

ARTICLES

Risk Governance and Deliberative Democracy in Health Care

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I argue in this Article that the concept of risk-centered governance is the best theoretical paradigm for understanding health law and the health care system. Over the past twenty years, an insurance-inflected discourse has migrated from the purely financial side of the health system into the heart of traditional medicine—the doctor-patient relationship. Rather than focus on doctrinal strands, I argue that scholars should analyze the law of health care as a set of governance practices organized around managing and allocating financial, as well as clinical, risk.

Over the same period, the body of law that structures most private group health insurance—ERISA—has effectively delegated control of risk pooling and resource allocation to the employers that sponsor group plans. Drawing on a history of ERISA that has not been explored in legal scholarship, I demonstrate how the private welfare state of workplace-based health insurance has evolved into the creation of what amounts to corporate sovereignty in controlling access to health coverage. The discourse of managing risk bonds these two components of health law and the health care system: patient care and access to coverage.

From a normative perspective, the greatest problem is a democracy deficit. I propose recognizing the function and power of health insurance risk pools by openly politicizing them as more democratic entities. Treating insurance risk pools as potential mechanisms of governance, rather than merely as actuarial units, would illuminate a wealth of questions with deep political implications: 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 sufficient to produce a risk allocation system that is equitable, as well as efficient and flexible. The Article builds on the egalitarian potential of social insurance as a technology of governance, and argues for filling a gap that exists not only in the current system, but also in all proposals for reform.

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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 year¹ merits serious

1. According to the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services, total health care expenditures for 2007 are projected to reach \$2.3 trillion. CTRS. FOR MEDICARE AND MEDICAID SERVS., U.S. DEP’T OF HEALTH AND HUMAN SERVS., NAT’L HEALTH

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 better paradigm for health law.

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 compose 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

EXPENDITURE PROJECTIONS 2006–2016 tbl.1, <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2006.pdf> (last visited May 24, 2008).

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 FOREST L. REV. 391, 404 (2006) (“If a specter 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. See 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.

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 insurance law; and finally, to propose new, experimentalist structures within a risk-governance model that 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 have 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 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. Contrary to most scholars, I argue that the proper way to remedy the inequities produced by current law is not by curbing ERISA preemption 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 dual dimensions: the financial risk of providing and paying for health care and the clinical risk of illness and death. Neither category is new to health care. What has changed dramatically has been the relative importance of and interpenetration between these two dimensions of risk.

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 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, section I.A defines that term and argues that a discourse of risk managerialism is the driving force behind governance in our contemporary health care system. Section I.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

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 & Jonathan Simon, *Embracing Risk*, in *EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY* 1, 11 (Tom Baker & Jonathan Simon eds., 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 we are 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 study of “what kinds of risk knowledge moves are made by the various participants in particular legal networks, and with what legal, social and epistemological effects.” Mariana Valverde et al., *Legal Knowledge of Risks*, in *LAW AND RISK* 86, 87 (Law Comm’n of Can. ed., 2005). This Article offers a response to Valverde, in the context of health law.

knowledges that support the practice of actuarial medicine and exposes the normative issues underlying the system.⁴

A. GOVERNANCE THROUGH A DISCOURSE OF RISK MANAGERIALISM

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 circular rather than subject-verb-object unidirectional, networked rather than hierarchical, and multi-dimensional beyond the state, encompassing nonjuridical zones such as market forces or culture.⁷ Governing, in this sense, is comprehensive and multidimensional; it is “to structure the possible field of action of others.”⁸

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

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); 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.

5. See generally Nan D. Hunter, “Public-Private” *Health Law: New Directions in Public Health*, 10 J. HEALTH CARE L. & POL’Y 89 (2007) (describing governance and governmentality theories both generally and specifically within health care).

6. Colin Gordon, *Governmental Rationality: An Introduction*, in THE FOUCAULT EFFECT: STUDIES IN GOVERNMENTALITY 1, 2 (Graham Burchell et al. eds., 1991) (quoting Michel Foucault).

7. See Hunter, *supra* note 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. 3 MICHEL FOUCAULT, *The Subject and Power*, in POWER: ESSENTIAL WORKS OF FOUCAULT, 1954–1984, at 326, 341 (James D. Faubion ed., 2000).

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 87 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 while a private accreditation organization provides the most significant oversight for hospitals.¹⁴ Statutory authority in forty-one states and the District of Columbia permits private sector judging companies to run the appeal systems for the denial of private or public system health insurance coverage.¹⁵

In these myriad ways, the fusion of public and private 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 is a natural fit.

9. See ALAN HUNT & GARY WICKHAM, *FOUCAULT AND LAW: TOWARDS 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) (book review).

10. Medicare covers slightly more than 44 million persons. See [StateHealthFacts.org](http://www.statehealthfacts.org/comparemactable.jsp?ind=290&cat=6), Total Number of Medicare Beneficiaries, 2008, <http://www.statehealthfacts.org/comparemactable.jsp?ind=290&cat=6> (last visited May 24, 2008). Medicaid covers just under 43 million. See [StateHealthFacts.org](http://www.statehealthfacts.org/comparemactable.jsp?ind=201&cat=4), Monthly Medicaid Enrollment, Dec. 2006, <http://www.statehealthfacts.org/comparemactable.jsp?ind=201&cat=4> (last visited May 24, 2008). Both numbers include more than six million “dual eligibles,” persons enrolled in both programs, an overlap structured so that the Medicaid program pays Medicare premiums for persons who qualify for Medicare but lack the funds to pay the premiums. See <http://facts.kff.org/chart.aspx?cb=50&sctn=136> (last visited Aug. 8, 2008).

11. See ALLEGRA N. KIM, CAL. RESEARCH BUREAU, *FEDERAL TAX INCENTIVES FOR HEALTH INSURANCE* 1–4 (2007), available at <http://www.library.ca.gov/crb/07/02/07-002.pdf>; see also U.S. CONG., JOINT COMM. ON TAXATION, *PRESENT LAW AND ANALYSIS RELATING TO THE TAX TREATMENT OF HEALTH SAVINGS ACCOUNTS AND OTHER HEALTH EXPENSES* (2006), available at <http://www.house.gov/jct/x-27-06.pdf>. In 2004, the total federal and state tax subsidy for employment-based coverage amounted to just under \$210 billion. See John Sheils & Randall Haught, *The Cost of Tax-Exempt Health Benefits in 2004*, *HEALTH AFF.*, w4-109 exh.1 (Feb. 25, 2004), <http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.106v1>.

12. 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, 1346–48 (2003).

13. See ROBERT I. FIELD, *HEALTH CARE REGULATION IN AMERICA: COMPLEXITY, CONFRONTATION, AND COMPROMISE* 22–24 (2007).

14. See *id.* at 44–46; see also Eleanor D. Kinney, *Private Accreditation as a Substitute for Direct Government Regulation in Public Health Insurance Programs: When Is It Appropriate?*, 57 *L. & CONTEMP. PROBS.*, Autumn 1994, at 47, 54–55.

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

If we think of governance metaphorically as a kind of epistemological meta-technology,¹⁶ 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.¹⁷

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 alters 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.¹⁸ His description of “a synthesis of principles of economics, statistics, probability, and decision theory [to be] applied to the complex and uncertain problems of medical decision making”¹⁹ 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 to minimize financial risk for providers. That story was yet to come. Rather, his objective was to increase the cost-effectiveness of medical care.²⁰ But his argument was of a piece with those beginning to be made by one of his Stanford colleagues, David Eddy, whose work drove the movement for evidence-based medicine: the claim that statistical analysis of outcomes should drive clinical decisions.²¹ Evidence-based medicine has spawned a cultural revolution within the profession, one that is still under attack from many physicians as “cookbook medicine.”²²

16. I use this phrase to mean a broadly conceptual mechanism for framing our understanding of how systems and institutions function and toward what ends.

17. See STEELE, *supra* note 3, at 6–7, 18–20; Francois Ewald, *Norms, Discipline and the Law*, 30 REPRESENTATIONS, Spring 1990, at 138, 142–44.

18. See Alain C. Enthoven, *Shattuck Lecture—Cutting Cost Without Cutting the Quality of Care*, 298 NEW ENG. J. MED. 1229 (1978).

19. *Id.* at 1236.

20. *Id.* at 1229.

21. See, e.g., MICHAEL L. MILLENSON, DEMANDING MEDICAL EXCELLENCE: DOCTORS AND ACCOUNTABILITY IN THE INFORMATION AGE 49–50, 128–36, 336–40 (1997).

22. See Trisha 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

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 have the norms changed for the responsible patient, who is now expected to do her part for the greater good by consuming health care prudentially. One aspect of the doctrine of moral hazard is that insurers seek to minimize pooling those risks which individuals can control.²³ The civic duty of self-management 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.²⁴

B. THE RISE OF ACTUARIAL MEDICINE

1. Material Bases

A number of factors gave rise to risk managerialism as the dominant discourse of governance in our health care system. The primary causes were the hyperinflation 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 delivery systems, 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 1970s, but it was worse in health care than in other sectors. Annual gross expenditure levels in medical care began to spike in the late 1970s, producing a rate of inflation that was a multiple of the inflation in other sectors.²⁵ These cost increases affected

PRACTICE OF MEDICINE 206 (2006) (defending the role of statistical studies in clinical judgment). The impact on the profession has spread beyond the United States. See MICHAEL POWER, *THE AUDIT SOCIETY: RITUALS OF VERIFICATION* 104–09 (1997) (describing the adoption of “clinical audit” systems by Britain’s National Health Service).

23. In general, moral hazard refers to the incentive provided by insurance to engage in actions that, without insurance, one would be reluctant to take. Insurers thus prefer to offer policies protecting against risks over which an insured lacks control rather than those which an insured can decide to assume. CAROL A. HEIMER, *REACTIVE RISK AND RATIONAL ACTION: MANAGING MORAL HAZARD IN INSURANCE CONTRACTS* 9, 149–50 (1985).

24. One of countless possible examples would be a newspaper advertisement by an insurance company exhorting readers “to be healthier in mind and body” and “to change your life for the better and the good.” See Sarah Nettleton, *Governing the Risky Self: How to Become Healthy, Wealthy and Wise*, in FOUCAULT: HEALTH AND MEDICINE 207, 207 (Alan Peterson & Robin Bunton eds., 1997). The health narrative fits into a long history of insurance companies relying on eligibility criteria that turn on the good or bad “characters” of those applying for coverage. See Tom Baker, *Insuring Morality*, 29 *ECON. & SOC’Y* 559, 561 (2000); Brian J. Glenn, *The Shifting Rhetoric of Insurance Denial*, 34 *LAW & SOC’Y REV.* 779, 785 (2000).

25. The inflation rate in the medical sector compared to the overall U.S. inflation rate was 8.7% versus 5.5% from 1980 to 1985; 7.5% versus 4.0% from 1985 to 1990; and 6.3% versus 3.1% from 1990 to 1995. See André Hampton, *Resurrection of the Prohibition on the Corporate Practice of Medicine: Teaching Old Dogma New Tricks*, 66 *U. CIN. L. REV.* 489, 502 n.78 (1998). As Henry Aaron and Joseph Newhouse pointed out, it is important to note that “inflation” can be a misleading term with

not only payers of health care (primarily insurance companies), but also purchasers of health insurance, such as employers. From 1976 to 1988, the cost of employer-sponsored insurance (ESI) doubled.²⁶ After a pause in the mid-1990s, the sharp upward spiral in costs has resumed.²⁷ Between 2002 and 2007, the cumulative growth in health insurance premiums was seventy-eight percent, far outstripping rates of inflation and wage growth.²⁸

How situations are defined, of course, establishes the parameters for what kinds of policy responses “make sense.” The economics-oriented experts who had “outlived, outtheorized, and outmaneuvered” those who saw the health care system more in political or social welfare terms²⁹ framed “the health polity as a sector of the economy.”³⁰ 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. Both payers and purchasers, in both public and private sectors, embarked on a series of initiatives designed to curb costs.³¹

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.³² An early byproduct of those efforts was utilization

regard to health care because, although medical sector expenses have unquestionably shot up, the data do not tell us how much of the increase is attributable to inflationary prices for essentially the same product and how much reflects increased prices for increased quality. See HENRY J. AARON, SERIOUS AND UNSTABLE CONDITION: FINANCING AMERICA'S HEALTH CARE 41–42 (1991) (quoting in part Joseph Newhouse).

26. Thomas Bodenheimer & Kevin Grumbach, *The Reconfiguration of U.S. Medicine*, 274 JAMA 85, 87 (1995).

27. John K. Iglehart, *Changing Health Insurance Trends*, 347 NEW ENG. J. MED. 956, 957 (2002); Bradley C. Strunk et al., *Tracking Health Care Costs*, HEALTH AFF., ¶ 9 & exh.1 (Sept. 26, 2001), <http://content.healthaffairs.org/cgi/content/full/hlthaff.w1.39v1/DC1> (showing that the rate of increase in health care spending dropped below the growth rate in gross domestic product during 1994–1997, but outpaced it in subsequent years).

28. KAISER FAMILY FOUND. & HEALTH RESEARCH AND EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2007 ANNUAL SURVEY 18, 19 exh.1.1 (2007), available at <http://www.kff.org/insurance/7672/upload/76723.pdf>.

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

30. *Id.* at 489.

31. See *id.* at 495; see also Bodenheimer & Grumbach, *supra* note 26; Peter Swenson & 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, 609–10 (2002).

32. In the fee-for-service system, insurers deferred to the certification by providers that the treatments and services that they had provided were medically necessary and reimbursement followed. See

review—the calculation of the number and nature of treatments prescribed, by patient and by physician.³³ Data from utilization reviews 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 future provision of services. 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 1990s 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 primary physicians who function as “gatekeepers” for referrals to specialists 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 percent 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 health maintenance organizations (HMOs) constituted only a small segment of

MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS & ECONOMICS OF RATIONING MECHANISMS 66–67 (1997). This is not to say, of course, that physicians had no awareness of the financial incentives that were created by the indemnity method of reimbursement. See Deborah A. Stone, *The Doctor as Businessman: The Changing Politics of a Cultural Icon*, 22 J. HEALTH POL. POL'Y & L. 533, 534 (1997) (arguing that “the role of money in the doctor-patient relationship” has long been controversial).

33. A typical definition of utilization review is the following, taken from the Maine Department of Insurance: “[a] program used in managed care plans . . . [involving reviews of] the necessity, use, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities.” Maine Bureau of Insurance, Glossary of Insurance Terms, <http://www.maine.gov/pfr/insurance/glossary.htm>.

34. See Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1652–54 (1992).

35. See, e.g., *Wickline v. California*, 239 Cal. Rptr. 810, 811 (Ct. App. 1986).

36. PETER D. JACOBSON, STRANGERS IN THE NIGHT: LAW AND MEDICINE IN THE MANAGED CARE ERA 8 (2002).

37. See Bodenheimer & Grumbach, *supra* note 26, at 87–88; JACOB S. HACKER, THE ROAD TO NOWHERE: THE GENESIS OF PRESIDENT CLINTON'S PLAN FOR HEALTH SECURITY 14–15 (1997).

38. See R. Adams Dudley & Harold S. Luft, *Managed Care in Transition*, 344 NEW ENG. J. MED. 1087, 1087 (2001).

the options used.³⁹ 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 most common approach.⁴⁰ “Capitation” refers to the practice by which 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.⁴¹

Down-streaming of financial risk to providers through capitation systems was generally paired with down-streaming of utilization management.⁴² 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.⁴³

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.⁴⁴ Scaling up, networks of these providers, including hospitals, formed.⁴⁵ 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 management, is the single most important development in the contemporary organization of medicine.”⁴⁶

As provider entities and networks grew larger, some sought to maximize their revenue and control by cutting out the managed care organization (MCO)

39. HMOs are one form of managed care organization. They are more tightly structured and more closely regulated than other forms. See GEORGE D. POZGAR, *LEGAL ASPECTS OF HEALTH CARE ADMINISTRATION* 412 (8th ed. 2003).

40. See Thomas Rice, *Financial Incentives as a Cost-Control Mechanism in Managed Care*, in *THE PRIVATIZATION OF HEALTH CARE REFORM: LEGAL AND REGULATORY PERSPECTIVES* 99, 103 (M. Gregg Bloche ed., 2003).

41. See *id.* at 101.

42. See Alice A. Noble & 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. *Id.*

44. In 1983, 75.8% of physicians were self-employed, including 40.5% in solo practices; 24.2% were employees of managed care or other organizations. In 1999, the self-employed figure had dropped to 61.8%, with only 28.4% in solo practice. The percentage of physicians who were employees had risen by more than 50%, to 38.2%. The trend is even more pronounced among new practitioners. See Dudley & Luft, *supra* note 38, at 1089. Another study examined the number of physicians who practiced either alone or with one other physician, and found that there was a decrease from 40.7% in 1996–1997 to 32.5% in 2004–2005. See Allison Liebhaber & Joy M. Grossman, *Physicians Moving to Mid-Sized, Single-Specialty Practices*, 18 *CTR. FOR STUDYING HEALTH SYS. CHANGE TRACKING REPORT 1* Fig.1 (Aug. 2007), available at <http://www.hschange.com/CONTENT/941/941.pdf>.

45. See JAMES C. ROBINSON, *THE CORPORATE PRACTICE OF MEDICINE: COMPETITION AND INNOVATION IN HEALTH CARE* 211 (1999).

46. *Id.* at 91.

completely and directly offering their own managed care products.⁴⁷ 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.⁴⁸ And as a surge of such networks declared bankruptcy,⁴⁹ state insurance commissioners began to wrestle with whether or how to classify *medical* practitioners as *insurers* for purposes of establishing criteria for solvency and rate-setting.⁵⁰

2. Actuarial Medicine

Specific financing arrangements in managed care are, of course, “constantly adapting and changing,” and “‘bedside’ rationing” incentives “vary in their intensity.”⁵¹ But by the mid-1990s, all three of the economic dynamics I describe above—massive cost increases, 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.”⁵² In today’s health care system, the merger of coverage and care decisionmaking 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 decisionmaking process.”⁵³

The goal of actuarial fairness is central to insurance. It requires the accurate pricing of risk, so that an insurer charges each group or 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.⁵⁴ The bedrock philosophy underlying insurance law is to facilitate the achievement of actuarial fairness.⁵⁵

47. See Bodenheimer & Grumbach, *supra* note 26, at 88–89; Dudley & Luft, *supra* note 38, at 1088.

48. The American Medical Association (AMA) 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, 32 (1995).

49. See Brant S. Mittler & André 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, 563–67 (2003).

50. See ROBINSON, *supra* note 45, at 232; 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, 267 (1996). In 1995, the National Association of Insurance Commissioners issued guidelines for the regulation of such arrangements under state insurance codes. *Id.* For a case study of how one state used its regulatory powers to cope with medical practices assuming financial risk, see Mittler & Hampton, *supra* note 49, at 572–77.

51. Noble & Brennan, *supra* note 42, at 292.

52. The term “actuarial medicine” has not previously been used in legal scholarship.

53. Kleinke, *supra* note 4, at 1457.

54. See KENNETH S. ABRAHAM, *DISTRIBUTING RISK: INSURANCE, LEGAL THEORY, AND PUBLIC POLICY* 83–89 (1986).

55. See Karen A. Clifford & Russel P. Iuculano, *AIDS and Insurance: The Rationale for AIDS-Related Testing*, 100 *HARV. L. REV.* 1806, 1809–12 (1987).

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 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 which has foundational importance in the health care and health law system: it is the measure for whether treatments and services are covered by health insurance contracts. But while almost endless variations exist for the meaning of this key phrase,⁵⁶ what many of them share is an allowance for the consideration of cost. In a comprehensive review of statutes and case law, health services research literature, industry documents, and 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.⁵⁷ 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 of, 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 decisionmaking point can slide along a scale of multiple actors who are involved at different points in treatment and coverage determinations. Risk—both clinical and finan-

56. A team of researchers from George Washington University reviewing the literature found dozens of different definitions in legal and extra-legal sources. See SARA ROSENBAUM ET AL., DEP'T OF HEALTH & HUMAN SERVS., *MEDICAL NECESSITY IN PRIVATE HEALTH PLANS: IMPLICATIONS FOR BEHAVIORAL HEALTH CARE* 45–63, 66–69 (2003). In addition to the materials covered by the Rosenbaum study, federal law allows the insurance companies that act as fiscal intermediaries or contractors in the Medicare system to define what is medically necessary in varying ways. See Timothy P. Blanchard, *Medicare Medical Necessity Determinations Revisited: Abuse of Discretion and Abuse of Process in the War Against Medicare Fraud and Abuse*, 43 ST. LOUIS U. L.J. 91, 102 (1999). State Medicaid programs employ yet additional definitions. See, e.g., TENN. CODE ANN. § 71-5-144 (West 2007). Yet other definitions emerged from the settlement of a class action brought by physicians who alleged that insurers misrepresented their payment policies in violation of RICO. Each of the major insurance companies settled on terms that included both definitions of "medically necessary" and special arbitration systems for resolving disputes. See, e.g., CAL. MED. ASS'N., *HEALTH NET SETTLEMENT OVERVIEW 1* (2005), available at <http://www.cmanet.org/upload/FinalSettlementOverviewHealthNet.pdf>.

57. ROSENBAUM ET AL., *supra* note 56, at 7, 26.

cial—is constantly being negotiated and renegotiated, assumed and shifted, in the interactions that identify what counts as medically necessary.

C. THE ARCHITECTURE OF KNOWLEDGES

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 knowledges created by the health care system.

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.

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.

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 multiprovider 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 decade⁶³—guidance protocols for physicians to use in deciding upon a course of treatment⁶⁴—illustrates how various disciplinary regimes

58. See ROBINSON, *supra* note 45, at 115.

59. See, e.g., AARON, *supra* note 25, at 31–33; ABRAHAM, *supra* note 54, at 91.

60. See Arnold J. Rosoff, *Evidence-Based Medicine and the Law: The Courts Confront Clinical Practice Guidelines*, 26 J. HEALTH POL. POL'Y & L. 327, 328 (2001).

61. See William M. Sage, *Enterprise Liability and the Emerging Managed Health Care System*, 60 LAW & CONTEMP. PROBS., Spring 1997, at 159, 204–05.

62. See J. Rosser Matthews, *Practice Guidelines and Tort Reform: The Legal System Confronts the Technocratic Wish*, 24 J. HEALTH POL. POL'Y & L. 275, 279–83 (1999).

63. See Lars Noah, *Medicine's Epistemology: Mapping the Haphazard Diffusion of Knowledge in the Biomedical Community*, 44 ARIZ. L. REV. 373, 417–18 (2002).

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." COMM. TO ADVISE THE PUB. HEALTH SERV. ON CLINICAL PRACTICE GUIDELINES, INST. OF MED., CLINICAL

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 entities⁶⁷ all aligned in their support for the development of CPGs and participated in the development of 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

Even without any explicit intervention by or interaction with a court, CPGs are effectively enforced simply through the contract terms between physicians and payers. They serve a disciplinary function through a norming effect. The widespread presence of such guidelines creates pressure for physicians to conform to what are promoted as “best” clinical practices.⁷²

PRACTICE GUIDELINES: DIRECTIONS FOR A NEW PROGRAM 38 (Marilyn J. Field & Kathleen N. Lohr eds., 1990) [hereinafter CLINICAL PRACTICE GUIDELINES].

65. When Congress created the Agency for Health Care Policy and Research (AHCPR) in 1987, the agency's primary mission was to use outcomes research to produce national guidelines for common medical procedures. See Matthews, *supra* note 62, at 282. One can now view hundreds of guidelines through the agency's website. (AHCPR was renamed the Agency for Health Research and Quality.) Agency for Health Research and Quality, Clinical Practice Guidelines, <http://www.ahrq.gov/clinic/cpsix.htm> (follow “National Guideline Clearinghouse” hyperlink).

66. The Institute of Medicine issued a laudatory report on CPGs in 1990, CLINICAL PRACTICE GUIDELINES, *supra* note 64, and dozens of professional societies have issued their own guidelines. See 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. See *id.* at 651–52.

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. REFORM 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. See Belkin, *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; fewer courts have allowed their use by plaintiffs to establish a breach of the standard of care. See Andrew L. Hyams et al., *Medical Practice Guidelines in Malpractice Litigation: An Early Retrospective*, 21 J. HEALTH POL. POL'Y & L. 289, 295–96 (1996); see also Noah, *supra* note 63, at 462–63.

70. See, e.g., David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893, 990 (2005) (endorsing judicial reliance on CPGs in malpractice litigation); Mello, *supra* note 66, at 708–10 (opposing); William R. Trail & Brad A. Allen, *Government Created Medical Practice Guidelines: The Opening of Pandora's Box*, 10 J.L. & HEALTH 231, 251–58 (1996) (endorsing their use only as an affirmative defense).

71. Hyams et al., *supra* note 69, at 292.

72. See Valverde, *supra* note 3, at 93 (describing best-practices guides as “normalizing knowledge formats” (internal quotation marks omitted)).

In response to various forms of public pressure, insurers have recently loosened the strictness of the direct financial incentives placed on physicians.⁷³ At the same time, however, the reliance on CPGs has dramatically increased. The percentage of physicians reporting that treatment guidelines had a “moderate” to “very large” impact on their practices increased by ten points from 1997 to 2001, to 56.2% of all physicians and 60.7% of primary care doctors.⁷⁴ As with the more obvious financial incentives, the CPGs are likely to induce slower, but perhaps more entrenched, norm change over time.⁷⁵

From the confluence of these economic, technological and intellectual developments, a common managerial discourse centered on risk now dominates health care. Increasing sophistication of statistics-based technologies of knowledge facilitates risk-allocation decisions that are at once both more precise and effective, and less obviously intrusive, than the cruder mechanisms of earlier stages of managed care. The distribution of financial risk in the health care system, once set and relatively stable (that is, a physician provides the service and gets paid), is now continuously evolving. And physicians, care-giving institutions, financiers of care, and, increasingly, patients⁷⁶ all participate in these evolving decisions.

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 Part, 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. Section II.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. Section II.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

73. See Mark A. Hall, *The Death of Managed Care: A Regulatory Autopsy*, 30 J. HEALTH POL. POL'Y & L. 427, 441–43 (2005); Bradley C. Strunk & James D. Reschovsky, *Kinder and Gentler: Physicians and Managed Care, 1997–2001*, 5 CTR. FOR STUDYING HEALTH SYS. CHANGE TRACKING REPORT (Nov. 2002), available at <http://www.hschange.com/CONTENT/486/486.pdf>.

74. Strunk & Reschovsky, *supra* note 73, at 3–4.

75. Cf. Arti K. Rai, *Health Care Fraud and Abuse: A Tale of Behavior Induced by Payment Structure*, 30 J. LEGAL STUD. 579, 583–85 (2001) (explaining the role of financial incentives in changing physician behavior).

76. Insurers stung by the cost in goodwill from the backlash against managed care increasingly 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, *supra* note 45, at 83–87.

field,⁷⁷ speakers described health law as “not yet a coherent field of law . . . [but] rather, a disjointed set of statutes and doctrines,”⁷⁸ one with “rules [that] come flying from all directions with no one taking the trouble to make them consistent,”⁷⁹ and haunted by “the specter of exhaustion” caused by the recycling of two intellectually spent explanatory paradigms: patient autonomy and market theory.⁸⁰

Efforts to redeem this “substantive cacophony”⁸¹ have emerged intermittently since the early 1980s, when the American Society of Law and Medicine commissioned a task force to review the teaching of health law.⁸² 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.⁸³ In other doctrinal categories of law as well, judicial recognition of the particularity of the physician’s role has created exceptions to general legal principles, cumulatively forming a zone of unique law.⁸⁴ 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 of health-care-related entities.⁸⁵ 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

77. Symposium, *Rethinking Health Law*, 41 WAKE FOREST L. REV. 341 (2006).

78. Einer R. Elhauge, *Can Health Law Become a Coherent Field of Law?*, 41 WAKE FOREST L. REV. 365, 365 (2006).

79. Carol A. Heimer, *Responsibility in Health Care: Spanning the Boundary Between Law and Medicine*, 41 WAKE FOREST L. REV. 465, 466 (2006).

80. *Rethinking Health Law*, *supra* note 77.

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

82. See 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 (1985).

83. See BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS, AND PROBLEMS 195–97 (5th ed. 2004).

84. See, e.g., *Kitzmiller v. Henning*, 437 S.E.2d 452, 454 (W. Va. 1993) (duty of confidentiality); *Stigliano v. Connaught Labs., Inc.*, 658 A.2d 715, 720 (N.J. 1995) (duty to testify about treatment rendered to patient).

85. See Barry R. Furrow, *From the Doctor to the System: The New Demands of Health Law*, 14 HEALTH MATRIX 67, 69–80 (2004).

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.⁸⁶

In light of these changes, academic debate has stalemated about which of three centers of gravity best define the core of health law today: the doctor-patient relationship, economics, or regulation. No adherent of any theory denies the existence of the forces highlighted by the other theories; rather, the debate centers on how best to 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,⁸⁷ centered on the “relational web” between provider and patient.⁸⁸ 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.⁸⁹

The second candidate for intellectual dominance is the economics approach that emphasizes the role of health law in facilitating private market forces.⁹⁰ 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.⁹¹ Critics counter the economics-centered worldview by invoking physicians’ professional norms of compassion and rescue to counter a solely economic analysis.⁹²

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

86. See Jeffery Boyd & Lauren Kelley, *Health Law 2000: Regulation, Litigation, or Stagnation?*, 15 HEALTH AFF. 31, 33 (1996).

87. Hall, *supra* note 81, at 357–62.

88. Mark A. Hall & Carl E. Schneider, *Where Is the “There” in Health Law? Can It Become a Coherent Field?*, 14 HEALTH MATRIX 101, 103 (2004).

89. See generally CARL SCHNEIDER, *THE PRACTICE OF AUTONOMY: PATIENTS, DOCTORS, AND MEDICAL DECISIONS* 9–32 (1998); Janet L. Dolgin, *The Evolution of the “Patient”: Shifts in Attitudes About Consent, Genetic Information, and Commercialization in Health Care*, 34 HOFSTRA L. REV. 137 (2005).

90. See generally CLARK C. HAVIGHURST, *HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH CARE REFORM* (1995).

91. See generally Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963).

92. See M. Gregg Bloche, *The Invention of Health Law*, 91 CAL. L. REV. 247, 303 (2003).

to health care and the need to control costs.⁹³ 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.⁹⁴ Second, there is deep social ambivalence about whether health care should be considered a public good or a commodity.⁹⁵ 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 the core of legal regulation of the health care system. 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.⁹⁶ A major proponent of this approach, Einer Elhauge, has argued for a “comparative paradigm analysis”⁹⁷ 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.⁹⁸ But this approach essentially consists of a decisionmaking 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 composed of the state, the

93. See generally Rand E. Rosenblatt, *Health Care Reform and Administrative Law: A Structural Approach*, 88 YALE L.J. 243 (1990).

94. See generally PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982).

95. See generally NORMAN DANIELS, *JUST HEALTH CARE* (1985).

96. See Elhauge, *supra* note 78.

97. *Id.* at 379.

98. See *id.* at 384–86.

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 nonetheless deeply connected, public and private institutions of collective risk allocation and management. Understanding health law as a discourse that reacts to and facilitates the flow of practices and policies that address financial risk, and how it interacts 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.⁹⁹

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 decisionmaking.¹⁰⁰

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.¹⁰¹ Performance data about individual doctors and hospitals could conceivably be incorporated into the consent process as well.¹⁰² Patient advocacy groups are seeking access to the Medicare database that contains detailed billing information from thousands of

99. See *Blum v. Yaretsky*, 457 U.S. 991, 1005 (1992) (finding no state action when the decision of a private nursing home had the effect of reclassifying level of Medicaid services); see also Clyde W. Summers, *The Privatization of Personal Freedoms and Enrichment of Democracy: Some Lessons from Labor Law*, 1986 U. ILL. L. REV. 689.

100. See *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir. 1972); Joan H. Krause, *Reconceptualizing Informed Consent in an Era of Health Care Cost Containment*, 85 IOWA L. REV. 261, 267–68 (1999).

101. *Shea v. Esenstein*, 107 F.3d 625, 629 (8th Cir. 1997) (ERISA fiduciary duty includes obligation to disclose financial incentive when advising patient not to seek specialist care). In many states, statutes impose disclosure requirements on health plans. See Tracy E. Miller & William M. Sage, *Disclosing Physician Financial Incentives*, 281 JAMA 1424, 1427 & n.33 (1999); see also, e.g., *Neade v. Portes*, 710 N.E.2d 418, 425–27 (Ill. App. Ct. 1999). See generally Bloche, *supra* note 92, at 271–74; Krause, *supra* note 100, at 346–61; David Mechanic & Mark Schlesinger, *The Impact of Managed Care on Patients' Trust in Medical Care and Their Physicians*, 275 JAMA 1693, 1694 (1996).

102. See *Johnson v. Kokemoor*, 545 N.W.2d 495 (Wis. 1996) (holding surgeon liable in part for not informing patient that he had not previously performed the procedure to which the patient consented); see also Aaron D. Twerski & Neil B. Cohen, *The Second Revolution in Informed Consent: Comparing Physicians to Each Other*, 94 NW. U. L. REV. 1 (1999).

providers in order to publish performance evaluations of those physicians.¹⁰³

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 a system for 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.¹⁰⁴ 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 population health increasingly turn on broad distributive questions. Mapping the dynamics of financial risk in both systems can offer the possibility of greater coherence between the two.

The same potential for transcending conceptual boundaries 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 in its financing mechanisms and its under-inclusiveness.¹⁰⁵ Yet, multiple national systems are grappling with how to meld processes for coverage determinations with quantitative models for budgeting and risk assessment.¹⁰⁶ Whatever the differences in the structures of various national systems, American and other health officials are encountering many of the same cross-cutting issues related to financial management—a shared concern 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 the Introduction have introduced instability into the legal concept of fiduciary duty.

103. *See, e.g.*, *Consumers Checkbook v. Dep’t of Health and Human Servs.*, 502 F. Supp. 2d 79 (D.D.C. 2007).

104. LAWRENCE O. GOSTIN, *PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT* 3–5 (2000).

105. *See* JACOB S. HACKER, *THE DIVIDED WELFARE STATE: THE BATTLE OVER PUBLIC AND PRIVATE SECTOR BENEFITS IN THE UNITED STATES* 7 (2002).

106. *See* TIMOTHY STOLTZFUS JOST, *HEALTH CARE COVERAGE DETERMINATIONS: AN INTERNATIONAL COMPARATIVE STUDY* 1–5 (2005).

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.¹⁰⁷ Its origins lay in the Hippocratic Oath's injunction that physicians shall enter houses only for the benefit of the ill, and not for personal gain, and it is reflected today also in the Declaration of Geneva and the ethics code of the British General Medical Council.¹⁰⁸ A fiduciary duty has also long been present in tort and contract principles in traditional health law.¹⁰⁹

But, in actuarial medicine today, a physician's fiduciary duty has essentially been ERISA-fied. ERISA is the statute that effectively regulates private sector health insurance.¹¹⁰ 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 medical concept of fiduciary duty¹¹¹—hence resulting in what I call the colonization of fiduciary duty by risk governance.

ERISA establishes fiduciary responsibilities for the persons or entities charged with the oversight and administration of an employee benefit plan.¹¹² 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

107. See, e.g., Jerome P. Kassirer, *Managing Care—Should We Adopt a New Ethic?*, 339 NEW ENG. J. MED. 397, 398 (1998). See generally JACOBSON, *supra* note 36, at 222–25.

108. See National Library of Medicine, *The Hippocratic Oath*, http://www.nlm.nih.gov/hmd/greek/greek_oath.html (last visited May 25, 2008); see also Declaration of Geneva: Physician's Oath, <http://www.cirp.org/library/ethics/geneva> ("The health . . . of my patient will be my first consideration . . .") (last visited May 25, 2008); General Medical Council, *Good Medical Practice* (2006), http://www.gmc-uk.org/guidance/good_medical_practice/duties_of_a_doctor.asp ("Make the care of your patient your first concern.") (last visited May 25, 2008).

109. See *supra* note 84; see also *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 466, 469 (Cal. 1990); Mary Anne Bobinski, *Autonomy and Privacy: Protecting Patients from Their Physicians*, 55 U. PITT. L. REV. 291, 349 n.211 (1994). Courts will sometimes simply make flat statements that a fiduciary duty exists between physician and patient, indicative of a kind of judicial notice of the fiduciary relationship, without requiring evidence or citing to authority. See, e.g., *Lockett v. Goodill*, 430 P.2d 589, 591 (Wash. 1967). Marc Rodwin has argued that the concept of doctors as fiduciaries for their patients is "a dominant metaphor" in health law, but that courts enforce it in only limited circumstances. See Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J.L. & MED. 241, 242 (1995).

110. ERISA governs all employee benefit plans in the private sector, including health insurance as well as pensions. See 29 U.S.C. § 1002(1) (2000). For a history of how it evolved to become such a critical component of health law, see *infra* notes 148–62 and accompanying text.

111. "ERISA's fiduciary duty provisions do not readily accommodate the professional norm of fidelity to individual patients." M. Gregg Bloche & Peter D. Jacobson, *The Supreme Court and Bedside Rationing*, 284 JAMA 2776, 2778 (2000).

112. See 29 U.S.C. § 1002(21)(A) (2000).

beneficiaries.¹¹³ Trust fiduciary duty attaches to the *fund* itself, and requires that the trustee exercise prudence in approving and rejecting any claims made on the fund.¹¹⁴ 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.¹¹⁵

The primary motivation for ERISA was to provide new rules for the solvency, disclosure policies, vesting rules, and administration of pension plans.¹¹⁶ 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.¹¹⁷ 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, sometimes contradictory goals—to provide health care benefits to their employees but also to control costs through managed care frameworks.

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. Herdrich*,¹¹⁸ 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, fifty miles away. Before the eight days were over, Herdrich's appendix ruptured, causing peritonitis.¹¹⁹

Herdrich sued Pegram and the HMO for medical malpractice and state law fraud.¹²⁰ Pegram and the HMO responded by arguing that ERISA preempted those claims and removed the case to federal court. Herdrich then asserted her own ERISA claim by arguing that Pegram and the HMO violated their fiduciary

113. See 29 U.S.C. § 1104(a)(1)(A) (2000); see also *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110–11 (1989).

114. AUSTIN WAKEMAN SCOTT ET AL., 3 SCOTT AND ASCHER ON TRUSTS § 17.8, at 1215–1220 (2006).

115. *Id.* § 17.15, at 1257–62.

116. See *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 510 (1981) (finding that Congress was concerned with workers actually receiving rights which had vested).

117. See 29 U.S.C. § 1002(1) (2000).

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

119. *Id.* at 215.

120. The plaintiff's first strategy was to plead only state law claims and avoid ERISA, doubtless because of the very limited remedies available under ERISA. There are no provisions for economic or non-economic damages in ERISA, only a right to restitution of the benefit. 29 U.S.C. § 1132 (2000 & Supp. 2005).

duties under ERISA. Her theory was that the terms of the HMO rewarded its physician owners for limiting medical care, and thus “created an incentive to make decisions in the physicians’ self-interest, rather than the exclusive interests of plan participants.”¹²¹

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.]”¹²² The Court concluded they were not.¹²³

The Court ruled that an HMO’s fiduciary duty under ERISA applied only to coverage decisions regarding benefits to be provided under a plan.¹²⁴ 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.¹²⁵

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 insurers¹²⁶ and stated that for any HMO structure, “there must be rationing and inducement to ration.”¹²⁷ 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.”¹²⁸

121. *Pegram*, 530 U.S. 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 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.

122. *Id.* at 214.

123. *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.

124. *Id.* at 237.

125. *Id.* at 211, 237. The Court suggested that physicians could still be held 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 224.

126. *Id.* at 219.

127. *Id.* at 221.

128. *Id.* at 232–33. The Court declined to undertake an assessment of whether the structure of the 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 under-treatment and the amount of expenditures to be allocated for health care. *See id.* Such an analysis, the Court said, was for the legislature to make. *See id.*

Regarding physicians, the Court noted that “the incentive of the HMO physician . . . to give treatment sparingly” cannot be easily overcome.¹²⁹ 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.¹³⁰ 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.”¹³¹ Allowing such claims would be wasteful and unnecessary as simply duplicative of medical malpractice claims.¹³²

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.¹³³ 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.¹³⁴

The difference between the two standards is that a medical malpractice standard is not intrinsically in conflict with a doctor’s concern about either her own income or cost-benefit calculations as to an insurance fund. Under reasonable and customary medical practice standards today, treating physicians could opt for the least expensive choice among what can reasonably be 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.¹³⁵

This result may well constitute acceptable health policy. My point is not to contest or analyze its utility as policy. Rather, it is simply to highlight how the Court’s legal conclusion regarding fiduciary duty under ERISA was shaped by

129. *Id.* at 234–35.

130. *See id.* at 235.

131. *Id.*

132. *Id.*

133. *See* Gail B. Agrawal, *Resuscitating Professionalism: Self-Regulation in the Medical Marketplace*, 66 *Mo. L. REV.* 341, 359–62 (2001) (distinguishing between an allowance for some consideration of the expense of different treatments and allocating resources across populations).

134. For a similar argument as to the distinction between fiduciary and malpractice standards in the context of informed consent law, see Bobinski, *supra* note 109, at 343–44.

135. *Cf.* William M. Sage, *UR Here: The Supreme Court’s Guide for Managed Care*, 19 *HEALTH AFF.* 219, 222 (2000) (characterizing the Court’s decision in *Pegram* as “render[ing] irrelevant” the distinction between ERISA’s duty of loyalty and the professional standard for physician loyalty to a patient’s interest).

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 on, concerns related to forms of financial risk that could create a significant drain on an insurance fund and negatively affect the physician's income.

The Court implicitly reaffirmed the primacy of risk governance in shaping health law doctrine in *Aetna Health Inc. v. Davila*.¹³⁶ There, plaintiffs sued an MCO for denying approval of various treatment recommendations that their physicians, who would be reimbursed by the MCO, had made.¹³⁷ The plaintiffs sued the MCO under a Texas statute that created tort liability for the failure to exercise "ordinary care in making health care treatment decisions."¹³⁸

The Fifth Circuit concluded that the MCO's denials of authorization for assertedly medically necessary services were "mixed eligibility and treatment decisions" and hence, pursuant to *Pegram*, were not fiduciary decisions covered by ERISA.¹³⁹ On that reasoning, the Fifth Circuit concluded that the state law claim was not preempted by ERISA and could proceed.¹⁴⁰

The Supreme Court reversed.¹⁴¹ The Court 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*. That is, a decision about whether a treatment was medically necessary would be considered a medical decision for purposes of liability only if made by a treating physician. When made by MCO reviewing staff, as in *Davila*, such a decision would be treated as a coverage decision subject to ERISA standards.¹⁴²

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 decision was to deny care.

136. See *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004).

137. *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 illnesses that would have been averted had the original recommendations been accepted. See *id.*

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

139. See *id.* at 206.

140. See *id.*

141. See *id.* at 204.

142. The practical ramification of this classification was the sharp curtailment of potential relief for plaintiffs. See *supra* note 120.

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."¹⁴³ 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 involving medical judgments are, just as much as any other benefits determinations, actions by plan fiduciaries."¹⁴⁴ This includes "even determinations based extensively on medical judgments."¹⁴⁵ 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—that is, insurance law—preempted any other legal remedy for failure to act reasonably in making the medical/coverage decision. In other words, the financial stability concerns animating ERISA preemption trumped.

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

In the Introduction to this Article, I made the claim for understanding risk governance as dominating health care today, with the concomitant rise of actuarial medicine. In Part I of the Article, 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

143. *Davila*, 542 U.S. at 219.

144. *Id.* at 220.

145. *Id.*

private health insurance risk in the United States, has been influenced by considerations of risk governance. In section III.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 both judicial and 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 in various employment settings. As we now know, the assumption that such a state of affairs would continue has proven not to be true, given the sharp decrease in union membership levels.

In section III.B, I describe how the Supreme Court’s interpretations of ERISA’s explicit and implicit preemption 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.

Finally, in section III.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 preemption 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 for so long as health insurance is tied to employment. My proposal in Part IV could be revised to achieve the same goal of deliberative democracy in health care were the United States to shift away from employer-sponsored plans and towards a single-payer system.

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*,¹⁴⁶ President Truman seized the coal mines to prevent a national strike over health insurance benefits.¹⁴⁷ 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.¹⁴⁸ Campaigns for health coverage that had been preserved, or sometimes expanded, by governmental action during the

146. *Youngstown Sheet & Tube Co. v. Sawyer*, 343 U.S. 579 (1952).

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

148. See JENNIFER KLEIN, *FOR ALL THESE RIGHTS: BUSINESS, LABOR, AND THE SHAPING OF AMERICA’S PUBLIC-PRIVATE WELFARE STATE* 178, 213–17 (2003).

war¹⁴⁹ spread rapidly through the economy when the war ended.¹⁵⁰

The ideological drive to incorporate health insurance into the workplace harmonized with the “industrial self-government” paradigm that dominated labor law at the time.¹⁵¹ 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.¹⁵² The infrastructure and rules of arbitration created by the CBAs substituted for the infrastructure and rules of the judiciary that existed in the parallel, traditional governmental state.¹⁵³

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.¹⁵⁴ 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.¹⁵⁵ The tax exemption for employee health benefits thus not only created a fiscal incentive

149. After Truman seized the mines, the Secretary of the Interior signed an agreement with the president of the United Mineworkers Workers (UMW) 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. *See id.* at 198; MUNTS, *supra* note 147. For a discussion of the UMW’s efforts after 1946, see MUNTS, *supra* note 147, at 29–47.

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

151. *See* *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 Wezel Stone, *The Post-War Paradigm in American Labor Law*, 90 *YALE L.J.* 1509, 1511–15 (1981). 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. *See Inland Steel Co. v. Nat’l Labor Relations Bd.*, 170 F.2d 247, 250–51, 254–55 (7th Cir. 1948), *cert. denied*, 336 U.S. 960 (1949). The Supreme Court’s denial of review effectively killed further litigation by employers arguing that health insurance benefits were not within the scope of collective bargaining. *See* KLEIN, *supra* note 148, at 231–32.

152. The CBA functioned as “essentially an instrument of government.” Archibald Cox, *Reflections upon Labor Arbitration*, 72 *HARV. L. REV.* 1482, 1492 (1959).

153. *See id.*

154. GARBARINO, *supra* note 150, at 22; MUNTS, *supra* note 147, at 33–35, 51.

155. STARR, *supra* note 94, at 334. Classifying health benefits as not part of compensation began as a temporary measure during World War II when wage controls were in effect. *See* FIELD, *supra* note 13, at 77–78.

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 1950s, 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.¹⁵⁶ Unions and employers fought over who would sponsor the health insurance plans. Employers saw advantages in seizing “the moral high ground” by initiating insurance benefits.¹⁵⁷ When the United Auto Workers (UAW) sought a jointly controlled health benefits plan in 1947, General Motors refused on the ground that health insurance should be considered solely a management prerogative.¹⁵⁸

Regardless of who sponsored the health plans, many union leaders believed that providing such plans for workers was advantageous for unions because it created a powerful bond between a union and its members. This was either because the union sponsored the plan itself (as several unions did)¹⁵⁹ or because the union would get credit for securing the benefit for its members from the employer.¹⁶⁰ In 1957, twenty-five percent of employees with health insurance were enrolled in a plan over which their union exercised some degree of control.¹⁶¹ As a result, union political support for a government-centered, national health coverage system diminished.¹⁶²

Tensions arose between management and labor with regard to whether an employer-sponsored plan had a duty to share fiscal information with the union.¹⁶³ In addition, instances of financial abuses by both labor and management of increasingly hefty health insurance and pension funds arose.¹⁶⁴ Congress re-

156. GARBARINO, *supra* note 150, at 1–2.

157. KLEIN, *supra* note 148, 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, *supra* note 148, at 210–11, 221–23, 239–40.

158. *See* Alan Derickson, *Health Security for All? Social Unionism and Universal Health Insurance*, 80 J. AM. HIST. 1333, 1350 (1994).

159. *See* KLEIN, *supra* note 148, at 188. In a number of industries, unions still sponsor and administer the health insurance plans. *See* GOTTSCHALK, *supra* note 157, at 44–53. In those instances, it is union-selected agents that are responsible for resolving disputes when a worker asserts that she was improperly denied coverage of a medical service recommended by her physician. *See, e.g.*, *Jones v. Laborers Health & Welfare Trust Fund*, 906 F.2d 480, 482 (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.”).

160. Union leaders believed that the plans provided “an important sense of identity and cohesion for union members who may have few other real attachments.” GOTTSCHALK, *supra* note 157, 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 148, at 197–99.

161. *See* GARBARINO, *supra* note 150, at 7, 19.

162. *See* Derickson, *supra* note 158, at 1356.

163. *See* KLEIN, *supra* note 148, at 224–26, 237.

164. *See id.* at 247; MUNTS, *supra* note 147, at 107–08.

sponded with the Welfare and Pension Plans Disclosure Act in 1958.¹⁶⁵ As even greater portions of overall employee compensation continued to pour into benefits, however, political demands grew for a more systematic and thorough policing of the funds.¹⁶⁶

The capstone to this reform movement was the enactment of ERISA.¹⁶⁷ 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 1960s.¹⁶⁸ Labor unions joined with business interests to support its enactment, largely because of the strength of their shared desire to avoid state regulation.¹⁶⁹ According to James Wooten, the effect was so profound that “preemption issues *created* the coalition that pushed ERISA through Congress.”¹⁷⁰

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 1980s,¹⁷¹ and today has reached a low-water mark of 7.4% of private industry workers.¹⁷² Second, health care costs were still relatively modest in 1974; the upward spike of medical sector inflation was imminent, but had not yet occurred.¹⁷³ Third, contingent on the first two, it was still plausible in 1974 to imagine that non-union employers

165. 72 Stat. 997, 999–1000 (repealed 1976); *see also* KLEIN, *supra* note 148, at 250–53; JAMES A. WOOTEN, *THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974: A POLITICAL HISTORY* 45–49, 81–83 (2004).

166. The single, most-powerful triggering event mobilizing demand for further reform was the default of the Studebaker-Packard Pension Plan in the early 1960s. *See* WOOTEN, *supra* note 165, at 51–79.

167. “ERISA represented the culmination of the disclosure act struggle . . .” KLEIN, *supra* note 148, at 261.

168. 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.” *See* WOOTEN, *supra* note 165, at 1. President Ford scheduled the signing ceremony for Labor Day, to highlight its “really . . . historic” importance. *See id.*

169. *See id.* at 7–8; Daniel M. Fox & Daniel C. Schaffer, *Semi-Preemption in ERISA: Legislative Process and Health Policy*, 7 AM. J. TAX POL’Y 47, 51 (1988); James A. Wooten, *A Legislative and Political History of ERISA Preemption, Part 2*, 14 J. PENSION BENEFITS 5, 10 (2007). Pro-union advocates routinely sought to reinforce federal power: Archibald Cox noted in 1954 that “[l]abor union lawyers are the strongest advocates of federal preemption, both in court and before congressional committees.” Archibald Cox, *Federalism and the Law of Labor Relations*, 67 HARV. L. REV. 1297, 1302 (1954). Catherine Fisk suggested that “some in Congress may have believed that making employee benefits an area of exclusive federal concern [through ERISA preemption] was merely the first part of a new phase in the construction of the American welfare state.” Catherine L. Fisk, *Lochner Redux: The Renaissance of Laissez-Faire Contract in the Federal Common Law of Employee Benefits*, 56 OHIO ST. L.J. 153, 163 (1995).

170. Wooten, *supra* note 169, at 10 (emphasis added).

171. 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).

172. News Release, Bureau of Labor Statistics, *Union Members in 2006*, at 1 (Jan. 2007), <http://www.bls.gov/news.release/pdf/union2.pdf>.

173. *See supra* text accompanying notes 25–28.

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.¹⁷⁴

As we now well know, global labor competition soon turned the tables, so that massively expensive health benefits have become the albatross of employers.¹⁷⁵ Health insurance terms of coverage have become a frequent source of give-backs in labor negotiations,¹⁷⁶ employer sponsorship of health insurance plans has decreased rather than increased,¹⁷⁷ and, in a deeply ironic twist on history, GM has offloaded a portion of its health insurance benefits obligation to the UAW.¹⁷⁸

Supreme Court decisions interpreting provisions of ERISA premised on these assumptions have been blind to how those assumptions have changed. The Court has rigidly adhered to 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, without any acknowledgment that collective bargaining itself had largely disappeared. Scholars, too, have overlooked the dramatic changes in workplace governance in critiques of how the courts have interpreted ERISA.

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 preemption provision has 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" by recognizing the dual realms of state and national government.¹⁷⁹ More modestly, the convergence of

174. See GOTTSCHALK, *supra* note 157, at 48–49, 116.

175. See Swenson & Greer, *supra* note 31, at 620–21; Eduardo Porter, *Cost of Benefits Cited as Factor in Slump in Jobs*, N.Y. TIMES, Aug. 19, 2004, at A1.

176. See, e.g., Corey Kilgannon, *Union Dissidents Say Transit Leader Gave Away Too Much*, N.Y. TIMES, Jan. 3, 2006, at B2.

177. See GOTTSCHALK, *supra* note 157, at 126–27; Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2007 Current Population Survey*, 310 EMPLOYEE BENEFIT RESEARCH INSTITUTE ISSUE BRIEF 4 (2007) (reporting that percentage of nonelderly population with employment-based insurance fell from 64.4% in 1994 to 62.2% in 2006); KAISER FAMILY FOUND. & HEALTH RESEARCH AND EDUCATIONAL TRUST, *supra* note 28 (60% of employers offered health benefits in 2007, compared to 69% in 2000; among firms with three to nine employees, the offer rate fell from 57% to 45%).

178. 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. See Sholnn Freeman & Frank Ahrens, *GM, Union Agree on Contract to End Strike*, WASH. POST, Sept. 27, 2007, at A1.

179. See *U.S. Term Limits, Inc. v. Thornton*, 514 U.S. 779, 838 (1995).

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 section, 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).¹⁸⁰

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,"¹⁸¹ 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 preemption jurisprudence appears less as a vacuum than as a *delegation*, specifically the delegation of effective regulatory power to employers.

A fundamental reality of the American health system is its voluntary baseline: employers may choose to offer health insurance, but they are not required to do so. If an employer decides to offer health insurance, ERISA establishes the framework for 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 ERISA framework empowers employers. Employers determine who is covered, how, and what the parameters of coverage will be.¹⁸² Employers also establish the mechanisms for deciding disputes over whether particular benefits are covered within the terms of the plan.¹⁸³ 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.

One can imagine a legal system 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 regulation. But

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

181. Justice Ginsburg has now taken up the point. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 222 (2004) (Ginsburg, J., concurring).

182. *See Lockheed Corp. v. Spink*, 517 U.S. 882, 887 ("Nothing in ERISA requires employers to establish employee benefits plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan.").

183. *See* 29 C.F.R. § 2560.503-1 (2001).

that is not the model for employers today. ERISA occupies the field for private sector workplace health insurance plans because of and through its preemption provisions.¹⁸⁴

1. The ERISA Accordion of “Relates to” Preemption

A three-set process that I call the “ERISA accordion” sets the bounds of ERISA’s explicit “relates to” preemption clause. The three steps are found in section 514 of the statute, 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”¹⁸⁵ 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 that would be preempted by ERISA.

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 relieve any person from any [State law] which regulates insurance”¹⁸⁶ The savings clause thus contracts the preemptive power of ERISA to fit only the space *not* occupied by state laws which regulate insurance. Since enactment of the McCarran-Ferguson Act in 1945,¹⁸⁷ regulation of insurance has been left almost entirely to state government.¹⁸⁸ The savings clause preserves this allocation of authority to the states.

In the third step, the accordion widens again to reinstate preemption 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”¹⁸⁹

Self-insured plans, therefore, enjoy the full benefits of ERISA preemption. 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

184. At the last minute, congressional conferees included a broad federal preemption clause to stave off multiple state standards. See WOOTEN, *supra* note 165, at 256, 258–59. The preemption 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.

185. 29 U.S.C. § 1144(a) (2000).

186. *Id.* § 1144(b)(2)(A).

187. 59 Stat. 34 (1945).

188. See *Prudential Ins. Co. v. Benjamin*, 328 U.S. 408, 429–31 (1946) (finding that the congressional purpose behind enactment was to “give support to . . . state systems for regulating . . . the business of insurance”).

189. 29 U.S.C. § 1144(b)(2)(B).

aside by the employer for paying benefits under the program.¹⁹⁰ 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.¹⁹¹

The movements of an accordion 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 preemption clause began, therefore, the Supreme Court had to pick its way—with little legislative guidance—through questions such as whether “relates to” should be given its broadest construction¹⁹² or whether a state law had to specifically mention or allude to EBPs in order to trigger “relates to” preemption.¹⁹³ 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.¹⁹⁴ 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 Preemption

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.”¹⁹⁵ The relief provided for in section 502 does not include any consequential or non-economic damages for the denial of a benefit under the plan. There is also no provision in the remedies section of ERISA that explicitly preempts other state-law remedies that could be used for conduct that violates ERISA.

Through case law, however, the Supreme Court has created a remedies preemption in ERISA that is separate and distinct from the law’s explicit accordion preemption provision. The Court has inferred remedies preemption

190. See Self-Insurance Institute of America, Inc., Self-Insured Group Health Plans, <http://www.siaa.org/i4a/pages/index.cfm?pageid=3339> (last visited May 25, 2008).

191. See, e.g., *FMC Corp. v. Holliday*, 498 U.S. 52, 65 (1990) (preempting state law prohibiting subrogation of the payment of the proceeds from a tort action to an insurer where the plan was self-insured); *NGS Am., Inc. v. Barnes*, 805 F. Supp. 462, 475–76 (W.D. Tex. 1992) (holding that ERISA preempted Texas statute which imposed regulations, fees, and taxes upon self-funded ERISA plans and their administrators).

192. See *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96–97 (1983). 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.

193. *Id.* at 98.

194. *Id.* at 104–05.

195. 29 U.S.C. § 1132(a)(9) (2000).

largely from a House-Senate Conference Report on ERISA.¹⁹⁶ The Conference Report states that suits to enforce benefit rights under ERISA are to be regarded solely as federal question claims, in the same way as suits asserting violations of the terms of a collective bargaining agreement are viewed as federal question claims that are preempted by section 301 of the Labor-Management Relations Act.¹⁹⁷ The catalyst for this statement appears to have been vigorous lobbying by representatives of organized labor, who sought to preserve the terms of their CBAs, including the establishment of arbitration panels for disputes arising under the CBA, from encroachment by state regulation.¹⁹⁸

In using ERISA's legislative history to infer an implied preemption of state law remedies for the denial of benefits under an ERISA governed plan, however, the Supreme Court never questioned the appropriateness of transplanting a preemption 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 rewrote 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.

3. The Evolution of ERISA's Two Forms of Preemption

The dynamics behind ERISA preemption have shifted in opposite directions for the two forms of preemption under ERISA. 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 preemption, finding that the preemption inquiry should begin with a presumption *in favor of* state laws regulating health care.¹⁹⁹ 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.²⁰⁰

During the same period, however, the Court has refused to budge from its broad application of remedies preemption, leading to the paradox that the implicit form of preemption under ERISA is now more powerful than the statute's explicit preemption command. This has not resulted from 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

196. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54–56 (1987).

197. H.R. REP. NO. 93-1280, at 327 (1974), as reprinted in 1974 U.S.C.C.A.N. 4639, 5107.

198. See Fox & Schaffer, *supra* note 169.

199. *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654–55 (1995).

200. 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 factors derived from the McCarran-Ferguson statute previously used to define insurance. 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 preempted by ERISA. *Id.* at 330.

risk governance. One particularly important actor that has influenced the Court to place sensitivity to financial risk allocation policy at the heart of its ERISA jurisprudence has been the Office of the Solicitor General.

The literalism in readings of ERISA's accordion preemption began in 1983 with the first ERISA preemption case concerning health benefits to reach the Supreme Court: *Shaw v. Delta Air Lines, Inc.*²⁰¹ *Shaw* involved a New York anti-discrimination statute that required employers to treat pregnancy the same as other health conditions.²⁰² Among the policies affected by the New York state law were health benefits plans covered by ERISA. 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,"²⁰³ the Court relied on the "breadth . . . apparent from [the] language" of section 514's preemption clause.²⁰⁴ 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 reference to such a plan."²⁰⁵

The brief filed by the Solicitor General's office in *Shaw* influenced the Court's analysis of congressional intent with regard to ERISA. The Court identified Congress's desire to accommodate an employer's interest in avoiding "conflicting or inconsistent State and local regulation of [EBPs]" as a major part of the purpose behind ERISA.²⁰⁶ The Solicitor General's brief stressed that goal, twice driving home the point that shielding employers from variances in state laws was intended by Congress "to foster the development of benefits plans."²⁰⁷

The Solicitor General's brief framed ERISA itself in negative terms, as a law placing significant burdens on employers, and suggested that broad preemption was the compensation for such burdens: "Sensitive to the fact that the private benefit plan system is voluntary on the part of employers, Congress determined to lessen the disruptive effect of the new federal law by saving plans from possibly inconsistent or duplicative state laws."²⁰⁸ The Solicitor General thus implicitly 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

201. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983).

202. Congress adopted the Pregnancy Discrimination Act (PDA) after the litigation began but prior to the Court's decision. Although ERISA did not preempt 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. *See id.* at 92-93.

203. 29 U.S.C. § 1144(a) (2000).

204. *Shaw*, 463 U.S. at 96.

205. *Id.* at 97.

206. *Id.* at 105 n.25.

207. Brief for the U.S. as Amicus Curiae Supporting Respondents at 17, *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983) (No. 81-1578).

208. *Id.* at 22.

from voluntarily sponsoring any health benefit plans.²⁰⁹

In *Pilot Life Insurance Co. v. Dedeaux*,²¹⁰ 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 preempted a Mississippi common law right of action for 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.²¹¹ During oral argument, after an extended colloquy with the Justices about whether an insured “could get [any] money” if an insurer persisted in stonewalling on payment,²¹² counsel for Pilot Life pressed a point raised by Justice White: that large punitive damages awards “would also raise insurance premiums substantially.”²¹³ Although there was no legislative history on this precise point, counsel reasoned that “in ERISA Congress had that concern . . . these plans are voluntary, nobody 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.”²¹⁴

The Court in *Pilot Life* recognized, for the first time, that ERISA’s system of remedies created its own powerful force for preemption without an explicit textual base.²¹⁵ The source for this new doctrine, which became an independent basis for preemption,²¹⁶ was the amicus brief filed by then Solicitor General Charles Fried.²¹⁷ 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.”²¹⁸ This language frames the interests as those of individual enrollees versus the broader need to entice employers to offer benefits. All intimations of employee collective bargaining or industrial self-government were gone.

By the time *Pegram v. Herdrich* reached the Court thirteen years later,²¹⁹ the Justices had developed a very clear-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

209. *See id.* at 28.

210. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

211. *Id.* at 43–44.

212. Transcript of Oral Argument at 9–10, *Pilot Life*, 481 U.S. 41 (1987) (No. 85-1043).

213. *Id.* at 14.

214. *Id.*

215. *Pilot Life*, 481 U.S. at 57 (describing ERISA’s enforcement and remedies provisions as the “most important[.]” consideration in the Court’s preemption analysis).

216. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 208–09 (2004).

217. *Pilot Life*, 481 U.S. at 52.

218. *Id.* at 54.

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

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.²²⁰ Two years later, in *Rush Prudential HMO, Inc. v. Moran*, the Court described ERISA policy as “inducing employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards.”²²¹

The existence of ERISA’s deemer clause, the third step of the ERISA accordion, supports the inference that Congress intended to protect discretionary management of risk. The deemer clause of the ERISA accordion explicitly treats some workplace plans differently. If a plan self-insures, that is, 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 preemption state laws that “regulate insurance”—simply does not apply to self-insured plans.²²² 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.²²³ 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 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 employer benefit plans (EBPs) that will remain subject to state laws regulating insurance, and those that will gain the benefit of complete preemption, is the goal of facilitating corporate governance organized around allocation of risk.

Contrary to some other scholars, 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 increased expenses directly caused by state rate-setting laws will not justify the

220. 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,” *id.* 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.

221. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002).

222. See *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990).

223. Justice Blackmun noted the apparent illogic, but deferred to ERISA’s explicit declaration of a distinct category. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 746–47 (1985).

“relates to” preemption²²⁴ and that benefits expensed from general company assets (such as vacation pay) rather than from an insurance fund cannot be considered part of an EBP under ERISA.²²⁵ Mere cost reduction associated with employee benefits has not been enough to cause the Court to defer to management decisions.

Rather it is the unpredictability of potential damages, especially punitive damages, that distinguishes the function of the implied but more powerful remedies preemption doctrine from the explicit guidance for preemption found in section 514. Indeed, the fears associated with out-of-control punitive damages have spawned a new branch of due process jurisprudence.²²⁶ Capital markets in the managed care industry also overreact to risk associated with litigation.²²⁷ 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 increases in corporate costs, but rather to the danger that a health insurance/care system based on voluntary actions by employers could crater and crash.

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 unpredictable financial risk. The greater receptivity to big business demands occurred during long stretches of Republican control of Congress and of the Executive Branch, which brought an unsurprising conservatism of the federal judiciary. But such receptivity continued largely without interruption during the Clinton Administration as well,²²⁸ and has been reflected in mostly unanimous decisions by the Supreme Court.²²⁹ The Supreme Court’s *sub silentio* policymaking has also been implicitly ratified by the absence of major alterations to ERISA by either of the political branches of the federal government.²³⁰

Today, after dozens of decisions, there is no mystery about the division of power. Bluntly put, the regulatory power of states over health care policy

224. N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 662 (1995) (“Cost uniformity almost certainly is not an object of pre-emption.”).

225. Massachusetts v. Morash, 490 U.S. 107, 115–16 (1989).

226. See, e.g., State Farm Mut. Auto Ins. Co. v. Campbell, 538 U.S. 408, 419–29 (2003) (noting that jury award of punitive damages may violate guarantee of procedural due process if excessive).

227. See M. Gregg Bloche & David M. Studdert, *A Quiet Revolution: Law as an Agent of Health System Change*, 23 HEALTH AFF. 29, 36–38 (2004).

228. Had President Clinton’s proposal for health care reform been enacted, of course, the changes would have been enormous: for example, employees who are not now covered would have been incorporated into regional health insurance alliances and certain minimum criteria would have applied to the package of benefits offered through workplace health insurance. See HACKER, *supra* note 37, at 124–27.

229. *Pilot Life, Pegram*, and *Davila* were all decided without dissents.

230. Modest changes to enhance portability and to require issuance of small group plans (with no caps on cost) emerged from enactment of the Health Insurance Portability and Accountability Act, 29 U.S.C. § 1161 (1994). In addition, regulations issued in 1998 reformed some of the procedural problems in the process for appealing denials of claims. See 29 C.F.R. § 2560.503-1 (2001).

involving workplace health insurance exists only when it is least likely to infringe on an employer's discretion to control and predict financial risk.²³¹ 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.²³² Using ERISA federalism, the Court has delegated 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 preemption doctrine for health insurance benefits (and there are virtually no defenders in the academy) argue for repealing or weakening the law's preemptive impact.²³³ I disagree. There are significant costs to the current system of employer-based health insurance and the ERISA preemption that shields such insurance from state regulation.²³⁴ I see no need to rehearse those well-developed arguments here. My claim, simply, is that critics of ERISA preemption have failed to explore and consider possible legitimate interests that might be served by strong preemption in the federal law, interests that might ultimately prove useful in achieving

231. 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 MCOs as the balance of power in the health care system has shifted. See JACOBSON, *supra* note 36, at 177–78. 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.

232. 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 significant. Enforcement of ERISA preemption provisions produced a massive undercutting of state government policymaking at the intersection of two traditionally state domains: insurance regulation and the police power of the state to regulate the health care system. See Michael S. Greve & Jonathan Klick, *Preemption in the Rehnquist Court: A Preliminary Assessment*, 14 SUP. CT. ECON. REV. 43, 50–53 (2006); Roderick M. Hills, Jr., *Against Preemption: How Federalism Can Improve the National Legislative Process*, 82 N.Y.U. L. REV. 1, 51–53 (2007); Samuel Issacharoff & Catherine M. Sharkey, *Backdoor Federalization*, 53 UCLA L. REV. 1353, 1376–80 (2006); Caleb Nelson, *Preemption*, 86 VA. L. REV. 225, 227–29 (2000).

233. See, e.g., Donald T. Bogan, *Protecting Patient Rights Despite ERISA: Will the Supreme Court Allow the States to Regulate Managed Care?*, 74 TUL. L. REV. 951, 1023–25 (2000); Henry H. Drummonds, *The Sister Sovereign States: Preemption and the Second Twentieth Century Revolution in the Law of the American Workplace*, 62 FORDHAM L. REV. 469, 543–52 (1993); James E. Holloway, *Revisiting Cooperative Federalism in Mandated Employer-Sponsored Health Care Programs Under the ERISA Preemption Provision*, 8 QUINNIPIAC HEALTH L.J. 239, 286–87 (2005); Edward A. Zelinsky, *Travelers, Reasoned Textualism, and the New Jurisprudence of ERISA Preemption*, 21 CARDOZO L. REV. 807, 863–70 (1999).

234. See Richard Briffault & Sherry Glied, *Federalism and the Future of Health Care Reform*, in THE PRIVATIZATION OF HEALTH CARE REFORM: LEGAL AND REGULATORY PERSPECTIVES 49, 65–71 (M. Gregg Bloche ed., 2003).

better equity in the current system.

In this section, therefore, I offer a partial defense of the system of the triple sovereignty (but without granting all prerogatives to management) that ERISA preemption has established. My argument is that it is worthwhile to illuminate progressive interests that might be served by workplace federalism. Such interests might then 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, I theorize corporate entities as resembling a functional hybrid of national and state governments, comprising some of the benefits of each. For example, allowing an employer with workers in multiple states to avoid conflicting state regulations permits that organization to capture the benefits of a national market and facilitates rational large-scale planning. 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.²³⁵

At the same time, the multiplicity of employers also serves some of the functions of the multiple states, a la Jeffersonian local autonomy and decentralized democracy. Although each organization 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 uniform workplace benefits structure that might leave employees without any power, through exit and mobility, to seek a job with a different set of benefits.²³⁶

Corporate sovereignty thus mimics the advantages associated with the powers

235. See THE FEDERALIST NO. 11 (Alexander Hamilton); THE FEDERALIST NO. 22 (Alexander Hamilton).

236. The common interests of an employer and employees in strong corporate sovereignty, at least in unionized workplaces where there is not a democracy deficit, was strikingly evident during oral argument in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985), 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. In that case, 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 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].

Transcript of Oral Argument at 6, *Metropolitan Life Ins.*, 471 U.S. 724 (1985) (No. 84-325). 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.

Id. at 7.

of states in a system of federalism. And the disadvantages of strong corporate sovereignty are similar to the disadvantages of state governments that are too strong in a system of federalism. If federal law exempts many EBPs from regulation centered in the geopolitical jurisdiction in which particular groups of workers live, that permits employers to trigger significant negative externalities for that locale. For example, 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.²³⁷

And, continuing the metaphor, just as in federalism debates about governmental jurisdictions, 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. And 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.²³⁸

Of course, the corporate-state analogy is imperfect. Obviously employers are not subject to the direct democratic control that, however incompletely, 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 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 not irrational along either legal or cultural dimensions.²³⁹

237. See, e.g., *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 183–84 (4th Cir. 2007). These externalized costs are the primary reason states struggle against ERISA preemption, as they seek to regulate access and cost in ways that can encompass persons in private employment-based insurance.

238. See JILL QUADAGNO, *ONE NATION UNINSURED: WHY THE U.S. HAS NO NATIONAL HEALTH INSURANCE* 146–49 (2005); Robert Galvin & Arnold Milstein, *Large Employers' New Strategies in Health Care*, 347 *NEW ENG. J. MED.* 939 (2002); SHARON SILOW-CARROLL & TANYA ALTERAS, *COMMONWEALTH FUND, VALUE-DRIVEN HEALTH CARE PURCHASING: FOUR STATES THAT ARE AHEAD OF THE CURVE* (Aug. 2007), http://www.commonwealthfund.org/usr_doc/1052_Silow-Carroll_value-driven_purchasing.pdf.

239. As I noted at the outset, this is only a partial defense of workplace federalism. Apart from the costs that have already been outlined by various commentators, see *supra* note 232, *infra* notes 244, 245, ERISA federalism affects political dynamics in health policymaking in negative ways. Large employers obviously have tremendous influence in Congress. As a practical matter, no reform of the

The free rein given to employers by ERISA's strong pre-emptive power provides independence to employers for crafting risk-governance approaches, including making decisions that affect the delivery of health services and quality improvement. Health policy writ small is thus effectively being enacted in localized laboratories of workplaces throughout the country. The question I want to turn to is the following: if these local laboratories were infused with democratic processes, could this corporate power be leveraged in a manner that would achieve more equitable results—both on a local and a national level?

IV. THE DEMOCRACY DEFICIT IN HEALTH CARE

In the current state of health insurance governance writ large, the American public lacks any significant input into the politics of risk distribution. There is no structure today that meaningfully engages citizens in grappling with questions of access and cost in health care. As a result, democratic engagement with health policy lacks both depth and a mechanism for active participation.

There are several recent examples of the American electorate engaging with health care issues. Among these have been the public's demand for health care reform fueled by insecurity about access to coverage;²⁴⁰ the longstanding aversion to what voters believe amounts to "socialized medicine"²⁴¹; and the populist backlash against managed care entities and insurers in the 1990s.²⁴²

But the public's engagement with health policy tends to be episodic and its understandings shallow. For example, the widespread populist backlash against the most stringent managed-care-cost-control mechanisms led to a surge of state legislation in the late 1990s.²⁴³ This backlash is probably best understood as a

health insurance/care system will go forward without significant employer 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 preempted by ERISA. *See Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 183 (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 preempted by ERISA. *See id.* at 198. 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. *See* Sidney D. Watson et al., *The Road from Massachusetts to Missouri: What Will It Take for Other States To Replicate Massachusetts Health Reform?*, 55 U. KAN. L. REV. 1331, 1331–32 (2007). 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*, 49 WM. & MARY L. REV. 229 (2007) (arguing that the Massachusetts health reform law that took effect in 2007 could not survive an ERISA preemption challenge).

240. *See* HACKER, *supra* note 37, at 16–20.

241. QUADAGNO, *supra* note 238, at 30–46; STARR, *supra* note 94, at 283–89.

242. *See* Mark A. Peterson, *Introduction: Politics, Misperception, or Apropos?*, 24 J. HEALTH POL. POL'Y & L. 873, 875 (1999).

243. *See* David Mechanic, *The Managed Care Backlash: Perceptions and Rhetoric in Health Care Policy and the Potential for Health Care Reform*, 79 MILBANK Q. 35, 37–38 (2001).

compound phenomenon. It is extremely difficult to tease apart the multiple 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 MCOs in denying appropriate treatment because of cost; and a demand by physicians for reinstatement of some measure of their traditional authority.

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.

The actual quality of public knowledge at the policy level, however, is low.²⁴⁴ 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, 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.²⁴⁵ 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.²⁴⁶ I argue that beyond the

244. Drawing data from multiple public surveys, researchers found that on average, only 36% of persons surveyed could correctly answer knowledge questions regarding a range of health-related issues and only 30% gave correct answers for questions addressing health policy. See Mollyann Brodie et al., *Health News and the American Public, 1996–2002*, 28 J. HEALTH POL. POL'Y & L. 927, 939 tbl.4 (2003).

245. 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 repelled by politics to want to participate. See JOHN R. HIBBING & 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). See Kay Lehman Schlozman et al., *Civic Participation and the Equality Problem*, in *CIVIC ENGAGEMENT IN AMERICAN DEMOCRACY* 427, 446–47 (Theda Skocpol & Morris P. Fiorina eds., 1999).

246. 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

identities of patient and consumer, individuals can and should assume 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 should seek to 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 section IV.A, I frame my argument for health care system citizenship as harmonious with the concept of a “public” developed by Jürgen 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 a broader, governmental level.

In section IV.B, I argue that policymakers should study the possibility that risk pools associated with employment-based health insurance would 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, this approach could leverage that structure in a progressive normative direction by enhancing the worker voice in those decisions.

To be clear: I share the concerns of many regarding the negative policy implications of tethering health insurance to the workplace.²⁴⁷ Indeed, I believe an optimal health care system would function as a universal, national plan.²⁴⁸ 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 argument and proposal for enhancing democratic engagement in health care system governance.

decentralization and stakeholder participation to develop new and less bureaucratic models of regulation and program administration. See generally Michael C. Dorf, *Legal Indeterminacy and Institutional Design*, 78 N.Y.U. L. REV. 875, 886 (2003) (stating that democratic experimentalism is “principally a model of participatory administration”); Michael C. Dorf & Charles F. Sabel, *A Constitution of Democratic Experimentalism*, 98 COLUM. L. REV. 267 (1998).

247. Even defenders of workplace-based health insurance recite a litany of its shortcomings. See, e.g., David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL’Y L. & ETHICS 23, 26–30 (2001).

248. Accord THEODORE R. MARMOR, UNDERSTANDING HEALTH CARE REFORM 179–94 (1994); Judith Feder, *Crowd-Out and the Politics of Health Reform*, 32 J.L. MED. & ETHICS 461 (2004); Steffie Woolhandler et al., *Proposal of the Physicians Working Group for Single-Payer National Health Insurance*, 290 JAMA 798 (2003).

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 Jürgen Habermas. In Habermas's work, the concept of a "public" denotes a cultural and social space, not a physical space, for dialogue about shared concerns.²⁴⁹ Central to Habermas's thinking is the claim that the quality of society depends on the quality of our dialogic engagement on important issues.²⁵⁰ The quality of that engagement, in turn, depends on whether the procedures for engagement reflect core ethical concerns such as equality of participation.²⁵¹

Because democracy is not possible without meaningful participation, we advance democratic norms in the governance of any system when we enhance 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 the democratic characteristics of such a system becomes how to empower citizens to participate more effectively in the politics of risk allocation and distribution.

My suggestion, therefore, is that we consider using *risk pools* as a venue for building publics in the Habermasian sense. Conceptually, a risk pool is the local organizational and 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 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). These are groups that generally lack social meaning for their members; governance of the group is subsumed, without much attention paid by its members, in an organization's financial management or simply into an insurer's classification system.²⁵²

But the risk pools on which group health insurance plans are based are different. I explore those differences in more detail in the following section. But my core argument is that such risk pools have the capacity to function also as publics. Acting locally, a risk-pool governance group could engage the basic questions such as 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 that will arise.

How much decisionmaking *power* a risk-pool governance group might hold is a separate question and is one that I outline below. The point I wish to make here is simply that creating a *process* by which such questions would be

249. See JÜRGEN HABERMAS, BETWEEN FACTS AND NORMS: CONTRIBUTIONS TO A DISCOURSE THEORY OF LAW AND DEMOCRACY 360 (1995).

250. *Id.* at 409.

251. *Id.*

252. See Jonathan Simon, *The Ideological Effects of Actuarial Practices*, 22 L. & Soc'y REV. 771, 772-74 (1988).

debated, and by which input would be solicited, could generate a new kind of health policy public: groups of health care system citizenry that are deliberatively engaged in small-scale associative institutions dealing with the distributionary politics of risk.

Risk-pool governance groups would thus 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 a 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 grand philosophical conflicts.²⁵³ Indeed, they would necessitate decisions to be resolved in a manner for which simple resort to abstract principles would simply not suffice.²⁵⁴

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 might 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 as better schools for democracy rather than as useful mechanisms for the enhancement of national health policy.

But I believe that the potential of such local governance groups is more significant than that. 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

253. 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 supermajoritarian support for “universal health care,” the consensus falls apart when individuals are asked to choose between methods for achieving that goal. See 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).

254. 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* note 249, at 60–61. In his conceptualization, however, ideal practical discourse requires a deep commitment to egalitarian rules of participation. I am not claiming that risk-pool governance groups would necessarily satisfy those criteria. See JÜRGEN 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).

governance groups will still need to confront head-on the tensions and trade-offs in allocating resources for health care through the setting of terms for insurance coverage.²⁵⁵

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.

Similar sets of managerial issues might well 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 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.²⁵⁶ In a world of individualism and competition, the very presence of insurance “legitimizes social obligation and mutual aid.”²⁵⁷ More widespread citizen engagement with such issues would, in effect, democratize the norm-setting implicit in the process of health insurance risk

255. For example, group participants might choose to prioritize cost controls more than is currently typical. 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. Employees who are organized and well informed could provide a powerful constituency for cost containment mechanisms. Long before managed care, unions that were significantly involved in health insurance policy in the 1950s sought to curb costs by arranging for prepaid medical services but were unable to overcome the combined opposition of insurers and the medical profession. See MUNTZ, *supra* note 147, at 159, 164–69, 172–76.

256. See Deborah A. Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity*, 6 CONN. INS. L.J. 11, 16 (1999).

257. *Id.* at 21.

allocation at the local level.²⁵⁸

Democratic governance at the level of risk pools could thus change the valence of risk discourse. Analysts often link a discourse of risk managerialism to economic models and market-based initiatives that are focused on efficiency rather than on equity.²⁵⁹ But a discourse of risk could just as naturally be 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.”²⁶⁰ 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 engagement by citizens in governance.²⁶¹ For that reason, I propose that policymakers consider the potential for workplace-based health insurance risk pools to be a foundation for a new health policy public.

Many health policy experts argue for de-linking health insurance from the workplace. Their argument is that the economic distortions from an employer sponsored insurance (ESI) system outweigh any benefits that come from administrative convenience.²⁶² The most powerful argument against ESI is that it is doubly destructive: it fragments the overall population, thus undercutting social insurance principles, and it subsidizes individual health care consumption, thus creating moral hazard.²⁶³ 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.²⁶⁴

I find these critiques of ESI to be compelling as rationales for a national,

258. Leonard Fleck has made a similar argument focusing on participation by individuals in the role of patients rather than as citizens or members of a risk pool. See Leonard M. Fleck, *Just Health Care Rationing: A Democratic Decisionmaking Approach*, 140 U. PA. L. REV. 1597 (1992).

259. See, e.g., STEELE, *supra* note 3, at 4.

260. Pat O’Malley, Experiments in Government: Government Analytics and a Strategic Knowledge of Risk 3 (2003) (unpublished manuscript, on file with author).

261. See 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 80 (2000).

262. DAVID U. HIMMELSTEIN ET AL., BLEEDING THE PATIENT: THE CONSEQUENCES OF CORPORATE HEALTH CARE 19, 49–53, 118–19 (2001); MARMOR, *supra* note 248, at 153–58; Briffault & Glied, *supra* note 234, at 65; David U. Himmelstein & Steffie Woolhandler, *National Health Insurance or Incremental Reform: Aim High, or at Our Feet?*, 93 AM. J. PUB. HEALTH 102 (2003).

263. See HIMMELSTEIN ET AL., *supra* note 262, at 15–20, 49–53, 118–19; Briffault & Glied, *supra* note 234, at 74.

264. HACKER, *supra* note 105, at 9.

universal system of health care delivery. Nevertheless, in this section, I offer a counterperspective: that progressives should hesitate before abandoning the workplace as an organizational locus for political participation in health system and risk allocation politics, even if financing mechanisms were restructured to incorporate a richer mix of public funding. My argument is that infusing such risk pools with worker governance can serve both instrumental and normative ends.²⁶⁵

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.”²⁶⁶ The link to employment creates a material reason for individuals to remain in rather than to exit the risk pool, which diminishes the likelihood of high transaction costs for the insurer. All of these factors make ESI risk pools attractive from an insurance perspective.

These same factors 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 governance process, 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.²⁶⁷

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-

265. To be clear: I do not argue for any goal less than universal coverage of the population. Proposals for how to achieve such universal coverage, however, often include building on the workplace-based system; an example would be the new system in Massachusetts. See John Holahan & Linda Blumberg, *Massachusetts Health Care Reform: A Look at the Issues*, HEALTH AFF., w432 (Sept. 14, 2006), <http://content.healthaffairs.org/cgi/content/full/25/6/w432>. One factor in the political reluctance to jettison the workplace system is the high level of satisfaction reported by participants. See SARA R. COLLINS ET AL., COMMONWEALTH FUND, WHITHER EMPLOYER-BASED HEALTH INSURANCE? THE CURRENT AND FUTURE ROLE OF U.S. COMPANIES IN THE PROVISION AND FINANCING OF HEALTH INSURANCE 2 (Sept. 2007), http://www.commonwealthfund.org/usf_doc/Collins_whitheremployer-basedhlins_1059.pdf; Sherry A. Glied & Phyllis C. Borzi, *The Current State of Employment-Based Health Coverage*, 32 J.L. MED. & ETHICS 404, 408 (2004). Large employers also resist abandoning a workplace-based system, although they eagerly seek ways to curb their expenses. See John A. MacDonald, *The Future of Employment-Based Health Benefits: Will Employers Reach a Tipping Point?* EBRI NOTES (Emp. Benefit Res. Inst., Wash., D.C.), Feb. 2008, at 2.

266. COLLINS ET AL., *supra* note 265; see also Glied & Borzi, *supra* note 265, at 407.

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

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.²⁶⁸ 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.²⁶⁹ Third, there is greater racial diversity in the American workplace than in most other civic settings, including neighborhoods and schools.²⁷⁰

The network of social connections at work also provides useful prerequisites for effective governance of health risk. The social connections in work settings can facilitate the development of norms of reciprocity and trustworthiness, which in turn reinforce patterns of cooperation.²⁷¹ This foundation of social capital can help to overcome problems of collective action, such as the resistance to engaging 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).²⁷² 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.²⁷³

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"²⁷⁴ and "deliberation days."²⁷⁵

Employment-linked insurance groups thus offer a singularly hospitable social environment for a democratic experimentalist project to take root. It would be neither plausible nor desirable to require every employer-sponsored plan regardless of size to have a risk-pool governance structure. But it seems realistic to imagine that policies might be put in place to *enable* risk-pool governance structures in workplaces with a large enough number of employees to constitute

268. See ESTLUND, *supra* note 261, at 119 (people discuss such issues more with coworkers than with any category of acquaintance other than relatives, and as much as with spouses).

269. *Id.* at 7.

270. *Id.* at 60.

271. *Id.* at 114 (quoting PUTNAM, *supra* note 261, at 19).

272. *Id.* at 115; see also GUIDO CALABRESI & PHILIP BOBBITT, TRAGIC CHOICES (1978); Arrow, *supra* note 91.

273. See Russell Korobkin, *Determining Health Care Rights from Behind a Veil of Ignorance*, 1998 U. ILL. L. REV. 801, 802-04.

274. JAMES F. FISHKIN, DEMOCRACY AND DELIBERATION: NEW DIRECTIONS FOR DEMOCRATIC REFORM 3, 93 (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.

275. BRUCE ACKERMAN & JAMES S. FISHKIN, DELIBERATION DAY (2004).

a robust risk pool and a meaningful degree of diversity.²⁷⁶

Perhaps the bottom-line governance issue is how much power these new structures would have and how much discretion and authority employers would retain. From an employer's point of view, a pre-negotiated overall budget would presumably be necessary before they would relinquish what is now unilateral control over specific issues of coverage and rationing. Worker release time for those engaged in the governance process, causing some additional firm costs, would be required. But external resources, such as private foundation or government funding, might provide the other necessary support for such groups. If so, pilot studies of risk-pool governance could be conducted on a budget-neutral basis for employers.

From the employee's perspective, the most powerful normative objection 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 these inequalities, the question is whether participants will be able to deliberate under conditions of egalitarian reciprocity and respect. If the aspiration of deliberative democracy is to create institutions which "tie[] the exercise of power to free reasoning among equals,"²⁷⁷ the very thickness of background social relations in a workplace may make it difficult to achieve that result among coworkers.

Labor unions and workplace safety and health committees could serve as partial models for workplace risk-governance mechanisms.²⁷⁸ Indeed, the concept of a risk-governance structure in essence duplicates, for non-unionized firms, one of the functions of unions. It thus speaks to the strong support among workers for new ways to participate in workplace governance,²⁷⁹ as well as the priority that even unionized workers have given to protecting health insurance as a benefit.²⁸⁰

An ideal mechanism would facilitate cooperation while effectively deflecting both obvious and subtle forms of manipulation and control, and ensuring

276. In another context, that of uninsured persons being organized into a risk pool and provided with access to a menu of health insurance policies offered through a government-administered marketplace, similar questions arise concerning how democratic the process will be in setting the ground rules for participation. The Massachusetts Insurance Connector, which sets rates and other terms of enrollment under that state's new individual mandate to purchase health insurance, has developed impressive mechanisms to provide for public input. See Watson et al., *supra* note 239.

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

278. Workplace safety and health committees mandated by state law have demonstrated effectiveness as third-party regulators. See David Weil, *Individual Rights and Collective Agents: The Role of Old and New Workplace Institutions in the Regulation of Labor Markets*, in EMERGING LABOR MARKET INSTITUTIONS FOR THE TWENTY-FIRST CENTURY 13, 30–37 (Richard B. Freeman et al. eds., 2005).

279. One survey of American workers found that a large majority of those who favored unions also wanted additional mechanisms (e.g. employee associations) that would allow them to influence decisionmaking. See RICHARD B. FREEMAN & JOEL ROGERS, WHAT WORKERS WANT 141–43 (1999).

280. Leslie E. Nulty, *Retrospective on Collective Bargaining in the 1980s*, in CONTEMPORARY COLLECTIVE BARGAINING IN THE PRIVATE SECTOR 541, 545 (Paula B. Voos ed., 1994).

representation of all worker interests.²⁸¹ The current status, however, is closer to gridlock. Existing labor law restrictions on employee representation by entities other than unions block experimentation,²⁸² and the historic hostility of U.S. employers to employee organizations may make any degree of cooperation seem utopian.²⁸³

I do not underestimate the difficulty of these obstacles. Addressing them will necessarily give rise to numerous complexities in a governance structure. Cooptation of workers by employer interests, the possible capture of the process by those most motivated to further their self-interest, or the simple failure of group members to fairly represent other workers all come to mind as possibilities. The history of gender and racial inequities within unions provides merely one example of the fact that more democratic norms in workplace relations are hardly a panacea for injustice.

Although a full discussion of these concerns is beyond the scope of this Article, ground rules would be necessary to prevent risk-pool governance groups from exacerbating, rather than moderating, inequities in health insurance. One protection would lie in limiting risk-pool governance to the largest workplace groups, those with a significant degree of built-in diversity of interests. Additionally, legal restrictions to require actuarial justification for limitations on coverage would be necessary to counteract tendencies to exclude those with stigmatized diseases, such as AIDS/HIV.²⁸⁴

University of Michigan Medical School researchers have achieved hopeful results suggesting that democratic structures would improve fairness and equity in access to health insurance. They developed an intricate game model for constructing a group health benefits package: "Choosing Healthplans All To-

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

282. See 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, 146–56 (1997) (reviewing non-union worker democracy institutions in European countries and existing models in the United States); Matthew W. Finkin, *Bridging the "Representation Gap,"* 3 U. PA. J. LAB. & EMP. L. 391 (2001) (expressing skepticism about non-union mechanisms).

283. See Nelson Lichtenstein, *Epilogue: Toward a New Century*, in INDUSTRIAL DEMOCRACY IN AMERICA: THE AMBIGUOUS PROMISE 275, 279–81 (Nelson Lichtenstein & Howell John Harris eds., 1993).

284. Under the Americans with Disabilities Act, employers can exclude specific medical conditions from coverage in a group health insurance plan, 42 U.S.C. § 12201(c) (2000), but the law is unsettled as to whether they must justify such an exclusion by demonstrating that there is an actuarial basis for it, compared to other covered diseases. Some courts have followed the agency's interpretation in requiring that insurers justify disability-based distinctions with actuarial data. See *World Ins. Co. v. Branch*, 966 F. Supp. 1203, 1208–09 (N.D. Ga. 1997); *Cloutier v. Prudential Ins. Co.*, 964 F. Supp. 299, 304–07 (N.D. Cal. 1997). The majority of courts, however, have concluded that the anti-discrimination mandate is satisfied if every enrollee in the plan is offered the same coverage package. *Ford v. Shering-Plough Corp.*, 145 F.3d 601, 608–10 (3d Cir. 1998). See generally Sharon Hoffman, *AIDS Caps, Contraceptive Coverage, and the Law: An Analysis of the Federal Anti-Discrimination Statutes' Applicability to Health Insurance*, 23 CARDOZO L. REV. 1315, 1324–30 (2002).

gether (CHAT).”²⁸⁵ Using it in a series of simulations, they found that participants were able to reach agreement on a series of trade-offs that they accepted as legitimate.²⁸⁶ In one version of the CHAT simulation, a group of insured persons was asked to decide whether to allocate resources from their own insurance programs to cover uninsured persons. All of the small groups and two-thirds of the individuals elected to do so for uninsured children, and one-third of the individuals elected to redirect resources for both adults and children who were uninsured.²⁸⁷

The Michigan studies do not answer the question of what would happen in real life if health insurance were made subject to more democratic decisionmaking, but new governance studies in other contexts, such as urban public schools, can supply other guidelines. 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.²⁸⁸ These can provide at least a starting point for addressing some of the most important concerns.

These issues illustrate the ambitiousness and difficulty of using risk-pool governance structures for enhancing democratic norms in health care policymaking. 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 these complexities can be explored.

C. SUMMARY: TOWARD JUSTICE

The proposal that I have outlined speaks to whether and how the concept, identity, and role of *citizen* can become a viable component of health care system governance. But the proposal also offers the potential for a new way to advance norms of distributional justice. The theoretical constructs that have been deployed thus far to engage the justice and equity aspects of health have fallen far short of success. Without claiming too much, I believe that greater attention to inscribing democratic norms in the structures of health insurance governance would enhance a discourse of interdependency that could, ulti-

285. See generally Susan Dorr Goold et al., *Choosing Healthplans All Together: A Deliberative Exercise for Allocating Limited Health Care Resources*, 30 J. HEALTH POL. POL'Y & L. 563 (2005).

286. *Id.* at 591–92; see also Marjorie Ginsburg et al., *(De)constructing “Basic” Benefits: Citizens Define the Limits of Coverage*, 25 HEALTH AFF. 1648, 1650–53 (2006) (presenting selected findings of study regarding compromises and tradeoffs in health benefits packages).

287. See Susan Dorr Goold et al., *Will Insured Citizens Give Up Benefit Coverage To Include the Uninsured?*, 19 J. GEN. INTERNAL MED. 868, 870–71 (2004).

288. 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 & 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).

mately, result in greater equity.

Risk governance in health care instantiates a powerful compound of economic policy and moral normativity. Its dimensions encompass both persons and conduct.²⁸⁹ The practices of allocating risk (whether through public or private mechanisms) 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. 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.

But the normative assumptions and values underlying this system are often masked. The empirical nature of actuarial understandings masks the power dynamics involved in these decisions and makes them seem natural or inevitable, rather than political.²⁹⁰ This masking capacity is heightened in the health care arena, where natural forms of physiological risks are 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 competition for limited resources. But popular understanding of the dominance of risk governance in the system is still largely inchoate.

The equity decisions masked through risk governance have not been effectively engaged through our traditional constructs for addressing justice issues. Liberal rights principles have never proven adequate or even fully relevant as a basis for confronting the gaping health care hole in the quality of American life. Negative liberty principles offer no purchase for contesting private actions,²⁹¹ 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.²⁹² Moreover, the individual fairness focus of a civil rights mandate can cut against an argument for community sharing of risk.²⁹³

289. 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 ET AL., *INSURANCE AS GOVERNANCE* 69 (2003); accord Baker, *supra* note 24.

290. Commenting on the use of actuarial reasoning in the case of *City of L.A. Dep’t of Water and Power v. Manhart*, Jonathan Simon described actuarial techniques as a “regime of truth [and] a way of exercising power” experienced as familiar and neutral methods of computation. Simon, *supra* note 252, at 772 (arguing that the unobtrusiveness of actuarial techniques is one basis of their importance because it diminishes political reaction to exercises of power).

291. Here I am simply bracketing the rich literature on positive rights. See, e.g., ROBIN WEST, *RE-IMAGINING JUSTICE* (2003); Susan Bandes, *The Negative Constitution: A Critique*, 88 MICH. L. REV. 2271 (1990).

292. See generally Sara Rosenbaum & Joel Teitelbaum, *Civil Rights Enforcement in the Modern Healthcare System: Reinvigorating the Role of the Federal Government in the Aftermath of Alexander v. Sandoval*, 3 YALE J. HEALTH POL’Y L. & ETHICS 215 (2003).

293. The “basic policy” of a civil rights approach “requires that we focus on fairness to individuals rather than fairness to classes.” *City of L.A. Dep’t of Water & Power v. Manhart*, 435 U.S. 702, 709

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,²⁹⁴ the subgroups among the uninsured are diverse: low-income workers and their children, self-employed entrepreneurs, and young adults who perceive that their need for health insurance is minimal and not worth the expense.²⁹⁵

Communitarian theories could offer more promise.²⁹⁶ 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.²⁹⁷ However, many communitarian theories tend to rely on assumptions of homogeneity within the group, which give them limited usefulness in the health care context.²⁹⁸

Debates on the ethical dimensions of health care have thus tended to be dominated by the conflict between norms associated with the insurance industry's principle of "fair discrimination" in allocating risk on one hand²⁹⁹ and the solidarity norms of social insurance on the other.³⁰⁰ For those who wish to advance norms of equity in health care, while still acknowledging the risk structure that governs the health system, it has been difficult to find a frame-

(1978) (invalidating a requirement that women employees contribute more than male employees to the pension fund because, on average, women live longer than men).

294. See CTR. ON BUDGET & POL'Y PRIORITIES, MORE AMERICANS, INCLUDING MORE CHILDREN, NOW LACK HEALTH INSURANCE 2 (Aug. 31, 2007), <http://www.cbpp.org/8-28-07health.pdf>.

295. See generally JOHN HOLAHAN ET AL., KAISER COMM'N ON MEDICAID AND THE UNINSURED, CHARACTERISTICS OF THE UNINSURED: WHO IS ELIGIBLE FOR PUBLIC COVERAGE AND WHO NEEDS HELP AFFORDING COVERAGE 1–16 (Feb. 2007), <http://www.kff.org/uninsured/upload/7613.pdf>.

296. See generally Gavin Mooney, "Communitarian Claims" as an Ethical Basis for Allocating Health Care Resources, 47 SOC. SCI. MED. 1171 (1998).

297. The issue is not subtle: 47 million Americans lack health insurance. See CTR. ON BUDGET & POL'Y PRIORITIES, *supra* note 294, at 1. 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. See Agency for Healthcare Research & Quality, *More than 17 Million Continuously Uninsured; One-Third Are Middle Income*, AHRQ NEWS AND NUMBERS (Oct. 2007), <http://www.ahrq.gov/news/nn/nn100307.htm>. Americans without insurance are far more likely to receive inferior and inadequate care. See INST. OF MED., CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE 3 (May 2002), <http://www.iom.edu/Object.File/Master/4/160/Uninsured2FINAL.pdf>. 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. See Mark V. Pauly & José A. Pagán, *Spillovers and Vulnerability: The Case of Community Insurance*, 26 HEALTH AFF. 1304, 1309–12 (2007).

298. See Susan H. Williams, *A Feminist Reassessment of Civil Society*, 72 IND. L.J. 417, 423–24 (1997).

299. See Clifford & Iuculano, *supra* note 55, at 1809–10.

300. See Sharona Hoffman, *Unmanaged Care: Towards Moral Fairness in Health Care Coverage*, 78 IND. L.J. 659 (2003); Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL'Y & L. 287 (1993). Opinion surveys document that most Americans believe that a right to health care exists in some form, but there is no consensus as to its scope or how to achieve it. See Robert J. Blendon et al., *Americans' Views of Health Care Costs, Access, and Quality*, 84 MILBANK Q. 623, 638–42 (2006); Mark Schlesinger, *Reprivatizing the Public Household? Medical Care in the Context of American Public Values*, 29 J. HEALTH POL. POL'Y & L. 969, 989 (2004); Robin Toner & Janet Elder, *Most Support U.S. Guarantee of Health Care*, N.Y. TIMES, Mar. 2, 2007, at A1.

work that engages both risk and equity in an effective manner.

I believe that addressing issues of equity within a risk-allocation paradigm is the best way to capture and articulate the stakes at issue in the debate. It allows us (indeed, it forces us) to articulate 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. Calling the system for what it is, and how it actually operates, may turn out to be the most effective way to address the underlying values issues.

Establishing a risk-centered normative frame will not, of course, resolve the tensions on its own. Like the rhetorics of insurance advertising described by Tom Baker³⁰¹ and Deborah Stone,³⁰² risk talk is highly elastic, capable of framing normative issues around invocations of both solidarity and short-term self-interest.³⁰³ It thus leaves the field open to the most successful norm entrepreneurs in a health care debate that Americans have never fully resolved.

My proposal addresses the lack of a framework through which advocates for greater equity can make their claims. It suggests a new institutional venue in which the inherent tensions and trade-offs between equity and efficiency in health care might be negotiated in a more open and democratic process.

This model of justice is frankly process-oriented. It is designed to function within, and thereby to alter, *any* health care system that is centered on risk allocation, regardless of whether such a system is structured around private or public institutions. The democracy gap exists both in the status quo and in currently proposed reforms. Regardless of whether, or how, the financing mechanisms change for our health care system, democratizing the policy inputs into that system will remain important.

Whether greater democracy would lead to greater distributional justice is the central question that we cannot answer without actual trial and error. It is at least possible that 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 might be replicated on the national scale.

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 decisionmaking.

301. Tom Baker, *Constructing the Insurance Relationship: Sales Stories, Claims Stories, and Insurance Contract Damages*, 72 TEX. L. REV. 1395, 1400–16 (1994).

302. Stone, *supra* note 300, at 287–89.

303. Indeed, a risk-centered frame, while necessary, can also be problematic. From a progressive political perspective, a shortcoming of risk talk is that it does not carry the same intrinsic egalitarian valence as rights talk.

Even after a history of past claims has accumulated, the constellation of future claims is always uncertain for individual participants. For that reason, risk-pool governance unites within the health care system what Michael Dorf and Charles 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.³⁰⁴

CONCLUSION

The era of actuarial medicine is not likely to end soon. The integrated system of financing and service delivery established by managed care, designed and implemented to control costs, has now changed the practice of medicine in ways that are likely to remain in place, regardless of which 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 evident 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 dominance, 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 decisionmaking.

304. Dorf & Sabel, *supra* note 246, at 274–75.