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Risk Governance and Democracy in Health Care

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Introduction

Everyone agrees that health law is important, but no one agrees on what it is. Any subset of law that channels two trillion dollars a year[1] merits serious attention, but scholars differ as to whether health law is an intellectually coherent field or a variation on "the law of the horse."[2] These scholars wrestle with a maze of doctrinal paths in health law that pass through torts, contracts, antitrust, bioethics, constitutional law and administrative law (among others), but seem to have no conceptual center.

I argue in this article that the best approach to understanding health law lies in focusing on the practices of governance in health care, rather than on the various legal doctrines implicated in health care delivery. Specifically, I argue that understanding the law that structures and regulates American health care today as a system of governance organized around principles of risk management and distribution can provide us with a new and useful paradigm for health law.

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[1] Stephen Heffler, et al., *U.S. Health Spending Projections for 2004-2014*, HEALTH AFFAIRS W5-75 (23 February 2005) (total health care expenditures for 2005 amounted to just under $2 trillion). [CHECK DATES]

[2] Sooner or later in any discussion of the intellectual viability of health law as a field, someone trots out the analogy of "the law of the horse." *See*, e.g., Henry T. Greely, *Some Thoughts on Academic Health Law*, 41 WAKE FOR. L. REV. 391, 404 (2006) ("If a spector is in fact haunting health law, that specter appears to be 'the law of the horse.'") The reference is to an essay by Judge Frank Easterbrook using the phrase to describe cyberlaw. Frank H. Easterbrook, *Cyberspace and the Law of the Horse*, 1996 U. CHI. LEGAL F. 207. Easterbrook argued that cyberlaw was simply another industry-specific category, not a coherent doctrinal field. *Id*. As with horses, one could collect and analyze cases dealing with transactions that happened to concern the industry – sales of its products or services, licensing, liability for accidents involving it, etc. – and call that a field, but he argued that law professors instead should "study general rules" such as torts or contracts, and apply them to cyberspace, or horses (or the health care system). *Id*. at 208.

What we have today is not your grandmother's health care system. The last thirty years have brought us three major changes: a widespread transformation from fee-for-service doctor-patient encounters to a system of managed care; a shifting of financial risk for health care expenditures away from insurers and onto providers and patients; and the construction of what amounts to employer corporate sovereignty in the formulation and administration of risk pools for group health insurance in the workplace.

These three phenomena have had dramatic effects on the underlying functions of health law. Risk allocation and insurance principles now dominate the structure of health care access and delivery. The discourse of risk and insurance has migrated from traditional finance questions into what has long been thought of as the heart of health care and health law: the doctor-patient relationship. As a result, I argue, the primary function of health law has become to manage, articulate and institutionalize a system of governance based on the principle of protection against financial, as well as, clinical risk.

Consider a simple example of the hegemony of risk-related discourse. Although there is constant talk about "universal access to health care," the policy issues that comprise that debate actually concern universal access to health *insurance*. We all assume that the latter serves as a proxy for the former. And yet, without any explicit acknowledgment on our part, we allow the phrase's shift in meaning to import to our understanding of "care" all of the questions and trade-offs that inevitably arise from the pooling and pricing of risk that are intrinsic to insurance.

For purposes of this article, I take the care/insurance transposition at face value, as correctly reflective of our country's system of health care today. I then use it as a springboard to raise broader theoretical and normative questions. This article thus has three goals: to develop risk governance as a new theoretical paradigm for understanding the health care system and thereby for understanding health law as a field; to demonstrate how risk governance has encouraged the rise of corporate sovereignty through health law doctrine; and finally, to propose new experimentalist

structures within a risk governance model can be used to democratize our current health care system.

The organization of the article tracks those goals. Part I develops the claim that the last twenty years has produced a health care system centered on the measurement and allocation of risk, or what I call "risk governance." I describe the material bases that resulted in what I term "actuarial medicine," explicate the new knowledges that support such medicine, and identify the normative tensions inherent in that system.

In Part II, I argue that understanding risk governance as the driving force in health care today provides us with the most coherent paradigm for understanding health care *law* as a field. I use the example of judicial interpretation of fiduciary duty – an issue that bridges doctrines of contract, tort and insurance law -- to show how conceptualizing health law as a mechanism of risk governance offers a more holistic and integrated conceptualization of health law than the other models offered to date.

Part III deconstructs and re-interprets the main body of law that actually allocates financial risk in private health insurance: the Employee Retirement Income Security Act (ERISA). I argue that the Supreme Court's broad interpretation of ERISA preemption has delegated risk pooling functions to employers in a manner that creates a realm of corporate sovereignty in health law. Courts interpreting ERISA have granted quasi-jurisdictional status to employer risk pools, but have done so without recognizing the ramifications of their action. Contrary to most scholars, I argue that the proper way to remedy the inequities produced by current law is not by curbing ERISA pre-emption and expanding state tort liability, but rather by constructing creative and workable mechanisms to remedy the democracy deficit in the corporate sovereignty of employer risk pools.

Part IV embarks on that endeavor. Most political sociologists assume that framing health issues around the concept of risk will invariably produce more conservative, neoliberal political outcomes. By contrast, I argue that the political valence of "risk" is subject to multiple appropriations, including ones that could generate ongoing pressures to move in a more egalitarian direction. I outline the advantages of

building on workplaces to create politically infused risk pools, drawing on new governance literature in the employment field to suggest incremental and pragmatic steps to foster more democratic structures for health risk governance.

Throughout, I seek to develop an analysis based in legal and political theory to illuminate how the practices and institutions of risk governance drive the contemporary American health care system.

I. A Theory of Risk Governance in Health Care

The story of the late twentieth century health care system is the story of the rise of risk as an organizing principle.[3] In health care, risk has a dual dimension: the financial risk of providing and paying for health care and the clinical risk of illness and death. Neither category is new to

[3] My argument about the political and intellectual dominance of risk analysis in health care draws on an emerging body of work in legal theory and the sociology of law that examines how the framework of risk has developed into an explanatory model extending to fields such as criminal law and social welfare policy. Two leading scholars in the field, Tom Baker and Jonathan Simon, have analyzed the spread of risk discourse from the insurance context into a variety of legal mechanisms for "governing through risk." Tom Baker and Jonathan Simon, *Embracing Risk,* in EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY (Tom Baker and Jonathan Simon, eds.) 11 (2002). I share Baker and Simon's orientation in focusing on the social construction of risk: "we are less interested in what *is* a risk than in what is done *in the name of* risk." *Id*. at 18. Perhaps the most comprehensive single treatment of the impact of risk analysis on jurisprudence is Jenny Steele, RISKS AND LEGAL THEORY (2004). Steele, a British law professor, explores a number of different approaches to risk, including its usefulness as a "collective technology" relevant to issues of distributive justice. *Id*. at 33-38, 57. Jonathan Simon's work examines risk discourse in criminal law, arguing that it constitutes a "powerful tool[] with which to interpret and frame all forms of social action as a problem for governance." Jonathan Simon, GOVERNING THROUGH CRIME: HOW THE WAR ON CRIME TRANSFORMED AMERICAN DEMOCRACY AND CREATED A CULTURE OF FEAR 17 (2007). Commenting on future directions, Mariana Valverde et al. call for more empirical study of "what kinds of risk knowledge moves are made by participants in particular legal networks, and with what legal, social and epistemological effects." Mariana Valverde et al., *Legal Knowledges of Risks* in LAW AND RISK (Law Comm'n of Canada, ed.) 86, 87 (2005).

health care. What has changed dramatically has been the relative importance and interpenetration between these two dimensions of risk.[4]

The concern paid in the health care system today to financial risk is inextricably intertwined with the attention paid to clinical risk. At the systemic level of health care delivery, one can no longer fully separate the management of care and of clinical risk from the management of financial risk. Clinical and administrative techniques designed to control some aspect of risk have reshaped the actual practice of medicine, resulting in what I call "actuarial medicine." Doctors and patients function today, however hesitantly or reluctantly, as prime actors in an economy of risk.

This Part analyzes how governance organized around risk allocation has become a dominant force in the health care system. Because risk governance is a relatively new concept in legal scholarship, Subpart A defines that term and argues that a discourse of risk managerialism is the driving force behind governance in our contemporary health care system. Subpart B describes the material bases that contributed to the rise of risk managerialism and that resulted in the actuarial medicine we have today. It also describes the new knowledges that support the practice of actuarial medicine and exposes the normative issues underlying the system.

A. Governance Through a Discourse of Risk Managerialism

[4] My analysis of risk governance in health care is also a friendly amendment to the characterization by several health policy experts that the late twentieth century period marked the "industrialization" of American health care. *See* Gary S. Belkin, *The Technocratic Wish: Making Sense and Finding Power in the "Managed" Medical Marketplace*, 22 J. HEALTH POL., POL'Y & L. 509, 510 (1997) (hereinafter *The Technocratic Wish*); J.D. Kleinke, *The Industrialization of Health Care*, 278 JAMA 1456 (1997). While many of the elements of industrialization, such as standardization, apply to the changes in the health care system that I will analyze, others, such as greater division of labor, do not. Moreover, I would argue that understanding the changes as a shift from the primacy of concern with clinical risk to at least an equal concern with financial risk provides a stronger framework for analyzing health care than the industrialization model, which is better suited for manufacturing enterprises.

This article refers to a system of "governance," rather than to the prohibitory or regulatory products of "government." That is because governance analysis permits us to move easily back and forth across public-private boundaries, providing insights into a unified discourse that channels the actions of providers, payers, and patients, whether in public or private health care systems.[5]

Using the conceptual framework of governance foregrounds the insight that "the conduct of conduct"[6] involves power exchanges that cross the borders between government, the market, civil society and private life. Rather than a model of social control that emanates from actions of the state, governance theory begins with an understanding that the channeling of actions, resources, and policies is far more complex than a top down model implies. "Governance" denotes a conceptualization of power that is circulatory rather than subject-verb-object unidirectional, networked rather than hierarchical, and multi-dimensional beyond the state, encompassing non-juridical zones such as market forces or culture.[7] Governing, in this sense, is comprehensive and multi-dimensional; it is "to structure the possible field of action of others."[8]

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[5] See Nan D. Hunter, *Public-Private Health Law: New Directions in Public Health*, 10 J. HEALTH CARE POL'Y & L. 89 (hereinafter *Public-Private Health Law*) (describing governance and governmentality theories both generally and specifically within health care.)

[6] Foucault in "The Subject and Power," quoted in Colin Gordon, *Governmental Rationality: An Introduction*, in THE FOUCAULT EFFECT (Graham Burchall et al., ed.) 2 (1999).

[7] *See* Hunter, *Public-Private Health Law, supra* n. 5 at 91-92. This description captures the strand of governance best categorized as governmentality theory. See *id*. at 90-92, making distinctions between three concepts of governance: dominant state authority; public-private models for administrative governance (often called "new governance" or "administrative governance"); and governmentality. For purposes of this article, I draw from both administrative governance and governmentality literature.

[8] Foucault, "The Subject and Power," at 221.

For legal scholars, governance theory offers a rich method for analyzing the intersection of law and norms, of legal and extra-legal discourses. Law can be understood as one set of institutional practices and embodied understandings that may be manifest in public or private sector policies, knowledges, social relations and identities.[9] Norms may serve the objectives of a variety of regulatory institutions, including but not limited to the state.

The conceptualization of governance as occurring as much through private as through public sector mechanisms fits particularly well with the American health care system, with its thorough intermingling of public and private structures. Public financing systems underwrite private sector health care for 95 million Americans through the Medicare and Medicaid systems.[10] The privately financed workplace system of health insurance depends on a hefty public subsidy through tax law.[11] American hospitals are a mix of public and private institutions, the latter including both for-profit and not-for-profit corporate forms.[12] Licensing decisions are made by state agencies for individual physicians[13] and by a private accreditation system acting as a proxy for the state for hospitals.[14] Statutory authority in forty-two states and the District of Columbia permit private sector judging companies to run the appeal systems for the denial of private or public system health insurance coverage.[15]

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[9] ALAN HUNT AND GARY WICKHAM, FOUCAULT AND LAW: TOWARD A SOCIOLOGY OF LAW AS GOVERNANCE 46-50 (1994); Hugh Baxter, *Bringing Foucault Into Law and Law Into Foucault*, 48 STAN. L. REV. 449, 452-63 (1996).

[10] Medicare covers 43 million persons; Medicaid covers 52 million. CITES

[11] tax law CITE. Amount in lost revenue

[12] Cites – Horwitz, others

[13] cites

[14] Eleanor D. Kinney, *Private Accreditation as a Substitute for Direct Government Regulation in Public Health Insurance Programs: When Is It Appropriate?,* 57 L. and Contemp. Prob. 47 (1994).

[15] Nan D. Hunter, *Managed Process, Due Care: Structures of Accountability in Health Care*, 6 YALE J. HEALTH POL'Y, L. AND ETHICS 93 (2006).

In these myriad ways, public-private hybridity characterizes virtually every aspect of American health care and health law, to the point that health law cannot be confidently categorized today as either public law or private law. Because public-private hybridity is also intrinsic to governance theory, the logical structure of a governance model is closely homologous to the public-private institutional structure of the health care system. It's a natural fit.

If we think of governance metaphorically as a kind of epistemological meta-technology, we can imagine it as providing the framework for channeling the various substantive and ideological streams that circulate through any number of institutions. Using this model for purposes of analyzing the health care system, I suggest we think of a discourse of *risk managerialism* as the substantive core, the driving force, behind the dynamics of governance in our contemporary health care system.

Risk managerialism means the framing of the practices of medical institutions, and the correlative legal doctrines of health law, around the *project of allocating various forms of risk*. In concrete terms, risk managerialism operates through the alignment of incentives and deterrents for actors, throughout the health care system, based on probabilities that can be calculated.[16]

I explore in more specificity below the knowledges created in the health care system that instantiate risk managerialism. But a factor central to the impact of risk managerialism is the extent to which it has altered the very identities and social relations associated with medical practice. In a watershed moment in 1978, Alain Enthoven called for physicians to shift away from their traditional approach to medical care as an art of healing and to move toward quantitative techniques in their delivery of health care.[17] His description of "a synthesis of principles of economics,

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[16] Steele, RISKS AND LEGAL THEORY, *supra* n. 3 at 6-7, 18-20; Francois Ewald, *Norms, Discipline and the Law*, 30 REPRESENTATIONS 138, 142-44 (1990).

[17] Alain C. Enthoven, *Shattuck Lecture: Cutting Cost Without Cutting the Quality of Care*, 298 N. Eng. J. Med. 1229 (1978).

statistics, probability, and decision theory [to be] applied to the complex and uncertain problems of medical decision making"[18] could serve as a definition of the forms of risk analysis that dominate health care practice today.

Enthoven's primary motivation for suggesting such a shift was not, however, to minimize financial risk for providers. That story was yet to come. Rather, his objective was to rationalize clinical care by eliminating variations in treatment methods for the same conditions.[19] But the movement for evidence-based medicine[20] - the claim that statistical analysis of outcomes should drive clinical decisions – has spawned a cultural revolution within the profession, one that is still under attack from many physicians as "cookbook medicine."[21]

Actuarial techniques and practices have begun to foster new subjective identities for patients as well as for physicians. Just as ethical standards for professionals have been reshaped to incorporate a conscious knowledge of financial as well as clinical risk, so too is the responsible patient expected to do her part for the greater good by consuming health care prudentially. The doctrine of moral hazard,[22] which minimizes pooling those risks which individuals can control, has become a central part of the rhetoric of health care policy, embedded in narratives that merge concepts of what is healthy, what is insurable and what is ethical.[23]

B. The Rise of Actuarial Medicine

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[18] *Id*. at

[19] *Id*. at

[20] CITE

[21] Greenhalgh, *Narrative-Based Medicine in an Evidence-Based World*, 318 Brit. Med. J. 323 (1999); Marshall B. Kapp, *"Cookbook" Medicine: A Legal Perspective*, 150 Archives Internal Med. 496 (1990); But see, KATHRYN MONTGOMERY, HOW DOCTORS THINK: CLINICAL JUDGMENT AND THE PRACTICE OF MEDICINE 206 (2006) (defending the role of statistical studies in clinical judgment).

[22] CITE

[23] CITE

1. Material Bases

It is important to briefly describe the factors that gave rise to risk managerialism as the dominant discourse of governance in our health care system. The primary causes were the hyper-inflation in the health care industry during the 1970s and 1980s; the influence of neoclassical economists who dominated the policy scene at the time and provided the intellectual support for using financial risk to manage costs; and finally, the resulting dominance of managed care over fee-for-service, with myriad approaches used by managed care structures and, sometimes, by doctors themselves, to shift financial risk to providers.

Inflation was widespread in the American economy in the 1970's, but it was worse in health care than in other sectors. Annual gross expenditure levels in medical care began to spike in the late 1970's, producing a rate of inflation that was a multiple of the inflation in other sectors.[24] These cost increases affected not only payers of health care (the various insurance companies), but also purchasers of health insurance, such as employers. From 1976 to 1988, the cost of employer sponsored insurance (ESI) doubled.[25] Moreover, unlike in the other sectors, the sharp spiral upward did not end in the following decade.[26]

How situations are defined, of course, establishes the parameters for what kinds of policy responses "make sense." The economics-oriented experts who had "outlived, out-theorized, and out-maneuvered" those who saw the health care system more in political or social welfare terms[27] framed "the

[24] Medical sector inflation compared to the overall U.S. inflation rate was 8.7 per cent versus 5.5 per cent from 1980 to 1985; 7.5 versus 4.0 for 1985 to 1990; and 6.3 compared to 3.1 for 1990 to 1995. Andre Hampton, *Resurrection*, 66 U. CIN. L. REV. 489, 502 n. 78 (1998). GET MORE RECENT DATA

[25] Thomas Bodenheimer and Kevin Grumbach, *The Reconfiguration of U.S. Medicine*, 274 JAMA 85, 87 (1995).

[26] Cite. Also stagflation – hacker, road to nowhere Increases subsided somewhat during the late 1990's, but currently are re-accelerating. CITE.

[27] Daniel M. Fox, *Health Policy and the Politics of Research in the United States*, 15 J. HEALTH POL., POL'Y AND L. 481, 496 (1990).

health polity … as [a] sector of the economy."[28] They argued that budget-breaking costs had created the problem and that new forms of financial discipline could become the solution. Indeed, for the neoclassical economists who were achieving political and intellectual dominance at the time, health care was a perfect problem on which to train their attention. The problem was of enduring urgency and it was occurring in an economic zone where few market models had already failed because so few had been tried.

In this environment, the goal of controlling costs leapt to the top of the health policy agenda and has remained there ever since.[29] Both payers and purchasers, in both public and private sectors, embarked on a series of initiatives designed to curb costs.[30]

The initial focus of this campaign centered on influencing physicians to incorporate cost consciousness and fiscal discipline into their provision of services, a consciousness and discipline perceived as generally lacking in the fee-for-service system.[31] An early byproduct of those efforts was utilization review -- the calculation of the number and nature of treatments prescribed, by patient and by physician.[32] Data from utilization review were used to create treatment norms for particular conditions and to deny reimbursement when services were provided for treatments outside the norm. The assumption was that providers would incorporate these lessons of reimbursement denials into the

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[28] *Id*. at 489.

[29] Bodenheimer at 87; Fox at 495; Hyman, 30 J. LEG. STUD. /// 537; Peter Swenson and Scott Greer, *Foul Weather Friends: Big Business and Health Care Reform in the 1990s in Historical Perspective*, 27 J. Health Pol. Pol'y & L. 605 (2002)

[30] The saga of cost-cutting in the health care arena has become an accepted narrative in the scholarship on health care. See, e.g., Hacker, Bodenheimer, Fox, others

[31] In the fee for service system, insurers deferred to the certification by providers that the treatments and services which they had provided were medically necessary and reimbursement followed. HALL, MAKING MEDICAL SPENDING DECISIONS ///PIN ; Rai, 30 J. LEG. STUD. // 583-85

[32] Included in HMO Act

future provision of services.[33] When that discipline proved inadequate, utilization review achieved a more direct cost control by setting up monitoring and policing procedures by which payers denied reimbursement in advance for care that fell outside the treatment norms for a particular condition.[34] A similar process occurred with hospitals.[35]

But utilization review, whether retrospective or prospective, was only the tip of the iceberg. Denials of reimbursement, or required pre-approval of services, could still be consistent with a fee-for-service structure. The real story began to happen at the institutional level.

The 1990's saw a massive transformation to managed care structures for the delivery of health care services. The essence of managed care is non-fee-for-service reimbursement of providers, combined with delivery mechanisms that limit care such as gatekeeper primary physicians and limited provider networks.[36] Large health insurance purchasers, primarily employers who sponsor workplace-based group plans, increasingly opted for the cost savings promised by managed care oversight of expenses.[37] By 1999, all but eight per cent of those who had insurance through their workplace were enrolled in health care plans that were based on some form of managed care.[38]

A variety of options were used in these plans to structure the contractual agreements with providers in a manner that would control costs. Traditional HMOs constituted only a small segment of the options used. Most options built on existing provider structures but entailed some form of assumption of risk by the provider. Down-streaming of financial risk to providers through capitation systems was the

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[33] CITE.

[34] case examples Wickline

[35] CITE.

[36] CITE

[37] Bodenheimer and Grumbach, *supra* note 25; JACOB S. HACKER, THE ROAD TO NOWHERE: THE GENESIS OF PRESIDENT CLINTON'S PLAN FOR HEALTH SECURITY (1997).

[38] R. Adams Dudley and Harold S. Luft, *Managed Care in Transition*, 344 N. ENG. J. MED. 1087 (2001).

most common approach.[39] For example, a provider would agree to accept a patient for a set reimbursement amount paid each month (regardless of the actual services used by the patient) and would commit to providing that patient with all needed services. The provider then carried the burden of ensuring that her pool of patients included the right mix to result in a profit at the end of the year.[40]

Down-streaming of financial risk to providers through capitation systems was generally paired with down-streaming of utilization management.[41] Once providers began bearing the financial risk of providing services to patients, many payers saw advantages in allowing those same providers to have control over their utilization management, allowing the risk-bearing entity to control its own costs.[42]

These institutional changes continued in a cascading series of developments. Solo and small group physician practices consolidated into larger entities to achieve greater efficiency and control in their pools of patients.[43] Scaling up, networks of these providers, including hospitals, formed.[44] As James Robinson, a leading economist, has noted: "[t]he growth and diffusion of the multi-specialty medical group, paid prospectively and delegated authority for utilization

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[39] CITE.

[40] CITE.

[41] CITE.

[42] Alice A. Noble and Troyen A. Brennan, *Managing Care in the New Era of "Systems-Think": The Implications for Managed Care organizational Liability and Patient Safety*, 29 J. L. MED. & ETHICS 290, 292 (2001).

[43] In 1983, 75.8 per cent of physicians were self-employed, including 40.5 per cent in solo practices; 24.2 per cent were employees of managed care or other organizations. In 1999, the self-employed figure had dropped to 61.8 per cent, with only 28.4 per cent in solo practice. The percentage who were employees had risen by more than 50 per cent, to 38.2 per cent. The trend is even more pronounced among new practitioners. Dudley and Luft, *supra* note /// at 1089.

[44] CITE

management, is the single most important development in the contemporary organization of medicine."[45]

As provider entities and networks grew larger, some sought to maximize their revenue and control by cutting out the managed care organization completely and directly offering their own managed care products.[46] Professional societies, such as the American Medical Association, provided technical and financial support to doctors who were developing business models that involved assuming insurance-style risk on their own.[47] And as a surge of such networks declared bankruptcy,[48] state insurance commissioners began to wrestle with whether or how to actually classify *medical* practices as *insurers* for purposes of establishing criteria for solvency and rate-setting.[49]

2. Actuarial Medicine

Specific financing arrangements in managed care are, of course, "constantly adapting and changing," and "bedside'

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[45] JAMES C. ROBINSON, THE CORPORATE PRACTICE OF MEDICINE: COMPETITION AND INNOVATION IN HEALTH CARE 91 (1999) (hereinafter CORPORATE PRACTICE).

[46] Dudley and Luft, *supra* note /// at 1088. B&G

[47] The American Medical Association established a Physicians Capital Source project in 1994 to match doctors with investors and to furnish assistance in writing business plans and on general management questions. One AMA official stated that "[p]hysicians are very concerned about whether they will have a place in the market of the future." Alicia Ault Barnett, *Do Health Plans Change Course When Doctors Take the Helm?*, 13 BUS. & HEALTH 32 (1995).

[48] CITE

[49] Ericka L. Rutenberg, *Managed Care and the Business of Insurance: When Is a Provider Group Considered To Be At Risk?*, 1 DePaul J. Health Care L. 267 (1996). For a case study of how one state used its regulatory powers, see Brant S. Mittler and Andre Hampton, *The Princess and the Pea: The Assurance of Voluntary Compliance Between the Texas Attorney General and Aetna's Texas HMOs and Its Impact on Financial Risk Shifting by Managed Care*, 83 B. U. L. Rev. 553 (2003). In 1995, the National Association of Insurance Commissioners issued guidelines for regulation of such arrangements under state insurance codes. Id.

rationing" incentives vary in their intensity.[50] But by the mid-1990's, all three of the economic dynamics I describe above – hyper-inflation, the dominance of managed care over fee for service, and the undertaking of financial risk directly by physicians and other providers – had taken hold.

The result is what I call "actuarial medicine."[51] In today's health care system, the merger of coverage and care decision-making means that "the calculation between cost and clinical effectiveness is no longer a struggle between physician and insurer; rather, it becomes incorporated into the physician's own clinical decision-making process."[52]

Central to insurance, of course, is the goal of actuarial fairness. This requires the accurate pricing of risk, so that an insurer charges each group of individual no more and no less in premiums than is necessary to cover the cost of future claims, plus administrative expenses and a reasonable profit.[53] The bedrock philosophy underlying insurance law is to facilitate the achievement of actuarial fairness.[54] Health insurance is but one example of actuarial fairness in action (or in dispute).

The downshifting of financial risk in the health care system has produced something new: actuarial fairness as a concept within *medicine* itself. From the provider's point of view, actuarial fairness within medicine means pricing one's bundle of services so as to produce enough income to cover the cost of providing those services to the purchaser's enrollees for the length of the contract, plus overhead and reasonable profit. This is the financial face of managed care as seen by the

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[50] CITE.

[51] The term "actuarial medicine has not been used in the legal literature in the manner in which I use it here. A Google search reveals that it has been used to mean XX in YY.

[52] Kleinke, *The Industrialization of Health Care*, *supra* n. 4, at 1457.

[53] cite

[54] CITE. The means toward that goal include enforcing contract terms such as explicit exclusions, construing vagueness against the insurer-drafter when necessary to prevent reneging on the insured's reasonable belief that risk had been assumed, requiring adequate financial solvency by those who would contract to take on significant levels of risk, and by policing the representations that would-be insurers could make. CITE.

provider, and it is the primary component of actuarial medicine.

The legal linchpin for actuarial medicine to work is an interpretation of "medically necessary" that allows for the consideration of costs in determining appropriate treatment. "Medically necessary" is a radically imprecise term. But while almost endless variations exist for the meaning of this key phrase,[55] what many of them share is an allowance for the consideration of cost. In a comprehensive review of the health services research literature and of trade journals, Rosenbaum et al. concluded that a consensus has emerged that medically necessary should be defined as "multi-dimensional," to include factors such as cost and relative effectiveness.[56] This approach essentially ensures that the ultimate measure of what will be "medically necessary" will be which treatment option, among those that are reasonably believed to be equal in safety and efficacy, costs the least.

In my view, "medically necessary" remains the universally used term because, not in spite of, the lack of a fixed definition. Its indeterminacy creates a zone in which incommensurate values such as cost-benefit analysis and compassion are expected and accommodated, if not exactly encouraged. The decision-making point can slide along a scale of multiple actors who are involved at different points in treatment and coverage determinations. Risk – both clinical and financial – is constantly being negotiated and renegotiated,

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[55] Some states have defined the term statutorily. see MPDC, others. Federal law allows the insurance companies that act as fiscal intermediaries or contractors in the Medicare system to define it and those definitions vary. See [medicare articles State Medicaid programs employ yet additional definitions. [examples – TN.] In settling a class action brought by physicians who alleged that insurers misrepresented their payment policies in violation of RICO, insurers negotiated settlements that included both definitions of medically necessary and special arbitration systems for resolving disputes. Cite. And the body of case law and administrative law that accumulates as denials based on lack of medical necessity are challenged also creates parameters and nuances that feed into the system. [articles, cases, Hunter, MP/DC article].

[56] Sara Rosenbaum et al., *Medical Necessity in Private Health Plans: Implications for Behavioral Health Care* 7, 26 (DHHS Publication No. (SMA) 03-3790 2003).

assumed and shifted, in the interactions that identify what counts as medically necessary.

3. Knowledges and Norms of Risk Governance

Risk governance in health care is grounded in the material realities of actuarial medicine that I have just described. But the impact of such governance goes beyond simple cost cutting or complex new delivery structures. At its heart, and essential to its success, are a set of new knowleges created by the health care system and a set of often hidden norms regarding social inclusion, equity, and access to care.

a. *Knowledges*

Intellectually, the financial side of health care has more than kept pace with the clinical side. Health care protocols have shifted from a mindset of responding to unique episodic events presented by single patients to a mindset of anticipating certain occurrences with a statistically-determined regularity, offering insurers and purchasers of large group plans the promise of an ability to "govern the future."[57]

Forms of knowledge based on statistical calculation provide the mechanisms by which the cost containment reforms described above are able to take hold. New technologies of measurement and evaluation that have developed within the health care system now enable the aggregation of treatment knowledge based on the systematic reporting of outcomes.[58] This synthesized data produces new knowledge. Larger physician practices and institutional provider networks enable the easy aggregation of data, and price competition puts a premium on the reliability of such data.

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[57] CITE.

[58] CITES For clinical risk – IOM study To Err is Human. Physician reaction - See also CITE, 53 VAND. L. REV. 831, 859- (YEAR) (characterizing the mode for transmission of knowledge within professions as tacit and informal, often by means of participation and anecdote).

Experience rating, the pricing of insurance for a given group based on past claims,[59] is not new. But the standardization of encounter and treatment data fields has enabled a quantum leap in the sophistication of predictive models.[60] Risk managers use data produced by multi-provider networks and institutions to measure and analyze patterns of care,[61] and outcomes research has become a major field within the medical academy.[62]

The production of more than 2,000 clinical practice guidelines (CPGs) over roughly the past decade[63] -- guidance protocols for physicians to use in deciding upon a course of treatment[64] -- illustrates how various disciplinary regimes within medicine have evolved together in a symbiotic, synergistic fashion in the generation of a discourse of risk managerialism. The government,[65] the medical profession,[66] and private market entities[67] all aligned in their support for the development of CPGs and participated in the development of

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[59] CITE

[60] Rosoff

[61] Sage

[62] CITE

[63] Noah – cite for the 2,000 number.

[64] The Institute of Medicine defines CPG's as "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances." Field and Lohr

[65] When Congress created the Agency for Health Care Policy and Research in 1987, its primary mission was to use outcomes research to produce national guidelines for common medical procedures. J. Rosser Matthews, *Practice Guidelines and Tort Reform: The Legal System Confronts the Technocratic Wish*, 24 J. HEALTH POL., POL'Y & L 275, 282 (1999). One can now view hundreds of guidelines on the agency website. (AHCRP was renamed the Agency for Health Research and Quality.) ADD URL CITE.

[66] The Institute of Medicine issued a laudatory report on CPG's in 1990, Field and Lohr, *supra* note /// and dozens of professional societies have issued their own guidelines. Michelle M. Mello, *Of Swords and Shields: The Role of Clinical Practice Guidelines in Medical Malpractice Litigation*, 149 U. Pa. L. Rev. 645, 650 (2001).

[67] For managed care organizations and other insurers, guideline development grew easily out of the methodology of utilization review. *Id.* at 651

such guidelines. CPGs are an ingenious device for addressing both financial and clinical risk, in essence marrying defensive medicine to cost control, rationalized by the discourse of science.[68]

The process of the institutionalization of CPGs by law is well underway. Courts have begun to allow use of CPGs as evidence of the standard of care to which physicians should be held in malpractice litigation.[69] And although there are differing views among scholars regarding the utility of CPGs in determining the outcome of cases,[70] litigators are nonetheless using them to screen cases.[71]

CPGs also serve a disciplinary function through a norming effect. The widespread presence of such guidelines create pressure for physicians to conform to what are promoted as "best" clinical practices, even without any explicit intervention by or interaction with a payer or a court.[72]

From the confluence of these economic, technological and intellectual developments, a common managerial discourse centered on risk now dominates health care. The increasing sophistication of statistics-based technologies of knowledge has facilitated risk allocation decisions that are more precise and effective. The distribution of financial risk in the health care system, once set and relatively stable (i.e., a physician provides the service and gets paid), now continuously evolves. And physicians, care-giving institutions, financers of care, and,

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[68] "[M]odern health plans virtually cannot operate without using some sort of clinical guidelines to decide which care is covered under the plan." E. Haavi Morreim, *Playing Doctor: Corporate Medical Practice and Medical Malpractice*, 32 U. Mich. J. L. Ref. 939, 1001 (1999). Gary Belkin argues that only a scientific rationale could have succeeded in threading the needle of cost reduction pressure and professional pride. Belkin, *The Technocratic Wish, supra* note 4, at 518.

[69] A number of courts have allowed a physician to defeat a malpractice claim by demonstrating that she followed the professional norm in her treatment decisions. CITES. Fewer courts have allowed their use by plaintiffs to establish a breach of the standard of care. CITES

[70] Mello, Hyman

[71] Hyams

[72] See Valverde, *Legal Knowledges of Risks, supra* n. 3, at 93.

increasingly, patients[73] are all participating in these evolving decisions.

b. Norms

The practices of allocating risk (whether through public or private mechanisms) parallel the quintessential functions of a state: they identify certain risks to be collective, others to be assumed by individuals; they mark certain actors as eligible for protection, others as not; and they incentivize certain conduct, but not all conduct, as socially beneficial because of its tendency to diminish certain forms of risk.[74] Allocating the multiple forms of financial risk in the health care system channels and structures choices about who will receive what forms of care, who will pay for what kinds of illness, and how quality or negligence will be defined.

Risk governance –- that is, governance driven by a discourse of risk managerialism channeled by both public and private actors – thus instantiates a powerful mixture of formal policy and moral normativity relating to both persons and conduct.[75] But the normative assumptions and values underlying the system are often masked.

The empirical nature of actuarial understandings mask the power dynamics involved in these decisions and make them seem natural or inevitable, rather than political. Commenting on the use of actuarial reasoning in the case of *Los Angeles Water and Power v. Manhart*,[76] Jonathan Simon described actuarial techniques as a "regime of truth [and] a way of

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[73] Insurers stung by the cost in good will from the backlash against managed care have developed product lines that shift elevated levels of financial risk to patient-consumers, through health savings accounts and higher co-pays and deductibles. See Robinson, CORPORATE PRACTICE *supra* n. 45 at xx.

[74] See IAN HACKING, THE TAMING OF CHANCE xx-xx (1990).

[75] Ericson et al note that insurance, the most common technology for risk distribution, "quantifies and commodifies moral commitments in every detail of underwriting, loss prevention, and indemnification." RICHARD V. ERICSON, AARON DOYLE, AND DEAN BARRY, INSURANCE AS GOVERNANCE 69 (citing Ewald). *See also* Tom Baker, *Insuring Morality*, XX.

[76] 435 U.S. 705 (1978).

exercising power" experienced as familiar and neutral methods of computation.[77] This masking capacity is compounded in the health care arena, where natural forms of physiological risks are so intertwined with financial risk in the everyday functioning of health care delivery.

Managed care has normalized the idea that the health care system is organized around interdependency and limited resources. But popular understanding of the dominance of risk governance in the system is largely inchoate. The widespread populist backlash against the most stringent managed care cost control mechanisms, which led to a surge of state legislation in the late 1990's,[78] is probably best understood as a compound phenomenon. It is extremely difficult to tease apart the multiple normative claims that fueled these initiatives: a demand for patient subjectivity against the culture of impersonal treatment by physicians who were strangers; a demand for accountability against the abuses of some MCO's in denying appropriate treatment because of cost; and a demand by physicians for reinstatement of some measure of their traditional authority.

But the concept of health justice as a strong norm has seldom made for fruitful debate. The conflict between norms associated with the insurance industry's principle of "fair discrimination" in allocating risk on one hand[79] and the solidarity norms of social insurance on the other have dominated debates on the ethical dimensions of health policy.[80] It has been difficult for those seeking to establish norms of equity in health care to find a framework that engages both risk and equity in an effective manner.

Rights principles have never proven adequate or even fully relevant as a basis for confronting the gaping health care

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[77] Simon, *supra* n. xx, at 772 (arguing that the unobtrusiveness of actuarial techniques is one basis of their importance because it diminishes political reaction to exercises of power).

[78] CITE

[79] 108 Harv. L. Rev.

[80] Hoffman, Stone. Opinion surveys document that most Americans believe that a moral right to health care exists in some form, but there is no consensus as to its scope. Cite.

hole in the quality of American life. Negative liberty principles offer no purchase for contesting private actions, and even equality mandates extending into the private sector seem off kilter for a problem that does not fit the minoritizing discourse of civil rights issues.[81] Moreover, the individual fairness focus of a civil rights mandate can cut against an argument for community sharing of risk.[82]

The demographic picture of uninsured Americans also does not easily fit a civil rights narrative. Uninsured Americans do not form a cohesive, identity-group style minority. Although lack of insurance correlates with lower income,[83] the largest subgroups among the uninsured are diverse: the children of low-income workers, self-employed persons, and young adults who perceive that their need for health insurance is minimal and not worth the expense.[84]

Communitarian theories may offer more promise. If we imagine ourselves as citizens in a health republic, we are joined in a community of risk. The overwhelming justice issue is that only some individuals are protected against unforeseeable adverse events.[85] However, many communitarian theories tend to rely on assumptions of homogeneity within the group,

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[81] Sara Rosenbaum //;

[82]The "basic policy" of a civil rights approach "requires that we focus on fairness to individuals rather than fairness to classes." Los Angeles Water and Power v. Manhart, 435 U.S. 705, 709 (1978) (invalidating a requirement that women employees contribute more than male employees to the pension fund because on average, women live longer than men).

[83] CITE

[84] CITE

[85] The issue is not subtle: 47 million Americans lack health insurance. Sept Census data. Of those, the Agency for Health Research and Quality has categorized 17 million as "continuously uninsured" because they have lacked coverage for at least four consecutive years. CITE Americans without insurance are far more likely to receive inferior and inadequate care. IOM, CARE WITHOUT COVERAGE 162. Indeed, there is a spillover effect beyond the uninsured: in communities with large numbers of uninsured persons, even those who have insurance experience less availability of services and receive lower quality of care than persons who live in communities with few uninsured persons. Mark V. Pauly and Jose A. Pagan, *Spillovers and Vulnerability: The Case of Community Insurance*, 26 HEALTH AFFAIRS 1304,1309-12 (September/October 2007).

which give them limited usefulness in the health care context.[86]

Addressing these normative conflicts with a risk allocation paradigm at the forefront of one's thinking can better capture the stakes at issue in the debates: who gets included and excluded in the pooling process, how allocation decisions are made, and whether there are systems of accountability and checks and balances built in to produce a risk allocation system that is equitable, as well as efficient and flexible, in determining how and to whom various kinds of risk are apportioned.

But a risk-centered normative frame does not resolve the tensions on its own. From a progressive political perspective, a shortcoming of risk talk is that it does not carry the same intrinsic egalitarian valence as rights talk.

The current movement toward "consumer-directed health care" (CDHC) illustrates this problem. CDHC is founded on re-modeling and re-branding of the patient as a consumer, and organizing delivery of health care around the principle that individuals must be disciplined to police their own consumption tendencies by bearing ever greater portions of the cost.[87] An ethics of individual responsibility, self-governance, and prudence constitute the elements for defining the good consumer, and thus the good patient.[88]

Choice is a highly celebrated (and rhetorically powerful) value in the politics of CDHC, but it is the choice of a purchaser selecting among available commodities.[89] Embedded in a liberal market universe of meaning, the CDHC model offers no space for importing more egalitarian norms into questions of either macro- or micro-rationing.

Like the rhetorics of insurance advertising described by Tom Baker[90] and Deborah Stone,[91] risk talk is highly elastic,

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[86] Williams, xx, 72 IND. L. J., 423-24 (date).

[87] DESCRIBE

[88] CITE

[89] CITE

[90] CITE

[91] CITE

capable of framing normative issues around invocations of both solidarity and short-term self-interest. It thus leaves the field open to the most successful moral entrepreneurs, in a debate that Americans have never fully resolved.

II. Risk Governance as a Paradigm for Health Law

Law regulates roles and institutions, and new vectors of risk have profoundly changed the roles and institutions within medicine. In this Section, I return to the perennial "law of the horse" problem and argue that understanding health law through the lens of risk governance offers greater intellectual coherence for the field than other frameworks that have been suggested. Subpart A provides an overview of the frameworks currently in use for understanding health law as a field and makes the case for the greater explanatory power of a risk governance paradigm. Subpart B offers, as a concrete example of such explanatory power, judicial changes in the meaning of "fiduciary" in the health care context.

A. Paradigms of Health Law

The material forces I describe above have catapulted the field of health law into a state of confusion. At a symposium convened in 2005 to "rethink" the field,[92] speakers described health law as "not yet a coherent field of law [but] rather a disjointed set of statutes and doctrines,"[93] one with "rules [that] come flying from all directions with no one taking the trouble to make them consistent,"[94] and haunted by "the specter of exhaustion" caused by the recycling of two

[92] Mark A. Hall, et al., *Rethinking Health Law: Introduction*, 41WAKE FOR. L. REV. 341 (2006). Gregg Bloche, in a symposium inaugurating the O'Neil Institute for National and Global Health Law at Georgetown University Law Center, made the same point. See Gregg Bloch, xx (forthcoming Georgetown Law Review)

[93] Einer R. Elhauge, *Can Health Law Become a Coherent Field of Law?* 41WAKE FOR. L. REV. 365 (2006).

[94] Carol A. Heimer, *Responsibility in Health Care: Spanning the Boundary Between Law and Medicine,* 41WAKE FOR. L. REV. 466 (2006).

intellectually spent explanatory paradigms: patient autonomy and market theory.[95]

Efforts to redeem this "substantive cacophony"[96] have emerged intermittently since the early 1980's, when the American Society of Law and Medicine commissioned a task force to review the teaching of health law.[97] But none of the explanatory frameworks proposed so far is adequate to conceptualize contemporary health care and health law.

The defense of health law as a coherent and independent field has long centered on the unique presence of professional authority. For example, the professional custom standard in medical malpractice law established a singular rule for tort liability in health care cases.[98] In other doctrinal categories of law as well, deference to medical judgment created exceptions to general legal principles of tort or contract, cumulatively forming a zone of unique law.[99] Similar to the manner in which family law was understood as founded on a set of altered standards for property, tort and contract designed to accommodate the dynamics of intimate life experience, health law was understood as resting on, and defined by, a set of doctrinal anomalies centered on professional autonomy.

Health law's claim to distinctiveness has diminished, however, in light of the growing focus on and role of economics in the health care system. From its original core centered on the legal oversight of the doctor–patient relationship, health law has grown with its field, becoming a complex edifice of heavily statutory law regulating thousands

[95] Mark A. Hall, et al., *Rethinking Health Law: Introduction, supra* n. 92.

[96] Mark A. Hall, *The History and Future of Health Care Law: An Essentialist View*, 41WAKE FOR. L. REV. 347, 354 (2006).

[97] Am. Soc'y Law and Med., *Health Law and Professional Education: The Report of the Task Force on Health Law Curricula of the American Society of Law and Medicine*, 63 U. DET. L. REV. 245 (1985).

[98] CITE.

[99] CITE.

of health care-related entities.[100] As health care has in fact become an industry, at least in scale, issues of economic theory have become more urgent, and economics-based approaches to regulation have come to the fore in health law, as they have in health policy more generally. Within health law, the zone concerned with institutional liability and cost-benefit regulatory issues expanded, as medical practice shifted away from dominance by independent professionals to large networks of practitioners who contracted with each other and with large institutions to acquire access to larger patient markets.[101]

In light of these changes, academic debate has stalemated about which of three centers of gravity best define the core of health law today. No adherent of any theory denies the existence of the forces highlighted by the other theories; rather, the debate centers on how to best capture the uniqueness and coherence (if any) of health law. In addition, each theory has its own internal conversation that occurs between adherents sharing its particular worldview.

The most traditional rendition of health law is the "essentialist" view,[102] centered on the "relational web" between provider and patient.[103] This approach frames the field as dominated by a core of professional authority, including the privilege of self-regulation accorded to physicians and the fiduciary duty of physicians towards their patients. The internal conversation within this worldview focuses on how the core of professional authority operates synergistically but in tension with rights accorded to patient autonomy.[104]

The second candidate for intellectual dominance is the economics approach that emphasizes the role of health law in

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[100] Nan D. Hunter, *Justice Blackmun, Abortion and the Myth of Medical Independence*, 72 BROOK. L. REV. 147, xx (2006).

[101] See supra TAN xx, describing changes in the economics of health care staffing.

[102] Hall, *supra* n. 92 at xx.

[103] Hall and Schneider

[104] Hall, *supra* n. 92 at xx.

facilitating private market forces.[105] This approach centers on the unique economic dynamics of the health care market, bedeviled by highly asymmetric information resources, a history of supplier-induced demand, and the fact that many consumers of care (particularly individuals in large group plans) are not the primary payers for that care.[106] The internal critique within this worldview draws on norms of compassion and rescue by physicians to counter a solely economic analysis.[107]

A third approach views health law as a form of regulatory law, focusing on the role of the state in balancing the tension between the need for broader access to health care and the need to control costs.[108] While this is similar to the regulatory law applicable to most economic sectors that mediate a power struggle between the state and the market, the internal conversation within this worldview centers on two dynamics that distinguish the regulatory landscape of health care. First, health regulation represents a struggle among *three* centers of power, as opposed to the normal dichotomous power contest between the state and entities in the private market. The third player – the profession – retains some degree of self-regulatory leeway, and allies itself sometimes with the regulators, sometimes with market entities.[109] Second, there is deep social ambivalence about whether health care should be considered a public good or a commodity.[110] As a result, there are only provisional and unstable resolutions of political questions about how much access should be guaranteed by public mechanisms.

None of these paradigms, however, can claim dominance as a satisfactory rationale for health law as a coherent field. Placing any one of them at the center of a concept of health law today omits too much of what constitutes

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[105] Havighurst, others

[106] Arrow

[107] Bloche

[108] Rosenblatt

[109] CITE

[110] Hoffman, 78 IND. L. J. 659, PIN; OTHERS////

the core of legal regulation of the health care system. For example, a distinctive tort liability standard and the (diminishing) scope of autonomous self-regulation that furnish much of the basis for the essentialist view provide us with little insight into insurance or financial risk questions in health law. Market-oriented perspectives centered in antitrust, tax law, and the analysis of financial incentive structures as market interventions discount the doctor-patient relationship and equity questions. Focusing on federal and state regulation of health care misses many of the private investment and liability issues.

One response to the scholarly stalemate seeks a legal process kind of solution -- focusing on institutional competence and drawing on different frameworks for different problems.[111] A major proponent of this approach, Einer Elhauge, has argued for a "comparative paradigm analysis"[112] through which certain decisions would be effectively assigned to different systems. For example, establishing a national budget for health care costs might be best decided through laws resulting from the political and regulatory process, while ensuring competitive service suppliers for consumers might be best achieved through laws that facilitate market forces.[113] But this approach essentially consists of a decision-making heuristic that might be applied in any number of fields. It does not purport to offer a comprehensive intellectual framework for understanding health law.

My argument is that the best way to understand health law is to focus not on the *tension* between the three centers of power comprised by the state, the market and the profession, but rather on the extraordinarily complex *synchronicity* among these three centers. And at the heart of this synchronicity lie decisions about *risk*.

Health care delivery systems, financing and payment structures, and bureaucracies of government regulating all aspects of health care together comprise a set of unrelated, but

[111] Elhauge, *supra* n. 93.

[112] *Id*. at 379.

[113] *Id*. at 384-86.

nonetheless deeply connected, public and private institutions of collective risk allocation and management. Understanding health law as reacting to and facilitating the flow of practices and policies that address financial risk, and its interplay with clinical risk, offers us a more holistic and integrated approach to the field. Moreover, a focus on risk suggests a path around the traditional division in legal doctrine between public and private realms, which has obscured the matrix of how power actually flows within the health care system.[114]

Informed consent doctrine provides one example of how a focus on concepts of risk knits together disparate structures within the health care system in a holistic manner. Informed consent law began as an anti-paternalism mechanism, using tort doctrine to remedy the power inequalities in the doctor-patient relationship by forcing disclosure of information about clinical risk material to the patient's decision-making.[115]

But informed consent law today is also being looked to as a possible means for addressing information asymmetries with regard to how doctors manage their financial risks. For example, informed consent law is currently grappling with when and by whom patients should be informed of the financial incentives that affect almost every physician's compensation.[116] Performance data about individual doctors and hospitals could conceivably be incorporated into the consent process as well.[117] Patient advocacy groups are seeking access to the Medicare database that contains detailed

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[114] Blum, Grijalva – state action in health care. See also, CITE, 1986 U. ILL. L. REV. 689 (discussing the protection of individual rights against abuses of private sector power).

[115] CITE.

[116] Shea v. Esensten, 107 F.3d 625 (8th Cir. 1997) (ERISA fiduciary duty includes obligation to disclose financial incentive when advising patient not to seek specialist care). In more than half the states, statutes impose disclosure requirements on health plans. Tracy E. Miller and William M. Sage, *Disclosing Physician Financial Incentives*, 281 JAMA 1424, PIN (1999). See, e.g., Neade v Portes, 303 Ill.App.3d 799, PIN (1999). See generally, Bloche, The Invention of Health Law, at 271-74.

[117] Johnson v. Kokemoor CITE. See also,

billing information from thousands of providers in order to publish performance evaluations of those physicians.[118]

In my view, the best way to view these developments in informed consent law is through a risk governance lens that forces us to focus on how the state, the private market, and the profession are all operating in the allocation and management of clinical and financial risk.

One can argue that using a risk governance approach to health law will render the field less distinctive, thus threatening whatever sense of intellectual coherence it can still muster. However, only the traditional professional autonomy model proffers a claim for the uniqueness of health law. The others, like the risk governance paradigm, focus on doctrines that have remained tailored to health care, but not unique to it. In my view, a risk governance model is a superior analytic tool because it provides us with more fully theorized and contemporarily relevant insights into the operations of the health care system.

Another advantage of the risk governance paradigm is that it can significantly bridge the gap between the traditionally private law of health care financing and delivery and the traditionally public law of the public health system. Public health principles are founded on an orientation to population health, rather than individual patient care.[119] The law governing the doctor patient relationship, by contrast, is about individual patient care. But both "bedside rationing" by doctors dealing with the merger of financial and clinical risk, and the allocation of public dollars for health care, increasingly turn on broad allocationary dynamics. Mapping the dynamics of financial risk in both systems can offer the possibility of greater coherence between the two.

The same potential for transcending intellectual borders lies in bringing a risk governance approach to comparative health law. The American health care system is often characterized in ways that highlight its singularity, particularly

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[118] Consumers Checkbook v. Dep't of Health and Human Services, ___F.Supp.2d ___, 2007 WL 2381005 (D.D.C. 2007).

[119] LAWRENCE GOSTIN, PUBLIC HEALTH:

in its financing mechanisms and its under-inclusiveness.[120] Yet multiple national systems are grappling with how to meld processes for coverage determinations with quantitative models for budgeting and risk assessment.[121] Whatever the differences, American and other health officials share many cross-cutting issues in these areas, a shared focus best highlighted by a risk governance approach.

B. The Colonization of Fiduciary Duty by Risk Governance

The new patterns of risk assumption within health care, that I describe in Part I, have introduced instability into the legal concept of fiduciary duty. The colonization of fiduciary duty by risk governance provides an example of how understanding health law through the lens of risk governance can help bring clarity and coherence to doctrinal developments in the field.

A physician's fiduciary duty to place the interests of her patients above all other concerns has long been an article of faith within the medical profession.[122] It has also long been present in tort and contract principles in traditional health law.[123]

But, in actuarial medicine today, a physician's fiduciary duty has essentially been ERISAfied. While ERISA does not explicitly dictate that a treating physician should interpret her fiduciary duty in a managed care setting differently than she did in a fee-for-service system, the judicial interpretation of the responsibility established by ERISA for both the sponsor and the insurer of a group plan have in effect trumped the purely

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[120] CITE.

[121] Timothy Jost,

[122] See JACOBSON,

[123] David Mechanic, *The Functions and Limitations of Trust in the Provision of Medical Care*, 23 J. HEALTH POLITICS, POL'Y AND L. 661 (1998); Maxwell J. Mehlman, *Fiduciary Contracting: Limitations on bargaining Between Patients and Health Care Providers*, 51 U. PITT. L. REV. 365 (1990).

medical concept of fiduciary duty – hence resulting in what I call the colonization of fiduciary duty by risk governance.

ERISA establishes fiduciary responsibilities for the persons or entities that are charged with the oversight and administration of an employee benefit plan.[124] The ERISA fiduciary concept draws primarily on the principle from trust law that a trustee has a duty of loyalty to administer a trust solely for the benefit of the beneficiaries.[125] Trust fiduciary duty does not attach principally to each individual beneficiary, any of whom could make claims that would deplete the full corpus of the trust.[126] Rather, the trustee's loyalty flows to the *fund* itself, and requires that the trustee exercise prudence in approving and rejecting any claims made on the fund.[127] The trustee's duty is to manage the fund in such a way that all of the beneficiaries will be able to share its benefits, not to direct that each beneficiary will necessarily receive the maximum she seeks from the trust.[128]

The primary motivation for ERISA was to provide new rules for the solvency, disclosure policies, vesting rules, and administration of pension plans.[129] In this context, the traditional duty of a trust fiduciary works relatively well. But because ERISA regulates "welfare" plans generally, it also governs plans providing health benefits.[130] In this context, the fiduciary relationship has become more complicated. As noted above, health care providers often manage both clinical and financial risk in an integrated fashion, and employers sponsoring health care plans want dual, sometime contradictory goals -- to provide health care benefits to their employees but also to control costs through managed care frameworks.

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[124] CITE

[125] CITE

[126] *See* BOGERT

[127] CITE

[128] CITE

[129] Alessi, 451 US 504, /// (1981) (Congress was concerned with workers actually receiving rights which had vested.)

[130] CITE

The result is a health law doctrine created by the Supreme Court that accommodates the realities of these merged identities on the part of providers and these dueling interests on the part of employers. Two cases decided within four years of each other demonstrate the twisting road taken by the Supreme Court to accommodate risk governance practices in health care.

In *Pegram v. Herdich*,[131] the Supreme Court faced a complex situation involving a defendant doctor who co-owned the HMO where she also worked as a treating physician. The doctor, Lori Pegram, found an inflamed mass in Cynthia Herdrich's abdomen. Despite the inflammation, Pegram chose not to order an ultrasound for Herdrich at a local hospital, but concluded instead that Herdrich could wait eight days for an ultrasound to be performed at a facility staffed by the HMO itself, 50 miles away. Before the eight days were over, Herdrich's appendix ruptured, causing peritonitis.[132]

Herdrich sued Pegram and the HMO for medical malpractice and state law fraud. Pegram and the HMO responded by arguing that ERISA preempted those claims and removed the case to federal court. Herdrich then argued that Pegram and the HMO violated their fiduciary duties under ERISA because the terms of the HMO rewarding its physician owners for limiting medical care "created an incentive to make decisions in the physicians' self-interest, rather than the exclusive interests of plan participants."[133]

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[131] Pegram v. Herdich, 530 U.S. 211 (2000).

[132] *Id*. at 215.

[133] *Id*. at 216. The plaintiff, Cynthia Herdrich, had coverage with the HMO through her husband's employer. The HMO had contracted with the employer who sponsored the group health plan to both provide medical services and to administer the group plan. Thus the HMO was responsible for assessing whether particular services were covered under a medically necessary standard, as well as for delivering the care. The patient alleged that the assessment regarding the exigency of her need for a diagnostic test was tainted by the physician's awareness that her own year-end bonus would be based on how successfully she reduced expenditures by, in part, directing that auxiliary services such as testing be performed by the in-network facilities which charged reduced rates. *Id*. at 226-27.

The sole legal question before the Supreme Court was "whether treatment decisions made by a health maintenance organization, acting through its physician employees, are fiduciary acts within the meaning of [ERISA.]"[134] The Court concluded they were not.[135]

The Court ruled that an HMO's fiduciary duty under ERISA applied only to coverage decisions regarding benefits to be provided under a plan.[136] By contrast, the Court declared that a doctor's decision to delay a diagnostic test in order for it to be performed by a facility affiliated with the HMO was a "mixed treatment-eligibility decision" and that such decisions were not covered under ERISA's fiduciary duty.[137]

The Court's decision in *Pegram* reads like a policy treatise on health care. It explains in depth the cost-benefit balancing process that occurs in health care today. The Court compared HMOs to other risk bearing entities, such as traditional insurers,[138] and stated that for any HMO structure, "there must be rationing and inducement to ration."[139] The Court observed that, under the plaintiff's theory, the mere existence of such a scheme would constitute a breach of ERISA fiduciary duty and the ultimate result "would be nothing less than elimination of the for-profit HMO."[140]

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[134] *Id*. at 214.

[135] *Id*. The District Court had concluded that Pegram and the HMO were not acting as fiduciaries under ERISA and dismissed the ERISA claim. Herdrich was then permitted to try her original malpractice counts to a jury, where she prevailed on both and received $35,000 in compensation. Herdrich then appealed the dismissal of the ERISA claim to the Court of Appeals for the Seventh Circuit, which concluded that Herdrich's allegations were sufficient to state a claim under ERISA. *Id*. at 217.

[136] *Id*. at .

[137] *Id*. at 229. The Court suggested that physicians could be individually liable on common law grounds if their standard of care, including their clinical assessment of what was medically necessary, fell below the professional norm standard for malpractice. *Id*. at .

[138] *Id*. at 219.

[139] *Id*. at 221.

[140] *Id*. at 233. The Court declined to undertake an assessment of whether the structure of defendant's financial inducements system exceeded "socially acceptable medical risk," id. at 221 because that judgment would require determination of the appropriate trade-offs between the risk of

Regarding physicians, the Court noted that "the incentive of the HMO physician … to give treatment sparingly" cannot be easily overcome.[141] The Court hypothesized that were it to recognize mixed treatment-eligibility decisions as covered by ERISA's fiduciary duty requirements, a physician's obvious defense to a charge of violating such duty would be that the decision had been justified by good medical reasons.[142] But this, the Court explained, would turn ERISA fiduciary claims into simple malpractice disputes that would be resolved on the malpractice standard of "reasonable and customary medical practice in like circumstances."[143] Allowing such claims would be wasteful and unnecessary as simply duplicative of medical malpractice claims.[144]

What the Court achieved in this analytical move, albeit completely without acknowledgement, was to signal the erasure of the *medical fiduciary* standard as an independent, viable standard for physicians in managed care settings. Under a traditional medical fiduciary standard, a physician makes treatment decisions based solely on the best interests of the particular patient; she does not properly consider rationing concerns.[145] In its place, the Court retained only the *medical malpractice* standard, which considers whether a physician's treatment decision is consistent with reasonable and customary medical practice standards.

The difference between the two standards is that a medical malpractice standard is not intrinsically in conflict with a doctor's concern about her own income or cost-benefit calculations as to an insurance fund. Under reasonable and

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undertreatment and the amount of expenditures to be allocated for health care. Id. Such an analysis, the Court said, was for the legislature to make. Id.

[141] *Id*. at 234.

[142] *Id*. at 235.

[143] *Id*.

[144] *Id*.

[145] Gail B. Agrawal, *Resuscitating Professionalism: Self-Regulation in the Medical Marketplace*, 66 Mo. L. Rev. 341, 360-61 (2001) (distinguishing between an allowance for some consideration of the expense of different treatments and allocating resources across populations).

customary medical practice standards today, treating physicians could opt for the least expensive choice among what can reasonably expected to be equally effective regimens.

By contrast, the traditional medical fiduciary duty does conflict with this kind of cost-benefit analysis or the favoring of personal gain. The net effect is that the trust concept as incorporated in ERISA, under which a duty of stewardship attaches to a collective (insurance) fund, has become the new version of medical fiduciary duty.[146]

This may be a perfectly fine policy result. My point is not to contest or analyze the utility of that policy approach. Rather, it is simply to highlight how the Court's legal conclusion regarding fiduciary duty under ERISA was shaped by the reality of risk governance in health care today. As reflected in and implicitly consolidated by the Court's *Pegram* decision, the medical fiduciary duty for physicians who practice in systems with financial incentives -- now a majority of American doctors -- has changed in substance if not in semantics. That duty now operates in tandem with, not as a prohibition of, concerns related to forms of financial risk that could negatively affect the physician's income.

The primacy of risk governance in shaping health law doctrine was reaffirmed in *Aetna Health Inc. v. Davila*.[147] There plaintiffs sued an MCO for denying approval of various treatment recommendations made by physicians who were reimbursed by the MCO.[148] The plaintiffs sued under a Texas statute that created tort liability for the failure to exercise

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[146] In the Court's opinion, Gregg Bloche wrote, "The moral and psychological costs of breach of trust at the bedside do not count. … In saying little about how plan administrators should manage this conflict and not acknowledging the constraints that the ethic of fidelity to individuals puts upon treating physicians' ability to strike a balance, the justices passed on two of the central moral questions in American medicine." M. Gregg Bloche, *U. S. Health Care After* Pegram: *Betrayal At the Bedside?*, 19 HEALTH AFF. 224, 226-27 (2000).

[147] 542 U.S. 200 (2004)

[148] *Id*. at 204-05. *Davila* consolidated cases involving denial of a specific medication recommended by a treating physician but for which the MCO denied approval, and denial of additional in-patient time, also recommended by the plaintiff's personal physician. In both instances, the MCO decisions allegedly caused illness that would have been averted had the original recommendations been accepted.

"ordinary care in making health care treatment decisions."[149] The Fifth Circuit concluded that denials of authorization for assertedly medically necessary services were "mixed treatment and eligibility decisions" made by the MCO and hence, pursuant to *Pegram*, not fiduciary decisions covered by ERISA.[150] On that reasoning, the Fifth Circuit concluded that the state law claim was not preempted by ERISA and could proceed.[151]

The Supreme Court reversed.[152] It explained that mixed treatment and eligibility decisions fell outside the definition of coverage decisions governed by ERISA's fiduciary duty *only* when such decisions were made by the treating physician, as had occurred in *Pegram*. They did not fall outside the scope of ERISA's fiduciary duty when they were made by MCO reviewing staff, as had been the case in *Davila*.

The Court's reasoning made it clear that it did not consider the mixed decisions made by the MCO reviewers to be any less *medical* in nature; they were clearly assessments of the medical necessity of care needed for a specific individual with a particular condition. But in a highly formalistic move, the Court concluded that the coverage function of the decision simply trumped the medical nature of the decision, even though the effect of the coverage decisions was to deny care.

The logic of the Court's analysis subordinated medical judgment to resource allocation. The Court noted that "a trustee managing a medical trust undoubtedly must make administrative decisions that require the exercise of medical judgment."[153] The opinion in *Davila* frames decisions about medical necessity as requiring no different process than that for decisions about pensions or vacation pay, other benefits governed by the ERISA structure. "[B]enefits determinations

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[149] *Id*. at 205 (describing claims under the Texas Health Care Liability Act.)

[150] *Id*. at 206.

[151] *Id*.

[152] *Id*. at 204.

[153] *Id*. at 219.

involving medical judgments are, just as much as any other benefits determinations, actions by plan fiduciaries."[154] This includes "even determinations based extensively on medical judgments."[155] The Court's reasoning creates a hierarchy of expertise, in which medical knowledge is but one factor in the larger project of conserving fund assets.

To summarize, the Court's dicta in *Pegram* accurately captures the "bedside rationing" reality of today's care, in which the medical fiduciary duty has melded with the ERISA standard for fiduciary duty, leaving only the medical malpractice standard to police conduct. *Pegram* normalized actuarial medicine by describing treatment decisions, correctly, as routinely incorporating financial considerations. In *Davila*, the Court ruled that the law governing risk distribution, i.e. insurance law, pre-empted any other legal remedy for failure to act reasonably in making the medical/coverage decision. In other words, the financial stability concerns animating ERISA pre-emption trumped.[156]

The important aspect of these decisions is not the particular doctrine they have generated under ERISA. Rather, my purpose in examining these cases has been to demonstrate the assumptions they reveal about the appropriate nature of medical practice and the dynamic relationship between financial and clinical risk concerns in the health care system.

These decisions illustrate that the defining characteristic of health law is no longer professional autonomy, but rather a tripartite structure of risk regulation that is often hidden by its private contractual delegation to providers. Doctors act as insurers because they often *are* insurers. The most powerfully explanatory blueprint of roles within the health care system today reveals an architecture based on the assumption of financial risk.

III. The Structural Constitution of Private Health Insurance

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[154] *Id*. at 220.

[155] *Id*.

[156] See further discussion of these concerns *infra* TAN ////

In Part I of this paper, I made the claim for understanding risk governance as dominating health care today, with the concomitant rise of actuarial medicine. In Part II of this paper, I argued that conceptualizing health law as responding to and facilitating risk governance in health care offers us the most coherent framework for understanding health law as a meaningful field.

In this Part, I seek to demonstrate how the Supreme Court's interpretation of the preemption provisions of ERISA, the primary statute that directly channels private health insurance risk in the United States,[157] was influenced by considerations of risk governance. In Subpart A, I explain the motivations for and development of ERISA, including the small governmental regulatory role that the law originally anticipated. I then offer an historical reading of ERISA that is largely absent from either judicial or scholarly treatments of the law -- that ERISA's policy preference for a small governmental regulatory role was premised on the background knowledge that *joint labor-management sovereignty* dominated the process for constructing health insurance plans through collective bargaining agreements throughout various employment settings. As we know, the assumption that this state of affairs would continue has proven not to be true in light of significant reductions in unionized work settings.

In subpart B, I describe how the Supreme Court's interpretations of ERISA's explicit and implicit pre-emption components have shifted the law's initial model of joint labor-management sovereignty to virtually complete *management sovereignty* —what I term "corporate federalism" in private health insurance. I explain how this shift can be best understood using the lens of risk governance analysis.

[157] CITE By comparison, in the public health insurance market, Medicare has similar enrollment size and concern with costs, but it is different in three critical ways: it is regulated primarily as a health care system rather than as an insurance system; it operates as a universal risk pool for the Americans mostly 65 and older that it covers; and it is subject to direct control by the political branches.

Finally, in Subpart C, I defend the original concept behind Congress' decision to devolve power to the workplace level through ERISA's structure. Contrary to the dominant view in scholarly analysis of ERISA's preemption doctrine, I argue that future health care reform efforts should leave such pre-emption in place. In doing so, I offer a partial defense of workplace federalism. These arguments establish the foundation for my normative proposal, in Part IV, in which I call for democracy-enhancing governance reforms in workplace risk pools.

A. ERISA: The Prequel

In 1946, six years before the steel mill seizure that triggered the constitutional crisis resolved in *Youngstown Sheet & Tube Co. v. Sawyer*,[158] President Truman seized the coal mines to prevent a national strike over health insurance benefits.[159] During the postwar period, worker demand for health insurance coverage, which had abated during a wartime no-strike pledge by unions, surged back to the forefront of domestic issues.[160] Campaigns for health coverage that had

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[158] 343 U.S. 579 (1952).

[159] Unlike the 1952 steel mill seizure, Truman in 1946 had statutory power under the War Labor Act (which expired in 1947) to take this action. RAYMOND MUNTS, BARGAINING FOR HEALTH: LABOR UNIONS, HEALTH INSURANCE AND MEDICAL CARE 33 (1967).

[160] JENNIFER KLEIN, FOR ALL THESE RIGHTS: BUSINESS, LABOR, AND THE SHAPING OF AMERICA'S PUBLIC-PRIVATE WELFARE STATE 178, 213-17 (2003).

begun in hazardous industries, such as coal,[161] spread rapidly through the economy when the war ended.[162]

The ideological drive to incorporate health insurance into the workplace harmonized with the "industrial self-government" paradigm that dominated labor law at the time.[163] Under this paradigm, workplaces were viewed as highly self-contained, largely independent zones, with powers analogous to those of sovereign entities. The collective bargaining agreement (CBA) was viewed by sympathetic courts and agency officials as the constitution for the workplace: within the terms set by federal labor statutes, unions and management would negotiate a mutually agreed upon charter for the governance of their world of employment.[164] The infrastructure and rules of arbitration created by the CBAs

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[161] Some of the earliest efforts to provide medical care related to the workplace arose in industries that required dangerous work, often in remote locations. CITES After World War II, Truman's seizure of the mines led to major victories for labor. With the mines under federal government control, the Secretary of the Interior signed an agreement with the president of the United Mineworkers Workers that included establishment of funding for health benefits. When operating control was returned to the owners, the health benefits system was continued and management's funding for it increased. KLEIN, *supra* note /// at 198; MUNTS, *supra* note // at 33. For discussion of the UMW's efforts after 1946, see MUNTS at 29-47.

[162] The number of individuals with health insurance through their workplaces rose from 2.7 million in 1948 to more than 7 million in 1950. JOSEPH W. GARBARINO, HEALTH PLANS AND COLLECTIVE BARGAINING 19 (1960).

[163] Steelworkers v. Warrior & Gulf Navigation Co., 363 U.S. 574, 581 (1960) (describing labor-management relations as a "system of industrial self-government"). See generally, Katherine van Wetzel Stone, *The Post-War Paradigm in American Labor Law*, 90 YALE L. J. 1509, 1511-15 (1981) [maybe Cox]. The Supreme Court cleared the field for health insurance to be part of the demands made within a system of industrial self-government when it left standing a court of appeals decision ruling that benefit plans fell within the "conditions of employment" subject to collective bargaining under the National Labor Relations Act. Inland Steel Co. v. National Labor Relations Board, 170 F.2d 247, 255 (7th Cir. 1948), *cert. denied* 336 U.S. 960 (1949). The Supreme Court's denial of review effectively killed further employer arguments that health insurance benefits were not within the scope of collective bargaining. See ///

[164] Cox.

substituted for the infrastructure and rules of the judiciary that existed in the parallel traditional governmental state.[165]

Under this industrial self-government paradigm, balancing the trade-offs between who would have access to health care and how the costs of such care would be covered fell within the scope of labor-management negotiation. The results of those negotiations were then filtered through private insurance markets. In line with the concept of the workplace as a parallel quasi-government, unions initially framed the cost of health benefits as a form of a "tax" to be paid by employers.[166] As Paul Starr has noted, this metaphor provided the basis for persuading Congress to enact a tax exemption in 1954 for employer contributions to health insurance, on the argument that treating such contributions as taxable income would amount to "double taxation" on the employer.[167] The tax exemption for employee health benefits thus not only created a fiscal incentive for employers to offer health insurance plan to employees, thus tethering health insurance to the workplace, but it also implicitly acknowledged how deeply the concept of workplace self-government was built into federal law.

By the 1950's, the extent to which "fringe" benefits such as health insurance had gained in importance compared to wages amounted to "something close to a revolution" for industrial relations.[168] Unions and employers even fought over who would sponsor the health insurance plans. Employers saw advantages in "seizing the moral high ground" by initiating insurance benefits.[169] When the United Auto Workers (UAW) sought a jointly-controlled health benefits

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[165] CITE.

[166] GARBARINO, *supra* note /// at 22; MUNTS, *supra* note /// at 33-35, 51.

[167] PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 334 (1982). Classifying health benefits as not part of compensation began as a temporary measure during World War II, when wage controls were in effect.

[168] GARBARINO at 1-2.

[169] KLEIN *supra* note /// at 220. See also MARIE GOTTSCHALK, THE SHADOW WELFARE STATE: LABOR, BUSINESS, AND THE POLITICS OF HEALTH CARE IN THE UNITED STATES 48 (2000); KLEIN at 210-11, 221-23, and 239-40.

plan in 1947, General Motors refused on the ground that health insurance should be considered solely a management prerogative.[170]

Regardless of who sponsored the health plans, many union leaders believed that providing such plans for workers would create a powerful bond between a union and its members, either because the union sponsored the plan itself (as several unions did) [171] or because the union would get credit for securing the benefit for its members from the employer.[172] In 1957, 25 per cent of employees with health insurance were enrolled in a plan over which their union exercised some degree of control.[173] As a result, union political support for a government-centered, national health coverage system diminished.[174]

Tension did arise between management and labor with regard to whether employer-sponsored plans had a duty to share fiscal information with unions.[175] In addition, instances of financial abuses by both labor and management of increasingly hefty health insurance and pension funds arose.[176] Congress responded with the Disclosure Act in 1958, and

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[170] Alan Derickson, *Health Security for All? Social Unionism and Universal Health Insurance*, VOL # J. AMER. HISTORY 1333, 1350 (1994).

[171] KLEIN, *supra* note /// at 188. In a number of industries, unions themselves sponsor and administer the health insurance plans. GOTTSCHALK supra note /// at 44-53. See, e.g., Jones v. Laborers Health & Welfare Trust Fund, 906 F.2d 480 (9th Cir. 1990), upholding denial by the union fund of a claim on the ground that the treatment sought was not medically necessary: "The language of the collective bargaining agreement provides the means by which the Trust Fund operates. …We will not upset the review process the parties have bargained for." *Id*. at 482.

[172] Union leaders believed that the plans provided "an important sense of identity and cohesion for union members who have few other real attachments." GOTTSCHALK *supra* note /// at 52. See also, *id.* at 42-44, 51. Klein describes a UMW program that transported injured workers from the mines to prestigious hospitals as creating dramatic scenes that carried the message that "the union would take care of its own." KLEIN, *supra* note /// at 19

[173] GARBARINO at 7, 19.

[174] Derickson, *supra* note /// at 1356.

[175] KLEIN at 224-26, 237.

[176] KLEIN at 247; MUNTS *supra* note /// at 107-08.

subsequently strengthened that law in 1962.[177] As even greater portions of overall employee compensation continued to pour into benefits, however, political demands grew for a systematic, thorough policing of the funds.[178]

The capstone to this reform movement was the enactment of ERISA.[179] ERISA was very much a product of its time, considered to be an enormous political victory on behalf of ordinary workers, in sync with the major civil rights statutes of the 1960's.[180]

Unfortunately, the law was founded on three assumptions that all evaporated within a decade. First, unionism was still a viable movement in 1974; the sharp plummet in union membership occurred in the 1980's,[181] and today has reached a low-water mark of 10 per cent of nonagricultural private sector workers.[182] Second, health care costs were still relatively modest in 1974; the upward spike of medical sector inflation was imminent, but had not yet occurred.[183] Third, contingent on the first two, it was still plausible in 1974 to imagine that non-union employers would compete for labor by seeking to match the health insurance benefits negotiated by unions, so that the overall trend would be a ratcheting up of health benefits for all employees.[184]

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[177] CITE. See KLEIN at 250-53; JAMES A. WOOTEN, THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974: A POLITICAL HISTORY 45-49, 81-83 (2004).

[178] Summary of reform efforts

[179] "ERISA represented the culmination of the disclosure act struggle..." KLEIN at 261.

[180] One of the prime congressional supporters of ERISA, Senator Jacob Javits, called it "the greatest development in the life of the American worker since social security." President Ford scheduled the signing ceremony for Labor Day, to highlight its "really … historic" importance. WOOTEN at 1.

[181] Katherine Van Wetzel Stone, *The Legacy of Industrial Pluralism: The Tension Between Individual Employment Rights and the New Deal Collective Bargaining System*, 59 U. CHI. L. REV. 575, 579 (1992).

[182] BNA *Daily Labor Report* No. 28 (Feb. 12, 1996) at D-4 Table 3. NEED MORE RECENT DATA

[183] See text *supra* at notes //////.

[184] GOTTSCHALK at 48.

As we now well know, global labor competition soon turned the tables, so that massively expensive health benefits have become the albatross of employers.[185] Health insurance terms of coverage have become a frequent source of give-backs in labor negotiations,[186] employer sponsorship of health insurance plans is steadily ratcheting down,[187] and, in a deeply ironic twist on history, GM has offloaded a portion of its health insurance benefits obligation to the UAW.[188]

Supreme Court decisions interpreting provisions of ERISA premised on these assumptions have been blind to how those assumptions have changed. Provisions that were based on principles intended to insulate collective bargaining from state regulation, which made sense in light of the prevailing paradigm of industrial self-regulation, have been adhered to rigidly by the Court without any acknowledgment that collective bargaining itself had largely disappeared.[189]

Understanding ERISA's origin in an era of widespread "industrial self-government" is crucial to an analysis not only of how this system of health insurance law now operates as a technology of governance, but also of its potential for democratic reform. But before addressing that potential, we need to recognize how the Supreme Court's interpretation of ERISA's pre-emption provision, without any acknowledgment

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[185] CITE

[186] CITE

[187] GOTTSCHALK *supra* note /// at 126-27.

[188] Beginning with their 2007-2008 contract, GM and the UAW have negotiated for the establishment of a Voluntary Employee Benefits Association (VEBA), which will operate as a trust fund to cover claims for health benefits by retired workers. Sholnn Freeman and Frank Ahrens, *GM, Union Agree on Contract to End Strike*, N. Y. TIMES, Sept. 27, 2007 at A-1.

[189] Nor has the conventional scholarly criticism of judicial ahistoricism concerning ERISA focused on these changes in workplace governance; rather, it has centered on changes in the health care delivery systems. For example, scholars have argued that courts should have interpreted ERISA differently in light of the difference between the fee-for-service delivery model that was dominant in 1974, and the managed care models under which the denial of a claim for benefits can have the effect of denying pre-authorization for the care ever to be administered.

of its collective bargaining roots, created a system of corporate federalism in health care.

B. The Invention of Corporate Federalism

According to Justice Kennedy, one of the Framers' greatest contributions to American law was to "split the atom of sovereignty" into recognition of the dual realms of state and national government.[190] More modestly, the convergence of ERISA's statutory text, its judicial interpretation, and financial pressure from inflation in the medical sector of the economy has produced a triple atomic split for governance of the health care insurance system, with the new offshoot being corporate sovereignty.

In this Subpart, I analyze ERISA along the dimensions of federalism. I argue that ERISA is best understood as creating a triple sovereignty of federal, state and corporate power for the governance of private health insurance. Under this structure, employers have gained authority to allocate health care risk through the control of decisions about which employees they will cover (pooling) and what benefits they will provide (rationing).[191]

This triple sovereignty is the result of the interpretation of ERISA by the judicial branch in a manner that blocks most state law regulation and by the subsequent lack of response by the federal political branch in a failure to amend ERISA. Although commentary regularly refers to the result of the Supreme Court's ERISA preemption doctrine as a "regulatory vacuum,"[192] a vacuum exists only if one limits one's view of regulation to purely governmental actions. If one understands private mechanisms to operate as part of governance, the Court's pre-emption jurisprudence appears less as a vacuum than as a *delegation*, specifically the delegation of effective regulatory power to employers.

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[190] 514 U.S. 779, 839

[191] I intend "rationing" to denote both setting the terms of what services the plan covers and adjudicating disputes that arise over those terms.

[192] Justice Ginsburg has now taken up the point. Aetna Insur. v. Davila, 542 U.S. at 222.

A fundamental reality of the American health system is its voluntary baseline: employers may voluntarily choose to offer health insurance, but they are not required to do so. Once an employer voluntarily decides to offer health insurance, ERISA controls the framework of decisions made by employers along two dimensions of risk: the composition of risk pools (pooling) and the authorization to determine the scope of coverage (rationing).

The framework established by ERISA is one that empowers employers. Employers determine who is covered, how, and what the parameters of coverage will be.[193] Employers also establish the mechanisms for deciding disputes over whether particular benefits are covered within the terms of the plan.[194] These issues of who is covered, for what, who gets to decide disputes that arise concerning those terms, and what the potential penalties are for wrongful denials of coverage set the boundaries of financial risk for the plan's sponsor, who is usually the employer.[195]

One can imagine a legal framework in which employers would generally make these decisions, but within constraints established by state law, either general laws (e.g., tort or contract laws) or laws specific to health care (e.g., health care regulation). But that is not the framework for employers today. ERISA occupies the field for private sector workplace health insurance plans because of and through its pre-emption provisions.[196]

Pre-emption operates in two ways under ERISA. The first is what I call the "ERISA accordion", a three-step process that sets the bounds of ERISA's explicit "relates to" pre-emption clause. The three steps of the ERISA accordion

[193] Lockheed, 517 U.S. 882, 887 ("Nothing in ERISA requires ///)

[194] CITE

[195] exceptions

[196] At the last minute, Congressional conferees included a broad pre-emption clause to stave off multiple state standards. Wooten. The pre-emption clause satisfied concerns by employers that they not have to conform to differing state criteria in establishing benefit plans and the desire of labor unions to maintain benefits as a bargaining chip which could be freely negotiated up or down, vis-à-vis other issues such as wages, without mandated minimums or other requirements set by state legislatures.

determine whether a state law will be enforceable against an employee benefit plan (EBP). The second form of pre-emption is implicit and derives from the law's remedial structure.

It has become a standard critique among scholars that the Court's interpretation of ERISA's pre-emption clause has been almost pathological in its rigidity, a case study of literalism run amok.[197] I disagree. In my view, the dynamics behind ERISA pre-emption have shifted in the roughly thirty-five years since its enactment, but in opposite directions for the two forms of pre-emption under ERISA.

For ERISA accordion pre-emption, the Court's interpretation began as a highly textualist, literal reading of the seemingly boundless phrase of "relates to" (the first step in the accordion), but has become more nuanced and less expansive. For example, in a sharp departure from its prior decisions, the Court since 1995 has allowed various state regulatory schemes to withstand "relates to" pre-emption.[198]

By contrast, remedies pre-emption under ERISA has become more powerful over the years. The Supreme Court has not reined in the scope of this form of pre-emption in the same way it has limited the "relates to" pre-emption. This is not because the remedies provided by ERISA are adequate. There are no provisions for economic or non-economic damages in ERISA, only a right to restitution of the benefit.[199] But the Supreme Court has been hostile to allowing claims for the regulatory authority of state law to prevail when that authority takes the form of the unpredictable outcomes of litigation.

The importance of risk governance provides the best explanation for why the Court has moved in different directions for these two forms of ERISA pre-emption. Formal state-level regulations that are held to escape the first step of the ERISA accordion or are saved by the second step, can be costly to plan sponsors. But there are opportunities for

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[197] Jay Conison, *ERISA and the Language of Preemption*, 72 Wash. U. L. Q. 619, 651-56 (1994); Catherine L. Fisk, *The Last Article About the Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 Harv. J. on Legis. 35, 90-98 (1996).

[198] travelers debuono miller

[199] USC cite

employers to contest the adoption of such regulations in the political branches and to influence their scope. Moreover, adoption of such regulations takes place over a period of time, and estimates of their cost impact can be built into predictive models and accounted for in a sponsor's fiscal planning.

By contrast, litigation results are much less predictable and result from a more idiosyncratic process. What the Supreme Court has done through its remedies pre-emption doctrine is to protect the ability of plan sponsors to control risk through an ongoing, reliable process of the calibration (and recalibration) of who and what will be covered by reimbursements from an insurance fund, coupled with the power to determine how disputes over whether the plan's administration adheres to its internal charter will be resolved.[200] Shielding risk allocation planning from the unforeseeable fortuities of litigation has become the dominant rationale behind ERISA's bifurcated pre-emption doctrine.

The Supreme Court's increasingly purposive outlook on ERISA has brought it to a deeper commitment to corporate control, even while the Court has been willing to accept some regulatory legislation at a state level. In the process, the Court created corporate federalism in health care.

1. The ERISA Accordion of "Relates to" Pre-emption

The three steps of the ERISA pre-emption accordion are found in Section 514, which begins by providing that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . "[201] If one imagines an accordion spread wide, the apparent meaning of the phrase "relate to any employee benefit plan" would seem to encompass an enormous range of state laws.

The broad scope of the "relates to" provision is curtailed, however, by what has been called the "savings clause." This is the second step that pulls the accordion in a bit. Also part of Section 514, the savings clause provides that the "relates to" provision "shall [not] be construed to exempt or

[200] USC cite

[201] USC cite

relieve any person from any [State law] which regulates insurance . . ."[202] The savings clause thus contracts the pre-emptive power of ERISA to fit only the space *not* occupied by state laws which regulate insurance. Since enactment of the McCarran-Ferguson Act in 1945,[203] regulation of insurance has been left almost entirely to state government.[204] The savings clause preserves this allocation of authority.

In the third step, the accordion widens again to reinstate pre-emption for certain entities. Under what is called the "deemer clause," no employer benefit plan (EBP) that is self-insured "shall be deemed to be an insurance company or other insurer … or to be engaged in the business of insurance … for purposes of any [State law] purporting to regulate insurance companies [or] insurance contracts . . ."[205]

Self-insured plans, therefore, enjoy the full benefits of ERISA pre-emption. In self-insured plans, employers fund the plans without purchasing insurance against the risk of claim costs exceeding the available funds that have been set aside by the employer for paying benefits under the program.[206] Insurance companies handle only the administrative aspects of processing claims in self-insured plans. If an EBP is self-insured, deference to traditional state authority to regulate insurance will not apply.[207]

The movements of an accordion can illustrate how the three steps relate to each other. But they tell us nothing about how wide or narrow each playing position will be. When litigation testing the ERISA pre-emption clause began, therefore, the Supreme Court had to pick its way with little legislative guidance through questions such as whether "relates

[202] USC cite

[203] CITE

[204] See Prudential v. Benjamin,

[205] USC cite.

[206] CITE.

[207] FMC Corp. v. Holliday, 498 U.S. 52 (1990) (pre-empting state law prohibiting subrogation of the payment of the proceeds from a tort action to an insurer, when the plan was self-insured.

to" should be given its broadest construction[208] or whether a state law had to specifically mention or allude to EBPs in order to trigger "relates to" pre-emption.[209] Similarly, even if "relates to" had a wide sweep, its impact would be significantly diminished if the Court accorded similar breadth to the category of state laws that "regulate insurance," whether directly or indirectly, whether statutorily or by common law principles.[210] The Court thus acquired the authority, through its interpretation of ERISA, to determine how much power the states would have to set the terms of private employment health insurance policy in America.

2. Remedies Pre-emption

Section 502 of ERISA sets forth the remedies available to enrollees in employee benefit plans who assert that they have been wrongfully denied a benefit due to them under the plan. This section provides exclusive federal court jurisdiction for actions brought under ERISA, and allows plaintiffs to "recover benefits due," enjoin violations of the statute or of the plan, seek attorney's fees and costs, and "obtain other appropriate equitable relief."[211] What is obviously missing from the relief provided for in Section 502 is any provision of consequential or non-economic damages for the denial of a benefit under the plan.

Through case law, the Supreme Court has created a remedies pre-emption in ERISA that is separate and distinct from the explicit accordion pre-emption. The Court inferred remedies pre-emption from a House-Senate Conference Report on ERISA.[212] That Conference Report stated that suits to

[208] Shaw. Because Section 514 was a late addition during the passage of ERISA, and because Congress's primary concern during the legislative process of ERISA was with pension plans rather than with health plans, the legislative history offers little to clarify Congressional intent with regard to this phrase..

[209] Shaw

[210] Shaw

[211] USC cite

[212] Cite to case.

enforce benefit rights under ERISA were to be regarded solely as federal question claims, in the same way that suits asserting violations of the terms of a collective bargaining agreement were pre-empted by Section 301 of the Labor-Management Relations Act.[213] Congress had been lobbied vigorously by representatives of organized labor who sought to preserve the terms of CBAs, including the establishment of arbitration panels for disputes, from encroachment by state regulation.[214]

In using ERISA's legislative history to infer an implied pre-emption of state law remedies for the denial of benefits under an ERISA governed plan, the Supreme Court never questioned the appropriateness of transplanting a pre-emption doctrine from a statute designed to protect the ability of unions and management to conclusively settle questions concerning the workplace into a legal context in which there was no counterweight to management power. Instead, the Court silently amended a provision designed to privilege collective bargaining agreements into a bar against seeking damages through state law, even for bad faith violations of one-sided contracts.

1. From Textualism to Revisionist Purposivism

In its early cases interpreting Section 514, the Court reliably invalidated state laws by a literal and expansive reading of the phrase "relates to." Since 1995, however, the Court has changed the ground rules for Section 514 pre-emption, finding that the pre-emption inquiry should begin with a presumption in favor of state laws regulating health care.[215] In addition to retracting the scope of "relates to," the Court has also expanded the scope of the second step in the accordion, the insurance savings clause.[216]

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[213] Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54-56 (1987).

[214] Daniel M. Fox and Daniel C. Schaffer, *Semi-Preemption in ERISA: Legislative Process and Health Policy*, 7 Am. J. Tax Pol'y 47, 51 (1988).

[215] Travelers

[216] In Kentucky Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329, 341-42 (2003), the Court "ma[d]e a clean break" from its prior rulings that limited application of the savings clause to laws that satisfied all three

During the same period, however, the Court has refused to budge from its broad application of remedies pre-emption, leading to the paradox that the implicit form of pre-emption under ERISA is now more powerful than the statute's explicit pre-emption command. This has not resulted because of a commitment to hyper-textualism or an antipathy to legislative purposes. Rather, I argue that the Court has become increasingly tied to ERISA's purpose as it relates to risk governance. One particularly important actor has influenced the Court to place sensitivity to financial risk allocation policy at the heart of its ERISA jurisprudence: the office of the Solicitor General.

The literalism in readings of ERISA's accordion pre-emption began with the first ERISA pre-emption case concerning health benefits to reach the Supreme Court: *Shaw v. Delta Airlines*.[217] *Shaw* involved a New York anti-discrimination statute that required employers to treat pregnancy the same as other health conditions.[218] Among the policies affected by the New York state law were health benefits plans covered by ERISA.[219] In ruling on whether the New York statute fell under the first step of the ERISA accordion as a "State law . . .[that] may now or hereafter relate to any employee benefit plan,"[220] the Court relied on the "breadth … apparent from [the] language" of Section 514's

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factors derived from the McCarran-Ferguson statute previously used to define insurance. In that case, the Court ruled that a statute requiring health benefit plans to include "any willing provider" in their provider networks "substantially affect[ed] the risk pooling arrangement between the insurer and the insured," and thus was covered by the savings clause and not pre-empted by ERISA.

[217] 463 U.S. 85 (1983).

[218] Congress adopted the Pregnancy Discrimination Act after the litigation began but prior to the Court's decision. Although ERISA did not pre-empt or preclude the PDA, the case was not moot because of the claim for benefits due before the PDA took effect and because the state law reached smaller employers that were not subject to the PDA. 463 U.S. at xx.

[219] Regardless of ERISA pre-emption, the state statute applied to employees of state and local government.

[220] USC cite

pre-emption clause.[221] The Court found that "the normal sense of the phrase" meant that a law related to an ERISA plan "if it has a connection with or a reference to such a plan."[222]

The Court also discerned two themes from Congressional intent behind ERISA. The first was, insofar as civil rights law would be affected, ERISA was consistent with a civil rights policy of favoring "'centralized administration of nondiscrimination [sic].'"[223] The second was an employer's interest in avoiding "conflicting or inconsistent State and local regulation of EBPs."[224]

The Solicitor General's brief filed in *Shaw* stressed only the second legislative rationale behind ERISA's pre-emption provision. In doing so, the brief twice drove home the point that shielding employers from variances in state laws was intended by Congress "to foster the development of benefits plans."[225] The brief framed ERISA itself in negative terms, with pre-emption offered as compensation for the burdens the law had created: "Sensitive to the fact that the private benefit plan is voluntary, Congress determined to lessen the disruptive effect of the new federal law by saving plans from possible inconsistent or duplicative state laws."[226] The Solicitor General warned the Court that if it did not interpret ERISA in a way that could allow large employers to achieve cost savings from single administrative systems, it might increase the number of uninsured by driving employers away from voluntarily sponsoring benefit plans.[227]

In *Pilot Life Insurance Co. v. Dedeaux*,[228] a case before the Court two years after *Shaw*, the need to encourage employers to offer voluntary plans again came to the fore. In *Pilot Life*, an insurance company asserted that ERISA pre-

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[221] 463 U.S. at 96.

[222] 463 U.S. at 97

[223] 463 U.S. at 104.

[224] 463 U.S. at 105 n. 25.

[225] SG Brief at 16.

[226] SG Brief at 22.

[227] SG Brief at

[228] 481 U.S. 41 (1987).

empted a Mississippi common law right of action for the bad faith denial of claims. The beneficiary of the plan had sued Pilot Life, the insurance company, in state court for damages from repeated denials and delays in the payment of a claim that the insurer had ultimately accepted.[229] During oral argument, after an extended colloquy with the Justices about whether an insured "could get any money" if an insurer stonewalled on payment,[230] counsel for Pilot Life pressed a point raised by Justice White: that large punitive damages awards "would raise insurance premiums substantially."[231] Although there was no legislative history on this precise point, counsel reasoned that "I think that in ERISA Congress had that concern… these plans are voluntary, no one has to set them up. This is a law to provide for a voluntary system that companies will take on individually. So it was intended to be run efficiently and effectively, and at low cost."[232]

The Court in *Pilot Life* ruled, for the first time, that implied remedies pre-emption in ERISA was an independent bar to the application of state law, calling that the "most important[]" consideration in its pre-emption analysis.[233] The source for this new doctrine was the amicus brief filed by then Solicitor General Kenneth Starr.[234] The Court concluded that the remedial scheme that Congress had adopted in ERISA "represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans."[235] All intimations of industrial self-government were gone.

By the time *Pegram v. Herdich* reached the Court thirteen years later,[236] the Justices had developed a very clear-

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[229] Id. at xx.

[230] Cite to transcript.

[231] Cite to transcript.

[232] Cite to transcript.

[233] 481 U.S. at 57. As noted above, the remedies pre-emption was implied from the legislative history of ERISA. See supra TAN .

[234] Id at 52.

[235] Id. at 54.

[236] 530 U.S. 211 (2000).

eyed focus on the relationship between potential liability for employers through litigation and how the health care system's structure was carefully balanced on a foundation of risk allocation. At the core of the *Pegram* opinion is an understanding of ERISA not simply as a specification of certain rights and duties, but as a charter under which employers voluntarily undertake the responsibility for providing health insurance coverage to the bulk of the U.S. population in return for the state ceding control to such employers of all determinants of risk in the health care setting.[237]

The existence of ERISA's deemer clause, the third step of the ERISA accordion, suggests that the Court may not have been wrong with regard to this particular aspect of Congressional intent. The deemer clause of the ERISA accordion explicitly treats some workplace plans differently. If a plan self-insures, i.e., if it assumes the risk itself without purchasing full insurance coverage for that risk, that plan receives a pass on even having to contest whether a state law regulates insurance. The second step of the accordion – exempting from pre-emption state laws that "regulate insurance" -- simply does not apply to self-insured plans. In effect, the greater the risk assumed by the sponsor of a plan, the stronger the sovereignty principle that will attach to the plan.

On the surface, it may be hard to discern a policy rationale for creating a tier of legal deference for employers depending on how they have chosen to structure their health benefit plans.[238] The deemer clause has the effect of exempting an entity from insurance regulation not because it is not really engaged in insurance practices (and for that reason

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[237] In *Pegram*, the defendant was the HMO, not the employer. But the Court's comments foreswearing a judicial role in "draw[ing] a line between good and bad HMOs," 530 U.S. at 221, ultimately reinforce the authority of the plan sponsor to adjust levels of financial risk by selecting an HMO or other provider network with whom to contract for services. As the Court noted, "whatever the HMO, there must be rationing and inducement to ration." *Id*. Deferring to the superior capacity of the legislative process to assess trade-offs, the Court concluded that "courts are not in a position to derive a sound legal principle to differentiate [HMOs]." *Id*. at 222.

[238] met life. Contrast earlier cases – northern services

should not fall within the scope of state laws regulating insurance), but because risk underwriting and spreading is precisely what it *is* engaged in. The only logical basis for making such a distinction between EPBs that will remain subject to state laws regulating insurance, and those that will gain the benefit of ERISA pre-emption, is the goal of facilitating corporate governance organized around allocation of risk.

I do not believe that one can attribute the Supreme Court's solicitude for protecting EBP sponsors from bothersome state regulation simply to an inclination by the Court to favor a corporate desire to lower costs and preserve profit levels. The Supreme Court has ruled that even increased expenses directly caused by state rate-setting laws will not justify "relates to" preemption;[239] and that benefits expensed from general company assets rather than from an insurance fund (such as vacation pay) cannot be considered part of an EBP under ERISA.[240] Mere cost reduction associated with employee benefits has not been enough to cause the Court to defer to management decisions. What seems essential in the ERISA health benefit cases is the Court's apparent belief that too much judicial tinkering could lead not simply to some increases in corporate costs, but rather to the danger that the health insurance/care system would itself crater and crash.[241]

In a steadily developing line of cases, the Court has shifted its framing and analysis of ERISA from a law designed to serve as a protective mechanism against sponsor abuse of employee benefits into a law that operates as a shield for plan sponsors against rising costs. The greater receptivity to big business demands occurred during long stretches of Republican control of the Congress and the Executive Branch, which brought an unsurprising conservatization of the federal courts. But such receptivity continued largely without interruption during the Clinton Administration as well, and has been

[239] DeBuono

[240] Massachusetts v. Morash, 490 U.S. 107, 115-16 (DATE).

[241] pegram

reflected in mostly unanimous decisions by the Supreme Court.[242]

Today, after dozens of decisions, there is no mystery about where the Court's interpretation of ERISA's pre-emption structure has left the division of power. Bluntly put, the regulatory power of states over health care policy involving workplace health insurance exists only when it is least likely to infringe on an employer's discretion to control and predict financial risk.[243] Through its interpretation of ERISA, the Court has developed a distinctive twist on federalism, sharply contrasting with its approach to Tenth Amendment cases and other situations involving conflicts between federal and state power.[244] Using ERISA federalism, the Court has delegated

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[242] Pilot Life, Pegram and Davila were all decided without dissents. The Supreme Court's sub silentio policymaking has also been implicitly ratified by the absence of alterations to ERISA by either Congress or the Executive Branch, whether under Democratic or Republican control. Note: amendments to appeals process in CFR As I note in the beginning of this section, corporate sovereignty in health care operates through the interpretation of ERISA pre-emption law by the judicial branch that blocks the application of state law, but also through the subsequent lack of response by Congress to amend ERISA with any substantively strong remedies.

[243] Peter Jacobson's study of the relationship between the legal system and managed care entities concluded that courts have consistently developed common law principles in support of market arrangements, shifting from doctrines reinforcing physicians' professional dominance to those protecting the contractual provisions negotiated by MCO's as the balance of power in the health care system has shifted. PETER D. JACOBSON, STRANGERS IN THE NIGHT: LAW AND MEDICINE IN THE MANAGED CARE ERA 177-78 (2002). I argue that the courts are doing more than reading weathervanes to see the changes in prevailing powers, but are also affirmatively protecting entities that have undertaken the social function of rationalizing financial risk.

[244] The Court developed its interpretation of ERISA during the same time period as its renaissance of deference to state as opposed to federal law. Especially under Chief Justice Rehnquist, the Court reclaimed and elaborated upon the concept of state sovereignty. ERISA jurisprudence, however, seemingly confounds this standard interpretation of the politics of federalism. While facilitating employer interests fits with a simple model of outcome-driven federalism, the ideological cost to conservatives from favoring federal law was huge. Enforcement of ERISA pre-emption provisions produced a massive undercutting of state government

the lion's share of health risk governance policymaking to private employers.

C. A Partial Defense of Workplace Federalism

At this point in the argument, many critics of ERISA doctrine (and there are virtually no defenders in the academy) argue for repealing or weakening the law's pre-emptive impact.[245] I disagree. In my view, these critics have not given sufficient weight to certain legitimate interests that are served by strong pre-emption in the federal law.

In this subpart, I offer a partial defense of the corporate sovereignty established through ERISA pre-emption, given the definite costs with the current system. My argument, however, is that it is worthwhile to illuminate those interests which are served by workplace federalism. Such interests might be leveraged in a manner that achieves more equitable results if the democracy deficit in workplace risk pool governance could be adequately addressed – a challenge I take up in the next section.

In the context of health insurance, corporate entities should be understood as resembling a functional hybrid of national and state governments, comprising some of the benefits of each. For example, allowing employers with workers in multiple states to avoid conflicting state regulations permits employers to capture the benefits of a national market

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policymaking at the intersection of two traditionally state domains: insurance regulation and the police powers authority of the states to regulate the health care system. See Michael S. Greve and Jonathan Klick, *Preemption in the Rehnquist Court: A Preliminary Assessment*, 14 Sup. Ct. Econ. Rev. 43 (2006); Roderick M. Hills, Jr., *Against Preemption: How Federalism Can Improve the National Legislative Process*, 82 N.Y.U. L. Rev. 1 (2007); Caleb Nelson, *Preemption*, 86 Va. L. Rev. 225 (2000).

[245] *See e.g.*, Henry H. Drummons, *The Sister Sovereign States: Preempton and the Second Twentieth Century Revolution in the Law of the American Workplace*, 62 Fordham L. Rev. 469 (1993-1994); James E. Holloway, *Revisiting Cooperative Federalism in Mandated Employer-Sponsored Health Care Programs Under the ERISA Preemption Provision*, 8 Quin. Health L. J. 239 (2005); Wendy K. Mariner, *Slouching Toward Managed Care Liability: Reflections on Doctrinal Boundaries, Paradigm Shifts, and Incremental Reform*, 29 J. L. Med. & Ethics 253 (2001).

and facilitates rational large-scale planning by these employers. In the traditional terms of the federalist debate, this is similar to the Hamiltonian notion of nation-building and the facilitation of a single market provided by a strong national government.[246]

The multiplicity of employers, however, also serves some of the functions of the multiple states, a la Jeffersonian local autonomy and decentralized democracy. Although each employer engages in central planning, there is no one omnipotent planning source for all employers. This degree of decentralization guards against the establishment of a single workplace benefits structure that might leave employees without any power, through exit and mobility, to seek a job with a different set of benefits.[247]

Corporate sovereignty thus mimics the advantages associated with the powers of states in a system of federalism. And the disadvantages of strong corporate sovereignty are

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[247] The merged interests of employers and employees in corporate sovereignty, at least in unionized workplaces where there is not a democracy deficit, was strikingly evident during oral argument in MetLife, a case in which both employers and unions joined in challenging a Massachusetts law that required all health insurance plans in the state to include coverage for mental health coverage. Counsel for plaintiffs argued that:

> [J]ust as there is no such thing as a free lunch, there is no such thing as a free
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> benefit. The mandated benefit has to be paid for. So, to offset the additional expense you either have to reduce wages or you have to sacrifice a benefit that you want for a benefit that you don't want … One union had to give up dental benefits and eyeglass benefits that they very badly wanted and had to increase eligibility requirements in order to get mental health benefits about which they were less concerned [but which had been mandated by the State.].

When Justice Rehnquist probed why the state's policy forcing these kinds of trade-offs should not be enforced, counsel responded:

> Because Congress made it quite clear that it wanted the benefit package to be a matter of private choice. To take an example, a coal miner has different health priorities, different needs, different desires than an airplane pilot would have. And, Congress very clearly left that part to private regulation.
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similar to the disadvantages of strong state governments in a federalist system. For example, when federal law exempts EBPs from regulation centered in the geopolitical jurisdiction in which particular groups of workers live, employers can trigger significant negative externalities for that region. If employers in a state can control, without any constraints by state regulation, which employees are admitted to an employer's risk pool (e.g., full time workers, but not part time workers) and what benefits individuals admitted to the risk pool will receive (e.g., physician coverage but not mental health coverage), that will necessarily leave a number of individuals outside of workplace plans or without access to certain benefits. The costs of that imbalance will be borne by state and federal taxpayers through increased costs in Medicaid and state public hospitals and emergency centers.[248] These externalized costs are the primary reason states struggle against ERISA pre-emption, as they seek to regulate access and cost in ways that can encompass persons in private employment-based insurance.

Just as in federalism debates about governmental jurisdictions, however, an argument in favor of employer independence, even in light of resulting externalities, is that such independence is the price of innovation. Allowing political space for variation enables laboratories of experimentation to exist. Corporate entities today do, in fact, function as laboratories in the development of health policy, not only with regard to health insurance coverage, but also with regard to delivery of health services and quality improvement.[249]

Of course, the corporate-state analogy is imperfect. Obviously employers are not subject to the direct democratic control that, however imperfectly, exists in states. From the citizen-worker's perspective, however, social relations may produce a simulacrum of collectivity. A sense of community attaches to the workplace as well as to political jurisdictions. Co-workers share an affiliative identity based on their

[248] See *Redesigning Care Delivery in Response to a High-Performance Network*, Health Aff. (2007); other

[249] CITES.

employment, which may be experienced as comparable in strength to their felt affiliation with their state of residence. Even without collective bargaining in the workplace, this sense of community can translate into a willingness to exert pressure in efforts to alter management decisions regarding benefits. In short, even if one disagrees with the comparison, an ERISA jurisprudence that treats corporate health insurance plan sponsors in ways analogous to how states are treated in traditional federalism is rational along both legal and cultural dimensions.[250]

The free rein given to employers by ERISA's strong pre-emptive power results in independence for employers in crafting risk governance approaches, including decisions that affect the delivery of health services and quality improvement. What that means is that health policy writ small is effectively being enacted in localized laboratories of workplaces throughout the country. The question is whether this power might be leveraged in a manner that achieves more equitable

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[250] As I noted at the outset, this is only a partial defense of workplace federalism. Apart from the costs already outlined in the system, ERISA federalism affects political dynamics in health policymaking. Large employers obviously have tremendous influence in Congress. As a practical matter, no reform of the health insurance/care system will go forward without their significant support. But employers do not have a legal entitlement to block reform should a proposal garner sufficient legislative and executive support to enable its enactment.

By contrast, at the state level, employers have what amounts to an ERISA-given veto that they bring to the bargaining table. The practical effects of this legally-created veto can be seen in the efforts of two states to require large employers to offer health insurance. In Maryland, a trade association challenged legislation requiring a "pay or play system" (known as the "Walmart law") as pre-empted by ERISA. Retail Industry Leaders Ass'n v. Fielder, 475 F.3d 180 (4th Cir. 2007). The Fourth Circuit Court of Appeals ruled that the effect of the state law was to mandate the terms of EBPs in Maryland and therefore the law was pre-empted by ERISA. Id. at xx. In Massachusetts, by contrast, a reform effort in the state was undertaken together with employer representatives and produced a law that employers chose to support. Sidney Watson, Kan. L. Rev. What might well have been a successful ERISA challenge has never been filed. See Edward A. Zelinsky, *The New Massachusetts Health Law: Preemption and Experimentation* (forthcoming) (arguing that the Massachusetts health reform law that took effect in 2007 could not survive an ERISA preemption challenge).

results, both on a local and a national level, if these local laboratories were infused with democratic processes.

IV. The Democracy Deficit in Health Care

In the current state of health insurance governance, the American public lacks any meaningful input into the politics of risk distribution. There is no structure that meaningfully engages the American public in grappling with questions of access and cost in health care. But if we could create a structure that facilitated serious discussion around these issues in an accessible manner, perhaps Americans could engage with questions of equity in health care in a manner that is hard to imagine today.

There are several recent examples of the American electorate engaging with health care issues. Among these have been the public's demand for reform fueled by insecurity about access to coverage;[251] the longstanding aversion to what voters believe amounts to "socialized medicine";[252] and the populist backlash against managed care entities and insurers in the 1990's.[253]

But the public's engagement with health policy tends to be episodic and its understandings shallow. Health care politics is misleading in its apparent accessibility. Virtually everyone experiences the health care system, either directly as a patient or indirectly through a friend or family member, and therefore has views about how the system can be improved. As a result, there is a great breadth of public opinion about health care. Politically, these reactions can translate into votes for a candidate whose views seem to mirror one's own.

But the actual quality of public knowledge at the policy level is low.[254] Part of what the public lacks is depth of knowledge. The system's underlying structures of financial risk allocation, embodied in such provisions as ERISA and tax law,

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are complex and not well known or understood. The result is that policy decisions are delegated to holders of specialized knowledge, and are effectively hidden from the public, even if they are hidden in plain sight.

The participatory dimension of the public's relation to health care policy is also largely missing.[255] Limits on public understanding and knowledge are exacerbated by limits on mechanisms by which members of the public can participate effectively in health care system governance. Although individuals are increasingly empowered as patients, particularly through their use of the web to retrieve information about symptoms and treatment, the idea that serious public engagement with health care system governance is a viable concept seldom surfaces in public consciousness. As a result, there is a huge democracy deficit in health care system governance today.

In this Part, I offer a normative argument for enhancing democratic engagement in health care system governance and a proposal for doing so grounded in the pragmatic spirit of democratic experimentalism.[256] I argue that beyond the identities of patient and consumer, individuals should assume

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[255] This situation is not unique to health policy, but is part of a larger socio-political landscape, in which many citizens express little trust in participatory forms of democratic politics because they are too busy, uninterested, or disgusted with politics to want to participate. See JOHN R. HIBBING AND ELIZABETH THEISS-MORSE, STEALTH DEMOCRACY 85-128 (2002). Levels of participation are also sharply skewed by economic class. A 1990 citizen participation study found that those with the highest incomes ($125,000 or more) were three times as likely to be involved in a civic organization as those with the lowest incomes ($15,000 or less). Kay Lehman Schlozman et al., *Civic Participation and the Equality Problem* in CIVIC ENGAGEMENT IN AMERICAN DEMOCRACY (Theda Skocpol and Morris P. Fiorina, eds.) 427, 452-53 (1999).

[256] In American legal scholarship, "democratic experimentalism" is most closely associated with an approach to public law that emphasizes collaborative regulatory initiatives, and uses principles of decentralization and stakeholder participation to develop new and less bureaucratic models of regulation and program administration. See Michael C. Dorf and Charles F. Sabel, *A Constitution of Democratic Experimentalism*, 98 COLUM. L. REV. 267 (1998); Michael C. Dorf, *Legal Indeterminacy and Institutional Design*, 78 N.Y.U. L. REV. 875, 886 (2003) (democratic experimentalism is "principally a model of participatory administration").

the role and identity of *citizen* in the health care system. Because governance encompasses more than just actions by the state, I believe that we can develop a meaningful concept of health care system citizenship and apply it to private sector institutions as well as to government. Drawing on insights from new governance theory, I argue that workplace-based risk pools have the potential to function not merely as actuarial groupings, but as political entities as well.

In Subpart A, I frame my argument for health care system citizenship as harmonious with the concept of a "public" developed by Jurgen Habermas. I argue that such a public can develop a knowledge base and body of experience with practical governance issues at a localized level. Cumulatively and over time, the emergence of this public might then reshape the dynamics of health care system policymaking on the governmental level.

In Subpart B, I argue that risk pools associated with *employment-based* health insurance provide the best platform for building new institutions of health care system citizenship. Because of the dense social connections that characterize most workplaces, the employment setting offers what is perhaps a unique environment for creating democracy-enhancing governance processes that can operate among members of a risk pool. In addition, because the legal structure created by ERISA already shifts significant control over pooling and rationing decisions to employer sponsors of health care, my approach leverages that structure by enhancing the worker voice in those employer decisions.

To be clear: I share the concerns of many regarding the negative policy implications of tethering health insurance to the workplace.[257] Indeed, I believe an optimal health care system would rely primarily on a universal, national scheme.[258] However, I also believe that the practical politics of our day dictate that employer-based health insurance will continue as a dominant force of our health care system for some time to come. In light of that reality, I offer the following normative

[257] For a sampling of those concerns, see e.g., Hacker, MORE .

[258] See e.g., Judith Feder, *Crowd-Out and the Politics of Health Reform*, 32 J. L. Med. & Ethics 461 (2004) MORE

argument and proposal for enhancing democratic engagement in our health care system governance through the workplace.

A. Building New Publics for Health Policy

One way to begin addressing the problem of Americans' shallow engagement with health policy issues is to conceptualize such debates as occurring within a "public," using the analytic structure developed by Jurgen Habermas.[259] In Habermas's work, the concept of a public denotes a cultural and social space, not a physical space, for dialogue about shared concerns.[260] Central to Habermas's thinking is the claim that the quality of society depends on the quality of our dialogic engagement on important issues.[261] The quality of that engagement, in turn, depends on whether our procedures for engagement reflect core ethical concerns such as equality of participation.[262]

Because democracy is not possible without meaningful participation, one can advance democratic norms in the governance of any system by enhancing the capacity of citizens to debate and discuss substantive issues and to participate in their resolution. If one sees the health care system as centered on risk managerialism, the central issue for enriching its democratic characteristics becomes how to empower citizens to more effectively participate in a politics of risk allocation and distribution.

My suggestion is that we consider using *risk pools* as a venue for building publics in the Habermasian sense. Conceptually, a risk pool is the local governance unit of any insurance plan. However, it is seldom thought of in terms of self-governance. Risk pools are actuarial constructs. They exist as clusters of individuals whose characteristics cause

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[259] *See generally* Hugh Baxter, *System and Lifeworld in Habermas's Theory of Law*, 23 CARDOZO L. REV. 473 (2002).

[260] JURGEN HABERMAS, BETWEEN FACTS AND NORMS: CONTRIBUTIONS TO A DISCOURSE THEORY OF LAW AND DEMOCRACY 360 (1995)

[261] *Id*. at 409

[262] *Id*.

them to fall within some category of risk relevant to the form of insurance being sold (e.g., the risk pool of teenage drivers or of beachfront property owners). They are groups that lack social meaning for their members; governance of the group is subsumed, without much focus by its members, within the organization's financial management.[263]

But I argue that the risk pools on which most group health insurance plans are based might also function as publics. Acting locally, a risk pool governance group could engage with the basic questions of who and what should be covered in a particular context, how to manage cost concerns, and what process should be used for resolving the inevitable disputes over coverage.

How much decision-making *power* a risk pool governance group might hold is a separate question and is one that I begin to address below. But the point I wish to make here is simply that creating a *process* by which such questions would be debated and by which input would be solicited could generate a new kind of health policy public: groups of health care system citizenry deliberatively engaged in small-scale associative institutions.

Risk pool governance groups would be sites outside formal political structures in which "public" deliberations would be taking place. In ideal form, these groups would create space for political participation, debate and opinion formation *within* the economic sector and *as part of* the system of risk managerialism. The deliberations of the group would require participants to engage with the arguments, concerns, and beliefs of others in the same risk pool, thus creating the potential for understandings that transcend self-interest.

The relatively small size of such groups, compared to the electorate, combined with the particularity of the issues before them, might also create the venue in which the ideological stakes of health politics could de-escalate. Health governance issues at the local level would be problems that need to be solved, rather than opportunities to argue about

[263] Jonathan Simon, *The Ideological Effects of Actuarial Practices*, 22 L. & SOC'Y REV. 771, 772-774 (1988)

grand philosophical conflicts.[264] Indeed, they would necessitate decisions to be resolved in a manner for which simple resort to abstract principles would not suffice.[265]

The smallness of scale of the groups could be considered a drawback for the large-scale project of remedying the democracy deficit in health care policy writ large. The kind of engagement I envision should increase the deliberative quality of a health policy decision for a localized risk pool, but would not necessarily produce debates about the more complex and global questions concerning health care. It would not, for example, address the larger questions of the proper role for market forces in determining care or the comparative advantages and disadvantages of a single-payer system. Given that reality, risk pool governance groups might be thought of simply as better schools for democracy rather than as a useful mechanism for the enhancement of national health policy.

I disagree. In the long run, localized engagement would almost certainly serve a broader educative function. The smaller scale of risk pools will have no evasive effect on the tough questions of cost and quality. Risk pool governance groups will still need to confront head-on the tensions and

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[264] The potential advantage from building participatory models from the ground up is evident from the recurrent stalemate on reform options. Public opinion polls document that although there is super-majoritarian support for "universal health care," the consensus falls apart when individuals are asked to choose between methods for achieving that goal. Jennifer Prah Ruger, *Health, Health Care, and Incompletely Theorized Agreements: A Normative Theory of Health Policy Decision Making*, 32 J. Health Pol. Pol'y & L. 51, 72-73 (2007).

[265] To that extent, they would offer the potential for "practical discourse," which Habermas describes as engagement with specific issues of immediate concern to those participating in the discussion. Habermas, supra n. xx, at 60. In his conceptualization, ideal practical discourse requires a deep commitment to egalitarian rules of participation, however, and I am not claiming that risk pool governance groups would necessarily satisfy those criteria. JURGEN HABERMAS, JUSTIFICATION AND APPLICATION: REMARKS ON DISCOURSE ETHICS 163 (1993); *Cf.* Michael Froomkin, *Habermas@Discourse.Net : Toward a Critical Theory of Cyberspace*, 116 HARV. L. REV. 749 (2003) (arguing that internet standard setting does satisfy Habermas's criteria for ideal practical discourse.).

trade-offs in allocating resources for health care through the setting of terms for insurance coverage.[266]

Ideally, broader policy preferences in such deliberative groups would emerge from an accumulation of smaller decisions. In the process, the individuals directly involved in the groups would become indigenous experts with regard to the risk pools. They would need to describe, explain and justify their decisions to their peers, and in return, their peers would be responsible for providing reaction and responses.

One can imagine that similar sets of managerial issues might arise for different risk groups. There would thus be the potential for networks of locally-based groups to affiliate and link up. One can envision the beginnings of a functioning, informed democratic political community organized around health care system governance issues.

Harnessing the economic power of risk pools to democratic governance structures could thus have a powerful effect on the quality of American political culture as it engages with health policy issues. Providing mechanisms for citizens to have a greater level of participation in shaping the parameters of their own health insurance could publicize the managerial discourse of risk allocation. It would allow for this discourse to be reinterpreted in a public discussion as a set of political, rather than predominately technical, questions. Such debates could only increase the sophistication and the accessibility of the public policy discussion at the meta-level.

Finally, an important contribution of self-governance structures at the level of risk pools would be to make it easier

[266] For example, group participants might choose to prioritize cost controls more than is currently typical. Some studies suggest that employees who have a say in such decisions are more likely than employers to trade higher quality for lower prices. Borzi and Glied. If one major problem in health care consumption patterns is that individuals are too shielded from the real costs of care by the role of employer-subsidized insurance, the active engagement of individuals in grappling with cost/coverage trade-offs can only be helpful. Long before managed care, unions that were significantly involved in health insurance policy in the 1950's sought to curb costs by arranging for prepaid medical services, but were unable to overcome the combined opposition of insurers and the medical profession. CITES

for citizens to infuse risk allocation discourse with moral values. As Deborah Stone has argued, insurance is a technology of governance which *invites* contemplation about issues of social responsibility because it requires resolution of questions about compassion and collective responses to suffering.[267] In a world of individualism and competition, the very presence of insurance "legitimates social obligation and mutual aid."[268] More widespread citizen engagement with such issues would, in effect, democratize the norm-setting implicit in the process of health insurance risk allocation at the local level.

Democratic governance at the level of risk pools could thus change the valence of risk discourse in this country. Analysts often link a discourse of risk managerialism to economic models and market-based initiatives that are not focused on equity.[269] But a discourse of risk could be just as naturally invoked to further strategies of inclusion and collective responsibility. "Risk centered governance," as Pat O'Malley has noted, comprises "a heterogeneous array of practices with diverse effects and implications . . . not limited to a cadre of experts practicing the dark arts."[270] Risk pool governance groups provide the potential of creating new democratic points of intervention in this discursive system.

B. New Workplace Governance

To build a public, in the Habermasian sense of creating an ongoing structured conversation based on knowledge and a respectful engagement with other citizens, requires a realistic infrastructure. Workplaces are major repositories of the kind of social capital that could enable meaningful participatory

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[267] Deborah A. Stone, *Beyond Moral Hazard: Insurance As Moral Opportunity*, 6 CONN. INS. L. J. 11, 16 (1999).

[268] *Id*. at 21.

[269] See, e.g., Steele, *supra* n. 3, at 4.

[270] Pat O'Malley, *Experiments in Government: Government Analytics and a Strategic Knowledge of Risk* (manuscript on file with author).

engagement by citizens in governance.[271] For that reason, I propose that we look to workplace-based health insurance risk pools as the foundation for a new health policy public.

Many health policy experts argue for de-linking health insurance from the workplace.[272] Their argument is that the economic distortions from an employer sponsored insurance (ESI) system outweigh any benefits that come from administrative convenience.[273] These analysts clearly explicate how ESI is doubly destructive: it fragments the overall population, thus undercutting social insurance, and it subsidizes individual health care consumption, thus creating moral hazard.[274] Political scientist Jacob Hacker convincingly argues that it is path dependency, not logical reasoning, that has kept us locked into the workplace system for health insurance.[275]

I find these critiques of ESI to be compelling as rationales for a national, universal system of health care delivery. Nevertheless, in this section, I offer a counter-perspective: that abandoning ESI also risks abandoning the democratic political potential of workplace-based risk pools. My argument is that infusing such risk pools with worker governance can serve both instrumental and normative ends.

Workplace-based risk pools for health insurance contain aggregations of individuals who share a common employer. Because membership in the plan is determined by reasons other than the goal of securing insurance, and because the plan invariably includes persons in a broad range of health status categories, ESI plans are "natural risk pools."[276] The

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[271] CYNTHIA ESTLUND, WORKING TOGETHER: HOW WORKPLACE BONDS STRENGTHEN A DIVERSE DEMOCRACY 114-16 (2003); ROBERT D. PUTNAM, BOWLING ALONE: THE COLLAPSE AND REVIVAL OF AMERICAN COMMUNITY (2000).

[272] CITE.

[273] Id.

[274] Cite

[275] JACOB S. HACKER, THE DIVIDED WELFARE STATE: THE BATTLE OVER PUBLIC AND PRIVATE SECTOR BENEFITS IN THE UNITED STATES 9 (2002).

[276] Borzi Glied

link to employment creates a material reason for individuals not to exit the risk pool lightly, which diminishes the likelihood of high transaction costs for the insurer. All of these factors make ESI risk pools attractive from an insurance perspective.

But these same factors may also make the ESI risk pool attractive as a site of governance for its participants. The link to employment that creates a material reason for individuals not to exit the risk pool also provides an incentive for employees to join a participatory risk governance process for the plan, were one to be offered. Indeed, I share Michael Gottesman's intuition that many employees might welcome the opportunity to negotiate collectively with employers about health insurance benefits and other collective goods, without committing to full-scale union representation on all issues.[277]

Most importantly, a workplace health insurance group maps precisely onto a set of rich, dense, and strong social relationships. Using the work of Robert Putnam and other social scientists, employment law scholar Cynthia Estlund has built a powerful argument that democratic theory has underestimated the importance of workplaces in advancing democratic ends.

Three of Estlund's assertions stand out as relevant to the project of workplace-based risk pool governance. First, people often build their civic skills in the workplace, through discussions of political and other issues of public importance conducted in relatively public spaces.[278] Second, outside of family or close friends, social ties at the workplace provide people with a stronger sense of belonging than any other institution in their lives.[279] Third, there is greater racial diversity in the American workplace than in most other civic settings, including neighborhoods and schools.[280]

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[277] Michael H. Gottesman, *In Despair, Starting Over: Imagining a Labor Law for Unorganized Workers*, 69 CHI.-KENT L. REV. 59, 80 (1993).

[278] Estlund, supra n. 269, at 119 (people discuss such issues more with co-workers than with any category of acquaintance other than relatives, and as much as with spouses).

[279] *Id*. at 7.

[280] *Id*. at 60.

The network of social connections at work also provides useful prerequisites for effective governance of health risk. The social connections at work settings facilitate the development of norms of reciprocity and trustworthiness, which in turn reinforce patterns of cooperation.[281] This foundation of social capital helps to overcome problems of collective action, such as the resistance to engage with difficult allocation decisions (the tragic choices problem) or the inclination to reject certain risks for oneself to achieve the gain that would result from someone else assuming them (the prisoner's dilemma problem).[282] Moreover, a normative advantage of collectively-made decisions about issues such as scope of coverage is that they are made by a group operating behind a veil of ignorance as to what serious illnesses they or their families might suffer.[283]

Using workplace-based risk pools also locates the project in a familiar setting. For that reason alone, it may be more realistic than proposals for entirely novel forms of participatory governance such as "national issues conventions"[284] and "deliberation days."[285]

Employment-linked insurance groups thus offer a singularly hospitable social environment for a democratic experimentalist project to take root. It is not plausible to require every employer-sponsored plan to have an employer/worker risk pool governance structure. But it seems realistic to imagine that policies might be put in place to *enable*

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[281] *Id*. at 114 (quoting Putnam at 19).

[282] *Id*. at 115. See also, GUIDO CALABRESI and PHILIP BOBBITT, TRAGIC CHOICES (1978) (///) and Kenneth Arrow ////

[283] *See* Russell Korobkin, *Determining Health Care Rights from Behind a Veil of Ignorance*, 1998 U. ILL. L. REV. 801.

[284] JAMES F. FISHKIN, DEMOCRACY AND DELIBERATION: NEW DIRECTIONS FOR DEMOCRATIC REFORM 3, 93, 105 (1991). Fishkin's approach seeks to create a structure that can serve as a mediating institution between opinion and policy, while at the same time fostering greater deliberative interaction among citizens. Although interesting gatherings have occurred, the products of these intensive sessions have not punctured the crust of established policy formation mechanisms.

[285] BRUCE ACKERMAN and JAMES S. FISHKIN, DELIBERATION DAY (2004).

risk pool governance structures in workplaces with a large enough number of employees to constitute a robust risk pool and a meaningful degree of diversity.[286]

Perhaps the bottom-line governance issue is how much control these new structures would have and how much discretion and authority employers would retain. If one assumes that group decisions would be constrained by a reasonable global budget established by management, it is not clear how strong employer resistance to giving up control might be. Worker release time for those engaged in the governance process, causing some additional firm costs, would be required. But external resources, such as foundation or government funding, might provide the other necessary support for such groups. If so, risk pool governance might function on close to a budget-neutral basis for employers.

Building on the current workplace model makes pragmatic sense in this political moment. Despite the clear shortcomings of linking health insurance to work at the meta-policy level, it is no accident that the only extant model in the United States for achieving close to universal coverage preserves employer-sponsored insurance.[287]

One of the most powerful normative objections to the development of risk pool governance mechanisms at the workplace is that it is naïve to imagine that such institutions will function outside of the power relations around them. Given those relations, the question is whether participants will be able to deliberate under conditions of egalitarian reciprocity and universal respect. If the aspiration of deliberative democracy is to create institutions which "tie[] the exercise of

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[286] There are various institutions that might serve as partial models for such groups, such as labor unions and worker councils. If these groups were extended beyond the workplace, a model for uninsured persons would be the Massachusetts Insurance Connector, which sets rates and other terms of enrollment under that state's new individual mandate to purchase health insurance. Sidney Watson, Kan. L. Rev. (forthcoming)

[287] See Mass. One factor in the political reluctance to jettison the workplace system is the high level of satisfaction reported by those whose health insurance comes through employment. See Borzi and Glied.

power to free reasoning among equals,"[288] the very thickness of background social relations in a workplace will make it difficult to achieve that result among co-workers.

I do not underestimate the ramifications of these power relations. They will necessarily give rise to numerous complexities in a governance structure. Cooptation of workers by employer interests, the possible self-disciplining of workers through the internalization of employer needs, or the simple failure of group members to fairly represent other workers all come to mind as possibilities.

Labor law scholarship analyzing possible mechanisms other than unions for worker representation has grappled with some of these issues. For example, despite strong support among employees for new ways to participate in workplace governance,[289] proposals to amend the National Labor Relations Act to allow employee participation plans remain controversial.[290] In practice, one needs a mechanism that allow workers' instinct to cooperate to flourish, that effectively deflects subtle forms of manipulation and control, and that ensures true representation of all worker interests.[291]

These issues illustrate the ambitiousness and difficulty of realizing the potential of risk pool governance structures.

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[288] Joshua Cohen, *Democracy and Liberty* in DELIBERATIVE DEMOCRACY 185, 193 (Jon Elster, ed.) (1998).

[289] A survey conducted in conjunction with the Dunlop Commission Report on the Future of Worker-Management Relations found that 90 per cent of workers wanted new mechanisms that would allow them to participate in decision-making. RICHARD FREEMAN AND JOEL ROGERS, WHAT WORKERS WANT 16 (1999).

[290] Stephen F. Befort, *Labor and Employment Law at the Millenium: A Historical Review and Critical Assessment*, 43 B. C. L. Rev. 351, 446-48 (2002) (arguing for development of employee participation initiatives); Charles B. Craver, *Mandatory Worker Participation is Required in a Declining Union Environment to Provide Employees with Meaningful Industrial Democracy*, 66 Geo. Wash. L. Rev. 135, /// (1997) (reviewing non-union worker democracy institutions in European countries and existing models in the United States); and Matthew W. Finkin, *Bridging the "Representation Gap*," 3 U. PA. J. LAB. & EMP. L. 391 (2001) (expressing skepticism about non-union mechanisms).

[291] See Mark Barenberg, *Democracy and Domination in the Law of the Workplace*, 94 COLUM. L. REV. 753, 762-64 (1994).

But such questions come with the territory of experimentalist projects. My goal here is not to set forth a full blueprint of a workplace-based risk pool governance structure. Rather, it is to encourage the *idea* of embarking on an experimentalist project through which such complexities will be explored.

Nor need we worry that such an idea will lack internal structure. Deliberative democracy scholars have developed procedures for coordinated oversight of local governance projects through measurement, audits and reviews, together with rules of participation that constrain those holding greater social, economic or political power from dominating group dynamics.[292] These can provide at least a starting point for addressing some of the most important concerns.

New forms of workplace democracy will require extensive resource investment to have a realistic chance of success. Access to outside expertise regarding health insurance options is obviously critical. The public sector, or segments within civil society such as foundations, would need to recognize such enterprises as offering important new opportunities for building democratic institutions and reinforcing deliberative norms in order for such resources to materialize.

Building small-scale democratic institutions is not a small project. But I have come to believe that engaging in such an enterprise would be an important step forward for our current health care system.

C. Summary: Toward Justice

Debates about justice in the health care system have tended to focus on the distribution of resources in the abstract. And they have most often produced political gridlock as

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[292] See e.g., ARCHON FUNG, EMPOWERED PARTICIPATION: REINVENTING URBAN DEMOCRACY 5-7, 22 (2004) (describing successful community empowerment project in Chicago centered in an urban school district); NEIL GUNNINGHAM AND PETER GRABOSKY, SMART REGULATION: DESIGNING ENVIRONMENTAL POLICY 101-03 (1998) (describing mechanisms and resources that can be made available to less powerful groups participating in collaborative regulation projects.)

policymakers grapple with conflicting priorities of equity and efficiency.

I do not venture here into formulating another comprehensive policy proposal to universalize access to health care and insurance. I propose instead a new institutional venue in which the necessary tensions and trade-offs in equity and efficiency might be negotiated via a more open and democratic process.

This model of justice is frankly process-oriented. It is designed to function within, rather than to block, a health care system that is centered on risk allocation. It is premised on the belief that informed dialogic participation at the local level on these issues can engender more knowledgeable engagement with broader health policy debates. And it is designed to create an institutional base from which resistance can be mounted to certain forms of risk distribution.

Part of my motivation in proposing a process model is simple pragmatism. In a sector as vast and complicated as the American health care system, a strategy that enables greater fairness in a localized setting may be the most effective strategy for achieving fairness on a more global scale. If individuals can successfully grapple with issues of equity in their own risk pools and create fair outcomes, perhaps some of those lessons and successes will be replicated on the national scale. In any event, regardless of whether, or how, financing mechanisms change in the future for our health care system, democratizing policy inputs into that system will remain important.

As an intellectual project, my proposal incorporates the egalitarian potential of insurance as a governance technology within the realm of democratic theory. The veil of ignorance never fully falls away from risk pool decision-making. Even after a history of past claims has accumulated, the constellation of future claims is always uncertain. For that reason, risk pool governance unites within the health care system what Dorf and Sabel describe as the two core meanings of democracy: the deliberative function of securing the good of all and the calculative function of achieving the good of each.[293]

[293] Dorf and Sabel, *supra* note /// at 274-75.

Risk governance should also be understood to encompass a potentially rich analysis of social relations as well as political theory or economics. Scholars should not lightly dismiss the reactions of actors within the health care system to the new roles and identities that institutional structures and risk practices have forced them to assume. Understanding these new dynamics can enrich our study of law in action, as well as challenge our conception of citizenship. Framing the health care system as risk governance allows us to untangle and analyze a particularly complex skein of institutions, practices and ideas.

Conclusion

The era of actuarial medicine is not likely to end soon. The integrated system of financing and service delivery of managed care, designed and set into place in order to control costs, has now changed the practice of medicine in ways that are likely to remain in place, regardless of what particular efforts at reform are successful.

Mechanisms governing and distributing financial risk are what drive the health care system today, employing an interlocking set of policies and mutually reciprocal practices based in both public and private sectors. All actors within the system – including not only insurers but also providers and patients – assume aspects of financial risk, and the system's viability is contingent on risk allocation. Understanding how the legal system reinforces this risk-centered governance provides a better explanation than do current health law paradigms of how the many strands of doctrine within that body of law cohere and why its substantive importance matches its financial heft.

Central to my project is the goal of framing risk governance practices within political theory and specifically as a problem for democracy. From that perspective, I argue that the doctrinal complexities of ERISA preemption law can be read as a charter of corporate sovereignty in a health risk governance universe. To counter that development, I identify a new and important role for health insurance risk pools as virtual jurisdictions with political and social meaning, rather

than merely actuarial units. In doing so, I argue that for something as central to our lives and our economy as the health system, we should interrogate much more vigorously than we have so far our conventional understanding of whether and how democratic norms and structures could supply mediating processes for risk-centered decision-making.