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The Persistence Of Opportunistic Business Models In Health Care And A Stronger Role For Insurance Regulators In Containing Health Care Costs

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Abstract

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KEYWORDS: prices, billing, unfair

THE PERSISTENCE OF OPPORTUNISTIC BUSINESS MODELS IN HEALTH CARE AND A STRONGER ROLE FOR INSURANCE REGULATORS IN CONTAINING HEALTH CARE COSTS

JACKSON WILLIAMS*

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I. INTRODUCTION

While much is heard about new “value-based” payment models for health care, the reality is that old-fashioned business models emphasizing higher unit prices and discrete billable services still prevail and succeed in driving up health care costs.¹ Indeed, providers have cited the spread of

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1. See Robert Berenson, *Addressing Pricing Power in Integrated Delivery: The Limits of Antitrust*, 40 J. HEALTH POL. POL’Y & L. 711, 712 (2015); Matthew Rae et al.,

global payment models as an excuse for continued market consolidation by providers.² Even relatively low-cost integrated delivery systems, such as Kaiser-Permanente, profit from opportunistic behavior by competing providers, since their premiums can “shadow” those of insurers who must contract with high-cost providers.³

Ideally, insurers would act as purchasing cooperatives on behalf of consumers, obtaining the lowest possible unit prices from providers.⁴ But the most effective tools that purchasers could deploy—including antitrust and other litigation against providers who act opportunistically—go unused.⁵ As the late health economist Warren Greenberg argued,⁶ this is partly because of the collective action problem inherent in a multi-payer market.⁷ In this context, the collective action problem refers to the fact that while many purchasers share an interest in lower unit prices for health care, it is not always in the interest of an individual purchaser to expend resources on measures, such as initiating costly litigation or provoking an acrimonious impasse that, if successful, would likely benefit competing insurers or employers as well.⁸ But, more generally, it has been observed that payers have not “pushed back” on prices.⁹

This Article argues that insurance regulators can catalyze cost containment efforts by encouraging, or mandating, insurers to act vigorously as agents of consumers in obtaining low prices from providers to include policing provider misconduct in health care markets.¹⁰ The Insurance Commissioner’s regulatory authority can solve the collective action problem

Snapshots: The Prevalence and Cost of Deductibles in Employer Sponsored Insurance, KFF.ORG (Nov. 2, 2012), <http://www.kff.org/health-costs/issue-brief/snapshots-the-prevalence-and-cost-of-deductibles-in-employer-sponsored-insurance>.

2. See CTR. FOR STUDYING HEALTH SYS. CHANGE, WALL STREET COMES TO WASHINGTON 2 (2004); Robert A. Berenson et al., *The Growing Power of Some Providers to Win Steep Payment Increases from Insurers Suggests Policy Remedies May Be Needed*, 31 HEALTH AFF. 973, 979 (2012).

3. Sarah Varney, *Could Kaiser Permanente’s Low-Cost Health Care Be Even Cheaper?*, NPR (June 25, 2012, 5:36 PM), <http://www.npr.org/sections/health-shots/2012/06/26/155726049/could-kaiser-permanentes-low-cost-health-care-be-even-cheaper>.

4. See Berenson et al., *supra* note 2, at 979.

5. See Berenson, *supra* note 1, at 714.

6. Warren Greenberg, *Private Antitrust As a Public Good*, 8 LOY. CONSUMER L. REP. 118, 118 (1996).

7. See *id.*

8. See *id.* at 122–23.

9. DIANA FARRELL ET AL., MCKINSEY GLOB. INST., ACCOUNTING FOR THE COST OF US HEALTH CARE: A NEW LOOK AT WHY AMERICANS SPEND MORE 105 (2008); see also *infra* Section IV.B.

10. See *infra* Section IV.B.

by apportioning costs and, thereby, incentivize cooperation.¹¹ The Commissioner can also serve as a coordinator of, and spokesperson for, joint efforts to bring down provider prices.¹²

II. THE INSURANCE COMPANY AS AN AGENT OF PURCHASERS

Two recent trends have significantly changed the way consumers interface with health insurance: Rising deductibles and self-funded plans.¹³ Today, for most consumers, the most important function of a health insurance company in a given year will not be paying for health utilization, but negotiating prices with providers.¹⁴

In 2003, only about half of employer-sponsored insurance (“ESI”) that covered workers’ health plans had a deductible at all—by 2013, it was 81%.¹⁵ In 2003, the average deductible was \$518, a decade later it was \$1273, a 146% increase.¹⁶ In about 20% of workplaces, employees have access to only high-deductible health plans, with a deductible averaging \$2100.¹⁷ For about forty-two million Americans with ESI who spend over \$300 on care but do not meet the average deductible in a given year, a 5% reduction in provider prices would yield an average of \$30 in direct and immediate savings on out-of-pocket costs.¹⁸ For this group, the principal role of the insurance company is that of purchasing cooperative—combining the buying power of multiple enrollees to obtain the lowest price.¹⁹

III. THE PROBLEM OF EXCESS PRICES

Comparisons of health care costs across the thirty industrialized countries, for which the Organization for Economic Cooperation and Development (“OECD”) publishes data, demonstrates “that the United States spends more on health care than any of the other OECD countries spend, without providing more services than the other countries do. This suggests

11. *See infra* Section IV.B.II.

12. *See infra* Section IV.B.II.

13. CTR. FOR STUDYING HEALTH SYS. CHANGE, *supra* note 2, at 2.

14. *See* Berenson, *supra* note 1, at 712; Jay Hancock, *Should Big Insurance Become Like Walmart to Lower Health Costs?*, KAISER HEALTH NEWS (Aug. 11, 2016), <http://www.khn.org/news/should-big-insurance-become-like-walmart-to-lower-health-costs>.

15. SARA R. COLLINS ET AL., COMMONWEALTH FUND, NATIONAL TRENDS IN THE COST OF EMPLOYER HEALTH INSURANCE COVERAGE, 2003–2013 4 (2014).

16. *Id.* at 5.

17. Rae et al., *supra* note 1.

18. *See id.*

19. *See* Berenson et al., *supra* note 2, at 979.

that the difference in spending is mostly attributable to higher prices of goods and services.”²⁰

According to the International Federation of Health Plans 2015 Comparative Price Report,²¹ an annual survey comparing medical prices per unit in Australia, New Zealand, South Africa, Spain, Switzerland, United Kingdom, and United States, the United States has the highest prices for two of five diagnostic tests compared, eight of eight surgical procedures compared, and hospital costs per day.²² In a finding that will amaze any American who has traveled to Switzerland and paid the equivalent of five dollars for a bottle of Coke, the survey reported that patients in Geneva, Illinois or Geneva, New York could expect to pay twice the price for a colonoscopy or magnetic resonance imaging (“MRI”) scan paid in those towns’ European namesake.²³

We know that in some local markets, provider unit prices are exceptionally high.²⁴ A 2005 United States Government Accountability Office Report found that in 28 of 232 metropolitan areas studied, hospital prices were 25% or higher than the national average, and in 32 of 319 metropolitan areas—many in Wisconsin, Oregon, Arkansas, Montana, and Louisiana—physician prices were 16% or higher than the national average.²⁵

Three factors driving higher prices are provider consolidation, provider “must-have” status, and the refusal of providers to participate in insurers’ networks.²⁶

A. *Provider Market Concentration*

In an analysis of commercial “insurance claims between 2007 and 2011 from three of the five largest U.S. insurers, Aetna, Humana, and United

20. Gerard F. Anderson et al., *It's the Prices, Stupid: Why the United States is So Different from Other Countries*, 22 HEALTH AFF. 89, 90 (2003).

21. INT’L FED’N OF HEALTH PLANS, 2015 COMPARATIVE PRICE REPORT: VARIATION IN MEDICAL AND HOSPITAL PRICES BY COUNTRY (2015).

22. *Id.* at 3, 11–24.

23. *See id.* at 13–14.

24. *See* U.S. GOV’T ACCOUNTABILITY OFF., GAO-05-856, FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM: COMPETITION AND OTHER FACTORS LINKED TO WIDE VARIATION IN HEALTH CARE PRICES 2 n.6, 11, 18 (2005).

25. *Id.*

26. Berenson et al., *supra* note 2, at 973–75; *see also* ZACK COOPER ET AL., THE PRICE AIN’T RIGHT? HOSPITAL PRICES AND HEALTH SPENDING ON THE PRIVATELY INSURED 27 (2015); Jeffrey Gold et al., *Reimbursement for Emergency and Non-Emergency Services Provided by Out-of-Network Physicians: The Issue of Balance Billing*, ABA HEALTH ESOURCE (Nov. 2011), https://www.americanbar.org/content/newsletter/publications/aba_health_esource_home/aba_health_law_esource_1111_gold.html.

Health care,” reported to the Health Care Cost Institute (“HCCI”), Cooper and colleagues compared private health spending levels among 306 Hospital Referral Regions.²⁷ They concluded that “health spending on the privately insured varies by more than a factor of three across the 306 hospital referral regions (“HRRs”) in the [United States],” and that “hospital transaction prices play a large role in driving inpatient spending variation across HRRs.”²⁸

[W]e find that hospitals’ negotiated transaction prices vary substantially across the nation. For example, looking at the most homogeneous of the seven procedures that examine, hospital-based MRIs of lower-limb joints, the most expensive hospital in the nation has prices twelve times as high as the least expensive hospital. What is more, this price variation occurs across and within geographic areas. The most expensive HRR has average MRI prices for the privately insured that are five times as high as average prices in the HRR with the lowest average prices. Likewise, within HRRs, on average, the most expensive hospital has MRI negotiated transaction prices twice as large as the least expensive hospital.²⁹

Cooper and colleagues concluded that even after controlling for such variables as “for-profit [status], having more medical technologies,” regional labor costs and patient mix,

[M]onopoly hospitals have 15.3[%] higher prices than markets with four or more hospitals. Similarly, hospitals in duopoly markets have prices that are 6.4[%] higher and hospitals in triopoly markets have prices that are 4.8[%] higher than hospitals located in markets with four or more hospitals. While we cannot make strong causal statements, these estimates do suggest that hospital market structure is strongly related to hospital prices.³⁰

In a study tracking hospital prices in California from 2004 to 2013,³¹ Melnick and Fonkych found that “[h]ospital prices increased substantially during a period of slow economic growth, and may have been driven in part

27. COOPER ET AL., *supra* note 26, at 1–2.

28. *Id.* at 2.

29. *Id.* at 3.

30. *Id.*

31. Glenn A. Melnick & Katya Fonkych, *Hospital Prices Increase in California, Especially Among Hospitals in the Largest Multi-Hospital Systems*, J. HEALTH CARE ORG., PROVISION, & FINANCING, June 2016, at 1.

by increased market power by large, multi-hospital systems—and possibly other smaller systems—practicing *all-or-none* contracting.”³² They concluded that:

[T]he market power effects of large hospital systems do not necessarily require consolidation between local competitors. Indeed, many of the hospitals in California’s largest systems do not have substantial overlapping markets with other system member hospitals. This suggests that hospitals in large hospital systems, by tying their hospitals together, are able to achieve market power over prices beyond any local market advantages.³³

[W]ith large size comes the potential to expand and protect market power. Large hospital systems that conduct “all-or-none” contracting have reportedly added other anti-competitive language to their contracts to protect and expand their market power including clauses that prohibit health plans or employers from developing “tiered” benefit packages that would allow them to . . . develop new products to stimulate competition through differential cost sharing across member hospitals. Another example is so-called gag-clauses which prohibit health plans from sharing detailed hospital specific utilization and pricing data with large employers which might be used to develop benefit packages that provide incentives for employees to use lower priced—and/or higher quality—hospitals.³⁴

Stanford University researcher Laurence C. Baker has assembled a database of county-level data on competition among physician practices, as measured by the Hirschman-Herfindahl Index (“HHI”), and average prices for physician services.³⁵ Baker notes that the “trend toward fewer and larger [physician practice] groups could increase . . . market concentration, resulting in fewer practices facing less competition and with greater economic power. This in turn could lead health plans to pay higher prices for physician services.”³⁶

An analysis by Baker and colleagues of the relationship between physician competition and prices paid for common office visits found that:

Less competition among physician practices is statistically significantly associated with substantially higher

32. *Id.* at 6.

33. *Id.*

34. *Id.* at 5–6.

35. Laurence C. Baker et al., *Physician Practice Competition and Prices Paid by Private Insurers for Office Visits*, 312 JAMA 1653, 1654–55 (2014).

36. *Id.* at 1654.

prices paid by private [Preferred Provider Organizations] to physicians in [ten] large specialties for office visits. . . . [T]he level of competition observed at the [ninetieth] percentile of the HHI distribution was associated with a price for an intermediate office visit with an established patient—CPT code 99213—between \$5.85 and \$11.67 higher than at the [tenth] percentile of the HHI distribution. Across all [ten] types of office visits, this difference in HHI was associated with mean prices for office visits 8.3% to 16.1% higher.³⁷

A subsequent study by Austin and Baker examining prices for fifteen common high-cost services, such as knee replacements and arthroscopic surgery, yielded similar findings.³⁸ In that article, Austin and Baker reported that they “frequently found market concentration levels that appear high, relative to the commonly encountered view that HHI levels above 2500 are concerning. HHIs were 2500 or more in more than half of [the] counties studied among the chosen procedures and specialties.”³⁹ Indeed, both the mean and median HHI for the many hundreds of counties in “[f]ourteen of the fifteen procedure-specialty combinations” they studied exceeded the Federal Trade Commission’s 2500 HHI benchmark for a highly concentrated market.⁴⁰ The scale of price differentials was sobering.⁴¹ For urology, where even the tenth percentile of HHI exceeded 2500, the amount paid for a vasectomy or kidney stone treatment in counties at the ninetieth percentile of prices, exceeded the amount in counties at the tenth percentile by two and a half times.⁴²

B. *Excessive Prices for Must-Have Providers*

Certain large and prestigious hospitals and physician groups are recognized as *must-have* parties to insurers’ provider networks, and demand and receive prices disproportionate to their clinical outcomes.⁴³ Insurers find they cannot exclude these providers from their networks, nor place them in lower tiers, and pass the costs along in the form of higher premiums.⁴⁴

37. *Id.* at 1659.

38. Daniel R. Austin & Laurence C. Baker, *Less Physician Practice Competition Is Associated with Higher Prices Paid for Common Procedures*, 34 HEALTH AFF. 1753, 1753–54 (2015).

39. *Id.* at 1759.

40. *Id.* at 1756–57.

41. *See id.* at 1759.

42. Austin & Baker, *supra* note 38, at 1757.

43. *See* Berenson et al., *supra* note 2, at 973.

44. *Id.* at 973–74.

For this reason, Robert Berenson argues that “antitrust policy and enforcement can only be one—and not the primary—approach to addressing provider pricing power.”⁴⁵ He contends “that the source of hospital and physician pricing power . . . lies . . . in its leverage negotiating contracts with health insurers,”⁴⁶ which is not the same as market concentration.⁴⁷

An essential element of health plan-provider negotiations over price and other contractual terms and conditions is the willingness of consumers to accept narrow or tiered network products that effectively limit their choice of provider to those willing to accept the health plan’s pricing. Without a credible threat of either excluding or disadvantaging high-cost providers by placing them in a higher consumer cost-sharing tier, health plans lack an important bargaining chip.

....

Another factor is that it has become common health care parlance to refer to “must-have” providers—especially hospitals—that must be included in a plan’s provider network to make the plan marketable to customers. Must-have hospitals, by definition, have pricing leverage over insurers because the plans cannot plausibly threaten to exclude or limit their participation in the insurer’s provider networks.⁴⁸

C. *Out-of-Network Hospital-Based Providers and Surprise Billing*

Recent years have seen what Berenson calls an “epidemic of physicians and hospitals in some cases purposefully remaining out of network to charge either the insurer or the unsuspecting consumer outrageously high amounts.”⁴⁹ The movement toward integration and accountable care has been met with stubborn resistance from hospital-based physicians at the many community hospitals that outsource their emergency rooms and other hospital-based specialties to large physician staffing corporations.⁵⁰ With their economy of scale, these companies have the capacity to bill both insurers and patients, and to pursue collection action against consumers for unpaid bills.⁵¹ By setting up shop in hospitals that are

45. Berenson, *supra* note 1, at 714.

46. *Id.*

47. *Id.*

48. *Id.* at 720.

49. *Id.*

50. See Berenson, *supra* note 1, at 727.

51. See Joseph Burns, *Health Plans Seek Leverage When Physicians Submit Extremely High Bills*, MANAGED CARE (Aug. 2011),

in-network, they gain access to a captive clientele of consumers who need care.⁵² As such, these companies see little advantage to signing network contracts with insurers that would discount prices.⁵³ Instead, they bill their charges, obtaining payments for the “usual, customary, and reasonable” (“UCR”) amounts from insurers and send surprise bills to consumers for the difference.⁵⁴

When physicians refuse to contract, the midpoint of the range of payments used to determine a UCR amount will shift rightward. Ordinarily, one would expect the distribution to be dominated by Medicare and Medicaid prices, and network rates discounted for the volume an insurer can offer, skewing the distribution to the left, with only a few data points at the right representing self-pay patients paying the full charges.

A distribution of reimbursements for services delivered by non-participating providers will be dominated by amounts representing a UCR payment tendered by an insurer plus any balance between that amount and the charge that is paid by the consumer. These data points will be higher dollar amounts, and as they proliferate within a specialty, such as emergency medicine, the UCR midpoint will ratchet upward. This means higher overall costs of care, and in making hospital-based specialties more lucrative, making those careers more attractive to medical graduates. This, in turn, could increase the supply and utilization of expensive emergency room care, at the expense of access to primary care.

In addition to the higher costs, there are two other consequences when hospital-based physicians decline to join insurer networks. For consumers, one immediate consequence arises from the fact that out-of-network expenditures may not count toward their deductible and out-of-pocket maximum, thereby undermining the Affordable Care Act’s limitations on medical debt. But the refusal of hospital-based physicians to participate in networks also has far-reaching implications for the payment and delivery system reforms that many policymakers and stakeholders hope will improve quality and efficiency. This is particularly true of emergency medicine physicians.

Generally speaking, current payment and delivery system reforms are aimed at giving a group of providers accountability for the total cost of

<http://www.managedcaremag.com/archives/2011/8/health-plans-seek-leverage-when-physicians-submit-extremely-high-bills>; Gold et al., *supra* note 26.

52. See Burns, *supra* note 51.

53. See *id.*

54. Gold et al., *supra* note 26; see also Burns, *supra* note 51; Deanna Dewberry, *In-Network Emergency Room, Out-of-Network Doctor Could Equal a Big Bill*, NBCDFW (Feb. 4, 2014), <http://www.nbcdfw.com/news/local/In-Network-Emergency-Room-Out-of-Network-Doctor-Could-Equal-a-Big-Bill-243590331.html>.

care of a population's health needs or for the cost of an individual's episode of care. In such circumstances, providers will be more mindful of opportunities to avert a potentially avoidable hospitalization and to use resources efficiently. In global budget models—whether a staff-model Health Maintenance Organization (“HMO”), an Accountable Care Organization, or Maryland's unique Global Budget Revenue program—providers must deliver care to covered persons within fixed financial benchmarks. Providers' incentives are to manage patients' chronic conditions through primary care and care coordination, so they are not hospitalized and, when patients do appear at a hospital, to avoid unnecessary resource utilization. Unless a global budget or episode payment system is imposed by the state—as in Maryland—insurers are the only entity capable of sponsoring such payment reforms.

The Emergency Department (“ED”) is at the fulcrum of any efforts to integrate care, so a refusal of emergency medicine physicians to contract with insurers will undermine reform activities. According to a recent Rand Corporation study, the ED now accounts for more than one half of hospital admissions, up from only about one third of admissions in the early 1990s.⁵⁵ While inpatient admissions overall have declined relative to population growth in the United States, there has been a 17% increase in admissions from the ED, offsetting the decrease in admissions from physician offices and other outpatient settings.⁵⁶

Meanwhile, a study recently published in the *Annals of Internal Medicine* indicates that nearly one in twelve patients who visit an ED return to an “acute care setting within three days,” with the thirty day re-visit rate being nearly one in five patients.⁵⁷

Yet even as there is consensus on the need to reduce avoidable hospitalizations and ED use, ED physicians increasingly position themselves outside the insurance system.⁵⁸ Their only bonds are to the physician staffing corporations that employ them and the hospital that contracts with

55. KRISTY GONZALEZ MORGANTI ET AL., RAND CORP., *THE EVOLVING ROLE OF EMERGENCY DEPARTMENTS IN THE UNITED STATES* 35, 50 (2013).

56. *Id.* at 24.

57. Reena Duseja et al., *Revisit Rates and Associated Costs After an Emergency Department Encounter: A Multistate Analysis*, 162 *ANNALS INTERNAL MED.* 750, 754 (2015).

58. See GONZALEZ MORGANTI ET AL., *supra* note 55, at 3; Elisabeth Rosenthal, *Costs Can Go Up Fast When E.R. Is in Network but the Doctors Are Not*, N.Y. TIMES (Sept. 28, 2014), https://www.nytimes.com/2014/09/29/us/costs-can-go-up-fast-when-er-is-in-network-but-the-doctors-are-not.html?_r=0.

them—two entities that generally have financial incentives to *increase* admissions and *increase* emergency room traffic.⁵⁹

IV. POLICY OPTIONS TO ADDRESS PROVIDER PRICING PROBLEMS

A. *All-Payer Rate Setting for Providers as a Policy Option*

A key distinction between America’s pluralistic system of multiple payers and those of peer nations, according to Anderson and colleagues, is that “the government-controlled health systems of Canada, Europe, and Japan allocate considerably more market power to the buy side.”⁶⁰ In essence, the health insurance plans overseas are more monopsonistic.⁶¹ Anderson argues that while a monopsonistic purchaser

is ultimately constrained by market forces on the supply side—that is, by the reservation—minimally acceptable—prices of the providers of health care below which they will not supply their goods or services. . . . [W]ithin that limit, monopsonistic buyers enjoy enough market clout to drive down the prices paid for health care, and health care inputs fairly close to those reservation prices.⁶²

For this reason, a number of prominent United States health-policy thought leaders endorse some type of all-payer rate setting regime.⁶³ In 2012, a who’s who of center/left health policy experts called for:

[A] model of self-regulation, [under which] public and private payers would negotiate payment rates with providers, and these rates would be binding on all payers and providers in a state. Providers could still offer rates below the negotiated rates. The privately negotiated rates would have to adhere to a global spending target for both public and private payers in the state. After a transition, this target should limit growth in health spending per capita to the average growth in wages, which would combat wage stagnation and resonate with the public. We recommend that an independent council composed of providers,

59. See GONZALEZ MORGANTI ET AL., *supra* note 55, at 27, 38, 55; Rosenthal, *supra* note 74.

60. Anderson et al., *supra* note 20, at 102.

61. *Id.*

62. *Id.*

63. See *id.*; Ezekiel Emanuel et al., *A Systemic Approach to Containing Health Care Spending*, 367 NEW ENG. J. MED. 949, 950 (2012).

payers, businesses, consumers, and economists set and enforce the spending target.⁶⁴

Robert Berenson endorses a regulatory approach that would place

price ceilings on negotiated rates that come out of insurer-provider negotiations and upper limits on billing to consumers, beyond the negotiated rates insurers agree to pay, set as a percentage above the Medicare yardstick. Setting upper limits would bound the prices, while permitting market negotiations to focus on selected networks with discounting and with new payment models—market approaches that can be difficult to preserve in a full-fledged all-payer rate-setting environment.⁶⁵

While many health policy analysts would like to see all-payer rate setting for providers, there are two major political barriers to this option.⁶⁶ First, it is contrary to the American preference for a light regulatory touch.⁶⁷ As seen in the continuing battles over state certificate-of-need laws, conservatives remain unconvinced that “health care is different” and merits restrictions on prices or supply that remain unthinkable in other areas of the economy.⁶⁸

Second, providers are vehemently opposed to restrictions on the prices they can charge, as seen in the opposition to the Massachusetts proposal for a *luxury tax* on expensive hospitals,⁶⁹ and to the proposed mergers of four large insurers announced in 2015.⁷⁰

64. Emanuel et al., *supra* note 63, at 950.

65. Berenson, *supra* note 1, at 738.

66. *See id.* at 725–26, 738; Berenson et al., *supra* note 2, at 979.

67. *See* Berenson, *supra* note 1, at 712, 729–30; Berenson et al., *supra* note 2, at 975.

68. *See* Berenson, *supra* note 1, at 726–27, 733; Berenson et al., *supra* note 2, at 975.

69. *See* H.R. 4070, 187th Gen. Court, Reg. Sess. (Mass. 2012); Chris Camire, *Reps Eye ‘Luxury Tax’ on Massachusetts Hospitals*, LOWELL SUN, http://www.lowellsun.com/news/ci_20618865/reps-eye-luxury-tax-massachusetts-hospitals (last updated May 14, 2012, 6:35 AM). The hospital *luxury tax* proposal was a provision of a Massachusetts House bill that would have imposed a 10% tax on hospitals charging more than 20% above the state median price for a specific service if they could not “prove they offer[ed] higher-quality service than [other] facilities.” H.R. 4070; Camire, *supra*. The funds were to have been redistributed to hospitals serving poor communities. Camire, *supra*; *see also* H.R. 4070. The provision was stripped from the final version of the legislation, but a variation on the concept has been revived for a current ballot initiative in Massachusetts. S.B. 2260, 187th Gen. Court, Reg. Sess. (Mass. 2012); Camire, *supra*.

70. Hancock, *supra* note 14.

But while health care provider rates are regulated in only one state, Maryland, there is a long-standing tradition of regulating insurer rates.⁷¹ This Article will argue in the next section that this regulatory structure can be marshaled to put downward pressure on provider prices.⁷²

B. *Insurance Regulation as an Alternative to Rate-Setting for Providers*

Robert Berenson notes that, to date, “the market response to the increase in prices resulting from growing provider leverage in rate negotiations has been limited and largely ineffective.”⁷³ McKinsey Global Institute argues that this is because of a health care supply chain in which “stakeholders are either unwilling or unable to resist cost increases that are passed along to them.”⁷⁴ In its view, cost increases from physicians and hospitals are “pass[ed] on . . . to the next player in the chain. . . . Unless the [United States] health system addresses this dynamic, medical inflation cannot help but continue.”⁷⁵

The consensus of a 2004 panel discussion on the health care industry was that employers are “missing in action” on health care prices:

[M]ost employers have not pushed back at providers and insurers to lower cost and premium trends, relying instead on shifting costs to workers through higher patient cost sharing—higher deductibles and co-insurance, for example. The panelists agreed that in the near term employers will continue to shift costs to workers but that cost sharing as a long-term cost-containment strategy [will not] work.⁷⁶

“We [have not] seen the employers kick in because their first line of defense has been cost shifting, which has been an effective strategy in the short run, but you can only raise the deductible to \$1000 one time. So, [there is] a cliff here that [we are] coming to,”⁷⁷ said Robert Laszewski, President of Health Policy and Strategy Associates.⁷⁸

[The] exception to the lack of purchaser pushback against higher cost and premium trends is the California Public Employees Retirement System, or (“CalPERS”), analysts agreed, but they

71. Berenson, *supra* note 1, at 712, 725 n.8, 738.

72. Berenson et al., *supra* note 2, at 979; *infra* Section IV.B.

73. Berenson, *supra* note 1, at 713.

74. FARRELL ET AL., *supra* note 9, at 30.

75. *Id.*

76. CTR. FOR STUDYING HEALTH SYS. CHANGE, *supra* note 2, at 2.

77. *Id.*

78. *Id.*

were skeptical that CalPERS' decision to exclude several dozen hospitals from its health maintenance organization—HMO—networks would prompt other purchasers to take a harder line.⁷⁹

One of CalPERS' strategies is described *infra*.⁸⁰ Employers and insurers could have good reason to be reluctant to apply pressure to providers.⁸¹ Purchasers must maintain a good working relationship with the doctors and hospitals to which they entrust enrollees' care.⁸² Further, the only recourse if a provider's price is too high is to walk away from negotiations and accept a narrower network that may be less attractive to employees and consumers.⁸³

The thesis of this Article is that purchasers might be emboldened if they are backed up by an insurance regulator who is leading and facilitating a coordinated pushback campaign. In the Author's view, many commissioners have two major legal tools available for deployment, but much of their role would be hortatory as public figures having a central role in the health care system oversight.

Insurance laws in at least three states already direct commissioners to inquire into underlying health care costs, specifically calling attention to provider prices.⁸⁴

79. *Id.*

80. See Ann Boynton & James C. Robinson, *Appropriate Use of Reference Pricing Can Increase Value*, HEALTH AFF.: BLOG (July 7, 2015), <http://www.healthaffairs.org/blog/2015/07/07/appropriate-use-of-reference-pricing-can-increase-value/>; *infra* Section IV.B.2.

81. See CTR. FOR STUDYING HEALTH SYS. CHANGE, *supra* note 2, at 2–3.

82. Burns, *supra* note 51.

83. See CTR. FOR STUDYING HEALTH SYS. CHANGE, *supra* note 2, at 2; Berenson et al., *supra* note 2, at 974–75.

84. See e.g., 42 R.I. GEN. LAWS § 42-14.5-2. With respect to health insurance as defined in Title 42, Section 14.5-2 of the Rhode Island Health Care Reform Act, “the health insurance commissioner shall discharge the powers and duties of office to:”

(1) [g]uard the solvency of health insurers; (2) [p]rotect the interests of consumers; (3) [e]ncourage fair treatment of health care providers; (4) [e]ncourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and (5) [v]iew the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.

42 R.I. GEN. LAWS § 42-14.5-2. “Changes in the insurer’s health care cost containment and quality improvement efforts included, as an appendix to the filing and labeled, ‘Appendix II: Cost Containment and Quality Improvement Efforts.’” OR. ADMIN. R. 836-053-0473 (2016). The cost containment and quality improvement efforts must:

(A) [e]xplain any changes the insurer has made in its health care cost containment efforts and quality improvement efforts since the insurer’s last rate filing for the same category of health benefit plan; (B) [d]escribe significant new health care cost containment initiatives and quality improvement efforts; (C) [i]nclude an estimate

To be sure, a commissioner cannot succeed in this project without the support of the payer community, including the insurers themselves. Insurers would have to embrace the role of price-cutter, even though, as explained *infra*, their financial incentive to do so can be ambiguous. One assumption is that industry rhetoric-deploring high prices is sincere and the regulatory path would be welcomed. Another assumption is that norms promulgated in the state-regulated insurance sphere would spill over into the larger employer-sponsored insurance sphere.

This effort would therefore also require the support of self-insured employers that retain insurance companies on an administrative services only basis. Employers have perhaps the greatest financial interest in obtaining lower prices from insurers, although the insurance commissioner's authority is at low ebb—if not absent altogether—when an insurer acts solely as a third party administrator.

Thus, to a great extent, the regime envisioned is one in which the commissioner is acting as much as a convener and coordinator as he is a regulator. An advisory committee of purchaser representatives and consumer advocates would give the project added heft. A commissioner who is a gubernatorial appointee—and most are—would also need the political support of a governor who believes its state is competitively disadvantaged by high health care costs. Success would also be greatly aided by the cooperation of the state's Attorney General. Attorneys General have traditionally wielded some oversight of health care as enforcers of antitrust law and as interpreters of laws governing non-profit corporations such as Blue plans and hospitals.

1. Use of Rate-Setting Authority to Require Pushback on Prices

According to a Kaiser Family Foundation analysis of state statutory authority to review health insurance rates, “[thirty-five jurisdictions]—including the District of Columbia—ha[ve] prior approval authority over . . . [premiums in] some portion of the individual and small group market,” with “[twenty-two] ha[ving] prior approval authority over all major medical

of the potential savings from the initiatives and efforts described in subsection (2)(g)(B) of this section together with an estimate of the cost or savings for the projection period; and (D) [i]nclude information about whether the cost containment initiatives reduce costs by eliminating waste, improving efficiency, by improving health outcomes through incentives, by elimination or reduction of covered services or reduction in the fees paid to providers for services.

Id. Section 1385.03(c)(3) of the California Health and Safety Code requires plans to detail “significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.” CAL. HEALTH & SAFETY CODE § 1385.03(c)(3) (West 2015).

health insurance products in both the individual and small group markets;” and in the remaining “states, prior approval authority [is] limited” to subgroups of products.⁸⁵ Additionally, the analysis noted “some states with little to no authority to regulate rates,” including some *file and use* states, have negotiated rate reductions.⁸⁶ The typical statutory grant of regulatory authority over premiums provides that “[r]ates shall not be excessive, inadequate, or unfairly discriminatory.”⁸⁷

Insurance regulators could withhold permission to increase premiums that reflect provider market power due to inappropriate consolidation and order insurers to pursue antitrust litigation when prices and HHI exceed a certain threshold. Rates could be set so that an insurer’s profits are reduced in proportion to excessive prices that are deemed to be within the insurer’s power to reduce. In other words, the regulator would prescribe upper limits on medical expenditures representing quantity times a target price in line with national averages. The target price could be lowered in increments annually to give time for insurers to act.

In this scenario, the commissioner would put insurers on notice that they need to push back on prices and levy a tentative, but avoidable, fine payable in the event that they do not act. This fine is meant to be borne collectively, not individually, to reflect provider market power only, and not any differential market power of insurers of varying size. The fine should be set to promote cooperation among insurers in preparing antitrust litigation and to have an *in terrorem* effect on providers that softens their negotiating stance. The commissioner, as a state actor with antitrust immunity, could lawfully coordinate insurers’ actions toward target price levels.

Suppose insurers file rates that assume a medical cost trend of 5%, based upon current provider prices, and a 3.5% profit margin. The commissioner could decree a lower cost trend based upon a target price and set rates so that if the target were not met, the insurer profit margin would be one or two percentage points lower.

It is worth noting that federal law mandating a minimum medical loss ratio using a percentage of gross revenues⁸⁸ may have a perverse effect making insurers less likely to push back on prices. For instance, a health plan with 10,000 enrollees, which has annual medical reimbursements at the United States per-enrollee average in 2009, would spend \$33,140,000,

85. SABRINA CORLETTE & JANET LUNDY, THE HENRY J. KAISER FAMILY FOUND., RATE REVIEW: SPOTLIGHT ON STATE EFFORTS TO MAKE HEALTH INSURANCE MORE AFFORDABLE 9 (2010).

86. *Id.* at 10.

87. D.C. CODE § 31-3508(e)(2) (2016); MICH. COMP. LAWS § 500.2403(1)(d) (2015); OR. REV. STAT. § 743.018(4)(b) (2015).

88. 42 U.S.C. § 2718 (2015).

permitting it to keep \$5,000,000 for administrative costs and profits. Meanwhile a plan with 10,000 enrollees in Rochester, New York—where prices and utilization are relatively low—would expect just \$23,190,000 in medical reimbursements, and would be allowed to keep only \$3,500,000 for administrative costs and profits. Presumably, insurance executives prefer operating in markets where higher provider prices give insurers additional cushions for administrative costs and profits.

The concept envisioned here is intended to be deployed in regions where costs are excessive and those costs are attributable to high prices. A commissioner can look to benchmarks to make a determination as to whether prices are excessive. National data is available from various sources, which can be used to compare a region's prices for hospitals and physicians.

Prices beyond a certain threshold could be the triggering mechanism for the pushback process. For example, the HCCI has promulgated a set of economic metrics they have dubbed the Healthy Marketplace Index (“HMI”), “intended to provide baseline measurements of health care market performance related price, productivity, and competition.”⁸⁹

An HMI measures a “basket of health care services allowing for consistent comparisons” across regions at the Core-Based Statistical Area (“CBSA”) level, permitting “differences between markets [to] be attributed to prices rather than the types or amounts of services used.”⁹⁰ An “index value of 1.00 indicates that, on average for a basket of services, the prices in the CBSA were equal to those of the total population.”⁹¹ A CBSA with an index value of 1.05 would have prices 5% higher.⁹²

Suffice it to say, there is no obvious threshold for a price index trigger. The Dayton, Ohio inpatient price index of 1.18 would seem to qualify as a true outlier, but the Milwaukee level of 1.09 would also justify taking action if it is causing insurance premiums to be unaffordable for consumers or businesses.

The triggering mechanism could have multiple parts. An HHI measurement exceeding 2500, or an even higher threshold, would verify that market concentration is the principal culprit in high prices. A third triggering benchmark could look to hospital financial indicators. High levels of hospital reserves, profit margins, or executive compensation could be viewed as markers of excessive prices.

89. See ERIC BARRETTE, HEALTH CARE COST INST., INC. TAKING THE PULSE OF HEALTH CARE MARKETS 1 (2015), <http://www.healthcostinstitute.org/wp-content/uploads/2016/12/Data-Brief-2-September-2015-HMI.pdf>.

90. *Id.* at 2.

91. *Id.*

92. *Id.* at 3.

While the substance of antitrust law relating to health care providers is beyond the scope of this Article, one can point to a template for private antitrust enforcement by an insurer against a provider: Litigation mounted in the 1990s by *Blue Cross and Blue Shield United of Wisconsin v. Marshfield Clinic*.⁹³ The case was hardly straightforward in either its atypical fact pattern—the insurer eventually prevailed because it proved the defendant had divided territories with a potential competitor but no damages were awarded; and judgment on a monopolization charge under Section 2 of the Sherman Act was reversed—or in its procedural journey—two trials and two trips to the Seventh Circuit Court of Appeals.⁹⁴ Rather, it illustrates the ideal envisioned: An insurer serving a high-cost region taking on a large health system that had stifled competition, bearing great expense to painstakingly assemble a complex case and pursue it aggressively.⁹⁵ Warren Greenberg, who served as an expert witness for the plaintiff, noted that this expense was borne entirely by one insurer, even though a successful outcome would have benefited competing insurers, consumers, and employers who did not contribute.⁹⁶ A multi-payer mandate from a commissioner to pursue such litigation would more fairly apportion costs.

To be sure, a rate ruling that effectively orders insurers to file antitrust litigation would represent a heavy lift.⁹⁷ First, there are legal hurdles.⁹⁸ As Robert Berenson wrote, “[t]he [h]orse [h]as [a]lready [l]eft the [b]arn”⁹⁹ in the sense that “monopolies lawfully acquired or, in the case of consummated mergers, fully entwined entities . . . are impractical to successfully unwind.”¹⁰⁰

In such instances, plaintiffs could request *conduct remedies* that would “regulate the conduct of the monopolist, for example, by providing for binding arbitration to resolve payer-provider price disputes or requiring maintenance of open medical staffs.”¹⁰¹

Second, litigation would be expensive. It would be helpful if one of the many philanthropies dedicated to health care policy could fund a forensic resource center to marshal legal and economic thinking relevant to modern

93. 152 F.3d 588, 590 (7th Cir. 1998); *see also* 65 F.3d 1406, 1408 (7th Cir. 1995).

94. *Blue Cross & Blue Shield United of Wis.*, 152 F.3d at 588, 590–96; *Blue Cross & Blue Shield United of Wis.*, 65 F.3d at 1416–17.

95. *See Blue Cross & Blue Shield United of Wis.*, 152 F.3d at 590–91.

96. Greenberg, *supra* note 6, at 118 n.1, 122, 123; *see also Blue Cross & Blue Shield United of Wis.*, 152 F.3d at 590–91.

97. *See Berenson, supra* note 1, at 713–14.

98. *See id.* at 725–26.

99. *Id.* at 725.

100. *Id.* at 726 (citation omitted).

101. *Id.* (citation omitted).

understanding of health care organizations, formulate principles and guidelines for applying antitrust and non-profit law, and collect evidence for and testify in adversarial proceedings.

2. Commissioners' Catchall Authority to Declare Insurance Acts and Practices Unfair

A commissioner's plenary authority to prohibit unfair practices could be used to prohibit insurers from capitulating to contracting terms that reflect inappropriate provider market leverage, particularly in the sphere of the must-have provider. Many states' insurance codes include a grant of authority similar to this:

If the [c]ommissioner believes that any person engaged in the insurance business is in the conduct of such business engaging in this state in any method of competition or in any act or practice not defined in NRS 686A.010 to 686A.310, inclusive, which is unfair or deceptive and that a proceeding by the Commissioner in respect thereto would be in the public interest, the Commissioner shall, after a hearing of which notice and of the charges against such person are given to the person, make a written report of the findings of fact relative to such charges and serve a copy thereof upon such person and any intervener at the hearing.¹⁰²

Melnick and Fonkych urge policymakers to limit:

“all-or-none” contracting by multi-hospital systems and prohibiting other anti-competitive contract language that flows from market power achieved by large multi-hospital systems. Such pro-competitive regulation would allow for hospital systems to integrate to improve efficiencies without the deleterious side effects of increased market power which can result in reduced price competition and higher costs to consumers.¹⁰³

A commissioner's catchall authority might be invoked to accomplish this.¹⁰⁴ Rhode Island's Health Insurance Commissioner has promulgated “Hospital Contracting Conditions, [and] [t]hese conditions support

102. NEV. REV. STAT. § 686A.170(1) (2016); *see also* CAL. INS. CODE § 790.06(a) (West 2016); KY. REV. STAT. ANN. § 304.12-130(1) (West 2016); MONT. CODE ANN. § 33-18-1003(1) (2015); N.C. GEN. STAT. § 58-63-40(a) (2016).

103. Melnick & Fonkych, *supra* note 31, at 6 (footnote omitted).

104. *See* STATE OF R.I. & PROVIDENCE PLANTATIONS OFFICE OF THE HEALTH INS. COMM'R, CONCISE STATEMENT OF THE PRINCIPAL REASONS FOR AND AGAINST THE ADOPTION OF THE AMENDMENTS TO OHIC REGULATION 2, POWERS AND DUTIES OF THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER 7–8 (2015).

affordable health insurance by making the approval of insurer rate filings contingent on the [h]ealth [i]nsurer's agreement to abide by contracting standards with hospitals that limit service price inflation, improve the quality of care, and work towards increased administrative efficiencies."¹⁰⁵

The Hospital Contracting Conditions have two main provisions.¹⁰⁶ One limits annual rates of price increases for inpatient and outpatient services to increases in the CMS Hospital Input Price Index plus 1% for each year covered by the contract.¹⁰⁷ The second "require[s] that insurer contracts with hospitals include a quality incentive program, [in which] at least 50% of the annual price increase for hospitals must be" tied to performance on quality measures.¹⁰⁸

According to Christopher F. Koller, the former Rhode Island Health Insurance Commissioner, legal authority for promulgating the conditions was implied by the combination of the statutory mandate to improve health care quality and efficiency and the power to approve rates.¹⁰⁹ The fact that no explicit oversight of hospital rates was granted to the Commissioner suggests that regulators in other states could also take an expansive view of catchall authorities to pursue this option.¹¹⁰

Tools used by government agencies as *active purchasers* are not closely analogous to those available to the insurance regulator, but could conceivably be adapted.¹¹¹ Covered California, the insurance exchange established in that state to implement the Affordable Care Act, has conditioned participation in its marketplace on an insurer's efforts to obtain low prices from providers.¹¹² Beginning in 2018, an insurer that wants to sell in the California exchange must "report on its strategy to assure that contracted providers are not charging unduly high prices, which may include but are not limited to: Telemedicine [and] [u]se of Centers of Excellence."¹¹³

While the intent is not explicitly stated, the mention of telemedicine and Centers of Excellence suggests that the state might encourage insurers to substitute providers who are outside the region for overpriced providers

105. *Id.* at 12.

106. *Id.*

107. *Id.*

108. *Id.* at 12–13.

109. *See* 42 R.I. GEN. LAWS § 42-14.5-2(4) (2016).

110. *See id.*; STATE OF R.I. & PROVIDENCE PLANTATIONS OFFICE OF THE HEALTH INS. COMM'R, *supra* note 104, at 7–8.

111. *See* 42 R.I. GEN. LAWS § 42-14.5-2(4); PLAN MGMT. ADVISORY GRP., COVERED CAL.: PLAN MANAGEMENT AND DELIVERY SYSTEM REFORM ADVISORY GROUP MEETING AND WEBINAR 18 (2016), hbex.coveredca.com/stakeholders/plan-management/PDFs/Plan-Management-Advisory-Group-FINAL-slides-2016-2-11.pdf.

112. PLAN MGMT. ADVISORY GRP., *supra* note 111, at 18.

113. *Id.*

within its service area.¹¹⁴ An insurer might be able to find academic medical centers outside its geographic market that have prestige equal to local must-have providers but are willing to treat patients at a lower cost.¹¹⁵ Covered California has also indicated that by 2019, insurers “will be expected to exclude hospitals and other facilities that demonstrate outlier high cost.”¹¹⁶

It is surely easier to tell insurers that they must exclude overpriced *outliers* from their networks in the exchange market than in the small group market because: (1) insurer participation in the exchanges is voluntary, and it is now presumed that it will constitute less than 100% of companies and (2) employer-sponsored insurance is a fringe benefit used to attract employees, so there is greater pressure to have a robust network.¹¹⁷ It might be easier to facilitate or mandate *reference pricing*, which preserves access to the high priced provider, than to ban the high-priced provider altogether.¹¹⁸

With reference pricing, a payer includes expensive, must-have providers in its network but requires the patient to pay the difference between what a lower-cost provider charges and the higher price.¹¹⁹

The payment limit typically is the median or some other mid-point in the distribution of prices in the local market. Consumers who select a provider that charges less than the purchaser’s limit receive standard coverage, with minimal cost sharing. Consumers who select a provider charging above the contribution limit must pay the entire difference.¹²⁰

The technique was pioneered by CalPERS, and it is unclear whether it has migrated from self-insured plans to fully-insured plans. Insurance regulators cannot set administered prices like Medicare or Maryland’s all-payer rate setting board; however, they could create safe harbors for reference prices by approving, in advance, acceptable price levels for a given procedure in a market. This could pressure high-cost providers to lower their prices. A commissioner might go a step further by declaring payments beyond a set *luxury* level to constitute an unfair insurance practice, having the effect of imposing a reference price requirement.

114. *See id.*

115. *See id.* at 18, 24.

116. *Id.* at 18.

117. *See id.* at 7, 13, 18, 22.

118. *See* Boynton & Robinson, *supra* note 80.

119. *Id.*

120. *Id.*

3. Convening Insurers to Fight Balance Billing

Under the *quantum meruit* doctrine, which governs medical billing in the absence of agreed-to price terms, out-of-network physicians are entitled only to UCR-based reimbursement.¹²¹ As such, an insurer's payment of the UCR amount should suffice to make the physician whole—at least two courts have held that balance billing is restricted under such circumstances.¹²² But, because most consumers do not have the savvy or resources to fight these bills, which may have an adverse effect on credit scores, this plainly illegal business model has succeeded.¹²³ Insurance regulators could spur insurers to pledge to defend collection lawsuits, which would likely bring an end to the out-of-network business model and bring these physicians into networks at lower prices.¹²⁴

Under common law principles, when a consumer obtains a service without an express agreement as to price, the legal doctrine of *quantum meruit* applies.¹²⁵ The classic example of this, as explained by Judge Richard Posner in *Confold Pacific, Inc. v. Polaris Industries, Inc.*,¹²⁶ is the patient who comes to the emergency room with no ability to inquire into or negotiate over prices.¹²⁷ In such circumstances,

the plaintiff [doctor] is entitled to the market value of his services rather than to the benefit that he conferred on the defendant, which might be much greater—for example, if the plaintiff physician had saved the defendant's life. The court tries to simulate a competitive market; and in such a market, price is based on the cost to the seller rather than on the subjective value to the buyer, which often is much greater.¹²⁸

The Pennsylvania Superior Court applied this doctrine in its decision in *Temple University Hospital, Inc. v. Healthcare Management Alternatives, Inc.*¹²⁹ That case involved the amount the hospital was owed by a health insurer for services rendered after the network contract between the parties

121. See *Gianetti v. Riether*, No. CV020398555S, 2011 WL 4347211, at *4–5 (Conn. Super. Ct. Aug. 24, 2011).

122. *Id.*; *Dennis v. PHC-Martinsville, Inc.*, No. CL 14-483, 2016 WL 4717657, at *7 (Va. Cir. Ct. Mar. 31, 2016).

123. See *Dennis*, 2016 WL 4717657, at *7.

124. See 42 R.I. GEN. LAWS § 42-14.5-2(5).

125. *Confold Pac., Inc. v. Polaris Indus.*, 433 F.3d 952, 958 (7th Cir. 2006).

126. 433 F.3d 952 (7th Cir. 2006).

127. *Id.* at 958.

128. *Id.*

129. 832 A.2d 501 (Pa. Super. Ct. 2003).

expired.¹³⁰ The hospital insisted that the insurer was liable for billed charges at its *published rates*, or *chargemaster*.¹³¹ But, evidence at trial established “that the [h]ospital . . . [received 80%] or more of its full published charges only [6%] of the time.”¹³² Further, data indicated “that the [h]ospital was paid its full published charges only [1] to [3%] of the time” and that its “full published [rates] represented 300% of the [h]ospital’s [actual input] costs.”¹³³

The Superior Court of Pennsylvania explained that in the absence of agreement on price terms, Pennsylvania “law implies a quasi-contract, which requires the defendant to pay to plaintiff the value of the benefit conferred,”¹³⁴ or “a reasonable fee for a health provider’s services.”¹³⁵ “Thus, in a situation such as this, the defendant should pay for what the services are ordinarily worth in the community.”¹³⁶ “Services are worth what people ordinarily pay for them.”¹³⁷

Since the relevant question is “what health care providers actually receive for those services,”¹³⁸ if a provider rarely recovers its billed charges, those charges “cannot be considered the value of the benefit conferred because that is not what people in the community ordinarily pay for medical services.”¹³⁹ The purpose of quantum meruit is to place the provider in the position he would have been in had services been delivered in the ordinary course of business, not in a “better position than [he] would have been had the services been performed for the majority of [his] other patients.”¹⁴⁰

Therefore, in instances where the insurer has tendered a UCR amount, the doctor has been compensated in full.¹⁴¹ As such, there ordinarily

130. *Id.* at 505.

131. *Id.*

132. *Id.* at 506.

133. *Id.*

134. *Temple Univ. Hosp., Inc.*, 832 A.2d at 507 (quoting *AmeriPro Search, Inc. v. Fleming Steel, Co.*, 787 A.2d 988, 991 (Pa. Super. Ct. 2001)).

135. *Id.* at 508 (citing *Eagle v. Snyder*, 604 A.2d 253, 254 (Pa. Super. Ct. 1992)).

136. *Id.* (citing *Eagle*, 604 A.2d at 254).

137. *Id.* (citing *Eagle*, 604 A.2d at 254, 256).

138. *Id.*

139. *Temple Univ. Hosp., Inc.*, 832 A.2d at 500.

140. *Id.* at 509; *see also* *Hailey v. Medcorp., Inc.*, No. L-05-1238, 2006 WL 2640238, at *4 (Ohio Ct. App. Sept. 15, 2006) (vendor can collect only “the reasonable value of the material and services that accrued to the actual benefit of the other party . . .”); *Doe v. HCA Health Servs. of Tenn., Inc.*, 46 S.W.3d 191, 197–98 (Tenn. 2001); *River Park Hosp., Inc. v. Bluecross Blueshield of Tenn., Inc.*, 173 S.W.3d 43, 57–58 (Tenn. Ct. App. 2002). In Illinois, providers can collect charges if they are equivalent to UCR. *See Victory Mem’l Hosp. v. Rice*, 493 N.E.2d 117, 119–20 (Ill. App. Ct. 1986).

141. *See Gianetti v. Riether*, No. CV020398555S, 2011 WL 4347211, at *5 (Conn. Super. Ct. Aug. 24, 2011).

should remain no lawful balance to collect from the patient.¹⁴² A Connecticut case, *Gianetti v. Riether*,¹⁴³ has so held.¹⁴⁴

Gianetti was a plastic surgeon on call in an emergency room.¹⁴⁵ He treated the defendant and was reimbursed \$349.54, on an out-of-network basis, by the defendant's insurance company; he then billed the patient for the balance of his \$425 charge, \$75.46.¹⁴⁶

The court held that the doctor did not meet his burden of proving "that \$425 was the reasonable value of such service."¹⁴⁷ "The plaintiff provided no evidence as to what similar doctors or physicians charge for similar work."¹⁴⁸ "The plaintiff provided no evidence concerning his usual and customary charges for similar work."¹⁴⁹ But the court went on:

Additionally, there is evidence from which the court can and does find that the reasonable value of the first item was only \$349.54. The court takes judicial notice that health insurance companies typically reimburse physicians for the usual and customary charges for similar medical services by area physicians. The amount reimbursed is *prima facie* evidence of the reasonableness of such charges. The plaintiff has failed to rebut such evidence. Consequently, the court finds that the plaintiff was fully compensated therefor.¹⁵⁰

Similarly, the court in *Dennis v. PHC-Martinsville, Inc.*,¹⁵¹ rejected a hospital's billed charges of \$111,115.37 and looked to "the reasonable value of . . . services rendered to" the patient.¹⁵² The court determined that it would be "the amount the hospital would have received had Dennis pre-paid his bill as an uninsured patient."¹⁵³ The hospital's policy was to grant a 75% discount from its chargemaster amount in such circumstances.¹⁵⁴ This amount was \$27,778.84, which was \$523.89 more than Dennis's insurer had

142. *See id.*

143. No. CV020398555S, 2011 WL 4347211 (Conn. Super. Ct. Aug. 42, 2011).

144. *See id.* at *5.

145. *Id.* at *1.

146. *Id.* at *5.

147. *Id.*

148. *Gianetti*, 2011 WL 4347211, at *5,

149. *Id.*

150. *Id.*

151. No. CL14-483, 2016 WL 4717657 (Va. Cir. Ct. Mar. 31, 2016).

152. *Id.* at *7.

153. *Id.*

154. *Id.*

paid.¹⁵⁵ As such, unlike Gianetti's patient, Dennis was ordered to pay a relatively small balance.¹⁵⁶

The hospital has appealed the ruling to the Virginia Supreme Court.¹⁵⁷ Three Virginia health care lawyers commented that "the *Dennis* decision is a shot across the bow for all hospitals" and "may have significant implications for the current rate-setting and debt collection process for hospitals."¹⁵⁸

A third decision is worth mentioning here, although it does not involve interpretation of the common law.¹⁵⁹ Texas' workers compensation statute sets forth several criteria for fixing the compensation of out-of-network providers, one of which is a *fair and reasonable* amount, which appears to be congruent with the standard for *quantum meruit* awards.¹⁶⁰

*Reimbursement of Air Ambulance Services Provided by PHI Air Medical*¹⁶¹ presented the question of whether an air ambulance service could collect its *full billed charges* that were "typically at least two to three times the Medicare rate" when 72% of the provider's patients received 125% of the Medicare rate or less.¹⁶² The insurance carriers involved had tendered reimbursement at 125% of Medicare.¹⁶³ An Administrative Law Judge, analyzing the facts under the *fair and reasonable* criterion, found that the billed charges did not meet the standard because "patients should not be required to pay two or three times the rates paid by 72% of PHI's patients."¹⁶⁴

In determining the appropriate reimbursement amount, the Administrative Law Judge looked to the provider's operating costs.¹⁶⁵ The judge settled upon 149% of Medicare as fair and reasonable because it

155. *Id.*

156. *Compare* Gianetti v. Riether, No. CV020398555S, 2011 WL 4347211, at *5 (Conn. Super. Ct. Aug. 24, 2011), *with* *Dennis*, 2016 WL 4717657, at *7.

157. Jeremy Ball et al., *The Dennis Decision: A Shot Across the Bow for Hospitals*, JDSUPRA (Aug. 10, 2016), <http://www.jdsupra.com/legalnews/the-dennis-decision-a-shot-across-the-20038/>.

158. *Id.*

159. *See* Decision and Order, *In re* Reimbursement of Air Ambulance Servs. Provided by Phi Air Med., Docket No. 454-15-0681.M4 (Tex. Dep't of Ins. Sept. 8, 2015).

160. TEX. LAB. CODE ANN. § 413.011(d) (West 2015); Jackson Williams, Policy Dir., Dialysis Patient Citizens & NAIC Funded Consumer Rep., Public Hearing on Surprise Balance Billing of Health Insurance Consumers (Oct. 1, 2015).

161. Decision and Order, *supra* note 217.

162. *Id.*

163. *Id.*

164. *Id.*

165. *Id.*

reflects PHI's average cost to provide service to each patient and to attain the profit it has earned the past few years. . . . [T]his is the amount that, if paid by every PHI patient, would allow PHI to operate exactly as it did during the time period at issue, making a profit that Carriers' expert conceded is adequate.¹⁶⁶

When state common "law caps out-of-network physician fees at the market price, . . . legislation is not necessary to prohibit balance billing."¹⁶⁷ The cases cited here indicate that balance billing is essentially a bluff that is not being called due to a collective action problem.¹⁶⁸ What is needed is a

coordinated effort to enforce current law. While [a] [c]ommissioner may not have jurisdiction over providers, she does have jurisdiction over insurers, and can therefore convene insurers and consumer advocates to act cooperatively. Patients pay balance bills because: (1) they [do not] know their rights; (2) they are afraid of unpaid bills affecting their credit scores; and (3) they would be unable to defend a collection lawsuit if the physician staffing company filed one. All three of these barriers can be overcome through sub-regulatory action by [a] [c]ommissioner and cooperation by insurers. This has been done before.

. . . .
 . . . [I]n the 1990s, no-fault auto insurers in Michigan were involved in a similar dispute with providers over the legality of balance billing. The insurers banded together, and with the approval of the insurance commissioner, did the following: (1) advised their insureds [not] to pay the balance bill; (2) told the insureds that if they were sued by the provider, the insurer would defend them and indemnify them if they lost the suit; (3) warned the credit reporting agencies [not] to report the balance on the consumer's credit report. The providers did not file collection suits but instead filed two class action lawsuits—one in state court, one in federal—seeking a declaratory judgment of their right to collect balances. Both suits were quickly dismissed, and the problem was resolved.

. . . .
 . . . [T]he favorable case law can be leveraged to protect . . . consumers . . . who are balance-billed [through] a collaboration in which stakeholders undertake the following activities: . . . Insurance Commissioner: respond to consumer complaints about balance billing by telling consumers they are free to disregard bills

166. Decision and Order, *supra* note 217 (footnote omitted).

167. Williams, *supra* note 160; *see also* Confold Pac., Inc. v. Polaris Indus., 433 F.3d 952, 958 (7th Cir. 2006).

168. *See Confold Pac., Inc.*, 433 F.3d at 958; Williams, *supra* note 160.

if the insurer has paid the UCR amount—the commissioner may have to verify that insurers are using a legitimate method of determining UCR; confirm that the *Temple* [rationale] applies to all hospital-based out-of-network providers; admonish credit reporting agencies that they must not report balance-bill debts furnished by these providers because they are inaccurate; promulgate an official [Explanation of Benefits notification (“EOB”)]; . . . Insurers: commit to defending and indemnifying their insureds in the unlikely event of a physician’s collection lawsuit; notify consumers of their rights on EOB forms; . . . Consumer Advocates: coordinate activities; publicize the project; disseminate the project to other states; find consumer attorneys willing to sue under the Fair Credit Reporting Act if credit reporting agencies do not cooperate.

I would not anticipate a need for insurers to actually defend individual lawsuits. The staffing companies would need to pull physicians away from their hospital shifts to testify in court if collection cases were defended. [F]urther, these companies operate across states and could not afford the risk of *making bad law*—generating a direct unfavorable legal precedent—that could immediately force changes to their business model in other states.

. . . .
 . . . [One suspects] that the simple fact of a joint announcement by [a] [c]ommissioner and insurers to pursue the Michigan option, communicated to consumers on the EOB, would suffice to end balance billing in [a state where it is a problem].¹⁶⁹

If not, however, the [c]ommissioner could help facilitate *bellwether trials*.¹⁷⁰ In the context of federal multi-district litigation, bellwether trials are arranged for cases deemed typical of the multiple claims consolidated before the multi-district litigation court.¹⁷¹ The outcomes of such trials give litigants a sense of the settlement value of claims, expediting compromise of all the litigation.¹⁷² In the context of out-of-network providers, bellwether trials could fix the *quantum meruit* value of services, ideally as a percentage

169. Williams, *supra* note 160; see also *Advocacy Org. for Patients & Providers v. Auto Club Ins. Ass’n*, 176 F.3d 315, 326–27 (6th Cir. 1999); *Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts., Inc.*, 832 A.2d 501, 510 (Pa. Super. Ct. 2003).

170. See *Advocacy Org. for Patients & Providers*, 176 F.3d at 328; *McGill v. Auto. Ass’n of Mich.*, 526 N.W.2d 12, 14 (Mich. Ct. App. 1994); Williams, *supra* note 160.

171. *Advocacy Org. for Patients & Providers*, 176 F.3d at 318, 328.

172. See *id.* at 318; Burns, *supra* note 51.

of Medicare rates.¹⁷³ The [c]ommissioner could play a coordinating role in getting payers to share the costs of such trials.¹⁷⁴

V. CONCLUSION

The problem of excessive provider prices is well understood, well documented, and one for which several existing legal and practical remedies are available. In the Author's view, the principal hurdle to alleviating the problem is one of will. The same multiplicity of purchasers that causes them disadvantage relative to providers in negotiating prices also deters individual purchasers from taking action upon which other purchasers could *free-ride*.

If lower health care prices are truly a *public good*, the solution is for government to marshal cooperative efforts among purchasers. The Insurance Commissioner's authority and stature as a representative of consumer interests make that office a natural locus for coordination.

173. See *Temple Univ. Hosp., Inc.*, 832 A.2d at 507–09; Gold et al., *supra* note 26.

174. See *Advocacy Org. for Patients & Providers*, 176 F.3d at 328 n.9. Commissioners may also have a regulatory option: Mandating, as part of their enforcement of network adequacy regulations, that an insurer have at least one *fully participating hospital* in their network. See HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY MODEL ACT § 5 (Nat'l Ass'n Ins. Comm'rs 2015). A fully participating hospital would be one that guarantees either that its hospital-based physicians will be in that insurer's network, or that the hospital will hold patients harmless for any balance billing. See Burns, *supra* note 51; Gold et al., *supra* note 26. This concept, first suggested by a regulator participating in a National Association of Insurance Commissioners workgroup, draws inspiration from the Blue Cross Blue Shield Association's Blue Distinction program. See *Blue Distinction Centers of Excellence*, EXCELLUS BLUECROSS BLUESHIELD, <http://www.excellusbcbs.com/wps/portal/xl/prv/pc/coe> (last visited May 8, 2017); Gold et al., *supra* note 26. That program lists *Centers of Excellence* for various procedures that have been vetted by BCBSA. See *Blue Distinction Centers of Excellence*, *supra*; Gold et al., *supra* note 26. The hospitals have the option of certifying that any hospital-based physicians delivering ancillary care during or in consequence of the procedure are also in-network, and presumably these hospitals will be more attractive to consumers worried about *surprise bills*. See Gold et al., *supra* note 26. The fully participating hospital proposal assumes two premises: First, that consumers would prefer such a hospital, even for emergency care, and consult their insurer's provider directory—or heed a fully-participating hospital's advertising—to learn which nearby hospital has that status; second, that hospitals would perceive a competitive advantage from the status and that one or more would require that the staffing agency granted the physician franchise in their facility agree to terms with insurers or submit their rates to binding arbitration. See *id.* To date, hospitals have been unwilling to impose such a requirement. *Id.*