
ARTICLE

CONVICTS AND CONVICTIONS: SOME LESSONS FROM TRANSPORTATION FOR HEALTH REFORM

DAVID A. HYMAN[†]

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[†] Richard & Marie Corman Professor of Law and Professor of Medicine, University of Illinois. I first learned about the impact of economic incentives on convict mortality during transportation to Australia in RUSSELL ROBERTS, *THE INVISIBLE HEART: AN ECONOMIC ROMANCE* 215-17 (2002).

This Article was completed prior to the Symposium on October 29-30, 2010. Although the references have been updated through March 2011, the predictions about PPACA’s prospects and challenges were made prior to the 2010 midterm elections.

I received helpful comments from William Sage, Charles Silver, and Noreen Sugrue. Of course, all errors are mine alone.

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[I]ncentives are more reliable than moral exhortations in changing behavior.

George F. Will¹

INTRODUCTION

It wasn't supposed to go this way. The Democrats had taken both houses of Congress in 2006 and the presidency in 2008. With a filibuster-proof majority in the Senate and a sizeable majority in the House, the decades-long road to Democratic delivery of comprehensive health reform had finally come to an end (along with conservatism and the Republican party). President Obama had promised to deliver health reform—although he allowed that if you liked your existing arrangements, you could keep them. Polls indicated that Democrats had maintained their traditional edge over Republicans in public trust to handle health care. Pharmaceutical companies and insurers had been bought off or intimidated into silence, ensuring there would not be a repeat of the “Harry and Louise” commercials that helped sink the Clinton health reform effort.² The path to success was clear, as long as the Administration let Congress write the bill. Once

¹ George F. Will, Op-Ed., *A Better Way to Pick a President*, WASH. POST, Sept. 26, 2010, at A25.

² Given the choice between a seat at the table and a place on the menu, the pharmaceutical companies cut an early deal, agreeing to discounted prices in exchange for an agreement that reimportation and direct negotiation over pricing would not be part of the Patient Protection and Affordable Care Act. See David D. Kirkpatrick, *White House Affirms Deal on Drug Cost*, N.Y. TIMES, Aug. 6, 2009, at A1. The companies also agreed to fund a \$150 million campaign promoting health reform. David D. Kirkpatrick, *Drug Industry to Run Ads Favoring White House Plan*, N.Y. TIMES, Aug. 9, 2009, at A13. The deal infuriated liberals, who had hoped to extract far more. See Glenn Greenwald, *Industry Interests Are Not in Their “Twilight,”* SALON.COM (Mar. 20, 2010, 9:21 AM), http://www.salon.com/news/opinion/glenn_greenwald/2010/03/20/health_care (contending that the Obama Administration bribed interest groups to neutralize their opposition to health care reform). The American Medical Association was promised that the Sustainable Growth Rate payment formula would be permanently fixed. David M. Herszenhorn & Sheryl Gay Stolberg, *Health Deals Could Harbor Hidden Costs*, N.Y. TIMES, July 8, 2009, at A1. Hospitals cut a deal as well. *Id.* Insurers were late to the party, and so they couldn't cut as good a deal. Plus, no one likes insurance companies anyway.

Congress enacted the Patient Protection and Affordable Care Act (PPACA),³ Democrats would receive the thanks of a grateful nation, and their electoral dominance would be assured.⁴ The only real question was whether to include a public option to placate the left; everything else appeared to be a done deal.

Reality intruded, as it always does. The enactment of PPACA was an excruciating and extended process, with twists and turns that a novelist would have been embarrassed to include in a work of fiction. Former Senate Majority Leader Tom Daschle, the President's first choice to lead the Department of Health and Human Services and run the health reform effort, was forced to withdraw his nomination after it emerged that he had underpaid his taxes by more than \$100,000.⁵ Opposition to PPACA led to loud and rancorous public meetings between legislators and their constituents during the summer of 2009.⁶ Opponents accused proponents of lying about whether people could keep their health care coverage and whether PPACA would cut Medicare; proponents accused opponents of lying about "death panels" and the "government takeover" of health care.⁷ The

³ Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as amended at scattered sections of 21, 25, 26, 29, and 42 U.S.C.).

⁴ See, e.g., Mark Halperin, *Can the GOP Succeed by Running Against Health Care?*, TIME.COM (Mar. 22, 2010), <http://www.time.com/time/world/article/0,8599,1974005,00.html> ("The President, however, may be indifferent to the acrid fussing of his Republican foes. He will be able to bask once again in the glow of positive press coverage . . .").

⁵ Jeff Zeleny, *Daschle Ends Bid for Post; Obama Concedes Mistake*, N.Y. TIMES, Feb. 4, 2009, at A1.

⁶ See, e.g., *Town Hall Meeting on Health Care Turns Ugly*, CNN.COM (Aug. 7, 2009), http://articles.cnn.com/2009-08-07/politics/health.care.scuffles_1_health-care-chants-meeting-room?_s=PM:POLITICS ("A health care town hall meeting in Florida on Thursday dissolved into bouts of heckling and violent pushing and shoving among attendees.").

⁷ Compare Shikha Dalmia, *Obama's Top Five Health Care Lies*, FORBES.COM (July 1, 2009, 12:01 AM), <http://www.forbes.com/2009/06/30/obama-health-care-reform-opinions-columnists-public-option-medicare.html> (criticizing President Obama for uttering "bald-faced lies" regarding health care reform), with Sharon Begley et al., *The Five Biggest Lies in the Health Care Debate*, NEWSWEEK, Sept. 7, 2009, at 42, 42 (criticizing PPACA's opponents for spreading "lies and exaggerations"), and Glenn Kessler, *Debunking Common Myths About Health-Care Reform*, WASH. POST, Jan. 19, 2011, at A3 (attempting to rebut the Republican contention that PPACA amounted to a "government takeover").

“public option” was in, then out, then (maybe) back in again.⁸ Medicare for the near-elderly was in, then out.⁹

When Senator McCain proposed to tax employment-based coverage during the 2008 presidential election and to provide an offsetting tax credit, the Obama campaign savaged the proposal—but PPACA included a similar provision (an excise tax on “Cadillac health plans”).¹⁰

It took seven months after the 2008 election for the Democrats to get a filibuster-proof majority in the Senate, with Al Franken finally declared the winner in the Minnesota race.¹¹ The House then passed one bill on November 7, 2009 (the Affordable Health Care for America Act),¹² and the Senate passed a substantially different bill (PPACA) on December 24, 2009.¹³

The Democratic filibuster-proof majority, however, was short lived. Before his death in August 2009, Senator Edward Kennedy convinced the Massachusetts legislature to change its election laws to allow the governor to appoint a successor until a special election was held if a Senate seat became vacant—which would be unremarkable, except that in 2004 he had pressed the Massachusetts legislature to enact legislation to keep the governor from appointing a successor until a special election was held.¹⁴ When the special election was held in January 2010, Scott Brown, a Republican, won the seat by campaigning against PPACA.¹⁵

⁸ See, e.g., Robert Pear & Gardiner Harris, *Alternate Plan as Health Option Muddies Debate*, N.Y. TIMES, Aug. 18, 2009, at A1; Tim Dickinson, *The Public Option: It's Baaaack!?*, ROLLING STONE NAT'L AFF. (Feb. 28, 2010, 3:30 PM), <http://www.rollingstone.com/politics/blogs/national-affairs/the-public-option-its-baaaack-20110228>.

⁹ See, e.g., *Medicare for 50-Somethings?*, N.Y. TIMES ROOM FOR DEBATE (Dec. 10, 2009, 7:23 PM), <http://roomfordebate.blogs.nytimes.com/2009/12/10/medicare-for-50-somethings> (describing “a plan being pushed by Senate Democrats as part of the national health care overhaul that would allow people over 55 to buy into the Medicare program at subsidized rates if they can't find coverage elsewhere”).

¹⁰ Health Care and Education Reconciliation Act of 2010 § 1401, 26 U.S.C.A. § 4980I (West Supp. 1A 2010).

¹¹ Monica Davey & Carl Hulse, *Minnesota Court Rules Democrat Won Senate Seat*, N.Y. TIMES, July 1, 2009, at A1.

¹² H.R. 3962, 111th Cong. (2009).

¹³ 155 CONG. REC. S13,891 (2009); see also Shailagh Murray & Lori Montgomery, *Senate Passes Health-Care Bill on 60-39 Vote*, WASH. POST., Dec. 25, 2009, at A1.

¹⁴ See Editorial, *What Ted Kennedy Wants*, WALL ST. J., Aug. 21, 2009, at A12 (“He’s trying to change election rules—again.”).

¹⁵ See Karen Tumulty, *Does Brown's Senate Win Mean the End of Health Reform?*, TIME.COM (Jan. 20, 2010), <http://www.time.com/time/politics/article/0,8599,1954980,00.html> (“Brown campaigned against his opponent, state attorney general Martha Coakley, on a promise to be the ‘41st Senator’—the one whose vote would give the Republicans the power to block Obama’s health care bill with a filibuster.”).

With Brown's victory, PPACA appeared to be dead as a doornail, and then Wellpoint announced that it was increasing premiums on individual policies in Indiana and California by "up to 39%"—triggering a firestorm of criticism.¹⁶ After flirting with "deem and pass" (i.e., "passing" the Senate bill without actually voting on it),¹⁷ the House ultimately passed PPACA on a party-line vote, along with a "sidcar" reconciliation bill amending PPACA that the Senate passed a week later.¹⁸ President Obama signed PPACA on March 23, 2010,¹⁹ and the sidcar (the Health Care and Education Reconciliation Act of 2010)²⁰ on March 30, 2010.²¹

Post-enactment, the twists and turns continued. President Obama nominated Dr. Donald Berwick to head the Center for Medicare and Medicaid Services on April 19, 2010; used a recess appointment on July 7, 2010, to place Berwick in the position before a confirmation hearing could even be scheduled; resubmitted his name for consideration for a permanent appointment on July 19, 2010; and resubmitted it once again on January 26, 2011.²² To date, there has not been a confirmation hearing, and it appears there will not be one—meaning Berwick will have to step down by December 31, 2011.²³

The 2010 midterm elections became nationalized over the issue of health reform. As the results of this election made clear, PPACA actually did include a death panel—but it targeted Democrats running for reelection.²⁴ An August 2010 briefing by Administration allies suggested that proponents should stop claiming PPACA would reduce

¹⁶ Susan Heavey, *Democrats Seize on Wellpoint's 39% Rate Hike to Renew Reform Effort*, INS. J. (Feb. 12, 2010), <http://www.insurancejournal.com/news/national/2010/02/12/107330.htm>.

¹⁷ See Adam Nagourney, *Point of (Dis)order*, N.Y. TIMES, Mar. 21, 2010, at WK1 (explaining that the Senate was considering "a deem-and-pass maneuver").

¹⁸ See David M. Herszenhorn & Robert Pear, *Final Votes in Congress Cap Battle over Health*, N.Y. TIMES, Mar. 26, 2010, at A17.

¹⁹ See Remarks on Signing the Patient Protection and Affordable Care Act, 2010 DAILY COMP. PRES. DOC. DCPD201000196 (Mar. 23, 2010).

²⁰ Pub. L. No. 111-152, 124 Stat. 1029 (to be codified in scattered sections of 20, 26, and 42 U.S.C.).

²¹ See Remarks on Signing the Health Care and Reconciliation Act of 2010 in Alexandria, Virginia, 2010 DAILY COMP. PRES. DOC. DCPD201000211 (Mar. 30, 2010).

²² Robert Pear, *Rising Calls to Replace Top Man at Medicare*, N.Y. TIMES, Mar. 8, 2011, at A12.

²³ *Id.*

²⁴ See Editorial, *Death Panels with a Twist*, N.Y. POST, Sept. 8, 2010, at 28, available at 2010 WLNR 17842138 ("Sarah Palin was right—the Democrats are for death panels after all. Unfortunately for them, it's their own vulnerable House members that the Dems are preparing to euthanize.").

health care spending and the deficit (two of the principal selling points, ceaselessly repeated by PPACA's proponents) and rely instead on personal anecdotes and promises to "improve" the legislation.²⁵ During the fall of 2010, some Democrats ran advertisements on health reform—but most of those were highlighting the fact that they voted against it.²⁶ In Iowa, the *Democratic* Governors' Association sent out mailers and ran television advertisements claiming that the *Republican* gubernatorial candidate (Terry Branstad) was too much like President Obama on health care!²⁷

Twenty-one states immediately filed suit claiming that PPACA was unconstitutional; the Department of Justice (DOJ) responded by arguing, *inter alia*, that the penalty for noncompliance was a tax, even though President Obama had previously stated in an interview, "I absolutely reject that notion."²⁸ PPACA's supporters asserted that these lawsuits were objectively frivolous, but attempts by the DOJ to have the cases dismissed resulted in a split decision with judges in Michigan,²⁹ Virginia,³⁰ and the District of Columbia³¹ upholding the law; a judge in Virginia striking down the individual mandate (but not all of PPACA);³² and a judge in Florida striking down the entirety of PPACA.³³ In state referenda, voters in Arizona, Missouri, and Oklahoma

²⁵ See Ben Smith, *New Dem Message: 'Improve' Health Care, Don't Talk Cost*, POLITICO (Aug. 19, 2010, 4:36 PM), http://www.politico.com/blogs/bensmith/0810/The_new_message_Improve_health_care_dont_talk_cost.html (revealing a confidential report by Administration allies advising Democrats not to make public policy arguments, but rather to "play on personal narratives").

²⁶ See, e.g., Jonathan Cohn, *Playing Offense on Health Care Reform*, NEW REPUBLIC (Oct. 1, 2010, 12:01 PM), <http://www.tnr.com/blog/jonathan-cohn/78098/Russ-Feingold-Campaign-Ad-Defends-Health-Care-Reform> ("Most Democrats campaigning for election right now have downplayed health care reform, except for those who have actually boasted of their votes against it.").

²⁷ Emily Schultheis, *DGA Funded Branstad 'Liberal' Ads*, POLITICO (July 15, 2010, 6:55 PM), <http://www.politico.com/news/stories/0710/39824.html>.

²⁸ Robert Pear, *Changing Stance, Administration Now Defends Insurance Mandate as a Tax*, N.Y. TIMES, July 18, 2010, at A14.

²⁹ *Thomas More Law Ctr. v. Obama*, 720 F. Supp. 2d 882, 895-96 (E.D. Mich. 2010).

³⁰ *Liberty Univ., Inc. v. Geithner*, No. 10-0015, 2010 WL 4860299, at *29 (W.D. Va. Nov. 30, 2010).

³¹ *Mead v. Holder*, No. 10-0950, 2011 WL 611139, at *25 (D.D.C. Feb. 22, 2011).

³² *Virginia ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768, 788 (E.D. Va. 2010).

³³ *Florida ex rel. Bondi v. U.S. Dep't of Health & Human Servs.*, No. 10-0091, 2011 WL 285683, at *40-41 (N.D. Fla. 2011); see also ACA LITIG. BLOG, <http://acaligationblog.blogspot.com/> (last visited Mar. 15, 2011) (collecting the filings in all cases).

disapproved of PPACA's individual mandate.³⁴ Voters in Colorado rejected a similar initiative by a narrow margin.³⁵

President Obama had promised that PPACA would not affect anyone's coverage,³⁶ but attempts to celebrate the six-month anniversary of PPACA's enactment were overshadowed by announcements that some insurers were withdrawing from the health insurance market entirely,³⁷ other insurers would no longer issue child-only policies,³⁸ and many were hiking their premiums to deal with the mandates and adverse-selection problems PPACA created.³⁹ Front-page news stories announced that PPACA's restrictions on medical loss ratios might cause major employers to drop coverage entirely unless they could ob-

³⁴ Merrill Matthews, *Arizona, Oklahoma Voters Reject ObamaCare Insurance Requirement*, FORBES: RIGHT DIRECTIONS (Nov. 3, 2010, 1:24 AM), <http://blogs.forbes.com/merrillmatthews/2010/11/03/three-states-voted-on-obamacare>.

³⁵ *Id.*

³⁶ See David A. Hyman, *Employment-Based Health Insurance: Is Health Reform a 'Game Changer?'*, N.Y.U. REV. EMP. BENEFITS & EXECUTIVE COMPENSATION 1A-1, 1A-18 to 1A-19 (2010) ("During the 2008 campaign, (then Senator) Obama routinely promised 'if you like your coverage you can keep it.' . . . President Obama repeated and expanded this claim during the battle over health reform, flatly claiming in a speech to the AMA that, 'no matter how we reform health care, we will keep this promise: If you like your doctor, you will be able to keep your doctor. Period. If you like your health care plan, you will be able to keep your health care plan. Period. No one will take it away. No matter what.'" (quoting President Barack Obama, Remarks at 2009 Annual Meeting of the AMA House of Delegates (June 15, 2009), available at <http://www.ama-assn.org/ama/pub/about-ama/our-people/house-delegates/2009-annual-meeting/speeches/president-obama-speech.page>)).

³⁷ See Reed Abelson, *Citing Law, Company Quits Health Insurance*, N.Y. TIMES, Oct. 1, 2010, at B1 ("The Principal Financial Group announced on Thursday that it planned to stop selling health insurance, another sign of upheaval emerging among insurers as the new federal health law starts to take effect. . . . Principal's decision closely tracks moves by other insurers that have indicated . . . that they plan to drop out of certain segments of the market, like the business of selling child-only policies.").

³⁸ *Id.*; see also Sarah Kliff & J. Lester Feder, *Child-Only Health Plans Endangered*, POLITICO (Jan. 27, 2011, 1:29 PM), <http://www.politico.com/news/stories/0111/48299.html> ("Health insurers in 34 states have stopped selling child-only insurance policies as a result of the health reform law, and the market continues to destabilize. . . . Twenty states now have no insurers offering child-only policies.").

³⁹ See, e.g., Bob Connors, *Health Care Reform Blamed for Huge Hike in Premiums*, NBC CONN. (Oct. 21, 2010, 3:37 PM), <http://www.nbcconnecticut.com/news/local/Health-Care-Reform-Blamed-for-Huge-Hike-in-Premiums-105041674.html> ("The state has given Anthem Blue Cross and Blue Shield the go ahead to raise premiums by as much as 47 percent for some members, and says health care reform is the reason why. . . . [Insurance Commissioner Thomas Sullivan said] the new rates included 'very rich benefits' mandated by federal law. . . . [Sullivan continued,] 'The rates that were filed and approved reflect the current cost to deliver care and the impact of more comprehensive benefit designs required under the federal healthcare reform law.'").

tain a waiver.⁴⁰ The Administration responded by expressing “outrage” at insurers’ failure to recognize that PPACA represents the triumph of good over evil and that insurers’ days of acting like price-gouging sociopaths were over.⁴¹ Behind the scenes, HHS granted scores of waivers in an increasingly frantic attempt to keep the bad press from overwhelming the celebration⁴²—a figure that climbed to more than 1000 in the intervening months.⁴³ The Administration announced the waivers on a webpage with the Orwellian heading, “Help-

⁴⁰ See, e.g., Janet Adamy, *McDonald’s May Drop Health Plan*, WALL ST. J., Sept. 30, 2010, at A1.

McDonald’s Corp. has warned federal regulators that it could drop its health insurance plan for nearly 30,000 hourly restaurant workers unless regulators waive a new requirement of the U.S. health overhaul. . . . Trade groups representing restaurants and retailers say low-wage employers might halt their coverage if the government doesn’t loosen a requirement for “mini-med” plans, which offer limited benefits to some 1.4 million Americans.

Id.

⁴¹ See Huma Khan, *Health Insurers Eliminate Child-Only Policies, Is It a Sign of Future Cutbacks?*, ABCNEWS.COM (Sept. 23, 2010), <http://abcnews.go.com/Politics/HealthCare/health-insurance-providers-administration/story?id=11701760> (“Administration officials agree that child-only policies represent only a small part of the individual market. Nevertheless, they expressed outrage at the move, saying insurance companies are trying to circumvent the new law.”).

Similarly, HHS Secretary Kathleen Sebelius threatened insurers that blamed price increases on health reform: “[T]here will be zero tolerance for this type of misinformation and unjustified rate increases. . . . [W]e will not stand idly by as insurers blame their premium hikes and increased profits on the requirement that they provide consumers with basic protections.” Letter from Kathleen Sebelius, Sec’y, U.S. Dep’t of Health & Human Servs., to Karen Ignani, President & Chief Exec. Officer, Am.’s Health Ins. Plans (Sept. 9, 2010), available at <http://www.hhs.gov/news/press/2010pres/09/20100909a.html>.

⁴² See Reed Abelson, *U.S. Turns to Waivers to Address Talk of Dropping Health Coverage*, N.Y. TIMES, Oct. 7, 2010, at B1 (“The waivers have been issued in the last several weeks as part of a broader strategic effort to stave off threats by some health insurers to abandon markets, drop out of the business altogether or refuse to sell certain policies.”).

⁴³ See Robert Pear, *Making Exceptions in Obama’s Health Care Act Draws Kudos, and Criticism*, N.Y. TIMES, Mar. 20, 2011, at A21 (observing that “the administration has relaxed the \$750,000 standard for more than 1,000 health plans covering 2.6 million people” and describing the efforts of states that have received or are seeking waivers); see also Robert Pear, *Four States Get Waivers to Carry out Health Law*, N.Y. TIMES, Feb. 17, 2011, at A18 (noting that Florida, New Jersey, Ohio, and Tennessee received “broad waivers . . . allowing health insurance companies to continue offering less generous benefits than they would otherwise be required to provide this year. . . . At a hearing of a House Energy and Commerce subcommittee, Republicans repeatedly asked: if the new law is so good, why have so many waivers been granted?”).

ing Americans Keep the Coverage They Have.”⁴⁴ For those keeping track at home, the sequence is as follows:

1. Promise everyone they can keep their coverage if PPACA is enacted;⁴⁵
2. Enact PPACA, which forces people to change their coverage because their insurer has responded to PPACA by withdrawing coverage entirely or threatening to do so;⁴⁶
3. Provide a waiver from PPACA to ensure that people won't lose their coverage;⁴⁷
4. Brag that you are “Helping Americans Keep the Coverage They Have” by providing a waiver from the law you enacted with the promise that people wouldn't lose their coverage.⁴⁸

Even PPACA's boosters acknowledge the daunting implementation challenges that lie ahead.⁴⁹

Despite—and perhaps because of—this record, PPACA functions as a political Rorschach test. To its enthusiasts, PPACA is a historic transformation that will dramatically broaden access, lower costs, reduce the deficit, and eliminate health care fraud, waste, and abuse. To its critics on the right, PPACA is a catastrophically misguided, ineffective, and unaffordable monstrosity, crammed down the throats of an unwilling public by special deals and legislative chicanery. To its critics on the left, PPACA is a disappointment of epic proportions; with control of the presidency and the House and a filibuster-proof majority in the Senate, the Democrats couldn't even deliver a public “option,” let alone a single payer.

PPACA has given rise to a massive amount of commentary—much of it devoted to an in-depth explication of why the writer's interpretation of PPACA (almost always chosen from one of the three options offered above) is the “correct” one. These explanatory efforts have been extremely persuasive to those who already agree with the writer's position, but they have proven to be less successful in reaching those who occupy one of the other two camps.

⁴⁴ *Helping Americans Keep the Coverage They Have and Promoting Transparency*, U.S. DEP'T OF HEALTH & HUMAN SERVS., http://www.hhs.gov/ocio/regulations/approved_applications_for_waiver.html (last visited Mar. 15, 2011).

⁴⁵ See *supra* note 36 and accompanying text.

⁴⁶ See *supra* notes 37-40 and accompanying text.

⁴⁷ See *supra* notes 42-43 and accompanying text.

⁴⁸ See *supra* note 44 and accompanying text.

⁴⁹ See generally Henry J. Aaron & Robert D. Reischauer, *The War Isn't Over*, 362 NEW ENG. J. MED. 1259 (2010) (cataloging various implementation challenges).

This Article focuses instead on lessons that reformers should have learned from transportation if they had actually wanted to reform the American health care system. Part I examines the mortality rate for the transportation of convicts from Britain and Ireland to America and Australia between 1718 and 1868. Part II considers the importance of three “I”s—incentives, institutions, and individuals—to the observed mortality patterns and connects these issues to several fundamental design defects in PPACA. Part III explores the importance of three additional “I”s—ignorance, incompetence, and ideology—in the design and implementation of PPACA. Finally, Part IV considers whether PPACA is sustainable, even taken on its own terms.

I. CONVICT TRANSPORTATION

Britain and Ireland shipped an estimated 50,000 convicts to America from 1718 to 1775⁵⁰ and 160,000 convicts to Australia from 1788 to 1868.⁵¹ The terms of the sentence, known as “transportation,” were clear and direct: “It is therefore ordered and adjudged by this Court, that you be transported upon the seas, beyond the seas, to such place as His Majesty, by the advice of His Privy Council, shall think fit to direct and appoint, for the term of your natural life,”⁵² or for a specified number of years. Once the convicts were transported, they were sold as indentured laborers for a specified term (when transported to America) or became the property of the governor to use as he saw fit

⁵⁰ A. ROGER EKIRCH, *BOUND FOR AMERICA: THE TRANSPORTATION OF BRITISH CONVICTS TO THE COLONIES, 1718–1775*, at 1 (1987); see also Kenneth Morgan, *Convict Transportation to Colonial America*, 17 REVS. AM. HIST. 29, 30 (1989) (book review).

⁵¹ SEAN O'TOOLE, *THE HISTORY OF AUSTRALIAN CORRECTIONS* 22 (2006). Although convicts were transported to a number of other locations (including Barbados, Jamaica, and Tangier), for the sake of simplicity this paper discusses only transportation to America and Australia.

Those transported are described throughout as “convicts.” While this description is accurate, it is important to note that the law imposed a sentence of transportation for such petty offenses as pickpocketing, vagrancy, prostitution, and stealing a meal or a small quantity of cloth. ALAN BROOKE & DAVID BRANDON, *BOUND FOR BOTANY BAY: BRITISH CONVICT VOYAGES TO AUSTRALIA* 95-102 (2005). Transportation was an exceedingly harsh punishment, but it was an improvement on the previous sentence for such offenses, which was death. See *id.* at 14-16 (describing the predominance of capital punishment in preceding centuries). For an overview of the demographics of convicts, including the offenses of which they had been convicted, see *id.* at 89-116. See also *THE AUSTRALIAN PEOPLE* 16-34 (James Jupp ed., 2001) (providing an extensive description of transported convicts).

⁵² ROBERT HUGHES, *THE FATAL SHORE: THE EPIC OF AUSTRALIA'S FOUNDING* 129 (Vintage Books 1988).

for the specified term (when transported to Australia).⁵³ The preamble to the Transportation Act of 1718 “made it clear that transportation was held to be a deterrent to crime, a punishment and a means of supplying the colonies with labour.”⁵⁴

Although Britain relied on transportation for almost two hundred years, the system became controversial. Supporters viewed it as a sensible way of ridding Britain of its criminal class, while opponents questioned whether it was a practical and cost-effective punishment.⁵⁵ Indeed, in 1810, Lord Chief Justice Ellenborough described transportation “as a summer’s excursion, an easy migration to a happier and better climate.”⁵⁶ Jeremy Bentham, who was trying to generate support for the “Panopticon,” had different concerns; from his perspective, transportation was costly, inhumane, and ineffective.⁵⁷

The literature on convict transportation to America and Australia is extensive, although the experiences of those sent to Australia are far better documented.⁵⁸ Sea travel was perilous, and those being transported were convicts—at a time when concern for the treatment of felons was far lower than it is today. How bad was convict mortality during transportation? For purposes of the analysis, I exclude deaths attributable to enemy navies, pirates, storms, and shipwrecks, and fo-

⁵³ See A.G.L. SHAW, *CONVICTS AND THE COLONIES: A STUDY OF PENAL TRANSPORTATION FROM GREAT BRITAIN AND IRELAND TO AUSTRALIA AND OTHER PARTS OF THE BRITISH EMPIRE* 30 (1966) (“The prisoner had to work for the public good; his services were ‘assigned’—in America to a settler, later, in Australia, to the governor.”).

⁵⁴ BROOKE & BRANDON, *supra* note 51, at 22.

⁵⁵ *Id.* at 32-33. See generally Frank Lewis, *The Cost of Convict Transportation from Britain to Australia, 1796-1810*, 41 *ECON. HIST. REV.* 507 (1988) (evaluating whether it was cost-effective to transport convicts to Australia).

⁵⁶ BROOKE & BRANDON, *supra* note 51, at 33.

⁵⁷ *Id.* at 33-34.

⁵⁸ Book-length treatments include *id.*; CHARLES BATESON, *THE CONVICT SHIPS, 1787-1868* (1959); BROOKE & BRANDON, *supra* note 51; FRANK CLUNE, *BOUND FOR BOTANY BAY: NARRATIVE OF A VOYAGE IN 1798 ABOARD THE DEATH SHIP HILLSBOROUGH* (1964); EKIRCH, *supra* note 50; GWENDA MORGAN & PETER RUSHTON, *EIGHTEENTH-CENTURY CRIMINAL TRANSPORTATION: THE FORMATION OF THE CRIMINAL ATLANTIC* (2004); O'TOOLE, *supra* note 51; and SHAW, *supra* note 53.

Articles on the subject include James Edward Gillespie, *The Transportation of English Convicts After 1783*, 13 *J. AM. INST. CRIM. L. & CRIMINOLOGY* 359 (1992); Farley Grubb, *Morbidity and Mortality on the North Atlantic Passage: Eighteenth-Century German Immigration*, 17 *J. INTERDISC. HIST.* 565 (1987); John McDonald & Ralph Shlomowitz, *Mortality on Convict Voyages to Australia, 1788-1868*, 13 *SOC. SCI. HIST.* 285 (1989); Mark Staniforth, *Deficiency Disorder: Evidence of the Occurrence of Scurvy on Convict and Emigrant Ships to Australia 1837 to 1839*, 13 *GREAT CIRCLE* 119 (1991), available at <http://ehlt.flinders.edu.au/archaeology/department/publications/staniforth/1991b.pdf>.

cus on onboard deaths—most of which were attributable to infectious diseases, including “gaol fever, smallpox, and dysentery.”⁵⁹

The literature on mortality during transportation to America is sketchy. Indeed, one of the only books on the subject of transportation to America devotes only six pages to the subject.⁶⁰ Another book on transportation devotes only a chapter to America (and nothing whatsoever to onboard mortality).⁶¹ To the extent records are available, they indicate that mortality was high when transportation began (10 to 14%), and staggeringly high on some voyages (40 to 50%).⁶² But over the course of the eighteenth century, mortality declined significantly. In one study of twelve voyages from Bristol during the period 1770-1775, onboard mortality was only 2.3%.⁶³ Similar declines in mortality were observed for the transportation of slaves, which fell to less than 5% by the end of the eighteenth century.⁶⁴ These figures may sound high, but the “Royal Navy’s rule of thumb calculation during the Napoleonic Wars was that one sailor in 30 would die of disease or accident Even in ships carrying free emigrants to the United States in the mid-nineteenth century, one in 30 died.”⁶⁵ For example, a study of German passengers to Pennsylvania during the period 1727-1805 found a mortality rate of 3.8%—although that figure was elevated since the author excluded all voyages on which there were no deaths.⁶⁶

Thus, by the end of the eighteenth century, mortality during the voyage had stabilized at roughly 2%. Since the voyage took 6 to 8 weeks, this was the equivalent of a death rate of 10 to 13 per 1000

⁵⁹ EKIRCH, *supra* note 50, at 103.

⁶⁰ *See id.* at 102-08. The book has a total of 277 pages, so the subject accounted for only 2% of the book.

⁶¹ *See* SHAW, *supra* note 53, at 21-37; *see also* BROOKE & BRANDON, *supra* note 51, at 20-24 (briefly discussing transportation to America).

⁶² *See* EKIRCH, *supra* note 50, at 103-05 (giving an average mortality rate of 10.7% for voyages between 1719 and 1736, and noting a voyage of the *Rappahannock* in which 48 of the 108 transported convicts died, a mortality rate of 44%).

⁶³ *Id.* at 104-05.

⁶⁴ *Id.* at 105. Slave transportation had higher mortality for a number of reasons, including the longer voyage. *Id.*

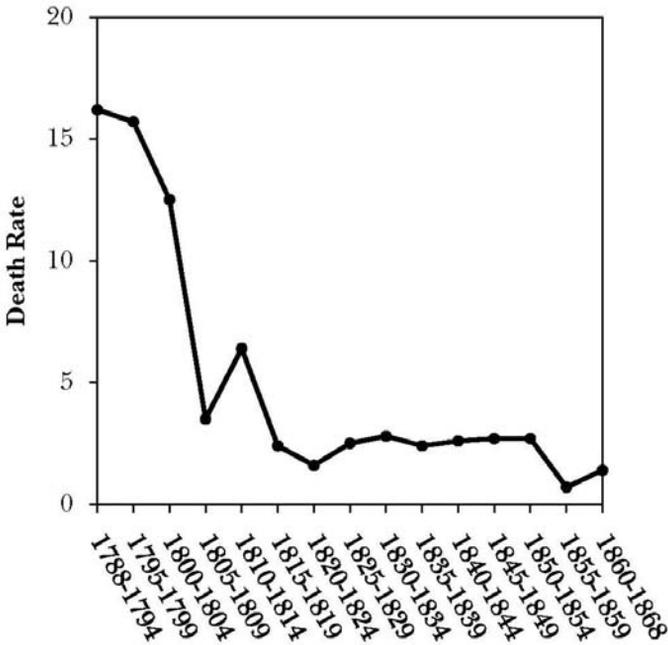
⁶⁵ BROOKE & BRANDON, *supra* note 51, at 165.

⁶⁶ Grubb, *supra* note 58, at 570 & n.10; *see also* James C. Riley, *Mortality on Long-Distance Voyages in the Eighteenth Century*, 41 J. ECON. HIST. 651, 655-56 (1981) (documenting higher risks for longer voyages, slaves, and “anyone venturing into a new epidemiological zone”).

transported convicts per month. The American Revolution put a stop to the transportation of convicts, and there was a twelve-year hiatus.⁶⁷

In 1786, the decision was made to found a penal settlement in Australia at Botany Bay, New South Wales.⁶⁸ The First Fleet (composed of six transports, three supply ships, and two warships) sailed for Australia in 1787 and arrived eight months later, in January 1788.⁶⁹ Over the intervening eighty years, more than 800 voyages were completed from Britain and Ireland to Australia.⁷⁰ Trip duration dropped significantly, and the ships varied in size, so one must control for those changes to compare onboard mortality over time. Figure 1 provides the results of that analysis.

Figure 1: Mean Death Rate Per 1000 Transported Convicts Per Month During Transportation to Australia, 1788–1868⁷¹



⁶⁷ See BROOKE & BRANDON, *supra* note 51, at 24 (“The American colonies ceased to be a destination for English convicts when the former gained their independence in the 1770s.”).

⁶⁸ *Id.* at 32-36.

⁶⁹ *Id.* at 42-46.

⁷⁰ *Id.* at 13.

⁷¹ The reported numbers are based on McDonald & Shlomowitz, *supra* note 58, at 288 tbl.1, which provides the mean monthly death rate per 1000 transported convicts.

As Figure 1 reflects, the mortality risk during 1788-1799 (15.7-16.2 dead per 1000 convicts per month) was comparable to the high-end estimate of mortality risk two decades earlier, during the final years of convict transportation to America. However, the mortality risk precipitously declined thereafter, stabilizing at a rate of roughly 2 dead per 1000 convicts per month for the last fifty-odd years of transportation. Figure 1 actually obscures the variance in mortality risk by presenting average mortality for all voyages during a five-year period (except for the initial and final periods, which average mortality for seven years and eight years, respectively). For example, during the sailing of the Second Fleet (January to June 1790), roughly 30% of the convicts died during the five-month voyage to Australia.⁷² Depending on the ship, this translated into a mortality risk ranging from 51 to 70 deaths per 1000 convicts per month.⁷³ Similarly high mortality was experienced on two ships that sailed in 1801 from Ireland to Australia.⁷⁴

Figure 1 also focuses solely on mortality during the voyage, but in the early years, many of those who made it to Australia were sick when they disembarked, and large numbers died shortly after reaching shore. A contemporaneous account gives a flavor of the scene when the Second Fleet arrived in Australia in 1790:

[N]early 450 [of the 828 convicts who made it to Australia alive] needed medical treatment when they reached Sydney. "Great numbers were not able to walk nor to move a hand or foot;" they were filthy, and "covered, almost, with their own nastiness," according to Chaplain Johnson who saw the disembarkation. "The slave trade is merciful compared with what I have seen in this fleet," wrote Captain Hill of the New South Wales Corps, who had travelled out in the *Surprize*.⁷⁵

Thus, Figure 1 actually downplays the risks of transportation to Australia during the early years. Despite this weakness, Figure 1 raises an obvious question: why did mortality during transportation drop dramatically beginning in 1800? Part II turns to this question and then evaluates the implications for health reform.

⁷² BATESON, *supra* note 58, at 111.

⁷³ Author's calculation.

⁷⁴ BATESON, *supra* note 58, at 161-68. The two ships, the *Hercules* and the *Atlas*, experienced mortality rates of 27% and 37%, respectively, translating into a mortality rate of 38 to 50 deaths per 1000 convicts per month. *Id.* at 162, 326 (with author's calculation). It was no accident that such high mortality was observed on ships that carried Irish convicts. See HUGHES, *supra* note 52, at 148-50 (noting that the Irish were "especially ill-treated" because "[m]any had been sent out for political offenses and . . . the captains feared mutiny").

⁷⁵ SHAW, *supra* note 53, at 108.

II. THE THREE “I”S OF TRANSPORTATION: INCENTIVES, INSTITUTIONS, AND INDIVIDUALS

What explains the drop in mortality during transportation, and what are the lessons for health reform? The short answer is that three “I”s—Incentives, Institutions, and Individuals—matter, both for transportation and for health reform. I consider each in turn.

A. *Incentives*

When incentives are misaligned, we should not be surprised that the results are not what we expected, let alone what we hoped for. Stated differently, rewarding *A* and expecting *B* is a recipe for disaster,⁷⁶ and that approach (at least in the early years of transportation to Australia) helps to explain the patterns of mortality described in Part I.

Private contractors were responsible for handling the actual transportation of convicts during almost all of the voyages, but the terms under which they were compensated changed in important ways over time. Each change in the contract terms affected the contractors’ economic incentives, which affected how closely they attended to the welfare of the convicts left in their charge.⁷⁷

From 1718 to 1775, the responsible governmental entities contracted with private contractors to transport convicts to America for a flat rate per head.⁷⁸ The amount paid per convict was strikingly modest, and there was effectively no regulation of the terms and conditions of passage—let alone supervision during the voyage.⁷⁹ Those responsible for transporting the convicts were tough-minded and ruthless, and they hired personnel who were at least as brutal, if not more so.⁸⁰ Indeed, many contractors alternated between transporting convicts and slaves—and used the same equipment for both groups of “passengers.”⁸¹

⁷⁶ See generally Steven Kerr, *On the Folly of Rewarding A, While Hoping for B*, 9 ACAD. MGMT. EXECUTIVE 7 (1995).

⁷⁷ As detailed in Section II.B, *infra*, there were also changes in the institutional arrangements on board, which influenced mortality rates as well.

⁷⁸ McDonald & Shlomowitz, *supra* note 58, at 287.

⁷⁹ See BATESON, *supra* note 58, at 4 (“The great defect in the organisation of transportation was the absence, until a comparatively late date, of any effective supervision during the voyage.”).

⁸⁰ EKIRCH, *supra* note 50, at 97-103.

⁸¹ *Id.* at 75. Those transported to America were known as “The King’s Passengers.” See generally PETER WILSON COLDHAM, *THE KING’S PASSENGERS TO MARYLAND AND VIRGINIA* (2006).

This arrangement could have been disastrous, but for the way in which property rights in the convicts were allocated. As noted above, on arrival in America, convicts were sold into indentured servitude.⁸² Contractors were entitled to the resulting proceeds.⁸³ Healthier convicts were worth more to buyers, so contractors had a direct economic incentive to ensure that convicts were in good health on landing. State regulation created an additional economic incentive: Virginia and Maryland enacted quarantine laws in 1766 that fined shipmasters “if they landed diseased convicts.”⁸⁴ And, of course, dead convicts had no economic value to the contractors.

These incentives meant that it was in the private contractors’ economic interest to ensure, to the extent possible, that their human cargo arrived in the colonies alive and in saleable condition.⁸⁵ Contractors responded by taking a variety of steps, including refusing to transport prisoners who were already sick when they were delivered, providing fresh clothing and blankets to those they transported, and improving conditions onboard the ships.

To be sure, these incentives did not work perfectly; many captains routinely chained convicts below deck in damp quarters for most of the voyage to prevent insurrection. Some captains also tried to limit expenses during the voyage, by restricting fresh water and provisions given to the convicts.⁸⁶ And there were occasionally outright disasters, when sadistic or incompetent captains were in charge:

At least a few captains, such as Edward Brockett of the *Rappahannock Merchant*, were totally unfit. During a voyage in 1725, Brockett frequently stayed drunk, squandered large quantities of provisions, and nearly wrecked the ship before it arrived in Virginia. . . .

The very worst excesses were revealed during the voyage of the *Justitia* in 1743. Under the command of Barnet Bond, the vessel carried some 170 felons from London to Maryland. Besides extorting money and

⁸² See *supra* note 53 and accompanying text.

⁸³ See EKIRCH, *supra* note 50, at 97.

⁸⁴ *Id.* at 107. Virginia’s quarantine law “was eventually disallowed by the crown, as was a similar statute in 1772.” *Id.*

⁸⁵ See *id.* at 97 (“[T]raders had a vital stake in the safe passage of transports, for, besides government fees, profits depended upon successful servant sales in America.”); see also BATESON, *supra* note 58, at 5-6 (“The contractors who had shipped convicts across the Atlantic had possessed a proprietary interest in their charges. The services of the prisoners, for the terms of their respective sentences, had been assigned to the contractors. The latter were at liberty to sell their interest in each convict to the highest bidder. . . . Financial considerations alone provided a powerful incentive to the contractors to land their prisoners in as healthy a state as possible.”).

⁸⁶ EKIRCH, *supra* note 50, at 97.

keelhauling disobedient prisoners, Bond set stringent water rations. Despite ample reserves of water on board, he allotted each transport only one pint a day. Some started to drink their own urine, and by the end of the voyage nearly fifty of them had died. Bond, who openly claimed their money and clothing, declared himself “Heir of all the Felons that should happen to dye under his Care.”⁸⁷

But such extreme instances were surprisingly rare, given the near-complete lack of regulatory restraints and the disinterest of the British government in the situation.

Compensation and property rights for transportation to Australia were structured quite differently. As detailed below, direct compensation to the shippers changed dramatically over time. But shippers never had an ownership interest in the convicts, who were to be turned over to the governor on arrival in Australia.⁸⁸ This was a completely different allocation of property rights than was the case with transportation to America, and it had disastrous consequences.

The First Fleet was provisioned, fitted out, and substantially staffed by the Royal Navy, although individual vessels were chartered through a shipbroker at a flat rate per ton.⁸⁹ The captain in charge of the First Fleet, Arthur Phillip, was also the designated governor of the penal settlement at Botany Bay—so he had a direct incentive to take all necessary steps to ensure the convicts arrived in good health.⁹⁰ Even though the First Fleet took eight months (including stops in Rio and the Cape of Good Hope), the onboard mortality rate was only 6.5 per 1000 convicts per month.⁹¹

In all subsequent voyages, private contractors were responsible for handling transportation.⁹² For the Second Fleet, and for several years thereafter, contractors were paid a flat rate for every convict that embarked in Britain, and they hired and paid all onboard personnel, with the exception of a naval agent and a commander of the guard, who were officers in the Royal Navy.⁹³ The naval agent could only be

⁸⁷ *Id.* at 101-02.

⁸⁸ See BATESON, *supra* note 58, at 5 (“This incentive of financial gain was absent from the Australian system.”).

⁸⁹ BROOKE & BRANDON, *supra* note 50, at 39-42.

⁹⁰ See BROOKE & BRANDON, *supra* note 51, at 44-46 (describing Phillip’s role as captain); SHAW, *supra* note 58, at 48 (describing Phillip’s “first Commission as Governor”).

⁹¹ Author’s calculations, based on BATESON, *supra* note 58.

⁹² See McDonald & Shlomowitz, *supra* note 58, at 287 (“Most convict voyages were undertaken by private contractors, who usually appointed the surgeons of the vessels.”).

⁹³ See *id.* (“[C]ontractors, masters, and surgeons were not paid by results, nor were they made directly accountable for their performance. Contractors were paid on a per capita basis whether the convict arrived dead or alive, and the pay of the master and

on one ship at a time, and his authority was ill-defined.⁹⁴ If the ship had a surgeon, he answered to the captain.⁹⁵

Because the contractors had no property interest in the convicts and were being paid a flat rate, they had no financial incentive to ensure the convicts arrived in good health. Indeed, if anything, they had the opposite incentive:

The contractors had no proprietary interest in the convicts. The services of the prisoners were assigned to them, but this was a legal formality: landing their charges the contractors were bound to transfer the assignments to the local governor or his deputy. Prohibited from selling the convicts' services, the contractors derived no financial benefit from landing them in a physically sound and healthy state. *Indeed, dead convicts were more profitable than the living, since every prisoner who died on the passage represented a saving in the expenditure on provisions.*⁹⁶

This issue was well understood by those involved. As a sailor on the Second Fleet noted in his diary:

The more they can withhold from the unhappy wretches, the more provisions they have to dispose of on a foreign market, and the earlier in the voyage they die the longer they can draw the deceased's allowance to themselves; for I fear few of them are honest enough to make a just return of the dates of their deaths to their employers.⁹⁷

Not coincidentally, when the Second Fleet arrived in Sydney, the first thing Captains Anstis and Traill (commanding the *Scarborough* and the *Neptune*, respectively) did "was to open a market on shore, selling the left-over food and clothing to the half-starved pioneers of the First Fleet."⁹⁸ Also not coincidentally, the *Scarborough* and the *Neptune* had a substantially higher death rate than the *Surprize*, the other ship in the Second Fleet.⁹⁹ Worst of all, those responsible for negotiating the contract had been warned about these risks but had gone ahead anyway. Sir Charles Middleton of the Admiralty reminded the Home Office in

surgeon was not conditional on satisfactory performance."); see also BATESON, *supra* note 58, at 5-6.

⁹⁴ McDonald & Shlomowitz, *supra* note 58, at 287-89.

⁹⁵ *Id.*

⁹⁶ BATESON, *supra* note 58, at 5-6 (emphasis added).

⁹⁷ HUGHES, *supra* note 52, at 146.

⁹⁸ *Id.*

⁹⁹ The Second Fleet had an overall mortality of 25.5%. BATESON, *supra* note 58. The death rate on the *Neptune* was 30.2%. *Id.* The death rate on the *Scarborough* was 27.1%. *Id.* The death rate on the *Surprize* was 14.2%. *Id.* Strikingly, excluding shipwrecks, during the eighty years of transportation to Australia, only one ship (the *Atlas*) had a higher raw death rate than the *Neptune* and the *Scarborough*, and the death rate on the *Atlas* was lower after accounting for trip duration. *Id.*

1786 that “the merchants who had taken convicts to America had ‘an interest in them after they were embarked,’ while on the voyage to Australia they had ‘no other advantage but the freight and the victualling, and take the risk of their Ships . . . upon themselves”¹⁰⁰

The disastrous experience of the Second Fleet caused “a small official flap . . . but memories were short and the victims, after all, were convicts.”¹⁰¹ The government promised a strict inquiry and criminal prosecution of those responsible.¹⁰² The inquiry was constrained because the government did not have any other good way to handle the ever-growing population of convicts, and any criminal prosecution would have to take place in England.¹⁰³ When two individuals were eventually tried for the death of a single convict, they were acquitted—and the firm that was responsible for the Second Fleet was hired to handle the Third Fleet!¹⁰⁴

A more significant legacy of the disastrous Second Fleet was the abandonment of the flat-rate payment structure.¹⁰⁵ Instead, the government began experimenting—first deferring payments to contractors (seventy-five percent of the fee when the convict embarked, and the balance when she landed) and then switching to success bonuses (one hundred percent of the standard fee for transportation, plus a bonus if the convict arrived alive, and a further bonus for masters and surgeons from the transport committee in England if the governor in Australia certified their “[a]ssiduity and [h]umanity”).¹⁰⁶ According to an 1862 speech by Edwin Chadwick, a prominent British economist, these arrangements transformed the system of transportation and the associated mortality risk:

Instead of contracts being made for the numbers embarked, payment was contracted for only for each person landed alive. This opened the eyes of shippers . . . and they engaged medical men and gave them means, and gave them, too, an interest in its instrumentary applications. The result was a reduction of the sickness and mortality . . . to about 1½ per cent. . . . [E]conomy beat sentiment and benevolence. It evoked unwonted care for the passengers, and secured to every poor man who died at least one sincere mourner. When the sentimentalist

¹⁰⁰ SHAW, *supra* note 53, at 108.

¹⁰¹ HUGHES, *supra* note 52, at 147.

¹⁰² *Id.*

¹⁰³ BATESON, *supra* note 58, at 18.

¹⁰⁴ *Id.*

¹⁰⁵ *Id.* at 20.

¹⁰⁶ *Id.* at 20-21; BROOKE & BRANDON, *supra* note 51, at 168.

and the moralist fails, he will have as a last resource to call in the aid of the economist¹⁰⁷

Although Chadwick's account gives all the credit for the decline in mortality risk to the changes in the financial structure of the contract for transportation, there were simultaneous changes in other institutional arrangements. Section II.B turns to the institutional setting of convict transportation and how it changed over time.

B. *Institutions*

The first set of institutions important to understanding why the mortality rate during transportation fluctuated are the gaols and hulks, where convicts were held until they were transported. Gaols were the only option from 1617 to 1775, and hulks and gaols were both used thereafter, depending on where the convict was located.¹⁰⁸ The gaols were jails, intended for short stays, and "notoriously unhealthy."¹⁰⁹ The hulks (prison ships anchored at Portsmouth, Deptford, and Woolwich, among other towns) were not much better.¹¹⁰

Once convicts left the gaols and hulks, they were assigned to individual ships for transport. Professors McDonald and Shlomowitz provide a nice summary of the institutional dynamics and how they changed over time:

Historians attribute the initially high mortality rates to a failure in organization. Most convict voyages were undertaken by private contractors, who usually appointed the surgeons of the vessels. These surgeons . . . had insufficient experience of naval conditions and authority to ensure that convicts would be well treated and that there would be an adequate system of sanitation on board. . . . [Further, their] advice could be (and on occasion was) overruled. . . . As a result of these organizational deficiencies, convicts were sometimes transported when known to be suffering from infectious diseases; masters sometimes defrauded convicts of part of their rations, did not keep their ships clean, did not isolate sick convicts, and mistreated convicts more generally.

In response to documentation of these abuses, a series of administrative reforms was gradually introduced: Medical officers were given in-

¹⁰⁷ Edwin Chadwick, Opening Address of the President of Section F (Economic Science and Statistics) of the British Association for the Advancement of Science (Oct. 1862), in 25 J. STAT. SOC. OF LONDON 502, 509 (1862).

¹⁰⁸ See McDonald & Shlomowitz, *supra* note 58, at 303 ("The impetus to the system of hulks came in 1776 . . .").

¹⁰⁹ EKIRCH, *supra* note 50, at 82.

¹¹⁰ McDonald & Shlomowitz, *supra* note 58, at 303-05 & tbl.4 (describing high death rates on the hulks).

creased authority to stop the transportation of sick convicts; contractors were paid by results . . . Finally, from 1815, surgeons were selected from the Royal Navy with the title “surgeon-superintendent” and were vested with the general control of the convicts.¹¹¹

These institutional changes were important. Prior to 1815, “most surgeons of convict ships were incompetent and were either students from the lecture room, or men who had failed in their profession and had taken to drink.”¹¹² These surgeons were easily overruled on-board, since they were hired by the contractor, answered to the captain, and had no independent authority.¹¹³ Similarly, those responsible for the hulks were repeatedly ordered not to send convicts out that were suffering from fever, but they still did so, “particularly [with convicts] from Ireland.”¹¹⁴

Once the transportation board took over responsibility for appointing superintendent-surgeons drawn from the ranks of the Royal Navy, there was a dramatic improvement in the quality of care transported convicts received.¹¹⁵ This change unquestionably reduced on-board mortality.¹¹⁶

In addition, there were a host of other institutional changes. The Transportation Board adopted regulations specifying “an imposing list of government demands. From the number of lifeboats to the size of rations, all was laid down, along with the exact responsibilities to convicts borne by captain, surgeon and officers.”¹¹⁷ One important institutional change was a prohibition on carrying cargo other than the convicts and stores for the voyage, as captains had been using cargo space that should have been devoted to convicts and their rations for other purposes.¹¹⁸ All of these institutional changes acted synergisti-

¹¹¹ *Id.* at 287-89; *see also* BATESON, *supra* note 58, at 10-57.

¹¹² John Pearn, *Surgeon-Superintendents on Convict Ships*, 66 *AUSTL. & N.Z. J. SURGERY* 253, 255 (1996) (quoting Surgeon William Redfern).

¹¹³ McDonald & Shlomowitz, *supra* note 58, at 287-89.

¹¹⁴ SHAW, *supra* note 53, at 113.

¹¹⁵ Pearn, *supra* note 112, at 255; *see also* BATESON, *supra* note 58, at 100-02.

¹¹⁶ *See* BATESON, *supra* note 58, at 253 (“The improvement [in death rates on the convict ships], unquestionably, was due primarily to the adoption of the system of appointing surgeon-superintendents, and to the policy of employing the same naval surgeons again and again . . .”).

¹¹⁷ HUGHES, *supra* note 52, at 144; *see also* BROOKE & BRANDON, *supra* note 51, at 165-68.

¹¹⁸ *See* BROOKE & BRANDON, *supra* note 51, at 169 (explaining that “to maximize profits,” companies “frequently . . . loaded their vessels with goods for which they knew there was a ready and profitable market in Australia,” but this practice was “expressly forbidden” in 1817).

cally with the changes in economic incentives outlined previously to make the voyage safer for those unfortunate enough to find themselves transported to Australia.

C. *Individuals*

Obviously, convict transportation involved many individuals. Some of these individuals behaved extremely badly, such as Captains Brockett and Bond¹¹⁹ and Captains Anstis and Traill of the Second Fleet.¹²⁰ In 1798, the captain of the *Hillsborough*, William Hingston, starved the prisoners and kept them in double irons below decks at night, resulting in high mortality—even though the contract specified a bonus would be paid for each convict landed alive.¹²¹ Similar complaints were raised against the captain and surgeon of the *Surrey*, which arrived in Australia in 1814.¹²² Others, however, behaved extremely well. During transportation to America, some merchants were noted for their concern for the convicts, providing high-quality clothing and food and hiring physicians for the voyage.¹²³

Predictably enough, the same range of conduct can be observed among government employees. On the hulks, prisoners routinely complained about theft, graft, sadism, and corruption.¹²⁴ Arthur Phillip, captain of the First Fleet and designated governor, refused to sail until he had pried the necessary provisions out of an indifferent Admiralty and Navy Board.¹²⁵ As noted above, Sir Charles Middleton warned the Home Office about the consequences of paying shippers a flat fee when they did not have an interest in whether their human

¹¹⁹ See *supra* note 87 and accompanying text.

¹²⁰ See BATESON, *supra* note 58, at 110-12.

¹²¹ HUGHES, *supra* note 52, at 148.

¹²² See Letter from Governor Macquarie to the Comm'rs of the Transp. Bd. (Oct. 1, 1814) ("I have much reason to apprehend that this destructive Disease originated in the mismanagement of two of the unfortunate Sufferers, namely the Captain and Surgeon . . ."), in 8 HISTORICAL RECORDS OF AUSTRALIA 274, 274 (1916). This report caused the Transportation Board to require superintendent-surgeons drawn from the Royal Navy. BROOKE & BRANDON, *supra* note 51, at 169-70.

¹²³ See EKIRCH, *supra* note 50, at 108 (citing James Cheston as an example of a captain who treated convicts remarkably well).

¹²⁴ See HUGHES, *supra* note 52, at 138-40 (describing prisoner mistreatment on the hulks).

¹²⁵ See SHAW, *supra* note 53, at 107 ("The government's initial preparations did them little credit. 'The garrison and convicts are sent to the extremity of the globe as they would be to America, a six weeks passage,' wrote Phillip tersely; but [the voyage was a success] thanks to his reiterated complaints (which should not, of course, have been necessary) [and] his thorough overhaul of the arrangements . . .").

cargo arrived alive and well, but he was ignored.¹²⁶ And, even after 1815, it mattered which surgeon-superintendent was on board.¹²⁷

The point is simple: incentives and institutions matter, and matter a lot, but so do individuals. And no system or policy is bullet-proof, no matter what precautions are taken.

D. *Implications for Health Reform*

What does convict transportation have to do with health reform? As indicated previously, incentives, institutions, and individuals are all important in getting what we want out of a system—whether our goal is to transport convicts from Britain and Ireland to America and Australia without undue mortality, or to deliver health care that is “safe, effective, patient-centered, timely, efficient, and equitable.”¹²⁸ The proponents of any change are likely to label it as “reform,” but the touchstone for whether a piece of legislation deserves that name is whether it actually affects incentives, institutions, and individuals in ways that make it more likely we will get what we actually want out of the system.

In health care, it is widely acknowledged that we have neither the appropriate incentives nor the proper institutions.¹²⁹ “With limited exceptions, our health care system relies on an encounter-based, quality-insensitive, fee-for-service system of compensation.”¹³⁰ In order to be paid, a health care provider must “physically interact with a patient or interpret a test that required direct physical interaction with the patient.”¹³¹ “Each such interaction generates a bill, with the amount varying greatly, depending on the nature of the service/interaction. However, payment does not vary based on the quali-

¹²⁶ See *supra* note 100 and accompanying text.

¹²⁷ See Pearn, *supra* note 112, at 255 (“The health of the convicts during the voyage was due primarily to the forcefulness and conscientiousness of the surgeon-superintendents and to the roles played by medical attendants The best of the former insisted on proper rations, appropriate diet, adequate ventilation and exercise, attention to safety and access to medical care.”). Although Pearn is careful not to point it out, those surgeon-superintendents who were not “the best” were unlikely to insist on better treatment and therefore unlikely to get as good results.

¹²⁸ COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 5-6 (2001), available at <http://www.nap.edu/openbook.php?isbn=0309072808>.

¹²⁹ See, e.g., David A. Hyman, *Health Care Fragmentation: We Get What We Pay For*, in THE FRAGMENTATION OF U.S. HEALTH CARE 21 (Einer Elhauge ed., 2010).

¹³⁰ David A. Hyman, *Follow the Money: Money Matters in Health Care, Just Like in Everything Else*, 36 AM. J.L. & MED. 370, 372 (2010).

¹³¹ *Id.*

ty of the service or on its medical necessity,”¹³² let alone whether it constituted optimal treatment. Although the absolute level of the bill per unit of service is tightly controlled, “[t]here are also almost no constraints on the volume of the services that may be provided.”¹³³

The consequences are predictable:

[W]e have a system that aggressively delivers massive quantities of health care services in a highly fragmented non-system, but pays little attention to whether the services in question actually contribute to health. Worse still, there is usually no “business case” for improving matters; delivering higher quality care and/or keeping one’s patients healthier can actually make a provider financially worse off.¹³⁴

Although this Article analyzes incentives and institutions separately, our institutional arrangements are built around the incentives our payment system creates.

Does PPACA actually address these problems? The short answer is that although a few provisions do attempt to address the incentive and institutional problems that beset the American health system, PPACA’s proponents had bigger fish to fry. PPACA accordingly focused on broadening access by means of insurance reform, rather than on changing the incentives driving health care treatment and overall spending or transforming the institutional arrangements through which care is delivered.

Indeed, on numerous occasions, Congress and the administration pulled their punches in addressing these problems—usually by trading stricter reforms in these areas for coverage provisions that they valued more highly. The result is that PPACA effectively went “all in” on the existing financing and delivery systems but did little to address the

¹³² *Id.*

¹³³ *Id.*

¹³⁴ *Id.* “A business case for quality exists when a provider can earn a profitable financial return on a quality-enhancing investment.” *Id.* at 372 n.3; see also DAVID BLUMENTHAL & TIMOTHY FERRIS, *THE BUSINESS CASE FOR QUALITY: ENDING BUSINESS AS USUAL IN AMERICAN HEALTH CARE*, at vii (2004), available at <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2004/Jul/The-Business-Case-for-Quality-Ending-Business-as-Usual-in-American-Health-Care.aspx> (“The absence of a ‘business case’ for improving the quality of health care—that is, evidence that health systems, providers, and others who invest in quality improvement will see a return on investment within a reasonable time frame—is widely acknowledged to be one of the most important obstacles to improving health care in the United States.”); Shella Leatherman et al., *The Business Case for Quality: Case Studies and an Analysis*, HEALTH AFF., Mar.–Apr. 2003, at 17, 18-19 (defining a “business case” and distinguishing it from other cases that can be made for improvements in health care).

cost problems that justified reform in the first place. I explained the core difficulty with this strategy in an earlier article:

[I]f you get the incentives right, most of the big problems will take care of themselves, leaving a far smaller and more tractable set of problems to be addressed through regulation, litigation, and benign neglect. But, if you don't get the incentives right, no amount of speeches, law review articles, op-eds, whining and hectoring, moral preening, regulatory oversight, legislation, lawsuits, or lectures about fairness and justice can take their place. Reformers should accordingly focus on getting the incentives right—and legislation that doesn't address the underlying incentive problem is not, in fact, "reform," no matter what else it may accomplish.¹³⁵

Or, as Sir Henry Maudsley memorably put it, "Reform, sir, reform? Don't talk to me of reform. Things are bad enough as they are."¹³⁶

III. THREE MORE "I'S": IGNORANCE, INCOMPETENCE, AND IDEOLOGY

Completeness requires some discussion of three additional "I's" that are likely to dog PPACA: ignorance, incompetence, and ideology. I consider each in turn.

A. Ignorance

Knowledge is power, but ignorance is the rule. Even if a government regulator somehow gets the knowledge necessary to address an issue, figuring out how to use the information and doing so effectively on a real-time basis is considerably more challenging—particularly with Congress looking over one's shoulder.

Consider the difficulties of running an administered pricing system like Medicare. Your goal is to pay the "just right" amount, but a number of complications arise. How much should prices vary by region? How much should prices vary by the type of provider delivering the service or the location at which the service is provided? Should higher-value or higher-cost services result in higher payment? Should lower-value services result in lower payment? Should payment rates incorporate an assessment of the social role of the institution (e.g., academic medical centers and safety-net institutions)? What about innovation? What is the correct price for new treatments and improvements in existing treatments?

¹³⁵ Hyman, *supra* note 130, at 387.

¹³⁶ See Chief Judge Irving R. Kaufman, Court of Appeals for the Second Circuit, Introductory Remarks at the Second Circuit Judicial Conference (Sept. 8, 1978) (quoting Maudsley in his opening address), *in* 82 F.R.D. 221, 297 (1979).

These problems are compounded by “voice”: providers who are “underpaid” relative to the market price will show up and protest loudly, while those who are “overpaid” relative to the market price will never volunteer that fact—and will manufacture arguments explaining why they deserve every penny. These problems are further compounded by politics: legislators will lobby for special deals for providers in their districts, frame payment formulas to deliver more cash to their states, and push back aggressively against attempts to fix even the most egregious problems. Consider what happened when Peter Orszag, then the head of the Office of Management and Budget, went to Capitol Hill in June 2009 to meet with a small group of House Democrats:

The meeting started well, with one lawmaker after another echoing his message that spending controls were critical to any health-care overhaul, according to two administration officials.

Then one member said her top priority was winning higher payments for oxygen suppliers, the officials say. Mr. Orszag was taken aback. Officials had been trying for years to cut payments to suppliers of oxygen and other medical equipment, which critics say are inflated. Yet when a new competitive bidding process was set to take effect last year, industry supporters in Congress were able to delay the plan. They are still fighting to block changes.¹³⁷

To be sure, this example illustrates both ignorance and the political economy of running an administered pricing system. But ignorance is likely to prove a major problem—particularly as the system one is trying to regulate becomes more complex, with more moving parts that interact with one another, and with other things. In such settings, there is considerable space for misunderstandings, miscommunications, and out-and-out mischief and misconduct. Worse still, centralized, top-down bureaucracies have very long decisionmaking cycles; by the time a decision has been made, the world has often moved on, and the decision cycle has to begin again. The core Hayekian insight is that centralized planning of the sort necessary to make PPACA “work” is infeasible even under the best of circumstances,¹³⁸ and health policy is never made under the best of circumstances.

¹³⁷ Laura Meckler, *Obama's Health Expert Gets Political*, WALL ST. J., July 24, 2009, at A1.

¹³⁸ See F. A. Hayek, *The Use of Knowledge in Society*, 35 AM. ECON. REV. 519, 524-25 (1945) (“[T]he economic problem of society is mainly one of rapid adaptation to changes in the particular circumstances of time and place We need decentralization because only thus can we ensure that the knowledge of the particular circumstances of time and place will be promptly used.”).

B. *Incompetence*

Incompetence is a harsh word, but it is a real phenomenon, and it complicates the design and implementation of all statutes. A preliminary caution: one should not lightly label any given decision as incompetent. The decision may be attributable to inadequate or inaccurate information (i.e., ignorance), rather than incompetence. Hindsight bias also colors our assessment, so we should evaluate decisions prospectively, using the information that was available to those making the decision and giving due deference to “judgment calls.” Finally, it is usually (but not always) wrong to label as “incompetent” a decision that resulted from differences in ideological preferences, tactics, or goals.¹³⁹ Even if one is mindful of these restrictions, PPACA provides several high-profile examples of out-and-out incompetence.

1. Front-Loading of Insurance Reform for Children

PPACA’s proponents had a problem. PPACA was not going to pass in Congress if its price tag was too high. The price tag was dictated by the scoring rules and ten-year budgetary window used by the Congressional Budget Office (CBO). To get a politically viable number, proponents thoroughly gamed the scoring process—by, among other things, front-loading the taxes and back-loading the benefits.¹⁴⁰ But that structure was a recipe for public opposition to PPACA—a fact that Congress had painfully learned twenty years earlier with the Medicare

¹³⁹ See *infra* Section III.C.

¹⁴⁰ See Hyman, *supra* note 36, at 1A-18, where I argue,

After considerable reverse engineering, PPACA incorporated a wide array of design features explicable only in terms of their ability to game the CBO budget process and its ten year budget window. These included front-loading of the taxes; back-loading of the benefits[;] excluding the costs of fixing the Medicare physician payment system; assuming cuts in Medicare that are unlikely to materialize; assuming a future Congress will allow the 40% excise tax on high-value benefits to take effect when the current Congress deferred its effective date; and my personal favorite, counting the revenue from a new voluntary long-term care insurance program (CLASS Act) as deficit reducing in the first decade of PPACA, even though those amounts must be paid out in the second decade, and the program is so actuarially unstable that the Chief Actuary of CMS warned before the program even began collecting premiums that there was a “very serious risk that the problem of adverse selection will make the . . . program unsustainable.”

Catastrophic Coverage Act of 1988.¹⁴¹ And opposition to PPACA was already so high that proponents were not looking for more push-back.

To address this problem, proponents decided to front-load some benefits. However, to the extent possible, the front-loaded benefits had to be off-budget or they would show up as costs in the CBO scoring, defeating the point of the exercise. PPACA accordingly front-loaded regulation of private insurance by requiring insurers to immediately offer “better” coverage, including increases in annual and lifetime limits,¹⁴² the ability to keep adult children on their parents’ policies until they reached the age of twenty-six,¹⁴³ and restrictions on rescissions and the percentage of premiums that could be spent on profit and overhead.¹⁴⁴

Many of these regulations were likely to increase premiums, but PPACA’s proponents apparently assumed that they could simply blame insurance companies for price-gouging, as they had done throughout the debate over health reform. But one specific front-loaded regulation had a far more dramatic impact. Effective six months post-enactment (September 23, 2010), PPACA banned the use of exclusions on preexisting conditions for coverage provided to children (aged eighteen and under).¹⁴⁵ The same prohibition was scheduled to go into effect for adults in 2014,¹⁴⁶ accompanied by an individual mandate that required every American to purchase coverage or pay a penalty.¹⁴⁷

The ban on preexisting conditions for children’s coverage that took effect on September 23, 2010, was not accompanied by a

¹⁴¹ Pub. L. No. 100-360, 102 Stat. 683 (codified as amended at scattered sections of 42 U.S.C.); see also David A. Hyman, *History’s Painful Lessons*, NAT’L REV. ONLINE (Aug. 20, 2009, 12:30 PM), <http://www.nationalreview.com/critical-condition/48448/historys-painful-lessons/david-hyman> (describing parallel public outcry against the two laws’ passage).

¹⁴² PPACA sec. 1001, § 2711, 42 U.S.C.A. § 300gg-11 (West Supp. 1A 2010).

¹⁴³ *Id.* sec. 1001, § 2714, 42 U.S.C.A. § 300gg-14.

¹⁴⁴ *Id.* sec. 1001, §§ 2712, 2718, 42 U.S.C.A. §§ 300gg-12, 300gg-18; see also *Answers for Families and Small Business*, HEALTHREFORM.GOV, <http://www.healthreform.gov/about/answers.html> (last visited Mar. 15, 2011) (describing these changes).

¹⁴⁵ PPACA sec. 1201, § 2704, 42 U.S.C.A. § 300gg-1 to -4; see also Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections, 75 Fed. Reg. 37188, 37190 (June 28, 2010) (describing the prohibition and noting that “for enrollees who are under 19 years of age, [it] becomes effective for plan years . . . beginning on or after September 23, 2010”).

¹⁴⁶ PPACA sec. 1201, § 2704, 42 U.S.C.A. § 300gg-1 to -4; *id.* § 1253, 42 U.S.C.A. § 300gg note; see also Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections, 75 Fed. Reg. 37,188, 37,190 (June 28, 2010) (“The prohibition generally is effective with respect to plan years . . . beginning on or after January 1, 2014 . . .”).

¹⁴⁷ PPACA § 1501, 10106, 26 U.S.C.A. § 5000A.

mandate to require the purchase of such coverage—at least not until 2014, when the mandate will go into effect for everyone.¹⁴⁸ This combination was a recipe for disaster, which struck in short order. Insurers substantially raised prices, some announced plans to withdraw entirely, and some of those selling individual policies to children announced that they would no longer do so.¹⁴⁹

Why does this particular design defect rise to the level of incompetence? During the debates over PPACA, the bill’s proponents repeatedly argued that the most important reason for an individual mandate was that it was the only way to eliminate the use of preexisting conditions without destabilizing the insurance market. Indeed, in the cases challenging the constitutionality of the individual mandate, the DOJ makes exactly that argument, claiming that it is “necessary and proper” to enact an individual mandate because otherwise the insurance regulations won’t work.¹⁵⁰

Worse still, during the 2008 presidential campaign, then-Senator Obama had embraced eliminating the preexisting condition term for children, coupled with a mandate requiring coverage¹⁵¹—effectively

¹⁴⁸ *Id.* § 1501(b), 26 U.S.C.A. § 5000A(a) (West Supp. 1A 2010); see also N.C. Aizenman, *Some Insurers to Halt New Child-Only Policies*, WASH. POST, Sept. 21, 2010, at A6 (explaining that “in 2014, when similar protections kick in for all individuals with preexisting conditions, virtually all Americans will be required to get health insurance,” but that “no such mandate [is] currently in place”).

¹⁴⁹ See, e.g., Aizenman, *supra* note 148 (“Some of the country’s most prominent health insurance companies have decided to stop offering new child-only plans, rather than comply with rules in the new health-care law . . .”); Dave Flessner, *Health Reform Leads to Drop in Child Insurance Plans*, TIMES FREE PRESS (Chattanooga, Tenn.), Sept. 25, 2010, at A1 (“Tennessee’s biggest health insurer will quit selling new child-only health insurance for individuals next week, joining an industry exodus from such plans . . .”); Julie Rovner, *Health Insurers Skirt New Coverage Requirement for Kids*, NPR SHOTS (Sept. 21, 2010, 9:04 AM), <http://www.npr.org/blogs/health/2010/09/21/130013723/colorado-insurers-skirt-new-coverage-requirement-for-kids> (cataloging numerous insurers dropping child-only plans in response to PPACA).

¹⁵⁰ See Kevin Sack, *Shifting Terrain in the Challenges to the Health Care Law*, N.Y. TIMES, Dec. 29, 2010, at A10 (explaining that DOJ “lawyers argue[] the insurance mandate is essential—both necessary and proper—to making other changes work, particularly prohibitions on discrimination by insurers against those with pre-existing medical conditions”). In the Florida litigation, Judge Vinson’s order granting summary judgment noted that the DOJ had argued that the individual mandate “is absolutely necessary for the Act’s insurance market reforms to work as intended. In fact, they refer[red] to it as an ‘essential’ part of the Act at least fourteen times in their motion to dismiss.” *Florida ex rel. Bondi v. U.S. Dep’t of Health & Human Servs.*, No. 10-009T, 2011 WL 285683, at *33 (N.D. Fla. Jan. 31, 2011).

¹⁵¹ See *Obama vs McCain on Health Care: Top 10 Issues*, USPHARM (Oct. 15, 2008, 8:16 AM), <http://www.uspharm.com/blog/2008/obama-vs-mccain-on-healthcare-top>

acknowledging that you could not easily get the former without the latter. So everyone involved knew or should have known what would happen but went ahead and did it anyway—and then blamed the insurance companies, rather than acknowledging that it was their own massive incompetence that caused the meltdown in the children’s coverage market.¹⁵²

2. Failure to Include a Severability Clause

PPACA does not include a severability clause. The House bill included a severability clause, but the Senate bill, which lacked a severability clause, became the basis for PPACA.¹⁵³ According to a Democratic aide who helped write PPACA, the omission of a severability clause was an “oversight.”¹⁵⁴ In the absence of a severability clause, a court must determine whether the statute would have passed without the disputed provision. If it would not have, the court must strike down the entirety of the statute,¹⁵⁵ which is exactly what a district court in Florida did on January 31, 2011, in the litigation brought by twenty-six states.¹⁵⁶ Even if those responsible for initially drafting PPACA thought the constitutionality of an individual mandate was a slam-dunk, it was still incompetent to omit a severability clause—particularly when opponents had made it clear they would challenge the constitutionality of the individual mandate.

There is a more charitable, albeit completely implausible, alternative interpretation. If striking down any provision in PPACA meant

10-issues (describing Obama’s position on health care reform during the presidential campaign).

¹⁵² The *Washington Post* describes a typical example blaming insurers. See Aizenman, *supra* note 148 (“We’re just days away from a new era when insurance companies must stop denying coverage to kids just because they are sick, and now some of the biggest changed their minds,” Ethan Rome, executive director of Health Care for America Now, an advocacy group, said in a statement. “[It] is immoral, and to blame their appalling behavior on the new law is patently dishonest.”). Such complaints are examples of the “chutzpah defense”—the defendant who kills both his parents and then throws himself on the mercy of the court because he is an orphan. If there is any “patent dishonesty” here, it is that of PPACA’s proponents.

¹⁵³ See Kevin Sack & Robert Pear, *Health Law Faces Threat of Rejection by Courts*, N.Y. TIMES, Nov. 27, 2010, at A11.

¹⁵⁴ See *id.*

¹⁵⁵ See *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 330 (2006) (“After finding an application or portion of a statute unconstitutional, we must next ask: Would the legislature have preferred what is left of its statute to no statute at all?”).

¹⁵⁶ See *Florida ex rel. Bondi v. U.S. Dep’t of Health & Human Servs.*, No. 10-0009T, 2011 WL 285683, at *38-39 (N.D. Fla. Jan. 31, 2011).

striking down the entirety of the statute, omitting a severability clause was one of the few policy levers with which proponents could try to win the game of “chicken” they were playing with the federal judges who would decide the constitutionality of PPACA.¹⁵⁷ However, it does not appear that any real consideration was given to the constitutionality of PPACA; individual legislators reacted with disbelief when the issue was raised with them.¹⁵⁸ As such, the omission of a severability clause was an example of rank incompetence, and not just a “sin of omission,” as PPACA’s enthusiasts have politely tried to describe it.¹⁵⁹

3. Behavioral Biases

Pre-enactment, health reform was not popular,¹⁶⁰ and it was clear that fixing the economy was a much higher priority for most Americans.¹⁶¹ But PPACA’s backers persisted, assuming the legislation would

¹⁵⁷ Cf. James DeLong, *California’s Multiplayer Version of Chicken*, ENTERPRISE BLOG (Nov. 8, 2010, 7:49 AM), <http://blog.american.com/?p=22270> (“[T]he way to win a two-car game of chicken is to take off your steering wheel and throw it out the window, thus showing the other player that you are committed to win or die.”). Herman Kahn was the first to formulate this strategy for winning a game of chicken, in a book on nuclear deterrence. HERMAN KAHN, *THINKING ABOUT THE UNTHINKABLE* 188 (1962).

¹⁵⁸ See, e.g., Press Release, Senator Patrick Leahy, Statement on the Constitutionality of the Patient Protection and Affordable Care Act (Mar. 24, 2010), available at http://leahy.senate.gov/press/press_releases/release/?id=b9033ad8-47f7-4d61-a1e7-9c571e77a243 (“Congress has acted within its constitutional authority to legislate for the general welfare of all Americans. No conservative activist court, on any level, should overstep the judiciary’s role by seeking to turn back the clock and deny a century of progress.”); Matt Cover, *When Asked Where the Constitution Authorizes Congress to Order Americans to Buy Health Insurance, Pelosi Says: ‘Are You Serious?’*, CNSNEWS.COM (Oct. 22, 2009), <http://www.cnsnews.com/node/55971> (“When CNSNews.com asked House Speaker Nancy Pelosi . . . where the Constitution authorized Congress to order Americans to buy health insurance . . . Pelosi dismissed the question by saying: “Are you serious? Are you serious?”); Debra Saunders, *Latest Pete Stark Video*, SFGATE TOKEN CONSERVATIVE (Aug. 2, 2010, 9:59 AM), http://www.sfgate.com/cgi-bin/blogs/djsaunders/detail?entry_id=69185 (showing a California Congressman asserting at a town hall meeting that “[t]he federal government . . . can do most anything in this country”).

¹⁵⁹ Brian Beutler, *An Error by Dems May Allow the Lawsuit Against Health Care Reform to Succeed*, TALKING POINTS MEMO (Nov. 30, 2010, 8:44 AM), <http://talkingpointsmemo.com/2010/11/conservative-suit-against-the-mandate.php>.

¹⁶⁰ See, e.g., Peter Suderman, *The Sisyphean Struggle to Sell ObamaCare*, REASON HIT & RUN (Mar. 21, 2011), <http://reason.com/blog/2011/03/21/the-sisyphean-struggle-to-sell> (presenting polling data indicating that health reform opponents have outnumbered supporters since June 2009).

¹⁶¹ See, e.g., PEW RES. CTR. FOR THE PEOPLE & THE PRESS, *PUBLIC’S PRIORITIES FOR 2010: ECONOMY, JOBS, TERRORISM 1* (2010), available at <http://people-press.org/files/legacy-pdf/584.pdf> (indicating that eighty-three percent of the public called the economy a “top priority,” while only fifty-seven percent felt similarly about health care); Jeffrey M. Jones, *Americans See More Priorities Vying for Obama’s Attention*,

become more popular postenactment.¹⁶² That decision was the result of a virtual catalog of behavioral biases in action. Optimism bias, check. Escalating commitment, check. The sunk-money fallacy, check. Salience bias, check. Confirmation bias, check. Herd behavior, check. Groupthink, check. Group polarization, check. Loss-aversion, check. Target fixation, check and mate.

Worse still, the very design of PPACA, with its centralization of regulatory authority and oversight, and the need for those responsible to make constant adjustments in implementation based on inadequate and flawed information, violates the “keep it simple, stupid” approach to regulatory design that Professor Richard Thaler, a leader in the field of behavioral economics, outlined in the *New York Times*: “Above all, I’d urge the head of [an] agency to devise rules under the assumption that, someday, he or she will be succeeded by a nitwit.”¹⁶³

None of this would rise to the level of incompetence unless the Obama Administration had proclaimed its expertise in behavioral economics and promised to avoid such behavioral biases—which, of course, it did.¹⁶⁴

GALLUP.COM (Oct. 28, 2009), <http://www.gallup.com/poll/123899/americans-priorities-vying-obama-attention.aspx> (citing similar polling results).

¹⁶² The same dynamic has persisted postenactment, prompting repeated efforts to “sell” PPACA to a (so far) unenthusiastic public. As one commentator described it in March 2011,

Poor Democrats. They’ve been insisting for over a year that if they just explain the health care overhaul’s “benefits” a little better, the public will eventually catch on and the law will become popular. Every few months they launch a new project intended to sell the law’s virtues; here we are, for example, at the law’s one year anniversary, and according to *The Hill*, the law’s backers are prepping yet another please-like-me PR mission. Almost inevitably, this campaign, like all those before it, will be followed by someone somewhere noticing that the needle on public opinion has yet to turn in favor of the law.

Suderman, *supra* note 160.

¹⁶³ Richard H. Thaler, Op-Ed., *Level Playing Fields*, in *Soccer and Finance*, N.Y. TIMES, July 25, 2010, at BU5.

¹⁶⁴ See Noam Scheiber, *The Audacity of Data*, NEW REPUBLIC, Mar. 12, 2008, at 27 (noting how behavioral economics has shaped the policy details and overall sensibility of the Obama Administration); Michael Grunwald, *How Obama Is Using the Science of Change*, TIME (Apr. 2, 2009), <http://www.time.com/time/magazine/article/0,9171,1889153,00.html> (describing the influence of behavioral economics on the Obama campaign and Administration). There is some indication that the enthusiasm for behavioral economics was waning before PPACA’s enactment. See Jonathan Weisman, *Economic Policy ‘Nudge’ Gives Way to a Shove*, WALL ST. J., Mar. 8, 2010, at A2 (“A little more than a year into its ascendancy at the White House, behavioral economics as a key policy-making tool may be on the wane.”).

4. Other Examples

These are not the only instances of rank incompetence. Those interested in more examples might examine the CLASS Act (which even the Administration now acknowledges is fatally flawed)¹⁶⁵ and Commerce Secretary Gary Locke's attempts to demonstrate his newly discovered expertise in analyzing GAAP tax accounting and securities disclosures relating to the financial impact of PPACA.¹⁶⁶

C. Ideology

When it comes to health care (and pretty much everything else), the two political parties have different priorities, strategies, and views of the appropriate role of government.¹⁶⁷ Everyone involved filters the information they receive and their assessments of the issues through their preexisting frames.

Ideology obviously mattered greatly in the design of PPACA, and it will matter even more in its implementation. But it also matters in terms of how PPACA is assessed. Those who are ideologically sympathetic to PPACA's goals and sponsors will be inclined to hail its virtues, ignore or discount its shortcomings, and give it the benefit of every reasonable doubt. Those who are ideologically opposed will have the opposite predispositions. Given this dynamic, it is unsurprising that proponents and opponents have each emphasized the political affiliation of the district judges that have ruled on the constitutionality of PPACA. Three judges nominated by Democrat Presidents have upheld PPACA, and two judges nominated by Republican Presidents have struck down some or all of PPACA.¹⁶⁸ To the extent commenta-

¹⁶⁵ See *supra* note 140; see also Robert Pear, *Long-Term Care Plan Needs Changes to Last, Federal Officials Say*, N.Y. TIMES, Feb. 22, 2011, at A18 ("Administration officials, who played down . . . concerns 15 months ago, say they now share them. Under questioning by a Republican at a Senate hearing last week, Ms. Sebelius said the original version of the program, known as Community Living Assistance Services and Supports, or Class, was 'totally unsustainable.'"). See generally Richard L. Kaplan, *Financing Long-Term Care After Health Care Reform*, J. RETIREMENT PLAN., July–Aug. 2010, at 7 (summarizing and evaluating CLASS).

¹⁶⁶ See Hyman, *supra* note 140.

¹⁶⁷ See N. Gregory Mankiw, Op-Ed., *How to Break Bread with the Republicans*, N.Y. TIMES, Jan. 2, 2011, at BU6 (describing Democrats' and Republicans' differing priorities and regulatory strategies).

¹⁶⁸ See, e.g., Nedra Pickler, *Obama Health Care Lawsuit Rejected by U.S. District Judge Gladys Kessler*, POLITICALTRUTHS.INFO (Feb. 22, 2011, 8:05 PM), <http://politicaltruths.info/2011/02/22/another-judge-throws-out-challenge-to-healthcare-reform-bill.aspx>.

tors are drawn from a broad cross-section of views, this “cheering for the home team” dynamic has no real impact. But if those who are analyzing PPACA are drawn from only one sliver of the political spectrum, there are likely to be a variety of well-established adverse consequences, including groupthink and group polarization.¹⁶⁹

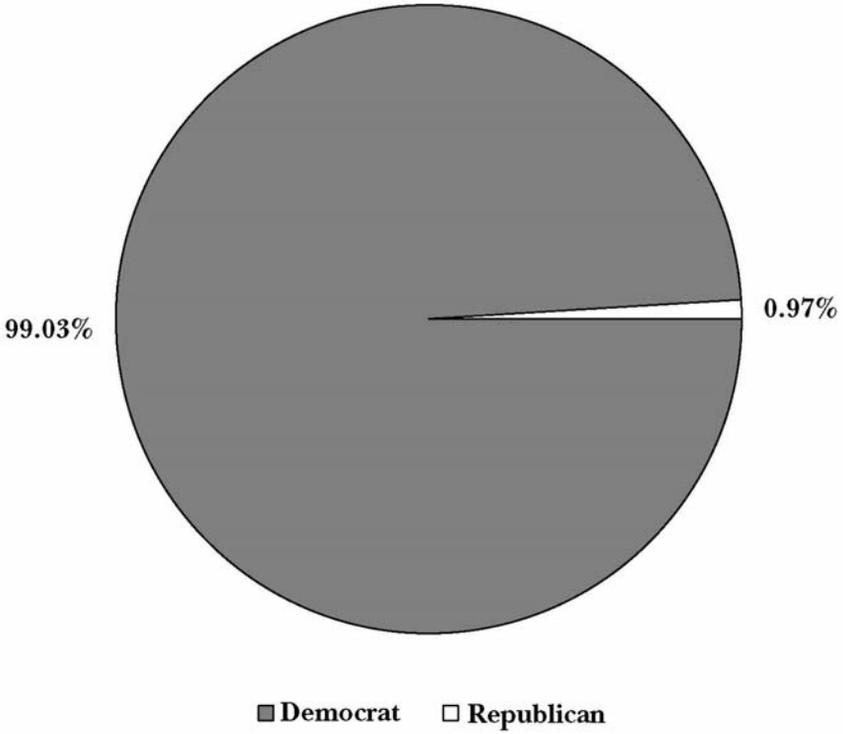
How big a problem are groupthink and group polarization likely to be for those commenting on PPACA? As a first cut at the issue, I obtained details of the campaign contributions made by all the speakers and moderators at this Symposium from a comprehensive online database that obtains and posts details of all contributions reported to the Federal Election Commission (FEC).¹⁷⁰ After excluding foreign nationals and the hospital administrator who provided the keynote address, approximately two-thirds of the academic participants (nineteen of thirty) had made a contribution during the twenty-year period the website covers (1990–2010).¹⁷¹ Total contributions were roughly \$52,000. Figure 2 provides a breakdown of the amounts contributed to Democrats and Republicans (and associated parties and PACs) by speakers at the Symposium.

¹⁶⁹ See generally IRVING L. JANIS, VICTIMS OF GROUPTHINK (1972) (arguing that a psychological phenomenon exists in which groups strive for unanimity at the expense of critical thinking); CASS R. SUNSTEIN, GOING TO EXTREMES (2009) (evaluating the causes of group polarization); Robert S. Baron, *So Right It's Wrong: Groupthink and the Ubiquitous Nature of Polarized Group Decision Making*, 37 ADVANCES EXPERIMENTAL SOC. PSYCH. 219 (2005) (reviewing data that confirms that groupthink occurs more broadly than originally hypothesized).

¹⁷⁰ See *Donor Lookup*, OPENSECRETS.ORG, <http://www.opensecrets.org/indivs/index.php> (last visited Mar. 15, 2011). This is not the first time campaign contributions have been used to assess such matters. See generally John O. McGinnis et al., *The Patterns and Implications of Political Contributions by Elite Law School Faculty*, 93 GEO. L.J. 1167 (2005).

¹⁷¹ I excluded the hospital executive because he is subject to different incentives to contribute than the other speakers. I excluded foreign nationals because they are prohibited by federal law from contributing to campaigns, although they may contribute to PACs. I assumed that all foreign nationals (judged by institutional affiliation) listed in the program were not permanent residents of the United States who are allowed to make contributions to campaigns.

Figure 2: Campaign Contributions to Democratic and Republican Candidates, Parties, and PACs for Speakers and Moderators at the 2010 *University of Pennsylvania Law Review* Symposium¹⁷²



¹⁷² Campaign contributions as reported by opensecrets.org on searches run from September 30, 2010, to October 6, 2010. Moveon.org was classified as a Democrat PAC. The contributions of nineteen speakers and moderators were recorded, and these contributions totaled \$51,328.

These findings have important limitations. Only two-thirds of those who spoke contributed an amount sufficient to be reported to the FEC. Some of the contributions are remote in time (although most are not). Finally, the fact that someone has contributed to a Democratic candidate does not necessarily indicate that the donor is supportive of any and all Democratic initiatives, including PPACA.

That said, Figure 2 is so skewed that it raises serious questions. Among social psychologists, one prominent researcher argued that a less skewed distribution of political views reflected the existence of a “tribal-moral community” with a “statistically impossible lack of diversity” that is “united by sacred values that hinder research and damage their credibility.”¹⁷³ Indeed, if we employed the standards that apply to judicial disqualification, many of the participants in the Symposium would not be allowed to opine on the merits of PPACA, since their sizeable contributions to Democrats (and Democrats only) provide sufficient evidence of bias that their impartiality might reasonably be questioned.¹⁷⁴ Those inclined to dismiss Figure 2 should ask themselves whether they would be quite so blasé if the skew were in the opposite direction.¹⁷⁵

To be sure, it is a different question whether the patterns documented in Figure 2 apply more broadly. Polling data provides some evidence on that question: in February 2011, “more than nine of 10 leaders in health care and health care policy believe the general direction set by [PPACA] is appropriate, with nearly seven of 10 favoring

¹⁷³ John Tierney, *Social Scientist Sees Bias Within*, N.Y. TIMES, Feb. 8, 2011, at D1 (quoting Jonathan Haidt).

¹⁷⁴ See 28 U.S.C. § 455(a) (2006) (“Any justice, judge, or magistrate judge of the United States shall disqualify himself in any proceeding in which his impartiality might reasonably be questioned.”). It is also possible that 28 U.S.C. § 455(b), which provides that a judge shall disqualify himself “[w]here he has a personal bias or prejudice concerning a party,” provides the necessary basis for disqualification.

¹⁷⁵ Cf. Tierney, *supra* note 173 (“‘Anywhere in the world that social psychologists see women or minorities underrepresented by a factor of two or three, our minds jump to discrimination as the explanation,’ said Dr. Haidt, who called himself a long-time liberal turned centrist. ‘But when we find out that conservatives are underrepresented among us by a factor of more than 100, suddenly everyone finds it quite easy to generate alternate explanations.’”).

To be sure, self-selection might explain some of the skew. See Michael F. Cannon, *Friends Want Friends to Do Health Care*, NAT’L REV. ONLINE (Oct. 16, 2007, 7:00 AM), <http://www.nationalreview.com/articles/222513/friends-want-friends-do-health-care/michael-f-cannon> (“I have a joke I tell my fellow health-policy wonks. It goes like this: What do conservatives and Christian Scientists have in common? *Wait for it* . . . They don’t do health care. *Zinggg!*”). However, self-selection does not defuse the risks of groupthink and group polarization; if anything, it increases them.

implementing the law with little or no change.”¹⁷⁶ Public support for PPACA is far lower, to say the least.¹⁷⁷

For those who prefer the point in the form of a joke, I return to the theme of PPACA as a Rorschach test:

A man goes to a psychiatrist. To start things off, the psychiatrist suggests they start with a Rorschach test. He holds up the first picture and asks the man what he sees.

“A man and a woman making love in a park,” the man replies.

The psychiatrist holds up the second picture and asks the man what he sees. “A man and a woman making love in a boat.”

He holds up the third picture. “A man and a woman making love at the beach.” This goes on for the rest of the set of pictures; the man says he sees a man and a woman making love in every one of the pictures.

At the end of the test, the psychiatrist looks over his notes and says, “It looks like you have a preoccupation with sex.”

And the man replies, “Well, you’re the one with the dirty pictures.”¹⁷⁸

Finally, for those who prefer Latin, *caveat lector*.

¹⁷⁶ KRISTOF STREMIKIS ET AL., THE COMMONWEALTH FUND, DATA BRIEF, PUB. NO. 1481, HEALTH CARE OPINION LEADERS’ VIEWS ON CONGRESSIONAL PRIORITIES 1 (2011), available at <http://www.commonwealthfund.org/Content/Publications/Data-Briefs/2011/Feb/Views-on-Congressional-Priorities.aspx>. The response rate for this survey was only fifteen percent, *id.* at 2, but the findings were consistent with previous surveys (with comparable response rates) conducted by Harris Interactive on behalf of the Commonwealth Fund. See KRISTOF STREMIKIS ET AL., THE COMMONWEALTH FUND, DATA BRIEF, PUB. NO. 1387, HEALTH CARE OPINION LEADERS’ VIEWS ON HEALTH REFORM, IMPLEMENTATION AND POST-REFORM PRIORITIES 2 (2010), available at <http://www.commonwealthfund.org/Content/Publications/Data-Briefs/2010/Apr/Health-Care-Opinion-Leaders-Views-on-Health-Reform-Implementation-and-Post-Reform-Priorities.aspx> (“Nearly nine of 10 respondents felt that reform will successfully expand access to affordable health insurance for Americans without coverage. Large majorities support key elements of the comprehensive reform package, including income-related premium subsidies, new insurance exchanges and market rules, and payment reform initiatives.”).

¹⁷⁷ See *supra* note 160 and accompanying text; see also Fred Barnes, *Obamacare on the Ropes*, WKLY. STANDARD, Feb. 14, 2011, at 15 (noting that PPACA’s “poll numbers fell in 2009, worsened in 2010, and haven’t improved in 2011. . . . A CNN poll in January found that 50 percent favor repeal of all Obamacare’s provisions. Quinnipiac put support for repeal at 48 percent, Gallup at 46 percent, both pluralities.”).

¹⁷⁸ *Funny Doctor Jokes*, COMEDY ZONE, <http://www.comedy-zone.net/jokes/laugh/doctor/doctor021.htm> (last visited Mar. 15, 2011).

IV. SUSTAINABILITY

The Obama Administration enthusiastically advocates sustainability. During the campaign, then-Senators Obama and Biden issued a fact sheet on environmental issues that used the word “sustainable” nine times in nine pages.¹⁷⁹ The Obama Administration issued an executive order on sustainability,¹⁸⁰ developed a roadmap for “ecosystem restoration focused on resiliency and sustainability” in the Gulf Coast,¹⁸¹ sought to “promote sustainable communities,”¹⁸² and takes every opportunity to tout the benefits of “green jobs” and other environmentally friendly initiatives.

Ironically, sustainability provides an apt metaphor for a signal failing of PPACA that has attracted little attention. PPACA consists of multiple interlocking and interdependent components. Each of these components has to be competently staffed, adequately funded, and effectively implemented. The announcement for the symposium at which this Article was presented gives some indication of the magnitude of what must be done:

Through the enactment of the Patient Protection and Affordable Care Act, Congress has authorized a massive and complex statutory scheme that creates new regulatory institutions, imposes an unprecedented mandate on individual citizens, regulates private insurance companies in rigorous new ways, and expands and transforms existing federal bureaucracies like Medicare and Medicaid.¹⁸³

“Massive.” “Complex.” “New regulatory institutions.” “An unprecedented mandate.” “Regulat[ion] . . . in rigorous new ways.” “Expand[ed] and transform[ed] . . . federal bureaucracies.” What could possibly go wrong?

¹⁷⁹ *Barack Obama and Joe Biden: Promoting a Healthy Environment*, OBAMA FOR AM., <http://www.barackobama.com/pdf/issues/EnvironmentFactSheet.pdf> (last visited Mar. 15, 2011).

¹⁸⁰ Exec. Order No. 13,514, 74 Fed. Reg. 52,117 (Oct. 9, 2009) (establishing an “integrated strategy towards sustainability in the Federal Government”).

¹⁸¹ Press Release, Exec. Office of the President, Council on Env'tl. Quality, Obama Administration Officials Release Roadmap for Gulf Coast Ecosystem Restoration Focused on Resiliency and Sustainability (Mar. 4, 2010), *available at* http://www.whitehouse.gov/administration/eop/ceq/Press_Releases/March_4_2010.

¹⁸² Press Release, U.S. Dep't of Hous. & Urban Dev., Top Obama Administration Officials to Promote Sustainable Communities, Environmental Justice at Smart Growth Conference (Feb. 4, 2010), *available at* http://portal.hud.gov/hudportal/HUD?src=/press/press_releases_media_advisories/2010/HUDNo.10-030.

¹⁸³ E-mail from Tom Baker, William Maul Measey Professor of Law & Health Scis., Univ. of Pa., to David A. Hyman, Richard W. & Marie L. Corman Professor of Law, Univ. of Ill. Coll. of Law (May 11, 2010, 14:32 EST) (on file with author).

Assume for the sake of argument that all of the necessary implementation decisions will be made by all-knowing angels (which, last time I checked, were in short supply) working in the bowels of federal office buildings (of which there is no shortage) using perfect information (which is always in short supply). Even in that unlikely set of circumstances, future Congresses and future administrations will have their own set of priorities, and they will systematically torque PPACA in ways that its proponents did not anticipate.

Consider a few possibilities. What will happen when Congress bows to constituent pressure and dismantles, delays, or limits the effect of particular components, such as the individual mandate and the tax on high-cost health plans? What will happen when funding (and cuts) of the specified amounts are not forthcoming? What will happen when shortages of physicians develop? What will happen when regulators are unable to overcome the informational and incentive problems that have beset previous attempts to dictate policy from the center? What will happen when Medicare beneficiaries realize that PPACA cuts their expected benefits and are unsatisfied with the too-cute-by-half response that PPACA doesn't cut their "guaranteed benefits?"¹⁸⁴ What will happen when the first (and second, and third, and nth) complaint about rationing is brought? How will PPACA withstand the hard knocks that will beset it at every turn from supposed friends and sworn enemies—particularly when a majority of states (which have primary responsibility for implementing the exchanges) have filed suit seeking to have PPACA declared unconstitutional¹⁸⁵ and the House of Representatives has already voted to repeal the statute?¹⁸⁶

Let me be concrete. The individual mandate is extremely unpopular—as is the penalty for noncompliance,¹⁸⁷ the mandatory filing of 1099s,¹⁸⁸ and the allocation of enforcement responsibility for both ob-

¹⁸⁴ See *Mayberry Misleads on Medicare*, FACTCHECK.ORG (July 31, 2010), <http://factcheck.org/2010/07/mayberry-misleads-on-medicare> (describing "guaranteed" as "a weasel word—a qualifier that sucks the meaning out of a phrase in the way that weasels supposedly suck the contents out of an egg").

¹⁸⁵ See, e.g., Editorial, *On Second Thought*, N.Y. TIMES, Mar. 10, 2011, at A30 (noting that twenty-six states joined a single lawsuit challenging PPACA in a Florida district court).

¹⁸⁶ Repealing the Job-Killing Health Care Act, H.R. 2, 112th Cong. (as passed by House of Representatives, Jan. 19, 2011); see also David M. Herszenhorn & Robert Pear, *As Vowed, House Votes to Repeal Health Care Law*, N.Y. TIMES, Jan. 20, 2011, at A1.

¹⁸⁷ PPACA § 1501(b), 26 U.S.C.A. § 5000A(b) (West Supp. 1A 2010).

¹⁸⁸ While this Article was in press, the mandatory filing of 1099 forms that PPACA had required was repealed with strong bipartisan support. See Comprehensive 1099

ligations to the IRS. The subsidies for individuals buying coverage through the exchanges are expensive.¹⁸⁹ The Medicare cuts that were added to satisfy the CBO are almost certainly nonstarters, or they will be once Medicare beneficiaries figure out that “their” money is being used to fund PPACA.

All of these provisions will be in play for a future Congress, which will feel no allegiance to the bargains the Obama Administration and a previous Congress struck—particularly when the cost of those bargains was foisted onto a future administration and Congress and the benefits were not sufficient to keep the Democrats from losing sixty-three seats (and their majority) in the House, as well as six seats in the Senate.¹⁹⁰ More broadly, PPACA’s lack of design redundancy means the statutory framework is exquisitely vulnerable to monkey-wrenching—and there is no shortage of people who are devoting considerable effort and creativity to finding ways of doing precisely that.¹⁹¹

Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011, Pub. L. No. 112-9, §§ 2–3, 125 Stat. 36 (to be codified at I.R.C. § 6041).

¹⁸⁹ The Congressional Budget Office originally scored the cost of these subsidies over the ten-year budgetary window at \$464 billion. HINDA CHAIKIND ET AL., CONG. RESEARCH SERV., R40902, PRIVATE HEALTH INSURANCE PROVISIONS IN PPACA (P.L. 111-148), at 2 (2010), available at http://bingaman.senate.gov/policy/crs_privhins.pdf. Because the subsidies don’t take effect until 2014, this means the subsidies will cost at least \$77 billion per year, although other estimates are higher.

¹⁹⁰ Jeff Zeleny, *G.O.P. Takes House; Reid Is Re-Elected and Keeps Leader’s Job*, N.Y. TIMES, Nov. 3, 2010, at A1. Stated in “econ-speak,” the Obama Administration and the Democratic majority in the 110th Congress deliberately created a program with massive negative externalities that future administrations, Congresses, and taxpayers will bear. None of those groups will feel a compelling obligation to internalize those costs.

¹⁹¹ See, e.g., David Brooks, Op-Ed., *Buckle Up for Round 2*, N.Y. TIMES, Jan. 7, 2011, at A19 (cataloging the ways in which the Republicans can make implementation of PPACA difficult); Albert R. Hunt, *In Congress, the Minority Is Just That*, N.Y. TIMES (Oct. 3, 2010), <http://www.nytimes.com/2010/10/04/us/04iht-letter.html?ref=global-home> (observing that Republicans “could wreak havoc with the measure’s implementation by denying monies for creating insurance exchanges to help 30 million uninsured Americans get coverage; not funding the Department of Health and Human Services or new enforcement agents for the Internal Revenue Service; and refusing to approve complicated rules and regulations”); see also Kristen Gerencher, *Where the Health-Reform Fight Will Go Next*, MARKETWATCH (Jan. 26, 2011, 12:00 AM), <http://www.marketwatch.com/story/where-the-health-reform-fight-will-go-next-2011-01-26> (“How successful could Republicans be in undoing the law? Virtually no one is certain, but many experts agree they could slow or derail its implementation by cutting funds necessary to staff federal agencies tasked with overseeing parts of the new law. They also could call constant hearings that raise the volume on controversial issues again. The use of ‘riders,’ where members of Congress attach additional proposals to bills considered must-haves by the president, is a common tactic as well.”); Jessica Rettig, *10 Ways the GOP Can Take Down Obamacare*, U.S. NEWS POL., <http://www.usnews.com/news/slideshows/10-ways-the-gop-can-take-down-obamacare> (last visited Mar. 15, 2011).

The fight then becomes about who will take the blame for the resulting train wreck. So long as PPACA's opponents can avoid a complete government shutdown over repeal, they can subject PPACA to the death of a thousand cuts, complete with repeated oversight hearings, floor speeches decrying the latest stupidity (whether deliberate or accidental) of those implementing PPACA, budgetary smart bombs, holds on appointments, filibusters, rifle-shot modifications made through reconciliation, agenda control, and every other stratagem that previous Congresses have used to vex, torment, frustrate, harry, and bullyrag previous Administrations.¹⁹² President Obama participated in the use of some of these stratagems against the Bush Administration during his term in the Senate, so he has no principled basis to complain if the same tactics (as well as some new ones) are used against his signature initiative. Similar fights will take place at the level of the states, which have primary responsibility for implementing the exchanges¹⁹³—even as the 2010 elections resulted in many states electing governors and legislatures that oppose PPACA.¹⁹⁴

I close by recounting two episodes that cast light on the probability of these grim dynamics engulfing PPACA. Both involve Senator Daniel Patrick Moynihan, who had a lengthy and distinguished career of public service and was chair of the Senate Finance Committee during the Clinton Administration's attempt to enact health reform.¹⁹⁵ A lifelong Democrat, he worked in both Democratic and Republican administrations.¹⁹⁶ Political consultant David Gergen, who displayed similar flexibility in the administrations for which he worked, re-

¹⁹² Cf. MARK TWAIN, A CONNECTICUT YANKEE IN KING ARTHUR'S COURT 243-44 (Bernard L. Stein ed., Univ. of Cal. Press 1979) (1889) ("It was beautiful to hear the lad lay out the science of war, and wallow in details of battle and siege . . . and every other imaginable thing above the clouds or under them that you could harry or bullyrag an enemy with, and make him wish he hadn't come . . .").

¹⁹³ PPACA § 1311(b), 42 U.S.C.A. § 18031 (West Supp. 1B 2010).

¹⁹⁴ See Jonathan Oberlander, *Beyond Repeal—The Future of Health Care Reform*, NEW ENG. J. MED. 2277, 2278 (2010) ("Republicans gained 7 governorships and 680 seats in state legislatures, with some races still undecided. As a result, many states will have legislatures and governors hostile to the health care reform law."); N.C. Aizenman & Amy Goldstein, *Be Rid of Health-Care Law or Ready for It, States Say*, WASH. POST, Feb. 22, 2011, at A3 (cataloging various strategies used by "mutinous" governors and noting that "[p]ractically every week, a Republican governor or lawmaker announces a new effort to kill the health-care law or undercut its implementation").

¹⁹⁵ Moynihan, *Daniel Patrick, (1927–2003)*, BIOGRAPHICAL DIRECTORY U.S. CONGRESS, <http://bioguide.congress.gov/scripts/biodisplay.pl?index=m001054> (last visited Mar. 15, 2011).

¹⁹⁶ See *id.*

counted a conversation he had with Moynihan in the midst of Clinton's health reform efforts:

Moynihan, a Democrat, told me that there were two essential prerequisites to passing major social reform in this country. The first, he said, was that landmark social legislation should be passed with significant, bipartisan support from both sides of the aisle—*otherwise, there would always be trouble with it*. . . . Secondly, he said, landmark social legislation should enjoy solid support from the public before it is passed.¹⁹⁷

PPACA utterly fails both of these “essential pre-requisites.” The only thing bipartisan about PPACA was the opposition to it. And, as noted above, opinion polling indicates that PPACA never enjoyed the support of a majority of the public at any point after June 2009.¹⁹⁸ Of course, it is possible that Moynihan was simply wrong about the pre-conditions for passing major social reform—but if he is even close to right, PPACA is headed for deep, deep trouble.

The second episode took place in February 1993. Senator Moynihan had signaled that he did not appreciate how the Administration was treating him and made it clear that the Senate Finance Committee would not take action on any of the Administration's priorities until the proper degree of respect was shown:

“Not since November,” says Pat Moynihan sadly. “Not a single call. Not from the President or any of his top people. I would have thought someone would have gotten in touch with me. I just don't get it.”

For the Senator from New York, a giant intellect who has succeeded Treasury Secretary Lloyd Bentsen as chairman of the powerful Finance Committee, these few whispered words are a warning shot at least the equal of the spontaneous outpouring of public outrage that doomed Zoë Baird last week. Finance's domain, Moynihan rightly says, “covers everything the President cares most about—economic recovery, trade issues, health care, welfare, Social Security, just about everything he got elected on. He's right when he says nothing he's proposed matters unless it passes the Congress. So he either talks to us sooner or he talks to us later.”¹⁹⁹

The response from the Clinton Administration was swift and clear: an anonymous senior administration official, later revealed to be

¹⁹⁷ David Gergen, *The Blair House Health Summit: Missing Pat Moynihan*, ANDERSON COOPER 360 (Feb. 24, 2010, 11:59 PM), <http://ac360.blogs.cnn.com/2010/02/24/the-blair-house-health-summit-missing-pat-moynihan/> (emphasis added).

¹⁹⁸ See *supra* note 177 and accompanying text; see also Henry J. Aaron, *The Midterm Elections—High Stakes for Health Policy*, 363 NEW ENG. J. MED. 1685, 1686 tbl. (2010) (quantifying the extensive bipartisan support for major social reform legislation prior to PPACA).

¹⁹⁹ Michael Kramer, *Still Waiting for Bill's Call*, TIME, Feb. 1, 1993, at 37.

Treasury Secretary (and former chair of the Senate Finance Committee) Lloyd Bentsen, was quoted in the same article as follows:

“Big deal,” says a top Administration official. “Moynihan supported Bob Kerrey during the primaries. He’s not one of us, and he can’t control Finance like Bentsen did. He’s cantankerous, but he couldn’t obstruct us even if he wanted to. The gridlock is broken. It’s all Democrat-ic now. We’ll roll right over him if we have to.”²⁰⁰

Clinton immediately called to apologize, but the incident permanently chilled Moynihan’s willingness to advance the President’s agenda.²⁰¹

A blunter and more telling response came from Lawrence O’Donnell, then Moynihan’s chief of staff (and now hosting an opinion and news show on MSNBC):

“[The Clinton Administration has] a War Room for everything. They don’t understand it’s not a fucking War Room. War Room is: I win. War ends when a person surrenders. Nobody here surrenders ever. You don’t fucking win. And you do not have an election against us where there’s a vote cast where we have to leave. We are here forever, and we don’t fucking surrender.”²⁰²

Until PPACA’s opponents are voted out of office, they “are here forever, and [they won’t] fucking surrender.” If the polls and the 2010 midterms are any indication, a large chunk of the public is siding with them. Given these circumstances, even design redundancy might not be sufficient to protect PPACA—but the absence of design redundancy is likely to prove devastating to PPACA’s implementation unless there is a dramatic turnaround in public and legislative regard for the statute.

CONCLUSION

What lies ahead? Yogi Berra famously observed that “[i]t’s tough to make predictions, especially about the future.”²⁰³ But it seems clear that Republicans will use every tool at their disposal to repeal or undermine the less popular parts of PPACA, while studiously ignoring the more popular portions. Democrats will similarly use every tool at their dis-

²⁰⁰ *Id.* The anonymous speaker was revealed to be Treasury Secretary Bentsen in Michael Kramer, *Headache Awaits W.*, N.Y. DAILY NEWS, Dec. 17, 2000, at 4, available at http://www.nydailynews.com/archives/news/2000/12/17/2000-12-17_headache_awaits_w_.html.

²⁰¹ *Id.*

²⁰² HAYNES JOHNSON & DAVID S. BRODER, *THE SYSTEM: THE AMERICAN WAY OF POLITICS AT THE BREAKING POINT* 356 (1997).

²⁰³ *Yogi Berra*, WIKIQUOTE, http://en.wikiquote.org/wiki/Yogi_Berra (last visited Mar. 15, 2011).

posal to defend the popular parts of PPACA, while disavowing the unpopular parts (when not professing ignorance as to how they got into the bill in the first place).

Of course, there is no reason the battlefield will remain limited to health care, and the tactics that were employed to enact PPACA (along with some new ones) will quickly become the new baseline for both sides in future legislative battles. The precise tactics that will be deployed are limited only by the creativity and ruthlessness of those involved. And if we know anything about our elected representatives and those they hire, it is that there is no shortage of creativity and ruthlessness. Buckle your seatbelts. It's going to be a bumpy ride.