PREFACE

At its inception, health care law was primarily state-based common law, rooted in "Law and Medicine," the original term for the field. Over time, the field has expanded alongside the increasing complexity of medicine and the health care industry. Private health insurance became the dominant payment mechanism, and a particular form of health insurance called managed care became the leading cost control model. Regulation of health insurance and managed care remained largely state-based, yet the role of the federal government has grown incrementally but consistently, both in public programs like Medicare and Medicaid and through major federal laws that preempted some state-based rules. Traditionally, health care law has been taught as state-based case law with a significant federal overlay, and administrative law was merely a relevant detail.

The time had come to shift the emphasis and recognize that health care is a highly regulated industry with a substantial federal administrative law superstructure, just like transportation, financial services, energy, aviation, and telecommunications, to name a few examples. After the passage of the Patient Protection and Affordable Care Act of 2010 (ACA), federal statutory and administrative law dominate the field, especially health insurance. You will learn in the following pages about the ACA's rather complicated history, marked by repeated attempts to repeal or erode it. Yet for all the challenges, the law remains largely in place and represents the most sweeping transformation of U.S. health care in a generation. The ACA was the farthest reaching in a long line of federal laws that enshrines choices about America's long-debated approaches to health insurance — private versus public provision of care, medical assistance eligibility, and the state-federal relationship in health care, among other themes. Likewise, most of the challenges to the law have operated in federal courts, Congress, and federal agency rule and policymaking, reflecting the increasingly dominant role of federal health care law. This book was the first health care law casebook to reflect that gravitational shift to the federal domain.

The second edition reflected legal and policy changes that occurred after the 2016 presidential election triggered a political swing affecting many facets of health law, such as federal limitations to the Medicaid program and zeroing out the tax penalty associated with the ACA's individual mandate. These political and philosophical shifts regarding the role of government and individual responsibility for health undermined the ACA. Yet, it survived further challenges and provided an essential safety net when the COVID-19 global pandemic triggered a health and economic crisis.

We issued a brief update in 2020 that included pandemic-related resources and anti-racism materials to reflect swings in health reform conversations related to the civic upheaval occurring as the 2020 presidential election approached. At that time, Democratic candidates were talking about health care as a human right,

and a federal "public option" was the most moderate of the coverage proposals in primary debates.

Once again, we found ourselves drafting a new edition facing shifting sands in health law. The Trump administration appointed three new justices to the Supreme Court and left office in the midst of the novel coronavirus pandemic. Continued public health emergencies and federal relief bills funneled money to states and people suffering the ongoing effects of the pandemic. The Biden administration entered office aiming to address the pandemic and to reinforce and improve the implementation of the ACA, which withstood another trip to the Supreme Court. In the third edition, we have incorporated the upheaval wrought by the pandemic while seeking balance with other developments, including increasing emphasis on health disparities and fundamental changes wrought by the Supreme Court, trying to ensure that readings are not quickly outdated. To preserve our commitment to offering a lean casebook, we removed or abbreviated coverage of certain topics, including Accountable Care Organizations, Comparative Effectiveness Research, and the individual health insurance mandate, that have been substantially amended, repealed, or deemphasized over time.

These recent shifts are reflected in the updated Chapter 1, introducing students to current debates about government power roiling among public health officials, legislatures, judges, and other state actors. We updated and divided Chapter 2 (public insurance) into two chapters so that students could better absorb Medicare and Medicaid features and apply some lessons of the pandemic to their understanding of public health insurance. This shifts the numbering of all subsequent chapters, but their order remains the same. Chapter 4 (private insurance) edits reflect the solidification of the ACA's reforms, including surprise billing legislation and changes in the exchange subsidies that attempted to fill the Medicaid coverage gap. We also shifted some materials from the previous Chapter 8 (duties related to patient care) to Chapters 2, 3, and 4. For example, EMTALA is addressed in the Medicare chapter (Chapter 2), and licensure issues are addressed in the structure and governance of health care chapter (Chapter 5). Health care fraud and abuse is updated with recent cases (Chapter 7), and the antitrust and competition materials (Chapter 8) reflect the turn toward a more aggressive approach to labor issues, along with developments in the state action doctrine. We have largely rewritten what is now Chapter 9. While we introduce equity in Chapter 1 as a fundamental theme that informs every aspect of health care law, this chapter offers a new opportunity to focus specifically on laws, such as section 1557 of the ACA, that explicitly address discrimination in health care. The regulation of the beginning and end of life chapter (Chapter 10) reflects the sea-change wrought by the Supreme Court's 2022 decision in *Dobbs v. Jackson Women's Health*, retaining some key cases for context and beginning to explore the state law chaos that has followed. Health Privacy in the Digital Age updates include the surfacing of telehealth that was driven by the pandemic (Chapter 11). The clinical research chapter (Chapter 12) condenses some historical materials while adding the right to try movement and other features of biomedical research that became more relevant during the pandemic.

The book retains its distinctive features, including themes that act as conceptual anchors in the shifting tides of health law and continuing emphasis on primary source materials beyond appellate cases. Health care law abounds with other

forms of legal authority, including statutory, regulatory, and sub-regulatory guidance. We use secondary sources sparingly, including only crucial commentary and data-driven empirical research, which are uniquely important for the practicing health care lawyer. The primary source materials remain our focal point, with longer excerpts and light editing, providing an experience that foreshadows the work that our students must do when they become practicing lawyers.

We do not attempt to cover all topics comprehensively. Instead, we chose our key topics carefully, making use of guidelines suggested by practicing attorneys and health law professors in the American Health Lawyers Association, the preeminent professional organization for health law practitioners. While surveying fewer topics than some other health law casebooks, we engage the selected topics in more depth, so students emerge with an understanding of the most important features for the practice of health care law. The result is a three- or four-credit-hour book that is shorter but leaves room for professors to supplement with additional topics they are keen to teach.

Finally, we continue to listen to students' feedback. First, we avoid extensive notes, moving most references to scholarly articles and other secondary sources to the teacher's manual, but we have slightly more explanatory narrative in the third edition. Second, we continue to use three different kinds of problems throughout the book: "Questions," which engage an excerpt directly; "Problems," which offer a practice-like scenario, hypothetical, or policy question to consider; and "Capstone Problems," which are designed to facilitate integrative and summative mastery of the chapter. While we firmly believe that the sometimes tedious, technical reading of statutes, regulations, cases, and other sources is the real work of health care lawyers, for pedagogical purposes, we highlight key issues, background, and other points of interest through boxed side notes, which enrich understanding in the moment of digesting a key source. We also shifted some Questions to precede statutory and other excerpts to facilitate a more directed reading experience.

Health care law is deeply complex, but teaching it needn't be. We hope you enjoy our labor of love.