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Public Funds, Public Functions, Private Actors

The Cognitive Dissonance of US Health Law

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1.1 INTRODUCTION

It is commonplace for critics of the US health care system to observe that it is neither a system nor focused on health.[1] This fundamental confusion is a feature, not a bug. Because of cultural resistance to government control and the political power of physicians, the American health care system tends to utilize private actors to perform public functions with (lavish) public funding, supposedly under the ethical and scientific direction of the self-governing medical profession. Consequently, "private law" plays an outsized role in American health governance, often – if not necessarily – working against rather than for what in other countries are incontrovertibly "public law" goals.[2]

US health care constitutes an extraordinarily large commitment of financial resources, currently exceeding US$5,000,000,000,000 annually (writing the word "trillion" does not do justice to an expenditure of this magnitude) and comprising over one-sixth of the national economy. Counting explicit exclusions from otherwise taxable funds as well as direct spending, more than half of the financing comes from public monies, representing as large a public per capita contribution as one would find in any other country – to which the United States adds a roughly equal private financial contribution. As a general matter, the same set of corporate organizations serving as intermediaries operate both the public (Medicare/Medicaid) and the private (employer-sponsored) health insurance systems, which process payment to the same private health professionals, health care facilities, and suppliers of medical

[1] Wendy Netter Epstein, The Healthcare System Misnomer, 82 Ohio St. L.J. 409 (2021); Farshad Marvasti & Randall S. Stafford, From "Sick Care" to Health Care: Reengineering Prevention into the U.S. System, 367 New Eng. J. Med. 889 (2012).

[2] Michel Rosenfeld, Rethinking the Boundaries between Public Law and Private Law for the Twenty First Century: An Introduction, 11 Int'l J. Con. L. 125 (2013), https://doi.org/10.1093/icon/mos053.

products, which in turn meet standards set by the same professional self-regulatory entities.

Efforts at "systemness" are further challenged by the deference of nearly all health law to the personal and collective judgments of the American medical profession, which tend to emphasize discrete services by identifiable physicians to individual patients.[3] As cataloged in 1982 by sociologist Paul Starr and confirmed in subsequent years, medical interests have repeatedly managed to defeat efforts to bring full public accountability to health care while simultaneously keeping massive amounts of public money flowing.[4] Although organized medicine chafes at "corporatization" as well as "socialized medicine," corporate lobbying power reinforces the system's transactional bias because the most extensive legal frameworks in US health care center on the generation and payment of often-lucrative clinical claims.

In essence, American health care can be thought of as a giant system of lawful money laundering, the result of which is to conceal massive public financial obligations that serve indisputably public purposes by embedding them in what appear to be private commercial transactions that arise largely from decentralized patient care encounters.[5]

Laundering public money through these private actors, many of whom are trusted physicians or nonprofit hospitals, results in more resources being made available than would be the case were health care deliberately designed for collective benefit and financed through explicit taxation and direct spending. Because of its reliance on medical professionalism, the laundered system also results in a lower degree of formal regulatory oversight and a less enforceable pledge of social solidarity or equity, substituting for those features the appearance if not often the reality of effective market competition.[6]

The entities involved in the laundered system and the relationships among them tend to be governed by private law. This creates space for diverse parties to pursue advantage using diverse arguments in diverse forums that create, refine, interpret, and adjudicate legal interests – most of which at some level involve claims on resources that would not be available absent the aforementioned public commitments. As a result, health law can involve any combination of judicial decision-

[3] Einer Elhauge, The Fragmentation of U.S. Health Care: Causes and Solutions (2010) (online ed., https://doi.org/10.1093/acprof:oso/9780195390131.001.0001).

[4] Paul Starr, The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry (1982).

[5] Robert I. Field, Mother of Invention: How the Government Created Free-Market Health Care 24–25 (2014).

[6] William M. Sage, Explaining America's Spendthrift Health Care System: The Enduring Effects of Public Regulation on Private Competition, in The Law and Policy of Healthcare Financing 17–36 (Wolf Sauter et al. eds., 2019); William M. Sage, Antitrust Law and Competition Policy in U.S. Health Care, in Oxford Handbook of U.S. Health Law 606–36 (I. Glenn Cohen et al. eds., 2016).

making, legislation, administrative regulation, medical professional self-regulation, and enforceable entitlements (i.e., payment guarantees).

Private law acts as a conservative – if not always an obstructionist – force in pursuing consensus goals regarding access to affordable medical care, which in turn makes it more difficult to promote collective health and well-being across the range of social sectors that must share public investment. Put bluntly, the cognitive dissonance between the private orientation we ascribe to US health care and the public funds that its specialized, very "medical" activities consume implies that (largely private) health law often acts at cross-purposes with (necessarily public) health policy.[7] This cognitive dissonance also implies that the laws most relevant to health, especially at the population level, involve fundamental social commitments to equity and opportunity that are not what we usually consider health law.[8]

This chapter begins with the evolution of American medicine from a "sovereign" self-regulating profession focused on direct patient service to a large industry that serves the social sector but that, because of its professional heritage, receives extensive public subsidies without equivalent public accountability. Next, the chapter identifies regulatory dynamics in American health care governance that structurally discourage movement from the prevailing, if dissonant, private law framework to one explicitly grounded in public law. The chapter concludes by highlighting the challenges and opportunities inherent in a private law approach to what is intuitively a public law domain.

1.2 HEALTH LAW AND THE JOURNEY FROM SELF-REGULATING PROFESSION TO SUBSIDIZED INDUSTRY

1.2.1 *Medicare and Medicalization*

Common retellings of American legal history situate a more fully formed sense of national identity across states in the post-Civil War period, the origins of the federal administrative state in Progressive Era responses to industrialization, and a centrally funded social safety net in New Deal and Great Society commitments. Medicare, enacted in 1965, was seen by many as the medical completion of Social Security's promise of income support for workers reaching retirement age.[9]

[7] William M. Sage, Relating Health Law to Health Policy: A Frictional Account, in Oxford Handbook of U.S. Health Law 3–28 (I. Glenn Cohen et al. eds., 2016).

[8] Elizabeth Tobin-Tyler & Joel B. Teitelbaum, Essentials of Health Justice: A Primer (2019); Dayna Bowen Matthew, Just Medicine: A Cure for Racial Inequality in American Health Care (2015); Lindsay F. Wiley, From Patient Rights to Health Justice: Securing the Public's Interest in Affordable, High-Quality Health Care, 37 Cardozo L. Rev. 833 (2016).

[9] David Blumenthal & James A. Morone, The Heart of Power: Health and Politics in the Oval Office (2010).

By channeling massive, permanent financial support to the American medical profession and those who supply its work, Medicare heralded a golden era of patient care. For achieving broader public goals of individual and population health, however, "Gilded Age" may better describe the Medicare half-century.[10] Medicare's political settlement with organized medicine reconstructed US health care governance around a precarious balance of national industrial support and deference to professional judgment. Compromise was accomplished in part by replicating forms of private health insurance that were unthreatening to physicians – which amplified organized medicine's longstanding fetishization of "choice" on both the doctor's and the patient's side of the therapeutic relationship and set in legislative stone a fragmented form of health care delivery inattentive to nonmedical drivers of health, especially those shared within communities and populations.[11]

This pragmatic approach continued up to and beyond the Patient Protection and Affordable Care Act of 2010 (ACA or Obamacare). Aroused by both partisan and interest group politics, voters did not challenge the framing of health care as a private matter by the ACA's opponents. Rationing through "death panels" and similarly false or exaggerated accusations of intended government incursion on private medical decisions became routine parts of public discourse. For fear of backlash, even the Obama administration never came closer to social solidarity than informed consumerism in its pro-ACA messaging.[12] As a result, the ACA's sweeping ambitions of remaking health care delivery and improving underlying health in addition to expanding coverage for medical services remain unfulfilled.[13]

Conceptually, the US health care system operates as an extrapolation to the population level of individual clinical encounters between skilled, ethical physicians and suffering, vulnerable patients. Roughly US$3 trillion in annual "health" expenditures derive from the services, orders, referrals, and recommendations of licensed medical professionals. From this perspective, large public investments in health are legitimate only insofar as they fit within the medical model, and there are strong incentives to "medicalize" social problems in order to let those who would help solve them cross into better-funded territory.[14] Law, particularly private law

[10] William M. Sage, Adding Principle to Pragmatism: The Transformative Potential of "Medicare-for-All," 20 Yale J. Health Pol'y L. & Ethics 1 (2021).

[11] Charles D. Weller, "Free Choice" as a Restraint of Trade in American Health Care Delivery and Insurance, 69 Iowa L. Rev. 1351, 1356 (1984).

[12] President Barack Obama, Remarks by the President on the Supreme Court's Ruling on the Affordable Care Act (June 25, 2015), https://obamawhitehouse.archives.gov/the-press-office/2015/06/25/remarks-president-supreme-courts-ruling-affordable-care-act (https://perma.cc/NW89-RRFZ).

[13] William M. Sage, Putting Insurance Reform in the ACA's Rear-View Mirror, 51 Hous. L. Rev. 1082 (2014).

[14] William M. Sage & Jennifer E. Laurin, If You Would Not Criminalize Poverty, Do Not Medicalize It, 46 J.L. Med. & Ethics 573 (2018); Craig Konnoth, Medicalization and the New Civil Rights, 72 Stan. L. Rev. 1165 (2020).

governing the organizational and financial relationships among private parties, is constitutive of this health policy orientation.

As a policy matter, the dense matrix of legal obligation in which US health care is embedded perpetuates inefficiency, trapping within medical practice organizations and the nonprofit sector massive economic value that could be redeployed both privately (as lower prices for consumers) and publicly (as explicit commitments to health beyond medical services).[15] An important question for policymakers today is whether the recent, large-scale engagement of "private equity" firms with the rapidly consolidating health care sector is mobilizing and appropriating these economic reserves, and whether – if that is the case – any of it can be reclaimed for public purposes.

1.2.2 *Physician Primacy and the Paradox of Hospitals*

Legal governance of the US health care system still relies heavily on a fiduciary model of professional service, applying self-regulatory standards to clinicians' dedication and skill, often construing equity as a matter of ethics and charitable obligation, basing payment on properly coded point-of-service claims for disaggregated care processes, and requiring a multitude of complex contracts among individuals, nonprofit organizations, and business corporations to both enable performance and assure compliance.[16]

Post-Medicare industrialization, technological innovation, and financial opportunism have added to legal complexity and potential conflict in multiple domains, often making physicians feel exploited or marginalized.[17] The nursing profession faces even greater risks of "burnout" as the COVID-19 pandemic recedes.[18] But the fundamental legal grounding of the health care system remains relational (i.e., private and professional), not regulatory (i.e., public and collective) – and therefore is subject primarily to private legal action and resolution.[19]

[15] William M. Sage, Fracking Health Care: The Need to Safely De-Medicalize America and Recover Trapped Value for Its People, 11 N.Y.U. J. L. & Liberty 635 (2017).

[16] William M. Sage, Assembled Products: The Key to More Effective Competition and Antitrust Oversight in Health Care, 101 Cornell L. Rev.609 (2016); Rand E. Rosenblatt, The Four Ages of Health Law, 14 Health Matrix 155 (2004).

[17] Nat'l Acads. of Sci., Eng'g, and Med., Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being (2019), https://doi.org/10.17226/25521.

[18] Nat'l Acads. of Sci,, Eng'g, and Med., The Future of Nursing 2020–2030: Charting a Path to Achieve Health Equity (Mary K. Wakefield et al. eds., 2021), https://doi.org/10.17226/25982 (https://perma.cc/RK45-X5SC); Allison Squires et al., "Should I Stay or Should I Go?" Nurses' Perspectives about Working during the COVID-19 Pandemic's First Wave in the United States: A Summative Content Analysis Combined with Topic Modeling, 131 Int. J. Nurs. Stud. (July 2022), www.ncbi.nlm.nih.gov/pmc/articles/PMC9020864/.

[19] Lindsay F. Wiley, The Struggle for the Soul of Public Health, 41 J. Pol., Pol'y & L. 1083 (2016); William M. Sage, Relational Duties, Regulatory Duties, and the Widening Gap between Individual Health Law and Collective Health Policy, 96 Geo. L.J. 497 (2008).

American hospitals, which comprise trillions of dollars of asset value and generate hundreds of billions of dollars of annual income, are emblematic of the cognitive dissonance inherent in the US health care system. Acute care hospitals in the United States are redoubtable facilities replete with advanced technology and specialized, trained professionals who perform delicate procedures and administer sophisticated medication to patients with serious illnesses and injuries. If "private" were in fact an accurate descriptor, hospitals would be integrated enterprises within a market-based system that produce these complex clinical services and deliver them at competitive prices. Although some US hospital companies operate abroad more or less on this model, virtually none do so here at home.[20]

Instead, US hospitals have served variously as fee-free workshops for loosely affiliated physicians, as community resources, or as hubs for education and technology-driven research. The most financially successful hospitals thrive on nonoperating income, including charitable donations that support ever larger and more lavish physical facilities. With respect to operating income, hospitals focus intently on generating revenues, which on the private side typically originate from pass-through organizations that administer claims for coverage sponsored by self-insured employers, rather than from hard-nosed buyers purchasing for their own accounts. Because government coverage (Medicare and Medicaid) applies "administered prices" that offer hospitals less money for clinical services than do private payers, a favorable or unfavorable "payer mix" rather than managing production costs or offering higher quality services typically makes the difference between success and financial failure.

The longstanding legal partition of most hospitals from the physicians who practice within their walls has further drained hospitals of both motivation and authority to manage the cost and quality of the care they offer. For decades, physicians kept hospitals under their control, aided by state case law and statutes prohibiting physician employment as the "corporate practice of medicine," and by other laws declaring that patient care decisions, including the awarding of "privileges" to use hospital resources, be made by self-governing "medical staffs" legally independent of hospital executives. It is a major point of hypocrisy for physicians who routinely oppose "socialized medicine" that, for generations, they have paid nothing to utilize surgical suites, diagnostic services, and hospital facilities for patient care that generates lucrative professional fees.[21]

At the same time, US hospitals have little systematic public accountability – even though public subsidy through grants, tax-favored charitable contribution, and tax-exempt bond financing has been primarily responsible for hospital construction and

[20] I. Glenn Cohen, Patients with Passports: Medical Tourism, Law, and Ethics (2014).

[21] Uwe Reinhardt, Wanted: A Clearly Articulated Social Ethic for American Health Care, 278 JAMA 1446 (1997) (letters to the editor and author's reply at 279 JAMA 745 (1998)).

capital expansion, and even though clinical revenues from public payers support major chunks of their operating budgets. Outside of intermittent allegations of financial malfeasance involving government programs ("fraud and abuse"), emergency care access obligations under the Emergency Treatment and Labor Act (EMTALA), and rare instances of criminal prosecution involving patient care, hospitals are seldom charged with violating explicit public duties.

Hospitals respond mainly to reputational concerns and the commercial and legal risks associated with particular patients, physicians, payers, and business partners. As a result, hospitals have been drawn repeatedly into transactions and disputes governed by private law – usually as a by-product of their relationships with physicians. Hospitals are frequently defendants in antitrust lawsuits brought by physicians denied medical staff privileges or by other parties alleging anticompetitive activities. And hospitals expend extraordinary resources negotiating payment agreements with their own suppliers and with third-party payers for care they deliver (i.e., private health insurers), which takes account of physicians' continuing professional authority without running afoul of intricate and ever-changing rules concerning potential fraud or abuse.

Malpractice claims against physicians often implicate hospitals because the riskiest, most technologically advanced, and most expensive care takes place in hospital settings. Disputes over insurance coverage of services that have been recommended to patients by physicians center on hospitals for similar reasons. Hospitals also must navigate legally and ethically complicated situations involving care at the beginning and end of life, few of which have been governed by public law.

Today, hospitals are on a steep learning curve with respect to their post-pandemic workforces. The very different management approaches and financial incentives that they historically have applied to physicians, nurses, and other staff are now converging on an employment model, with private law doing most of the work defining and adjusting that model.[22]

1.3 REGULATORY DYNAMICS AS STRUCTURAL REINFORCERS OF PRIVATE HEALTH LAW

Given the intimacy associated with medical need and the substitution of professional for familial caregivers at times of greatest personal vulnerability, a governance model drawn from private law that assigns primacy to physicians might be psychologically appealing whatever the government's actual role. Still, identifiable regulatory dynamics tend to perpetuate confusion about how much public funding the

[22] Carol K. Kane, Policy Research Perspectives: Updated Data on Physician Practice Arrangements: For the First Time, Fewer Physicians Are Owners than Employees, Am. Med. Ass'n, 6 (2019), https://www.ama-assn.org/system/files/2019-07/prp-fewer-owners-benchmark-survey-2018.pdf (https://perma.cc/8ZD4–5XZD).

health care system absorbs and what that sizeable investment should accomplish – which the country's prevailing political polarization, including urban–rural divides within many states, exacerbates.

1.3.1 *Federalism*

In brokering a compromise on the constitutionality of the ACA's "individual mandate" (and, in related language, its Medicaid expansion) in 2012, Chief Justice John Roberts offered a familiar conservative defense of American federalism as protecting individual freedom. "The Commerce Clause," he stated, "is not a general license to regulate an individual from cradle to grave, simply because he will predictably engage in particular transactions. Any police power to regulate individuals as such, as opposed to their activities, remains vested in the States."[23] Even as nationally important and expensive a project as health care could not constitutionally be declared a federal matter.

One cannot overstate the extent to which state law has centered the health care system on private therapeutic relationships. During the late nineteenth and early twentieth centuries, the traditional "police powers" of state government to regulate health and safety were applied increasingly through licensing of individuals and facilities, largely disconnecting medical care from public hygiene, and entrusting the former to professional self-regulation. State health law is therefore presumptively oriented toward private physicians and their patients, while relying on professionally controlled licensing boards to define misconduct and on state courts to enforce professionally based standards of care in specific cases of alleged harm.

The national role in health governance, by contrast, has primarily involved payment for services authorized to be prescribed or delivered under state law (with the Food and Drug Administration's [FDA's] national authority over the safety and effectiveness of drugs and medical devices the exception that proves the rule). Federal intervention is also almost entirely a product of the half-century since Medicare was enacted under professional pressure as a passive, blank-check form of "socialized medicine" – whereas state health law has a much longer and more intrusive history. Medicare regulation has grown substantially over the years, but much of it operates indirectly through state-based oversight processes and national self-regulatory entities such as the Joint Commission.

It is true that Medicare payment policy today sets the tone for payment under employer-based private coverage. It is equally true, however, that Medicare has generally stayed in the lane defined for it by the conventional health insurance model of physician-dictated, medically coded claims – again conceptualizing health care as an aggregation of private transactions rather than a public commitment in service of public goals. Medicare has almost never directly challenged state health

[23] Nat'l Fed. of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012).

laws to better serve its beneficiaries and the public – such as by liberalizing scope of practice or improving hospitals' response to medical errors.[24]

1.3.2 *Fiscal Politics*

Politicians who raise taxes or promote "big government" usually lose elections. Even legislators who vote for popular (and, to nearly all economists, necessary) aid packages during times of acknowledged economic crisis such as the Great Recession of the late 2000s or the COVID-19 pandemic risk the public turning against them when normalcy returns.

When Medicare was enacted in 1965, the federal Budget Control Act was nearly a decade in the future and the fiscal infrastructure of government policymaking was minimal. The votes that passed Medicare were motivated by the merits of Medicare. By the time the Clinton administration's health reform proposal was defeated in 1994, however, extensive budget control requirements had been placed in both federal law and the procedural rules of Congress. Since then, legislation in essence has to secure passage twice – once on its substance, and again on its effects on federal financial obligations as "scored" by the Congressional Budget Office (CBO).[25]

Politicians of both parties therefore have strong incentives to hide public spending on health care behind a curtain of ostensibly private conduct. One sees this not only in the US health care system's reliance on tax-subsidized, employer-based coverage and private nonprofit hospitals but also in how budget-strapped public schools and health departments try to offload financial responsibility for care delivery onto premium dollars that flow through the health insurance sector. Similar considerations lead legislators to shift money in other off-budget ways, such as by changing rules regarding market exclusivity for intellectual property (e.g., prescription drugs). A side-effect of these strategies is to expand the importance of private law in determining how health insurers, health care providers, suppliers, and a host of intermediaries transact business.

President Clinton's proposed Health Security Act never even reached a vote. It died on the day that the CBO concluded (reluctantly, as its rules were not intended for evaluating such major changes in national policy) that requiring private employers to transfer funds to private health plans through regional nonprofit "alliances" should be considered an exercise of sovereign power – immediately

[24] William M. Sage & Eleanor D. Kinney, Medicare-Led Malpractice Reform, in Medical Malpractice and the U.S. Health Care System 318–49 (William M. Sage & Rogan Kersh eds., 2006).

[25] Timothy M. Westmoreland, Invisible Forces at Work: Health Legislation and Budget Processes, in The Oxford Handbook of U.S. Health Law 873–91 (I. Glenn Cohen et al. eds., 2017).

converting the dollar value of all existing private coverage into a massive, politically intolerable federal tax hike.[26] The ACA avoided a similar fate in CBO scoring through artful drafting and a bit of luck, but in return incurred a high degree of litigation risk because it placed greater obligations on private parties and politically diverse states. That tradeoff was responsible in large part for the ACA's prolonged and repeated scrutiny in the US Supreme Court.[27]

1.3.3 *Interest Groups*

Redistribution of public resources is part of nearly every major government decision and is greater in US health care than in any other context except overall tax policy. The Medicare program alone contributes approximately 24 percent of total national health care spending, with Medicaid adding another 19 percent. The vast majority of this spending supports private activities that (unlike, say, defense spending) are used by members of the public rather than by government itself, and very little is subject to competitive bidding.

The most pronounced, and clearly inflationary, transfers are from tax revenues (or equivalent borrowing) to medical special interest groups – what has sometimes been called the "medical-industrial complex."[28] Because the recipients of government payments for medical goods and services are generally reputable private health care providers, suppliers, and insurance intermediaries, these transfers have a side benefit of increasing political support for what might otherwise be viewed as excessive or misguided charity. Moreover, the absence of a coherent national health insurance or care system in the United States means that there is no collective political interest in questioning aggregate expenditures or weighing the comparative benefit of spending on medical care versus other areas.

Medical interest groups expend enormous energy (and funds) to secure their slice of this very large pie and to resist efforts by others to wrest it away. Having one's services covered by Medicare (and, therefore, also by private insurers), and having Medicare pay a generous price, is the sine qua non of success among private health care providers – and, to be fair, among patient groups seeking the best-trained specialists and most advanced technologies for diagnosis and treatment. Medicare "payment reform" is therefore an endless and often fruitless endeavor – as the

[26] Robert D. Reischauer, Testimony of the Director of the Congressional Budget Office to the House Energy Committee, Subcommittee on Health and the Environment, regarding the Clinton Health Plan (Feb. 10, 1994).

[27] William M. Sage & Timothy M. Westmoreland, Following the Money: The ACA's Fiscal-Political Economy and Lessons for Future Health Care Reform, 48 J.L. Med. & Ethics 434 (2020).

[28] William M. Sage, Minding Ps and Qs: The Political and Policy Questions Framing Health Care Spending, 44 J.L. Med. & Ethics 559 (2016); Bruce C. Vladeck, The Political Economy of Medicare, 18 Health Affs. 22 (Jan.–Feb. 1999).

enduring power of Medicare's physician-dominated Relative-Value Update Committee (RUC) to "recommend" generous payment for specialty services using the American Medical Association's (AMA's) own copyrighted CPT codes amply attests.[29] In addition, Medicare's interest-group politics tend to freeze in place state law because Medicare funding relies so heavily on the distinctions that state law makes among health care professionals and between those professionals and health care facilities.

The politics of drafting statutes and regulations in the United States gives these private parties and their lobbyists a very strong voice in forming ostensibly public law, which they deploy for their private advantage, and which carries over to their private agreements and disputes. Private jockeying for public financial support also co-opts much of the informational infrastructure of the US health care system. Information in the health care system is collected primarily to secure payment for codable claims, and only incidentally for safety, quality, cost management, or community/population health improvement. Health-related social services suffer particularly because they seldom fit a clinician-driven, professionally coded, claims-based model.

1.3.4 *Constitutionalism*

American constitutionalism tends to reinforce perceptions of US health care as private. A Constitution that emphasizes – both structurally and in the Bill of Rights – protection against restrictions imposed by government rather than receipt of assistance from government can seem (and may be) inhospitable to efforts that seek to formalize health care as a collective investment and health as a collective asset. This bias includes the state-federal divisions of authority that the Constitution imposes – which perpetuate deference to professional self-regulation at the state level and empower state courts of general jurisdiction to make what are effectively public policy decisions based on the facts and equities in private lawsuits.

The ACA survived constitutional review by the skin of its teeth, suffering significant if not irreparable harm to its core purposes of universalizing coverage, streamlining care, and improving population health. Moreover, the legal-political process of litigating the ACA on both constitutional and statutory grounds resulted in a substantial strengthening by a conservative Supreme Court majority of individual and states' rights.[30] The backlash against public health mandates during the COVID-19 pandemic led to even stricter judicial limits on collective health strategies as exceeding federal administrative authority or as infringements of individual

[29] Miriam Laugesen, Fixing Medical Prices: How Doctors Are Paid (2016).

[30] Nat'l Inst. of Family and Life Advocs. v. Becerra, 585 U.S. 755 (2018); Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682 (2014).

rights of speech and religion (though not of arguably parallel rights regarding reproductive freedom).[31]

Private law governance sidesteps many, if not all, of these constitutional concerns. For example, private entities, including hospitals and universities, can attempt to address health care misinformation and disinformation in ways that government itself, including professional licensing boards, generally cannot.[32] In addition, private employers sponsoring insurance coverage are usually governed by the federal Employee Retirement Income Security Act (ERISA), potentially preempting conflicting state laws regarding controversial clinical services such as abortion or transgender care.[33]

1.4 CONCLUSION

About fifteen years ago, I speculated that the US health care system might never shift from a relational to a regulatory footing absent a severe shock such as an economic collapse or a crisis of communicable disease.[34] We have had both events since then, with at least a partial public response. There probably would have been no ACA without the global recession that preceded it, nor would so many people retain health insurance coverage today absent the COVID-19 pandemic.

But fundamental change has proved elusive – in part because those who profit from existing arrangements cloak themselves in the undoubted virtue of skilled physicians and nurses while younger generations of those professionals have yet to convey a sense of ethical urgency to the public.[35] The COVID-19 pandemic revealed many unfortunate truths about the US health care system's dependence on private pathways to serve public purposes, but even that tragedy has failed to generate much productive policy debate.[36] The cognitive dissonance remains, along with the flaws it perpetuates.

I therefore end on a sober note. Private law in the current health care environment is not necessarily forward-looking and offers no assurances of solidarity, of justice, or even of progress in the vital project of maintaining America's health in the face of population aging, climate change, and political or economic instability. Even the pronounced trend since the Great Recession, in both scholarship and

[31] Roman Catholic Diocese of Brooklyn v. Cuomo, 141 S.Ct. 63 (2020).

[32] Hoeg v. Newsom (E.D. Cal. Jan. 25, 2023), https://nclalegal.org/wp-content/uploads/2023/01/Hoeg-v.-Newsom-PI-Decision.pdf; William M. Sage & Y. Tony Yang, Reducing "COVID Misinformation" While Preserving Free Speech, 327 JAMA 1443 (2022), https://jamanetwork.com/journals/jama/fullarticle/2790859.

[33] Brendan S. Maher, Pro-Choice Plans, 91 Geo. Wash. L. Rev. 446 (2023).

[34] William M. Sage, Solidarity, in Connecting American Values with American Health Care Reform 10–12 (Thomas H. Murray & Mary Crowley eds., 2009); Sage, supra note 19.

[35] Donald M. Berwick, The Moral Determinants of Health, 324 JAMA 225, 225–26 (2020).

[36] William M. Sage, What the Pandemic Taught Us: The Health Care System We Have Is Not the System We Hoped We Had, 82 Ohio St. L.J. 857 (2021).

practice, to make explicit the public responsibilities of the corporate sector now faces a backlash.[37] On the other hand, as many authors in this volume explain, private law presents a variety of opportunities for decentralized improvements (which, after all, is the central premise of the "Triple/Quadruple Aim") as well as creating some possibilities for systematic effect.[38] We should make the most of them.

[37] Compare Donald C. Langevoort, The Social Construction of Sarbanes-Oxley, 105 Mich. L. Rev. 1817 (2007) to Marc Andreesen, The Techno-Optimist Manifesto (Oct. 18, 2023), The Techno-Optimist Manifesto | Andreessen Horowitz (a16z.com).

[38] Rishi Sikka, Julianne M. Morath & Lucian Leape, The Quadruple Aim: Care, Health, Cost and Meaning in Work, 24 BMJ Quality & Safety 608 (2015).