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HEALTH CARE & PHARMACEUTICALS

Health Care Reform and the Logic of Emergence

M. Gregg Bloche & Sujata M. Jhaveri*

Health policy wonks who get frustrated about the difficulty of doing health care reform often resort to the parable of the “boiled frog” to convey the dire consequences of failure. The story of the “boiled frog” (with a few embellishments) goes something like this:

- A frog hops into a pot of water—or an experimenter with bad intentions puts him there.
- The experimenter (who does not think much of animal rights activists) puts the pot on a stove and turns on the gas.
- The water warms slowly. Because he is cold-blooded, the frog’s body temperature rises to match the water’s.
- The frog does not notice that he—and the water—are getting warmer. He stays in the pot—he could hop out but he does not—until the water boils and he becomes part of our dinner.

But there is a problem with the parable: researchers (with bad attitudes!) have actually done this to frogs. German physiologist Friedrich Goltz reported in 1869 that frogs immersed in cool water become jumpy, then quite agitated as

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the water is warmed past room temperature.¹ They, in fact, try desperately to escape, and do so if there is not a lid on the pot. Unless, that is, researchers (with worse attitudes!) first cut out their brains; then the frogs blithely disregard their progress toward the dinner table.

So the parable of the boiled frog sells frogs short. Only brainless frogs do nothing, as we have done in health care policy. It is fitting that some concerned about climate change have also seized upon the frog parable, since our health care system is fast becoming the fiscal equivalent of global warming. Even as the number of people without medical coverage closes in on fifty million, we are on track towards spending fifty percent of our gross domestic product on medical care before this century comes to an end.² So says the Congressional Budget Office, which points out the obvious: we are not really going to spend fifty percent of our GDP on health care.³ The consequences of doing so would be disastrous—for our fiscal stability, economic standing in the world, and other personal and national priorities. Something big will have to change.

Calls for “cost-control” or even cost reduction fail to convey the challenge we face. Indeed, cost reductions of a one-time nature are, over the long term, almost beside the point. Take, for example, calls from political liberals for reductions in administrative costs (often blamed on private insurers) and calls from conservatives for reductions in costs arising from the medical malpractice system. Proposals along these lines might trim health spending by several or more percentage points, their advocates say. But this is a one-time-only savings—cost reduction that pales in comparison to the cumulative impact,

1. Friedrich Goltz, BEITRAGE ZUR LEHRE VON DEN FUNCTIONEN DER NERVENCENTREN DES FROSCHES (1869). Michael Jones deserves credit for bringing this pearl to public attention in an *Atlantic Magazine* blog post, Michael Jones, Guest-post wisdom on frogs (July 21, 2009), http://jamesfallows.theatlantic.com/archives/2009/07/guest-post_wisdom_on_frogs.php (last visited Nov. 30, 2009).

2. CONGRESSIONAL BUDGET OFFICE, THE LONG-TERM OUTLOOK FOR HEALTH CARE SPENDING 12 (2007). These CBO projections presume excess cost growth rates (rates by which medical cost increases exceed GDP growth for Medicare, Medicaid, and other health spending) that are well below historical averages. *Id.* at 10–11. Were medical costs to continue to rise at historical rates, health spending would soar to an unimaginable 100 percent of GDP within seventy-five years. *Id.* at App. D.

3. *See id.* at 1. (“In reality, federal law will change in the future, ensuring that the basis for the projections will not turn out to be correct.”).

over a decade or more, of *annual* medical spending increases of several percent or more.

What will need to change is well-captured by the expression “Bending the Curve,” made popular among health policy wonks by an eponymous Commonwealth Fund report on cost-containment strategies, published in 2007.⁴ The challenge before us is not cost reduction; it is reduction in the rate at which health care spending is now rising. Health Care spending has been growing for a half century or more at rates several percentage points higher than inflation and GDP growth. There is broad agreement, based on extensive evidence, that this unsustainable rate of increase is not, in the main, due to medical price inflation, aging boomers, or avaricious insurers (rates of increase are not much higher in the U.S. than in industrialized countries where private medical insurance plays a lesser role⁵). Rather, this rate of increase is due to advances in medical technology, powered by scientific discoveries and availability of insurance (both public and private) to cover these advances’ costs.

The challenge before us, if we are to “bend the curve,” is to put the brakes on this process, gently—without denying tens of millions of people access to a decent minimum of medical care and without cutting back on care senselessly, absent regard for comparative clinical benefit. Can the law of health care provision empower us to achieve this?

Standard wisdom holds that health law is ill-situated to do so. Health law, it is widely thought, is part of the problem. American health law today is a chaotic and incomplete patchwork created by fifty state court systems, twelve federal circuits that act in disconnected fashion (only rarely overseen by the U.S. Supreme Court), fifty state legislatures and sets of regulatory agencies, and myriad other actors. In short, health law verges on chaos—and often goes over the verge. Multiple doctrines are at war with each other, core values are in sharp conflict, and there is bitter disagreement over the basics of

4. CATHY SCHOEN ET AL., THE COMMONWEALTH FUND, BENDING THE CURVE: OPTIONS FOR ACHIEVING SAVINGS AND IMPROVING VALUE IN U.S. HEALTH SPENDING (2007), available at http://www.commonwealthfund.org/usr_doc/EMBARGOED_FULL_REPORT_Bending_the_Curve_optimized.pdf.

5. ORGANIZATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, OECD HEALTH DATA 2009.

what reform of the American way of health care governance should aim to accomplish.⁶ This disagreement has paralyzed the politics of health reform.⁷

Commentary on health care law often acknowledges this problem,⁸ yet rarely takes it seriously. Health law scholars are wont to criticize the field's incoherence, then to will this incoherence away by urging one or another single, overarching solution. In so doing, they presume the existence of a few key decision-makers able to implement this solution by somehow exercising top-down authority over the law in their domains. Writers variously urge market-driven reform, more robust regulation, and an expanded role for government as health care payer. But putting any of these visions into effect would require health law's myriad deciders to step in rhythm to a single beat. That, we contend, is the stuff of fantasy.

The central challenge for health law reformers, in our view, is the impossibility of imposing any unifying, overarching vision. Commentators who assume this challenge away overlook health care law's astonishing degree of fragmentation. They ignore health law's myriad, disconnected decision-makers, competing stakeholders, and contradictory (but passionately-felt) moral commitments. Rather than treating this fragmentation as something to be swept aside by some overarching vision that we all should embrace, would-be health law reformers should accept fragmentation, verging on chaos, as inevitable. To this end, we will offer some ideas about how aspiring reformers might try to navigate this fragmentation and perhaps even turn health law's contradictory impulses toward reformist ends.

In most fields of law, the presumption of top-down decision makers is a close-enough approximation to reality. The U.S.

6. See HAYNES JOHNSON & DAVID S. BRODER, *THE SYSTEM: THE AMERICAN WAY OF POLITICS AT THE BREAKING POINT passim* (1996).

7. See generally THEDA SKOCPOL, *BOOMERANG: CLINTON'S HEALTH SECURITY EFFORT AND THE TURN AGAINST GOVERNMENT IN U.S. POLITICS* 83–95, 133–63 (1996).

8. See Megan McArdle, *The Healthcare Debate is a Kabuki Theatre of Incoherence*, BUSINESS INSIDER, Nov. 23, 2009, <http://www.businessinsider.com/the-healthcare-debate-is-a-kabuki-theatre-of-incoherence-2009-11>; see also John R. Graham, *Another Incoherent Health-Care Poll in the New York Times*, NATIONAL REVIEW ONLINE, June 22, 2009, <http://corner.nationalreview.com/post/?q=MTE5M2FIZTkyNGJiOTY5NTlmNTkyMTQ0MjEzMzVlOTc>.

Supreme Court holds sway over constitutional law, and various agencies set rules within their regulatory realms, subject to judicial review and legislative oversight. The Federal Communications Commission (FCC), the Securities and Exchange Commission (SEC), and the Environmental Protection Agency (EPA) are classic examples within their respective fields of law. The law of health care provision in the US does not function this way. No single authority sets the rules or is in position to implement the proposals and paradigms that commentators urge. Health law is the product of many scattered deciders who act not in concert but in interdependent fashion. These scattered deciders have multiple, clashing understandings of what legal governance should aim to accomplish. No single understanding can prevail.

Rather, health law exhibits the properties of an emergent system—a system with a design that arises from ongoing feedback among these deciders. Its design—its intelligence—transcends these deciders. Indeed, it is a common feature of emergent systems that their component elements do their part absent awareness of their places in the larger scheme.

Ants, for example, “decide” to forage or to fight or to ferry food from distant places based on pheromone levels they detect. They neither take orders from their superiors nor grasp their larger mission on the colony’s behalf. Our neurons do the same thing, receiving signals then firing to activate or suppress follow-on brain cells that participate in networks tied to perceiving and understanding and acting upon the world. Neurons, of course, have no sense of their larger networking mission; they simply follow the laws of chemistry and physics. The logic of our thoughts and behaviors emerges from this. The designs of cities, societies, and economies likewise emerge from the motives and actions of individuals who think they know what they are doing but who are mostly unaware of their roles in fashioning and sustaining neighborhoods, subcultures, industries or the other social forms that organize our collective lives.

We are, of course, different from ants and neurons. We are more flexible, since our neural networks evolve in response to events, and we are, at times, more self-aware. But what we have in common with our remote six-legged relatives is that the intelligence of our social forms transcends our sense, while in the fray, of our motives and actions. The logic of American

health law is similarly emergent, for better and often for worse.

Take for example, the tension between malpractice law's reliance upon professional standards of care and the proposition that markets should permit consumers to pick from among different levels of care, an idea that is embedded in antitrust doctrine, and, to some degree, judicial interpretation of health insurance contracts. Commentators on health law typically treat this tension as a failure of coherence.⁹ Market-orientated commentators complain that liability for breach of professional standards keeps health plans and providers from offering lower-cost care and coverage options.¹⁰ On the other hand, liberals, who object to tying medical care to ability to pay, defend professional standards as a floor below which levels of care should not fall.¹¹

Viewing health law as an emergent system yields a different understanding—one that treats this apparent incoherence as a channel for feedback among scattered deciders with differing perspectives. A deeply felt commitment to health equity and to the ideal of life's pricelessness animates tort law's deference to professional standards of care. Were the law to utterly abandon its reliance on professional standards, it would detach itself from these concerns. This might undermine people's belief in law's responsiveness to their hopes and fears. Yet life, of course, is not priceless—the market price of life is probably about \$100,000 per quality-adjusted life year,¹² resources are scarce, and Americans revere the market as the most efficient and least authoritarian way to manage scarcity. Antitrust and other doctrines that promote consumer choice in health care express this. The legal regimes that govern medical malpractice and restraints on competition therefore embody competing ideals to which Americans are inextricably

9. See, e.g., Anne Zieger, *Antitrust Laws Could Hobble Healthcare Reform*, FIERCE HEALTHCARE, May 27, 2009, <http://www.fiercehealthcare.com/story/antitrust-laws-could-hobble-healthcare-reform/2009-05-27>.

10. See, e.g., Clark C. Havighurst, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM 146 (1995).

11. See, e.g., Sara Rosenbaum et al., *Who Should Determine When Health Care is Medically Necessary?*, 340 NEW ENG. J. MED. 229 *passim* (1999) (urging reliance on professional standards to determine levels of care and health insurance coverage).

12. David M. Cutler & Elizabeth Richardson, *The Value of Health: 1970–1990*, AM. ECON. ASS'N PAPERS AND PROCEEDINGS, May 1998, at 97.

committed.

From an emergent systems perspective, this is not a contradiction. It is an opportunity for mutual feedback among component systems that constitute health law. Antitrust lawyers who take a combative stance toward professional standards can stay true to their conviction, as can egalitarians that see health care allocation based on ability to pay as anathema. Both sides think they know what they are doing—campaigning to make health law more consistent and to get it right by cleansing it of the pernicious influence of the opposing view. Both sides, meanwhile, participate in a larger process of which they may be only dimly aware, a process of feedback between legal schemes that sometimes sustains existing arrangements and that at other times pushes health care governance hard in one direction or another as scattered deciders take account of developments in neighboring suites of law.

Myriad other feedback schemes shape the regulatory governance of health care. Some of these schemes involve classic tensions in American public life—between national and local governance (the struggle over ERISA pre-emption of state efforts to expand coverage¹³ is a case in point), equity and autonomy (the debate over the extent to which informed consent law should accommodate individuals' varied preferences¹⁴ is illustrative), and public versus personal responsibility for finding shelter against life's vicissitudes (this is the central theme of recurring battles over the scope of health insurance initiatives for the disadvantaged).

Such feedback schemes enable the expression of values and concerns that are at odds with each other but deeply felt, to the point that health law cannot realistically discard them. Legal and regulatory actions that offend these values inspire responses—from the losing parties and from legal decision makers with different perspectives. Decision-makers charged with implementing different legal regimes—tort and contract, ERISA, antitrust, and many others—send negative or positive feedback signals through their responses.

13. See, e.g., *Golden Gate Rest. Ass'n v. City and County of S.F.*, 512 F.3d 1112 (9th Cir. 2008), *petition for cert. filed*, (No. 08-1515) (July 10, 2009).

14. See, e.g., JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 48–84 (1984).

For instance, refusal by state judges to endorse contractual departures from professional standards of care in medical malpractice cases sends a dampening message to antitrust and other decision makers who are eager to advance the market model in the medical realm. Conversely, state courts' growing willingness since the 1970s to permit insurers to deny coverage for physician-prescribed services on contract law grounds signals that their support for professional authority has diminished. The Supreme Court's refusal to give full effect to the market model, even in the antitrust context (for example, the Justices' acceptance of professional restrictions on price advertising¹⁵) may reflect its summing of these and other mixed signals, from many decision makers, about the comparative desirability of untrammelled competition and deference to professional norms.

Consider Justice Souter's mixed messages about the sweep of markets in the medical realm. In the year 2000, in *Pegram v. Herdrich*, he characterized clinical standards of care as the product of market-driven cost benefit trade-offs beyond the scope of regulatory oversight under ERISA.¹⁶ But just two years later, in *Rush Prudential HMO v. Moran*, he portrayed medical standards of care as a matter of professional opinion, not contract.¹⁷ For some, this inconsistency merits scorn. It is poor judicial craftsmanship, pure and simple, or so it seems. But it is also a sign of the Court's role as a processor of mixed messages about the role of markets and professionalism in health care governance.

The Justices participate in overlapping networks of feedback involving health law's myriad decision makers. In response to the varied signals the Justices receive, they rely upon competing models of medical governance, all of which have some legal force. So it is hardly surprising that the Court sends messages that don't cohere. Consistency would require the Justices to discard large parts of health law, embodying values and concerns Americans are unwilling to abandon. Within the networks of decision-making that constitute health care law, negative feedback tends to support the status quo,

15. *California Dental Ass'n v. Fed. Trade Comm'n*, 526 U.S. 756, 759 (1999).

16. *Pegram v. Herdrich*, 530 U.S. 211, 231–32 (2000).

17. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 386 (2002).

and positive feedback tends to promote change. Novel judicial, regulatory, and legislative gambits typically provoke suppressive responses, but they sometimes catch fire, propagating to broader networks of decision-makers.

The law's embrace of the market paradigm is the highest profile case of this phenomenon. Isolated market-oriented initiatives in the 1970s—the Supreme Court's abandonment of the “learned professions” exemption from antitrust law¹⁸ and Congressional passage of a law promoting HMOs¹⁹—triggered positive responses, probably boosted by rising skepticism toward professional authority. Other decision-makers picked up, then amplified the signal. The Federal Trade Commission began antitrust enforcement against health care providers,²⁰ state regulators backed away from “Certificate of Need” limitations on hospitals' capital investment,²¹ and courts, as mentioned earlier, began allowing insurers to decline coverage for physician-prescribed care.²²

Preceding and parallel developments in “neighboring” doctrinal spaces widened the possibilities for propagation. Most of those who urged more robust informed consent requirements during the 1960s and 1970s didn't mean to promote medical markets. But they did just that, by winning broader legal and cultural recognition for patient autonomy.²³ This in turn primed courts', regulators', and the public's receptivity to the competition paradigm.²⁴ Likewise, for the Congress that enacted ERISA in 1974²⁵—in response to pension fund scandals

18. *Goldfarb v. Va. State Bar*, 421 U.S. 773 (1975).

19. 42 U.S.C.A. § 300e (1982).

20. Clark C. Havighurst, *Antitrust Enforcement in the Medical Services Industry: What Does It All Mean?*, 58 MILBANK MEMORIAL FUND Q. 166, 167–68 (1980); *see, e.g., In re Medical Staff of Memorial Medical Ctr.* 110 F.T.C. 541 (1988); *In re Preferred Physicians, Inc.* 110 F.T.C. 157 (1988); *In re Hospital Corp. of America* 106 F.T.C. 361 (1985).

21. *See* Frank A. Sloan, *Government and the Regulation of Hospital Care*, AM. ECON. REV. 196, 198 (1982); Christopher J. Conover & Frank A. Sloan, *Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?*, 23 J. HEALTH POL., POL'Y & L. 455 (1998) (reviewing the effect of historical changes in certificate of need laws).

22. *Pegram v. Herdrich*, 530 U.S. 211, 218 (2000).

23. *See e.g.,* RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 139–40 (1986).

24. *See e.g.,* Victor R. Fuchs, *The “Competition Revolution” in Health Care*, 7 HEALTH AFF. 5 (1988).

25. Employee Retirement Income Security Act (ERISA) of 1974, Pub. L.

that shattered American workers' confidence—the implications for health insurance were an afterthought.²⁶ But by preempting most state regulation of employee benefit plans (and substituting few minimum requirements of its own); ERISA largely deregulated the market for medical coverage.

Out of many interwoven networks of deciders, health care law emerges. This self-organizing process hardly guarantees a governance system that serves us well. By way of analogy, emergence in biological systems generates tumors, seizures and other phenomena that careen out of control when the feedback mechanisms that maintain homeostasis fail. America's worsening crises of cost and access,²⁷ clinical mistakes that kill tens of thousands of patients a year,²⁸ and the proliferation of treatments absent proof of their value²⁹ strongly suggest that in health care law much has gone awry. How to intervene to make health law part of the solution—or, at the least, to keep law from making the problems worse—is a question that calls for attention to the dynamics of emergence.

How might focus on the dynamics of emergence guide reformers' efforts to reshape, or at least nudge, the law of health care provision? We want to suggest a few possibilities on

No. 93–406, 88 Stat. 829 (1974) (codified as amended in scattered sections of 29 U.S.C. (2006)).

26. 29 U.S.C. §§ 1001–1461 (2007).

27. Todd P. Gilmer & Richard G. Kronick, *Hard Times and Health Insurance: How Many Americans Will Be Uninsured by 2010?* (web exclusive), 28 HEALTH AFF. w573–w574 (2009).

28. See generally INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (executive summary) (Linda T. Kohn, Janet M. Corrigan, & Molla S. Donaldson, eds.) (1999), available at http://books.nap.edu/html/to_err_is_human/reportbrief.pdf; see also Drew E. Altman et al., *Improving Patient Safety—Five Years After the IOM Report*, 351 NEW ENG. J. MED. 2041 (2004). But see Troyen A. Brennan et al., *Accidental Deaths, Saved Lives, and Improved Quality*, 353 NEW ENG. J. MED. 1405 (2005) (suggesting that while the 1999 IOM report shed light on a major concern within American health care, it focuses too strongly on the concept of preventable individual accidental deaths rather than use of evidence-based medicine to improve quality of care).

29. See, e.g., ELLIOT FISHER ET AL., HEALTH CARE SPENDING, QUALITY, AND OUTCOMES: MORE ISN'T ALWAYS BETTER available at http://www.dartmouthatlas.org/atlas/Spending_Brief_022709.pdf (discussing overuse of clinical interventions without evidence of their efficacy); JOHN E. WENNBERG ET AL., THE QUALITY OF MEDICAL CARE IN THE UNITED STATES: A REPORT ON THE MEDICARE PROGRAM 222 (1999), available at <http://www.dartmouthatlas.org/atlas/99Atlas.pdf> (discussing overuse use of treatments absent scientific proof of benefits and harms).

the access-to-care front. Most Americans say they support universal coverage. But political and legal obstacles that are manageable through emergence-oriented reform strategies have repeatedly stymied attempts to achieve it. A large barrier is ERISA preemption of state initiatives.³⁰ Many of these state initiatives require employers to either cover their workers or pay into public funds to subsidize insurance; this raises the issue of whether ERISA preempts such state laws.³¹ Less tangible obstacles include ideological resistance to publicly supported coverage as incompatible with personal responsibility and the risk-aversion of health care stakeholders, who often oppose change that could disrupt cash flows upon which they have come to rely.

Clearing the ERISA barrier to state-level reform efforts would open up a variety of potential evolutionary pathways toward nationwide universal coverage. States have seized the initiative on the health reform front with creative, bipartisan ideas about how to expand coverage.³² From a conventional health reform perspective, the prospect of 50 different state systems is anathema. A single national system, whether market-oriented or government-administered, would seem essential to avoid Byzantine bureaucratic and legal complexity. However, from a pragmatic perspective, perhaps incremental reform via state models should be promoted. Ideological and interest-group gridlock at the federal level makes national reform difficult, as recent reform battles have reminded us.³³ State-by-state progress, meanwhile, could build momentum toward nationwide insistence on universal coverage, so long as high-visibility state initiatives are seen as successful and, thus, worth propagating.

30. 29 U.S.C. § 1144(a) (2006).

31. Amy B. Monahan, *Pay or Play Laws, ERISA Preemption, and Potential Lessons from Massachusetts*, 55 U. KAN. L. REV. 1203 (2007).

32. See generally Joel C. Cantor et al., *Challenges of State Health Reform: Variations in Ten States*, 17 HEALTH AFF. 191 (1998); Richard P. Nathan, *Federalism and Health Policy*, 24 HEALTH AFF. 1458 (2005); see also, John E. McDonough et al., *The Third Wave of Massachusetts Health Care Access Reform* (web exclusive), 25 HEALTH AFF. 420 (2006) (detailing how the most well-known state health reform initiative is constructed).

33. Dan Eggen, *Health-care Lobbyists Continue Spending Spree*, THE WASHINGTON POST BLOG (Oct. 21, 2009, 5:00 AM), http://voices.washingtonpost.com/health-care-reform/2009/10/health-care_lobbyists_continue.html.

Similarities in design are likely to result from the propagation of successful state models along informal networks of influence. These similarities would ease administrative burdens. But if large employers or health plans become sufficiently concerned about the Balkanization of legal and regulatory requirements, they could press Congress and the White House for federalization of the emerging universal coverage system. They might well succeed, demonstrating the power of feedback mechanisms to transform health policy and law in circuitous fashion—and locking in a national commitment to medical coverage for all. Support for state initiatives is thus a wise gamble from an emergent systems perspective, even if one aspires, ultimately, to a federal regime of universal coverage.

There is, of course, no guarantee that state-driven reform would lead to any particular model for expanding coverage. But more likely than not, one or a few prevailing models would emerge as the states' experiences influence each other. Nor must state-level reform lead, in the end, to state governance of health insurance coverage. Congress and the White House could respond to state initiatives by imposing an overarching federal scheme. Were this to happen, state reforms would still have served a vital purpose by nudging the country toward universal coverage.

This rationale favors legislative revision of ERISA to clear the way for state experimentation—and, in the meanwhile, judicial construction of ERISA to minimize preemption of state initiatives.³⁴ There's ample doctrinal space for such a judicial reading. The Supreme Court has said, in a case involving state regulation of hospital charges, ERISA's pre-emptive provisions are to be read narrowly when they infringe traditional state power over health matters.³⁵ Some lower court precedent poses a threat to state-level "pay or play" requirements,³⁶ but the

34. 29 U.S.C. §§ 1001–1461 (2007).

35. See *N.Y. Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 659–62 (1995) (holding that state law requiring hospitals to collect higher payments from commercial insurers than from nonprofit Blue Cross & Blue Shield Plans survives §514 preemption).

36. See *e.g.*, *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 183 (4th Cir. 2007) (holding that legislation by the Maryland General Assembly which called for employees to spend a certain percentage of their total payroll on health insurance costs or pay the amount to the state was preempted by ERISA). *But see* *Golden Gate Rest. Ass'n v. City and County of S.F.*, 512 F.3d

accretion of state reform initiatives would put pressure on judges not to stymie legislators when neither Supreme Court precedent nor the plain language of ERISA requires it.

Objections to publicly supported coverage on the ground that it is incompatible with personal responsibility pose a larger challenge. Denunciations of universal coverage as “socialism” or the like may be overwrought, but they’ve gained populist traction because of many Americans’ worries about subverting self-reliance.³⁷ Commentators, advocacy groups, public officials, and others who favor government action to increase access have offered lots of counterarguments. This debate has been joined in American politics since Theodore Roosevelt urged national health insurance during his Bull Moose run for the presidency in 1912.³⁸ There have been incremental steps forward—Medicare and Medicaid in 1965, Medicaid expansion during the ‘80’s, and SCHIP in 1997. Yet portrayals of public coverage as a handout and a step towards socialism have maintained their resonance.

Universal coverage proponents have struggled to rebut this portrayal. But the logic of emergence suggests another approach, one that takes advantage of the tension between people’s commitments to universal coverage and self-reliance. Rather than ruing this tension, health policy progressives should harness its political energy by weaving individual responsibility and mutual obligation together into a new reciprocity of personal and public commitment to health.³⁹

This new reciprocity might start with an enhanced sense of individual obligation—to eat sensibly, exercise regularly, avoid smoking and otherwise care for ourselves. It ought to include an obligation to buy health insurance. Our failure to do these

1112 (9th Cir. 2008) (holding that a similar law survives ERISA preemption).

37. See, e.g., Editorial, *Misinformation, Mayhem Mar Debate on Health Care*, USA TODAY BLOG, (Aug. 10, 2009, 12:21 AM), <http://blogs.usatoday.com/oped/2009/08/our-opinion-misinformation-mayhem-mar-debate-on-health-care.html>; Sam Stein, *Steele Calls Obama Health Care Socialism, Agrees This His Waterloo*, HUFFINGTON POST, July 9, 2009, http://www.huffingtonpost.com/2009/07/20/steele-calls-obama-health_n_240989.html.

38. Kaiser Family Foundation, *National Health Insurance—A Brief History of Reform Efforts in the U.S.* (Focus on Health Reform series) (March 2009), available at <http://www.kff.org/healthreform/upload/7871.pdf>.

39. M. Gregg Bloche, *Health Care for All?*, 357 NEW ENG. J. MED. 1173–75 (2007).

things ought to carry consequences, like premium surcharges and a measure of embarrassment over personal behavior that adds health risk without corresponding social benefit. The state, in exchange, should offer some protection when self-reliance falters. Americans who cannot afford coverage ought to be able to turn to their government for help in acquiring it. If the US is to come close to universal coverage, personal responsibility will probably need to play a larger role than it did in the mid-20th century welfare state.

The risk-aversion of health care stakeholders is perhaps the least-appreciated obstacle to coverage expansion. Health care reform disrupts existing subsidies and revenue streams by replacing them with promised alternatives. Risk-averse stakeholders often oppose reform proposals even when the resulting disruptions are likely to yield net benefits by replacing current funding streams with larger subsidies and revenues. Foremost among the disruptions likely to ensue from coverage expansion (and its public financing) is the shift from veiled cross-subsidies to visible means of financing care for the less well off.⁴⁰ Americans subsidize care for the medically indigent through a variety of mechanisms that few understand. These include extra payments from the Medicare Trust Fund to hospitals with large numbers of uninsured patients, as well as private insurance premiums set high enough to contribute to the cost of indigent care.⁴¹ Publicly sponsored coverage for the less well off would supplant these cross-subsidies with a high-profile tax, an inviting political target. The prospect of these cross-subsidies' disappearance or diminution alarms hospitals and clinics who fear that public funding for broader coverage won't suffice to replace this bird in hand.

Stakeholders' concerns about the disruption of their revenue streams as the result of movement toward universal coverage are a large obstacle to reform. In California, these concerns proved fatal to Governor Arnold Schwarzenegger's

40. See H.R.3962, 111th Cong. (2009); H.R. 3590, 111th Cong. (2009). The House Democrats' bill, unveiled on November 18, 2009, would impose a 40 percent tax on so-called "Cadillac plans," which have insurance premiums above \$8,500 for an individual and \$23,000 for a family. Those thresholds represent the total paid by both employer and employee.

41. See generally Gail R. Wilensky, *Solving Uncompensated Hospital Care: Targeting the Indigent and the Uninsured*, 3 HEALTH AFF. 50 (1984).

2007 reform plan.⁴² And these concerns need to be taken seriously. From a conventional policy wonk perspective, this disruption shouldn't count. It is just a transition problem. If one or more universal coverage proposals represent an improvement over today's tangled web of inefficient cross-subsidies, it ought to be enacted, policy wonks and law professors like to say, unless a competing scheme would improve things even further.

But from an emergent systems perspective, transitions are crucial periods, not merely details to be worked out bureaucratically and legally after new policies are chosen. Rather, transitions are the terrain that must be crossed to achieve policy ends. Obstacles have to be anticipated—obstacles created by stakeholders, cumbersome bureaucratic structures, and extant legal regimes. Further, public perceptions are crucial, as is illustrated by voters' resistance to new taxes even when these would supplant payroll deductions that cross-subsidize care for the poor.

Presidents Franklin Roosevelt and Lyndon Johnson understood this last point when they insisted on characterizing working Americans' contributions towards Social Security and Medicare as insurance premiums, not taxes. Aspiring architects of expanded medical coverage today would do well to fashion schemes that separate collection of general tax revenues from public financing of care for people unable to meet their own medical needs. This is more than just rhetoric; both promising political pathways and insurmountable obstacles to reform emerge from the structure of people's perceptions about the options they confront. More generally, aspiring architects of reform should avoid large, immediate disruption of current financial arrangements, even when the policy case for disruption is powerful. Sudden disruption of settled expectations invites fierce political and legal resistance from

42. Governor of the State of California, Governor's Health Care Proposal 7 (Jan. 8, 2007), *available at* http://gov.ca.gov/pdf/press/Governors_HC_Proposal.pdf. California Governor Arnold Schwarzenegger proposed to pay for expanded medical coverage in part by pooling current cross-subsidy streams and rechanneling them from hospitals and clinics to support insurance premiums for the less well-off. Health care providers, who receive these cross-subsidies, have fretted about the prospect that they could lose these cross-subsidies and still face a substantial uncompensated care burden, absent the achievement of universal coverage.

stakeholders—resistance that puts reform at risk.

From an emergent systems perspective, getting reform right is more than a matter of preparing the blueprint for the best policy in the abstract. It requires charting a path through networks of political and legal influence. Policies that postpone the prospect of disruption—leaving open multiple, more gradual evolutionary possibilities—will tend to arouse less resistance.

There is, for example, a strong public policy case for ending tax exemption of not-for-profit hospitals upon the advent of universal, comprehensive coverage.⁴³ The prevailing rationale for property and income tax exemption of hospitals has long been that they provide for people unable to pay. Universal coverage would render this rationale obsolete. Elimination of these tax subsidies would make additional state and federal dollars available to support insurance for those unable to afford it. Redirecting public funds from subsidies for hospitals to coverage for the uninsured would both empower patients and better match public spending with clinical need. This all makes sense, at least to us;⁴⁴ yet the not-for-profit hospital sector's resistance to its loss of tax exemption weighs heavily against trying to do so as part of health reform. Exemption, even for hospitals that provide minimal charity care, has become a settled expectation. The industry is reluctant to give up this bird-in-hand. Enactment of universal coverage at either the state or federal level without the non-profit hospital sector's support is difficult to imagine, so the demise of this otherwise unjustifiable subsidy isn't worth demanding. The landscape of health care financing is crisscrossed with subsidy schemes like this one—hard to justify on policy grounds but built into settled expectations to the point that their elimination isn't worth the political cost.

Since the enactment of Medicare and Medicaid, opponents of publicly sponsored universal coverage have displayed a deeper intuitive awareness of the dynamics of emergence than have advocates of health insurance for all. A stunning example

43. M. Gregg Bloche, *Health Policy Below the Waterline: Medical Care and the Charitable Exemption*, 80 MINN. L. REV. 299 *passim* (1995).

44. *But see* Jill R. Horwitz, *Why We Need the Independent Sector: The Behavior, Law and Ethics of Not-For-Profit Hospitals*, 50 UCLA L. REV. 1345, 1408 (2003) (arguing that nonprofit hospitals supply social benefits that merit the tax exemption).

played out in 1993 as congressional Republicans scrambled to prepare for President Clinton's anticipated health care reform juggernaut. Republican Senate and House leaders eyed plausible compromises that might have achieved near-universal coverage with a reduced role for government. These compromises hewed to traditional Republican principles. They would have left open a wide playing field for competition between health plans, minimally restricted by federal regulators.

But conservative strategist William Kristol looked beyond the policy logic of the possible deals, toward the longer-term implications of government-guaranteed coverage.⁴⁵ For Republicans, he intuited, the implications of universal coverage were disastrous.⁴⁶ Enactment of any publicly financed scheme to cover all would rekindle Roosevelt-era confidence in government as guarantor of personal security, undermining the broader Republican case for lower taxes and less government.⁴⁷ Conversely, utter defeat for health care reform on President Clinton's watch would deliver a lasting blow to Americans' belief in government's ability to solve complex social problems—and to confidence in Democrats' ability to deliver on their promises.⁴⁸

In a memo that quickly achieved iconic status among conservatives, Kristol urged Republicans to go all-out to kill health care reform.⁴⁹ "There should be no deals, no carefully nuanced compromises," Kristol argued. "The Clinton plan should come to nothing except disillusionment."⁵⁰ Swayed by Kristol's analysis, House and Senate Republican leaders abandoned compromise alternatives in favor of a scorched-

45. Adam Meyerson, *Kristol Ball: William Kristol Looks at the Future of the GOP*, POL'Y REV, Winter 1994, at 14, 15; Thomas B. Edsall, *Happy Hours*, N.Y. TIMES, Jan. 18, 2007, at A27. In an influential memo, Mr. Kristol wrote: "Any Republican urge to negotiate a 'least bad' compromise with the Democrats, and thereby gain momentary public credit for helping the president 'do something' about health care, should also be resisted. The plan should not be amended; it should be erased." *Id.*

46. Meyerson, *supra* note 45, at x.

47. *Id.*

48. *Id.* at 15.

49. Theda Skocpol, *The Rise and Resounding Demise of the Clinton Plan*, HEALTH AFFAIRS, Spring 1995, at 66, 75–76.

50. *Id.*; Meyerson, *supra* note 45, at x.

earth stance toward health care reform.⁵¹ By the fall of 1994, the Clinton plan had succumbed. Just a few months later, disillusioned voters delivered both houses of Congress to Republicans for the first time in forty years.⁵² Universal coverage disappeared from the national agenda for a decade, during which time the ranks of the uninsured grew by about a million a year. And more than that, Americans maintained their skepticism toward government's ability to transform their lives for the better through grand social policy schemes. Kristol had gotten it right.

Until, that is, 2009. Suddenly, out of sheer terror, as Barack Obama took the presidential oath in January, Americans looked to government with large expectations. Suddenly, as economic catastrophe loomed, Americans saw regulation as an urgent need. During the early months of 2009, pundits suggested that the cost of financial rescue would preclude comprehensive health reform, including universal coverage. But the opposite turned out to be the case. "Tea parties" & "town-hall" shoutfests aside, government's sudden, large involvement in finance—with seemingly successful results (we've avoided a 2nd Great Depression)⁵³—elevated Americans' sense of what the state should attempt, in health care and other spheres.

The reform bills that wended their way through the House and Senate in 2009—and the reform principles promoted by President Obama—displayed an acute sensitivity to the dynamics of emergence.⁵⁴ Their organizing principle was the importance of minimizing disruption of established arrangements and settled expectations. To this end, these proposals left employment-based coverage in place. They pursued universal coverage by expanding Medicaid to reach lower-income Americans not now eligible for these programs

51. Manish C. Shah & Judith M. Rosenberg, *Health Care Reform in the 103D Congress—A Congressional Analysis*, 33 HARV. J. ON LEGIS. 585, 609 (1996).

52. Skocpol, *supra* note 49, at 67.

53. See OFFICE OF THE SPECIAL INSPECTOR GENERAL FOR THE TROUBLED ASSET RELIEF PROGRAM, QUARTERLY REPORT TO CONGRESS: ADVANCING ECONOMIC STABILITY THROUGH TRANSPARENCY, COORDINATED OVERSIGHT AND ROBUST ENFORCEMENT 3 (2009).

54. See Affordable Health Care for America Act, H.R. 3962, 111th Congress (as passed by House, November 7, 2009); America's Healthy Future Act of 2009, S. 1796 111th Congress (2009).

and by subsidizing middle-income Americans' purchase of private insurance. They avoided extending Medicaid and The State Children's Health Insurance Program (SCHIP) to people at income levels within the marketing sights of private insurers. And the subsidies these bills promised for the purchase of private coverage offered a multibillion dollar benefit for insurers. The only likely, near-term "losers" were employers who do not now provide coverage: most of these proposals required employers to choose between offering insurance and paying a tax (or "fee") to support the public subsidies.⁵⁵

These reform plans aimed to build momentum for coverage expansion by leveraging some existing arrangements and minimizing disruption to others. On the other hand, they opened pathways toward long-term, fundamental change.

By establishing insurance exchanges to pool risk (and thereby reduce premiums) for individual insurance purchasers and small employer groups, they created an economically viable alternative to workplace-based coverage. Over time, this alternative purchasing mechanism could eclipse the workplace as America's main source for private insurance. The ability of insurance exchanges to attract large numbers of purchasers and to offer many coverage choices would give them formidable advantages over employment-based plans. Vast purchasing pools could turn these exchanges into the "Amazon.coms" of medical coverage, able to out-perform all but the largest employers on price.

Things *could* play out this way, but, then again, they may not. The bills that advanced through Congress in 2009 leave this question open. They treat the future of employment-based coverage as a thing to be decided in emergent fashion. Its persistence, or demise, will be determined by millions of Americans, acting as best they can to protect their families and themselves, with minimal attention to the policy impact of their choices.

A more provocative possibility is the emergence of "single payer" coverage from these plans. This prospect mobilized the insurance industry—and some other health care

55. See Affordable Health Care for America Act, H.R. 3962, 111th Congress § 412 (as passed by House, November 7, 2009), America's Healthy Future Act of 2009, S. 1796 111th Congress § 1306–1307 (2009).

stakeholders—to oppose the so-called “public option” with a vengeance. If a public plan were to fare better than its rivals in the competition for subscribers—whether because of lower administrative costs, better deals with doctors and hospitals, or other reasons—it could eventually come to overshadow them. This growth could feed back upon itself in positive fashion, by empowering the plan to obtain lower prices from providers, thereby crowding out private competitors. Absent Congressional intervention to limit the public plan’s monopsony power over providers or to otherwise restrain its growth, it could evolve into “single payer” coverage. This long-run outcome—ideal in the eyes of some and nightmarish to others—is hardly foreordained. American antipathy toward government bureaucrats and one-size-fits-all solutions could limit the public plan’s appeal.

Unfortunately, the reform proposals that made their way through Congress in 2009 offered much less to address the long-term growth of medical spending. To be sure, reforms that target administrative costs, the medical tort system, and the myriad inefficiencies in health care delivery have considerable potential to achieve cost reductions. Such reductions “ratchet down” the medical cost curve. But they do little to diminish its long-term, upward slope. If we are to “bend the curve” downward—that is, if we’re to substantially reduce the rate of health care cost growth in the decades ahead—we will need to break free from—or finesse—a political constraint that has so far prevented real progress toward long-term cost-containment.

The constraint is this: weighing clinical benefits against costs and saying no to care that prolongs lives at too great an expense is essential, if we’re to control costs, yet unspeakable in politics and in the marketplace. The “R-word”—rationing—remains taboo. Policy proposals that even suggest the setting of limits, or lay the foundations for it, arouse public ire. The “death panels” kerfuffle during the summer of 2009 underscored this issue’s explosive potential, as did Rush Limbaugh’s claim earlier in the year that the economic stimulus bill passed by Congress in February created a “national health care rationing board.”⁵⁶

56. Lori Robertson, *Doctor’s Orders?*, FactCheck.org, Feb. 20, 2009, <http://www.factcheck.org/2009/02/doctors-orders/> (“Radio host Rush Limbaugh repeated such charges on Feb. 10, telling his listeners that ‘if the cost of your treatment as a seasoned citizen is deemed by the government to be too

Political liberals have shown equal willingness to score points with the “R-word.” They have done so in response to Republican proposals to transform the Medicare entitlement into a fixed-value voucher for the purchase of private health insurance—and in response to proposals to end or cap the tax deductibility of employees’ and employers’ contributions toward health insurance premiums. Industry stakeholders (doctors, drug companies, and others) who stand to lose from limits on medical cost growth have taken similar advantage of this taboo. They’ve attacked limit-setting by both private and public payers as “rationing,” and this has gained them political traction.

So long as society rejects the setting of limits, neither law nor markets can impose it. But changes in law and policy have some potential to nudge us toward greater willingness to weigh costs and benefits at the bedside. A robust program of comparative effectiveness research, greater price transparency, and the tying of insurance co-payment requirements to the clinical value of tests and treatments hold promise in this regard. These strategies are emergent in their orientation: they aim to open pathways toward *cultural* change that would make clinical limit-setting more acceptable.

Creative steps are also possible in the meanwhile, before Americans are culturally ready to say “no” to potentially beneficial care on account of cost. Emergent systems thinking suggests an evolutionary strategy, anchored in people’s different expectations about pricey treatments that are available now and that might arise as medicine advances. Most Americans bristle at being denied today’s state-of-the-art care on account of cost. But they are not angry at doctors or health plans for failing to provide access to the nanotechnologies and micro-electronics of, say, the mid-21st century. They are not upset because they don’t get the care “Dr. McCoy” delivers during cable TV reruns of “Star Trek.” There’s a cost-control opportunity here that doesn’t depend on wide-spread willingness to ration care. If we rein in the development of ever-more-expensive technology that yields small marginal benefits, we can bend the health care cost curve downward without saying “no” to identified patients.

expensive based on how much longer you have to live, then you don’t get treated.”).

We can do so by shrinking the huge premiums we pay doctors and hospitals' for doing invasive, technology-intensive procedures, compared to what we pay them for counseling patients or delivering biologically-powerful but minimally-invasive treatments. This won't save much money now, since doctors' fees are only a small fraction of health spending. But it will diminish doctors' and hospitals' incentives to adopt the clinical interventions that are the main drivers of medical costs—ever more sophisticated technologies that achieve only small clinical benefits.

A concern here is the risk of discouraging real breakthroughs—advances that yield high value, relative to cost. But major breakthroughs tend to result from leaps in *biological* understanding of disease—advances that open the way for elegant, decisive interventions. Penicillin, which destroys bacterial cell walls, is the classic example. A more recent case is the revolution in our understanding of lipid metabolism, which opened the way for development of the statins, drugs taken by millions of Americans to slow the growth of artery-clogging plaque. Therapies that target pathophysiology in such elegant fashion tend to be relatively cheap, once the basic science that undergirds them has been paid for. By contrast, our most costly treatments—those that Lewis Thomas famously termed “half way technologies”⁵⁷ — tend to rest on comparatively crude understandings of the biology of disease. They are, paradoxically marvels of engineering, electronics, and materials science, and of modest, often minimal medical benefit. Examples include drug-coated stents designed to keep atherosclerotic arteries open, high-technology life support, and last-ditch radiation and chemotherapy regimens meant mainly to sustain hope.

Such treatments account for much of the medical spending that occurs in the last months of life. They are expensive because they are both technology-intensive and clinically indecisive. Their inability, in most cases, to make more than a modest therapeutic difference leads, perversely, to their intensive and sustained (rather than one-shot) use. In medicine, as in warfare, decisive victory is cheaper than a drawn-out struggle.

Reducing the rewards available to doctors and hospitals for

57. LEWIS THOMAS, LIVES OF A CELL 31–37 (1975).

adoption of “half-way” technologies will, in turn, diminish investment in efforts to develop them. Venture capitalists and investment bankers will be less likely to take a chance on them. Firms will adjust their research and development budgets accordingly. Unidentified future patients would forgo some therapeutic benefits. But popular ire over denial of beneficial care wouldn’t come into play, since the treatments “withheld” don’t exist. This strategy is emergence-oriented in two ways. First, it exploits openings for relatively modest changes in current law. It seeks out, and aims to exploit, non-linear relationships between legal change and real-world impact. Second, it anticipates actors’ adjustments to changed incentives—and to other actors’ adaptations.

The emergent systems perspective makes sense of the seeming chaos that besets American health law and policy. It cautions us that no single “grand theory” of health care governance will or can triumph over others. It empowers health reformers to develop pragmatic agendas for change by looking for evolutionary possibilities immanent in current law, institutions, politics, and culture. Health law’s fragmentation and incoherence are large obstacles to urgently-needed change. But they reflect the ongoing collision of values and interests that shape the health sphere’s legal governance. Whether we can avert health care’s threat to our nation’s solvency while extending twenty-first century medicine’s benefits equitably to all will turn on our ability to seize the opportunities this collision engenders.