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# THE FOUR AGES OF HEALTH LAW

*Rand E. Rosenblatt*<sup>†</sup>

**AMERICAN HEALTH LAW** continues to be shaped largely by three familiar models. Each model was dominant in a particular historical period, although that dominance was usually contested by one or more of the other models. The most complete hegemony was achieved by the first model, *the authority of the medical profession*, from roughly 1880 to 1960. Under this paradigm, legal authority over virtually all aspects of health care delivery was delegated to the medical profession—indeed to individual physicians in private practice—and justified primarily by what was seen as doctors' scientific expertise.

A second model, which became dominant in health law from about 1960 to about 1980 and continues to the present, is that of the *modestly egalitarian social contract*. This paradigm holds that patients and society as a whole, as well as physicians and other stakeholders, have legitimate rights and interests in the health care system. The role of law in this model is to achieve a fair resolution of conflicting interests, especially in the light of highly unequal information and power between patients and other actors. Given this model's egalitarian values, fairness has typically been articulated as access to care largely on the basis of medical need, high quality of care, and respect for patient autonomy and dignity. By the standards of the rest of the developed world, notably western Europe and Canada, the American social contract has been limited and uneven—hence the phrase “modestly egalitarian.”

A third perspective holds that however modest by international standards, the American social contract is far too regulatory and redistributive, and should be replaced by legal principles appropriate to full-fledged *market competition*. The function of law in this model is to ensure that choices about health insurance and health services are made by individuals based on their own financial resources (assuming them to be above some specified minimum), and (in some versions of the model) to eliminate as much as possible hidden “cross-subsidies.” Individual (or aggregated individual) choice under financial constraint is believed to maximize efficiency (people want to pay only for cov-

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erage or services that really benefit them, and providers will respond to such market pressure by economizing) and freedom, properly understood. The market competition model developed in the early 1970s, began affecting policy very quickly, and became the dominant paradigm in the 1980s and 1990s.<sup>1</sup>

Each of these three models continues to exercise influence in political and legal contexts. While it is unlikely that we would ever again delegate to doctors the sweeping authority they enjoyed before 1960, the ideal of the trustworthy, independent physician delivering the best possible medical care for her or his individual patients still has powerful appeal or, as some market advocates see it, pernicious influence.<sup>2</sup> Similarly, while the egalitarian social contract model has been subjected to relentless intellectual and political criticism, the idea of access to health care on the basis of medical need remains attractive, and the countervision of health care distributed according to ability to pay remains troubling for public opinion and explicit policy.<sup>3</sup>

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<sup>1</sup> For my own earlier discussions of these models, see RAND E. ROSENBLATT ET AL., *LAW AND THE AMERICAN HEALTH CARE SYSTEM* 2-3, 24-35, 131-35, 823-24 (1997) (providing background for and comparisons among the three models); Rand E. Rosenblatt, *Health Law*, in *THE POLITICS OF LAW: A PROGRESSIVE CRITIQUE* 147 *passim* (David Kairys ed., 3d ed. 1998) (summarizing the three models of American health law: professional authority and autonomy, egalitarian social contract, and market competition); Rand E. Rosenblatt, *Conceptualizing Health Law for Teaching Purposes: The Social Justice Perspective*, 38 J. LEGAL EDUC. 489 (1988) (discussing how to teach the three models of health law to students). For structures that are conceptually similar, see Einer Elhauge, *Allocating Health Care Morally*, 82 CAL. L. REV. 1451, 1452 (1994) (arguing that health law policy employs four different paradigms to allocate resources: market, professional, moral, and political); James A. Morone, *The Health Care Bureaucracy: Small Changes, Big Consequences*, 18 J. HEALTH POL. POL'Y & L. 723, 723 (1993) (describing "three working models of authority in health care politics: professional, democratic, and bureaucratic (with an additional handful of largely theoretical alternatives, most notably the free market)"). Cf. M. Gregg Bloche, *The Invention of Health Law*, 91 CAL. L. REV. 247, 253-54 (2003) (identifying the emerging dominant health law and policy paradigm as "welfare maximization" or "traditional economic reasoning," and arguing that it is not pragmatically realizable); Mark A. Hall, *Law, Medicine and Trust*, 55 STAN. L. REV. 463, 465-66 (2002) (identifying social justice and economic efficiency as proposed and competing "unifying themes" for health law, and advocating instead the concept of "therapeutic jurisprudence"). For discussion of the public health and bioethics models, see *infra* text accompanying notes 5-9.

<sup>2</sup> For an example of the perceived appeal, see Hall, *supra* note 1 (arguing that trust is essential in the physician-patient relationship). For an example regarding the perceived pernicious effects, see Clark C. Havighurst, *How the Health Care Revolution Fell Short*, LAW & CONTEMP. PROBS., Autumn 2002, at 55, 72-73 (explaining that because the courts have not "replace[d] the old professional paradigm of medical care . . . the legal system [thus] stands as a major obstacle to empowering consumers and completing the health care revolution").

<sup>3</sup> On recent public attitudes, see Elizabeth A. Pendo, *Images of Health In-*

Yet, it is also true that many in more affluent socio-economic groups appear uncomfortable with the implications of universal coverage, and favor or at least acquiesce in some version of the market model. This is because their deepest commitment is to unrestrained access for themselves to the latest medical technology, combined with a fear that extending such access to all would be too costly and would result either in higher premiums and taxes and/or rationing applicable to everyone, including themselves.<sup>4</sup> The result is that all three perspectives

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*urance in Popular Film: The Dissolving Critique*, J. Health L. (forthcoming 2004) (citing *Fundamental Health Care Values*, HARRIS INTERACTIVE HEALTH CARE NEWS, Mar. 14, 2003, at 1-2, at

[http://www.harrisinteractive.com/news/newsletters\\_healthcare.asp](http://www.harrisinteractive.com/news/newsletters_healthcare.asp) (75% of respondents “agree that ‘people who are unemployed or poor should be able to get the same amount and quality of medical services as people who have good jobs and are paying substantial taxes,’” and 69% of respondents “disagree that ‘it’s fair that people who pay more in taxes (or in health insurance premiums) should be able to get better medical care than those who pay little or nothing.” Regarding subsidizing of the sick by the healthy, 60% of respondents “disagree[ ] that ‘it is unfair to take money through taxes from the young and middle-aged who work to pay for the medical care of those who are old and sick’” and 57% of respondents “disagree[ ] that ‘it’s unfair to require the majority of people who are healthy to pay for most of the cost of treating those who are sick and are heavy users of hospitals and doctors.’”). These results are consistent with responses to same questions polled by Louis Harris & Associates (the predecessor of Harris Interactive) in 1991, *id.*, and with other survey findings. See also Elhauge, *supra* note 1, at 1485 n.111 (citing JOHN F. KILNER, WHO LIVES? WHO DIES? 180 (1990) and stating that “a consistent majority of Americans have opposed allowing ability to pay to be a criterion affecting the allocation of medical resources”). In addition, Alan Enthoven, a prominent advocate of a market competition approach to health care delivery, wrote in 1980 that “[m]ost Americans consider access to a decent level of medical care to be part of the right to ‘life, liberty, and the pursuit of happiness.’ Thus we are not willing to leave the distribution of medical purchasing power to the market and other forces that determine income distribution.” ALAIN C. ENTHOVEN, HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COST OF MEDICAL CARE 81 (1980). See also TIMOTHY STOLTZFUS JOST, DISENITLEMENT? THE THREATS FACING OUR PUBLIC HEALTH – CARE PROGRAMS AND A RIGHTS – BASED RESPONSE 23-109 (2003) (analyzing numerous ways that American law and policy do and do not recognize a right to health care); Deborah Stone, *Managed Care and the Second Great Transformation*, 24 J. HEALTH POL. POL’Y & L. 1213, 1214-17 (1999) (While noting that the “backlash” against managed care is driven by the self-interest of those who have health insurance, and coincided (at least in the late 1990s) with a relative lack of concern for the over 43 million who are uninsured, the backlash can also be interpreted in more solidaristic terms as “a cold shudder against the market paradigm, which, taken to its logical endpoint as managed care seems to be doing, respects no human bonds, shows no mercy, and has no use for kindness, loyalty, and other moral qualities of community”). See also sources reporting countervailing or ambivalent public attitudes in note 4 *infra*.

<sup>4</sup> See, e.g., James A. Morone, *Populists in a Global Market*, 24 J. POL. POL’Y & L. 887, 891 (1999) (interpreting the managed care backlash as a defense of “that honored American tradition: rationing by class. The wealthy have always gotten lavish care, the middle classes have done fine, the poor and uninsured faced depriva-

have been contending actively for influence over numerous issues of health policy and law.

Two other models deserve mention: public health and bioethics. Many of the advances in health status and outcomes in the United States and other developed countries between 1850 and 1950 occurred not because of hospital science or individual treatment, but because of public health science: scientifically-informed sanitation, water supply, food inspection, housing reform, vaccination, public health education, and accurate diagnosis and isolation of the contagiously ill.<sup>5</sup> However, the influence of the public health model was effectively marginalized by the medical profession (and other powerful economic and political actors) for most of the twentieth century, because it threatened to drain resources from profitable fee-for-service treatment of

tion (amid long speculation about just how 'deserving' they may have been)."). By imposing care restrictions on middle- and upper-middle class patients, managed care violated this tradition and provoked the backlash. See also DAVID J. ROTHMAN, *BEGINNINGS COUNT: THE TECHNOLOGICAL IMPERATIVE IN AMERICAN HEALTH CARE* 4-6 (1997) (discussing the unlimited access to healthcare technology that middle class Americans have demanded and its effect on preventing universal access to health care); but see Grant Recher, *Reform and Remembrance: The Place of the Private Sector in the Future of Health Care Policy*, 28 J. HEALTH POL. POL'Y & L. 355, 361-62 (2003) (reporting "long-term public opinion about health care and health care reform is ambiguous and apparently contradictory and often is [factually] wrong"). See also Robin Toner, *Boiling Brew: Politics and Health Insurance Gap*, N.Y. TIMES, Sept. 30, 2003, at A19 (discussing the "political paralysis" that has occurred in the past when "middle-income voters sense[d] that they are being asked to pay more so that others get health care"). Public opinion expert Bill McInturff has projected that "[a] lot of 2004 will be a fight about who is perceived to pay versus who is perceived to get the benefit." *Id.*

<sup>5</sup> "One of the most dominant ideas in nineteenth-century medicine had been that *social* conditions foster disease. [P]ublic health workers [ ] repeatedly showed that people living in bad social and economic conditions were much more vulnerable to the great infectious scourges that still assaulted the modern world." MELVIN KONNER, *MEDICINE AT THE CROSSROADS: THE CRISIS IN HEALTH CARE* 82 (1993). The great example is tuberculosis, widely but mistakenly believed to have been cured by Robert Kochs discovery of the tuberculosis bacillus in 1882. In fact, the fatal effects of tuberculosis that struck down the English poet John Keats and millions of his contemporaries in the 18th and 19th centuries began diminishing in the more prosperous parts of Europe in the 1850s, long before Kochs discovery. See, e.g., THOMAS DORMANDY, *THE WHITE DEATH: A HISTORY OF TUBERCULOSIS* 78, 224 (2000). Tracking improvements in nutrition, housing, and workplace conditions remarkably closely, tuberculosis mortality continued to decline rapidly after 1900, e.g. about an eight-fold decline in the United States between 1900 and 1950, well before the first effective antibiotic, streptomycin, was discovered by Selman Waksman and became available in 1950. See, e.g., David Rosner, *Twentieth Century Medicine*, in *THE COLUMBIA HISTORY OF THE 20TH CENTURY* 483, 504 (Richard W. Bulliett ed., 1998); DORMANDY, *supra*, at 82, 224-25.

individual patients and, more broadly, to criticize social inequality.<sup>6</sup> In the late twentieth century, increasing evidence of the link between low income and other oppressive social conditions and poor health has resurrected the egalitarian side of nineteenth-century public health, thereby potentially linking it (once again) to a strongly egalitarian version of the social contract paradigm.<sup>7</sup>

Beginning in the mid-1960s, a series of courageous whistleblowers (notably Dr. Henry Beecher of the Harvard Medical School) revealed shocking disregard for patient well being in medical experimentation undertaken at leading universities and by the United States Public Health Service in the notorious "Tuskegee experiment."<sup>8</sup> For a

<sup>6</sup> See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 180-97 (1982).

<sup>7</sup> In 1952, Rene and Jean Dubos said of tuberculosis, "Tuberculosis is a social disease . . . the impact of social and economic factors on the individual [must] be considered as much as the mechanisms by which tubercle bacilli cause damage to the human body." RENEE DUBOS & JEAN DUBOS, *THE WHITE PLAGUE: TUBERCULOSIS, MAN AND SOCIETY* xxxvii (Rutgers Univ. Press 1987) (1952). The point is equally relevant and dramatic today with respect to AIDS in our time: the high rates of infection and mortality in parts of Africa, the Caribbean, Latin America and Asia are caused not so much by the HIV virus itself, which we now know how to contain by education and chemotherapy, but by political, economic and cultural conditions. See, e.g., PAUL FARMER, *PATHOLOGIES OF POWER* (2003) (giving case histories and citing numerous sources); Helen Epstein, *The Mystery of AIDS in South Africa*, N.Y. REV. BOOKS, July 20, 2000, at 50-55 (discussing the views expressed by the government and the secrecy surrounding clinical trials in South Africa); Elisabeth Rosenthal, *In Rural China, a Steep Price of Poverty: Dying of AIDS*, N.Y. TIMES, Oct. 28, 2000, at A1 (discussing the rise of AIDS in rural China and the denial of the Chinese government to acknowledge the rising issue). See also David Mechanic, *Who Shall Lead: Is There a Future for Population Health?*, 28 J. HEALTH POL. POL'Y & L. 421 (2003) (discussing both the history and the recent developments in population health and analyzing the challenges to making population health concerns an important part of our current health policy); Wendy E. Parmet & Anthony Robbins, *A Rightful Place for Public Health in American Law*, 30 J. L. MED. & ETHICS 302 (2002) (acknowledging the importance of public health as a discipline and arguing that it is time for the topic to be addressed in legal education). For a related but somewhat different version of the debate distinguishing between so-called "new" and "old" public health paradigms, see Richard A. Epstein, *Let the Shoemaker Stick to His Last: A Defense of the "Old" Public Health*, 46 PERSP. BIOL. & MED. S138 (Supp. 2003) (arguing that public health is efficient and therefore justified only when it focuses on its purportedly "old" function of containment of infectious diseases rather than the "new" function of regulating any area that affects the general health of a large number of individuals) and Lawrence O. Gostin & M. Gregg Bloche, *The Politics of Public Health: A Response to Epstein*, 46 PERSP. BIO. & MED. S160 (Supp. 2003) (finding benefits to the "new" public health and attributing Epstein's efficiency arguments to his own political and moral preferences). Perspectives in Biology and Medicine is available to subscribers through Project Muse, <http://muse.jhu.edu>.

<sup>8</sup> See DAVID J. ROTHMAN, *STRANGERS AT THE BEDSIDE: A HISTORY OF HOW LAW AND BIOETHICS TRANSFORMED MEDICAL DECISIONMAKING* 1-4, 70-84 (1991).

number of political and bureaucratic reasons, this stimulated the development of new rules for informed consent and other ethical aspects of medical experimentation. The development of new technologies for prolonging life from the 1960s onwards, and the question of when these technologies should be withdrawn, further strengthened the influence of bioethics on experimentation and life-prolonging technology.<sup>9</sup>

At the dawn of the twenty-first century, it is possible that we are entering a “fourth age” of health law and policy, and indeed of law and policy more generally. In part, this may be because the three major models have been unable to reconcile in a credible and legitimate way our society’s (or at least its politically-influential sectors’) simultaneous and arguably contradictory values regarding health care: (1) solidarity and mutual aid, which in the United States is often understood as including unrestricted access to the most advanced medical technology; (2) efficiency and cost containment; and (3) no or minimal governmental interference with the ability of health care entrepreneurs, pharmaceutical companies, insurance companies, physicians and other well-situated players to make very large incomes and profits.<sup>10</sup> Interacting with and transcending these conflicts are two other potential major components of a fourth age: globalization, which many see as having profound effects on the nation-state, democracy, and the feasibility and nature of a social contract; and what is known as “the biotechnology revolution,” also expected to pose major di-

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Credit for exposure of the Tuskegee Study goes to Peter Buxton, a junior non-physician employee of the Public Health Service who was not involved with the Study. See Rand E. Rosenblatt, Sylvia A. Law & Sara Rosenbaum, *supra* note 1, at 890-91 (citing sources).

<sup>9</sup> See generally ROTHMAN, *supra* note 8 (explaining that as technology increased, doctors lost much of their discretion concerning the care of their patients); TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* (5<sup>th</sup> ed. 2001); Alexander M. Capron, *A “Bioethics” Approach to Teaching Health Law*, 38 J. LEGAL EDUC. 505 (1988) (discussing how bioethics is a core concern of teaching health law). For a work that connects the bioethics and egalitarian public health models, see HEALTH AND HUMAN RIGHTS (Jonathan M. Mann et al. eds., 1999).

<sup>10</sup> See note 4 *supra*. See generally Robert G. Evans, *Going for the Gold: The Redistributive Agenda behind Market-Based Health Care Reform*, 22 J. HEALTH POL. POL’Y & L. 427 (1997); Mark V. Pauly, *Who Was that Straw Man Anyway? A Comment on Evans and Rice*, 22 J. HEALTH POL. POL’Y & L. 467 (1997); Robert G. Evans, *Response: Coarse Correction – And Way Off Target*, 22 J. HEALTH POL. POL’Y & L. 503 (1997). For a pervasive sense of political and policy complexity, drift, denial, and paralysis in the health care sector (albeit with some contributors perceiving or advocating various ways forward), see *Special Conference Issue: Who Shall Lead?*, 28 J. HEALTH POL. POL’Y & L. 181-24 (2003).

lemmas and have deep ramifications. As discussed below, the meaning and direction of this new age is sharply contested.

Part One of this article explores the three major models of health law, including judicial opinions that exemplify each model's style of reasoning. Part Two then considers briefly the debate about the possibilities of a "fourth age."

Two matters require some preliminary clarification. First, the term "social contract" is used in this article to refer to statutes and judicial doctrines that seek to articulate an explicitly social or political, as distinguished from what is known as a professional or market, conception of fairness and good policy. This distinction is not intended to imply that professional and market conceptions are not themselves "social" in nature, and derive instead from an allegedly "natural" source, such as "science" or "the laws of economics." The professional and market approaches to health law, like all models of law or policy regarding health or anything else, are socially created.<sup>11</sup> Even models that appear to minimize the role of society and government—such as so-called "unregulated markets"—rest on extensive social and governmental value choices, authority and, if need be, coercion.<sup>12</sup> The phrase "modestly egalitarian social contract" emphasizes the social (primarily legislative or judicial) source of egalitarian

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<sup>11</sup> See, e.g., OLIVER WENDELL HOLMES, *THE COMMON LAW* 5 (Mark DeWolfe Howe ed., 1963) ("The life of the law has not been logic: it has been experience. The felt necessities of the time, the prevalent moral and political theories, intuitions of public policy, avowed or unconscious . . . have had a good deal more to do than the syllogism in determining the rules by which men should be governed."). See also PAUL W. KAHN, *THE CULTURAL STUDY OF LAW: RECONSTRUCTING LEGAL SCHOLARSHIP* (1999) (arguing that the culture of the law's rules needs to be studied like any other culture to discover their founding myths, beliefs, methodologies, and historical sources). For a specific example from the history of health care delivery, see Paul Starr's account of the rise of the modern hospital. STARR, *supra* note 6 (discussing the rise of the modern hospital). "What drove this transformation was not simply the advance of science, important thought that was, but the demands and example of an industrializing capitalist society, which brought larger numbers of people into urban centers, detached them from traditions of self-sufficiency, and projected ideals of specialization and technical competence." *Id.* at 146. See also Thomas Morawetz, *Insurance: How It Matters as Psychological Fact and Political Metaphor*, 6 *CONN. INS. L.J.* 1, 7-10 (1999-2000) (noting that the debates about health care and insurance necessarily revisit all of the main questions of politics).

<sup>12</sup> See, e.g., Stone, *supra* note 3, at 1216-17 (discussing the changing of life and health into objects of commerce, and the backlash against managed care as society's response); KARL POLANYI, *THE GREAT TRANSFORMATION* (1944) (discussing the social implications of the emergence of the market economy); David M. Frankford, *Privatizing Health Care: Economic Magic to Cure Legal Medicine*, 66 *S. CAL. L. REV.* 1, 9-10 (1992) [hereinafter *Privatizing Health Care*] (arguing that advocates of market competition in health care delivery confuse naturalistic causality with human freedom).



legal norms, while not meaning to imply that the professional authority and market competition perspectives are not also socially created and authorized.

Second, the notion of a model refers primarily to the assumptions, values, background norms, orientations, etc., of private and governmental decisionmakers. Thus, when I say that the professional authority model was dominant from about 1880 to about 1960, I mean that one can see the influence of the model in such contexts as legislation, judicial opinions, positions of the American Medical Association, and hospital bylaws and practices. Interestingly, at the time of their dominance, neither the professional authority nor social contract models generated a large and highly visible “advocacy” academic literature that sought to promote those models. In contrast, the market competition perspective has indeed generated such a literature, some of which distinguishes itself sharply from the “market model” that has actually been implemented as a matter of health law and policy.<sup>13</sup>

## I. PART ONE: THREE MODELS OF HEALTH LAW

### A. The Model of Professional Authority

The model of professional authority dominated health law and policy in the United States from about 1880 to about 1960.<sup>14</sup> During this period the main point of health law—its more or less conscious purpose—was to support the authority and autonomy of individual physicians engaged in the private practice of medicine. Thus the law allowed and even aided doctors to suppress salaried and prepaid financial arrangements, and to insist on being paid a fee for each discrete service, thereby maximizing physician control over the terms and amount of payment.<sup>15</sup> The law also gave doctors control over

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<sup>13</sup> See, e.g., Havighurst, *supra* note 2, at 72-74 (arguing that even though consumers have been given more choices in their health care, the system fails consumers by looking to custom and consensus in the medical community with respect to such matters as malpractice and insurance coverage); James Maxwell & Peter Temin, *Managed Competition Versus Industrial Purchasing of Health Care Among the Fortune 500*, 27 J. HEALTH POL. POL'Y & L. 5 (2002) (contrasting managed competition theory with actual health purchasing practices of most major American corporations).

<sup>14</sup> For a comprehensive and brilliant presentation of the origins and rise of this model see STARR, *supra* note 6, at 79-378. See also Mark A. Peterson, *Introduction: Who Shall Lead?*, 28 J. HEALTH POL. POL'Y & L. 181, 182 (2003) (citing literature supporting the proposition that the professional leadership model was predominant for most of the twentieth century).

<sup>15</sup> See STARR, *supra* note 6, at 198-34.; People *ex rel.* Kerner v. United Med. Service, Inc., 200 N.E. 157 (Ill. 1936) (ordering closure of for-profit clinic that wished to employ doctors on a salaried basis).

licensing standards and enforcement,<sup>16</sup> what patients they would accept,<sup>17</sup> hospital policies regarding doctors,<sup>18</sup> and what patients should be told about their treatment, if anything.<sup>19</sup> With respect to medical malpractice liability, the “medical custom” and “locality rule” doctrines meant that in many contexts, a patient could only recover for injuries if a local colleague of the defendant doctor testified that he had committed negligence.<sup>20</sup> Needless to say, this was a requirement that usually could not be satisfied. This sweeping delegation of authority to physicians was later justified on a theory of “agency”: the doctor could and should be trusted to act as the knowledgeable agent for the patient’s well being.<sup>21</sup> At the time, the equation of the doctor’s purported scientific expertise with sound public policy was so obvious as barely to merit discussion.

A paradigm case from the age of professional authority is Judge Cardozo’s 1914 opinion for the New York Court of Appeals in *Schloendorff v. Society Of New York Hospital*.<sup>22</sup> The issue was whether the hospital had legal responsibility for an operation having been performed on a patient without her consent, despite the patient having made several efforts to explain to the resident physician, the nurse preparing her for the procedure, and the physician administering the anesthetic, that she was consenting only to an “examination” and not to an “operation.”<sup>23</sup> While Judge Cardozo famously articulated the patient’s right to decide what should happen to her own body,<sup>24</sup>

<sup>16</sup> E.g., ROSENBLATT ET AL., *supra* note 1, at 968-69 (discussing licensure history and grounds for disciplining a physician).

<sup>17</sup> See *Hurley v. Eddingfield*, 59 N.E. 1058 (Ind. 1901) (holding that neither state licensure nor the common law limits a physician’s freedom to refuse to render services to any person seeking to employ the physician).

<sup>18</sup> See, e.g., *St. John’s Hosp. Med. Staff v. St. John Reg.’l Med. Ctr.*, 245 N.W.2d 472, 473-74 (S.D. 1976) (finding bylaws created and passed by the medical staff could not be altered by the hospital’s board of directors without the consent of the medical staff).

<sup>19</sup> E.g., ROSENBLATT ET AL., *supra* note 1, at 890-91 (listing sources).

<sup>20</sup> See Jon R. Walz, *The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation*, 18 DEPAUL L. REV. 408, 410-11 (1969) (discussing the history and legal implications of the locality rule’s role in medical malpractice litigation)

<sup>21</sup> See, e.g., Carolyn Hughes Tuohy, *Agency, Contract, and Governance: Shifting Shapes of Accountability in the Health Care Arena*, 28 J. HEALTH POL. POL’Y & L. 195, 197 (2003) (relating the agency principle of microeconomics to the relationship in health care between patient and physician).

<sup>22</sup> 105 N.E. 92 (1914).

<sup>23</sup> The patient’s allegations were not surprisingly contested by the doctors and nurses, but since the hospital had won in the trial court by directed verdict, the appeals court had to assume that the patient’s allegations were true. *Id.* at 93.

<sup>24</sup> “Every human being of adult years and sound mind has a right to deter-

the issue of *hospital* liability was a different matter.<sup>25</sup> Cardozo could imagine only one theory that supported hospital liability: that the hospital was the employer (“master”) who controlled everyone involved in the treatment process, including the eminent surgeon who performed the operation. Since this seemed starkly contrary to actual fact—no hospital administrator (who in those days was typically not even a physician) would presume to “control” an eminent surgeon in the details of his work—it must follow that the hospital had no responsibility at all for any part of the process, including the alleged failure of the nurse (who was indeed the hospital’s employee) to inform the surgeon of the patient’s wishes.<sup>26</sup> Similarly, when a for-profit corporation established a low-cost clinic in Chicago in the 1930s where salaried and licensed physicians could treat patients, the Illinois Supreme Court granted a request for an injunction by the Attorney General to shut the clinic down, on the theory that the corporation was practicing medicine without a license (and, of course, was not eligible to obtain a license, which could be granted only to individuals). The court summarily dismissed the corporation’s argument that “it” was not practicing medicine, but only providing a place where the doctors would practice (and undoubtedly provide services to patients who could not afford the charges of fee-for-service medicine).<sup>27</sup>

Strikingly absent in these “all or nothing” opinions is the possibility of shared or overlapping responsibility, so evident to modern eyes accustomed to looking at complex institutional structures and relationships. That a judge as thoughtful as Cardozo could not see this is a testament to the power of the professional authority model of health law. So strong was the belief in, and commitment to, the physician’s authority over patient care, that any suggestion that the authority be

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mine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages.”

*Id.*

<sup>25</sup> The statement in note 24, *infra*, evidently contemplates potential liability for the surgeon, but there is no discussion in Cardozo’s opinion of any lawsuit against or settlement with the surgeon who performed the operation. If indeed the surgeon was not sued, one can speculate about the reasons, including the possibility that the patient may not have spoken directly to the surgeon, and therefore was relying on hospital employees such as the nurses, or on arguable agents of the hospital such as the anesthetist, to convey her message

<sup>26</sup> *See id.* at 94-95 (stating that physicians and surgeons are professional men and in no way bound to control by hospital administrators and that though nurses are employees of the hospital they are acting on the orders of the physicians and not the hospital itself).

<sup>27</sup> *People ex rel. Kerner v. United Med. Service, Inc.*, 200 N.E. 157, 163-64 (Ill. 1936).

shared was perceived as a complete denial of the physician's authority, and hence, unthinkable.

While providing doctors with sweeping control over health care, the professional authority model also set the limits of the problems it could solve, and therefore contained the seeds of its own fall from dominance. Three issues in particular were beyond its ken. The first was access to adequate (or any) care for people who could not afford fee-for-service medicine (which included most of the aged) and/or faced barriers such as race, ethnicity, and geography. "Charity" by hospitals and individual physicians was supposed to meet this need, but evidently could not, and even those served often received strikingly inferior care.<sup>28</sup> "The purpose of publicly sponsored and charitable health services . . . was primarily to protect the healthy, well-off population from the contagiously ill or socially disruptive poor, and to provide teaching material (in the form of patients) for medical education. '[The] health of the individual was secondary, if not incidental.'"<sup>29</sup> A huge number of people were effectively excluded from care, resulting in shock when the nation had to mobilize for World War II and found that about forty percent of the young men called were physically unfit to serve.<sup>30</sup>

Second, physician "self regulation" could not reliably achieve quality of care, or even police the most egregiously incompetent or impaired physicians. The mechanisms of self-regulation—professional and industry-administered accreditation standards and internal peer review by the hospital's medical staff—generated vague standards of care, poorly defined procedures, and overlapping and

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<sup>28</sup> See generally STARR, *supra* note 6, at 262 (summarizing evidence of lack of care in the REPORT OF THE COMMITTEE ON THE COSTS OF MEDICAL CARE (1932)).

<sup>29</sup> Rand E. Rosenblatt, *Dual Track Health Care—The Decline of the Medicaid Cure*, 44 U. CIN. L. REV. 643, 644 (1975) (quoting ROBERT STEVENS & ROSEMARY STEVENS, *WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID* 15 (1974)).

<sup>30</sup> See Rand E. Rosenblatt, *Health Care Reform and Administrative Law: A Structural Approach*, 88 YALE L.J. 243, 264-65 (1978) (discussing background to the Hospital Survey and Construction (Hill-Burton) Act of 1946, Pub. L. No. 79-725, 60 Stat. 1040, which was enacted to increase the availability of health care services). In 2003, this problem remains unsolved to some extent. In addition to 17.3 percent of the non-elderly population without health insurance, KAISER FAMILY FOUNDATION, *HEALTH INSURANCE COVERAGE IN AMERICA, 2002 DATA UPDATE* (December 2003), Figure 2, available at <http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=29340>, "40 percent of all lower-ranking [National] Guard and reserve members nationwide" lack health insurance when not on active duty, leading to some being physically unfit for duty when called for active service. Ray Rivera, *Legislation would give reserves insurance*, SEATTLE TIMES, Nov. 21, 2003, at B1.

rotating committees that diffused responsibility.<sup>31</sup> To expect physicians who had bonded together during intense training, depended on each other for patient referrals and the financial viability of their hospitals, and shared a strong professional culture of perfectionism and resistance to criticism to police each other aggressively was fantasy on its face. The consequences could be extreme. For example, a hospital medical staff permitted a charming doctor to do complex spinal surgery for which he was totally unqualified.<sup>32</sup> He persuaded patients who did not need the surgery at all to undergo it, paralyzed them through his incompetence, and then falsified the hospital records to hide his responsibility.<sup>33</sup> The hospital's defense was that it had followed the standards and practices of the accreditation and peer review process designed and administered by the hospital industry and medical profession through the private Joint Commission on the Accreditation of Hospitals. Perhaps not surprisingly, a California trial judge found the system of professional authority inadequate in light of the socially defined standard of reasonable care.<sup>34</sup>

Third, the professional authority model had no internal mechanism for controlling costs, other than the vague and voluntary norms of professionalism. To be sure, as long as patients had to pay for most care out of their own pockets, their ability to pay operated as a check on doctors' fees. But as private health insurance, fueled by federal tax exemption, union contracts, and corporate desire to maintain employee loyalty spread during the 1940s and 1950s, patients' ability to pay was no longer limited by their immediate incomes. Thus, doctors fees and hospitals' costs were free to, and did, rise sharply, especially after the enactment of public health insurance (Medicare and Medicaid) in 1965.

#### B. The Model of the Egalitarian Social Contract

From the perspective of the modestly egalitarian social contract, unreviewable physician authority is seen as potentially dangerous and

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<sup>31</sup> See ROSENBLATT ET AL., *supra* note 1, at 927-28, 933-34 (describing the hospital's administrative structure and the diffusion of responsibilities for monitoring the quality of care); K. J. Williams, *The Quandary of the Hospital Administrator in Dealing with the Medical Malpractice Problem*, 55 NEB. L. REV. 401 (1976) (discussing how medical staff organization creates problems for medical administrators in medical malpractice suits).

<sup>32</sup> *Gonzales v. Nork*, No. 228566 (Super. Ct. Cal. Nov. 19, 1973), *reprinted, in part, in* SYLVIA LAW & STEVEN POLAN, *PAIN AND PROFIT: THE POLITICS OF MALPRACTICE* app. at 215-45 (1978).

<sup>33</sup> *Id.*

<sup>34</sup> *Id.*

self-interested. To achieve fairness in access to care, quality of care, and the financing of care in a context of inequality between patients and other actors (doctors, hospitals, insurance companies), the law must in some circumstances override professional and industry custom, practices, and contractual arrangements and define and enforce a "social contract."<sup>35</sup> Under this model, statutes, regulations, and judicial doctrines require health insurance contracts to comply with socially-defined standards of need and fairness,<sup>36</sup> and prohibit hospitals from denying emergency care.<sup>37</sup> Similarly, judicial doctrines have framed informed consent in terms of what a reasonable patient would want to know,<sup>38</sup> and imposed vicarious and direct liability on hospitals and managed care organizations (MCOs), regardless of the private contractual arrangements between the institutions and individual providers.<sup>39</sup> Other major components of the social contract model include the federal statutes creating social insurance for the elderly (Medicare) and a substantial number of the poor (Medicaid),<sup>40</sup> judicial doctrines recognizing legal rights for patients and providers in these programs,<sup>41</sup> and laws prohibiting discrimination in health care on the basis of race, gender, and disability.<sup>42</sup>

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<sup>35</sup> To be sure, in many contexts and relationships private contracts would remain enforceable, subject to the general principles of contract and other applicable law.

<sup>36</sup> See, e.g., *Metro. Life Ins. Co. v. Mass.*, 471 U.S. 724 (1985) (holding that a Massachusetts state statute mandating coverage of mental health benefits in health insurance contracts is not preempted by ERISA); *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999) (holding that a state judicial doctrine that permits insurers to deny claims on grounds of lateness as defined by the policy only if they can show actual prejudice not preempted by ERISA).

<sup>37</sup> E.g., *Examination and Treatment for Emergency Medical Conditions and Women in Labor Act ("EMTALA")*, 42 U.S.C. §1395dd (2000) (providing that an emergency department must stabilize and screen patients, even those unable to pay); *Thompson v. Sun City Cmty. Hosp., Inc.*, 688 P.2d 605, 610-11 (Ariz. 1984) (holding that patients in need of emergency care must be afforded such care by a state licensed hospital).

<sup>38</sup> E.g., *Canterbury v. Spence*, 464 F.2d 772, 780-83 (D.C. Cir. 1972)

<sup>39</sup> See, e.g., *Jackson v. Power*, 743 P.2d 1376 (Alaska 1987) (imposing non-delegable duty on hospital for quality of emergency room care despite hospital's argument based on contract with emergency care subcontracter); *Darling v. Charleston Community Hospital*, 33 Ill. 2d 326, 211 N.E. 2d 253 (1965) (applying corporate liability to hospital despite hospital's argument of contrary industry custom); *Boyd v. Albert Einstein Medical Center*, 547 A.2d 1229 (Pa. 1988) (requiring trial on whether physician is an ostensible agent of an HMO).

<sup>40</sup> See, e.g., *Rosenblatt, Law & Rosenbaum*, *supra* note 1, at 14-16, 368-410 (Medicare), 410-66 (Medicaid).

<sup>41</sup> See, e.g., *Duggan v. Bowen*, 691 F. Supp. 1487 (D.D.C. 1988) (Medicare); *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498 (1990) (Medicaid). See generally *Rand E. Rosenblatt, The Courts, Health Care Reform, and the Reconstruction of American*

A number of paradigm cases, primarily in the 1950s and 1960s but extending both earlier and later, held that contrary to *Schloendorff*, hospitals have both vicarious and direct (or “corporate”) responsibility for negligence in treating patients.<sup>43</sup> The reasoning of these opinions both reflected and helped constitute the emerging social contract model of health law. Many factors contributed to this shift in the perspective of judges and other policymakers. For example, focusing only on health care delivery, the growth of Blue Cross and other forms of private health insurance, notably for hospitalization, from the mid-1930s onward transformed many formerly charity or near-charity patients into paying customers, giving hospitals a financial base for expansion and transformation. The federal Hill-Burton Act, which provided over four billion dollars in public funds for construction of public and private non-profit hospitals between 1946 and 1972, highlighted the societal importance of adequate hospital facilities and services.<sup>44</sup> Hospitals themselves, through the American Hospital Association and its state organizations, and (after 1951) through the Joint Commission on the Accreditation of Hospitals (JCAHO), issued standards and guidelines that proclaimed the “public service” nature of hospitals as institutions, and their corporate mission of providing high quality care.<sup>45</sup>

Perhaps equally important were the jurisprudential legacy of Legal Realism and the political legacy of the New Deal. Legal Realism encouraged judges to break out of the all-or-nothing categories of traditional legal doctrine, look at how institutions were actually func-

*Social Legislation*, 18 J. HEALTH POL., POL'Y & L. 439 (1993); Sara Rosenbaum & David Rousseau, *Medicaid At Thirty-Five*, 45 ST. LOUIS U.L.J. 7 (2001).

<sup>42</sup> See, e.g., *Bryan v. Koch*, 627 F.2d 612 (2d Cir. 1980) (finding no racially discriminatory motive or effect in hospital closure); Sara Rosenbaum & Joel Teitelbaum, *Civil Rights Enforcement in the Modern Healthcare System*, 3 YALE J. HEALTH POL'Y, L. & ETHICS 215 (2003); *Newport News Shipbuilding & Dry Dock Co. v. EEOC*, 462 U.S. 669 (1983) (applying the Pregnancy Discrimination Act, 42 U.S.C. § 2000e(k)); *Olmstead v. L.C.*, 527 U.S. 581 (1999) (applying the Americans with Disabilities Act, 42 U.S.C. §§ 12101-12213).

<sup>43</sup> In addition to *Bing v. Thunig*, 143 N.E.2d 3, 8-9 (N.Y. 1957), see *President and Dir. of Georgetown Coll. v. Hughes*, 130 F.2d 810 (D.C. Cir. 1942) (abolishing charitable immunity for hospitals); *Darling v. Charlestown Cmty. Hosp.*, 211 N.E.2d 253, 260 (Ill. 1965) (applying corporate liability to hospital); *Thompson v. Nason Hosp.*, 591 A.2d 703, 708 (Pa. 1991) (same).

<sup>44</sup> See *Rosenblatt*, *supra* note 30, at 264-70 (summarizing the legislative history of and the public benefit endowed by the Hill-Burton Act).

<sup>45</sup> See *ROSENBLATT ET AL.*, *supra* note 1, at 917, 931 (citing statement made in 1935 by Dr. Malcolm MacEachern, Director of Professional Relations of the American Hospital Association to the effect that *all* hospitals are “public” and have a responsibility to the community).

tioning, and craft more flexible legal principles.<sup>46</sup> The political legacy of the New Deal included the view that liberty (and indeed democracy) were threatened when private markets did not enable people to meet basic human needs; that the inability to meet these needs on a large scale was not simply aggregated individual failing or the inescapable logic of the market, but was rather the product of an interdependent society, and that government could and should intervene in markets and institutions whose workings threatened fundamental well-being.<sup>47</sup> In 1957, the New York Court of Appeals overruled its *Schloendorff* precedent for these kinds of reasons. First, wrote Judge Fuld in *Bing v. Thunig*,<sup>48</sup> hospitals had been transformed from arguably fragile charities to large, businesslike institutions.

They regularly employ on a salary basis a large staff of physicians, nurses and internes [*sic*], as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly, the person who avails himself of "hospital facilities" expects that the hospital will attempt to

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<sup>46</sup> See Rand E. Rosenblatt, Note, *Legal Theory and Legal Education*, 79 YALE L.J. 1153, 1165-72 (1970) (discussing Legal Realism).

<sup>47</sup> See, e.g., *West Coast Hotel v. Parrish*, 300 U.S. 379, 391 (1937) (upholding State's minimum wage for women as a valid constitutional restriction of contractual liberty, because "the liberty safeguarded [under the Due Process Clause of the 14th Amendment] is liberty in a social organization which requires the protection of law against the evils which menace the health, safety, morals, and welfare of the people"); Franklin D. Roosevelt, Eleventh Annual Message to Congress (Jan. 11, 1944), in *THE ESSENTIAL FRANKLIN DELANO ROOSEVELT* 290, 294-95 (John Gabriel Hunt ed., 1995):

We have accepted, so to speak, a second Bill of Rights . . . [a]mong these [rights] are: [t]he right to a useful and remunerative job . . . ; [t]he right to earn enough to provide adequate food and clothing and recreation . . . ; [t]he right of every family to a decent home; [t]he right to adequate medical care and the opportunity to achieve and enjoy good health; [t]he right to adequate protection from the economic fears of old age, sickness, accident, and unemployment; the right to a good education.

See also Richard B. Stewart, *Evaluating the New Deal*, 22 HARV. J. L. & PUB. POL'Y 239, 240 (1998-1999):

First, the New Deal firmly established the proposition that the federal government ought to take responsibility for the overall productivity and health of the economy at the macro-economic level . . . .Second, the New Deal established the proposition that the federal government has a basic responsibility for protecting individuals and families against the economic risks of an industrial market economy through various means of social insurance and assistance.

<sup>48</sup> 143 N.E.2d 3 (N.Y. 1957)



cure him, not that its nurses or other employees will act on their own responsibility.<sup>49</sup>

Second, social expectations about due care and fairness had changed. The idea that certain kinds of institutions and actors should be flatly immune from damages, and could cause harm without recourse, violated basic concepts of due care and accountability. "The rule of nonliability is out of tune with the life about us, at variance with modern-day needs and with concepts of justice and fair dealing."<sup>50</sup> Or, as the California Supreme Court stated in a 1963 opinion, a hospital's demand that patients sign a release from liability for future negligence as a condition of admission is unenforceable. "[T]he hospital cannot claim isolated immunity in the interdependent community of our time. It, too, is part of the social fabric, and prearranged exculpation from its negligence must partly rend the pattern and necessarily affect the public interest."<sup>51</sup>

Change in the common law liability of hospitals was only a small part of the social contract phenomenon. The crisis of western capitalism in the 1930s, the rise of fascism, and the defeat of and exposure to the horrors of Nazi Germany in World War II, among other large-scale factors, led to major changes in political and legal consciousness. There was widespread conviction, embodied in such diverse forms as the National Labor Relations Act of 1935, Universal Declaration of Human Rights of 1948,<sup>52</sup> the expansion of the European social welfare systems, and the movements to dismantle the European empires in Asia and Africa, that predatory hierarchies of many sorts were no longer acceptable. "Human rights" and "social rights," so long reserved primarily for the well-off and educated members of the (largely white and male) "political class," now had to be extended much more widely, although exactly how widely remained a matter of bitter contention.<sup>53</sup> In the United States these trends found expression

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<sup>49</sup> *Id.* at 8.

<sup>50</sup> *Id.* at 9.

<sup>51</sup> *Tunkl v. The Regents of the Univ. of Cal.*, 383 P.2d 441, 449 (1963).

<sup>52</sup> The Universal Declaration of Human Rights was, of course, drafted by a committee chaired by President Roosevelt's widow and formidable political presence in her own right, Eleanor Roosevelt. Article 25(1) of the Declaration provides that:

Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

For discussion of this Article and the movement for international human rights as it relates to health care, see FARMER, *supra* note 7, at 213-46.

<sup>53</sup> See generally ERIC FONER, *THE STORY OF AMERICAN FREEDOM* 195-247

in the African-American civil rights movement of the 1950s, 1960s and beyond, the movements of other racial and ethnic groups, notably Native Americans, and the legal services, welfare rights, women's rights, disability rights, and gay rights movements of subsequent years. Judicial opinions, statutes, regulations, and legal scholarship using the social contract model in many areas were inspired by these social movements, and several generations of lawyers and legal academics, myself included, were mobilized into the field of health law through them.<sup>54</sup>

The legacy of the egalitarian social contract can be found in a paradigm case from the United States Supreme Court which, though not itself about health law, established the principle that the rule of law applied to federal social welfare legislation generally, including (as held in subsequent cases) medical assistance for the poor (Medicaid).<sup>55</sup> In *Rosado v. Wyman*,<sup>56</sup> a bipartisan six-justice majority<sup>57</sup>

(1998) (exploring the impacts of the New Deal and World War II on American society and the rights of individuals); J. M. ROBERTS, TWENTIETH CENTURY: THE HISTORY OF THE WORLD, 1901 to 2000 554 (1999) (discussing how political and social ideas were originally confined to their European origins but are currently spreading more widely); cf. ERIC HOBSBAWM, THE AGE OF EXTREMES: A HISTORY OF THE WORLD, 1914-1991 268-74 (1994) (linking the unprecedented economic growth of the advanced capitalist nations during the 30 years after World War II to the "restructuring of capitalism" along more egalitarian and centrally directed lines).

<sup>54</sup> Since Professor Max Mehlman invited the participants in this Symposium to say something about their own path into health law, I will say that I took a course with Professor Edward Sparer on Welfare Rights and a seminar with Professor Robert Stevens on Medicaid in the late 1960s at the Yale Law School; worked with (later to be) Professors Lee Albert and Sylvia Law on a Medicaid case at the Columbia Center for Social Welfare Law in 1969, and became a staff attorney at the Health Law Project of the University of Pennsylvania Law School (under the direction of Edward Sparer and Sylvia Law) in 1972. I worked on the Project's "Health Law Materials" that were used in a number of health law courses in the 1970s and served as the inspiration for the casebook by Rand E. Rosenblatt, Sylvia A. Law & Sara Rosenbaum, ROSENBLATT ET AL., *supra* note 1. For an account of Ed Sparer's outstanding research and advocacy in the field of health and social welfare law see Rand E. Rosenblatt, *Equality, Entitlement, and National Health Care Reform: The Challenge of Managed Competition and Managed Care*, 60 BROOKLYN L. REV. 105, 112-16 (1994).

<sup>55</sup> See, e.g., *Bass v. Rockefeller*, 331 F. Supp. 945 (S.D.N.Y. 1971) (holding that the Social Security Act protects Medicaid recipients from state modifications that would reduce benefits without federal approval); *Bass v. Richardson*, 338 F. Supp. 478 (S.D.N.Y. 1971) (holding that the state could not cut Medicaid benefits without showing that § 1902(d) has been met); *Wilder v. Virginia Hosp. Assn.*, 496 U.S. 498 (1990) (holding that mandatory provisions of the Medicaid Act create rights enforceable under 42 U.S.C. § 1983).

<sup>56</sup> 397 U.S. 397 (1970).

<sup>57</sup> Justice Harlan's opinion was joined by his fellow Republican Potter Stewart, liberal Democrats William Douglas, William Brennan, and Thurgood Marshall, and conservative Democrat Byron White. New Deal Democrat Hugo Black and

opinion by then-considered conservative Justice John Marshall Harlan, stood for three important principles. First, statutes dealing with complex social policy issues (in *Rosado*, about cost-of-living adjustments to welfare eligibility standards) should be interpreted if at all possible as sources of meaningful law. Implicitly acknowledging the tendency of the political branches of government to underenforce and ignore legal provisions benefiting the poor and other politically weak groups, Justice Harlan said that courts (and agencies) should avoid reading statutes in ways that make them “a futile, hollow, and indeed, a deceptive gesture”<sup>58</sup>—laws that seem to promise something for the poor, but “really” mean nothing more than formal assurances and empty bureaucratic labels. Second, the statute may contemplate not a clear rule or benefit, but a process of structured or bounded discretion, in which a federal or state agency is supposed to take certain information and values into account. Such a “consideration rule” gives rise to a right of the ultimate beneficiaries to have that consideration take place.<sup>59</sup> Third, statutes such as these, even when framed as conditions on federal funding to the states, can be treated as individual (and, through class actions, group) rights, enforceable in court directly against the relevant state decisionmakers. Congress’ delegation to a federal agency of authority to define and enforce these statutory conditions did not preclude direct judicial action against the states, unless Congress had clearly indicated such preclusion. This was particularly true where neither Congress nor the agency had given beneficiaries access to the administrative process or effective administrative remedies. “We are most reluctant,” wrote Justice Harlan, “to assume that Congress has closed the avenue of effective judicial review to those individuals most directly affected by the administration of its program.”<sup>60</sup>

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Republican Warren Burger dissented. There were eight justices on the Supreme Court at that moment rather than the usual nine.

<sup>58</sup> *Rosado*, 397 U.S. at 415.

<sup>59</sup> *Rosado* can be viewed formally or technically as not being about structured discretion, because the Court interpreted the particular federal statutory provision at issue as requiring the state to adjust its “standards of need” (dollar amounts for different-sized families below which the family is said to be “in need”), leaving the state no, or virtually no, discretion as to that matter. However, the opinion placed this provision in a broader context: the state still had discretion to set actual grant levels at a lower dollar amount than the standards of need, and the statutory requirement of updating the standards was understood as forcing the state to engage in a candid process of acknowledging how much below its own standards it had decided to pay. *Id.* at 413-14.

<sup>60</sup> *Id.* at 420 (finding that state welfare provisions are judicially reviewable). For additional discussion of the *Rosado* principles, their incorporation into social welfare and health law, and the attack on them by Chief Justice Rehnquist and his

The social contract model speaks to most areas of health care delivery, ranging from financing and access to the meaning of quality and the nature of the physician-patient relationship. It does not provide formulas or easy answers; on the contrary, it asserts that these are matters of social and political choice broadly understood, informed by expertise and values relevant to health care delivery, but not to be resolved solely by the purportedly simple (but actually quite contested) metrics of “medical expertise” or “efficiency.” In particular, the social contract model tends to see health insurance as social insurance, i.e. as a means of meeting the basic human need for health care

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colleagues, see Rand E. Rosenblatt, *The Courts, Health Care Reform, and the Reconstruction of American Social Legislation*, 18 J. HEALTH POL. POL'Y & L. 439 (1993). Activist conservative advocates and judges have continued to attack the *Rosado* principles aggressively, notably in *Westside Mothers v. Haveman*, 133 F. Supp. 2d 549 (E.D. Mich. 2001), *rev'd*, 289 F. 3d 852 (6th Cir. 2002), *cert. denied*, 537 U.S. 1045 (2002). The district judge in *Westside Mothers* invited a private organization to make the arguments against beneficiary enforcement of the federal Medicaid statute when the state failed to pursue them with what he viewed as sufficient vigor. *Id.* at 552. For a review and critique of the *Westside Mothers* decision, see Sylvia A. Law, William Howard Taft Lecture, *In the Name of Federalism: The Supreme Court's Assault on Democracy and Civil Rights*, 70 U. CIN. L. REV. 367, 392-95 (2002). As the Sixth Circuit summarized:

In a detailed and far-reaching opinion, the district court held that Medicaid was only a contract between a state and the federal government, that spending-power programs such as Medicaid were not supreme law of the land, that the court lacked jurisdiction over the case because Michigan was the “real defendant and therefore possess[ed] sovereign immunity against suit,” [133 F.Supp.2d at 553] that in this case *Ex parte Young* was unavailable to circumvent the state's sovereign immunity, and that even if it were available § 1983 does not create a cause of action available to plaintiffs to enforce the provisions in question.

289 F.3d at 857. The Sixth Circuit “reverse[d] on all issues presented,” reasoning that “[b]inding precedent has put the issue to rest. The Supreme Court has held that the conditions imposed by the federal government pursuant to statute upon states participating in Medicaid and similar programs are not merely contract provisions; they are federal laws.” *Id.* at 857 - 858 (citing *Bennett v. Ky. Dep't of Educ.*, 470 U.S. 656, 669 (1985)). The Supreme Court denied certiorari without dissent, 537 U.S. 1045 (2002). Nevertheless, President Bush nominated Jeffrey Sutton, Esq., the private attorney who made the radical anti-enforceability arguments that prevailed in the district court, to the Sixth Circuit Court of Appeals, and the Senate confirmed his appointment. See Neil A. Lewis, *Senate Approves a Nominee; Filibuster is set for Another*, N.Y. TIMES, Apr. 30, 2003, at A22. See also *M.A.C. v. Betit*, No. 2:02CV1395, 2003 WL 22119134, at \*6 (D. Utah, Aug. 26, 2003) (holding particular provisions of federal Medicaid statute unenforceable by private beneficiaries because neither the general authorizing language of the Medicaid Act nor the specific provisions relied on by the plaintiffs “contain rights-creating language unequivocally conferring an individual right to support a cause of action under [42 U.S.C. § 1983],” as required by *Gonzaga University v. Doe*, 536 U.S. 273 (2002)). The statute at issue in *Rosado* also contained no explicit rights-creating language.

with funds derived from the society or some large sub-group within it. The financial burden of health care is inevitably distributed unevenly, with sick or injured people facing far more costs than others.<sup>61</sup> In the social contract view, the goal of health insurance is to spread these costs as broadly as possible, so as to lower the per capita financial impact, reduce administrative expenses (no need for risk selection), and provide as many people as possible with reasonably-priced access to health insurance and health services against the largely random risks of illness and injury. To achieve this kind of universalism, or what Deborah Stone calls the “logic of solidarity” and mutual aid,<sup>62</sup> payments into the system (through taxes, premiums, and patient out-of-pocket cost-sharing) have to be generally equal and affordable (and thus subsidized for lower-income enrollees), and benefits have to be as far as possible available to all on the basis of medical need, with minimal influence of “ability to pay, past consumption of medical care, or expected future consumption.”<sup>63</sup>

Like the professional authority model before it, the social contract model, as it emerged in American health law and policy, was unable to solve three major and related problems. First, because of the considerable political power of the hospital industry and organized medicine, the major federal health insurance programs enacted in 1965—Medicare and Medicaid—had to acquiesce to hospital control of prices through payment of dramatically misnamed “reasonable costs,” and (for Medicare) physician control of prices through fee-for-service payment for “reasonable,” “customary,” or “prevailing” charges.<sup>64</sup> These mechanisms, which were substantially in place until the early 1980s, the absence of a strong constituency for restraint; and the high political costs of “control[ing] the incomes of all those with interests in the health care industry,”<sup>65</sup> made it impossible for the social contract model to constrain very rapid increases in prices and overall health expenditures. Second, as medical and pharmaceutical technol-

<sup>61</sup> See JOST, *supra* note 3, at 8-9 (“[T]he 1% of the population that spends the most on health care is responsible for 27% of health care costs, and ... the top 10% [ ] for nearly 70%.” On the other hand, “the least expensive 50% of the population accounts for only 3% of health care expenditures”).

<sup>62</sup> Deborah Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL’Y & L. 287, 290 (1993) (discussing whether solidarity principle or actuarial logic should govern health insurance).

<sup>63</sup> *Id.* at 292.

<sup>64</sup> See, e.g., STARR *supra* note 6 at 374-78 (regarding the power of hospitals to initially wield considerable control over prices and payment); THEODORE MARMOR, *THE POLITICS OF MEDICARE* 85-86 (1973) (illustrating how the methods and costs of paying physicians and hospitals were the most serious problems under Medicare).

<sup>65</sup> STARR, *supra* note 6, at 412.

ogy continued its explosive development, many began to believe that there needed to be some way to regulate or restrain use of the most expensive (and often experimental or at least not clearly proven beneficial) modalities. But the increasingly entrepreneurial and income-driven culture of doctors and hospitals precluded low-visibility rationing, and the framers of the social contract (political leaders and to a lesser extent, judges) could find no acceptable political or legal basis for rationing.<sup>66</sup> Third, political leaders working with the social contract model were unable to devise a method of redistribution that would fund universal access and be politically acceptable to those who already had private health insurance—much of the middle class (including unionized blue-collar sectors) and more affluent socioeconomic groups. Instead, programs such as Medicare and Medicaid had to rely primarily on relatively regressive tax bases—the federal payroll tax and out-of-pocket cost-sharing for Medicare, and (for the non-federal share) state sales and income taxes for Medicaid. These limitations guaranteed various inadequacies in coverage and provider payment in both programs, as well as over forty million people without health insurance. President Clinton attempted to solve these problems with a national health insurance proposal that ingeniously combined the social contract, market competition, and professional authority models, but was unable to mobilize the political support needed to overcome intense opposition.<sup>67</sup>

### C. The Market Competition Model

Advocates of market competition rose to prominence in the 1970s by launching two major attacks on the previously dominant professional authority and social contract models. First, they argued that both the scientific justification for professional authority and the pub-

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<sup>66</sup> For examples and discussion of judicial and political reaction to insurers' efforts to deny payment for expensive care of an arguably debatable benefit—high dose chemotherapy with autologous bone marrow transplants for various stages of breast cancer—see ROSENBLATT ET AL., *supra* note 1, at 224-37, 251-61 and ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 196-213 (2001 & 2001-02 Supp.).

<sup>67</sup> Among many other reasons, the Clinton plan was seen as having failed, in part, because its policy synthesis was too complex, untried, and understandably reticent about its cost containment features, and because too much energy was spent on policy analysis and design and too little on political "communication and persuasion." JACOB HACKER, THE ROAD TO NOWHERE: THE GENESIS OF PRESIDENT CLINTON'S PLAN FOR HEALTH SECURITY 179 (1997). See also THEDA SKOCPOL, BOOMERANG: CLINTON'S HEALTH SECURITY EFFORT AND THE TURN AGAINST GOVERNMENT IN U.S. POLITICS (1996) (analyzing the failure of the Health Security effort and the tremendous political opposition President Clinton could not overcome).

lic interest justification for the social contract were largely illusory, particularly as expressed in actual American health care policy. Most health care services were not matters of immediate life-and-death, nor scientifically validated as "necessary," but rather were matters of comfort and convenience, and should be properly treated as discretionary consumption.<sup>68</sup> The asserted logic of solidarity or mutual aid largely functioned as a cover for self-interested and powerful groups to grab a monopolistic (in the case of doctors and hospitals) or otherwise unfair share of common resources. Hence, the profound inequity of tax-subsidized employment-based health insurance, which allows the upper-middle class to avoid paying taxes on lavish employer-provided health insurance policies, while providing no benefit to low-wage workers whose employers offer no health insurance at all, and, according to Professor Clark Havighurst, much less benefit to lower-income insured workers who often lack the upper-middle class's social connections with elite doctors and aggressive sense of entitlement.<sup>69</sup> Second, the market advocates argued, in the classic fashion of all conservative arguments against equality and mutual aid,<sup>70</sup> that the egalitarian social contract model led to perverse and dysfunctional results, notably unrestrained cost increases and misallocation of resources. By severing the demand for health services from the individual's obligation to pay, tax subsidies and social insurance (including its private American version, community-rated Blue Cross/Blue Shield) supported consumption of decreasingly beneficial services, while denying desperately needed care to those with inadequate economic and political power to secure the benefits of politically-structured solidarity.

More generally, the market advocates denied that government regulation could provide any solution to the problems of equity and

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<sup>68</sup> See Charles Fried, *Health Care, Cost Containment, Liberty*, in *ETHICAL ISSUES IN MODERN MEDICINE* 527, 527-29 (John Arras & Robert Hunt eds., 1983); Clark C. Havighurst & James Blumstein, *Coping with Quality/Cost Trade-Offs in Medical Care: The Role of PSROs*, 70 *NW. U. L. REV.* 6, 12 (1975). Support for this view was said to come from the small area "geographic variation" studies by Dr. John Wennberg and others, who showed that widely varying geographical rates in surgical procedures and hospitalization could not be explained by demographic factors such as age or incidence of illness. Therefore, the argument went, these procedures were less an objective necessity than a "choice" shaped by medical fashion and/or patients' own culturally-influenced expectations. See, e.g., ENTHOVEN, *supra* note 3, at 46.

<sup>69</sup> See Havighurst, *supra* note 2, at 86-87, 92-94 (discussing the basis of the inequities of our present health care system).

<sup>70</sup> See generally ALBERT O. HIRSCHMAN, *THE RHETORIC OF REACTION: PERVERSITY, FUTILITY, JEOPARDY* (1991) (discussing the perversity, futility, and jeopardy theses, which are typically used by conservatives to attack liberal egalitarian policies).

cost containment. Governmental or (as in the case of Blue Cross/Blue Shield) private nonprofit financing and regulatory programs are notoriously subject to “capture” by powerful and well-organized interests (in this context, doctors and hospitals),<sup>71</sup> as the history of Blue Cross/Blue Shield, Hill-Burton, Medicare, and Medicaid seemed to confirm. Moreover, governmental agencies lack the technical skills and political authority to influence the powerful forces of economic self-interest that operate in the health care industry as they do anywhere else.<sup>72</sup> The market advocates proposed to solve two of the three problems that bedeviled the social contract model: cost containment and rationing. Both would be accomplished in the only way that, in this view, was politically acceptable to most Americans as well as pragmatically feasible: the market, which constrains costs through the pressures of competition and rations through the magic of “voluntary” consumer choice in response to price signals.<sup>73</sup> The third problem—universal access or health insurance—admittedly could not be solved through purely market means, because some redistributive mechanism had to be built in to subsidize access for low-income people. Even here, though, market advocates claimed that a dominant market principle would help. Once the market had achieved cost containment and rationing for most of the population, the redistributive task would be smaller and less politically controversial.

As with the earlier emergence of the social contract model, the political and intellectual rise of the market competition model was due to factors both internal and external to health care delivery. The inability of the social contract model to restrain annual double-digit increases in health care spending, epitomized by the Carter Administration’s proposal of and failure to enact hospital price controls, strongly reinforced in the health care context a broader deregulatory movement among economists, other policy experts, and politicians away from “command and control” approaches and in favor of market mechanisms.<sup>74</sup> The pro-market, anti-government phenomenon, like

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<sup>71</sup> See ENTHOVEN, *supra* note 3, at 111.

<sup>72</sup> See *id.* at 102-03, 111-13.

<sup>73</sup> *Id.* at 111-13.

<sup>74</sup> See, STARR, *supra* note 6, at 412-13; ENTHOVEN, *supra* note 3, at 97-101.

See also CLARK C. HAVIGHURST, HEALTH CARE CHOICES 98 (1995) [hereinafter HEALTH CARE CHOICES] (discussing how federal policy concerning health care changed in the late 1970’s); cf. ROBERT KUTTNER, EVERYTHING FOR SALE: THE VIRTUES AND LIMITS OF MARKETS 34-37 (1996). Detailed accounts of the rise of the market competition perspective can be found in Gail B. Agrawal & Howard R. Veit, *Back to the Future: The Managed Care Revolution*, 65 LAW & CONTEMP. PROBS., Autumn 2002, at 11, 11-36 and James C. Robinson, *The Politics of Managed Competition: Public Abuse of the Private Interest*, 28 J. HEALTH POL. POL’Y & L. 341, 341-



the social contract model before it, was also connected to larger and deeper forces. Such phenomena as suburbanization, the decline of manufacturing and organized labor, the reaction of many Americans against the movements for African-American civil rights, feminism, and gay rights, the Watergate crisis, the cultural ferment of the 1960s and 1970s, and the deregulation of international finance and trade formed a complex brew in which a new conservative political coalition would arise that linked, more effectively than ever before, laissez-faire capitalism and social traditionalism (including religious fundamentalism and significant support for hierarchies of race, gender, and sexual orientation).<sup>75</sup>

An idea critical to the market model is that the individual health care consumer experiences the true costs of her or his choices. Where the social insurance model wants to separate the consumption of health care as much as possible from the individual's ability to pay, and regards linking the two as largely irrational, the market competition model wants to intensify the connection. Thus two prominent law professor advocates of the market competition model, Clark Havighurst and James Blumstein, state that the appropriate test for evaluating a health care financing system's performance is whether "it give[s] reasonable individuals what they want *and only what they want*, in the sense that, understanding the alternatives, they would purchase it for themselves assuming their income is not below a certain level, perhaps the median in the population."<sup>76</sup>

The problem, according to the market advocates, is that the failure to tax employment-based health insurance or deduct its cost from employees' wages gives employees the false impression that both the insurance and health services are "free," thereby leading to inefficient overconsumption of health insurance and health care services. In terms of Havighurst's and Blumstein's criterion above, this overconsumption means that millions of Americans are receiving more health insurance and more health care services than they "really want," because what they "really want" can only be determined by how they

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46 (2003).

<sup>75</sup> See, e.g., THOMAS BYRNE EDSALL & MARY D. EDSALL, CHAIN REACTION: THE IMPACT OF RACE, RIGHTS, AND TAXES ON AMERICAN POLITICS (1992) (arguing that the Republican party gained support during the second half of the twentieth century by utilizing the issues of race and taxes); THOMAS BYRNE EDSALL, THE NEW POLITICS OF INEQUALITY 73 *passim* (1984) (explaining how and why various adversarial and generally conservative groups came together to support the Republican Party in the 1970's and how that convergence created a shift in the balance of power in American politics).

<sup>76</sup> Havighurst & Blumstein, *supra* note 63, at 15-16 (emphasis in the original).

would spend their money if they had to buy health insurance and health services with their own after-tax dollars. The goal of market reform is to reduce or eliminate the current tax exclusion of health insurance, and thereby drive middle-income people's insurance down to the level where it should properly be—at the level they will choose when they pay for it with their own after-tax dollars. They would then experience individual responsibility for, and freedom of, their choices.<sup>77</sup> Of course, better-off people would be free to buy better insurance and services.

Having (by hypothesis) created millions of cost-conscious consumers searching for the best health insurance “deal,” what kind of competition among insurers should be encouraged or required by law and policy? Interestingly, two of the most prominent academic market advocates—Alain Enthoven and Havighurst—reject what Enthoven calls “a completely free market” in favor of “rules to channel the competition along socially desirable lines,”<sup>78</sup> widely known as “managed competition.” Although Enthoven and Havighurst appear to differ somewhat on the relative roles of government and private entities, they both endorse standardized health insurance policies with a few tiers of benefits and co-payments, so that consumers can easily compare options and prices.<sup>79</sup> Enthoven would have government mandate open enrollment and community rating, so as to “require all insurers (or at least all those whose policies are eligible for tax subsidies) to accept the bad risks (those who need insurance the most) along with the good risks and to charge them the same premium.”<sup>80</sup>

Under Havighurst's approach, a “sponsor” of managed competition (e.g. a large employer, coalition of smaller employers, “purchasing cooperative,” or governmentally-designated entity) would “make” or regulate the market of competing “health plans” through similar rules and policies, including risk-adjusted payments reflecting the “risk profiles of the populations attracted by each plan” (thereby forc-

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<sup>77</sup> See Fried, *supra* note 63, at 529-30 (discussing why individuals should determine what level of health care they need and why each should be responsible for its cost). For a critique of this vision of freedom, see *Privatizing Health Care*, *supra* note 12, at 10, *passim* (arguing that the market conception of human freedom is incoherent, because it reduces normative human choice to the “freedom” to obey or comply with the “natural” or “empirical” dictates of markets).

<sup>78</sup> ENTHOVEN, *supra* note 3, at 78. See also Clark C. Havighurst, *Controlling Health Care Costs: Strengthening the Private Sector's Hand*, 1 J. HEALTH POL. POL'Y & L. 471, 490-91 (1976-1977) (arguing in favor of a “market oriented” health care system which would take into account social justice concerns).

<sup>79</sup> ENTHOVEN, *supra* note 3 at 127-29; HEALTH CARE CHOICES, *supra* note 69, at 26.

<sup>80</sup> ENTHOVEN, *supra* note 3 at 80.

ing the better health risks to subsidize the so-called bad risks) and discretionary power to exclude plans from the market that fall short of "reasonable" contract terms and "style of care."<sup>81</sup> By deterring competition to enroll healthier patients, both versions hope to force price competition to reflect true quality and efficiency, including "cost/quality trade-offs." Havighurst particularly emphasizes new kinds of contracts between health plans (insurers or integrated insurer-providers) and their enrollees and providers, in which plans would "overtly differentiate themselves from one another in the nature and content of the services they provide."<sup>82</sup> Havighurst's strategy is to allow plans to offer, and moderate or low income consumers to purchase, something less than "first-class, state-of-the-art, American style medical care," which he refers to as a "health care Cadillac."<sup>83</sup> The exact nature of these lesser quality, more risky insurance contracts and medical "practice style[s]"<sup>84</sup> is not, in my view, entirely clear. At times Havighurst suggests that they would authorize "small compromises on content and quality" or "slightly greater risks."<sup>85</sup> He also states that "[a] crucial assumption . . . is that government will provide, either directly or through the tax system, adequate public support of individuals' purchasing power, so that consumers are not forced to carry their economizing to socially objectionable extremes."<sup>86</sup> At other times Havighurst appears to characterize the lower cost options in terms of "vital basic services," "bare-bones coverage," "aggressive economizing," and "only the most essential needs."<sup>87</sup> In any event, under his proposed approach to health law Havighurst wants moderate and low-income consumers to have the option to waive many or most

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<sup>81</sup> HEALTH CARE CHOICES, *supra* note 69, at 36-38.

<sup>82</sup> *Id.* at 137.

<sup>83</sup> *Id.* at 104.

<sup>84</sup> *Id.* at 136.

<sup>85</sup> *Id.* at 104.

<sup>86</sup> *Id.* at 25-26. Enthoven states, "we are not willing to leave the distribution of medical purchasing power to the market and other forces that determine income distribution," and therefore the government should assist "the poor" through a system of income-related premium subsidies "that are large enough to enable them to purchase . . . a good-quality comprehensive health care plan" including "choice" among available plans. ENTHOVEN, *supra* note 3 at 81. Given that "the typical family policy for all types of health plans averaged \$9,068 a year in the spring of 2003," Tony Pugh, *Health-Plan Premiums Spike 14 pct. in One Year*, PHILA. INQUIRER, Sept. 10, 2003, at C1, and that median family income was \$42,409 in 2002, Lynette Clemetson, *More Americans in Poverty in 2002, Census Study Says*, N.Y. TIMES, Sept. 27, 2003, at A10, it appears that subsidies would have to extend beyond "the poor" in 2003.

<sup>87</sup> HEALTH CARE CHOICES, *supra* note 69, at 104, 105, 138, 140. How these terms can be seen as consistent with a standardized benefits package is also not self evident.

of their legal rights under tort and contract law, as a way of further lowering the plan's price and freeing providers to engage in economizing practice styles.<sup>88</sup>

The market competition model has played out rather differently in the real world of health law and policy. One of the key components of Enthoven's and Havighurst's vision—the deterrence of preferred risk selection and channeling of price competition into some version of quality and efficiency—was not enacted into law and has otherwise largely failed to take place. On the contrary, from the perspective of the for-profit health insurance industry, risk selection, medical underwriting, and experience rating are the essence of a properly functioning market.<sup>89</sup> Health insurance is not seen as a social mechanism for paying for the health care needs of a population. Rather, insurance is seen as a transaction between two economically “rational” actors—an individual (or group of aggregated individuals) and an insurance company. Each of these actors is trying to achieve maximum economic utility. The individual (or group) wants the lowest possible price for the desired insurance coverage. The insurance company wants the maximum profit. The logic of this perspective leads to market fragmentation, the exact opposite of the universalism and solidarity of social insurance. In the market, individuals want to associate themselves with the lowest possible risk group, and exclude people with serious illnesses or other high cost characteristics. Insurance companies want to segregate risk pools as much as possible—the industry term is “actuarial fairness”—so as to charge low competitive prices to healthy groups and high, actuarially appropriate premiums to people with high cost characteristics.<sup>90</sup>

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<sup>88</sup> *Id.* at 266, 303-19.

<sup>89</sup> See generally Stone, *supra* note 57 (discussing conflicting distributive justice theories affecting American health politics); see also Deborah Stone, *The Rhetoric of Insurance Law: The Debate Over AIDS Testing*, 15 LAW & SOC. INQUIRY 385, 388-91 (1990) [hereinafter *Rhetoric of Insurance Law*] (analyzing the effect of using HIV/AIDS diagnostic testing in insurance underwriting).

<sup>90</sup> Stone, *supra* note 57, at 290. For arguments in favor of risk rating, see *Rhetoric of Insurance Law*, *supra* note 84, at 392-93 (explaining the view that insurers have a “positive duty” to separate identifiable risk groups, otherwise the healthy will end up subsidizing the unhealthy); Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 942, 963-64 (1963) (justifying the use of risk rating by explaining why pooling unequal risks is problematic). For arguments against risk rating, see David M. Frankford, *Neoclassical Health Economics and the Debate Over National Health Insurance: The Power of Abstraction*, 18 LAW & SOC. INQUIRY 351, 365-71 (1993) [hereinafter *Neoclassical Health Economics*]; Bryan Ford, *The Uncertain Case for Market Pricing of Health Insurance*, 74 B.U. L. REV. 109, 110-20 (1994) (arguing that the use of market pricing and risk rating undermine the ability of insurance to provide community coverage for all people). See also, Mark V. Pauly, *Risk Variation and Fallback Insurers in Universal*

A paradigm case for the market competition model of this sort is *McGann v. H. & H. Music Co.*<sup>91</sup> John McGann, an employee of H & H Music, discovered that he was afflicted with AIDS in December 1987 and soon submitted his first claims for reimbursement under the company's group health insurance policy, which provided for lifetime benefits up to one million dollars. In July 1988, the company informed its employees that it was not renewing its group health insurance policy, and that its new self-insured health plan included a five thousand dollar lifetime cap on benefits payable for AIDS-related (but no other) illnesses.<sup>92</sup> McGann sued H & H Music under section 510 of the Employee Retirement Income Security Act (ERISA),<sup>93</sup> arguing that the five thousand dollar AIDS cap was directed specifically at him in retaliation for exercising his rights under the company's then-existing plan, and that to prohibit such actions by employers, the previously-existing health plan should be interpreted as containing an implied promise not to "deselect" a known employee from the insurance pool.

To understand this argument, imagine that before McGann accepted a job with H & H Music, he had asked about the health benefits. Assume that the company spokesperson had replied: "You will have one million dollars in lifetime health coverage, except if you develop an unusual and expensive condition we may re-design the plan to limit severely your benefits for that condition." McGann and many other prospective employees might have refused such job conditions, and the company's failure to make this clear may have helped induce McGann to accept these conditions unknowingly.

The company conceded that the benefit reduction was prompted by knowledge of McGann's illness and that McGann was the only covered person then known to have AIDS, but the district court ruled for the company on the grounds that the employer had an absolute right to alter the terms of the plan regardless of its intent in making the alterations.<sup>94</sup> The Fifth Circuit affirmed, holding that while ERISA

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*Coverage Insurance Plans*, 29 INQUIRY: J. HEALTH CARE ORG. PROVISION & FIN. 137 (1992) (arguing that fallback insurers should be utilized as a compromise between complete risk rating and the prohibition against risk rating).

<sup>91</sup> 946 F.2d 401 (5th Cir. 1991), *cert. denied*, 506 U.S. 981 (1992).

<sup>92</sup> Other changed characteristics of the new plan included "increased individual and family deductibles, elimination of coverage for chemical dependency treatment, adoption of a preferred provider plan and increased contribution requirements." *Id.* at 403 n.1.

<sup>93</sup> ERISA, 29 U.S.C. § 1140 (2000) (prohibiting discrimination against a participant or beneficiary who exercises any right she is entitled to under an employee benefit plan).

<sup>94</sup> *McGann*, 946 F.2d at 403-04.

protected beneficiaries' rights under a plan, once an employer had changed a plan in a procedurally correct manner, employees no longer had any rights other than those specified in the new plan.<sup>95</sup> Quoting a Sixth Circuit opinion, the *McGann* court explicitly stated that ERISA embodied the model of market competition, in that "courts have no authority to decide which benefits employers must confer upon their employees; these are decisions which are more appropriately influenced by forces in the marketplace and, when appropriate, by [other] federal legislation."<sup>96</sup> In the wake of the *McGann* decision, the *New York Times* reported that many union and small employer health plans and at least one state high-risk insurance pool had adopted similar limitations on AIDS-related treatment.<sup>97</sup>

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<sup>95</sup> See *id.* at 405. By dropping its insurance policy and establishing a self-insured plan, H & H Music insulated itself (under ERISA's "deemer clause") from any state law requiring coverage or prohibiting discrimination in benefits. See 29 U.S.C. § 1144(b)(2)(B) (2000) (commonly known as the "deemer clause").

<sup>96</sup> *Id.* at 407 (quoting *Moore v. Reynolds Metals Co. Ret. Program for Salaried Employees*, 740 F.2d 454, 456 (6th Cir. 1984)). Arguing (successfully) against Supreme Court review, the Solicitor General stated that while ERISA did not regulate employers' design of plan benefits, the Americans with Disabilities Act (ADA), 42 U.S.C. §§12101 et seq. (enacted in 1990 and hence not applicable to the events in *McGann*) could resolve the problem. See Robert Pear, *U.S. to Argue Employers Can Cut Health Coverage*, N.Y. TIMES, Oct. 16, 1992, at A18. While the Equal Employment Opportunity Commission indeed interpreted the ADA as prohibiting disease-specific caps in most circumstances, see 1993 Daily Lab. Rep. (BNA) 109 d22 (June 19, 1993), the federal courts have rejected this view. See, e.g., *Doe v. Mutual of Omaha Ins. Co.*, 179 F.3d 557 (7th Cir. 1999) (holding that § 302(a) of the ADA does not prohibit disease specific caps, but rather, this practice is regulated by state law). Under Enthoven's approach, a policy with a disease-specific benefits cap would presumably not be eligible for federal funding through individuals' tax credits unless the government-defined standard policy permitted it. See ENTHOVEN, *supra* note 3, at 121-23. Havighurst states that plans may use disease-specific "practice guidelines" but should combine them "with other contractual strategies to implement a consistent plan policy throughout all the gray areas of medical practice." HEALTH CARE CHOICES, *supra* note 69, at 241. The reason plans should not use practice guidelines "to curb the use of a few costly treatments" is to prevent consumers from shopping for plans that might be generous for their particular (uncurbed) conditions. See *id.* Under Havighurst's approach, if expensive treatments for AIDS were not cost justified in terms of their health benefits at the time *McGann* was making claims (the late 1980s), the plan would have been justified in refusing to pay for them, ideally under appropriate general contractual language. On the other hand, a plan that capped payment for all AIDS-related costs, including humane, palliative care, might be refused entry into the managed care market by a reasonable plan sponsor. See *id.* at 38.

<sup>97</sup> Milt Freudenheim, *Patients Cite Bias in AIDS Coverage by Health Plans*, N.Y. TIMES, June 1, 1993, at A1. See also Stone, *supra* note 57, at 300-08 (reporting widespread de facto medical underwriting even for relatively large groups); *Rhetoric of Insurance Law*, *supra* note 84, at 390 n.7 (reporting that according to a 1988 Office of Technology Assessment survey of insurance underwriting practices, Medical Testing and Health Insurance, Doc. No. OTA-H-384, at 80, 85, "[s]eventy-seven of the

A second paradigm case of the market competition model is *Corcoran v. United Health Care*.<sup>98</sup> In this case, a physician recommended that a woman be hospitalized for the final weeks of her high-risk pregnancy, but a utilization review subcontractor (United Health Care) of the employer's self-insured health plan refused payment approval, and authorized part-time at-home nursing care instead.

This appears to be the kind of health insurer cost-benefit discretion that Havighurst has in mind. Hospitalization is obviously a very expensive way to control for the risk of fetal distress. If there were no scientific cost-benefit studies validating hospitalization over less expensive part-time at-home nursing, the insurer should have the authority to pay only for the less expensive care so as to keep premium costs within the employees' collective budget. The fact that while the patient was at home and not attended by the nurse the fetus went into distress and died is simply the incidental and voluntarily chosen result of the family's limited resources, the legitimacy of which is not (by hypothesis) challenged. It would be equivalent to someone dying in an automobile accident "because" they were driving a lightweight, low-cost automobile, which was all they could afford. As long as the automobile had passed the standards of state safety inspection, no one could complain that their legal rights had been violated because others, with more money, could afford heavier and safer vehicles.<sup>99</sup>

To be sure, Havighurst strongly advocates contractual candor about the health plan's authority to make such decisions, so as to make higher risk contracts legally enforceable (as they indeed turned out to be in *Corcoran* even with debatable candor) and politically legitimate.<sup>100</sup> Much to Havighurst's frustration, insurers seem to regard this as advice to commit marketing, liability, and provider-relations suicide.<sup>101</sup> Moreover, many moderate or lower-income peo-

commercial small-group insurers, 58% of the commercial large-group insurers, 77% of the Blue Cross-Blue Shield small-group plans, and 7% of the Blue Cross-Blue Shield large-group plans either screened or planned to screen for high-risk applicants"). *But see* Havighurst, *supra* note 2, at 69 n.50 (citing MARK A. HALL, REFORMING PRIVATE HEALTH INSURANCE 57 (1994), and FAMILIES USA, NO SALE: THE FAILURE OF BAREBONES INSURANCE (1993) for the contrary proposition, that "very few employers opted, when it was offered, for health insurance without certain state-mandated benefits and with arbitrary dollar or other caps on coverage").

<sup>98</sup> 965 F.2d 1321 (5th Cir. 1992), *cert. denied*, 506 U.S. 1033 (1992).

<sup>99</sup> *See* John A. Siliciano, *Wealth, Equity, and the Unitary Medical Malpractice Standard*, 77 VA. L. REV. 439, 439-40 (1991) (arguing that lower standards of medical care for the poor are no more problematic than the safety differences between a Volvo and a Volkswagen).

<sup>100</sup> Havighurst, *supra* note 2, at 96-100.

<sup>101</sup> *Id.* at 100. Havighurst also criticizes the managed care industry for not having been candid with consumers and for not having educated them during the

ple do not seem to accept riskier health care with the same grace that they appear to accept riskier automobiles.<sup>102</sup> The Corcorans' state law suit for damages claimed that United had been negligent in performing its role, which raised important questions about the nature of United's duty of care to patients, the applicable standard of care, and the qualifications of and procedures and criteria used by the personnel who denied authorization for the hospital stay.

The Fifth Circuit framed the key legal issue as whether United was making "medical decisions" about the care to be provided a particular patient or "benefit determinations" about what the plan would pay for.<sup>103</sup> Plan publications stressed both functions, and repeatedly stated that utilization review was based on "nationally accepted medical guidelines" and was "independent, professional review" that works "together with your doctor . . . to assure that you and your family receive the most appropriate medical care."<sup>104</sup> The Fifth Circuit reasoned that while United did make medical decisions, it did so "incident to benefit determinations," and therefore ERISA preempted any state-law damage action against it.<sup>105</sup> To allow such actions would impose costs varying among states on health plans using utilization review to achieve cost containment, thereby "decreasing the pool of funds available to reimburse participants" and contravening Congress' purported judgment that state law not "interfere" with ERISA's "carefully constructed scheme of federal regulation."<sup>106</sup> The *Corcoran* court acknowledged that ERISA itself does not provide for any dam-

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more politically favorable 1980s when cost savings were also much easier to achieve. *Id.* at 74-77.

<sup>102</sup> Havighurst sees consumers' false consciousness on this point as based on their continued insulation from the actual costs of their care, and hence neither their economic nor political choices "reveal their true preferences." *Id.* at 78.

<sup>103</sup> *Corcoran*, 965 F.2d at 1329-31.

<sup>104</sup> *Id.* at 1323-24.

<sup>105</sup> *Id.*

<sup>106</sup> 965 F.2d at 1331.

<sup>106</sup> *Id.* at 1333. The argument that tort damages for seriously injured patients must be precluded so as to preserve the limited pool of available funds was previously used to bar charitable patients from recovery under the doctrine of charitable immunity for hospitals. For reasons why this doctrine was abandoned, see *President and Dir. of Georgetown Coll. v. Hughes*, 130 F.2d 810, 822-23, 827 (D.C. Cir. 1942) (debunking torts-based arguments for maintaining a system of charitable immunity). For reasons why ERISA's express preemption provision, ERISA § 514, should not be regarded as "carefully constructed," see, e.g., *Rosenblatt, Law & Rosenbaum*, supra note 1, at 173-177 (discussing legislative history and last-minute expansion of § 514). For reasons why ERISA's remedies provisions, notably ERISA § 502, as interpreted by the Supreme Court, are widely regarded as conceptually erroneous and a policy disaster, see, for example., *Cicio v. Does*, 321 F.3d 83, 106 (2d Cir. 2003) (Calabresi, J., dissenting in part).



ages for “medical malpractice committed in connection with a plan benefit determination,”<sup>107</sup> and that therefore “the Corcorans have no remedy, state or federal, for what may have been a serious mistake.”<sup>108</sup> The court found this “troubling for several reasons,” notably that it eliminated a financial incentive for ERISA plans “to seek out the companies that can deliver both high quality services and reasonable prices,”<sup>109</sup> thereby implicitly encouraging health plans to use utilization reviewers who were dangerously committed to denying care. Nonetheless, the Fifth Circuit held that this is what the ERISA law meant, and that any needed changes were up to Congress to make.<sup>110</sup> Congress has not acted as of October 2003, eleven years after the *Corcoran* opinion. In the meantime, the Supreme Court and lower federal courts began to interpret ERISA to allow some state law litigation based on the social contract model to mitigate the unrestrained market.<sup>111</sup>

*Corcoran* and its political aftermath highlight a split between real world market-based health law and policy and at least some of the market model’s academic advocates. For example, Havighurst believes that managed care entities should be legally accountable, because that would help make their rationing policies and decisions politically and legally legitimate and acceptable to the public.<sup>112</sup> For these reasons, his version of the market model appears to be critical of Congress’ inaction in the wake of cases such as *Corcoran*.<sup>113</sup> On the

<sup>107</sup> *Corcoran*, 965 F.2d at 1333

<sup>108</sup> *Id.* at 1338.

<sup>109</sup> *Id.* at 1338.

<sup>110</sup> *Id.* at 1338-39.

<sup>111</sup> Without explicitly so holding, the Supreme Court cast considerable doubt on *Corcoran*’s continued viability in its opinion in *Pegram v. Herdrich*, 530 U.S. 211, 229, 231 (2000) (holding that “to the extent” that “an HMO” makes “mixed eligibility and treatment decisions” – i.e. whether a particular treatment is medically necessary for an individual patient – “through its physicians,” it is not to be treated as a fiduciary under ERISA). For the Fifth Circuit’s own view that *Pegram* and other Supreme Court decisions cast doubt on *Corcoran*, see *Roark v. Humana, Inc.*, 307 F.3d 298, 313-15 (5th Cir. 2002). Although the Fifth Circuit panel that decided *Roark* considered itself bound by the now dubiously correct *Corcoran* in one of the four cases consolidated in *Roark*, *id.* at 315, the same panel followed its view of *Pegram* in two of the other consolidated cases and held that ERISA § 502 did not support removal (also known as “complete preemption,” *id.* at 305) of state law liability claims against managed care entities, *id.* at 305-311. The Supreme granted certiorari on this ruling on November 3, 2003, *sub nom.* *Aetna Health Inc. v. Davila*, 124 S.Ct. 462 (2003) and *Cigna Healthcare of Texas, Inc. v. Calad*, 124 S.Ct. 463 (2003). By way of disclosure, I am a co-author of an amicus brief to the Supreme Court urging affirmance of the Fifth Circuit’s ruling regarding ERISA § 502.

<sup>112</sup> See Havighurst, *supra* note 2, at 75-77, 98-99.

<sup>113</sup> *Id.* at 98-99. Havighurst notes that:

other hand, Havighurst is clear that the new law of managed care liability should not rest on what he sees as the self-interested and scientifically unvalidated "professional standard" of care, and he hopes that properly drafted and disclosed economizing contracts will get a more supportive reception from the courts than has been traditionally accorded insurance contracts.<sup>114</sup> Under his proposal, there would be a new law of managed care liability that would draw the line between appropriate and inappropriate market-based rationing based on the values of the rationing or market phenomenon itself. Under this regime (assuming ERISA had been appropriately amended or reinterpreted) there could have been a trial on the merits in *Corcoran*, but the plaintiffs might well still lose, because the standard of care would have been reduced by the health insurance contract as interpreted in the light of the values of market competition.

Like the other two models, the market competition model has been able to address some problems better than others. Its managed care dimension is widely credited with restraining increases in health care costs during much of the 1990s. Whether this can be accurately attributed to "market competition" is debatable; certainly the vision of numerous insurer-provider entities supplying consumers with elaborate information and cost-effective choices has not come to pass. What did happen was a shift in bargaining power, with physicians and hospitals losing power to relatively concentrated insurer-managed care entities who aggregated large numbers of "covered lives" and were, therefore, able to drive hard bargains over price and (to a less clear extent) utilization controls.<sup>115</sup> But while this version of market

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[P]rofit-oriented health plans were allowed to become responsible *de facto* for controlling the cost of care while remaining generally immune from any legal responsibility for its quality. This situation [created by cases such as *Corcoran*], which is now being ameliorated by curbing plans' ability to control costs, was so illogical as to induce wonder how the political/legal system ever allowed it to develop. In any event, it is within the power of individual health plans to assume such liability voluntarily, thereby perhaps re-legitimizing their efforts to resist the effects of moral hazard.

*Id.* While this is a perfectly logical proposal, one can imagine most, perhaps all managed care plans being reluctant to accept it.

<sup>114</sup> *Id.* at 72-74 (tort law); Havighurst, *supra* note 69, at 271-302 (modifying by contract tort liability rules and remedies); *id.* at 303-28 (contract interpretation and remedies).

<sup>115</sup> See Havighurst, *supra* note 2, at 58-64 (seeing the gains of the market-based "health care revolution" as antitrust enforcement, some (but not nearly enough) de-legitimizing of medical professional patterns of clinical practice through variations research, extracting competitive price discounts, pre-determination of coverage, and, of ambiguous value, passing some financial risk to providers). See also Agrawal & Veit, *supra* note 69, at 41-42 (stating that managed care slowed health care spending, particularly from 1993 to 1998 (but not thereafter), reduced hospital lengths of stay,

competition was able to implement some forms of cost containment and rationing, it was not able to convince the American people that these steps were legitimate. This was partly because the process was fragmented among numerous companies, often poorly administered and explained, and largely secret. In addition, the adamant refusal of managed care entities to subject themselves to legal accountability, while victorious in cases such as *Corcoran*, was disastrous from a political/public relations point of view, with audiences cheering negative portrayal of HMOs in popular movies such as the 1997 film *As Good As It Gets*.<sup>116</sup> Moreover, the most powerful argument for rationing—that it transfers resources from low-value (or even wasteful) to higher-value health care interventions<sup>117</sup>—could not be credibly made, because American law imposed no restraints on how the funds saved by rationing should be used, a phenomenon made clear by the high incomes paid to the leaders of the newly entrepreneurial health care “industry.”<sup>118</sup>

In many respects, the academic versions of the market competition model have not been realized.<sup>119</sup> In addition to the many reasons

encouraged more outpatient procedures, and held down payments to providers).

<sup>116</sup> See Clark C. Havighurst, *The Backlash Against Managed Health Care: Hard Politics Make Bad Policy*, 34 IND. L. REV. 395, 395 (2001) (noting positive audience response to “an anti-HMO expletive”); Pendo, *supra* note 3 (noting audience response to *As Good As It Gets* and extensively analyzing the films *Critical Care*, *The Rainmaker*, and *John Q.* for their portrayal of managed care, the accuracy of the portrayals, and the individualistic solutions arrived at in each film).

<sup>117</sup> David M. Eddy, *Rationing Resources While Improving Quality: How to Get More for Less*, 272 JAMA 817, 818 (1994) (arguing that trading resources from low-value to high-value practices is an effective way to ration health care resources).

<sup>118</sup> See Havighurst, *supra* note 2, at 75 (“[C]onsumers could not see HMOs’ vaunted accomplishments. Reported cost savings, for example, appeared to accrue only to employers, plan shareholders, or well-paid CEOs—even when they were in fact passed on, unlabeled (and therefore taken for granted), in higher take-home pay.”). See also GEORGE ANDERS, *HEALTH AGAINST WEALTH: HMOs AND THE BREAKDOWN OF MEDICAL TRUST* 55-73 (1996) (detailing HMO executives’ extravagant financial compensation).

<sup>119</sup> For accounts of this phenomenon, see Havighurst, *supra* note 2, at 71. See also Agrawal & Veit, *supra* note 69, at 52-53 (noting that the system continues to lack the information and incentives needed to cause participants to make cost-conscious choices or to require payers to offer a wide range of benefit options); Robinson, *supra* note 69, at 346-47 (noting that the key tasks in the agenda to align public and private interests through market competition, such as purchasing alliances for individuals and small businesses, have not been achieved); Peter D. Jacobson, *Who Killed Managed Care? A Policy Whodunit*, 47 ST. LOUIS U. L.J. 365, 369 (2003) (discussing how managed care failed to live up to people’s expectations); John V. Jacobi, *After Managed Care: Gray Boxes, Tiers and Consumerism*, 47 ST. LOUIS U. L.J. 397, 397-99 (2003) (arguing that managed care failed to eliminate the problems it was created to solve).

discussed by Havighurst and others, another is worthy of note: the extensive regulation of the market needed to achieve the social values of managed competition, and the proposed subsidies for lower-income patients, could not be realized because they are inconsistent with the laissez-faire political values and interests associated with a pro-market regime. These values and interests oppose redistributive subsidies and pro-consumer market regulation and favor unprecedented tax cuts and redistribution upwards to the wealthy.<sup>120</sup> Indeed, this is the version of “market competition” that has been implemented: a considerable shift of wealth and power from physicians and hospitals to employers, managed care entrepreneurs, and others imposing cost containment, while denying hospitalization to some patients who need it,<sup>121</sup> and denial of most or all coverage to some easily targeted high cost patients with serious illnesses, disabilities, and chronic conditions.<sup>122</sup> As numerous analysts have observed, the future of managed care is quite unclear—indeed, it has been widely pronounced to be “dead”<sup>123</sup>—and some are expecting it to be replaced, at least for significant numbers of employees, with “consumer-driven” health coverage characterized by some combination of high deductibles and cost-sharing, defined contribution by employers, and employee web-

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<sup>120</sup> For a prediction of exactly these sorts of political values associated with an emphasis on market competition, see Rand E. Rosenblatt, *Health Care, Markets, and Democratic Values*, 34 VAND. L. REV. 1067, 1108-15 (1981) (arguing that the logic of political values associated with market competition very likely entails parsimonious redistribution, despite the theoretical possibility of generous subsidies).

<sup>121</sup> See, e.g., *Batas v. Prudential Ins. Co. of Am.*, 724 N.Y.S.2d 3 (N.Y. App. Div. 2001) (analyzing a situation where the insurer’s nurse-reviewer, without consulting treating physician, refused to grant extended hospitalization to pregnant patient with Crohn’s Disease). The patient could not afford to self-pay and “elect[ed]” early discharge, only to return to hospital seven days later with high fever and severe pain. Two days later while waiting for pre-authorization for exploratory surgery, patient’s intestine burst and required emergency removal of part of her colon; four days later, on the basis of “Milliman & Robertson Guidelines,” insurer’s nurse-reviewer demanded that the patient be discharged. According to the Milliman and Robertson website in 2001, <http://www.milliman-hmg.com/publications/hmg/hmgqa.html>, the guidelines are “a set of optimal clinical practice benchmarks for treating common conditions for patients who have no complications.” *Batas*, 724 N.Y.S.2d at 9 n.1.

<sup>122</sup> See, e.g., *Bedrick v. Travelers Ins. Co.*, 93 F.3d 149 (4th Cir. 1996) (ruling that the insurer’s reviewing physician’s criteria for denial of ongoing coverage for most physical, occupational, and speech therapy prescribed for infant with spastic quadriplegia were neither stated nor referenced in the insurance contract, nor were they present in the insurer’s own guidelines, and holding that the denial of coverage was in violation of applicable ERISA procedures and in violation of reviewing physician’s duty as ERISA fiduciary to provide “full and fair hearing”).

<sup>123</sup> Jacobson, *supra* note 113, at 365; Jacobi, *supra* note 113, at 398, 400. See also James C. Robinson, *The End of Managed Care*, 285 JAMA 2622 (2001) (finding that a decade of managed care has yielded economic successes but political failure).

facilitated choice among price tiers of coverage and providers.<sup>124</sup> These mechanisms will almost certainly further “separate[e] the fates of people in society on various bases, including wealth, age, employment status and geography,” “impai[r] the movement toward systemic improvement of health care [quality],”<sup>125</sup> and diminish our experience of compassion and social responsibility.<sup>126</sup>

## II. PART TWO: A FOURTH AGE FOR HEALTH LAW?

Recent developments within American health care delivery seem to point in two different directions. As noted immediately above, the failure to achieve the socially-responsible versions of managed competition—informed and (where needed) subsidized consumers choosing among plans competing (under public or private “regulation”) over quality and efficiency—may well lead to a far less structured and egalitarian, and hence likely more dangerous market. Poorly subsidized, perhaps risk-selected, and financially stressed consumers must then “accept” high cost sharing, crudely-framed benefit exclusions, and low-cost providers with little understanding of what they are getting. Alternatively, as sharply rising health care (notably pharmaceutical) costs and health insurance premiums,<sup>127</sup> as well as massive losses of well-paid jobs with benefits,<sup>128</sup> push many lower-middle and middle-middle class citizens into the ranks of the uninsured or underinsured,<sup>129</sup> the political demand for governmental action of an egalitar-

<sup>124</sup> Jon R. Gabel et al., *Consumer-Driven Health Plans: Are They More Than Talk Now?*, HEALTH AFF.: WEB EXCLUSIVES W395 (2002), available at [http://www.healthaffairs.org/WebExclusives/Gabel\\_Web\\_Excl\\_112002.htm](http://www.healthaffairs.org/WebExclusives/Gabel_Web_Excl_112002.htm) (Nov. 20, 2002) (discussing the increase in consumer-driven healthcare plans but warning that its success has not yet been tested).

<sup>125</sup> Jacobi, *supra* note 113, at 407-08.

<sup>126</sup> Cf. Deborah A. Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity*, 6 CONN. INS. L.J. 11, 16 (1999-2000) (arguing that insurance creates an opportunity for people to help their neighbors through risk pooling).

<sup>127</sup> See Pugh, *supra* note 81 (reporting a survey by the Kaiser Family Foundation and the Health, Research and Educational Trust that “the typical family policy for all types of health plans averaged \$9,068 a year in the spring of 2003, compared with \$7,954 in the spring of 2002”).

<sup>128</sup> See, e.g., Louis Uchitelle, *A Statistic That’s Missing: Jobs That Moved Overseas*, N.Y. TIMES, Oct. 5, 2003, at A20. “[T]he high-end estimate comes from Mark Zandi, chief economist at Economy.com, who calculates that 995,000 jobs have been lost overseas since the last recession began in March 2001. That is 35 percent of the total decline in employment since then. While most of the loss is in manufacturing, about 15 percent is among college-trained professionals.” *Id.*

<sup>129</sup> E.g., Robert Pear, *Big Increase Seen in People Lacking Health Insurance*, N.Y. TIMES, Sept. 20, 2003, at A1 (reporting Census Bureau study showing that

ian and regulatory sort may intensify, as already appears to be happening in the run-up to the 2004 presidential election.<sup>130</sup>

The sense of a great fork in the road between hyper-individualism and unrestrained competition, on the one hand, and some way of reconstituting solidarity and associated social policies, on the other, is also reflected in the great uncertainty about the complex forces known in shorthand as "globalization." For many, globalization is seen as embodying and validating market competition and raising it to a level of awesome, unprecedented power. In one starkly stated version, internationalized markets in capital and production, together with internationalized culture and communications, are said to have made the classic "nation-state," democratic politics, social welfare policies, and law itself virtually obsolete.<sup>131</sup> National governments can no longer enforce policies to better the economic welfare of their citizens; protectionism, high wages, taxes, and transfer payments are, the argument goes, subject to effective veto by capital, which can move itself and jobs to other nations with great speed.<sup>132</sup> Moreover, even aside from capital's "exit" option, governmental regulation and transfers have lost much of their policy credibility, as the advocates of the market revolution in health care argued in the 1970s and 1980s. Thus, there is little for politics or law to decide, because "supporting the market" is the only policy that is both empirically feasible and consistent with the new transcendent value of "individual liberty." In this view, then, there is no distinct fourth age of health law or anything else; the market competition model has triumphed decisively.

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The number of people without health insurance shot up last year by 2.4 million, the largest increase in a decade, raising the total to 43.6 million, as health costs soared and many workers lost coverage provided by employers . . . . The increase brought the proportion of people who were uninsured to 15.2 percent, from 14.6 percent in 2001. . . . [M]iddle-income households accounted for most of the increase in the number of uninsured. In households with annual incomes of \$25,000 to \$74,999, the number of uninsured people rose last year by 1.4 million, to 21.5 million, and the increase was most noticeable among households with incomes of \$25,000 to \$49,999.)

<sup>130</sup> See, e.g., Toner, *supra* note 4. Unlike the debate in 1993-94 over the Clinton plan, ten years of experience with managed care has left private sector solutions with far less legitimacy than they once had. Of course, the actual response of the federal government will be greatly affected by who wins control of the presidency and each house of Congress in the November 2004 elections.

<sup>131</sup> See PHILIP BOBBITT, *THE SHIELD OF ACHILLES: WAR, PEACE, AND THE COURSE OF HISTORY* 213-42 (2002). For a positive review of this book, see Dennis Patterson, *The New Leviathan*, 101 MICH. L. REV. 2501 (2003) (forthcoming). For a critique, see Rand E. Rosenblatt, *Constitutional Interpretation and the Dynamics of World History* (in progress).

<sup>132</sup> See BOBBITT, *supra* note 131, at 220-21. See also Uchitelle, *supra* note 128.

The market forces associated with globalization are undeniable, although their actual extent and impact, particularly in the United States, are open to much debate. More fundamental is the question of how political and legal systems can and should try to interact with those forces.<sup>133</sup> It is evident even to celebrators of globalization's benefits, such as Thomas L. Friedman of the *New York Times*, that pure markets are incoherent and self-destructive; left to their own logic, they cannot create the social cohesion, long-term investment in human capital, and rule of law that they need for their own survival and flourishing. Visiting post-genocide Rwanda in 1996 with then-U.S. ambassador to the United Nations Madeleine Albright, Friedman

started to get mad . . . about the budget debate that was then going on in the U.S. Congress. . . . [W]hen I listened at that time to the infamous 1994 class of freshmen Republicans, I heard mean-spirited voices . . . voices for whom the American government was some kind of evil enemy. I heard men and women who insisted that the market alone should rule, and who thought it was enough to be right about the economic imperatives of free trade and globalization, and the rest would take care of itself. I heard lawmakers who seemed to believe America had no special responsibility for maintaining global institutions, such as the UN, the World Bank, and the IMF, which are critical for stabilizing an international system from which America benefits more than any other country. . . .

. . . [The freshmen Republicans] should come to war-torn Africa and get a real taste of what happens to countries where there is no sense of community, no sense that people owe their government anything, no sense that anyone is responsible for anyone else, and where the rich have to live behind

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<sup>133</sup> As an empirical matter, free trade and unregulated markets were not in fact the dominant basis of economic success for newly emerging national economies from the 1950s through the 1980s. Indeed, the Asian "economic miracles" of Japan, South Korea, Taiwan, Malaysia, and Singapore were based on "government leadership in industrial planning, a high degree of financial leverage, and some degree of protection for the domestic economy, as well as the ability to control wages," GEORGE SOROS, *THE CRISIS OF GLOBAL CAPITALISM: OPEN SOCIETY ENDANGERED* 110 (1998)—the latter meaning in some countries authoritarian and violent suppression of labor movements. In addition to organized governmental violence, the lack of social protection demanded by market theory and practice gives rise to what Third World health activist Dr. Paul Farmer terms "structural violence." FARMER, *supra* note 7, at 40. See Amartya Sen, *Forward to FARMER, supra* note 7, at xii-xvi (2003) (discussing the meaning of Farmer's phrase "structural violence").

high walls and tinted windows, while the poor are left to the tender mercies of the marketplace . . . .

. . . . I don't want to live in such a country, or such a world. It is not only morally wrong, it will become increasingly dangerous.<sup>134</sup>

Those who struggle against the unregulated market vision hope that globalization can develop as a kind of extended postmodernism that will undermine not only national boundaries, but all sorts of familiar categorical oppositions, including "state regulation" and "free markets." If "government" is indeed morphing into a branch of "the market," so are "markets" morphing into government, with for-profit companies running public schools, prisons, military logistics, and much of the health care system, including a considerable portion of Medicare and Medicaid.

Proponents of a new, what I would call "fourth age" of health law and policy argue that the true logic of globalization should not be understood as unregulated market competition, but as a much more interesting, creative, and sophisticated mix of market techniques, institutional interaction, and democratic participation.<sup>135</sup> Thus Carolyn Hughes Tuohy explores in the health care context (albeit with substantial reservations) new techniques known as "governance" in which "government actors exercise influence not through command and control but through negotiation and persuasion" "in the context of com-

<sup>134</sup> THOMAS L. FRIEDMAN, *THE LEXUS AND THE OLIVE TREE* 435-36 (Anchor Books 2000) (1999).

<sup>135</sup> For examples of a rapidly-growing literature of this sort (whether or not explicitly focused on globalization), see, for example., Jody Freeman, *Extending Public Law Norms Through Privatization*, 116 HARV. L. REV. 1285 (2003) and Archon Fung & Erik Olin Wright, *Deepening Democracy: Innovations in Empowered Participatory Governance*, 29 POL. & SOC. 5 (2001); Charles F. Sabel & William H. Simon, *Destablization Rights: How Public Law Litigation Succeeds*, Harv. L. Rev. (forthcoming 2004) (April 16, 2003 draft is available at <http://ww2.law.columbia.edu/sabel/papers/Chayes20clean.doc>); Joshua Cohen & Charles Sabel, *Directly-Deliberative Polyarchy*, available at <http://www2.law.columbia.edu/sabel/papers/DDP.html>; Andrew Gamble, *The Limits of Democracy*, in REINVENTING DEMOCRACY 117, 128-30 (Paul Hirst & Sunil Khilnani, eds., 1996); Michael C. Dorf & Charles F. Sabel, *A Constitution of Democratic Experimentalism*, 98 COLUM. L. REV. 267 (1998). See also numerous works by Roberto M. Unger, notably Roberto Mangabeira Unger, *The Boutwood Lectures: The Second Way* (Jan. 2002), at <http://law.harvard.edu/faculty/unger/English/newwr.php>. Some of this work is discussed in MARK TUSHNET, *THE NEW CONSTITUTIONAL ORDER* 168-72 (2003). For an example of this general perspective applied to health policy, see MARY RUGGIE, *REALIGNMENTS IN THE WELFARE STATE: HEALTH POLICY IN THE UNITED STATES, BRITAIN, AND CANADA* ix-xi, 1-27 & *passim* (1996).



plex organizational networks.”<sup>136</sup> James A. Morone and Elizabeth H. Kilbreth argue that “[a] changing social environment—marked by globalization, immigration, a culture war, and managed care—could be addressed by robust, local, democratic health reforms.”<sup>137</sup> William M. Sage sees the health care delivery system as characterized by “incomplete transformations”—“to industrial organization, informed consumerism, and universality,” and, therefore, driven to policy outcomes in less than optimal litigation and judicial decisions.<sup>138</sup> In these circumstances, Sage suggests empowering “various subsystems of ‘cabined discretion’ apart from the courts.”

These would be decision-making bodies in institutions, geographic areas, or subject matters whom users would value for their judgment and virtue as well as their expertise. No single entity would dictate overall policy, and each entity would be influenced by some combination of user exit and user voice in addition to the decision maker’s loyalty. An entity charged with establishing a schedule of damages to be paid on a no-fault basis for avoidable injuries in lieu of malpractice litigation would be a good test of this model.<sup>139</sup>

Whether any of these or other innovations is pursued evidently depends on initiatives and developments at all levels of politics and society.

The existing and still-to-come biotechnology revolution underscores in the most dramatic way the need for new frameworks of social conversation and choice, addressed elsewhere in this symposium. Genetic privacy, access to health and life insurance, and employment discrimination raise serious issues.<sup>140</sup> The prospect of well-off members of society purchasing for themselves or their children genetically or chemically-enhanced health, beauty, athletic ability, intelligence, memory, and the like—something that of course already exists in a number of ways—raises profound issues of equality, freedom, and

<sup>136</sup> Tuohy, *supra* note 21, at 202. Tuohy notes that the governance model “sits uneasily with established concepts of democratic government because lines of accountability within networks may be multiple, tangled, and obscured.” *Id.* at 203. Proponents would argue that there will be new modes of democratic accountability.

<sup>137</sup> James A. Morone & Elizabeth H. Kilbreth, *Power to the People? Restoring Citizen Participation*, 28 J. HEALTH POL. POL’Y AND L. 271, 271 (2003) (abstract).

<sup>138</sup> William M. Sage, *Unfinished Business: How Litigation Relates to Health Care Regulation*, 28 J. HEALTH POL. POL’Y AND L. 387, 414 (2003).

<sup>139</sup> *Id.* at 414-15.

<sup>140</sup> See, e.g., LORI B. ANDREWS, MAXWELL J. MEHLMAN & MARK A. ROTHSTEIN, *GENETICS: ETHICS, LAW AND POLICY* 592-734 (2002).

democracy, as well as our experience of “human nature.”<sup>141</sup> Some advocates of free market or “entrepreneurial” globalization see our government and society as being constituted in a new form—a “market-state”—characterized by “sublime indifference” to “who should be allowed to grow taller or be endowed with perfect pitch . . . .”<sup>142</sup>

[T]he basis for human assessment in the various competitions of the meritocracy [is shifting] from a passive acceptance of inherited abilities to a quest for the enhanced, or engineered, faculties made possible by molecular biology. Here, too, the market-state’s apparent indifference to the state’s role in ensuring justice fits the new, wide-open landscape of apparent opportunity. A State that tried to sort out who [should have access to biological enhancement] would soon find itself hopelessly overcommitted financially or the center of group warfare . . . . The market-state, with its sublime indifference to such questions and its refusal to guarantee outcomes, is more survivable in the new world of genetic technologies. These technologies have the power to enhance autonomy as never before, freeing men and women from their own genes, and providing choices only dreamt of until now.<sup>143</sup>

Since Bobbitt assumes that we cannot afford to grant this revolutionary new autonomy to everyone, and accepts with enthusiasm that it should be distributed according to the market, i.e. ability to pay, this freedom is that of the privileged to become stronger and more privileged in the most profound ways. Such a prospect has led Francis Fukuyama, who celebrated the triumph of capitalism over the Soviet Union as “the end of history,”<sup>144</sup> to decide that history is not quite over.

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<sup>141</sup> See, e.g., FRANCIS FUKUYAMA, *OUR POSTHUMAN FUTURE: CONSEQUENCES OF THE BIOTECHNOLOGY REVOLUTION* 4-17, 216-18 (2002) (depicting a world where people have all their desires realized but, as a result, cease to be human beings); ANDREWS, MEHLMAN & ROTHSTEIN, *supra* note 135, at 281-98.

<sup>142</sup> BOBBITT, *supra* note 131, at 232.

<sup>143</sup> *Id.*

<sup>144</sup> See Francis Fukuyama, *The End of History?*, NAT’L INT., Summer 1989, at 3 (arguing that the end of the Cold War is signaling the end of history as we know it and beginning “the final form of human government”); FRANCIS FUKUYAMA, *THE END OF HISTORY AND THE LAST MAN* (1992) [hereinafter FUKUYAMA, *THE END OF HISTORY*].

We do not have to accept any of these future worlds [e.g. “far more hierarchical and competitive,” or a “soft tyranny envisioned in *Brave New World*”] under a false banner of liberty . . . We do not have to regard ourselves as slaves to inevitable technological progress when that progress does not serve human ends. True freedom means the freedom of political communities to protect the values they hold most dear, and it is that freedom that we need to exercise with regard to the biotechnology revolution today.<sup>145</sup>

The biotechnology revolution will thus pose for us with stark consequences the question that “the market revolution” in health care thought it had already answered: do we as a “political community” have values that we “hold most dear,” and what are they, or are we primarily (exclusively?) an aggregation of individuals for whom the meaning of freedom is choice within the scarcity of each person’s “own” resources? The fact that we are, or will be, facing this question is itself a remarkable commentary on our recent history.

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<sup>145</sup> FUKUYAMA, *THE END OF HISTORY*, *supra* note 144, at 218.