He knows that extensive means testing will transform Medicare into a program for the poor elderly. And "[o]nce the Medicare program does not include all the elderly, it becomes much easier for legislators to impose significant funding and benefit cuts, and the political punch of pro-Medicare demagoguery becomes much less powerful when all that is at stake is the health and welfare of poor people" (p. 89). Segregate the poor and then cut their benefits.

Maybe it's the Devil who helps those who help themselves (and only themselves). Never taking the idea of solidarity seriously, Hyman mocks those who embrace such ideas for "their continued willingness to guzzle communitarian Kool-Aid" (p. 70). Hyman, though, has perhaps guzzled his own flavor of Kool-Aid; regardless of the benefits of universal insurance for the elderly, either in the form of political unity or spillover benefits, practical politics will stop the Devil in his tracks. There is no way on God's green earth that the current generation of wealthy, elderly beneficiaries is going to permit their Medicare benefits to be cut.

In 1969, Harold Demsetz coined the term "nirvana approach" to describe a faulty form of public policy analysis in which the analyst notes that perfect markets would produce a particular result, observes that actual markets aren't perfect, and therefore concludes that government should step in to regulate them.⁶² In *Medicare Meets Mephistopheles*, Hyman engages in something like a reverse nirvana fallacy. He notes that perfect markets would produce a particular result, observes that Medicare isn't perfect, and therefore concludes that we should let actual markets reign to reach his desired result. Yet Hyman's idea of actual markets is decidedly idealistic. And, according to Demsetz, the relevant policy choice is between "alternative real institutional arrangements," not between "an ideal norm and an existing 'imperfect' institutional arrangement."⁶³ To consider whether Medicare or a market-based alternative is the better way to go, we need to consider the market alternative with all its warts—the inevitable moral hazard and adverse selection, the rampant externalities, the incentives for providers to skimp on quality, and human weakness.

This is why *Medicare Meets Mephistopheles* is a terrific overview of a troubled system, but a missed opportunity to help reform Medicare. Providing health care fairly and efficiently is a complicated process that

61. See, e.g., David M. Cutler & Richard J. Zeckhauser, *The Anatomy of Health Insurance* (Nat'l Bureau of Econ. Research, Working Paper No. 7176, 1999).

62. Harold Demsetz, *Information and Inefficiency: Another Viewpoint*, 12 J.L. & ECON. 1 (1969).

63. *Id.* at 1.

necessarily involves a heavy dose of government. Libertarian railing against big government, regulation, and all lefty foolishness that market proponents despise doesn't get one very far in determining how to get health care to 300 million people. In the end Hyman doesn't offer any realistic alternative to this government-regulated muddle because, God knows, his plans are unacceptable anywhere but in hell.

