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**FROM THE TECHNICAL TO THE PERSONAL:
TEACHING AND LEARNING HEALTH INSURANCE REGULATION
AND REFORM**

ALLISON K. HOFFMAN*, WHITNEY A. BROWN** &
LINDSAY CUTLER***

INTRODUCTION

In the Fall of 2016, I taught Health Law and Policy for the fourth consecutive semester. In this repeat loop, one thing has become increasingly clear: the aspect of this survey course that I work with most closely as a scholar—the regulation of health care financing and insurance, including the Patient Protection and Affordable Care Act¹ (ACA)—is also the material that I find the most challenging to teach. Every time I reflect on teaching this material, and hear from students about how they learn this material, the thing that stands out is how critical it is that my students understand the profound impact that this technical subject has on individuals' lives.

As my touchstone in teaching health insurance regulation and reform, I strive to connect with the human impact of this convoluted field of regulation. When I teach state and federal insurance regulations and ACA policies, I delve

* Professor of Law, UCLA School of Law. Thank you to students like Lindsay and Whitney, who make teaching a pleasure and an opportunity for me to continue to grow and learn. I dedicate this Article to my health law and policy instructor and mentor, Ted Marmor, whose invitation to work as his Teaching Assistant provided my first steps into teaching.

** J.D. Candidate 2017, UCLA School of Law. A class—even one as inherently interesting as Health Law and Policy—is only as good as the professor who teaches it. I feel so lucky that mine was Professor Hoffman. I am grateful for her mentorship and to have witnessed (and been the beneficiary of) her matchless ability to instill her passion for the discipline in her students. Thanks also to Lindsay for many thought-provoking discussions in class, in preparing this Article, and beyond.

*** J.D. Candidate 2017, UCLA School of Law, David J. Epstein Program in Public Interest Law and Policy. I am so grateful to have taken Health Law and Policy with Professor Hoffman at UCLA Law, and for the invaluable experience of co-authoring this Article. It is rare to have the opportunity to reflect on and think through the experience of learning with both a classmate and a professor, and I am extremely thankful to them both.

1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029. Subsequent references in this Article to the Patient Protection and Affordable Care Act refer to the Act, as amended.

into the technical, and then zoom out to consider how these technical details affect individuals and their security and well-being and, in turn, what this impact suggests about our social values.

Health insurance regulation simultaneously shapes and is an expression of social values.² It defines the types of harms we expect individuals to shoulder on their own and what we are willing to mitigate collectively, as a society. Every rule that expands the scope of insurance—whether private or social insurance—is a signal of greater social solidarity with respect to each other’s health. Every contraction of the scope of insurance is the opposite, and leaves individuals more vulnerable to poor health or financial insecurity due to high health care spending. These broader implications are what draw me to the topic—as a teacher and as a scholar. My ultimate goal is for my students to understand this social meaning: why insurance is regulated as it is, how that regulation reflects larger social values, and the impact—both intended and unintended—that insurance regulation has on the shape of our society.

Teaching health insurance regulation is objectively challenging, more so than most other subjects I teach, as I discuss below. In addition, I find it personally challenging to teach it because I am deeply immersed in its intricacies. Depth of knowledge in a field is undoubtedly valuable for a professor. I often draw on my practice experience as a health law associate when I teach. I can still remember the fear of negotiating a HIPAA³ business associate agreement for the first time, or flipping furiously through Stark Law⁴ regulations at midnight, while eating potato chips and chocolate from the Lindt store in the lobby of the Boston office of Ropes & Gray, where I worked. When I teach HIPAA or the Stark Law, I can still remember learning them myself. But after working on health insurance regulation and reform for nearly a decade as a scholar, I find it harder to identify which aspects of this topic are obvious and which are challenging and counterintuitive. Simply put, too much of it makes sense to me. I am reminded of this fact each time I teach. As I map out the many ways we pay for health care in the United States—group versus individual plans, self-insured versus fully-insured employer plans, public versus private insurance—and how each category is subject to different rules

2. See Allison K. Hoffman, *Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1873 (2011); Allison K. Hoffman, *Reimagining the Risk of Long-Term Care*, 16 YALE J. HEALTH POL’Y, L. & ETHICS 239 (2016). We use health care “financing” and “insurance” interchangeably throughout this Article to refer to the various types of private insurance and public insurance that pay for health care.

3. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936.

4. The Ethics in Patient Referrals Act of 1989 is called the “Stark Law” in honor of its sponsor, Representative Fortney “Pete” Stark. 42 U.S.C. § 1395nn (2012); 42 C.F.R. §§ 411.350–411.389 (2015).

and regulatory bodies, students look at me with puzzlement. Their looks remind me that these distinctions are illogical.

When asked to write this Article on teaching health insurance regulation and reform, I figured I should confirm that what I thought worked in the classroom was actually working. To this end, I asked two of my former students to reflect on *learning* health insurance regulation and reform in my Health Law and Policy class, and I discovered that some of my aims were hitting the mark and others could benefit from refinement, in ways that I will discuss below. In Part I of this Article, I describe my goals and approaches in teaching these topics as well as why this material can be difficult to teach. My student co-authors reflect on their own experiences in learning this material in Part II, including what they took away from it and what questions remain. Both of my co-authors have a deep interest in health law, and each came to my class with different, relevant background knowledge and work experience. In the final Part of the Article, I highlight how my co-authors' insights have informed my teaching.

I. REFLECTIONS ON TEACHING HEALTH INSURANCE REGULATION AND REFORM

A. *What I Cover in a Health Law and Policy Survey Course*

I teach health insurance regulation in two different settings: a seminar focused specifically on this topic and a four-unit survey class on health law, more broadly. Teaching the seminar is more straightforward. Fourteen weeks are devoted exclusively to health insurance, which provides ample time to cover both its normative and technical aspects.⁵ Because it's a seminar, the students tend to have more tolerance for a sampling of topics and a theoretically driven approach, with fewer seeking the legal practice version of the material. Plus, having self-selected into a course focused solely on health insurance, most students are actively interested in understanding the nuances of the topic, as opposed to students who have enrolled in a survey course called "Health Law and Policy." In Spring of 2017, for example, the seminar students enthusiastically spent five weeks researching and critiquing key policy elements of Republican proposals to repeal and replace the ACA—ranging from health savings accounts to insurance competition across state lines to

5. I spend the first several classes of my insurance seminar building a normative framework for thinking about health insurance. The second part of the course—three to four classes—aims to illustrate the status of health insurance and health care in the United States historically, before the enactment of the ACA, employing empirical studies to tease out why we spend more on health care and get worse outcomes than other countries do. The final and longest part of the seminar examines how the ACA changed the world of health financing and regulation and selects from hot topics in health insurance regulation and reform at the time of the class.

block grants or per capita financing for the Medicaid program. The students expect the course to be technical, and they generally embrace its complexity.

The task of teaching health insurance regulation in the survey course is much more difficult and is the focus of the rest of this Article. UCLA Law generally offers the health law survey course annually, and between twenty and forty students enroll. The class covers topics related to law and medicine (e.g., privacy, informed consent, medical malpractice), the more complex regulatory health law topics (e.g., fraud and abuse laws, licensure and accreditation, tax status, and antitrust), and health care financing regulation and reform.

I spend about eight or nine two-hour class sessions on health care financing: two classes that provide an overview of private health insurance, public health insurance, and reimbursement (covering everything from how hospitals set prices to Medicare reimbursement rules); three on managed care liability and preemption doctrine under the Employee Retirement Income Security Act of 1974 (ERISA);⁶ and three to four on the ACA and ongoing health reform efforts. What results is an action-packed four weeks and a fire-hose introduction to one of the most complicated and important topics in health law and indeed in modern American society.

B. What Makes Things Challenging

Several factors make teaching health insurance regulation especially difficult. Students' reasons for taking a health law course diverge most strongly in this unit. This is where the future health law practitioners part ways from students who are simply seeking insight into a timely topic—one that they see in the *New York Times* headlines and hear their medical student friends and physician family members either cheering or complaining about. The students who plan to practice health law know they must understand the rules and regulatory structures of insurance. They will negotiate contracts between insurers and providers or litigate them when they go wrong. They will answer client questions about the ACA and about state insurance regulation compliance. These students tend to push their way through difficult classes on ERISA preemption and managed care liability because they expect knowing it will behoove them in the long run. Students who come to the course for general edification, however, can lose steam in these classes.

Another challenge is that individual preconceptions and biases can impede learning. In 2009, I sat in on a seminar that now-Dean of University of Pennsylvania Law School, Ted Ruger, was teaching as a visiting professor at Harvard Law School. He devoted a class to discussion of the so-called individual mandate to carry health insurance—then a requirement just in

6. Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified in part at 29 U.S.C. ch. 18).

Massachusetts⁷ and the topic that I examined during my fellowship at Harvard.⁸ He asked the students their opinions about it, and, from a crowd of well-educated Harvard law students, he got a typical, and relatively uninformed, “young invincible”-style response: self-interested resistance to having to pay more than one’s “fair” share. The twenty-something law students uniformly saw it as patently unfair (to them) and, as a result, bad public policy.

This viewpoint is endemic in our individualistic, bootstrap society and can impede a student’s ability to internalize evidence that could persuade one to believe otherwise—that the individual mandate might be a just policy. It also arises from a shallow or narrow understanding of insurance. Even if insurers had perfect information, it would be impossible to price insurance so that it precisely captures individual risk (in other words, there is no perfectly actuarially “fair” insurance).⁹ Though some expensive conditions recur from year to year, many expensive health risks are unpredictable and uncontrollable.¹⁰ This viewpoint also typically assumes that people in poor health have had some hand in it themselves. Thus, it would make sense to charge them more if they are unhealthy of their own accord; but designating what is under someone’s control—and, by implication, less worthy of collective assistance—is more complicated than what appears at first blush. Even risk factors, such as smoking or poor nutrition, that seem to be within an individual’s full control, may not be.¹¹ Knowing and internalizing these facts—that insurance could never be “fair” from an actuarial perspective and that, for the most part, people cannot control whether they need expensive

7. An Act Providing Access to Affordable, Quality, Accountable Health Care, 2006 Mass. Acts 77, 92 (codified as amended at MASS. GEN. LAWS ch. 111M, § 2 (2008)).

8. Allison K. Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 AM. J.L. & MED. 7 (2010).

9. While some believe that an efficient insurance market could eliminate interpersonal redistribution by charging each individual a perfectly actuarially rated premium (defined as the exact amount the individual is likely to consume in health care costs over the coverage period), the reality is that even in the most “efficient” of insurance markets, insurance is redistributive among insureds. KENNETH S. ABRAHAM, *DISTRIBUTING RISK* 77–78 (1986).

10. Mark W. Stanton, *The High Concentration of U.S. Health Care Expenditures*, RESEARCH IN ACTION, June 2006, at 1, 5 (“An acute episode of pneumonia or a motor vehicle accident might lead to an expensive hospitalization for an otherwise healthy person, who might be in the top 1 percent for just that year but have few expenses in subsequent years.”).

11. See Jonathan S. Feinstein, *The Relationship Between Socioeconomic Status and Health: A Review of the Literature*, 71 MILBANK Q. 279, 306 (1993); Neil Pearce & George Davey Smith, *Is Social Capital the Key to Inequalities in Health?*, 93 AM. J. PUB. HEALTH 122, 125 (2003) (describing that health is related to social factors because of “the influence of social cohesion on health-related behaviors”); see also S.A. Reijneveld, *The Impact of Individual and Area Characteristics on Urban Socioeconomic Differences in Health and Smoking*, 27 INT’L J. EPIDEMIOLOGY 33, 35, 38 (1998) (finding that poor health behaviors in impoverished areas overwhelmingly are due to individuals’ low socioeconomic status).

medical care—makes it harder to take the young invincible stance of indignant opposition to mandatory insurance coverage.

Yet another challenge is that insurance regulation is a daunting topic, even for the most ambitious student. Students must first understand how insurance works. Insurance is about managing and spreading risk, and risk is a notoriously difficult concept to understand.¹² It deals in probabilities and unusual events that are often hard to relate to. Regulations, in turn, aim to keep insurers financially solvent and to direct how risk is spread, and among whom. These basic concepts are intimidating, even to many law professors.

To make matters worse, there is no singular approach to health insurance in the United States. In many other countries, students would find something more akin to an insurance “system,” as a starting point.¹³ The United States lacks a singular, coherent health insurance system.¹⁴ Rather, Americans finance their health care in many ways, each regulated differently.¹⁵ At the highest conceptual level, people pay for care with private insurance, public insurance, or out of pocket.¹⁶ Each of these categories divides into many subcategories. Private insurance is most often obtained through an employer, a particular defining characteristic of the U.S. approach. But some people buy it on their own directly from an insurer, increasingly so after the ACA made it easier for people to get and afford insurance in this way.¹⁷ Public financing also takes various forms. Medicaid, which is the largest public insurance program, currently insures about sixty-two million low-income or disabled

12. For an overview of cognitive biases with respect to risk and uncertainty, see Christine Jolls & Cass R. Sunstein, *Debiasing Through Law*, 35 J. LEGAL STUD. 199, 203–25 (2006). See also Howell E. Jackson, *Accounting for Social Security Benefits*, in BEHAVIORAL PUBLIC FINANCE 261, 271–75 (Edward J. McCaffery & Joel Slemrod eds., 2006).

13. This assertion is not completely true, because most countries’ health financing systems involve some mix of public and private insurance, but most do have a more straightforward primary, typically public mode of financing insurance for the whole population that people can subsequently add onto or opt out of. See, e.g., THE RIGHT TO HEALTH AT THE PUBLIC/PRIVATE DIVIDE: A GLOBAL COMPARATIVE STUDY (Colleen M. Flood & Aeyal Gross eds., 2014) (cataloging the mix of public and private health care financing in over a dozen heterogeneous countries).

14. See THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS (Einer Elhauge ed., 2010).

15. See, e.g., Timothy Stoltzfus Jost, *Access to Health Insurance and Health Benefits*, in THE OXFORD HANDBOOK OF U.S. HEALTH LAW (I. Glenn Cohen, Allison K. Hoffman & William M. Sage eds., 2017) (describing each of these forms of payment, as well as charity care and government provision).

16. *Id.*

17. In 2015, 177 million people reported employer-based private coverage and 50 million reported directly purchased health insurance coverage. JESSICA C. BARNETT & MARINA S. VORNOVITSKY, U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2015, at 4 (2016).

beneficiaries using both state and federal funds.¹⁸ Before the ACA, Medicaid eligibility was “categorical” (and it still is in some states). Eligibility was not simply based on being poor. To qualify, an individual also needed to be under age eighteen, a parent of a dependent child, pregnant, or disabled. The second-largest public insurance program, Medicare, covers fifty-two million elderly or disabled individuals.¹⁹ Other public programs provide benefits for children whose families’ incomes are too high to qualify for Medicaid (State Children’s Health Insurance Program), American Indians and Alaska Natives (Indian Health Service) and military and veterans (TRICARE and CHAMPUS). And, even after major reform aimed at increasing the number of insured Americans, nine percent of people remain uninsured, some of whom fell through the cracks of the ACA²⁰ and others, mostly undocumented immigrants, who were intentionally excluded.²¹

A student must understand this convoluted picture of health care financing before beginning to examine its regulation. Take, for example, the legal question of whether a managed care company may be liable for denying a beneficiary medical care. To answer this question, it is necessary first to identify if the beneficiary gets her health benefits through an employer, on her own from an insurance company, or from a public source. Next, a student must understand the business structure of the plan. Who makes utilization decisions? Are the doctors employed, or are they independent contractors? How are doctors paid and does the payment structure affect medical decisions and denials?²² These threshold questions, necessary precursors to assessing liability, can themselves be difficult to grasp.

A final challenge for students is that health insurance policy and doctrine are steeped in questions of politics and morality, especially so with respect to legal challenges to the ACA, a lightning rod for conflicting social values.

18. *Id.*

19. *Id.*

20. Of those people still uninsured in 2015, when asked their primary reason for being uninsured, nearly half reported that insurance remains too expensive, nine percent said that they chose not to buy insurance, twenty percent said that they did not know about or think that the individual mandate applies to them, and eleven percent tried to get coverage and failed. *Key Facts About the Uninsured Population*, KAISER FAMILY FOUNDATION (Sept 29, 2016), <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/> [<https://perma.cc/B6GY-AZXR>].

21. *Id.*

22. *See, e.g., Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229 (Pa. Super. Ct. 1988). This is the first case on managed care liability in the Health Care Law and Ethics textbook edited by Hall, Bobinski, and Orentlicher. To understand the court’s decision, readers must understand that the HMO contracts with doctors who are organized within an Independent Practice Association, where physicians receive capitated payments and year-end bonuses, depending on patients’ specialist and hospital utilization. Just to understand this arrangement is difficult yet necessary to make sense of the court’s decision that there is a colorable question of fact with regard to liability for the health maintenance organization in this case.

National Federation of Independent Business v. Sebelius's inquiry into the legality of the individual mandate had as much to do with conflict over who should pay for health care and who should be able to get it as it did about what Congress can do according to Article I of the Constitution—even though Justice Roberts's opinion, for the most part, expressly rests on the latter.²³ The broad-reaching displacement of state insurance regulation by ERISA is shaped more by the business lobby and the particular stronghold of employer-sponsored insurance than by any clear picture of statutory intent. To understand the development of legal doctrine, students must be willing to delve equally into the explicit reasoning of each case and the normative and political questions underlying it.

C. *My Strategies (and Gimmicks)*

To overcome the challenges of teaching this complex, technical, and controversial subject, I attempt to tie the technical aspects of health insurance to a human face, highlighting the impact on individuals. Every student has a story of her experiences with the health care system and with health insurance, related to her own health, a parent's health, or, as came up in class this past fall, with a pet's health and health insurance (in all seriousness). This personal contact makes it easier for students to think about the practical impact of health insurance regulation. I offer here five examples of the types of images, videos, and hypotheticals on which I rely to attempt to make difficult aspects of health insurance regulation more human and accessible. In addition, I share my own experiences navigating health insurance and health care choices and, even with my expertise, how I have found doing so frustrating or impossible at times. My general approach is to dive deeply into the technical aspects and then to resurface to consider the broader effect of the technical rules on individuals, families, and communities.

1. The Health Care Spending Curve: A Picture that Is Worth a Thousand Words to Introduce Health Insurance Theory

On day one of my health law class, I introduce the idea of insurance, including what it is, how it works, and what types of normative questions it raises. I begin with the famous curve of health care spending to illustrate the 80/20 rule (a version of which is illustrated in Figure 1²⁴)—that twenty percent of the population is responsible for eighty percent of the health care spending every year.

23. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012).

24. *See, e.g.*, NAT'L INST. FOR HEALTH CARE MGMT., UNDERSTANDING U.S. HEALTH CARE SPENDING 3 (July 2011), <http://www.bcnys.org/inside/health/2011/HealthCarePremiumsNIHCM0711.pdf> [<https://perma.cc/WP7P-YJL3>] (analyzing data from the National Health Expenditure Accounts at cms.gov).

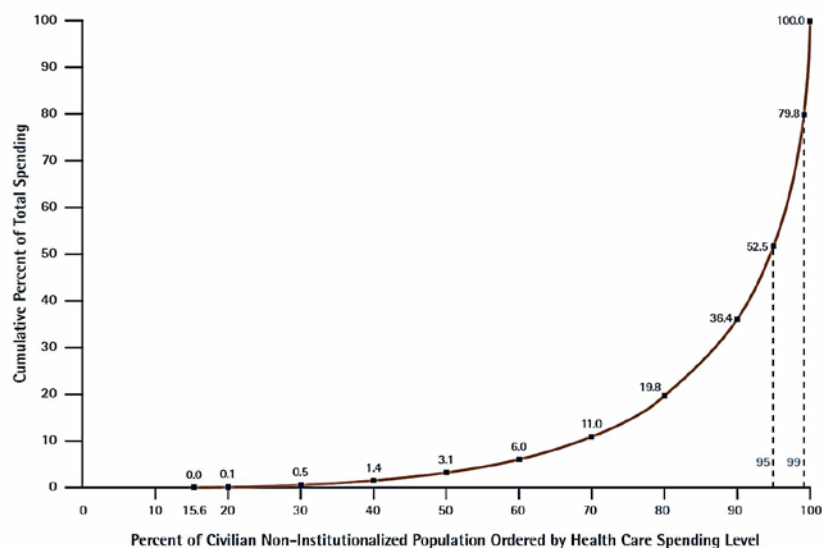


Figure 1. Distribution of Health Care Spending in 2008

Most health law professors probably introduce this curve at some point in the semester. I start with this image on day one for two reasons. The first is simply to get my students to understand the risk-spreading function of insurance. Some people will spend more on health care this year than they could possibly afford on their own, more in fact than the average U.S. household earns in a year and more even than the median household's net worth.²⁵ Then I ask them to consider who makes up the space under that curve, and we imagine the many people who might have an expensive year, from the middle-aged man who has a heart attack, to the woman who has a baby, to the twenty-something with a chronic disease, to the child diagnosed with leukemia or born prematurely, to the paradigmatic aging person in need of constant care. This exercise humanizes the curve and illustrates that an insurance risk pool is just a group of individuals, like those sitting together in the classroom. Next, we discuss predictability of being in the high end of the spending curve—some

25. The average household income was \$56,516 in 2015. BERNADETTE D. PROCTOR ET AL., U.S. CENSUS BUREAU, *INCOME AND POVERTY IN THE UNITED STATES: 2015*, at 5 (Sept. 2016), <https://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-256.pdf> [<https://perma.cc/P7MB-93KX>]. Median household net worth was \$68,828 in 2011. MARINA VORNOVITSKY ET AL., *DISTRIBUTION OF HOUSEHOLD WEALTH IN THE U.S.: 2000 TO 2011*, at 7, <https://www.census.gov/people/wealth/files/Wealth%20distribution%202000%20to%202011.pdf> [<https://perma.cc/PM8D-J9GJ>]. Average spending for the top one percent of spenders in 2009 was on average \$90,000 and for the top five percent was on average \$41,000. NAT'L INST. FOR HEALTH CARE MGMT., *THE CONCENTRATION OF HEALTH CARE SPENDING 2* (July 2012), <http://www.nihcm.org/pdf/DataBrief3%20Final.pdf> [<https://perma.cc/P3CR-EGX8>].

are there more predictably, like the person with a chronic disease or the woman who had a baby, while others find themselves there with little to no warning due to a diagnosis of cancer, a heart attack, or a car accident.²⁶ It is, at least to some degree, impossible to know which person in the pool will be expensive this year.

The second reason I spend time with this image on the first day is to begin to frame different normative visions of health insurance, contrasting in particular one of actuarial fairness versus one of solidarity.²⁷ Considering that some people are very expensive and sometimes for reasons outside of their control, who should bear the costs of their medical care?

For those who ascribe to a model of actuarial fairness, in a perfect world, over a lifetime, an insured individual would only pay in premiums what she spends on health care (plus administrative costs and reasonable insurer profit). Insurance is like a borrowing and savings mechanism. Some years an insured individual pays more than she spends and others she pays less than she needs, but if insurance works “correctly,” she comes out even or near even over the course of her lifetime. This first vision favors only intrapersonal distribution of health care costs over a lifetime.

A contrasting vision is that insurance does and should facilitate redistribution.²⁸ In a perfect world, an insured would pay premiums hoping that she never needs to use those dollars on her own care and that, instead, they pay for care for people who are less lucky than she is. This second vision is based on interpersonal distribution of health care costs and insurance as a form of social solidarity, a mechanism where everyone contributes so that the less fortunate are able to access the care they need. In this view of insurance, the goal is to distribute resources from the flat of the curve on the left side of Figure 1—from the fifty percent of people in the United States who spend nothing on health care in a given year—to those in the steep of the curve that year, who likely could not finance the care they need out-of-pocket. This is a more capacious view of what justice demands and one that I plant in my students’ minds early so that, even if they disagree with it, they will at least be cognizant of this alternative as the semester rolls out.

2. Insurance Gaps Before and After the Affordable Care Act Through the Lens of One Man’s Search for Health Insurance

Later in the semester, I begin the health care financing unit with two days on public and private health insurance, describing the evolution and

26. Stanton, *supra* note 10, at 5.

27. See, e.g., Deborah Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL., POL’Y & L. 287, 289 (1993) (outlining two visions of distributive justice for health insurance, solidarity versus actuarial fairness).

28. *Id.*

implications of how we pay for health care in the United States. At the end of these classes, to make sure the students understand the many parts in application, I pose a hypothetical about Rick, a fifty-year-old man living in Tennessee who has a chronic health condition and has been laid off from a relatively low-wage job, leaving him unemployed and living off meager unemployment benefits. I ask the students what his options were for maintaining health insurance, which he critically needs, before the ACA.²⁹ The answer emerges that he had no viable option. Some people in his position might take advantage of COBRA, a federal law preceding the ACA that allows some people with employer health plans to keep their same coverage for at least eighteen months after losing a job.³⁰ But, to do so, Rick would have to pay the full cost of the health insurance benefits, including the employer's former contribution plus his own, which he cannot afford. As a single adult, he was not categorically eligible for Medicaid before the ACA—at least not until his disease results in disability. He is not old enough for Medicare. He suffers from a preexisting health condition that would have precluded him from purchasing affordable individual coverage. He is sick and out of luck. In fact, his inability to get health insurance, despite his desperate need for it, is emblematic of what motivated the passage of the ACA.

Then, we consider if he is better off after the ACA. Unfortunately, the answer is no, providing an interesting twist on this hypothetical that I used for years prior to the ACA's passage to illustrate the need for reform. Under the original design of the ACA, he would have had access to Medicaid since he earns under the federal poverty level. The ACA directed that states eliminate categorical eligibility so that *anyone* earning under 138% of the federal poverty level could enroll in Medicaid. States that did not expand eligibility risked losing the entirety of the federal funding they were getting for Medicaid. Responding to a legal challenge to this requirement, the U.S. Supreme Court held that this choice—to expand or else lose the federal funds that constitute on average ten percent of a state's budget—was unconstitutionally coercive.³¹ As a result of this decision, a state can now choose either to keep its pre-ACA categorical eligibility rules and funding levels or to expand its program to everyone earning up to 138% of the federal poverty level and receive additional federal funding. As of January 2017, thirty-two states had adopted the expansion.³²

29. I believe this hypothetical is loosely based on a slide authored by Sara Rosenbaum.

30. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 1001(c)(2), 100 Stat. 82, 223–24.

31. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2574 (2012).

32. *Current Status of State Medicaid Expansion Decisions*, KAISER FAMILY FOUNDATION (Jan. 1, 2017), <http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/> [https://perma.cc/9ZAS-PYGW].

Rick's home state of Tennessee did not expand its Medicaid program; rather, it maintained pre-ACA categorical eligibility rules. As a result, Rick now embodies an unfortunate unintended result of the ACA. He earns too little to qualify for subsidized private insurance on the ACA's health insurance exchanges, which the ACA made available only to people earning 100% to 400% of the federal poverty level based on the assumption that anyone earning under 100% would be eligible for Medicaid coverage, and he does not have access to Medicaid in light of the Supreme Court's decision. The process of thinking through every different iteration and realizing that Rick, a middle-aged man with a chronic health condition, has no viable option for insurance coverage even after the ACA is eye-opening for many of my students. It brings to life the problems of building out reform on a fragmented financing system.

3. Investigative Journalism on Out-of-Network Pricing and the Games Providers Pay

I spend one class explicitly discussing the price of health care and approach it in an intentionally provocative way, by highlighting some of the worst practices, including chargemaster pricing, which can result in indefensibly high medical bills for uninsured patients, and providers' behavior to maximize Medicare reimbursement, which toes the line between strategic and fraudulent. Students read Steven Brill's famous *Time Magazine* article "Bitter Pill,"³³ exposing inflated hospital list prices, and a series of *Wall Street Journal* articles on health care pricing and billing practices from the "Medicare Unmasked" series that won the *Journal* a Pulitzer Prize in investigative reporting in 2015. This year, I added articles about the astronomical increases in prices for prescription drugs and medical devices when they come under the ownership of for-profit companies like Valeant, Turing Pharmaceuticals, and Mylan (whose six-fold increase in the price of the life-saving EpiPen device recently captured the public's attention).³⁴ In each of these articles, the writer emphasizes the human impact of high health care prices: low-income people filing for bankruptcy over six-figure medical bills or scrambling to figure out how to pay for life-saving treatment, older people suffering harms from being discharged from skilled nursing facilities too quickly or being held there longer than ideal for their rehabilitation, and parents struggling to afford potentially life-saving EpiPens for their children with allergies.

Each of these pieces is shocking. My goal is provocation, in part. It is also to make explicit that health care is a business, and often an extremely profitable one, where business decisions cost people their health or their lives. Finally, I highlight that any financing system creates incentives, and people

33. Steven Brill, *Bitter Pill: Why Medical Bills Are Killing Us*, TIME (Feb. 20, 2013).

34. See Jonathan D. Rockoff, *Mylan Faces Scrutiny Over EpiPen Price Increases*, WALL ST. J. (Aug. 24, 2016).

respond to those incentives. This is useful framing for later discussion of self-referral and anti-kickback laws.

4. Video Hypothetical on the Bottom Line of ERISA Preemption

With ERISA preemption, we delve more deeply into the technical than with any other unit in the class. ERISA, passed in 1974, regulates employee benefits; the law was passed to create safeguards for pensions but included health and other employee benefits in its regulatory ambit as an afterthought,³⁵ one that has had a tremendous impact. This is because ERISA preempts, or pushes aside, state laws and remedies that overlap with it, and has left a vacuum of regulation and remedies in its wake. The law directs that ERISA supersedes any state laws that “relate to” an employer health plan, known as section 514 preemption. ERISA also prevents someone from seeking state remedies if she is harmed because of a denial of benefits under an employer health plan, known as section 502 preemption.³⁶ ERISA preemption is difficult, both because of its complexity and because of the inconsistency in the way the Supreme Court has interpreted the statute. Yet for students interested in health reform or civil justice, who need a functional understanding of how benefits are regulated, understanding ERISA is critical.

There is real risk of losing some students in the ERISA morass and never getting them back again. I rely on several tools to try to keep students aboard. First, I chart out ERISA preemption visually, using everything from pictures of concentric circles of preemption (Figure 2, below) to flowcharts.³⁷ I start with this simple visual to illustrate how the two parts of ERISA preemption work together, and as the unit proceeds, I plot each case onto this roadmap.

35. See JAMES A. WOOTEN, *THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974: A POLITICAL HISTORY 2* (2004).

36. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, § 502(a)(1)(B), 88 Stat. 829, 891 (codified at 29 U.S.C. § 1132(a)(1)(B)).

37. Thank you to Jessica Mantel for sharing her fabulous flowcharts with me.

ERISA Preemption Under § 502 and § 514*

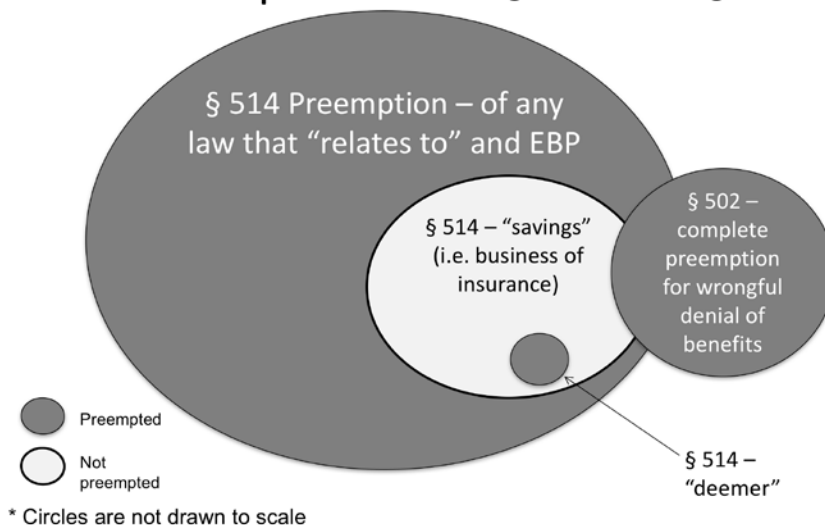


Figure 2. Charting ERISA Preemption

Second, I strategically place our unit on the Affordable Care Act right after ERISA preemption to reel possible defectors back in. Finally, and most importantly, I attempt to illuminate the human impact of ERISA preemption using an in-class exercise, so students understand and remember the bottom line of this technical jurisprudence, even if they forget all the doctrinal details.

This exercise focuses on ERISA section 502, which allows beneficiaries to bring a federal civil suit if denied benefits owed under an employer health plan.³⁸ The Supreme Court has interpreted section 502 to preclude any state tort action seeking remedy for harms that arise from such a denial.³⁹ This means that the only way a person can seek remedy for these harms is in federal court under ERISA section 502. In conjunction, the Supreme Court has interpreted the remedies available under section 502 very narrowly, allowing compensation only for the value of benefits denied and the payment of future benefits.⁴⁰ As a result, if a beneficiary is denied care due to her under her employer health plan and she is seriously harmed because of that denial, ERISA leaves her without remedy for these harms. She can recoup the cost of

38. Section 502(a)(1)(B) says that a beneficiary may bring a civil action to “recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.” § 502(a)(1)(B), 88 Stat. at 891.

39. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004).

40. *Id.* at 222–23 (Ginsburg J., concurring). See *Varhola v. Doe*, 820 F.2d 809, 817 (6th Cir. 1987); *Sokol v. Bernstein*, 803 F.2d 532, 534–38 (9th Cir. 1986); *Harsch v. Eisenberg*, 956 F.2d 651, 754–61 (7th Cir. 1992), *cert. denied*, 506 U.S. 818 (1992).

care denied but not damages related to lost work or disability or death that results from the denial.

Even after we discuss the case that expressly affirms this rule, *Aetna v. Davila*, it can still be difficult for students to internalize its counterintuitive and, arguably, cruel results: a health plan that negligently denies someone care does not have to compensate her for harms that result. In a concurring opinion, Justice Ginsburg expresses her disapproval of this rule, calling on Congress to revisit an “unjust” preemption regime.⁴¹

To drive home this lesson, I use a video hypothetical from an NBC Nightly News story about Michael Fields, a forty-six-year-old man whose insurer repeatedly denied his physician’s request for a cardiac nuclear stress test to look for blockages in his arteries.⁴² The news story is instructive at multiple levels. First, the test was denied by a company called MedSolutions, a medical benefits management company that was hired to review requests on behalf of Fields’s insurer, Blue Cross/Blue Shield of Delaware. Students can consider how the existence of a company like MedSolutions fits into the story of defensive medicine. Studies point to increased use of diagnostics, especially in cardiovascular care, as a response to tort liability concerns.⁴³ MedSolutions could, in theory, use evidence-based medicine to counterbalance unwarranted overuse, but, in reality, it went too far. An investigation by the U.S. Senate Commerce Committee showed a pattern of inappropriate denials, perhaps unsurprising considering that MedSolutions’s compensation was contingent on achieving at least a twenty percent reduction in spending.⁴⁴

Fields’s denial was among those identified as wrongful. His doctor recommended the nuclear stress test; when the insurer denied it, the doctor appealed twice and both times the appeals were again denied. I ask students: “What if his doctor had given up at this point? Could the doctor be liable for negligent care? Would the insurer, or its agent, be liable for any harms Fields suffered because of this wrongful denial?” This last question is the one that reinforces the impact of ERISA preemption. Fields would have had to bring a federal claim for wrongful denial of benefits under ERISA section 502, because ERISA preempts any state tort claim. And if he won, he would recover only the value of benefits denied: the cost of the nuclear stress test. The question that drives home the enduring effect of ERISA preemption coupled

41. *Davila*, 542 U.S. at 222 (Ginsburg, J. concurring).

42. Lisa Myers, Rich Gardella & Azriel Relph, *Insurer Denied Needed Medical Tests, Senate Finds*, NBC NIGHTLY NEWS WITH BRIAN WILLIAMS (Apr. 18, 2011, 11:43 AM), http://www.nbcnews.com/id/42613298/ns/nbc_nightly_news_with_brian_williams/t/insurer-denied-needed-medical-tests-senate-finds/#.WafnpJMrJo4 [https://perma.cc/82X3-MW5T].

43. See, e.g., Katherine Baicker, Elliott S. Fisher & Amitabh Chandra, *Malpractice Liability Costs and the Practice of Medicine in the Medicare Program*, 26 HEALTH AFF. 841 (2007).

44. Myers et al., *supra* note 42.

with the Supreme Court's narrow interpretation of its available remedies is the following: "If Fields had died the following week of a heart attack because he did not get a timely nuclear stress test, what remedy could his widow have been able to seek in court?" The answer, students realize with disbelief, is the same: the cost of the stress test. Period.⁴⁵

Fortunately for Fields, his determined doctor sent him to the hospital for emergency care, where cardiologists found an artery blocked and performed quadruple heart bypass surgery the following day. By shifting to video and a compelling human story, I attempt to capture my students' attention and heartstrings in order to underscore the impact of complex ERISA doctrine. Even if they do not remember the details of sections 514 and 502, most remember the story of Michael Fields.

5. Buying Insurance on an ACA Exchange: This Cannot Be What They Intended?

Finally, as we study the ACA and its insurance expansion, I ask my students to judge the effects of one part of the ACA expansion for themselves. I ask them to choose a health plan on the California health insurance exchange, Covered California, which has a shop-and-compare function for potential buyers.

The experience of going onto Covered California's website, entering their data, and trying to pick a plan usually illuminates several things. First, "choice" is a myth to a large degree in a world where plans are highly regulated. The benefits and cost-sharing structures are surprisingly similar among plans in similar categories, or "metal levels" (so named because plans are designated as platinum, gold, silver, or bronze, in order of decreasing actuarial value). Second, to the extent the plans are at all distinguishable on their face, the choice between plans is unnavigable even for discerning law students. It's difficult to tell why premium prices differ from one plan to another, and to the extent premium variation is due to differences in provider networks, it is impossible to decipher and judge the relative value of different networks, especially in California where online provider directories are riddled with errors.⁴⁶ There are consumer ratings on the plans, but it is unclear how reliable they may be or what exactly they reflect. Finally, when looking at

45. This example is a slight oversimplification because it shows a pattern and practice of wrongful denials that might expose MedSolutions and Blue Cross/Blue Shield to other legal claims, but the takeaway is that the most straightforward claim for wrongful denial of benefits would not allow a remedy for wrongful death.

46. See MANATT HEALTH & CALIFORNIA HEALTHCARE FOUND., DIRECTORY ASSISTANCE: MAINTAINING RELIABLE PROVIDER DIRECTORIES FOR HEALTH PLAN SHOPPERS 3, 5–6 (2015), <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20D/PDF%20DirectoryAssistanceProvider.pdf> [<https://perma.cc/C7FB-2T55>] (describing problems with the accuracy of California provider directories).

plans, students struggle to decide if it is better to pay more upfront for a plan with a low deductible or to risk it, opt for a high-deductible plan, and hope for a healthy year.

In one fell swoop, this exercise pulls the rug out from under the idea of relying on smart consumer purchase decisions to send market signals to improve health insurance and health care delivery—the theoretical idea underlying the exchanges and much of modern health law and policy, including recent Republican proposals for reform.⁴⁷ It reveals that, even in a state with a relatively good marketplace experience, most insurance consumers are taking a shot in the dark.

II. REFLECTIONS ON LEARNING HEALTH INSURANCE REGULATION AND REFORM

Since all these efforts are aimed at helping my students understand health insurance regulation and reform, I thought it would be useful to hear from the intended audience. This Part is authored by two of my former students, Whitney Brown and Lindsay Cutler, who discuss why they took Health Law and Policy, what they found most interesting or memorable about the unit on insurance regulation and reform, and what they were left wondering or wanting to know at the end of the semester. Of course, every student's experience is different, but my hope is that these reflections illuminate what comes through most strongly to my students and what would benefit from more refinement, which I address briefly in the Conclusion.

A. *Defining “Health Law”*: Reflections by Whitney Brown

I came to law school with a particular interest in health law, having previously studied public health in a master's program and having been steeped in the health policy world while working in several congressional offices on Capitol Hill during the years immediately following the passage of the Affordable Care Act. What attracted me to a course in health law was thus a combination of motivations—a desire for information that I might one day use in practice, an interest in the discipline that grew out of my own (sometimes harrowing) brushes with the health care system and health insurance specifically, and a general scholarly curiosity about the areas of health law that I had not previously encountered. Admittedly, I also sought a compelling answer to a recurrent question from extended family and garrulous airplane row-mates: “Oh, you're interested in health law? What *is* health law?”

47. Alain C. Enthoven, *The History and Principles of Managed Competition*, 12 HEALTH AFF. 24 (1993); see Allison K. Hoffman, *Health Care's Market Bureaucracy* (draft on file with author).

What differentiated the classes devoted to health insurance and financing from other parts of the course was how implicit policy decisions are in shaping these areas of law. During other units, Professor Hoffman would pause instruction after identifying the black letter law so that we could weigh the implications of the rules or doctrines we were learning (e.g., Should physicians have a duty to treat patients? Are EMTALA's⁴⁸ requirements of screening, stabilization, and transfer for emergency medical services a net positive or net negative for our health care system?). While discussing health insurance regulation, however, questions about social values were ubiquitous and unavoidable—choices about what our health system should prioritize so clearly undergirded every design decision, from how managed care is structured to the rationale for applying ACA cost-sharing subsidies only to plans silver-level or higher in value, that engaging in full-stop policy discussions would have been redundant. The ultimate effect of regulatory choices or specific provisions of the ACA became clear only when judged as part of the law's overall design and the shape of the health care system as a whole, as the Supreme Court's decision in *King v. Burwell*⁴⁹ so distinctly demonstrated. In other words, it became clear to me that it is no more possible to extract and divorce a particular health law doctrine from its social and political implications than it is to view a statutory provision in isolation from its surrounding statutory context.

This recognition that normative decisions were inextricable from the doctrine itself—and that in enacting a statute or promulgating an insurance regulation, Congress and administrative agencies, respectively, must confront difficult questions about who should be covered, when, and why—is what made the insurance unit among the most illuminating of the semester. And it unexpectedly shifted the way I think about areas of law that are similarly laced with thorny contextual and normative decisions, such as business, tax, and administrative law. Rather than merely learning and mentally filing away the black letter law, I found myself trying to get to the bottom of the *should* and the *why* of the doctrine as I read—for instance, should the degree of deference a court gives an executive agency depend on whether the agency is attempting to enhance regulation of an industry or to deregulate? Why is the interest on a home mortgage tax deductible but rent is not? What normative choices underlie this decision? Having developed a heightened attention to underlying policy and normative decisions while studying health insurance regulation, I feel more attuned to the richness and complexity of legal doctrines generally.

Within only weeks of beginning the course, I realized that health law—and health insurance regulation in particular—was far more pervasive and multifaceted than I had previously understood. Before taking the class, I

48. 42 U.S.C. § 1395dd (2012).

49. 135 S. Ct. 2480 (2015).

thought of health law, and health insurance regulation in particular, as a fairly idiosyncratic field. I was surprised to learn instead that it poses many of the same questions that regularly occupy the federal judiciary in other contexts: How are we to understand Congress's commerce power?⁵⁰ To what extent should context and congressional intent be considered when interpreting a potentially ambiguous statute?⁵¹ How broadly should "personhood" be construed?⁵² When should justiciability concerns preclude a court from ruling on the merits of a claim?⁵³ How does (or should) the Court interpret preemption language in federal statutes (e.g., ERISA's "relates to") and how do such decisions affect the balance of power between state and federal governments?⁵⁴ It was both surprising and refreshing to recognize that understanding modern jurisprudence, especially after the passage of the ACA, essentially requires an understanding of health insurance (and, similarly, that understanding health insurance demands engaging with the Court's recent jurisprudence).

Perhaps the greatest challenge of learning this material was to master the details without losing sight of the big picture. It became clear to me that tugging at any of the threads we were learning could yield a trove of fascinating policy decisions and political backdrop—much of which was beyond the scope of a fourteen-week course. How and why were certain essential health benefits chosen for guaranteed coverage under the ACA, and others left out? How is it that the law could have overlooked such glaring gaps in coverage as those exemplified by the "family glitch"⁵⁵ or the "Rick from Tennessee" example that Professor Hoffman discusses above?⁵⁶ Stepping back from these in-the-weeds questions, more foundational inquiries often loomed. Why does health insurance remain so often tied to employment, particularly today when the average baby boomer holds more than eleven jobs before the age of fifty?⁵⁷ Does this system still make sense? What would an alternative

50. See, e.g., *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012).

51. See, e.g., *King*, 135 S. Ct. at 2489.

52. See, e.g., *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2797 (2014).

53. See, e.g., *U.S. House of Representatives v. Burwell*, 130 F. Supp. 3d 53, 67–69 (D.D.C. 2015).

54. See, e.g., *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 943 (2016).

55. Tricia Brooks, *Health Policy Brief: The Family Glitch*, HEALTH AFF. (Nov. 10, 2014), http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_129.pdf [<https://perma.cc/JX6H-PHRD>] ("The problem is that the definition of 'affordable'—for both an individual employee and a family—is based only on the cost of individual-only coverage and does not take into consideration the often significantly higher cost of a family plan.").

56. See *supra* Part I.C.2.

57. BUREAU OF LABOR STATISTICS, NEWS RELEASE: NUMBER OF JOBS HELD, LABOR MARKET ACTIVITY, AND EARNINGS GROWTH AMONG THE YOUNGEST BABY BOOMERS: RESULTS FROM A LONGITUDINAL SURVEY 2 (Mar. 31, 2015), <http://www.bls.gov/news.release/pdf/nlsoy.pdf> [<https://perma.cc/5X8J-N9TN>].

look like? More than most classes, this one left me craving more—more context, more political backdrop, more comparative information about how the challenges of our health care system measure up to those of other countries, more insight into how health insurance will be conceptualized and effectuated in the future. I may have left the class with more questions than answers—questions that have only become more urgent in the wake of the 2016 election, as we await the future of the ACA and health care regulation—but for me, these questions affirm my interest in continuing to examine this extensive field of law.

*B. Challenging Preconceptions of Health Care Reform: Reflections by
Lindsay Cutler*

An interest in health care access is what led me to Health Law and Policy at UCLA. Prior to law school, I worked on the outreach campaign for NMHIX, the New Mexico Health Insurance Exchange, and on the New Mexico Medicaid expansion. After seeing the implementation of the ACA on the ground, I imagined the entire course would be a semester of precisely the health insurance regulation and reform “fire-hose” this Article discusses.

While I quickly found out that health law and policy is broader than I had anticipated, I looked forward most to the part of the course on the ACA. The process of learning about health insurance reform felt like a sort of bungee-jump—a plunge into the technical depths of ERISA or legal challenges to the ACA’s individual mandate⁵⁸ and then rebounding to ask 10,000-foot questions about how the ACA attempted to fill in the cracks in health care access and to wrap around such an employer-dependent health care financing system.

As became most clear to me in this unit, there is something unique about studying health care in a law school classroom—few subjects taught in law school are as deeply personal. Throughout the semester my classmates and I connected with the material in many different ways, as revealed through anecdotes about run-ins with student health insurance or past professional experience in the health care field. The unit on health insurance regulation and reform was the part of the class where I saw our entry points into the material diverging the most. Some classmates’ perspectives stemmed from the physician in their family, others from a sick relative or from being denied insurance coverage because of a preexisting condition. This vast array of background perspectives, compounded by the effect of the headline news shaping our frames of reference, fueled our perceptions and misperceptions of the subject. For example, many of us, accustomed to hearing that the ACA offered affordable coverage for all, were shocked to find out just how many

58. Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2600 (2012) (holding that the individual mandate to purchase health insurance under the Affordable Care Act was constitutional under the Tax and Spending Clause).

people were left out of the expansion and just how many holes remained after the ACA's patchworking. Professor Hoffman navigated our different perspectives by reminding us of the big picture: whether it was a colorful hypothetical or our own experience, these individualized interactions with insurance and doctors were powerfully indicative of the path that health care reform was taking.

The area I recall struggling with most was the concept of ERISA preemption and the gap that remains for those whose only remedy for wrongful denial of benefits in an employer health plan is the nominal payment of benefits denied and of future benefits, since ERISA preempts state tort claims and remedies for harms stemming from such denials.⁵⁹ Though not the subject I was most excited to learn, seeing the pitfalls of ERISA strengthened my understanding of the evolution of health care financing in the United States. To me, the takeaway from ERISA was that it denied individuals caught between state and federal law meaningful access to the health care system. I saw ERISA as representative of the extent to which market forces shape insurance in the public and private spheres and the way in which the struggle for regulation of employer-based insurance is rife with public and administrative tensions.

Moving from ground level to 10,000 and then 30,000 feet by understanding first the technicalities and then the policy implications of ERISA preemption also helped me see how the macro goals of health care reform—increasing access, reducing cost, and improving quality—can pull in opposite directions. Though limiting benefits may reduce spending for employee plans, individuals can also be denied life-saving treatment or be barred from accessing meaningful care. The complexity of ERISA, and the market forces at play in removing employee claims from state law through preemption, deepened my appreciation of how the systems I had previously worked with on the ground, NMHIX and New Mexico Medicaid, were in theory designed to do the opposite: to increase access to meaningful care, where such access may not have previously existed. It seems even more important, in the context of ERISA's impact, for individuals, even possibly those who *are* able to obtain benefits through an employee plan, to have the option to access health care outside of the employer context. Having the ability to purchase a plan on the health care exchange and, in turn, to seek full legal recourse for harms stemming from benefits denials is another way that the exchanges and Medicaid expansion could provide increased access.

What struck me most deeply in thinking about the particular reforms the ACA embraced was an article we started the course with entitled "Getting There from Here," by Dr. Atul Gawande. In it Gawande describes the path-dependent nature of health reform in various countries over the last century.⁶⁰

59. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 204 (2004).

60. Atul Gawande, *Getting There from Here*, THE NEW YORKER (Jan. 26, 2009).

Gawande, writing before the ACA passed, tracked other countries' health care systems, reforms, and problems to their social and political roots—what he called their particular origin stories.⁶¹ Path dependence, as presented in the article, is the theory that small, historical events play a powerful and underestimated role in shaping current health care reform. This article helped me understand how U.S. health care financing came to be so patchworked, and I have returned to it repeatedly both for answers and for inspiration for further study.

I walked away from Health Law and Policy with a deeper understanding of the complexity of our health care system's problems and the rationales behind the ACA's often perplexing policies. But so much of what I loved learning and found fascinating and motivating a year ago has changed since the November 2016 election. Taking this survey course in the Spring of 2016 and reflecting on it in the months since has taught me to think critically about the design of essential care systems, who and what they are intended to exclude, and how that reflects national social values. My health law classmates and I are certainly not the only ones thinking about these underlying social values at present, as moves to dismantle the ACA have provoked Americans and others around the globe to ask, sometimes in gut-turning disbelief, "wait, just how do we get *there* from *here*?"

CONCLUSION:

WHAT I TAKE AWAY FROM MY STUDENTS FOR MY FUTURE TEACHING

My conversations with Lindsay and Whitney and their reflections on learning in my class affirmed that teaching health insurance regulation and reform in a survey health law class is tricky and will undoubtedly be imperfect. One could spend a lifetime—and many, including myself, do—thinking about the nuances of health insurance policy and regulation and the many values imbedded in it. The challenge, as I see it, is how to impart the high points for practicing health law and to cultivate erudite law graduates.

As this Article has described, my primary strategy is to zoom in on the technical rules or legal reasoning and then pull back out to see the effect that they have on people's lives and livelihoods. This process reveals how technical rules embody and reinforce social values. In conversation with Lindsay and Whitney, I thought about how this strategy, which Lindsay nicely described as the bungee-jump approach, forces students to pivot quickly between minutia and the big picture. What struck me is that both of my students recognized this telescoping in and out in class, and each experienced it differently. For Whitney, this approach illuminated where macro questions and social values are rooted in detailed statutes and doctrine. It helped her see policy and law as

61. *Id.*

more fluid domains. For Lindsay, this bungee jump was novel and yet somewhat jarring as we moved through the material in the class, but it eventually enabled her to fit the many pieces we studied into a coherent whole, which she did in part relying on the Gawande article she describes as a guide.

Seeing how two successful students responded differently was telling. Fortunately, it affirmed that they were learning much of what I hoped they would. It also revealed the moments where I could work to make some of my intended messages come through more clearly, or with more ease, for my students.

One insight was to make the course's implicit themes more explicit. For example, I realized that I never clearly elucidated the idea, described in the Introduction to this Article, that I see insurance as both an expression of and force that shapes social values. This idea motivates the way I approach this material, and it could help students to understand my vantage on the journey through it. I taught the course again as we drafted this Article, and I paused early in the unit to unravel this idea while discussing the ACA policy that someone buying health insurance on an exchange may be charged fifty percent higher premiums if she uses tobacco products.⁶² We examined how this insurance regulation reflects social disapproval of tobacco use, a discussion that was especially interesting with the participation of several international LL.M. students, including a student from France whose difficulty wrapping her mind around this rule illustrated its particular cultural valence.

As another example, in this last iteration of the course, I referred back to the Gawande article to mark the idea of path dependence more explicitly, as Lindsay was doing on her own. Expressly discussing the theme of path dependence provided the opportunity to challenge Gawande's thesis that path dependence is inevitable, by asking students to imagine alternate universes that the ACA might have created. This discussion, in turn, teases out questions that Whitney was left to ponder on her own at the end of the course. Was Medicare for all an option back in 2010? Would it have been better? Is our employer-based health insurance system a done deal or might its prominence lessen over time? Even if its prominence remains, will and must it substantively remain largely deregulated? If so, what is the cost of such deregulation? What might be the next steps in health insurance reform and will they be future chapters in a story of path dependence?

As part of this theme of path dependence, I also shared an idea that I have written about elsewhere: the places where the ACA is most controversial, resulting in public uproar and litigation, are the very places where it pushes most

62. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1201, 124 Stat. 119, 154 (codified as amended at 42 U.S.C. § 300gg (2012)).

strongly away from the preexisting system and its norms.⁶³ The individual mandate faces resistance in part because it cuts against the notion of free market private insurance and more strongly toward a solidaristic system of health insurance. The ACA's requirement that employer plans cover all preventive care without cost sharing, including FDA-approved forms of contraception, violates ERISA's zone of deregulation for employer plans.⁶⁴ The ACA can thus be seen as simultaneously path dependent and path changing. What is now fascinating is that the ACA has quickly become the path on which the future of health insurance is dependent, a point that Republicans in Congress and President Trump must contend with as they contemplate making significant changes to the ACA.

Finally, and relatedly, my students' insights suggested the need to spend more time teaching the historical origins of the current system—from the initiation and instantiation of the employer-based health care financing system to Medicare and Medicaid to ERISA and the evolution of managed care. I started teaching health law just prior to its modern transformation by the ACA and have debated the right balance of pre- and post-ACA content. Understanding the preexisting state of health care illuminates the very problems that prompted the ACA. Each year, I add more nuance on the history of health care delivery and financing and, especially, the evolution of managed care. Some of the greatest puzzles in health law exist because of the quickly changing picture of how we pay for health care in the United States, from mostly out-of-pocket at the beginning of the twentieth century to a convoluted insurance system by the end, to whatever will come next. Laws that made sense (or at least caused little trouble) at one moment in time, such as ERISA section 502 preemption rules at a time when insurers did not deny care prospectively, can have untoward effects at a later moment. When teaching about an area of regulation that is ever-changing, it can be easy to phase out older material in favor of present controversies, but Whitney's insights reminded me that the former may be necessary to illuminate the latter.

I realize, as I weave in more history, that many of my own views on health insurance regulation and reform and what is possible are informed by my knowledge of this history and how health care financing and regulation has changed over time (and could, impliedly, continue to change in the future). This past semester, I devoted even more time to this historical arc to impart a foundational knowledge in the same way that my health law and policy professors, Ted Marmor and Jerry Mashaw, did for me a decade and a half ago.

63. Allison K. Hoffman, *What Health Reform Reveals About Health Law*, in *THE OXFORD HANDBOOK OF U.S. HEALTH LAW* (I. Glenn Cohen, Allison K. Hoffman & William M. Sage eds., 2017).

64. *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2762 (2014); *Zubik v. Burwell*, 136 S. Ct. 1557, 1560–61 (2016).

What I remember from my own health law and policy class in law school is not the details of Stark Law rules or antitrust doctrine (in fact, I'm fairly certain my professors didn't touch on this doctrine). What I remember is the two of them prodding me and my classmates with questions like whether nonprofit hospitals still deserve tax-exempt status in the modern era of health care big business and what role and profit margins private insurance companies should have in our health care financing system. They gave me insight into the tremendous impact evolving legal rules and policies have on society as a whole, and on individuals' lives—a connection that now motivates my own research and teaching.

