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The Dynamism of Health Law: Expanded Insurance Coverage as the Engine of Regulatory Reform

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The Dynamism of Health Law: Expanded Insurance Coverage as the Engine of Regulatory Reform

Gabriel Scheffler*

Can law improve the delivery of health care? The predominant view is that law serves as a barrier to reforming the health care delivery system. Health law scholars of all stripes blame regulations for impeding innovation, limiting competition, and exacerbating fragmentation in health care.

I argue that this view neglects an important—but overlooked—feature of health law: the dynamic relationship between laws that expand health insurance coverage and laws that regulate the delivery of health care. By expanding health insurance coverage and increasing the demand for health care, laws such as Medicare, Medicaid and the Affordable Care Act catalyze policymakers to experiment with reforms to delivery system regulations over time. I chart the evolution of three key areas of delivery system law, and find that insurance expansions have contributed to dramatic changes in each of these areas.

Recognizing health law’s “dynamism” sheds light on two debates that are central to health care reform. First, contrary to what some scholars have argued, it reveals that expanding health insurance coverage should be viewed as a catalyst for delivery system reform, rather than being in competition with it. Second, it strengthens the case for further expanding health insurance coverage. I argue that a dynamic regulatory system is better able to address problems of access, costs, and quality; to adapt to other changes in the underlying health care system; and to facilitate policy learning.

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INTRODUCTION

A central question in health law and policy concerns how to improve the delivery of health care. It is often remarked that the United States spends far more money than any other country on health care, and yet Americans on average have worse life expectancies than other developed countries.¹ Health scholars searching for an explanation for this troubling disparity have tended to fixate on flaws in the health care "delivery system"—problems with how doctors, hospitals, and other health care providers deliver care to patients.²

1. ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, HEALTH AT A GLANCE 2017: OECD INDICATORS, <https://www.oecd.org/unitedstates/Health-at-a-Glance-2017-Key-Findings-UNITED-STATES.pdf> [<https://perma.cc/792G-WYTK>] (last visited Jan. 2, 2020).

2. See, e.g., JOHN E. WENNBURG ET AL., IMPROVING QUALITY AND CURBING HEALTH CARE SPENDING: OPPORTUNITIES FOR CONGRESS AND THE OBAMA ADMINISTRATION (2008); Donald M. Berwick & Andrew D. Hackbarth, *Eliminating Waste in US Health Care*, 307 JAMA 1513 (2012);

These flaws are striking. By some estimates, around 25% or 30% of health care spending is wasted on things like unnecessary care, administrative costs, and outright fraud.³ Spending on medical care varies dramatically across different parts of the country, but higher-spending regions do not have discernably better health outcomes.⁴ Thousands of patients die each year as a result of preventable medical errors.⁵ Americans pay prices for medical care that dwarf those in other developed countries.⁶

Perhaps surprisingly to non-health specialists, many health scholars view the law as the root of the problem.⁷ Richard Saver has called this view the “law-as-barrier perspective,” holding that “inflexible legal rules constrain delivery system innovation” by “block[ing] value-enhancing opportunities, often in favor of incumbent stakeholder interests.”⁸

William M. Sage, *Putting Insurance Reform in the ACA's Rear-View Mirror*, 51 HOUS. L. REV. 1081, 1083 (2014) [hereinafter Sage, *Insurance Reform*] (noting that policy relating to “medical services and products, rather than insurance . . . is commonly if inelegantly termed ‘delivery system reform.’”).

3. See, e.g., INST. OF MED., *BEST CARE AT LOWER COST: THE PATH TO CONTINUOUSLY LEARNING HEALTH CARE IN AMERICA* 12–13 (2013); William H. Shrank, Teresa L. Rogstad & Natasha Perekh, *Waste in the US Health Care System: Estimated Costs and Potential for Savings*, 322 JAMA 1501 (2019).

4. See, e.g., Elliott S. Fisher et al., *The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care*, 138 ANN. INT. MED. 273 (2003); Elliott S. Fisher et al., *The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care*, 138 ANN. INT. MED. 288 (2003).

5. See INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* 26 (2000) (estimating that between 44,000 and 98,000 Americans die each year as a result of preventable medical errors).

6. Gerard F. Anderson, Peter Hussey & Varduhi Petrosyan, *It's Still the Prices, Stupid: Why the US Spends So Much on Health Care, and a Tribute to Uwe Reinhardt*, 38 HEALTH AFF. 87 (2019).

7. See, e.g., Einer Elhauge, *Why We Should Care About Health Care Fragmentation and How to Fix It*, in *THE FRAGMENTATION OF U.S. HEALTH CARE* 1, 11 (Einer Elhauge ed., 2010) [hereinafter Elhauge, *Health Care Fragmentation*] (“The dominant cause of fragmentation . . . appears to be the law, which dictates many of the fragmented features described above and thus precludes alternative [sic] organizational structures.”); William M. Sage, *Relating Health Law to Health Policy: A Frictional Account*, in *THE OXFORD HANDBOOK OF U.S. HEALTH LAW* 3, 5–6 (I. Glenn Cohen, Allison K. Hoffman & William M. Sage eds., 2017) [hereinafter Sage, *Relating Health Law to Health Policy*] (“The concrete—and correct—answer known mainly to health lawyers is that the accumulation of professional privileges, judicial decisions, statutes and regulations, and unconditional public subsidies over the course of more than a century has severely distorted U.S. healthcare markets and crippled competition. Because of long-term regulation, production of health services is fragmented, price competition is minimal, entry barriers are high, geographic markets are small and often bottlenecked, large insurers and large providers are mutually entrenched, and innovation is channeled toward inputs that best suit flawed production processes.”); Timothy S. Jost & Ezekiel J. Emanuel, *Legal Reforms Necessary to Promote Delivery System Innovation*, 299 JAMA 2561, 2561 (2008) (“One of the biggest barriers to delivery system innovation is the complex web of laws and regulations.”).

8. Richard S. Saver, *Health Law's Uneasy Relationship with Delivery System Innovation*, in *THE OXFORD HANDBOOK OF U.S. HEALTH LAW* 659, 659 (I. Glenn Cohen, Allison K. Hoffman & William M. Sage eds., 2017) [hereinafter Saver, *Uneasy Relationship*]. Of note, Saver himself argues that law “sometimes breaks this pattern quite dramatically” by “act[ing] as an endogenous force for ushering in

Many of these criticisms focus on the laws governing the health care delivery system. These laws—such as scope of practice restrictions, the corporate practice of medicine doctrine, and Certificate of Need (CON) laws—regulate the *supply* of health care. They determine, among other things, which professions and entities can legally provide health care services, what types of services they can offer, and the conditions and arrangements under which they can provide them.⁹ Although many of these laws have laudable aims, such as protecting public safety and lowering health care costs, health care scholars of all stripes have condemned them for contributing to some of the most prominent afflictions troubling the health care delivery system, including inadequate competition,¹⁰ excessive fragmentation,¹¹ and a dearth of innovation.¹²

To make matters worse, delivery system laws are viewed as difficult to change. Scholars have emphasized the “path dependence” of health law,¹³ and describe delivery system laws in particular as stagnant and antiquated.¹⁴ According to these critics, the problem lies in a combination of inertia and interest group dynamics: many of the existing laws are supported by interest groups such as

innovation, sometimes providing needed governmental support to overcome underproduction of public-good-like services and delivery models.” *Id.* at 674.

9. See Sandra Johnson, *Structure of Governmental Oversight of Quality in Healthcare*, in THE OXFORD HANDBOOK OF U.S. HEALTH LAW 490, 490 (I. Glenn Cohen, Allison K. Hoffman & William M. Sage eds., 2017).

10. William M. Sage & David A. Hyman, *Antitrust As Disruptive Innovation in Health Care: Can Limiting State Action Immunity Help Save a Trillion Dollars?*, 48 LOY. U. CHI. L.J. 723, 730–34 (2017).

11. See Elhaug, *Health Care Fragmentation*, *supra* note 7, at 1 (defining *health care fragmentation* as a situation where “having multiple decision makers make a set of health care decisions that would be made better through unified decision making”); Joan K. Krause, *Integration, Fragmentation, and Human Nature: The Role of the Fraud and Abuse Laws in a Changing Healthcare System*, in THE OXFORD HANDBOOK OF U.S. HEALTH LAW 852, 852–53 (I. Glenn Cohen, Allison K. Hoffman & William M. Sage eds., 2017) [hereinafter Krause, *Integration, Fragmentation, and Human Nature*]; Randall D. Cebul, James B. Rebitzer, Lowell J. Taylor & Mark E. Votruba, *Organizational Fragmentation and Care Quality in the U.S. Healthcare System*, 22 J. ECON. PERSP. 93 (2007).

12. See, e.g., John H. Cochrane, *After the ACA: Freeing the Market for Healthcare*, in THE FUTURE OF HEALTHCARE REFORM IN THE UNITED STATES 161 (Anup Malani & Michael H. Schill eds., 2015); Lesley H. Curtis & Kevin A. Schulman, *Overregulation of Health Care: Musings on Disruptive Innovation Theory*, 69 L. & CONTEMP. PROBS. 195 (2006); Jost & Emanuel, *supra* note 7.

13. See, e.g., Saver, *Uneasy Relationship*, *supra* note 8, at 673.

14. See, e.g., Allison K. Hoffman, *What Health Reform Reveals About Health Law*, in THE OXFORD HANDBOOK OF U.S. HEALTH LAW 49, 61 (I. Glenn Cohen, Allison K. Hoffman & William M. Sage eds., 2017) (“[T]he ACA offers a window into how healthcare regulation can have paralyzing effects on innovation, especially in healthcare delivery. Health law has entrenched an antiquated notion of medicine—that of a doctor as a revered professional and lone wolf.”); Nicole Huberfeld, *Be Not Afraid of Change: Time to Eliminate the Corporate Practice of Medicine Doctrine*, 14 HEALTH MATRIX 243, 292 (2004) (characterizing the corporate practice of medicine doctrine as an “archaic doctrine” that “does nothing to advance quality of care”); Peter D. Jacobson, Laura M. Napiewocki & Leah A. Voigt, *Regulating the U.S. Health Care System: Failure in Motion*, 36 J. HEALTH POL. POL’Y & L. 583, 585 (2011) (“[T]he rapidly changing health care delivery system requires a dynamic regulatory capability, as opposed to the static regulatory approach now dominant.”).

physicians and hospitals who benefit from the status quo.¹⁵ It is especially difficult to change delivery system laws in a way that curbs health care spending, since doing so will necessarily lead to reduced profits and job losses in the health care sector.¹⁶ This dynamic was most memorably articulated by the late economist Uwe Reinhardt, who pronounced it a “cosmic law” that “*Every dollar health spending=Someone’s health-care income.*”¹⁷

That is not to say there have been no efforts to change the status quo. To the contrary, one of the central goals of the 2010 Patient Protection and Affordable Care Act (ACA) was to improve the delivery system.¹⁸ Most prominently, the ACA included several initiatives designed to shift from a “fee-for-service” reimbursement system, in which providers are reimbursed mainly based on the amount of care that they provide (e.g., ordering a test, performing a procedure, etc.), to a “value-based system,” in which providers are rewarded for improving patients’ health.¹⁹ Nevertheless, these efforts have been met with some skepticism from many health scholars, who among other things point out that they largely leave the existing delivery system regulations in place.²⁰ Empirical evidence suggests that so far these

15. See Sage, *Relating Health Law to Health Policy*, *supra* note 7, at 13 (“American health law strongly supports the medical profession.”); Saver, *Uneasy Relationship*, *supra* note 8, at 673 (“The ability of incumbents to leverage law to block innovation is part of a larger pattern of path dependence underlying the delivery system. Existing institutions and structures, as well as historical contingencies, have channeled the delivery system along established directions, making more radical, innovative change less likely.”); Sage & Hyman, *supra* note 10, at 732 (“The deep legal architecture of health care strongly favors physician self-regulation, and furthers physicians’ professional insularity and self-interest.”).

16. STEVEN BRILL, AMERICA’S BITTER PILL: MONEY, POLITICS, BACKROOM DEALS, AND THE FIGHT TO FIX OUR BROKEN HEALTHCARE SYSTEM 58 (2015) (quoting Jon Kingsdale) (“Though there is broad agreement on the need for containment, any particular cost containment idea means reducing revenue flow to somebody, and there is always stronger opposition from even a smaller party than there is broad depth of broad support.”); Amitabh Chandra & Jonathan Skinner, *Health Care Employment Growth and the Future of US Cost Containment*, 319 JAMA 1861 (2018).

17. UWE E. REINHARDT, PRICED OUT: THE ECONOMIC AND ETHICAL COSTS OF AMERICAN HEALTH CARE 57 (2019).

18. See JOHN E. MCDONOUGH, INSIDE NATIONAL HEALTH REFORM 155–81 (2011) (summarizing the main delivery system reform provisions in the ACA); Sage, *Insurance Reform*, *supra* note 2, at 1085 (“The ACA’s true breakthrough—and its arguable overreach—is not its attempt to universalize health insurance, but its unprecedented goals of also making medical care better and more efficient and of improving underlying health.”).

19. See WHITE HOUSE COUNCIL OF ECONOMIC ADVISERS, THE ECONOMIC RECORD OF THE OBAMA ADMINISTRATION: REFORMING THE HEALTH CARE SYSTEM 1, 47–56 (2016) [hereinafter ECONOMIC RECORD].

20. See, e.g., Nicholas Bagley, *Bedside Bureaucrats: Why Medicare Reform Hasn’t Worked*, 101 GEO. L.J. 519, 525 (2013) [hereinafter Bagley, *Bedside Bureaucrats*] (characterizing the set of Medicare delivery system reforms in the ACA as a “disappointment”); Theodore Marmor & Jonathan Oberlander, *From HMOs to ACOs: The Quest for the Holy Grail in U.S. Health Policy*, 27 J. GEN. INTERNAL MED. 1215, 1217 (2012) (“[O]ur history of failed cost control offers sobering lessons about exaggerated expectations, the limits of organizational reforms, and the recurring temptation to oversell reform ideas like ACOs as panaceas and the harbingers of a new, radically transformed, and vastly improved health care system.”); Theodore W. Ruger, *Of Icebergs and Glaciers: The Submerged*

payment reforms have yielded mixed results, leading to some improvements in quality measures but relatively modest reductions in health care spending.²¹

In this Article, I argue that the “law-as-barrier perspective” neglects a central feature of health law: the dynamic relationship between laws that expand health insurance (“health care financing laws”) and laws regulating the delivery of health care. In contrast to the perception of health law as stagnant and antiquated, I show that health care financing laws are in fact largely responsible for what I refer to as health law’s “dynamism.”

By increasing the *demand* for health care, these laws serve to catalyze state and federal policymakers to repeatedly experiment with regulatory reforms designed to improve access to health care, ensure quality, and reduce health care costs. The expansion of health insurance has contributed to a dynamic system, one in which regulators are frequently amending delivery system regulations, then monitoring and assessing the consequences of those amendments in practice, and making further changes when necessary. This Article illustrates how the enactment of Medicare and Medicaid and the ACA have promoted this dynamism by showing how they have contributed to substantial changes in three consequential areas of delivery system law, each of which is viewed as emblematic of the “law-as-barrier perspective.”

Uncovering this dynamic relationship also has implications for the future of health care reform. It implies that expanding health insurance should be viewed as a catalyst for delivery system reform, rather than being in competition with it. Contrary to Richard Epstein and David Hyman, who argue that achieving universal health insurance without reforming the regulations governing the health care delivery system will only further lock us into “the current dysfunctional state of affairs,”²² in fact the opposite is true. The history of the interactions between health care financing laws and health care delivery laws suggests that future efforts to further expand health insurance (whether through enacting a single payer-system or through building on the ACA’s existing framework) will create pressure for more fundamental reforms to this legal regime—and to the structure of the health care delivery system.

Constitution of American Healthcare, 75 L. & CONTEMP. PROBS. 215, 221 (2012) (“The ACA’s architecture is clearly and profoundly solicitous of the extant structures of the medical delivery system.”). *But see* Einer R. Elhauge, *Obamacare and the Theory of the Firm*, in *THE FUTURE OF HEALTHCARE REFORM IN THE UNITED STATES* 202, 217 (Anup Malani & Michael H. Schill eds., 2015) (pointing out that the Affordable Care Act at least provides regulators with some tools for the federal government “to remove legal barriers to efficient health care integration”).

21. *See, e.g.*, Jonathan Skinner & Amitabh Chandra, *The Past and Future of the Affordable Care Act*, 316 JAMA 497, 497–98 (2016); J. Michael McWilliams et al., *Early Performance of Accountable Care Organizations in Medicare*, 374 NEW ENG. J. MED. 2357 (2016); Austin Frakt, *‘Value’ of Care Was a Big Goal. How Did It Work Out?*, N.Y. TIMES UPSHOT (Sept. 23, 2019), <https://www.nytimes.com/2019/09/23/upshot/medicare-health-value-costs.html> [<https://perma.cc/JK3G-7XQP>].

22. Richard A. Epstein & David A. Hyman, *Fixing Obamacare: The Virtues of Choice, Competition, and Deregulation*, 68 N.Y.U. ANN. SURV. AM. L. 493, 516 (2013).

I also conclude that this dynamism is a positive force for improving health care delivery, and that recognizing it strengthens the case for further expanding health insurance coverage. First, expanding insurance coverage prompts reforms aimed at addressing problems of access, costs, and quality. Second, it enables delivery system regulations to evolve in response to other changes in the health care system. Third, it facilitates learning about the optimal regulatory approach by enabling policymakers to reverse course and correct mistakes. These advantages are especially important in the context of health care, given the strong justifications for expanding health insurance coverage, the continual evolution in health care technology and modes of delivering patient care, and the uncertainty as to the optimal strategy for regulating the health care delivery.

As far as I am aware, this is the first work to explore the general relationship between expanding health insurance coverage and reforming health care delivery laws. Kenneth Arrow foreshadowed health law's dynamism in his classic 1963 article, *Uncertainty and the Welfare Economics of Medical Care*, albeit in very general terms.²³ Other scholars such as Paul Starr and John Kingdon have pointed out how the enactment of Medicare precipitated new regulations aimed at reducing health care costs in particular,²⁴ while Joan Krause, Frances Miller, and Clark Havighurst have examined the implications of health insurance expansions for fraud and abuse laws.²⁵ Yet these earlier works do not take a holistic view of how health care financing laws influence health care delivery laws by influencing the demand for health care, nor do they fully develop the implications of this relationship for health law and policy.

This Article proceeds in four parts. Part I reviews three of the most prominent and widely criticized types of health care delivery system laws—scope of practice restrictions, the corporate practice of medicine doctrine, and CON regulations—and outlines the prevailing view of these laws as barriers to improving the delivery of health care.

Part II then examines why expanding health insurance coverage has served to transform these laws. It first shows that increasing insurance coverage serves to increase the demand for health care through several channels; next, drawing on work by Arrow and Kingdon, it explains why this increase in demand in turn creates pressure to reform health care delivery laws.

Part III then illustrates this causal chain by showing how Medicare and Medicaid—and to a lesser extent, the ACA—have led to changes in each of the

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

24. See JOHN W. KINGDON, AGENDAS, ALTERNATIVES, AND PUBLIC POLICIES 106–07 (2011); PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 398–404 (1982) [hereinafter STARR, SOCIAL TRANSFORMATION].

25. See Clark C. Havighurst, *American Health Care and the Law—We Need to Talk!*, 19 HEALTH AFF. 84, 88–90 (2000); Joan H. Krause, *Fraud in Universal Coverage: The Usual Suspects (And Then Some)*, 55 U. KAN. L. REV. 1151 (2007); Frances H. Miller, *Doctors' Conflicts of Interest (& Altruism) in the United States and Great Britain*, 27 IND. L. REV. 687, 693 (1994).

aforementioned three areas of delivery system law. Somewhat surprisingly, these changes have not been consistently pro-regulatory or deregulatory: health care financing laws contributed to the enactment of CON laws, but they have also contributed to the curtailment of the corporate practice of medicine doctrine and scope of practice restrictions—both of which predated the widespread availability of health insurance.

Part IV argues that expanding health insurance coverage is the best way to achieve more fundamental reforms to health care delivery laws. It also argues that on balance, having a dynamic regulatory system in health care is normatively desirable in health care, and that recognizing this dynamism strengthens the case for further expanding coverage.

The Article concludes by exploring the implications of this dynamism for the field of health law as a whole. In contrast to the popular characterization of health law as a “patchwork” of divergent laws with little internal coherence,²⁶ I argue that uncovering the linkages between health care financing laws and health care delivery laws strengthens the case for conceptualizing and approaching health law as a distinct field of scholarly inquiry.

I. HEALTH CARE DELIVERY SYSTEM LAWS AND THEIR DISCONTENTS

Health care providers are subject to a voluminous array of federal regulations, state laws, and private certifications and standards.²⁷ In this section, I limit myself to briefly describing three prominent areas of law governing the delivery of health care, and sketching out some of the main criticisms that have been leveled against them. These laws have two main things in common: First, they are widely viewed as impeding beneficial developments in the delivery of health care by restraining innovation, limiting competition, and increasing fragmentation. Second, they are perceived as emblematic of health law’s intractable nature, and of its excessive deference to health care providers.

A. Scope of Practice Restrictions

State occupational licensing laws are the oldest form of laws governing the health care delivery system.²⁸ These laws generally provide that it is unlawful to practice without a license, lay out certain educational, training, and testing requirements, and establish a state licensing board (usually primarily composed of

26. See, e.g., M. Gregg Bloche, *The Invention of Health Law*, 91 CAL. L. REV. 247, 321 (2003) (“The law of health care provision is a chaotic, dysfunctional patchwork.”).

27. Kieran Walshe & Stephen M. Shortell, *Social Regulation of Healthcare Organizations in the United States: Developing a Framework for Evaluation*, 17 HEALTH SERV. MGMT. RES. 79, 79–80 (2004).

28. See Lewis A. Grossman, *The Origins of American Health Libertarianism*, 13 YALE J. HEALTH POL’Y L. & ETHICS 76, 88–89 (2013) (describing how some states enacted medical licensing laws before the American Revolutionary War).

members of the licensed profession) to interpret and enforce the statute.²⁹ In addition, licensing laws specify the range of services that health care providers are allowed to perform—their so-called “scope of practice”—along with any relevant conditions.³⁰

Licensing laws set quite different scopes of practice for different professions. Physicians were the first health care profession to be licensed,³¹ and are the only health care profession whose legal scope of practice is “all-encompassing.”³² Licensing laws grant the exclusive authority to physicians to perform any service that is circumscribed within “the practice of medicine,” which tends to be defined quite expansively. For instance, Indiana’s medical practice act defines the practice of medicine as including:

[T]he diagnosis, treatment, correction, or prevention of any disease, ailment, defect, injury, infirmity, deformity, pain, or other condition of human beings; the suggestion, recommendation, or prescription or administration of any form of treatment, without limitation; [and] the performing of any kind of surgical operation upon a human being, including tattooing.³³

Because the practice of medicine is deemed to be exclusively within the purview of physicians, any non-physician who knowingly engages in any of these services without a medical license could be deemed to be practicing medicine without a license—which in this case is deemed a Class C felony.³⁴

By contrast, other health care providers, including nurses, physician assistants, pharmacists, and dental hygienists, have had to carve out much narrower scopes of practice. For example, Indiana defines “practical nursing” to include:

[C]ontributing to the assessment of the health status of individuals or groups; participating in the development and modification of the strategy of care; implementing the appropriate aspects of the strategy of care; maintaining safe and effective nursing care; and participating in the evaluation of responses to the strategy of care.³⁵

Licensing laws also often require that non-physicians must be supervised by a physician in order to perform certain types of tasks. For instance, Indiana allows

29. BARRY R. FURROW, THOMAS L. GREANEY, SANDRA H. JOHNSON, TIMOTHY STOLTZFUSS JOST & ROBERT L. SCHWARTZ, *HEALTH LAW* 6 (2015); Timothy Stoltzfus Jost, *Introduction—Regulation of the Healthcare Professions*, in *REGULATION OF THE HEALTHCARE PROFESSIONS* 2–5 (Timothy Jost ed., 1992).

30. Johnson, *supra* note 9, at 504–09.

31. Barbara J. Safriet, *Closing the Gap Between Can and May in Health-Care Providers’ Scopes of Practice: A Primer for Policymakers*, 9 *YALE J. REG.* 301, 306 (2002).

32. Barbara Safriet, *Impediments to Progress in Health Care Workforce Policy: License and Practice Laws*, 31 *INQUIRY* 310, 311 (1994).

33. Johnson, *supra* note 9, at 502–03 (quoting *IND. CODE ANN.* § 25-22.5-1-1.1 (1978)) (emphasis added).

34. *IND. CODE ANN.* § 25-22.5-8-2 (1978).

35. *IND. CODE ANN.* § 25-23-1-1.3 (1993).

nurse anesthetists to “administer anesthesia if the certified registered nurse anesthetist acts under the direction of and in the immediate presence of a physician.”³⁶

Although some scope of practice requirements may be warranted, others place excessive limitations on the types of functions performed by non-physician health care providers, thereby limiting access to health care—and potentially also raising health care costs.³⁷ William Sage and David Hyman describe licensing laws as “the most pernicious practice,” and argue that they “discourage existing competitors from adopting practices introduced to the market by disruptive innovators” and “limit the ability of other licensed health professionals to enter the market, even when they have extensive training in diagnosis and treatment.”³⁸

One illustrative piece of evidence that scope of practice requirements are not set at an optimal level is that they vary widely from state to state. For example, whereas twenty-two states and the District of Columbia allow Nurse Practitioners (NPs) to diagnose patients, initiate and manage certain conditions, and prescribe medications independently, twelve states require NPs to have physician oversight in order to prescribe, diagnose, and treat patients.³⁹ This variation cannot be justified by quality concerns, given that health care education and training standards are evidence-based and set nationally.⁴⁰

A wide range of institutions, including the Institute of Medicine, the Pew Health Professions Commission, and the Federal Trade Commission have argued in favor of expanding scope of practice restrictions for health professionals such as Advanced Practice Nurses (APNs) (a category that includes Nurse Practitioners, Registered Nurse Anesthetists, Nurse-Midwives, and Clinical Nurse Specialists)⁴¹ as a way to improve access to both primary and acute care without sacrificing quality.⁴²

36. IND. CODE ANN. § 25-23-1-30 (1993).

37. See, e.g., E. Kathleen Adams & Sara Markowitz, *Improving Efficiency in the Health-Care System: Removing Anticompetitive Barriers for Advanced Practice Registered Nurses and Physician Assistants*, THE HAMILTON 7 (June 2018), http://www.hamiltonproject.org/papers/removing_anticompetitive_barriers_for_advanced_practice_registered_nurses_a [<https://perma.cc/Y43T-L8ZR>]; Morris M. Kleiner, Allison Marier, Kyoung Won Park & Coady Wing, *Relaxing Occupational Licensing Requirements: Analyzing Wages and Prices for a Medical Service*, 59 J.L. & ECON. 261 (2016); Gabriel Scheffler, *Unlocking Access to Health Care: A Federalist Approach to Reforming Occupational Licensing*, 29 HEALTH MATRIX 293, 310–15 (2019); Tanya Wanchek, *Dental Hygiene Regulation and Access to Oral Healthcare: Assessing the Variation Across the US States*, 48 BRIT. J. INDUS. REL. 706 (2010).

38. Sage & Hyman, *supra* note 10, at 734.

39. Scheffler, *supra* note 37, at 313–14.

40. Robert Kocher, Topher Spiro, Emily Oshima Lee, Gabriel Scheffler, Stephen Shortell, David Cutler & Ezekiel Emanuel, *Doctors Without State Borders: Physicians Practicing Across State Lines*, HEALTH AFF. BLOG (Feb. 18, 2014), <http://healthaffairs.org/blog/2014/02/18/doctors-without-state-borders-practicing-across-state-lines/> [<https://perma.cc/RU64-Z224>].

41. Nat’l Council of State Boards of Nursing, *APRNs in the U.S.*, NCSBN, <https://www.ncsbn.org/aprn.htm> [<https://perma.cc/3LNQ-GTYA>] (last visited Jan. 2, 2020).

42. See, e.g., EDITH RAMIREZ, JULIE BRILL, MAUREEN K. OHLHAUSEN & JOSHUA WRIGHT, FED. TRADE COMM’N, POLICY PERSPECTIVES: COMPETITION AND THE REGULATION OF

B. *The Corporate Practice of Medicine Doctrine*

The general rationale of the corporate practice of medicine doctrine is to prevent corporations, as well as individuals who do not possess a medical license, from unduly interfering with medical decision-making.⁴³ It entails three specific related prohibitions: First, it prevents unlicensed individuals or corporations from directly employing physicians. Second, it prevents unlicensed individuals from owning or controlling entities that provide health care services. Third, it prohibits licensed health care providers from engaging in “fee splitting,” sharing their professional earnings with unlicensed individuals or entities.⁴⁴

The origins of the corporate practice of medicine doctrine date back to the early twentieth century, when the American Medical Association (AMA) was growing increasingly concerned by the advent of new business-oriented health care delivery models.⁴⁵ At least two new delivery models began to crop up during that period: “contract practice,” in which corporations directly employed physicians to provide medical care for their own employees; and “corporate practice,” in which corporations employed or contracted with physicians and advertised their services to the public.⁴⁶ Critics of these models, including the AMA, perceived these arrangements as threats to the autonomy of the medical profession and to the quality of patient care.⁴⁷ More cynically, physicians opposed these corporate models because they threatened to dilute the profits from delivering health care.⁴⁸

In response, the AMA introduced new restrictions in its code of professional ethics against both contract practice and corporate practice, such as those condemning any arrangements under which corporations profit from providing medical services.⁴⁹ In addition, a series of court rulings during the early twentieth

ADVANCED PRACTICE NURSES (2014), <https://www.ftc.gov/reports/policy-perspectives-competition-regulation-advanced-practice-nurses> [<https://perma.cc/BL66-PQ3X>]; INST. OF MED., THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH 9 (2011); LEONARD J. FINOCCHIO ET AL., PEW HEALTH PROFESSIONS COMM'N, REFORMING HEALTH CARE WORKFORCE REGULATION: POLICY CONSIDERATIONS FOR THE 21ST CENTURY 9–13 (1995).

43. Huberfeld, *supra* note 14, at 251–52.

44. *Id.* at 244.

45. CHRISTY FORD CHAPIN, ENSURING AMERICA'S HEALTH: THE PUBLIC CREATION OF THE CORPORATE HEALTH CARE SYSTEM 20 (2015) (“The notion of an overtly competitive, commercial health care market dominated by medical corporations terrified physician leaders.”); STARR, SOCIAL TRANSFORMATION, *supra* note 24, at 198–99.

46. CHAPIN, *supra* note 45, at 16–20; STARR, SOCIAL TRANSFORMATION, *supra* note 24, at 200–06; Jeffrey F. Chase-Lubitz, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry*, 40 VAND. L. REV. 445, 456–57 (1987); Adam M. Freiman, *The Abandonment of the Antiquated Corporate Practice of Medicine Doctrine: Injecting a Dose of Efficiency into the Modern Health Care Environment*, EMORY L.J. 697, 702 (1998); Huberfeld, *supra* note 14, at 247–48.

47. Chase-Lubitz, *supra* note 46, at 457–58; Freiman, *supra* note 46, at 702.

48. STARR, SOCIAL TRANSFORMATION, *supra* note 24, at 215–16 (“Doctors opposed corporate enterprise in medical practice not only because they wanted to preserve their autonomy, but also because they wanted to prevent the emergence of any intermediary or third party that might keep for itself the profits potentially available in the practice of medicine.”).

49. Freiman, *supra* note 46, at 703.

century held that corporate practice arrangements violated state medical licensing laws.⁵⁰ Although most medical practice acts do not explicitly prohibit the corporate practice of medicine, courts interpreted their requirements that persons have a valid license in order to practice medicine as implicitly also prohibiting corporations from practicing medicine.⁵¹ In some cases, courts justified their interpretations of medical practice acts by relying on public policy concerns: for example, worrying that the corporate practice of medicine doctrine would impair the doctor-patient relationship or commercialize the medical profession.⁵²

As the practice of medicine has evolved from solo practitioners to large integrated health care organizations, the doctrine has ceased to be enforced in most states.⁵³ The Supreme Court dealt the AMA a major setback in 1982 when it affirmed a Federal Trade Commission order that the AMA's ethical restraints on the corporate practice of medicine violated the Federal Trade Commission Act.⁵⁴ In addition, many states have carved out explicit exceptions to the doctrine, including for non-profit health care organizations, health care organizations owned and managed by licensed physicians, health maintenance organizations (HMOs), and medical schools.⁵⁵

Nevertheless, the corporate practice of medicine doctrine continues to influence how health care organizations are structured and managed today. The corporate practice doctrine helps to explain, for example, why Medicare pays doctors separately from hospitals, and why hospital staffs in the United States are typically members of independent medical staffs, rather than hospital employees.⁵⁶ Medical staff committees, rather than the hospital, are generally responsible for

50. See, e.g., *Parker v. Bd. of Dental Exam'rs of State of Cal.*, 216 Cal. 285, 295 (1932) ("The letter of the statute authorizes *persons* only to engage in the practice of dentistry. The underlying theory upon which the whole system of dental laws is framed is that the state's licensee shall possess consciousness, learning, skill, and good moral character, all of which are individual characteristics, and none of which is an attribute of an artificial entity."); *People v. Painless Parker Dentist*, 85 Colo. 304, 313 (1929) ("It is, however, altogether clear that the inhibition of the statute against the practice of dentistry in this state is applicable not only to natural persons, but it applies as well to an artificial person or a corporation, because, in the very nature of things, the corporation cannot meet the conditions upon which the right to a license depends, and no one, whether an ordinary person or an artificial being, is entitled to practice unless, among other requirements, he first secures a license from our state board of dental examiners.").

51. See Freiman, *supra* note 46, at 704–4–05; *Right of the Corporation to Practice Medicine*, 48 YALE L.J. 346, 347–48 (1938); Huberfeld, *supra* note 14, at 250–051.

52. See, e.g., *Bartron v. Codington Cty.*, 68 S.D. 309, 329 (1942) ("Being convinced that the practice of the learned professions by a profit corporation tends to the commercialization and debasement of those professions, we are of the opinion that such a mode of conducting the practice is in contravention of the public interest and is against public policy.").

53. Freiman, *supra* note 46, at 733–40.

54. *Am. Med. Ass'n v. F.T.C.*, 455 U.S. 676 (1982).

55. See Freiman, *supra* note 46, at 706–08.

56. MARK A. HALL, MARY ANNE BOBINSKI & DAVID ORENTLICHER, *HEALTH CARE LAW AND ETHICS* 1273 (8th ed. 2013).

overseeing physicians working in the hospital.⁵⁷ The prevailing view is that while corporate practice prohibitions have been weakened, they remain “legal landmines,” remnants of an old and nearly forgotten war, half-buried on a field fast being built up with new forms of health care organizations.⁵⁸ The fear of tripping these landmines hampers innovation by inhibiting health care organizations from experimenting with new delivery models.⁵⁹

Over the years, many scholars have argued in favor of abolishing the corporate practice of medicine doctrine altogether.⁶⁰ These critics argue that the original justifications undergirding the doctrine no longer apply in a world in which the delivery of health care is increasingly team-based, and where managed care companies exert influence over how care is delivered.⁶¹ Rather than serving to promote quality, they argue that the corporate practice of medicine doctrine in fact degrades the quality of health care by making our health care delivery system more fragmented.⁶² Critics argue that the corporate practice of medicine doctrine contributes to this fragmentation by preventing health care organizations from exerting control over physicians’ decisions and making it more difficult for health care organizations to implement patient-safety initiatives.⁶³

C. Certificate of Need Laws

Certificate of Need (CON) laws were ostensibly designed to halt the growth in health care spending by requiring hospitals to demonstrate “community need” before making new capital investments.⁶⁴ The theory underlying CON laws, known as “Roemer’s Law” (named after health services researcher Milton Roemer), was that the construction of new health care facilities itself leads to unnecessary health care utilization—a theory succinctly encapsulated by the maxim, “a built bed is a

57. Kristin Madison, *Defragmenting Health Care Delivery Through Quality Reporting*, in THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS 87 (Einer Elhauge ed., 2010).

58. Arnold J. Rosoff, *The Business of Medicine: Problems with the Corporate Practice Doctrine*, 17 CUMB. L. REV. 485 (1986); see also Chase-Lubitz, *supra* note 46, at 470–71; Huberfeld, *supra* note 14, at 253 (“While the doctrine may seem too outdated to be enforced, the statutes and regulations that form the doctrine remain in current statutory compilations and, like a sleeping dragon, need only a slight stimulus to be set into action.”).

59. See Chase-Lubitz, *supra* note 46, at 470; see also Saver, *Uneasy Relationship*, *supra* note 8, at 660 (defining health care delivery innovations as “typically alter[ing] the bundle of healthcare services offered, how the services are paid for, the process for delivering the services, the medical personnel involved, the site of delivery, the use of products and technology, or the organizational structure under which care is provided”).

60. See, e.g., Cebul et al., *supra* note 11, at 109; Huberfeld, *supra* note 14; Jost & Emanuel, *supra* note 7, at 2562.

61. Huberfeld, *supra* note 14, at 257–60.

62. Cebul et al., *supra* note 11.

63. See Elhauge, *Health Care Fragmentation*, *supra* note 7, at 12.

64. James B. Simpson, *Full Circle: The Return of Certificate of Need Regulation of Health Facilities to State Control*, 19 IND. L. REV. 1025, 1025 (1986).

filled bed.”⁶⁵ Perhaps counterintuitively, hospitals have historically found CON laws appealing, both as a means of erecting barriers to entry for potential competitors and as a way of forestalling more dramatic government intervention into the health care market.⁶⁶

CON laws grew out of previous “health planning” initiatives that involved the federal government and state governments in the construction of health care facilities.⁶⁷ The most prominent of these was the Hill-Burton Act of 1946, which provided federal grants and loans to states that came up with detailed plans identifying their need for new health care facilities and how to address those needs.⁶⁸

CON laws emerged during the 1960s and early 1970s, at a time when hospital prices were rising at six percent above the general rate of inflation.⁶⁹ New York enacted the first CON law in 1964, and twenty states enacted their own CON laws between the 1971 and 1973 legislative sessions.⁷⁰ In 1974, Congress passed the National Health Planning and Resources Development Act (NHPDA), which offered funding to state CON programs that met certain federal standards.⁷¹ By 1980, all fifty states had enacted their own CON legislation.⁷²

The heyday of CON laws proved to be short-lived, however, and they fell out of favor during the 1980s. The advent of managed care and the introduction of Medicare’s Prospective Payment System created new incentives for hospitals to control health care spending, which in turn appeared to render CON less necessary.⁷³ This was accompanied by a growing perception among policymakers and researchers that CON laws were failing to reduce health care spending.⁷⁴ In 1987, Congress turned against CON laws and repealed the NHPDA,⁷⁵ prompting

65. Nicholas Bagley, *Medicine As a Public Calling*, 114 MICH. L.J. 57, 88 (2015) [hereinafter Bagley, *Medicine As a Public Calling*].

66. See STARR, SOCIAL TRANSFORMATION, *supra* note 24, at 398–99 (“The interest of state legislatures was plainly cost control. However, the main inspiration for certificate-of-need came from the American Hospital Association and its state affiliates. The hospitals, anxious to avoid other forms of control, stood to benefit from the limits on competition that this sort of regulation would create.”); see also Sallyanne Payton & Rhoda M. Powsner, *Regulation Through the Looking Glass: Hospitals, Blue Cross, and Certificate-of-Need*, 79 MICH. L. REV. 203 (1980) (arguing that these were in fact the driving goals behind CON laws, rather than controlling health care spending).

67. See Bagley, *Medicine As a Public Calling*, *supra* note 65, at 85–88.

68. Hospital Survey and Construction Act of 1946, 42 U.S.C. § 291 (2012).

69. MARTIN S. FELDSTEIN, THE RISING COST OF HOSPITAL CARE 13 (1971).

70. Clark C. Havighurst, *Regulation of Health Facilities and Services by “Certificate of Need”*, 59 VA. L. REV. 1143, 1144 (1973) [hereinafter Havighurst, *Regulation of Health Facilities and Services by “Certificate of Need”*].

71. National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1975).

72. HALL, BOBINSKI & ORENTLICHER, *supra* note 56, at 1223.

73. Bagley, *Medicine As a Public Calling*, *supra* note 65, at 89; Christopher J. Conover & Frank A. Sloan, *Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?*, 23 J. HEALTH POL. POL’Y & L. 455, 456–57 (1998).

74. *Id.*

75. Drug Export Amendments Act of 1986, Pub. L. No. 99-660, § 701, 100 Stat. 3743, 3799 (1986).

eleven states to repeal their CON laws by 1990.⁷⁶ In recent years, however, the drive to abolish CON laws has slowed,⁷⁷ and as of February 2019, thirty-four states plus the District of Columbia still have CON programs in place.⁷⁸

CON laws have also been the subject of widespread criticism.⁷⁹ The most prominent criticism of CON laws is that they are anti-competitive. By restricting new entrants into the market, CON laws exacerbate hospital concentration and potentially impede innovation.⁸⁰ The Department of Justice and the Federal Trade Commission have repeatedly criticized CON laws, writing, “on balance, CON programs are not successful in containing health care costs, and . . . they pose serious anticompetitive risks that usually outweigh their purported economic benefits.”⁸¹ Others have argued that CON laws are vehicles for politically influential hospitals to secure favorable regulatory treatment at the expense of less well-connected ones.⁸²

There are few scholars who are willing to defend CON programs as currently constituted.⁸³ Several scholars and policymakers have called for amending CON laws or even repealing them outright.⁸⁴ Others have argued that the real problem with CON programs is that they are too limited, as they have no authority to limit hospitals’ operating expenses or control hospitals’ prices, and that more expansive regulatory programs could more effectively control health care spending.⁸⁵

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76. Matthew D. Mitchell & Christopher Koopman, *40 Years of Certificate-of-Need Laws Across America*, MERCATUS CTR. (Sept. 27, 2016), <https://www.mercatus.org/publication/40-years-certificate-need-laws-across-america> [<https://perma.cc/MJ7B-ZQ96>].

77. Emily Whelan Parento, *Certificate of Need in the Post-Affordable Care Act Era*, 105 KY. L.J. 201, 212 (2017).

78. *Certificate of Need State Laws*, NAT’L CONF. ST. LEGISLATURES (Feb. 2016), <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx> [<https://perma.cc/UVB4-LMX5>].

79. See, e.g., HALL, BOBINSKI & ORENTLICHER, *supra* note 56, at 1225–26 (subsection entitled “The Failure of CON Regulation”).

80. Erin C. Fuse Brown, *Resurrecting Health Care Rate Regulation*, 67 HASTINGS L.J. 85, 96 (2015).

81. F.T.C. & U.S. DEP’T JUSTICE, *IMPROVING HEALTH CARE: A DOSE OF COMPETITION* 22 (2004).

82. See Havighurst, *Regulation of Health Facilities and Services by “Certificate of Need,” supra* note 70, at 1186–87 (“Limited investigation suggests further that established community hospitals, major medical centers, hospitals associated with religious and similar organizations, and well-entrenched proprietaries seem to be capable of receiving special attention for applications which would be rejected out of hand if submitted by less well-connected interests.”).

83. Parento, *supra* note 77, at 218 (“Among academic scholars, it is rare to find ardent, or even lukewarm defenders of CON programs.”).

84. See, e.g., Jost & Emanuel, *supra* note 7, at 2562; Maureen K. Ohlhausen, *Certificate of Need Laws: A Prescription for Higher Costs*, 30 ANTITRUST 50, 53 (2015) (“[T]here has been a lengthy, bipartisan consensus at the FTC that state CON laws should be repealed.”); William M. Sage, *Getting the Product Right: How Competition Policy Can Improve Health Care Markets*, 33 HEALTH AFFS. 1076, 1080 (2014) (calling for reducing or removing CON laws, and other barriers to market entry).

85. HALL, BOBINSKI & ORENTLICHER, *supra* note 56, at 1225.

In sum, the predominant view of these three types of laws—scope of practice restrictions, the corporate practice of medicine doctrine, and CON laws—is that they represent barriers to improving the health care delivery system. In addition, they are perceived as difficult to change, largely because they are supported by interest groups who benefit from the status quo. Although this view has some truth to it, I show in Parts II and III that this “law-as-barrier perspective” overlooks a central feature of health law: the impact of health care financing laws on the health care delivery system.

II. PATHWAYS OF INFLUENCE

This Section explores the relationship between health care financing laws and health care delivery laws in two stages. First, it outlines three different channels through which health care financing laws serve to increase the demand for health care. Second, it explains why increasing the demand for health care in turn affects health care delivery laws. Drawing on work by Kenneth Arrow and John Kingdon, it shows that the connection between health insurance and health care delivery laws can be viewed as one manifestation of a larger relationship between market failures and nonmarket institutions in health care.

A. Health Care Financing Laws and the Demand for Health Care

Health care financing laws serve to transform health care delivery laws through increasing the demand for health care. Historically, this has transpired through three main channels: First, expanding health insurance increases patients’ access to care and causes patients to utilize more health care services. Second, financing laws have encouraged providers to deliver more health care services by increasing the amount of money in the health care system and paying providers based on the amount of services they provide (known as “fee-for-service” reimbursement). Third, over time, expanding health insurance also leads hospitals and medical centers to adopt new expensive new medical technologies, and sends a signal to technology developers to create more such technologies. This Section briefly discusses each of these mechanisms, as well as the benefits and concerns associated with them.

1. Increasing Patients’ Access to Health Care

The first—and most obvious—way that expanding health insurance serves to increase the demand for health care is through increasing patients’ access to health care services.⁸⁶ Improving access to health care is one of the central purposes of

86. INSTITUTE OF MEDICINE, ACCESS TO HEALTH CARE IN AMERICA 4 (1993) (defining health care *access* as having “the timely use of personal health services to achieve the best possible health outcomes”).

health insurance—and one of the central goals of health care reform.⁸⁷ By lowering the cost that individuals face when obtaining health care, health insurance enables patients to access health care that they value but would not otherwise be able to afford.⁸⁸

A large body of empirical research confirms that expanding health insurance coverage improves access to health care and causes patients to use more health care services.⁸⁹ The two most well-known studies on the effects of health insurance are both randomized controlled trials: the RAND Health Insurance Experiment and the Oregon Health Insurance Experiment. The RAND Experiment, conducted in the late 1970s and early 1980s, randomly assigned participants to different health insurance plans with different levels of cost-sharing (i.e., these plans covered different percentages of individuals' total health care costs), and found that those individuals enrolled in plans with lower cost-sharing had higher levels of health care utilization.⁹⁰ More recently, in 2008, the state of Oregon randomly allocated Medicaid coverage to recipients via a lottery, allowing researchers to compare individuals who received Medicaid coverage to those with no health insurance.⁹¹ Follow-up analyses found that those recipients who gained Medicaid coverage had more hospital admissions, emergency department visits, and outpatient visits, and ordered more prescription drugs.⁹²

87. See, e.g., Timothy Jost, *Affordability: The Most Urgent Health Reform Issue for Ordinary Americans*, HEALTH AFF. BLOG (Feb. 29, 2016), <https://www.healthaffairs.org/doi/10.1377/hblog20160229.053330/full/> [<https://perma.cc/W2NU-FK4G?type=image>] (“A primary goal of the ACA was to improve access to health care.”); Wendy K. Mariner, *Health Reform: What's Insurance Got to Do with It? Recognizing Health Insurance As a Separate Species of Insurance*, 36 AM. J.L. & MED. 436, 439 (2010) (“A key goal of health reform is to give everyone access to health care. Health insurance is simply a means to that larger end: appropriate, affordable health care regardless of employment, residence, health status, age or other factors that currently inhibit access.”); see also Allison K. Hoffman, *Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act*, 159 U. PENN L. REV. 1873, 1888 (2011) (calling the “Health Promotion” theory of health insurance as the theory “that the primary goal of health insurance is to mitigate the risk of harms to health”).

88. John A. Nyman, *American Health Policy: Cracks in the Foundation*, 32 J. HEALTH POL. POL'Y & L. 759, 768 (2007) [hereinafter Nyman, *American Health Policy: Cracks in the Foundation*].

89. See Benjamin D. Sommers, Atul A. Gawande & Katherine Baicker, *Health Insurance Coverage and Health—What the Recent Evidence Tells Us*, 377 NEW ENG. J. MED. 586, 588 (2017) (describing several studies which find that health insurance expansions increase health care utilization).

90. See generally JOSEPH P. NEWHOUSE, *FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT* (1993).

91. In this respect, it differed from the RAND Experiment, which compared individuals who all had health insurance but with different levels of cost-sharing. Liran Einav & Amy Finkelstein, *Moral Hazard in Health Insurance: What We Know and How We Know It*, 16 J. EUR. ECON. ASS'N 957, 963–64 (2018), <https://economics.mit.edu/files/14545> [<https://perma.cc/M4A5-VR3F>].

92. See AMY FINKELSTEIN, *MORAL HAZARD IN HEALTH INSURANCE* 21 (2015) [hereinafter FINKELSTEIN, *MORAL HAZARD IN HEALTH INSURANCE*]; Amy Finkelstein et al., *The Oregon Health Insurance Experiment: Evidence from the First Year*, 127 Q.J. ECON. 1057 (2012); Amy Finkelstein et al., *Effect of Medicaid Coverage on ED Use — Further Evidence from Oregon's Experiment*, 375 NEW ENG. J. MED. 1505 (2016).

There is also a growing body of empirical evidence that expanding health insurance improves health outcomes by increasing access to health care. In 2017, Benjamin Sommers, Atul Gawande, and Katherine Baicker conducted a thorough review of the empirical literature on the effects of health insurance, and concluded that “coverage expansions significantly increase patients’ access to care and use of preventive care, primary care, chronic illness treatment, medications, and surgery,” and that “some of these changes will ultimately help tens of thousands of people live longer lives.”⁹³ More recent studies have continued to bolster the link between health insurance expansions and improved health outcomes.⁹⁴

Despite the benefits of health insurance coverage, economists and policymakers have historically been quite concerned that health insurance leads to *excess* demand for health care.⁹⁵ The theory underlying this concern, referred to as *moral hazard*, is that by lowering the price of health care, insurance causes people to consume health care services that they do not value sufficiently to justify the costs of providing that care.⁹⁶

Concerns about moral hazard have led a number of health economists over the years to theorize that health insurance is inefficient.⁹⁷ Mark Pauly first articulated this possibility in an influential 1968 essay, venturing that the total benefits from health insurance in terms of reducing financial risk could potentially be smaller than its costs in terms of causing excess utilization and health care spending.⁹⁸ In a 1973 article, Martin Feldstein went further, concluding—at a time

93. Sommers, Gawande & Baicker, *supra* note 89, at 590–91.

94. See, e.g., Sameed Ahmed M. Khatana et al., *Association of Medicaid Expansion with Cardiovascular Mortality*, 4 JAMA CARDIOLOGY 671 (2019) (finding that Medicaid expansion was associated with lower cardiovascular mortality).

95. See ECONOMIC RECORD, *supra* note 19, at 27 n.13 (“While many non-economists consider it a self-evidently good thing when expanded insurance coverage increases use of health care, a long-standing strand of economic research emphasizes the possibility that health insurance will drive overconsumption of health care by insulating enrollees from the cost of services, a phenomenon referred to as ‘moral hazard.’”) (citation omitted).

96. See Joseph P. Newhouse, *Medical Care Costs: How Much Welfare Loss?*, 6 J. ECON. PERSP. 3, 15 (1992) (“[T]he dominant view of health insurance in the economics literature, at least in the American literature, is that ‘too much’ health insurance leads consumers to demand ‘too much’ medical care at each point in time, which is reasonably well established, as well as ‘too much’ technological change, which is less well established.”). One potential alternative form of moral hazard, which is referred to as *ex ante* moral hazard (as opposed to the predominant notion of moral hazard, which is sometimes called *ex post* moral hazard), is the notion that having health insurance causes individuals to take less good care of their health. Yet there is little empirical evidence substantiating this effect. See Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. REV. 237, 284 (1996) (“There is no strong evidence that insurance reduces the level of care individuals take to prevent bodily injury.”); Einav & Finkelstein, *supra* note 91, at 963.

97. Nyman, *American Health Policy: Cracks in the Foundation*, *supra* note 88, at 765.

98. Mark V. Pauly, *The Economics of Moral Hazard: Comment*, 58 AMER. ECON. REV. 531, 535 (1968); see also JOHN A. NYMAN, *THE THEORY OF DEMAND FOR HEALTH INSURANCE* 9 (2003) [hereinafter NYMAN, *THE THEORY OF DEMAND FOR HEALTH INSURANCE*] (referring to Pauly’s article as perhaps “the single most influential article in the health economics literature”).

when over 24 million Americans were uninsured⁹⁹—that “American families are in general overinsured against health expenses,” and that “the current excess use of health insurance produces a very substantial welfare loss.”¹⁰⁰

More recently, a number of scholars—most prominently, John Nyman—have challenged this account. Nyman argues that while health insurance may cause some amount of excess utilization, most moral hazard is actually efficient because it enables patients to access health care that they value highly but would not otherwise be able to access, due to financial constraints.¹⁰¹ Under this view, the increased utilization caused by obtaining health insurance “is not a distortion of the system; it is just getting rid of the problem of the liquidity constraints that people face.”¹⁰² Nyman refers to this as “efficient moral hazard,”¹⁰³ while Jonathan Gruber calls it “an income or liquidity effect.”¹⁰⁴

Nevertheless, concerns about moral hazard have proven quite influential over the years.¹⁰⁵ The theory of moral hazard has undergirded many health insurance “innovations” in recent decades, including the proliferation of “cost-sharing” in health insurance plans (in the form of deductibles, co-pays, co-insurance, etc.), the advent of the “managed care” movement, and the introduction of health savings accounts.¹⁰⁶

2. Affecting Providers' Treatment Behavior

The second way that expanding health insurance increases the demand for health care is through changing the ways that providers deliver care. For most of U.S. history, physicians operated as solo practitioners and practiced on a small scale “because there were no substantial economies to be achieved in a large scale

99. Robin A. Cohen et. al., U.S. Dep't of Health and Human Servs., *Health Insurance Coverage Trends, 1959-2007: Estimates from the National Health Interview Survey*, NAT'L HEALTH STAT. REPORTS (2009).

100. Martin S. Feldstein, *The Welfare Loss of Excess Health Insurance*, 81 J. POL. ECON. 251, 251, 275 (1973).

101. See generally John A. Nyman, *The Economics of Moral Hazard Revisited*, 18 J. HEALTH ECON. 811 (1999); John A. Nyman, *The Value of Health Insurance: The Access Motive*, 18 J. HEALTH ECON. 141 (1999).

102. Jonathan Gruber, *Commentary*, in MORAL HAZARD IN HEALTH INSURANCE 50 (2015).

103. NYMAN, THE THEORY OF DEMAND FOR HEALTH INSURANCE, *supra* note 98, at 103.

104. Gruber, *supra* note 102, at 49.

105. See Malcolm Gladwell, *The Moral-Hazard Myth*, NEW YORKER (Aug. 29, 2005), <https://www.newyorker.com/magazine/2005/08/29/the-moral-hazard-myth> [<https://perma.cc/C462-2JZE>] (“[M]oral hazard has profoundly shaped the way think tanks formulate policy and the way experts argue and the way health insurers structure their plans and the way legislation and regulations have been written.”).

106. Nyman, *American Health Policy: Cracks in the Foundation*, *supra* note 88, at 760.

practice.”¹⁰⁷ U.S. hospitals and health care facilities, which originated as religious or charitable institutions, had long been organized as non-profit entities.¹⁰⁸

Yet with first the growth of employer-sponsored health insurance and then the enactment of Medicare and Medicaid, a wave of money flooded the health care system, precipitating a surge of new entrepreneurial ventures. Clark Havighurst describes how Medicare in particular transformed the culture of health care:

Perhaps Medicare’s most significant side effect was to make the health care sector an arena for profit-seeking activity more than ever before. For the first time, hospitals and physicians could expect to be paid well for much of the care they had previously provided for less. They also saw huge increases in demand for even the costliest of their services. Entrepreneurs suddenly saw new opportunities in health care, and physicians saw opportunities to become entrepreneurs themselves.¹⁰⁹

Between 1976 and 1982, the number of hospitals owned or managed by for-profit organizations nearly doubled, even while the overall number of hospitals decreased.¹¹⁰ In 1980, Arnold Relman, the then-editor of the *New England Journal of Medicine*, published an article in the *Journal* decrying “the New Medical-Industrial Complex,” and warning that physicians’ growing financial entanglements in the health care system risked creating conflicts of interest and preventing them from curbing over-utilization.¹¹¹

These effects were compounded by the fact that Medicare employed the traditional fee-for-service reimbursement model. In the decades following the enactment of Medicare, fee-for-service reimbursement has been widely blamed for encouraging providers to deliver those services that are most profitable, rather than those which are most beneficial for patients, and for driving up overall health care spending.¹¹² Of course, many non-financial factors affect providers’ treatment behavior as well, such as their education and training, potential legal liability, and uncertainty about the proper course of treatment.¹¹³ Nevertheless, a substantial

107. Victor R. Fuchs, *Can the Traditional Practice of Medicine Survive?*, 125 ARCHIVES INTERNAL MED. 154, 155 (1970).

108. Bradford H. Gray, *An Introduction to the New Health Care for Profit*, in THE NEW HEALTH CARE FOR PROFIT: DOCTORS AND HOSPITALS IN A COMPETITIVE ENVIRONMENT 1, 7 (Bradford H. Gray ed., 1983).

109. Havighurst, *American Health Care and the Law*, *supra* note 25, at 89; see also ROBERT I. FIELD, HEALTH CARE REGULATION IN AMERICA: COMPLEXITY, CONFRONTATION, AND COMPROMISE 173 (2007) (“The driving force behind the commercial transformation of American health care was the development of insurance.”).

110. Gray, *supra* note 108, at 2.

111. Arnold S. Relman, *The New Medical-Industrial Complex*, 303 NEW ENG. J. MED. 963 (1980).

112. See Ezekiel J. Emanuel & Victor R. Fuchs, *The Perfect Storm of Overutilization*, 299 JAMA 2789, 2790 (2008). This phenomenon is often referred to as *physician-induced demand* or *supplier-induced demand*. See generally EM Johnson, *Physician-Induced Demand*, in 3 ENCYCLOPEDIA OF HEALTH ECONOMICS 77 (Anthony J. Culyer ed., 2014). Jonathan Gruber refers to it as *provider-side moral hazard*. Gruber, *supra* note 102, at 47–49.

113. See Lisa Rosenbaum, *The Less-Is-More Crusade—Are We Overmedicalizing or*

body of empirical research finds that financial incentives do affect providers' treatment decisions.¹¹⁴ For instance, one recent study found that on average, a two percent increase in physician payment rates led to a three percent increase in the provision of health care services.¹¹⁵

In an effort to curb excess demand, the ACA included several initiatives designed to shift health insurance away from fee-for-service reimbursement and toward reimbursing providers based on the extent to which they improve patients' health (known as "value-based health care").¹¹⁶ The law promoted a variety of new payment models such as Accountable Care Organizations, which were explicitly designed to "base payments on the results health care organizations and health care professionals achieve for all of their patients' care."¹¹⁷ Nevertheless, for the time being at least, fee-for-service remains the dominant provider payment method in the United States.¹¹⁸

3. Encouraging the Development and Adoption of Technology

Finally, expanding health insurance coverage increases demand by changing the course of technological development in medicine.¹¹⁹ The growth of medical technology is thought to be one of the primary drivers of health care spending.¹²⁰ Economists have argued that over time, expanding health insurance encourages hospitals and medical centers to adopt expensive new technologies, and even further on, incentivizes innovators to develop more such technologies in the first place.¹²¹ For instance, there is evidence the enactment of Medicare led to the adoption of open-heart surgery facilities and cardiac intensive care units.¹²² Once again, fee-for-service reimbursement compounds these incentives by encouraging

Oversimplifying?, 377 NEW ENG. J. MED. 2392, 2394 (2017); Lisa S. Rotenstein & Anupam B. Jena, *It's Time to Rethink the Anatomy of Behavior*, HEALTH AFF. BLOG (June 22, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180618.721948/full/> [<https://perma.cc/U3PP-WB92>].

114. See Johnson, *supra* note 112 (summarizing the empirical evidence).

115. See Jeffrey Clemens & Joshua D. Gottlieb, *Do Physicians' Financial Incentives Affect Medical Treatment and Patient Health*, 104 AM. ECON. REV. 1320 (2014).

116. See ECONOMIC RECORD, *supra* note 19, at 47–56.

117. Barack Obama, *United States Health Care Reform: Progress to Date and Next Steps*, 316 JAMA 525, 528 (2016).

118. Samuel H. Zuvekas & Joel W. Cohen, *Fee-For-Service, While Much Maligned, Remains the Dominant Payment Method for Physician Visits*, 35 HEALTH AFF. 411, 411 (2016).

119. See, e.g., FINKELSTEIN, MORAL HAZARD IN HEALTH INSURANCE, *supra* note 92, at 36–40.

120. See Newhouse, *supra* note 96.

121. Sherry A. Glied, *Health Insurance and Market Failure Since Arrow, in UNCERTAIN TIMES: KENNETH ARROW AND THE CHANGING ECONOMICS OF HEALTH CARE* 103, 107 (Peter J. Hammer et al. eds., 2003).

122. Amy Finkelstein, *The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare*, 122 Q.J. ECON. 1, 26–29 (2007) [hereinafter Finkelstein, *The Aggregate Effects of Health Insurance*].

the adoption and development of costly new technologies, even if their benefits are uncertain or marginal.¹²³

Taking these long-term technological effects on the health care system into account implies that health insurance has a much larger impact on the demand for health care than its immediate incentive effects on patients and providers alone would suggest.¹²⁴ According to one estimate that tries to factor in these technological effects, the spread of insurance between 1950 and 1990 can explain roughly half of the increase in health care spending during this time.¹²⁵

The story of technological development in medicine is not all negative. The U.S. health insurance system has likely led to the development of some valuable technologies, and likely also means that Americans are often the first ones to be able to take advantage of new medical technologies.¹²⁶ On the whole, however, many economists believe that the way in which the United States' insurance system interacts with technology is inefficient, in that it causes excess expenditures on unproductive medical technologies with uncertain benefits.¹²⁷

B. Arrow's "Feedback Loop" and Agenda-Setting

Through each of the channels described above, health insurance serves to increase the demand for health care. As I will show in Part III, concerns about health insurance leading to excess demand have in turn historically led regulators to experiment with changes to delivery system regulations in order to stem any adverse consequences on health care access, health care costs, and health care quality.

Kenneth Arrow appeared to foreshadow this relationship among health insurance, increased demand for health care, and health care delivery laws, in his classic 1963 article, *Uncertainty and the Welfare Economics of Medical Care*. The central thesis of his article was that many of the distinctive nonmarket institutions present in the health care system (such as medical licensing, physician codes of ethics, etc.)

123. Nicholas Bagley, Amitabh Chandra & Austin Frakt, *Correcting Signals for Innovation in Health Care*, HAMILTON PROJECT 1, 10 (Oct. 5, 2015), http://www.hamiltonproject.org/papers/correcting_signals_for_innovation_in_health_care [<https://perma.cc/BG44-DTSN>] ("Perhaps the primary explanation for high rates of inefficient use of medical technology is widespread use of reimbursement methods that encourage a high volume of care without regard to its value."). The interactions between our health insurance system and the development and adoption of medical technology are sometimes referred to as "dynamic moral hazard." See, e.g., Peter Zweifel & Willard G. Manning, *Moral Hazard and Consumer Incentives in Health Care*, in 1A THE HANDBOOK OF HEALTH ECONOMICS 409, 413 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000).

124. See Finkelstein, *The Aggregate Effects of Health Insurance*, *supra* note 122, at 3 (estimating that the introduction of Medicare is over six times what the RAND estimates would have predicted based solely on changing patients' incentives).

125. *Id.*

126. Amitabh Chandra & Jonathan Skinner, *Technology Growth and Expenditure Growth in Health Care*, 50 J. ECON. LIT. 645, 647 (2012).

127. Katherine Baicker, Amitabh Chandra & Jonathan S. Skinner, *Saving Money or Just Saving Lives? Improving the Productivity of US Health Care Spending*, 4 ANN. REV. ECON. 33, 46 (2012).

arose in response to market failures, and in particular, to *information asymmetries*, which he defined as “inequalities of information between the insurer on one hand and the physician and patient on the other.”¹²⁸

The relationship between health insurance and health care delivery laws can be understood as part of this general relationship between market failures and nonmarket institutions. Arrow theorized that the market will undersupply health insurance on its own due to information asymmetries between insurers and individuals, and thus advocated the government should step in to provide health insurance.¹²⁹ Yet Arrow presciently observed that “widespread medical insurance increases the demand for medical care,”¹³⁰ which in turn tends to lead to “market forces . . . [being] replaced by direct institutional control.”¹³¹ Although it is unclear exactly what Arrow had in mind by “direct institutional control,” that description would seem to encompass health care delivery laws, such as Certificate of Need restrictions.¹³²

In sum, under Arrow’s account, the relationship between health care financing laws and health care delivery laws is one manifestation of a broader feedback loop in health care between market failures and government responses. The market’s failure to provide health insurance to the public has necessitated government-provided health insurance, which has increased the demand for health care, which in turn has created pressure for the government to change delivery system regulations.¹³³

Why does increased demand for health care generate political pressure for reforming delivery system laws? The account that follows suggests two main reasons: First, policymakers have historically (and in some cases, justifiably) been

128. Kenneth J. Arrow, *Reflections on the Reflections*, in *UNCERTAIN TIMES: KENNETH ARROW AND THE CHANGING ECONOMICS OF HEALTH CARE* 321, 321 (Peter J. Hammer et al. eds., 2003) [hereinafter *Arrow, Reflections on the Reflections*].

129. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, *supra* note 23, at 961.

130. *Id.* at 961.

131. *Id.* at 962.

132. Arrow made at least one other oblique reference to “direct controls” in a 2002 essay reflecting on his original 1963 article and the responses it generated. See Arrow, *Reflections on the Reflections*, *supra* note 128, at 321–22 (“The role of moral hazard in medical insurance arises from inequalities of information between the insurer on one hand and the physician and patient on the other. By itself, this phenomenon was well known in other kinds of insurance (where the term moral hazard arose) and was met by various devices, such as deductibles and ceilings. Direct controls came later, as I conjectured.”).

133. Others have described this dynamic in similar terms. See Glied, *supra* note 121, at 107 (“[T]he interplay between market failures, wherever they originate, and institutions that Arrow described in 1963 continues now. Just as Arrow argued in 1963, each of these market failures has generated its own set of institutional responses, and, in turn, these institutional responses have led to further market failures.”); Michael Chernew, *General Equilibrium and Marketability in the Health Care Industry*, in *UNCERTAIN TIMES: KENNETH ARROW AND THE CHANGING ECONOMICS OF HEALTH CARE* 37, 37–38 (Peter J. Hammer et al. eds., 2003) (“The central thesis of this essay is that market and nonmarket institutions have a symbiotic relationship, with nonmarket institutions serving to improve resource allocation in areas where markets fail or do not exist.”).

concerned that—if left unaddressed—this increased demand will negate the effectiveness of expanding health insurance in improving access to care, or, exacerbate costs and quality problems. This account aligns with political scientist John Kingdon’s emphasis on the role that “problem recognition”—or “[h]ow people define something as a problem”—plays in determining which issues rise to the top of policymakers’ agendas.¹³⁴ Second, to the extent that health insurance expansions are publicly financed, they render the cost of health care more visible and urgent since it is now reflected in the government’s budget, rather than just in individuals’ own balance sheets. This is again supported by the work of Kingdon, who highlights budgetary considerations as playing an especially important role in pushing health care issues to the top of the policymaking agenda.¹³⁵

There are a couple distinctions between the account offered in this Article and Arrow’s. First, Arrow does not explicitly acknowledge the notion of a dynamic regulatory system. To the contrary, he later emphasized the path dependence of the health care delivery laws, suggesting that he may have viewed the relationship between insurance expansions and subsequent reforms as more of a one-off cause-and-effect relationship.¹³⁶ By contrast, I find that health insurance expansions have created a system in which delivery system regulations are continually adjusting and evolving.

Second, whereas Arrow theorized that the nonmarket institutions present in health care “actually improved efficiency,”¹³⁷ I do not assume that this is always the case. For instance, I show how Medicare and Medicaid contributed to the enactment of CON laws, which have been widely criticized in retrospect. Nevertheless, I argue that the overall *dynamism* of health law—while not always leading to optimal outcomes in every individual case—is on the whole normatively desirable.

134. KINGDON, *supra* note 24, at 90, 198.

135. *Id.* at 105–07.

136. *See* Arrow, *Reflections on the Reflections*, *supra* note 128, at 326 (“One type of explanation is that history matters. At a formal level, the system is governed by dynamic relations, which have some degree of instability, so that small variations can produce large and long-lasting deviations in outcome after a while. The equations for predicting weather seem to be of this kind. One decision creates enduring structures that are costly to change.”).

137. *Id.* at 323; *see also* Arrow, *Uncertainty and the Welfare Economics of Medical Care*, *supra* note 23, at 947 (“The doctrine that society will seek to achieve optimality by non-market means if it cannot achieve them in the market is not novel. Certainly, the government, at least in its economic activities, is usually implicitly or explicitly held to function as the agency which substitutes for the market’s failure. I am arguing here that in some circumstances other social institutions will step into the optimality gap, and that the medical-care industry, with its variety of special institutions, some ancient, some modern, exemplifies this tendency.”); Chernew, *supra* note 133, at 39 (“In the absence of this rich set of markets, Arrow contended that nonmarket institutions would develop so that resource allocation would come closer to the competitive ideal than would otherwise occur if only the incomplete set of markets were relied upon.”).

III. HEALTH INSURANCE AND THE EVOLUTION OF HEALTH CARE DELIVERY LAWS

This Section shows how the two most important health care financing laws in U.S. history—the 1965 Medicare/Medicaid legislation and the 2010 Affordable Care Act—influenced the three major areas of delivery system law outlined above by increasing the demand for health care. This increased demand has tended to exacerbate preexisting concerns about the “iron triangle” objectives of health care policy: ensuring access, reducing costs, and improving quality.¹³⁸ These concerns in turn have generated political pressure to reform health care delivery system laws.

Importantly, these effects have not consistently been pro-regulatory or deregulatory. Medicare and Medicaid contributed to the enactment of Certificate of Need laws, but these programs (and to a lesser extent, the ACA) also contributed to the curtailment of the corporate practice of medicine doctrine and scope of practice restrictions.

This Section focuses primarily on the impacts of Medicare and Medicaid, but I highlight the ACA’s effects as well where relevant. Because the ACA’s main coverage provisions only went into effect in 2014 and because these regulatory changes play out slowly over many years, it seems likely that the ACA’s impacts will grow over time. However, recent policy changes that have undermined the ACA’s coverage expansion may make this less likely.¹³⁹

A. Physician Shortages and the Curtailment of Scope of Practice Laws

The first way in which health insurance expansions have influenced health care delivery laws is through accentuating concerns about the supply of health care providers being insufficient to meet the rising demand for health care. In the 1950s and 1960s, as more physicians began to leave general practice and enter specialized medical fields, there was a growing perception of a shortage of primary care physicians.¹⁴⁰

During these decades, the government issued a series of reports warning that “the health of American citizens was threatened by a physician shortage,” compounded by a shortage of other health professionals.¹⁴¹ These reports called for an expansion in medical education, and recommended that physicians delegate more

138. DAVID CUTLER, *THE QUALITY CURE* 1–2 (2014); see generally WILLIAM KISSICK, *MEDICINE’S DILEMMAS: INFINITE NEEDS VERSUS FINITE RESOURCES* (1994) (introducing the concept of the iron triangle and theorizing that these three objectives will inevitably be in tension with one another).

139. Margot Sanger-Katz, *After Falling Under Obama, America’s Uninsured Rate Looks to Be Rising*, N.Y. TIMES UPSHOT (Jan. 23, 2019), <https://www.nytimes.com/2019/01/23/upshot/rate-of-americans-without-health-insurance-rising.html> [<https://perma.cc/KHG3-4CAR>].

140. JULIE FAIRMAN, *MAKING ROOM IN THE CLINIC: NURSE PRACTITIONERS AND THE EVOLUTION OF MODERN HEALTH CARE* 16 (2008) [hereinafter FAIRMAN, *MAKING ROOM IN THE CLINIC*].

141. *Id.*; see also STARR, *SOCIAL TRANSFORMATION*, *supra* note 24, at 364.

responsibilities to other health professions.¹⁴² In doing so, they “provided an unintended opening and an avenue for other health professionals to broaden their roles by taking on functions traditionally considered within the realm of medicine.”¹⁴³

The establishment of Medicaid and Medicare in 1965, and the accompanying prospect of millions of elderly and poor individuals suddenly obtaining health insurance and flooding health care facilities, lent greater urgency to these concerns. In a 1966 interview with *The New York Times*, the president of the New York Hospital-Cornell Medical Center blamed Congress for “enact[ing] legislation which promises the American people health care without first anticipating the number of doctors, nurses, hospital beds and other medical resources needed to accomplish it,” calling the decision to expand health insurance without first expanding the supply of health care providers “another example of the eccentric planning peculiar to this country.”¹⁴⁴ During this period, newspapers ran numerous other stories deeming the shortage of health care providers a “crisis,” and focusing in particular on Medicare’s role in increasing the demand for health care.¹⁴⁵

Congress too was concerned that the enactment of Medicare would lead to a shortage of providers. Shortly after the implementation of Medicare, the legal counsel of one hospital in Nebraska warned the U.S. Senate Committee on Labor and Public Welfare that with recent enactment of Medicare, “this Nation is faced with the most critical shortage of nurses in its history.”¹⁴⁶ These concerns persisted in the years that followed, as signs of a shortage materialized. For instance, in 1971, 133 counties did not have an active physician, up from 98 counties in 1963.¹⁴⁷

In response to these concerns, Congress passed the Allied Health Professions Personnel Training Act, which provided additional funding and training for the health care professions.¹⁴⁸ The legislative history of the Act is replete with expressions of concern that Medicare created a shortage of health care providers. For example, in a speech on the House floor in support the Act, one member of Congress underscored the imperative of training additional non-physician providers to meet the rising demand stemming from Medicare:

142. FAIRMAN, MAKING ROOM IN THE CLINIC, *supra* note 139, at 17.

143. *Id.*

144. *Medicare Hobbled by Shortages, Says New York Hospital Chief*, N.Y. TIMES, July 4, 1966, at 13.

145. *See, e.g., More Physicians Needed*, N.Y. TIMES, April 28, 1966, at 42; David Lawrence, *Medicare May Bring on Further Problems*, L.A. TIMES, July 11, 1965, at J6; Richard D. Lyons, *Doctor Shortage Nearing a Crisis*, N.Y. TIMES, Sept. 28, 1967, at 1; Cabell Phillips, *Need for Nurses Called Critical*, N.Y. TIMES, Feb. 15, 1966, at 22; Harry Nelson, *New Medical Programs Push Doctor Shortage to Crisis Point*, PHILA. INQUIRER, Dec. 5, 1965, § 7, at 1.

146. *Health Professions Personnel, Hearing Before the Subcomm. on Emp’t and Manpower of the Comm. on Labor and Pub. Welfare*, 89th Cong. 326 (1966) (statement of Richard H. Hansen, Legal Counsel, St. Elizabeth Hospital).

147. FAIRMAN, MAKING ROOM IN THE CLINIC, *supra* note 140, at 36.

148. Allied Health Professions Training Act of 1966, Pub. L. No. 89-751, 80 Stat. 1222 (1966).

As the House knows, I have long been a strong advocate of a health program for the aged, but I would be the first to admit that the legislation will be of little value unless we have sufficient facilities and personnel to make health care available to all who need it. This is another reason why I feel it is important that we not delay in establishing a program to train students in the allied health professions. These paramedical people can take a tremendous load off our doctors, dentists, and professional nurses and enable them to treat more people more quickly and more effectively.¹⁴⁹

These concerns in turn contributed to states' scaling back scope of practice restrictions on non-physician providers. In 1971, a special committee appointed by the Secretary of Health, Education, and Welfare called for broadening nurses' roles in health care delivery, citing the "increasing demand" for health care services.¹⁵⁰ Others called for expanding the roles of physician assistants as well.¹⁵¹ That same year, Idaho became the first state to authorize NPs to diagnose patients and prescribe medications, subject to regulations promulgated by the medicine and nursing boards.¹⁵² Thirty other states shortly followed suit.¹⁵³

Over time, Richard Cooper and Linda Aiken write, "[l]icensure . . . shifted from restricting entry to empowering a diverse array of NPCS [non-physician clinicians] whose scope of practice overlaps that of physicians."¹⁵⁴ They attribute this trend primarily to concerns about a physician shortage.¹⁵⁵ Similarly, Ruth Elder and Bonnie Bullough write, "[t]he major impetus behind the development of NPs was a perceived shortage of physicians."¹⁵⁶

149. 112 CONG. REC. 13,989 (1966).

150. U.S. PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, EXTENDING THE SCOPE OF NURSING PRACTICE: A REPORT OF THE SECRETARY'S COMMITTEE TO STUDY EXTENDED ROLES FOR NURSES 4 (1971).

151. T. Elaine Adamson, *Critical Issues in the Use of Physician Associates and Assistants*, 61 AM. J. PUB. HEALTH 1765, 1765 (1971) ("The demand for medical services has been increasing rapidly, especially since the introduction of Medicare and Medicaid Productivity of the medical care system can be augmented . . . by the transfer of some of the physician's tasks to physician associates and physician assistants.").

152. IDAHO CODE § 54-1413(e) (1971) (repealed by 1977 Idaho Sess. Laws 279); Barbara J. Safriet, *Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing*, 9 YALE J. ON REG. 417, 445 (1992) [hereinafter Safriet, *Health Care Dollars and the Regulatory Sense*].

153. Bonnie Bullough, *The Law and the Expanding Nursing Role*, 66 AJPH 249, 251 (1976) [hereinafter Bullough, *The Law and the Expanding Nursing Role*] (listing "30 states which have enacted amendments to their nurse practice acts in the last five years to facilitate nurses taking on diagnostic and treatment functions" and describing these developments as "moving so fast they have taken on an almost revolutionary character").

154. Richard A. Cooper & Linda H. Aiken, *Human Inputs: The Health Care Workforce and Medical Markets*, in UNCERTAIN TIMES: KENNETH ARROW AND THE CHANGING ECONOMICS OF HEALTH CARE 71, 72 (Peter J. Hammer et al. eds., 2003).

155. *Id.* at 74 ("[T]he most powerful stimulus to their expansion was the perceived shortage of primary care physicians and the ability of NPCs not only to provide the needed services, but also to enhance the productivity of clinical teams.").

156. Ruth G. Elder & Bonnie Bullough, *Nurse Practitioners and Clinical Nurse Specialists: Are the Roles Merging?*, 4 CLINICAL NURSE SPECIALIST 78, 79 (1990). *But see* Diane O. McGivern,

Of course, concerns about physician shortages predated Medicare and Medicaid, and other factors played a role in the expansion of non-physician providers as well, including organized activism by nurses and broader social movements.¹⁵⁷ Frances Porcher has argued that there was in fact no real shortage of primary care providers, but rather that “[s]avvy nursing leaders exploited the opportunity presented by *the perception* of a shortage of primary care to advance their agenda to create expanded roles for nurses.”¹⁵⁸

Nevertheless, the prospect of a looming physician shortage caused by millions of people gaining health insurance played a contributing role in relaxing restrictions on non-physician providers.¹⁵⁹ Julie Fairman noted that “[t]he impact of federal

Environmental Factors Shaping Advanced Practice, in NURSE PRACTITIONERS: THE EVOLUTION AND FUTURE OF ADVANCED PRACTICE 161, 161–62 (Eileen M. Sullivan-Marx et al. eds., 5th ed. 2010) (“The drive behind advanced-practice role development and expansion is frequently presented in the simplest terms. Most contemporary literature notes that the NP role arose solely to compensate for the lack of physician services, giving credence to the view of NPs as substitutes or extenders, as opposed to providers of both necessary and unique services. This linear connection between physician supply and development of advanced practice from nursing . . . diminishes the powerful nursing dialogue that guided NP role development and the strong holistic perspective that distinguishes NPs’ contribution from medicine.”).

157. See, e.g., FAIRMAN, MAKING ROOM IN THE CLINIC, *supra* note 140, at 2–3; Julie A. Fairman, *Historic and Historical Opportunities: Nurse Practitioners and the Opportunities of Health Reform*, in NURSE PRACTITIONERS: THE EVOLUTION AND FUTURE OF ADVANCED PRACTICE 3, 6–7 (Eileen M. Sullivan-Marx et al. eds., 5th ed. 2010); Bullough, *The Law and the Expanding Nursing Role*, *supra* note 153, at 249 (“Various factors have contributed to the need for this role expansion, including the shortage of primary care physicians created by the shift away from primary to a specialty orientation in medicine, the growing consumer demand for adequate health care, and, in some cases, such as the coronary and intensive care units, the improved technology which has afforded new opportunities for skilled nurses to save the lives of a significant number of patients.”).

158. Frances K. Porcher, *Licensure, Certification, and Credentialing*, in NURSE PRACTITIONERS: EVOLUTION OF ADVANCED PRACTICE 415, 433 (Mathy D. Mezey et al. eds., 4th ed. 2003) (emphasis added).

159. Ellen D. Baer, *Philosophical and Historical Bases of Advanced Practice Nursing Roles*, in NURSE PRACTITIONERS: EVOLUTION OF ADVANCED PRACTICE 37, 38 (Mathy D. Mezey et al. eds., 4th ed. 2003) (“The passage of Medicare/Medicaid legislation in 1965 created an expanded demand for health services. The supply and distribution of primary care physicians was unable to meet this demand. In addition, the services demanded were broader in scope than those contained within the domain of medicine prior to the 1960s The nursing profession stepped into the breach.”); ELISABETH ROSENTHAL, AN AMERICAN SICKNESS 72 (2017) (“The use of physician extenders in the United States has its roots in the late 1960s and early 1970s. There was a perceived shortage of doctors, particularly in the area of primary care, as many more Americans got insurance and more doctors trained as specialists.”); Tine Hansen-Turton, Jamie Ware & Frank McClellan, *Nurse Practitioners in Primary Care*, 82 TEMP. L. REV. 1235, 1242 (2010) (“The opportunities for nurses in primary care grew again in the 1960s as the country experienced a physician shortage following the adoption of the Medicare and Medicaid programs in 1965, which spurred greater demand on the health care system than before.”); John Michael O’Brien, *How Nurse Practitioners Obtained Provider Status: Lessons for Pharmacists*, 60 AM. J. HEALTH-SYS. PHARMACY 2301, 2032 (2003) (“In 1965, the Medicare and Medicaid programs provided health care coverage to low-income women, children, the elderly, and people with disabilities. The sudden availability of coverage increased the demand for expanded primary care services. Because physicians were unable to meet this demand, nurses ‘stepped into the breach.’”); Safriet, *Health Care Dollars and Regulatory Sense*, *supra* note 152, at 444 (observing that several events contributed to the

funding on the nurse practitioner movement cannot be forgotten,” and emphasized in particular the role that Medicare played:

Grounded by generous federal funding for health professional education (the Training Acts of the early 1960s), this movement gained impetus through the changes wrought by Medicare (1966) and the state-federal partnership of Medicaid (in the late 1960s). These new federal and state entitlement programs came at a time when physicians increasingly specialized and the number of those providing general medical care declined, creating shortages in poor urban and rural communities. Medicare and Medicaid created access to acute and specialty medical care, which is where the bulk of the demand for health care resided. It increased the number and type of patients receiving health care services without substantially changing the system of health delivery With these changes came transformations in how physicians and nurses were educated, paid, and where and how they practiced.¹⁶⁰

More recently, the Affordable Care Act contributed to further easing scope of practice restrictions for non-physician providers. Once again, forecasts of tens of millions of individuals gaining health insurance amplified concerns about a physician shortage.¹⁶¹ In 2010, the year the ACA was signed into law, the Association of American Medical Colleges released a study predicting a shortage of 63,000 doctors by 2015, with the ACA alone expected to be responsible for half that shortage.¹⁶²

Prominent media outlets published stories with ominous headlines, such as “Doctor Shortage Likely to Worsen with Health Law,”¹⁶³ “Doctor Shortage, Increased Demand Could Crash Health Care System,”¹⁶⁴ “Thanks to Obamacare,

expansion of nursing in the mid-1960s, including the introduction of Medicaid and Medicare and the looming shortage of physicians).

160. FAIRMAN, MAKING ROOM IN THE CLINIC, *supra* note 140, at 3.

161. See, e.g., Bagley, *Medicine As a Public Calling*, *supra* note 65, at 63 (“Policymakers’ greatest immediate concern is a coming ‘doc shortage,’ especially a shortage of primary-care physicians, who were in short supply even before the ACA’s enactment.”); Peter D. Jacobson & Shelley A. Jazowski, *Physicians, the Affordable Care Act, and Primary Care: Disruptive Change or Business As Usual?*, 26 J. GEN. INT. MED. 934, 934 (2011) (“With expanded access to primary care for millions of new patients, physicians and policymakers face increased pressure to solve the perennial shortage of primary care practitioners.”).

162. *AAMC Releases New Physician Shortage Estimates Post-Reform*, AAMC (Sept. 30, 2010), <https://www.aamc.org/newsroom/newsreleases/2010/150570/100930.html> [<https://perma.cc/H6W2-G5F9>].

163. Annie Lowrey & Robert Pear, *Doctor Shortage Likely to Worsen with Health Law*, N.Y. TIMES, July 29, 2012, at A1.

164. Jen Christensen, *Doctor Shortage, Increased Demand Could Crash Health Care System*, CNN (Oct. 2, 2013), <https://www.cnn.com/2013/10/02/health/obamacare-doctor-shortage/index.html> [<https://perma.cc/64RH-CSYB>].

A 20,000 Doctor Shortage Is Set to Quintuple,”¹⁶⁵ and “Why the Doctor Can’t See You.”¹⁶⁶ One CNN story quoted a doctor who darkly compared the ACA to “giving everyone an ATM card in a town where there are no ATM machines.”¹⁶⁷ Some news reports observed that Massachusetts had experienced lengthy wait times for doctors’ appointments after passing its own health care reform law in 2006, a law which served a model for the ACA.¹⁶⁸

These concerns prompted numerous calls for expanding non-physician providers’ scopes of practice. Professional groups such as the American Association of Nurse Practitioners seized on the ACA as a reason in favor of loosening scope of practice restrictions.¹⁶⁹ The National Governors Association advocated that states “reexamine their scope of practice laws governing nurse practitioners,” in part to meet the rising demand for health care due to the ACA.¹⁷⁰ In his 2013 testimony before the U.S. Senate Committee on Health, Education, Labor & Pensions (HELP), Uwe Reinhardt argued in favor of developing a national scope of practice regime that “reflect[s] the expertise of both . . . physicians and nurse practitioners.”¹⁷¹

Other related factors played a role as well. For instance, the ACA itself included some specific provisions that further encouraged reliance on NPs, including additional funding for nurse training and nurse-managed clinics.¹⁷² Perhaps most notably, the Institute of Medicine (IOM) published an influential report in 2011 which recommended, among other things, that states reform their scope of practice laws to allow APNs “to practice to the full extent of their

165. Sally Pipes, *Thanks to Obamacare, A 20,000 Doctor Shortage Is Set to Quintuple*, FORBES (June 10, 2013), <https://www.forbes.com/sites/sallypipes/2013/06/10/thanks-to-obamacare-a-20000-doctor-shortage-is-set-to-quintuple/#4658ec22322e> [<https://perma.cc/22XR-K43K>].

166. John C. Goodman, *Why the Doctor Can’t See You*, WALL STREET J. (Aug. 14, 2012), <https://www.wsj.com/articles/SB10000872396390443404004577578980699719356> [<https://perma.cc/6U94-9R8G>].

167. Christensen, *supra* note 164.

168. See, e.g., Goodman, *supra* note 165; *National Health Preview*, WALL ST. J. (May 10, 2011), <https://www.wsj.com/articles/SB10001424052748703864204576313370527615288> [<https://perma.cc/S8TC-52XK>].

169. Sarah Kliff, *Obamacare Is Ramping Up a Health-Care Turf War*, WASH. POST WONKBLOG (Feb. 27, 2013), <https://www.washingtonpost.com/news/wonk/wp/2013/02/27/how-obamacare-is-ramping-up-a-health-care-turf-war/> [<https://perma.cc/SMD3-FNM5>] (“In Washington, D.C., and in state houses, the American Association of Nurse Practitioners is making the case that it’s time to broaden the scope of practice laws — and that the Affordable Care Act significantly strengthens their case.”).

170. *The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care*, NAT’L GOVERNORS ASS’N (2012), <https://www.nga.org/files/live/sites/NGA/files/pdf/1212NursePractitionersPaper.pdf> [<https://perma.cc/3C2D-SZLV>].

171. *30 Million New Patients and 11 Months to Go: Who Will Provide Their Primary Care: Hearing Before the Subcomm. on Primary Health and Aging of the H. Comm. on Health, Educ., Labor & Pensions*, 113th Cong. 39 (2013) (statement of Uwe E. Reinhardt, Princeton University).

172. Patient Protection and Affordable Care Act, Pub. L. No. 111–148, §§ 5202, 5208, 124 Stat. 119, 607 (2010).

education and training.”¹⁷³ The IOM report specifically noted that the ACA rendered it more urgent to expand nurses’ scope of practice, warning that “overly restrictive scope-of-practice regulations” for APNs pose a “serious barrier” to care for the millions of people gaining coverage under the ACA.¹⁷⁴

Once again, partly in response to these pressures, states loosened their scope of practice restrictions for non-physicians, such as NPs and Physician Assistants.¹⁷⁵ Since the beginning of 2010, the year the Affordable Care Act was signed into law, ten states have expanded their scope of practice regimes for NPs to “Full Practice,” bringing the total number to twenty-two states and DC (as of June 2017).¹⁷⁶ According to one study, nearly 1800 state laws relating to scope of practice restrictions were proposed between 2011 and 2012, of which 350 were adopted.¹⁷⁷

Again, not all of these changes can be attributed to the ACA, but it played a contributing role.¹⁷⁸ One article published in 2010 reported that twenty-eight states were considering expanding NPs’ scope of practice after the ACA’s passage, and provocatively speculated, “[a] nurse may soon be your doctor.”¹⁷⁹ State legislators in Nevada and Connecticut explicitly invoked the ACA’s insurance expansion

173. INST. OF MED., *THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH* 278 (2011).

174. *Id.* at 85–86, 96.

175. Matt Brothers, *The PPACA’s Impact on the Scope of Practice of Nurse Practitioners*, 23 ANNALS HEALTH L. ADVANCE DIRECTIVE 79, 83 (2013) (“The passage of the PPACA already led to a flurry of state legislation regarding nurse practitioners. Much of this legislation is designed to ease restrictions on the scope of practice of nurse practitioners.”).

176. Email from Michelle L. Cook, Vice President of Research, Am. Ass’n of Nurse Practitioners, to author (June 23, 2017) (on file with author). The American Association of Nurse Practitioners defines “Full Practice” as follows: “[s]tate practice and licensure laws permit all [nurse practitioners] to evaluate patients; diagnose, order and interpret diagnostic tests; and initiate and manage treatments, including prescribing medications and controlled substances, under the exclusive licensure authority of the state board of nursing.” *State Practice Environment*, AM. ASS’N NURSE PRACTITIONERS, <https://www.aanp.org/legislation-regulation/state-legislation/state-practice-environment> [<https://perma.cc/2G7F-WNR3>] (last updated Dec. 20, 2018).

177. Catherine Dower, Jean Moore & Margaret Langelier, *It Is Time to Restructure Health Professions Scope-Of-Practice Regulations to Remove Barriers to Care*, 32(11) HEALTH AFF. 1971, 1971 (2013) (citing *Scope of Practice Legislative Database, 2011–2013*, NAT’L CONF. OF STATE LEG.’S, <http://www.ncsl.org/issues-research/health/scope-of-practice-legislation-tracking-database.aspx>); see Adams & Markowitz, *supra* note 37 (“The current trend is toward more provider independence—known as fully authorized SOP—and fewer restrictions on practice (appendix figures 1–3). For example, the number of states allowing completely independent practice and prescribing authority for CNMs more than tripled from 9 to 29 between 1994 and 2017 (Markowitz et al. 2017; authors’ calculations).”).

178. See Johnson, *supra* note 9, at 504 (“The great concern over the shortage of primary care physicians to meet these goals is . . . fostering a push to expand practice opportunities for [APNs and PAs].”).

179. Carla K. Johnson, *Doctor Shortage? 28 States May Expand Nurses’ Role*, MED. EXPRESS (Apr. 13, 2010), <https://medicalxpress.com/news/2010-04-doctor-shortage-states-nurses-role.html> [<https://perma.cc/G924-8WXL>].

during the lead-up to passing laws expanding NPs' scope of practice.¹⁸⁰ Similarly, in 2014, former Governor Steve Beshear of Kentucky explicitly linked the passage of a bill expanding NPs' prescribing authority with concerns about the ACA causing a shortage of primary care physicians.¹⁸¹ Beshear later attested that although he believed that loosening scope of practice restrictions was warranted irrespective of whether the ACA had been enacted, his state would not have implemented changes to its scope of practice laws had it not been for the new health care law.¹⁸²

B. The HMO Act and the Erosion of the Corporate Practice of Medicine Doctrine

Medicaid and Medicare also played a crucial—though less direct—role in the erosion of the corporate practice of medicine doctrine. Health care spending growth continued unabated into the early 1970s, driven by cost growth for outpatient hospital services.¹⁸³ Labor leaders and Democrats, led by Senator Edward Kennedy, increasingly pushed to enact a national health insurance program, and Kennedy released a report aimed at building support for his initiative titled “The Health Care Crisis in America.”¹⁸⁴

Only a few months after he took office in 1969, President Richard Nixon echoed this language, warning that the health care system faced a “massive crisis” stemming from “massively increasing demands in this field,” and that “unless action

180. MINUTES OF THE MEETING OF THE ASSEMB. COMM. ON COMMERCE & LABOR, 77th Sess. (Nev. Feb. 27, 2013), <https://www.leg.state.nv.us/Session/77th2013/Minutes/Assembly/CL/Final/326.pdf> [<https://perma.cc/V5VF-4T59>]; MINUTES OF THE S. COMM. ON COMMERCE, LABOR & ENERGY, 77th Sess. (Nev. May 1, 2013), <https://www.leg.state.nv.us/Session/77th2013/Minutes/Senate/CL/Final/1042.pdf> [<https://perma.cc/4LRF-LHXB>]; MINUTES OF THE S. COMM. ON COMMERCE, LABOR & ENERGY, 77th Sess. (Nev. May 17, 2013), <https://www.leg.state.nv.us/Session/77th2013/Minutes/Senate/CL/Final/1208.pdf> [<https://perma.cc/TK66-RWY6>]; Arielle Levin Becker, *Senate Votes to Allow Nurse Practitioners to Practice Independent of Doctors*, CT MIRROR (Apr. 9, 2014), <https://ctmirror.org/2014/04/09/senate-votes-to-allow-nurse-practitioners-to-practice-independent-of-doctors/> [<https://perma.cc/6HJA-ZHXU>].

181. Anna Hartkeymeyer, *Kentucky Broadens the Scope of Practice for Nurse Practitioners*, COUNCIL ST. GOV'TS. (July 25, 2014), <http://knowledgecenter.csg.org/kc/content/kentucky-broadens-scope-practice-nurse-practitioners> [<https://perma.cc/S3VQ-HDBG>] (“As more people gain access to health care as a result of the Affordable Care Act, this bill is a step in the right direction to begin addressing the current and projected shortfall of primary care physicians in Kentucky,” said Kentucky Governor Steve Beshear in a press release following the signing of Senate Bill 7.”).

182. UNIV. OF PA. LEONARD DAVIS INST. OF HEALTH ECONs., LDI HEALTH POLICY SEMINAR WITH STEVE BESHEAR, JD: PEOPLE OVER POLITICS: THE SOLUTION TO OUR HEALTHCARE LOGJAM (2018).

183. AARON C. CATLIN & CATHY A. COWAN, CENTERS FOR MEDICARE & MEDICAID SERVICES, HISTORY OF HEALTH SPENDING IN THE UNITED STATES, 1960–2013, at 9–10 (2015), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/HistoricalNHEPaper.pdf> [<https://perma.cc/37MY-BGHD>].

184. Jennifer Evans & Jaclyn Schiff, *A Timeline of Kennedy's Health Care Achievements and Disappointments*, KAISER HEALTH NEWS (Sept. 17, 2010), <https://khn.org/news/kennedy-health-care-timeline/> [<https://perma.cc/PB5M-2WD5>]; see also PAUL STARR, REMEDY AND REACTION 52–53 (2011).

is taken . . . we will have a breakdown in our medical care system which could have consequences affecting millions of people throughout this country.”¹⁸⁵ Soon, the Nixon Administration began “casting about for a solution to the rising and seemingly uncontrollable costs of the Medicare and Medicaid programs that had helped to generate a climate of health care crisis that was troubling the Congress.”¹⁸⁶

As luck would have it, Thomas Joe, then a top assistant to John Veneman, the Under Secretary of the Department of Health, Education and Welfare (HEW), reportedly encountered Dr. Paul Ellwood on a plane, where the latter reportedly sold him on the concept of “health maintenance organizations” (HMOs),¹⁸⁷ hybrid health care organizations that both treat patients and offer insurance coverage in exchange for a fixed annual fee per patient.¹⁸⁸ Ellwood, a pediatric neurologist and the founder of a Minneapolis-based think tank, is credited with coining and popularizing the term HMO,¹⁸⁹ though such organizations—also referred to as prepaid group plans—date as far back as the 1930s.¹⁹⁰

Only a couple weeks after the fateful plane ride, Ellwood submitted a memo to the White House making the case for a “Health Maintenance Strategy,” just in advance of a meeting between high-level White House officials and HEW officials.¹⁹¹ Ellwood envisioned that HMOs would offer comprehensive care to patients in exchange for prepayment, and compete against each other and against traditional plans based on price and quality.¹⁹² Ellwood painted HMOs as a market-based alternative to enacting more regulations on health care services, an option that the Nixon Administration viewed as unpalatable.¹⁹³

The Administration proved receptive to Ellwood’s arguments, and in 1971, President Nixon made HMOs a central element of his “National Health Strategy.”¹⁹⁴ Congress and the Administration were under pressure to curb rising

185. President Richard Nixon, *Remarks at a Briefing on the Nation’s Health System*, AM. PRESIDENCY PROJECT (July 10, 1969), <https://www.presidency.ucsb.edu/documents/remarks-briefing-the-nations-health-system> [https://perma.cc/82LU-HJN9].

186. Patricia Bauman, *The Formation and Evolution of the Health Maintenance Organization Policy, 1970-1973*, 10 SOC. SCI. & MED. 129, 130 (1976).

187. KINGDON, *supra* note 24, at 6.

188. Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 436–37 (1988).

189. Clark C. Havighurst, *Health Maintenance Organizations and the Market for Health Services*, 35 L. & CONTEMP. PROBS. 716, 718–19 (1970).

190. STARR, REMEDY AND REACTION, *supra* note 184, at 54.

191. Bauman, *supra* note 186, at 130–31.

192. CARL F. AMERINGER, *THE HEALTH CARE REVOLUTION: FROM MEDICAL MONOPOLY TO MARKET COMPETITION* 64 (2008).

193. Paul M. Ellwood, Jr. et al., *Health Maintenance Strategy*, 9 MED. CARE 291, 295 (1971) (“The health maintenance policy is expected to substantially lessen the Federal government’s role in the planning and management of health programs, and therefore, should not be regarded as ‘just another Federal health program.’”).

194. President Richard Nixon, *Special Message to the Congress Proposing a National Health Strategy* (Feb. 18, 1971), AM. PRESIDENCY PROJECT, <https://www.presidency.ucsb.edu/documents/>

health care costs, and a Presidential Commission had recently expressed support for prepaid practice as a promising organizational innovation to slow health care spending.¹⁹⁵ Nixon himself was familiar with the most successful prepaid group plan, Kaiser Permanente, which was then the largest health care organization in California.¹⁹⁶

Importantly, both Ellwood and Nixon explicitly argued that Medicare and Medicaid had rendered the HMO Act necessary by increasing the demand for health care without simultaneously reforming the health care delivery system. Ellwood's memo (a version of which was later published as an academic paper) blamed Medicare and Medicaid for increasing demand and cautioned against further expanding health insurance, warning that it would inexorably lead to more regulations.¹⁹⁷

Similarly, in President Nixon's eyes, the HMO Act was a necessary response to Medicare and Medicaid, which had increased the demand for health care and spurred rising health care costs. In a 1972 speech advocating for his "National Health Strategy," Nixon traced the necessity of the HMO Act back to Medicare and Medicaid:

One basic shortcoming of a solution to health care problems which depends entirely on spending more money, can be seen in the Medicare and Medicaid programs. Medicare and Medicaid did deliver needed dollars to the health care problems of the elderly and the poor. But at the same time, little was done to alter the existing supply and distribution of doctors, nurses, hospitals and other health resources. Our health care supply, in short, remained largely the same while massive new demands were loaded onto it. The predictable result was acute price inflation, one basic cause of our health economic quandary of the past 11 years If we do not lessen this trend, all other reform efforts may be in vain.¹⁹⁸

In 1973, Congress passed the Health Maintenance Organization (HMO) Act to encourage the development of HMOs.¹⁹⁹ The law promoted HMOs in several

special-message-the-congress-proposing-national-health-strategy [https://perma.cc/7FJV-DU6X] [hereinafter Nixon, *Special Message to the Congress Proposing a National Health Strategy*].

195. NATIONAL ADVISORY COMMISSION ON HEALTH MANPOWER: REPORT 66-68 (1967) (noting that Kaiser has lower hospital and outpatient utilization and costs than the rest of the United States).

196. STARR, REMEDY AND REACTION, *supra* note 184, at 54-55.

197. Ellwood, Jr. et al., *supra* note 193, at 291.

198. President Richard Nixon, *Special Message to the Congress on Health Care* (Mar. 2, 1972), AM. PRESIDENCY PROJECT, <https://www.presidency.ucsb.edu/documents/special-message-the-congress-health-care> [https://perma.cc/JZF9-GEHY] [hereinafter Nixon, *Special Message to the Congress on Healthcare*]; see also Nixon, *Special Message to the Congress Proposing a National Health Strategy*, *supra* note 194 ("It does little good . . . to increase the demand for care unless we also increase the supply This axiom was ignored when Medicaid and Medicare were created and the nation paid a high price for that error. The expectations of many beneficiaries were not met and a severe inflation in medical costs was compounded.").

199. Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e (2018).

ways, including providing grants and loans to develop and operate HMOs and requiring large businesses to offer an HMO in their benefit plan if possible.²⁰⁰ At the same time, it also required HMOs to meet certain conditions to be eligible for funding, such as offering a more generous set of benefits and not discriminating based on health status.²⁰¹

Most importantly for purposes of this Article, the law also promoted HMOs by undermining the corporate practice of medicine doctrine. The corporate practice prohibition could be invoked to prohibit HMOs, especially for-profit ones.²⁰² At the time that the HMO Act was being debated in Congress, proponents of HMOs viewed the corporate practice of medicine doctrine as one of the major barriers to the development of HMOs.²⁰³

The need for addressing the corporate practice doctrine was cited as part of the reason for enacting the HMO Act,²⁰⁴ and an early version of the Act explicitly preempted the corporate practice prohibition, at least as it applied to non-profit HMOs.²⁰⁵ Although the final version of the Act did not ultimately go that far, it made clear that any application of the corporate practice of medicine doctrine to prohibit the development of HMOs would be preempted.²⁰⁶ According to George Harris and Derek Foran, “[t]he HMO Act was instrumental in breaking down the barriers to corporate ownership of medical service providers.”²⁰⁷

200. 42 U.S.C. §§ 300e-4, -9 (2018).

201. STARR, SOCIAL TRANSFORMATION, *supra* note 24, at 401.

202. Robert T. Holley & Rick J. Carlson, *The Legal Context for the Development of Health Maintenance Organizations*, 24 STAN. L. REV. 644, 657–58 (1972) (“[I]t is clear that a majority of courts feels that the furnishing of medical care through a corporate structure is undesirable, and condemns organizations on that basis alone. Since HMOs are corporations, the rule will probably be applied to them.”); Philip C. Kissam & Ronald M. Johnson, *Health Maintenance Organizations and Federal Law: Toward a Theory of Limited Reformmongering*, 29 VAND. L. REV. 1163, 1184 (1976) (“All HMOs, particularly profitmaking ones, may be prohibited by application of the hoary, but occasionally viable, common law rule against the corporate practice of medicine.”); Note, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis*, 84 HARV. L. REV. 887, 960 (1977) (“The common law rule that a corporation cannot engage in a ‘learned calling’ would appear, on its face, to bar incorporated prepaid group practice.”).

203. Chase-Lubitz, *supra* note 46, at 481; Huberfeld, *supra* note 14, at 277.

204. Huberfeld, *supra* note 14, at 277.

205. *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis*, *supra* note 202, at 962 n.52 (“The proposed Health Security Act . . . would eliminate the corporate practice rule for nonprofit participating organizations, provided an administrative board finds the arrangements are not likely to cause lay interference with professional acts or professional judgments.”).

206. Chase-Lubitz, *supra* note 46, at 482 (“[A]ny application of the prohibition would conflict with the legislation so directly that preemption would appear certain.”); Kissam & Johnson, *supra* note 202, at 1218 (“By implication the Act also preempts the application to qualified HMOs of the common law rule against the corporate practice of medicine.”).

207. George C. Harris & Derek F. Foran, *The Ethics of Middle-Class Access to Legal Services and What We Can Learn from the Medical Profession’s Shift to a Corporate Paradigm*, 70 FORDHAM L. REV. 775, 814 (2001); see also Saver, *Uneasy Relationship*, *supra* note 8, at 674 (“The federal HMO Act of 1973 is credited with jump-starting managed care and promoting HMOs as a viable alternative in the private market. It did so by preempting obstructive state laws for federally qualified HMOs and

Through the financial inducements it provided and these regulatory curtailments, the Act contributed to a dramatic expansion in HMOs across the country.²⁰⁸ Following the HMO Act, almost all of the states went further and specifically exempted HMOs from their corporate practice of medicine laws.²⁰⁹ Although the Act's regulatory requirements initially limited its effectiveness,²¹⁰ enrollment in HMOs doubled in the first half of the 1970s, and continued to grow throughout the late 1970s and through the 1980s.²¹¹

Thus, by increasing demand for health care and spurring health care cost growth, Medicare and Medicaid led to the enactment of the HMO Act, which in turn contributed to the erosion of the corporate practice of medicine doctrine. The end result is that while corporate practice prohibitions remain "legal landmines," they are far less potent than they used to be.²¹²

C. *The Health Costs Crisis and the Rise of Certificate of Need Laws*

The enactment of Medicare and Medicaid also contributed to the expansion of CON laws, through increasing the demand for health care and driving up government expenditures on health care. With the implementation of these new programs in 1966, millions of elderly and poor Americans gained health insurance coverage for the first time. That year alone, 18.9 million people enrolled in Medicare Part A (covering hospital services and nursing home care), 17.6 million enrolled in Medicare Part B (covering physician and other services), and 4 million enrolled in Medicaid.²¹³ As more states implemented Medicaid, enrollment swelled to 17 million by 1973, while Medicare enrollment inched upwards to 23.1 million enrollees.²¹⁴

As referenced above, Medicare's reimbursement structure also further increased the demand for health care. Initially, Medicare reimbursed physicians and hospitals on a retrospective fee-for-service basis (i.e., physicians and hospitals were reimbursed for whatever they spent), as long as their costs were "reasonable"²¹⁵—a determination which was effectively left to the hospitals and physicians

requiring certain employers to offer an HMO option as part of the health benefits available to employees in order to obtain favorable tax treatment for employee health expenses.").

208. Harris & Foran, *supra* note 207, at 817.

209. Sara D. Mars, *The Corporate Practice of Medicine: A Call for Action*, HEALTH MATRIX 241, 260 (1997).

210. Gail B. Agrawal & Howard R. Veit, *Back to the Future: The Managed Care Revolution*, 65 L. & CONTEMP. PROBS. 11, 32 (2002) ("The implementation of the HMO Act sputtered for several years after its enactment, due partly to the Act's burdensome requirements and partly to bureaucratic mismanagement.").

211. Lynn R. Gruber, Maureen Shadle & Cynthia L. Polich, *From Movement to Industry: The Growth of HMOs*, HEALTH AFF. 197, 198 (1988).

212. See Rosoff, *supra* note 58 and accompanying text.

213. CATLIN & COWAN, *supra* note 183, at 9.

214. *Id.*

215. Medicare Act of 1965, Pub. L. No. 89-97, sec. 102(a), § 1814(b), 79 Stat. 286, 296.

themselves.²¹⁶ The regulations interpreting these provisions permitted hospitals to seek reimbursement for costs associated with directly providing patient care, as well as for “capital costs” (e.g., interest on debt, depreciation).²¹⁷

These developments soon led to spiraling health expenditures. Medicare’s reimbursement structure sparked a “medical arms race,” as hospitals competed based on who could adopt the latest costly new medical technology.²¹⁸ Health care spending grew at an annual rate of 11.9% from 1966 through 1973, up from its 8.9% rate from 1960 to 1965.²¹⁹ The pace of health care price growth too began to accelerate, rising by 5.1% from 1966 to 1973.²²⁰ One estimate finds that Medicare alone was responsible for increasing hospital spending by nearly 40% between 1965 and 1970.²²¹ These trends were met with alarm. Christy Chapin observes that “[a]fter 1965, voters and policymakers discussed health care using terms customarily reserved for national catastrophes.”²²²

Rising government expenditures stemming from Medicare (a federal program) and Medicaid (a joint federal-state program) placed growing budgetary pressure on both the federal government and the states. Between 1966 and 1967, the government’s share of health care spending increased from 24% to 29%.²²³ Medicare expenditures alone reached \$10.7 billion in 1973,²²⁴ while Medicaid spending reached \$6.5 billion by 1971.²²⁵

To stem these rising costs, state and federal policymakers implemented a raft of new regulations on physicians and hospitals to curb health care spending, the “chief manifestation” of which were Certificate of Need (CON) laws.²²⁶ CON laws varied in their structure and approach, but they generally required that the government certify that there was an existing health need before allowing new

216. Bagley, *Beside Bureaucrats*, *supra* note 20, at 527.

217. See generally Eleanor D. Kinney & Bonnie Lefkowitz, *Capital Cost Reimbursement to Community Hospitals Under Federal Health Insurance Programs*, 7 J. HEALTH POL. POL’Y & L. 648, 649 (1982).

218. JAMES C. ROBINSON, *THE CORPORATE PRACTICE OF MEDICINE* 23–25 (1999); see also Havighurst, *American Health Care and the Law*, *supra* note 25, at 86 (“The uncontrolled moral hazard inherent in these financing arrangements eventually gave rise to unprecedented cost escalation, as benefit/cost ratios were almost totally neglected in physicians’ clinical choices and, consequently, also in decision making on capital spending and technological development.”).

219. CATLIN & COWAN, *supra* note 183, at 8.

220. *Id.* at 10.

221. Finkelstein, *The Aggregate Effects of Health Insurance*, *supra* note 122.

222. CHAPIN, *supra* note 45, at 234.

223. CATLIN & COWAN, *supra* note 183, at 11.

224. *Id.* at 9.

225. John D. Klemm, *Medicaid Spending: A Brief History*, 22 HEALTH CARE FINANCING REV. 105, 106 (2000).

226. Havighurst, *Regulation of Health Facilities and Services by “Certificate of Need,” supra* note 70, at 1143.

health care facilities to enter the market or existing facilities to make large capital investments.²²⁷

Soon after the implementation of Medicaid and Medicare, CON laws began to proliferate. In 1964, just one year before the passage of Medicare and Medicaid, New York became the first state to enact its own CON law in response to rising hospital costs.²²⁸ Yet it was only after the implementation of Medicaid placed growing fiscal pressures on state governments that other states followed suit.²²⁹ In part responding to this pressure, by 1972, twenty states had adopted their own CON laws.²³⁰

The federal government too turned to CON laws to stem rising health care spending. In 1966, Congress passed the Comprehensive Health Planning and Services Act, which provided funding for state and local agencies to coordinate their planning activities and to provide broader access to health care.²³¹ In 1972, Congress built on this momentum by passing legislation giving the Secretary of Health, Education, and Welfare the authority to deny Medicare or Medicaid reimbursement for health care facilities' capital expenditures if the state had not certified them as meeting a community need.²³² This latter legislation was explicitly designed to address the perverse incentives created by Medicare and Medicaid's open-ended reimbursement provision for capital expenditures.²³³

In 1974, Congress passed the National Health Planning and Resources Development Act (NHPDA), which offered funding to state CON programs and required them to meet federal standards or else forgo eligibility for Medicare and Medicaid.²³⁴ Like the previous federal planning statutes, the NHPDA was largely intended to address mounting health care spending, which was in turn driven by Medicare and Medicaid.²³⁵

227. Simpson, *supra* note 64, at 1025

228. Payton & Powsner, *supra* note 66, at 209–10.

229. STARR, SOCIAL TRANSFORMATION, *supra* note 24, at 398 (“Impelled by rising costs, state governments led the way toward stiffer regulation of the health care industry. New York in 1964 had been the first state to regulate capital expenditures of hospitals and nursing homes, but few followed its example until soaring Medicaid expenditures at the end of the decade obliged state legislatures to take action.”).

230. *Id.*

231. Comprehensive Health Planning and Services Act, 42 U.S.C. § 246 (1966).

232. See Social Security Amendments of 1972, Pub. L. No. 92–603, § 221, 86 Stat. 1329, 1386 (codified as amended at 42 U.S.C.A. §1320a-1 (2014)); Simpson, *supra* note 64, at 1038.

233. Simpson, *supra* note 64, at 1038 (“The Social Security Amendments of 1972 contained several measures designed to restrain Medicare and Medicaid program cost increases caused by incurred-cost reimbursement.”).

234. National Health Planning and Resources Development Act of 1974, Pub. L. No. 93–641, 88 Stat. 2225 (1975)

235. *Id.* (“The massive infusion of Federal funds into the existing health care system has contributed to inflationary increases in the cost of health care Increases in the cost of health care, particularly of hospital stays, have been uncontrollable and inflationary.”).

Again, of course, there were multiple forces responsible for the proliferation of CON laws. For instance, larger hospitals found CON laws appealing as a means of forestalling more serious government regulation and reducing competition.²³⁶ The “legitimacy of professional dominance” that had long existed in health care began to erode.²³⁷ CON laws also built on a tradition of “health planning” initiatives that Congress had previously endorsed by enacting the 1946 Hill Burton Act.²³⁸

Nevertheless, Medicaid and Medicare played a decisive role by triggering spiraling health expenditures and drastically increasing the government’s share of the burden. Sallyanne Payton and Rhoda Powsner have written that the implementation of Medicare and Medicaid represented “a watershed in the developing relationship between government and the hospitals.”²³⁹ Whereas previously, “government had been a bystander in what was principally a private sector problem,” Medicare and Medicaid precipitated “the need and the desire to act, driven by [the government’s] own self-interest as a major purchaser of medical services . . . in containing its own financial liabilities.”²⁴⁰ Paul Starr offers a similar assessment, writing that the “distinctive factor” that explains the “growing health care regulation of the 1970s” is “that a large share of medical costs had been socialized . . . [and that] [g]overnment[s], employers, and commercial insurers balked at both the rise in costs and the uncertainty that inflation created for them.”²⁴¹

Some readers may view this account of the rise of CON laws as a cautionary tale, since CON laws subsequently fell out of favor and have been roundly criticized as ineffectual and anti-competitive.²⁴² Their emergence in the aftermath of Medicare and Medicaid may illustrate the responsiveness of the delivery system to changes in health insurance, but it also shows that the delivery system reforms that result from this process are not guaranteed to be successful.

More recently, however, some scholars have concluded that the problem with CON laws was not that they were enacted in the first place, but rather that they did not go far enough, for example, by giving regulators the authority to control hospital prices.²⁴³ In recent years, more health law scholars have begun to advocate for reinstating economic regulation of the health care sector, and more specifically, for regulating health care prices.²⁴⁴ Thus, even if CON laws did not have their

236. See Payton & Powsner, *supra* note 66.

237. ROBINSON, *supra* note 218, at 30.

238. Havighurst, *Regulation of Health Facilities and Services by “Certificate of Need,” supra* note 70, at 1148.

239. Payton & Powsner, *supra* note 66, at 259.

240. *Id.* at 259–60.

241. STARR, SOCIAL TRANSFORMATION, *supra* note 24, at 403.

242. See *supra* Part I.C.

243. HALL, BOBINSKI & ORENILICHER, *supra* note 56, at 1225.

244. See, e.g., TRACY YEE ET AL., NAT’L INST. FOR HEALTH CARE REFORM, RESEARCH BRIEF NO. 4, HEALTH CARE CERTIFICATE-OF-NEED LAWS: POLICY OR POLITICS? 1 (2011) (“As health care

intended effect, they still represented a defensible policy response to the problem of rising health care costs.

* * *

To review, health care financing laws have played a central role in shaping the landscape of health care delivery laws through shifting the public's demand for health care. The enactment of Medicaid and Medicare—and to a lesser extent, the ACA—increased the demand for health care through at least three channels: increasing access to health care; encouraging providers to deliver additional services; and creating incentives that encouraged the development and proliferation of expensive new technologies over time. The resulting increase in demand in turn exacerbated concerns about reduced access to health care and rising health care costs (and in particular government expenditures on health care), which in turn caused regulators to enact new regulations—or change existing ones—in order to address these problems.

These forces have helped to shape the landscape of health care delivery laws today. Out of the three areas of health care delivery law outlined in this Article, two (the corporate practice of medicine doctrine and scope of practice restrictions) predated the widespread availability of health insurance and have been substantially weakened by the expansions of insurance under Medicare, Medicaid, and the ACA, whereas the origins of the remaining one (Certificate of Need laws) can be traced back to the expansion of health insurance under Medicare and Medicaid.

To be sure, health care financing laws are not the only forces responsible for these changes in health care delivery laws. For instance, other factors besides the HMO Act, such as the Supreme Court's 1982 decision that upheld a Federal Trade Commission order finding the AMA's ethical codes in violation of federal antitrust laws, contributed to the erosion of the corporate practice of medicine doctrine.²⁴⁵ More generally, as Louise Trubek has emphasized in her work on the New Health Governance, physicians, payers, and consumers have played important roles in encouraging policy experimentation and new approaches to regulating health

spending continues to grow more rapidly than the nation's economy, there is renewed interest in certificate-of-need regulation as a way to improve health planning and help control spending growth.”); Bagley, *Medicine As a Public Calling*, *supra* note 65, at 62 (arguing that “if the market-oriented approaches that are ascendant today prove unsatisfactory, public utility regulation is an option worth exploring”); Barry R. Furrow, *Cost Control and the Affordable Care Act: CRAMPing Our Health Care Appetite*, 13 NEV. L.J. 822, 850 (2013) (“State governments might revisit the merits of rate regulation, which proved unpopular in the 1990s and was largely abandoned. More direct regulation of provider rates might set upper bounds on permissible rates negotiated between health plans and providers in relation to Medicare rates.”); Fuse Brown, *supra* note 80, at 85 (“It is time to resurrect rate regulation and place it squarely in the center of any policy strategy to control health care prices and spending.”).

245. *Am. Med. Ass'n v. F.T.C.*, 455 U.S. 676 (1982); *see also* Chase-Lubitz, *supra* note 46, at 475–78.

care.²⁴⁶ Nevertheless, health care financing laws have played a prominent role in creating the conditions leading to these changes in health care delivery laws.

Moreover, although I have solely focused on three areas of health care delivery laws, there are other examples of how expanding health insurance coverage has prompted reforms to delivery system regulations. Perhaps most prominently, both the Medicare/Medicaid legislation and the Affordable Care Act contributed to the enactment of more stringent fraud and abuse legislation. Congress enacted the Anti-Kickback statute and the Stark Law in response to the concern that Medicare's reimbursement structure was incentivizing providers to engage in unnecessary or inappropriate care.²⁴⁷ A few decades later, the Affordable Care Act included a panoply of anti-fraud provisions, including amendments to the Stark and Anti-Kickback laws, increases in anti-fraud budgets, and new disclosure requirements for health care providers.²⁴⁸

While a full exploration of the origins of these reforms is beyond the scope of this Article, Joan Krause suggests that there may be a more general relationship between health care financing laws and fraud and abuse laws. She observes that “[h]ealth care fraud is primarily a crime of opportunity, an opportunity created by the vast sums of money that flow through our complicated health care reimbursement system,” and posits that “[a]ny effort to increase the number of people who participate in that system – as health care reform clearly aims to do – risks an increase in fraud unless countermeasures are taken.”²⁴⁹ Thus, the overall impacts of health insurance expansions on delivery system laws likely go well beyond the specific effects described in this Article.

IV. POLITICAL AND NORMATIVE IMPLICATIONS

Uncovering these interactive effects shows that health care financing laws are largely responsible for health law's “dynamism.” In contrast to the perception of health care delivery laws—and health law in general—as stagnant and inflexible, the history that has unfolded since the adoption of Medicare, Medicaid, and the

246. See, e.g., Louise G. Trubek, *New Governance Practices in U.S. Health Care*, in LAW AND NEW GOVERNANCE IN THE EU AND THE US 249 (Gráinne de Búrca & Joanne Scott eds., 2006); Louise G. Trubek, *New Governance and Soft Law in Health Care Reform*, 3 IND. HEALTH L. REV. 139 (2006).

247. See generally Krause, *Integration, Fragmentation, and Human Nature*, *supra* note 11, at 858–59.

248. Joan H. Krause, *Following the Money in Health Care Fraud: Reflections on a Modern-Day Yellow Brick Road*, 36 AM J. L. MED. 343, 366 (2010) (citing Pub. L. No. 111-148 (2010)); see also Jeffrey B. Hammond, *What Exactly Is Healthcare Fraud After the Affordable Care Act?*, 42 STETSON L. REV. 35, 38 (2012) (“Taken in its entirety, the [ACA] represents the largest single, collective change to federal fraud and abuse law since the creation of the Medicare and the Medicaid programs.”).

249. Joan H. Krause, *Following the Money in Health Care Fraud*, *supra* note 247, at 368–69; see also Joan H. Krause, *Fraud in Universal Coverage: The Usual Suspects (and Then Some)*, 55 U. KAN. L. REV. 1151, 1151 (2007) (“[W]ith few exceptions, health care fraud is a crime of opportunity rather than one of desperation. Thus, any reform effort that increases the opportunities to commit fraud, such as increasing the number of players in the health care system and the obligations imposed on them, may well end up losing more money to fraudulent activities.”).

Affordable Care Act shows that these laws have contributed to numerous regulatory reforms designed to improve access to health care, ensure quality, and reduce health care spending. Far from remaining fixed, health care delivery law has been in flux for the last half-century: repeatedly undergoing a variety of complex changes in response to increases in demand stemming from health care financing laws.

Recognizing this dynamic relationship has two primary implications for the future of health care reform: First, it implies that further expanding health insurance would generate political pressure for additional reforms to the health care delivery system. Second, it strengthens the case for further expanding health insurance coverage. I argue that health law's dynamism is normatively desirable since it is better able to address problems of access, costs, and quality; to adapt to other changes in the underlying health care system; and to facilitate policy learning.

A. Should Delivery System Reform Come Before Health Insurance Reform?

The question of whether to prioritize expanding health insurance coverage (sometimes referred to as *demand-side* health care reform) or reforming the health care delivery system (sometimes referred to as *supply-side* reform) has long bedeviled health care policymakers. President Nixon complained that the Johnson Administration had enacted Medicare and Medicaid without increasing the supply of health care providers.²⁵⁰ During the lead-up to the passage of the ACA, one reported source of tension within the Obama Administration was how much to prioritize tackling health care spending by reforming the delivery system versus expanding health insurance coverage.²⁵¹

Several economists and legal scholars appear to view expanding health insurance coverage and health care delivery reform not merely as distinct goals, but as ones that are in competition with one another.²⁵² For instance, Richard Epstein and David Hyman have argued that deregulation of the health care delivery system “in ways that will increase quality and reduce the cost of health care” should be prioritized over further expanding health insurance, and have warned that that pursuing universal health insurance first will only further lock us into “the current dysfunctional state of affairs.”²⁵³

250. See Nixon, *Special Message to the Congress on Health Care*, *supra* note 198.

251. See, e.g., BRILL, *supra* note 16, at 113 (“The economic team wanted to use reform to bend the cost curve . . . [whereas the] healthcare reform policy team . . . wanted to expand coverage.”).

252. See, e.g., Cochrane, *supra* note 12, at 162 (“I focus on the supply and demand for health care, which gives this essay a bit of novelty. Curiously, most of the current policy debate, and most of our regulation, focuses on health insurance, the question of who will pay the bill, as if the market for health care were functioning normally.”); Alex Tabarrok, *Supply Side Health Care Reform*, MARGINAL REVOLUTION (Mar. 27, 2017), <https://marginalrevolution.com/marginalrevolution/2017/03/supply-side-health-care-reform.html> [https://perma.cc/HKZ6-MF5J] (“We fight over health care policy because we focus on demand and redistribution. We could reach greater agreement if we focused on supply and innovation.”).

253. Epstein & Hyman, *supra* note 22, at 516.

By contrast, this Article suggests that the opposite is true. Far from being in competition with delivery system reform, improving health insurance coverage can act as a catalyst to reforming delivery system laws. Although there are still powerful political economy constraints that favor the status quo in health care, expanding health insurance coverage is one way to overcome these constraints and enact meaningful reforms to health care delivery laws.

Contrasting today's health care delivery system with the one that preceded the enactment of Medicare and Medicaid helps to bring the effects of expanded insurance coverage into sharper relief. Until the 1970s, the health care delivery system "had long been static."²⁵⁴ Most physicians operated as solo practitioners, largely insulated from competition, and free from control by corporations and hospitals.²⁵⁵ The laws governing the health care delivery system—such as the corporate practice of medicine doctrine and licensing laws—served to support and preserve this system.²⁵⁶

The health care delivery system today is unrecognizable from the one that existed roughly half a century ago.²⁵⁷ The past several decades have witnessed the enactment of a plethora of new laws governing health care professions and hospitals, as well as modifications and outright repeals of preexisting delivery system regulations and doctrines. These changes did not happen all at once, but rather in fits and starts. In the realm of fraud and abuse laws alone, Congress enacted new legislation at least seven times between the 1970s and 1996.²⁵⁸ Some regulatory changes—such as CON laws—have been enacted, only to be substantially scaled back shortly thereafter.

The proliferation of health insurance coverage by laws such as Medicare and Medicaid has helped to drive these regulatory changes. Given interest groups' intense efforts to preserve the status quo,²⁵⁹ and their opposition to controlling health care spending in particular,²⁶⁰ it seems possible that it will take further increases in the demand for health care to precipitate a sufficiently salient and

254. Agrawal & Veit, *supra* note 210, at 12.

255. *Id.*

256. Rand E. Rosenblatt, *The Four Ages of Health Law*, 14 HEALTH MATRIX 155, 162 (2004) ("The model of professional authority dominated health law and policy in the United States from about 1880 to about 1960. During this period the main point of health law—its more or less conscious purpose—was to support the authority and autonomy of individual physicians engaged in the private practice of medicine.").

257. See Havighurst, *American Health Care and the Law*, *supra* note 25, at 85 ("Once upon a time, the U.S. health care industry was not beset on all sides by law and lawyers. Indeed, when I first surveyed the field of health law in the late 1960s, the list of emergent legal issues in health care was quite short.").

258. *Id.* at 90.

259. See generally FRANK R. BAUMGARTNER, JEFFREY M. BERRY, MARIE HOJNACKI, DAVID C. KIMBALL & BETH L. LEECH, *LOBBYING AND POLICY CHANGE: WHO WINS, WHO LOSES, AND WHY* (2009).

260. See REINHARDT, *supra* note 17 and accompanying text.

broad-based concern about health care costs that the government will finally enact more effective cost-control measures. This hypothesis appears supported by John Kingdon's work on agenda setting, in which he has argued that the perception of a problem or a crisis is one of the key factors in determining whether a particular issue rises to the top of policymakers' agendas.²⁶¹

This same logic has been applied to a number of other contexts.²⁶² For instance, former Treasury Secretary Henry Paulson has argued that it took the failure of Lehman Brothers during the 2008–2009 financial crisis to force Congress to take the unpopular legislative measures that, in his view, were necessary to stave off an even greater economic disaster.²⁶³ Ten years after Lehman's failure, speaking for himself, Former Treasury Secretary Timothy Geithner, and Former Chairman of the Federal Reserve Benjamin Bernanke, Paulson says: "the . . . thing which we've all said is it takes a crisis to get Congress to act."²⁶⁴ Similarly, in 2008, Rahm Emanuel, then-Chief of Staff to President-Elect Obama famously said, "you never want a serious crisis to go to waste . . . Things that we had postponed for too long, that were long-term, are now immediate and must be dealt with. This crisis provides the opportunity for us to do things that you could not do before."²⁶⁵ Scholars have linked other prominent crises such as the thalidomide tragedy in the 1950s, the Three Mile Island nuclear accident, and the Love Canal pollution disaster, with important regulatory and legislative changes.²⁶⁶

Of course, expanding health insurance coverage is distinguishable from these examples in that it is not in itself a "crisis." Rather, there are strong independent justifications for seeking universal health care coverage. As described above, a growing body of empirical research finds that health insurance expansions improve financial wellbeing, access to health care, physical and mental health outcomes, and reduce mortality in certain areas.²⁶⁷ Yet in solving one problem (inadequate insurance coverage), the government has historically exacerbated concerns about preexisting problems with the health care system, as well as budgetary concerns, and in doing so, it has created greater pressure to reform the health care delivery system.

261. See KINGDON, *supra* note 24, at 90–115.

262. Daniel Carpenter & Jisela Sin, *Policy, Tragedy, and the Emergence of Regulation: The Food, Drug & Cosmetic Act of 1938*, 21 *STUD. AMER. POL. DEV.* 149, 153 (2007) ("The claim that regulation follows certain critical events (either actual events or journalistic exposes) is common to historians of numerous fields of regulation.")

263. *Panic, Fear and Regret*, MARKETPLACE (Mar. 20, 2018), <https://features.marketplace.org/bernanke-paulson-geithner/> [<https://perma.cc/J8JX-HMAD>] ("[O]ne thing the Lehman shock did was energized the system politically, and that was . . . what it ended up taking for us to get these emergency authorities to let us to recapitalize the whole financial system and avoid a catastrophe But it took an emergency to get them to act.")

264. *Id.* (emphasis added).

265. Gerald F. Seib, *In Crisis, Opportunity for Obama*, WALL STREET J. (Nov. 21, 2008), <https://www.wsj.com/articles/SB122721278056345271> [<https://perma.cc/2L57-JEN6>].

266. Carpenter & Sin, *supra* note 262, at 153.

267. See, e.g., Sommers, Gawande & Baicker, *supra* note 89.

Importantly, while expanding health insurance tends to lead to reforming delivery system laws, it does not determine the direction that that reform will take.²⁶⁸ For instance, historically, opponents of expanding health insurance coverage have been wary that doing so would lead to greater government involvement in health care.²⁶⁹ These concerns were not completely unfounded: Medicare and Medicaid did contribute to the enactment of CON laws, after all. However, as this Article shows, in some instances, health insurance expansions have (perhaps surprisingly) contributed to scaling back delivery system regulations. For instance, Medicare, Medicaid, and the ACA have indirectly contributed to the loosening of scope of practice restrictions governing non-physician health professionals, and to the weakening of the corporate practice of medicine doctrine. (The genesis of the HMO Act in particular—which reportedly was precipitated by a chance encounter between Paul Ellwood and a Nixon administration official on a plane²⁷⁰—suggests there is nothing preordained about the form that a particular policy solution will take.) Thus, it is possible that achieving universal health insurance will have both regulatory and deregulatory effects.

In sum, in contrast to the prevailing view, expanding health insurance coverage is in fact an effective way to overcome the political obstacles to reforming health care delivery and make the regulatory system more capable of change. Would-be delivery system reformers thus have reason to desire expanding health insurance coverage, rather than treating these delivery system reforms as being in tension with expanding health insurance coverage.

B. Is Dynamism Normatively Desirable?

Having a dynamic system means that regulators are continually in the process of evaluating and amending delivery system regulations, then monitoring and assessing the consequences of those amendments in practice, making further changes when necessary, and so on. This dynamism has three primary advantages in the context of health care delivery system regulations: it creates pressure to enact reforms to improve health care access, costs, and quality; it enables delivery systems

268. See Carpenter & Sin, *supra* note 262, at 178 (“Our general conclusion, then, is that crises can in fact ‘lead to’ or ‘cause’ regulation, but the way in which they do so is politically contingent on the action of framing, an action that no one actor can entirely control.”).

269. For example, the American Medical Association historically opposed efforts to establish a national health insurance program on the grounds that doing so would lead to radical incursions on physicians’ autonomy and “socialized medicine.” See, e.g., CHAPIN, *supra* note 46, at 160 (“AMA leaders understood that once third parties controlled the capital flowing through the health care system then doctors would occupy a defensive position, both professionally and economically. Cost containment measures would inevitably entail diminished doctor sovereignty.”); STARR, REMEDY AND REACTION, *supra* note 184, at 45 (describing how Ronald Reagan delivered a speech as part of an AMA campaign against the Medicare legislation, in which he explained that “[t]he Medicare bill . . . was part of a larger plot to bring socialism to America” and that “[s]oon the government would be telling doctors where to practice”).

270. See *supra* note 186 and accompanying text.

regulations to adapt to other changes in the health care system; and it facilitates policy learning.

1. Prompting Policies to Address Access, Costs, and Quality

As described above, health economists and policymakers have historically been quite concerned that expanding health insurance coverage would lead to excess demand for health care, and that the total costs of expansion would therefore exceed the total benefits.²⁷¹ John Nyman notes that beginning in the 1970s, the predominance of moral hazard theory led “generations of health economists . . . to view health insurance as problematic,” and suggests that the predominance of this view explains why “few American health economists during this period called for the creation of a national health insurance program.”²⁷²

Recognizing the dynamic relationship between health insurance and regulatory reform reveals an important but overlooked wrinkle in this discussion. It shows that, precisely by increasing the demand for health care, the expansion of coverage generates pressure for policymakers to enact regulatory reforms which aim to address problems of access, costs, and quality. These reforms are framed as being necessary to prevent or mitigate unintended effects stemming from the increased demand for health care, but the problems they focus on (e.g., access, costs) are persistent problems in any health care system. These regulatory responses have been largely unappreciated and even unnoticed. Although some economists have investigated how health insurance expansions have affected the health care system as a whole over time, they typically have treated the regulatory environment as fixed, and have not accounted for any corresponding regulatory adaptation.²⁷³

Part III shows a few ways in which expanding health insurance coverage has prompted regulators to enact policies aimed at improving health care access and

271. See *supra* notes 95–100 and accompanying text.

272. Nyman, *American Health Policy: Cracks in the Foundation*, *supra* note 89, at 765. In recent years, economists’ views toward the expansion of health insurance appear to have become more favorable, possibly in response to the critiques of moral hazard theory or to the empirical evidence about the value of health insurance. For instance, a 2015 survey of a group of prominent academic economists found that over two-thirds of them either agreed or strongly agreed with the statement, “[e]xpanding health insurance to more people through the ACA’s public subsidies and Medicaid expansion will generate gains in the health and well-being of the newly insured that exceed the costs,” while nearly one-quarter was either uncertain or disagreed. Chi. Booth, *Health Insurance Subsidies*, IGM FORUM (Oct. 5, 2015), <http://www.igmchicago.org/surveys/health-insurance-subsidies> [<https://perma.cc/Y5PG-EXG7>]. Nevertheless, concerns about excess demand stemming from health insurance remain influential today.

273. See Finkelstein, *The Aggregate Effects of Health Insurance*, *supra* note 122, at 2 (“The basic insight is that market-wide changes in health insurance may have fundamentally different effects on the health care sector than what partial equilibrium analyses such as the Rand Experiment would suggest.”). Curiously, one exception is physician shortages: some health scholars argued that the ACA would not lead to a physician shortage, in part based on the assumption that states were likely to revise their scope of practice laws. See Scott Gottlieb & Ezekiel J. Emanuel, *No, There Won’t Be a Doctor Shortage*, N.Y. TIMES, Dec. 4, 2013, at A35.

costs. For instance, several states have loosened their scope of practice restrictions in response to concerns that expanding health insurance coverage would reduce access to health care by leading to a physician shortage. Loosened scope of practice restrictions have in turn served to increase the number of health care providers and improve patients' access to health care, especially for rural and vulnerable populations.²⁷⁴ The proportion of primary care being provided by NPs and Physician Assistants has increased substantially in recent years,²⁷⁵ and states with more expansive scope of practice laws have more NPs, greater growth in NPs, and more care provision by NPs.²⁷⁶

Similarly, the erosion of the corporate practice of medicine doctrine has likely played a role in curbing health care spending. The enactment of the HMO Act and the erosion of the corporate practice doctrine also contributed to the “managed care revolution,” which in turn led to a moderation in health care spending growth during the 1990s.²⁷⁷ Managed care companies helped to limit physician and facility fees and curb unnecessary care.²⁷⁸ Partly as a result, health care spending slowed for more than a decade, and barely budged at all from 1993 to 1998.²⁷⁹ Although the rise of managed care ultimately precipitated a political backlash, it continues to play an important role in controlling health care spending today.²⁸⁰

274. See, e.g., Adams & Markowitz, *supra* note 37, at 6 (“By unnecessarily limiting the tasks that qualified APPs [advanced practice providers] can perform, SOP [scope of practice] restrictions exacerbate [primary care] shortages and limit access to care. At the same time, researchers have not found evidence that less-restrictive SOP is associated with any diminution of quality or any harms to public health.”); Diane Alexander & Molly Schnell, *Just What the Nurse Practitioner Ordered: Independent Prescriptive Authority and Population Mental Health* (Fed. Reserve Bank of Chi., Working Paper No. 2017-8, 2019) (finding that broadening prescriptive authority for Nurse Practitioners is associated with improvements in mental health and decreases in mortality related to mental health); Morris M. Kleiner, Allison Marier, Kyoung Won Park & Coady Wing, *Relaxing Occupational Licensing Requirements: Analyzing Wages and Prices for a Medical Service*, 59 J.L. & ECON. 261 (2016) (finding that more stringent scope of practice restrictions for NPs increase the price of well-child visits without any evidence of improved health outcomes).

275. See, e.g., Thomas Bodenheimer & Laurie Bauer, *Rethinking the Primary Care Workforce — An Expanded Role for Nurses*, 375 NEW ENG. J. MED. 1015 (2016); Hillary Barnes, Michael R. Richards, Matthew D. McHugh & Grant Martsolf, *Rural and Nonrural Primary Care Physician Practices Increasingly Rely on Nurse Practitioners*, 37 HEALTH AFF. 908 (2018).

276. See Ying Xue et al., *Impact of State Nurse Practitioner Scope-of-Practice Regulation on Health Care Delivery: Systematic Review*, 64 NURSING OUTLOOK 71, 73 (2016).

277. See Agrawal & Veit, *supra* note 210, at 41 (“The managed care industry did slow health care spending. Thirty years of data showed that managed care plans brought hospital costs under control by eliminating unnecessary hospital stays and by limiting hospital lengths of stay.”); Uwe E. Reinhardt, *The Predictable Managed Care Kvetch on the Rocky Road from Adolescence to Adulthood*, 24 J. HEALTH POL. POL’Y & L. 897, 905 (1999) (“The managed care industry also can take credit for having been instrumental in breaking, at long last, the intolerable upward spiral in American health spending that had been driven for decades by the old, ‘employer-provided’ health insurance system.”).

278. Clark C. Havighurst, *Backlash Against Managed Health Care: Hard Politics Make Bad Policy*, 34 IND. L. REV. 395, 396–97 (2001).

279. Agrawal & Veit, *supra* note 210, at 42.

280. See, e.g., Katherine Baicker, Michael Chernew & Jacob Robbins, *The Spillover Effects of Medicare Managed Care: Medicare Advantage and Hospital Utilization*, 32 J. HEALTH ECON. 1289 (2013)

Although Part III focuses primarily on initiatives to address health care access and costs, it briefly outlines how Medicare and Medicaid contributed to the enactment of fraud and abuse laws that were intended to prevent over-utilization, as well as “excess commercialization” and “distorting incentives” that might interfere with the quality of patient care.²⁸¹ Although the current fraud and abuse regime is far from perfect, even some of its most fervent proponents of deregulation in health care concede that it serves a necessary role in guarding against unnecessary care.²⁸²

That is not to claim that every regulatory change stemming from health care financing laws is ideal, or that it always improves efficiency. As most clearly illustrated by the example of CON laws, regulators will inevitably on occasion “overshoot the optimal mark.”²⁸³ Yet even in the case of CON laws, which have been subject to nearly uniform criticism in recent years, different health scholars have drawn different lessons from the nation’s experience with those laws—and some scholars now view economic regulation of the health care sector as the most promising means of controlling prices.²⁸⁴ Thus, although there is no guarantee that regulators will always enact optimal policies, having a dynamic regulatory system means that at least regulators are capable of changing delivery system regulations to address problems of access, costs, and quality, and they may continue to adjust their policy responses until they have the intended effect.

2. *Adapting to Other Changes in the Regulatory Environment*

A dynamic regulatory system is also able to evolve in response to other changes in the underlying health care system, such as technological developments or new modes in delivering patient care.²⁸⁵ A regulatory scheme designed to fulfill

(finding that enrollment in Medicare managed care leads to declining hospital costs both in the Medicare and commercially insured population); David Dranove, Christopher Ody & Amanda Starc, *A Dose of Managed Care: Controlling Drug Spending in Medicaid*, (Nat’l Bureau of Econ. Research, Working Paper No. 23956, 2017) (finding that Medicaid managed care organizations reduce drug spending); *see also* Trubek, *New Governance Practices in U.S. Health Care*, *supra* note 246, at 249 (“The managed care backlash came about in part by an alliance between physicians and consumers to fight the intrusion of the ‘outsiders’ into the physician-patient relationship. Although physicians won this battle, managed care had changed the environment in which they practised through the development of large integrated hospital and clinic systems, where most physicians now practise; the creation of evidence-based medicine; and increased reliance on allied health care professionals.”).

281. HALL, BOBINSKI & ORENTLICHER, *supra* note 56, at 1372.

282. Epstein & Hyman, *supra* note 22, at 533 (“We do not suggest repeal of the anti-kickback statute. Although we believe those responsible at HHS should create more safe harbors and be more flexible in their interpretation of the statute in advisory opinions, the statute is an important guardian of the fiscal integrity of the Medicare program, given that the overwhelming majority of Medicare beneficiaries are still in the traditional (fee-for-service) part of the program, where kickbacks pose an obvious incentive for overutilization.”).

283. Saver, *Uneasy Relationship*, *supra* note 8, at 675.

284. *See supra* note 244 and accompanying text.

285. *See* Elhauge, *Health Care Fragmentation*, *supra* note 7, at 16 (“Indeed, the level and types of

one purpose may become unnecessary (or give rise to unintended consequences) if the surrounding environment changes. For instance, it is widely believed that anti-fraud and abuse laws need to be revised as the health care system shifts away from fee-for-service reimbursement toward value-based payment.²⁸⁶

One especially vexing problem for regulators is how to adapt regulations in the face of innovation.²⁸⁷ If regulations remain fixed and constant, then they risk stifling beneficial innovations. This has long been one of the primary critiques of health law: that it is stagnant and path dependent, and suppresses innovations that would otherwise improve the health care delivery system.²⁸⁸ In addition, static regulatory schemes are also thought to be more vulnerable to “bad” innovations aimed at subverting or bypassing regulatory protections.²⁸⁹

Again, there are reasons to think that these considerations are especially important in the context of health care delivery regulations, given the necessity of developing modes of delivering patient care that are higher-quality and more cost-effective. Peter Jacobson, Laura Napiewocki, and Leah Voigt emphasize the necessity of having a dynamic regulatory system that evolves in response to changes in technology and health care delivery:

[T]he goal of regulation should be to facilitate market arrangements rather than to replace them. To achieve this goal, the regulatory approach must be dynamic and flexible. That is, regulators must be able to respond to innovative market arrangements within a realistic length of time. Most important, the regulatory framework must better reflect changes in how health care is organized and how physicians deliver care. It must also facilitate needed changes in the delivery system, yet retain flexibility to adapt to new ways of providing health care.²⁹⁰

integration that are most effective are likely to change over time with changes in technology, costs, and consumer preferences, just as they do in other industries, so it is important to maintain a legal framework that allows such shifts over time.”); *see also* Wendy Wagner, William West, Thomas McGarity & Lisa Peters, *Dynamic Rulemaking*, 92 N.Y.U. L. REV. 183, 242 (2017) (arguing that perhaps the most important normative advantage of dynamism in the context of administrative rulemaking is that “an agency may employ dynamic rulemaking to adapt to changes in the physical, technological, or policy environment in which it operates.”).

286. *See, e.g.*, Carmel Schachar, *Are Fraud and Abuse Laws Stifling Value-Based Care?*, NEW ENG. J. MED. CATALYST (Sept. 12, 2018), <https://catalyst.nejm.org/fraud-and-abuse-laws-stifling-value-based-care/> [https://perma.cc/X7D5-HJQX?type=image].

287. *See generally* CRISTIE FORD, INNOVATION AND THE STATE: FINANCE, REGULATION, AND JUSTICE 144 (2017) (inquiring “whether it is possible to develop a regulatory approach whose fundamental underlying assumptions include . . . the default presumption that innovation will be continually changing the regulatory context and object, undermining and potentially circumventing regulation, and potentially obscuring or making irrelevant its stated purposes.”).

288. *See supra* notes 13–15 and accompanying text.

289. Cary Coglianese, *Innovation and Regulatory Vigilance*, JOTWELL (Oct. 19, 2018), <https://adlaw.jotwell.com/innovation-and-regulatory-vigilance/> [https://perma.cc/MF3U-XDGV] (reviewing CRISTIE FORD, INNOVATION AND THE STATE: FINANCE, REGULATION, AND JUSTICE (2017)).

290. Jacobson, Napiewocki & Voigt, *supra* note 14, at 587–88.

Dynamic regulations are particularly important in parts of the health care system where technology is evolving quickly.²⁹¹ For instance, Nicholson Price has advocated for a “flexible, adaptive approach” to regulating what he calls “Black Box Medicine,” health care providers’ growing reliance on opaque algorithms in delivering medical care.²⁹² To the extent that expanding health insurance creates the conditions for policymakers to reform and readjust health care delivery laws, they will be more flexible and better able to adapt to these types of developments.

3. *Facilitating Policy Learning*

Finally, a dynamic regulatory system facilitates policy learning. It enables policymakers to experiment with riskier policies that may be desirable because of their potential benefits, or because they may help to elicit knowledge about the best regulatory approach.²⁹³ It does so because if regulators do implement policies that turn out to be unsuccessful, then they are able to correct them at a later stage; by contrast, if the policies are successful, then they may retain them.²⁹⁴

Scholars have long emphasized the importance of dynamism in facilitating policy learning and leading to the development of better regulations.²⁹⁵ For instance, some scholars in the field of “New Governance” have advocated for “adaptive” regulations that “continuously generate new learning and . . . adjust in response to new information and changing conditions.”²⁹⁶ Similarly, several scholars have promoted the notion of “adaptive management,” which is thought of as “an

291. Sharon B. Jacobs, *The Energy Prosumer*, 43 *ECOLOGY L.Q.* 519, 572 (2017) (arguing that a “decentralized, incremental, or experimentalist” regulatory approach is appropriate for “complex and rapidly developing technology”).

292. Nicholson Price II, *Regulating Black-Box Medicine*, 116 *MICH. L. REV.* 421, 459 (2017).

293. See Yair Listokin, *Learning Through Policy Variation*, 118 *YALE L.J.* 480, 534 (2008) (emphasizing the desirability of “reversibility” in policy because of the potential of high-variance/low-expected-value policies to “provide better outcomes and better knowledge”).

294. *Id.*; see also Wagner, West, McGarity & Peters, *supra* note 285, at 242 (“Dynamic rulemaking has many desirable characteristics. Most would agree that it is needed to correct errors in previously promulgated rules.”).

295. See, e.g., Charles E. Lindblom, *The Science of “Muddling Through,”* 19 *PUB. ADMIN. REV.* 79 (1959).

296. Bradley C. Karkkainen, *‘New Governance’ in Legal Thought and in the World: Some Splitting As Antidote to Overzealous Lumping*, 89 *MINN. L. REV.* 471, 474 (2004); see, e.g., Orly Lobel, *The Renew Deal: The Fall of Regulation and the Rise of Governance in Contemporary Legal Thought*, 89 *MINN. L. REV.* 342, 395–96 (2004) (“The regulatory model has often proved stagnant and sluggish, curtailing revision and improvement While regulation has been an ordering act, governing is a learning process. The new model is better positioned to accept uncertainty and diversity, advancing iteratively toward workable solutions. The role of law is to promote practices that allow revision and improvement.”); David M. Trubek & Louise G. Trubek, *New Governance & Legal Regulation: Complementarity, Rivalry, and Transformation*, 13 *COLUM. J. EUR. L.* 539, 542 (2007) (“The continual change and expansion of knowledge which characterize society means that all solutions should be regarded as provisional. Given this situation, it seems preferable for legislators to develop broad frameworks, but let stakeholders develop concrete solutions based on easily revisable rules.”).

iterative, incremental decisionmaking process built around a continuous process of monitoring the effects of decisions and adjusting decisions accordingly.”²⁹⁷

Although this Article has primarily emphasized how expanding health insurance coverage influenced changes in delivery system laws, policy learning played a role in these changes as well. For instance, as described above, the ongoing curtailment of scope of practice restrictions has been influenced by a body of evidence that some non-physician providers can deliver a broader array of services without compromising the quality of patient care.²⁹⁸

Certificate of Need laws present another example of policy learning, albeit an incomplete one. Congress repealed the federal pro-CON law in 1987, leading several other states to repeal their own CON laws thereafter—though the drive to repeal CON laws appears to have stalled in recent years.²⁹⁹ One factor contributing to the decline of CON laws was that policymakers increasingly began to believe—based in part on a burgeoning body of empirical research—that these laws were ineffective at controlling health care spending.³⁰⁰

Promoting policy learning is especially important in the context of health care delivery system regulations, given that there is substantial epistemic uncertainty surrounding the appropriate strategy for regulating the delivery of health care. Timothy Jost and Ezekiel Emanuel have written that although the current delivery system “fails to generate optimal results, the best alternative is unknown,” and “it is unlikely that there is a single best way to organize and deliver health care services.”³⁰¹ Kieran Walshe and Stephen Shortell survey health care regulators and regulated entities and find substantial variation as to these parties’ beliefs about the optimal regulatory approach.³⁰² To the extent that the regulatory system is dynamic and policymakers are able to reverse course in the future, the effects of any negative or unintended outcomes created by pursuing these policies will be minimized.

Of course, dynamism by itself is not sufficient to guarantee policy learning. There is a danger that regulators may careen haphazardly from one regulatory approach to another, without learning from past experiences. Yet dynamism is a necessary condition for policy learning: the more dynamic a system is (i.e., the easier it is for regulators to change course in the future), the less costly it is for regulators

297. J.B. Ruhl, *Regulation by Adaptive Management—Is It Possible?*, 7 MINN. J.L. SCI. & TECH. 21, 28 (2005). Holly Doremus calls this process “learning by doing.” Holly Doremus, *Precaution, Science, and Learning While Doing in Natural Resource Management*, 82 WASH. L. REV. 547, 550 (2007); see, e.g., Robin Kundis Craig & J.B. Ruhl, *Designing Administrative Law for Adaptive Management*, 67 VAND. L. REV. 1 (2014); J.B. Ruhl & Robert L. Fischman, *Adaptive Management in the Courts*, 95 MINN. L. REV. 424 (2010).

298. See *supra* note 37.

299. See *supra* notes 75–78 and accompanying text.

300. See Bagley, *Medicine As a Public Calling*, *supra* note 65, at 89; Conover & Sloan, *supra* note 73, at 456–57.

301. Jost & Emanuel, *supra* note 7, at 2561.

302. See Walshe & Shortell, *supra* note 27, at 92.

to experiment with policies that are likely to yield the most information about the best policy.³⁰³ Moreover, just as health insurance expansions create pressure for policymakers to experiment with regulatory reforms, they may also encourage policy learning by rendering certain policy problems more salient, and by generating “natural experiments” which researchers can then evaluate and use to inform future policy design.³⁰⁴

* * *

To be sure, dynamic regulations are not appropriate in every context. For instance, dynamism may be undesirable for regulations that apply primarily to individuals or small businesses, given that—unlike larger and better-resourced regulated entities—they may not have sufficient capacity to understand and comply with regulations that are often changing.³⁰⁵ Dynamism may also be inappropriate for areas of regulation that signal strong normative commitments (such as civil rights or child labor laws), where frequent tinkering might appear to undermine the strength of those commitments.³⁰⁶

Still, there are reasons to think health law’s dynamism is, on balance, a positive force for improving health care delivery. A dynamic regulatory system in health care is able to address problems of access, costs and quality, to adapt to other changes in the underlying health care system, and to facilitate policy learning and correct regulatory missteps. These virtues are particularly important in health care, which is characterized by increasing demand, rapidly evolving technology and modes of delivering patient care, and substantial uncertainty as to the proper approach to delivering health care.

CONCLUSION

In contrast to the perception of delivery system laws as stagnant and antiquated, this Article shows that they are continually being revised and amended, and that this dynamism is a neglected strength of health law. That is not to deny the problems with the current regulations governing the delivery of health care. Yet it shows that by increasing the demand for health care, laws that expand health insurance coverage have cascading effects on the health care delivery system over

303. See Listokin, *supra* note 293, at 534.

304. For instance, there have been numerous recent high-quality empirical studies that have exploited the expansion in health insurance coverage under the ACA to study the effects of health insurance on financial security, health care access, and health outcomes. See, e.g., Sommers, Gawande & Baicker, *supra* note 89.

305. See Jonathan H. Adler, *Dynamic Environmentalism and Adaptive Management: Legal Obstacles and Opportunities*, 11 J.L. ECON. & POL’Y 133, 154 (2015) (“A system in which agencies were free to recalibrate regulatory obligations would provide little certainty for regulated entities Insofar as agencies maintain discretion to alter their decisions, they risk upsetting the expectations of those that have relied upon the agency’s decision.”).

306. Craig & Ruhl, *supra* note 297, at 25.

time, in ways that frequently heighten preexisting concerns about access, costs, and quality.

This conclusion has clear implications for the future of health care reform. First, it shows that expanding health insurance coverage helps to build momentum for reforming health care delivery laws. Thus, counterintuitive though it may seem, one way to achieve more fundamental reforms to delivery system laws—and to delivery of health care—would be to further expand health insurance coverage.

Second, recognizing this relationship strengthens the normative case for further expanding health insurance coverage. It shows that that the doing so helps to generate pressure for regulatory reforms to improve health care access, costs, and quality; it enables delivery systems regulations to adapt to other changes in the health care system, such as new technologies and new modes of delivering patient care; and it facilitates policy learning.

This dynamic relationship also has implications for the field of health law. Health law scholars have long grappled with the perception that health law is a “patchwork” of complex and divergent laws with little internal coherence.³⁰⁷ This is at least in part because health law lacks many of the features of more traditional legal fields: it has no single unifying legal form; it has no central institutional actor; and it has evolved often by historical accident rather than through a more linear orderly process.³⁰⁸

Health law scholars have responded to this perception in different ways: some have argued that health law deserves recognition as a distinct field because it addresses a unique set of relations among persons and because the law accommodates these relations in distinctive ways.³⁰⁹ Others have tried to show that a specific analytical or normative paradigm—such as a market approach or a patients’ right approach—explains the features of health law.³¹⁰

By contrast, rather than trying to impose a single unifying framework, M. Gregg Bloche argues that health law is best understood as an “emergent system,”

307. See, e.g., Bloche, *supra* note 26, at 321 (“The law of health care provision is a chaotic, dysfunctional patchwork.”); Einer Elhauge, *Allocating Health Care Morally*, 82 CAL. L. REV. 1449, 1452 (1994) (“Health law policy suffers from an identifiable pathology [H]ealth care law borrows haphazardly from other fields of law, each of which has its own internally coherent conceptual logic, but which in combination results in an incoherent legal framework and perverse incentive structures.”).

308. Theodore W. Ruger, *Health Law’s Coherence Anxiety*, 96 GEO. L.J. 625, 627 (2008).

309. Einer Elhauge, *Can Health Law Become a Coherent Field of Law?*, 41 WAKE FOREST L. REV. 365, 371 (2006) (“It seems to me that health law does meet the above functional test for what constitutes a field of law. Many different legal fields may, in some sense, apply to the health care industry but seem transformed in significant ways by the application The distinctiveness of health care relations thus does seem to change the applicable law.”); Mark A. Hall, *The History and Future of Health Care Law: An Essentialist View*, 41 WAKE FOREST L. REV. 347, 362–63 (2006) (“[H]ealth care law is an academic sub-discipline that inquires how law should and does take account of the special features of medicine and treatment relationships.”).

310. Mark A. Hall & Carl E. Schneider, *Where Is the “There” in Health Law? Can It Become a Coherent Field?*, 14 HEALTH MATRIX 101, 102 (2004).

one arising from “[c]ountless market actors, public planners, and legal and regulatory decisionmakers interact[ing] in oft-chaotic ways, clashing with, reinforcing, and adjusting to each other.”³¹¹ He argues that health law should be treated as a distinct field because better understanding these interactions is an essential prerequisite for figuring out how to improve the health care system, and because “legal scholars and practitioners who specialize in health care . . . are best situated to see how the moving parts fit together.”³¹²

This Article shows one important way in which “the moving parts fit together,” and in doing so, it illustrates the importance of studying health law holistically. These dynamic interactions and the lessons drawn from them suggest that it is not an arbitrary choice to have a field of law organized around the health care system: examining health law holistically enables health law scholars to uncover interactive effects that reverberate throughout different parts of the health care system and to chart important relationships and effects that bear on the future of health care reform.³¹³

311. M. Gregg Bloche, *The Emergent Logic of Health Law*, 82 S. CAL. L. REV. 389, 478 (2009). Ted Ruger has proposed a similar rationale, arguing that it is health law’s very multiplicity of legal forms and actors that distinguishes it as a scholarly field. Ruger, *supra* note 308, at 639.

312. Bloche, *supra* note 311, at 396–97.

313. *Id.* at 404.