TEACHING *THE LAW OF AMERICAN HEALTH CARE*

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We are delighted and uniquely postured to contribute to this issue on teaching health law having just published a new, first-edition casebook designed for the basic survey course. In writing our casebook, *The Law of American Health Care*,[1] we started from scratch, rethinking the topics to include and themes around which to organize them. Like many health law professors, we were schooled in and continued to propound the traditional themes of cost, quality, access, and choice.[2] While those concerns certainly pervade many areas of health care law, our casebook's overarching themes emphasize different issues, namely: federalism, individual rights, fiduciary relationships, the modern administrative state, and market regulation.[3] These new themes, we believe, better capture the range of issues and topics essential for the new generation of health lawyers.

WRITING *THE LAW OF AMERICAN HEALTH CARE*

When we set out to write *The Law of American Health Care*, our objectives were threefold: (1) simplify; (2) emphasize primary sources; and (3) reorganize the classic state-based law approach to "Law and Medicine" to reflect the dominance of federal law in the post-Affordable Care Act (ACA)[4] era. In this essay, we will discuss not only how we went about achieving these goals but also how the topical nature of health care law can be addressed through the use of themes, and how themes can facilitate learning on the fly when health care law changes, as it inevitably does.

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1. NICOLE HUBERFELD, ELIZABETH WEEKS & KEVIN OUTTERSON, THE LAW OF AMERICAN HEALTH CARE (2017).

2. BARRY R. FURROW, THOMAS L. GREANEY, SANDRA H. JOHNSON, TIMOTHY S. JOST & ROBERT L. SCHWARTZ, HEALTH LAW: CASES, MATERIALS AND PROBLEMS (7th ed. 2013).

3. HUBERFELD ET AL., *supra* note 1, at 5–6.

4. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

I. SIMPLIFY

To address the first goal, which was key to offering a digestible, one-semester, basic Health Law course in one book, we made hard choices about topics and materials to include and exclude. We organized the material into three core topics: health insurance, the business of health care, and patient protections.[5] We tied the key topics together through the use of five themes, provided in the Introduction and listed above, which arise throughout the material. Through three core units and overarching themes, we introduce students to the essentials for health care law practice. At many law schools, and for many law students, only one health law course will be offered or taken. To keep the subject manageable and simplify the learning process of an inherently complex field, we chose not to cover—at least not as discrete chapters or units—certain topics that some consider central to the field of health law and practically blasphemous to exclude.

For example, we do not address public health law as a stand-alone topic, but it is interwoven throughout other subjects under each of the three core topics. At least two of us have been actively involved with a group of public health law scholars, practitioners, and advocates (dubbed the "George Group," after Georges Island in Boston Harbor, where a small group of scholars birthed the idea) seeking to increase the prominence and inclusion of public health in scholarship, teaching, and policymaking. Thus, to emphasize public health's integration and increased prominence to the next generation of health law attorneys and policymakers, we featured a foundational public health law case, *Jacobson v. Massachusetts*,[6] in the introductory chapter. *Jacobson* illustrates an overarching and important health law theme: the intractable tension between individual rights and governmental police powers. The case also introduces the theme of health care federalism, another longstanding and central feature of American health care, which operates and is regulated at both the federal and state level. Thus, consistent with the George Project mission and trends in health care policy that recognize the importance of serving both the collective and the individual, we underscored the importance and pervasiveness of public health law across our three topics of health insurance, the business of health law, and patient protections.

As another example, we also largely excluded coverage of professional liability, both against individual physicians and health care entities, though these subjects also are interwoven into other material. Mention health law to many laypersons, and they will assume that you mean medical malpractice law. Thus, it may seem difficult to justify exclusion of such a historically central topic. In reality, however, students receive an adequate introduction to

5. HUBERFELD ET AL., *supra* note 1, at ix.

6. 197 U.S. 11 (1905).

professional standards of care, informed consent, and other tort-related theories of recovery in their first-year curriculum. Other issues such as proof of causation and introduction of expert and scientific evidence to establish the essential elements of the medical malpractice claims are taught in evidence classes. From those foundational courses, students will possess the basic analytical and research skills to work in that area. By contrast, other topics that we included are less familiar and accessible without specialized training. That said, issues related to the physician-patient relationship are addressed in our chapter on Duties Related to Patient Care,[7] including the content of the duty to treat and other common law and statutory approaches to regulating quality of care, because the material contains specialized rules that cannot be gleaned from other courses.

Given the goal of simplification, instructors and students may be surprised by our choice to include in-depth coverage of health care fraud and abuse, beginning in the Introduction with a knotty False Claims Act case about physicians performing unnecessary cardiac surgeries.[8] The case illustrates another central theme—fiduciary duties in health care relationships—but also pulls students into the thick of contemporary organizational, financial, and ethical issues. Fraud and abuse is a rapidly changing and particularly intricate topic, with detailed statutory and regulatory schemes, that requires the special attention of a focused health care law course and cannot be left to applied learning from other law school subjects. Though instructors may be tempted to avoid this topic or to cover it briefly, health care fraud and abuse is so vital to modern health law practice, whether representing clients in litigation, administrative compliance, or transactional matters, as outside or in-house counsel, that we decided robust coverage is essential.

Our choice to include extensive coverage of fraud and abuse, despite the inherent challenges of keeping those materials current and teaching complex topics, reflects a different facet to the goal of simplification: provide a practice-ready experience with lightly edited primary sources and using questions and problems to focus the reading experience. Our coverage choices were influenced by the American Health Lawyers Association's (AHLA) Health Law Curriculum Guidance,[9] which emphasizes both topical coverage and skill-based methodologies. Drawing on AHLA's guidance, we also provided ample coverage of health care business law, including corporate fiduciary duties,[10]

7. HUBERFELD ET AL., *supra* note 1, at 461–522.

8. Campbell v. Redding Med. Ctr., 421 F.3d 817 (9th Cir. 2005).

9. *AHLA Health Law Curriculum Toolkit*, AMERICAN HEALTH LAWYERS ASS'N, https://www.healthlawyers.org/hlresources/PI/Pages/LawSchoolProject.aspx [https://perma.cc/N6F2-VE4W].

10. HUBERFELD ET AL., *supra* note 1, at 233–77.

antitrust,[11] and tax-exempt organizations.[12] Those are topics that students could study in other law school classes but that have unique health law components that warrant special consideration.

To that same end, we repeatedly asked ourselves, is this a topic with which counsel to an institutional health care provider, physician group, or other allied health provider would need familiarity? On that basis, we justified coverage of topics on the regulation of reproduction,[13] end-of-life decision making,[14] and regulation of human-subjects research,[15] subjects historically separated out as "bioethical." Although hospital counsel might not regularly be called to the bedside of a patient to advise on the family's or providers' rights to terminate life support, they will regularly encounter advance directives and similar legal instruments, may be affected by their state legislature's attempts to restrict access to abortion by regulating health care providers, and will need to certify a patient for various insurance coverage matters, including hospice. Likewise, while a minority of providers may be involved in large-scale biomedical research, many engage in small-scale experiments. And, as participants in the contemporary, complex, and ever-integrating health care industry, awareness of the ethical principles and federal laws by which new treatments, devices, and pharmaceuticals come to market is critical. In an age when patients are lobbying for "right to try laws,"[16] providers who offer cutting-edge medical treatments need lawyers who understand how patients gain access to novel procedures or other medical technologies.

The goal of simplification thus serves to make the topical nature of health care law somewhat easier to digest pedagogically. With fewer separate subjects, the persistent themes and underlying contradictory theories of health care law become clearer. Despite the unifying principles of the ACA, the United States is still very much mired in a debate regarding the market-based theory versus the social justice theory of health care. Every change that occurs in the law emphasizes one side or the other in this debate. The ACA shifted significantly toward social justice while still leaving many aspects of the private market in place. This pendulum could easily swing again (and appears to be doing so under President Trump), so emphasizing this tension, and teaching along the themes of governmental powers and individual rights, fiduciary relationships in health care business, and the modern administrative

11. *Id.* at 403–58.
12. *Id.* at 279–316.
13. *Id.* at 524–59.
14. *Id.* at 559–96.
15. HUBERFELD ET AL., *supra* note 1, at 645–721.
16. RIGHT TO TRY, http://righttotry.org [https://perma.cc/X2PQ-ZFH6]; *see, e.g.*, GA. CODE ANN. § 31-52-1 (2015); MINN. STAT. § 151.375 (2016); MISS. CODE ANN. § 41-131-1 (2015).

state, will help students to tackle new subjects as the law metamorphoses over time.

II. EMPHASIZE PRIMARY SOURCES

Our second objective in writing *The Law of American Health Care* was to depart from the conventional casebook organization of heavily edited appellate cases followed by extensive case notes that raise additional issues, cite similar cases, and flag colleagues' related research. The topical nature of health care law can make it difficult for students to pull the pieces together; therefore, we envisioned a book comprised almost entirely of lightly edited primary sources, linked by clear expository text. In the case of health law, primary sources include not only appellate cases but also statutes, regulations, government advisory opinions or memoranda, preambles to administrative rulemaking, commission reports, and empirical health policy research. We provide essential narrative framing for the selected materials because many of them will feel foreign to most students, but largely we let the sources speak for themselves, guiding teachers and students to dig in and draw out the key points. An expansive view of what counts as primary sources is critical to how health care law is actually practiced in the United States and is a key component to the theme of the modern administrative state.

Our approach necessitated inclusion of ample excerpts from federal and state statutes and regulations, even though they are challenging to teach. After the first year of law school, students are steeped in the case method and are able to walk through the facts, issue, rule, reasoning, and holding of an appellate opinion. They typically have far less experience working with legislative and administrative law and may simply skim over those portions of the assigned reading, lacking any methodology for unpacking them. To focus their reading, we provided comprehension questions following primary sources, as well as numerous problems that call for students to apply the materials they have just digested to a hypothetical fact-pattern, short drafting exercise, or policy discussion. Regulations and informal guidance from administrative agencies present particular challenges as not all students will have taken an Administrative Law course (all students in health law should do so before they graduate). Thus, we weave into the coverage across chapters the theme of the modern administrative state and its close cousin, federalism, through such essential topics as congressional delegation of power to administrative agencies, judicial deference to agency decision making, notice and comment rulemaking, and informal regulatory guidance as they arise organically within the primary sources.

The bulk of the book is comprised of primary sources, but we made a few exceptions for particular secondary sources. Some were in the cannon of health

law literature, including excerpts from Kenneth Arrow's 1963 paper, *Uncertainty and the Welfare Economics of Medical Care*,[17] Norman Daniels's 1981 essay, *Health-Care Need and Distributive Justice*,[18] and Paul Starr's 1982 classic, Pulitzer Prize-winning book, *The Social Transformation of American Medicine*.[19] The Arrow and Daniels pieces establish central and opposing themes in health care: market imperfections and social egalitarian principles. Key elements from Arrow's article still resonate in much of health care law, as American health care is animated by the tension between commitment to private market approaches and a gradually emerging consensus around broader, unified public policy solutions. The Starr excerpt efficiently and classically summarizes the history of private health insurance. We also included a few data-driven slides or studies published by key secondary sources such as *Health Affairs*, *Kaiser Family Foundation*, and *The Commonwealth Fund*. The ability to read and interpret data and robust industry reporting is an essential skill for the modern health lawyer, especially given how often the statutory framework shifts.

Each chapter concludes with a capstone problem, a detailed fact-pattern, real-world example, or drafting exercise, to help students synthesize the key points from the chapter in a hands-on, real-world way. Some of the problems are modified from final exam questions that we have given. Others are taken from our experiences in private practice. For all, the goal is that students close the chapter with a clearer understanding of how the topics that they just studied operate and why they matter to the overall project of learning about American health care.

III. REORGANIZE

Our third objective—fundamentally reorganizing the topics in the post-ACA era—was one of the major drivers for offering a new approach. Existing titles originated in a different era of health care delivery, before the federal government assumed far-reaching authority over private health insurance markets and significantly expanded public health care programs. Health care law is a constantly shifting landscape amid congressional debates, implementation hurdles, and persistent policy-oriented litigation. In *The Law of American Health Care*, we endeavored to proceed with beginners' minds, letting go of conventions and organizing the topics to reflect the current and next generation of health law, which is fundamentally federal and regulatory

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

18. Norman Daniels, *Health-Care Needs and Distributive Justice*, 10 PHIL. & PUB. AFF. 146 (1981).

19. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982).

rather than based in state common law. This is likely to remain true under a Republican re-write of the ACA.

Structurally, it was tempting to begin a survey course with subject matter familiar to the students, such as tort law duties of care, before proceeding into the more difficult insurance and business law topics. But, in the modern era, American health care is organized around third-party payers and the regulatory parameters that accompany financing programs and markets. Health care organizations and integrated delivery systems are the product of influential public payment experiments, choices, and structures. The preoccupation with health care fraud and abuse has no context without understanding government health care programs. Regulation of competition through antitrust laws is necessarily about the characteristic payment arrangement in health care markets. Many laws protecting patients arise out of government health care regulation, Medicare conditions of participation, or reimbursement methodologies. In closing the book with patient-related duties and laws, we do not mean to minimize the importance of those topics but rather to place them in the context of the modern health care industry.

One of our most radical organizational choices was to open with a "double-length chapter" on public health insurance. Traditional coverage would have led with private insurance regulation, followed by cursory coverage of government health care programs (namely, Medicare and Medicaid), treating the public programs as a fallback for individuals unable to find coverage on the private market. The current operation and likely future trajectory of health care in the United States is toward greater government regulation and provision of essential health care. A steadily increasing percentage of Americans are covered by Medicare, Medicaid, or other government health care programs;[20] nearly a third of the nation's population is covered by these programs. Medicaid covers approximately seventy-four million lives.[21] Public programs are no longer gap-fillers but instead have become central statutory frameworks and key policy drivers that require meaningful attention.

It is challenging to introduce students to intricate government health care programs along with essential health insurance concepts, but confronting these materials first has a leveling effect in the classroom, as most students will not know what to make of such ideas and will labor equally to grasp them. The

20. *Health Insurance Coverage of the Total Population*, KAISER FAMILY FOUNDATION, http://kff.org/other/state-indicator/totalpopulation/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D [https://perma.cc/K6BR-5RL4].

21. *Total Monthly Medicaid and CHIP Enrollment*, KAISER FAMILY FOUNDATION (Nov. 2016), http://kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=0&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D,%22nested%22:%7B%22all%22:%7B%7D%7D%7D [https://perma.cc/9BR8-JNDQ].

chapter covers these topics thoroughly and relies heavily on key themes of federalism, the modern administrative state, and market regulation. We give students a good taste of key concepts, including Medicare and Medicaid reimbursement, Medicaid waivers, and recent Supreme Court decisions including *National Federation of Independent Business v. Sebelius*[22] and limits on review of state noncompliance in *Armstrong v. Exceptional Child Center, Inc*.[23] We are convinced of the importance of orienting students' understanding of the array of health insurance options to include government plans as central components, not afterthoughts. An analogy might be certain world maps that are inverted to show the southern hemisphere on top, offering a new perspective on the size and prominence of often marginalized continents, including South America and Africa. With a thorough understanding of public provision of health insurance as a foundational coverage mechanism and key policy driver, students move on to consider the private market in which the other half of the American population obtains insurance.

We also significantly reorganized the approach to private insurance regulation compared to pre-ACA casebooks. For those of us who have studied and taught health law before and since the ACA, it is tempting to take a historical approach, describing how private markets operated and were regulated before, and then to explain the significant changes brought by the federal overhaul. But rather than teaching what the law *was* and what it *may become*—the only approach possible for a period of time after 2010 while so many critical pieces of the statute were in flux—we strive to teach what the law *is*. Although skirmishes continue on the ACA front, key components of the law are likely to remain in place, though possibly given different names. President Trump campaigned heavily on the promise to "repeal and replace" the ACA. But, as of this writing one month into the new Administration, supporters and advisors appear stymied on how to selectively dismantle some of the less popular provisions of the law without wholly undercutting reforms on which Americans across the socioeconomic and political spectrum have come to rely.

We resisted the temptation to dive first into the thick of the private market reforms with which students may be most familiar. Indeed, some students interested in health care law may ask if their school offers an "ACA class," reflecting the misunderstanding that the ACA is a stand-alone law rather than a body of laws necessarily and pervasively interwoven into longstanding statutes and other health care laws. After introducing the penalty for failure to carry minimum essential health coverage, we turn to employer-sponsored health insurance, through which a slim majority of Americans receive coverage.[24] We

22. 132 S. Ct. 2566 (2012).
23. 135 S. Ct. 1378 (2015).
24. KAISER FAMILY FOUNDATION, *supra* note 20.

include solid, but restrained coverage of ERISA, which maintains a relatively hands-off regulatory approach to employer-sponsored plans, even post-ACA. The final section of the chapter walks students through the newly important individual and small group markets. Among other topics, we trace a line between HIPAA's restrictions on preexisting condition exclusions and community rating provisions in large group plans and the ACA's extension of similar provisions to the non-group market.

CONCLUSION—EMBRACING THE CHALLENGE OF TOPICALITY

We believe emphasis on simplifying the number of and approach to health care law topics, focusing on primary sources, and reorganizing the materials make the basic health law course more satisfying for both instructors and students. But health care law is largely an applied field, and one that is stubbornly topical and changeable. This is where themes and theory are important teaching tools as well as an important future knowledge acquisition tool for students.

Our central organizing themes—federalism; individual rights; fiduciary relationships; the modern administrative state; and market regulation—are time-tested and persistent. They encompass cross-cutting dynamics of health care and health care law. And, each of these themes offer vectors along which students can expand their study of health law and its many subspecialties as well as embrace modifications to the field and never-before studied problems and questions. Whatever their form of practice, health lawyers will also find that the introduction to theories of health economics and social justice are anchors in deciphering changing laws and policies. The cross-section of topics, themes, and theories makes health care law uniquely difficult and endlessly fascinating.