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Resurrecting Health Care Rate Regulation

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Resurrecting Health Care Rate Regulation

ERIN C. FUSE BROWN*

Our excess health care spending in the United States is driven largely by our high health care prices. Our prices are so high because they are undisciplined by market forces, in a health care system rife with market failures, which include information asymmetries, noncompetitive levels of provider market concentration, moral hazard created by health insurance, multiple principal-agent relationships with misaligned incentives, and externalities from unwarranted price variation and discrimination. These health care market failures invite a regulatory solution. An array of legal and policy solutions are typically advanced to control our health care prices and spending, including: (1) market solutions that focus on transparency and consumerism to discipline health care prices; (2) antitrust enforcement to promote competition in the provider market; (3) consumer protections that protect individual uninsured or underinsured patients from unfair prices; (4) health care payment and delivery reforms that alter financial incentives of health care providers to reduce overutilization and improve efficiency; and (5) regulation of provider payment rates. The literature on these health care policy approaches reflects the fragmentation of the U.S. health care system, typically considering each approach in isolation, and it is difficult to make sense of an a la carte menu of approaches. This Article sets forth an analytic framework to simultaneously and comprehensively evaluate all the policy solutions to discipline health care prices by measuring each solution for its ability to address the health care market failures. Applying this policy-against-market-failure analysis leads to the following conclusion: only one solution—rate regulation—is capable of addressing the widespread and growing provider monopoly problem. More politically popular market approaches such as price transparency and payment and delivery reforms can correct the market failures from information asymmetries and principal-agent problems, but because they do not address the market power of providers, they will be ineffective to control health care prices and spending without accompanying rate regulation. 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.

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INTRODUCTION

In the United States we spend considerably more on health care than any other wealthy, developed country whether measured as a percentage of GDP or on a per capita basis.¹ According to health economists, the explanation of our excess health care spending is: “It’s the prices, stupid.”² We spend more in the United States on health care because our health care prices are high. That may sound like a tautology, but it is not.³ Higher health care expenditures in the United States might alternatively be explained by higher consumption, that we are sicker or fatter than our counterparts in Europe or Asia, that we have more defensive medicine as a result of our malpractice system, or that we have higher administrative costs from our fragmented and complicated system of providers and payers.⁴ However, none of these factors sufficiently explain our excess health care spending.⁵ The story of our unchecked health care spending in the United States is a story about high and undisciplined prices.⁶ The price dynamics of our health care system are epitomized by the chaotic and complex pricing system for hospital services, which are an outsized exemplar of the larger pricing problem in U.S. health care.

The nonsystem for hospital pricing is particularly bewildering when observed on the level of the individual patient. Hospital services are among the most expensive things we will buy in our lifetime, but we do not shop for hospital care like any other similarly large purchase, such as

1. Luca Lorenzoni et al., *Health-Care Expenditure and Health Policy in the USA Versus Other High-Spending OECD Countries*, 384 LANCET 83, 83 (2014).

2. Gerard F. Anderson et al., *It’s The Prices, Stupid: Why The United States Is so Different From Other Countries*, 22 HEALTH AFF. 89, 103 (2003).

3. In the health care context, the terms “price,” “spending,” “cost,” and “charge” have different and often confused meanings. In this Article, *health care prices* are the amounts a provider expects to be paid by payers and patients for the items and services rendered; *health care spending* is the amount of expenditures by public (government) and/or private households or institutions on health care goods and services; *health care costs* are the direct and indirect input costs to the provider incurred to deliver the health care services to the patients; and *charges* are the rates the provider sets for a given item or service before any negotiated or governmental discounts. See HEALTHCARE FIN. MGMT. ASS’N, PRICE TRANSPARENCY IN HEALTH CARE: REPORT FROM THE HFMA PRICE TRANSPARENCY TASK FORCE 5–7 (2014); ORG. FOR ECON. CO-OPERATION AND DEV., OECD FACTBOOK 2011–2012: ECONOMIC ENVIRONMENTAL AND SOCIAL STATISTICS (2011), <http://www.oecd-ilibrary.org/sites/factbook-2011-en/12/03/03/index.html?ns/Chapter&itemId=/content/chapter/factbook-2011-112-en> (defining health expenditure).

4. Gerard F. Anderson et al., *Health Spending in the United States and the Rest of the Industrialized World*, 24 HEALTH AFF. 903, 904 (2005); Hamilton Moses III et al., *The Anatomy of Health Care in the United States*, 310 JAMA 1947, 1949 (2013).

5. U.S. health care spending is “excess” in the sense that it exceeds the amount that one would expect the United States to spend given its wealth in comparison to other OECD countries. Based on national income and health spending in other OECD countries, analysts would expect the United States to spend about eleven percent of GDP on health care (or \$4849 per capita), far less than the more than seventeen percent of GDP (or nearly \$8000 per capita) than it does spend. David Squires, *Explaining High Health Care Spending in the United States: An International Comparison of Supply, Utilization, Prices, and Quality*, 10 COMMONWEALTH FUND, May 2012, at 3.

6. Anderson et al., *supra* note 2, at 103.

a house, a car, or a college degree. Hospital prices are not just high; they are almost completely impenetrable and senseless to the patient-consumer, characterized by extreme variation, price discrimination, opacity, and complexity.⁷ Most hospitals will not (or cannot) reveal the price of an MRI, hip replacement, or any other hospital service until they have already delivered the care and the bill.⁸ The same service may cost a fraction of the price at a hospital just a few miles away.⁹ The price patients are charged depends on who is paying and the hospital's market power, not its costs or quality.¹⁰ If the patient is paying for the hospital care out-of-pocket, she may pay double what an insurance company would pay, and three times what Medicare pays.¹¹ Many individuals go bankrupt, lose their homes to liens or foreclosure, have their wages seized, or their credit damaged as a result of unaffordable hospital bills and aggressive debt collection practices.¹² The chaos and lack of restraint in hospital pricing creates enormous personal and systemic harms as both prices and patients' share of their health care costs rise. The problems of excess U.S. health care spending and the bewildering individual experience of hospital billing stem from a failure of markets to discipline prices in the health care system.

The market for health care services is beset by features of market failure.¹³ The U.S. health care system is characterized by information

7. Erin C. Fuse Brown, *Irrational Hospital Pricing*, 14 Hous. J. Health L. & Pol'y 11, 15–29 (2014).

8. Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, 25 HEALTH AFF. 57, 64–66 (2006).

9. OFFICE OF INFO. PRODS. AND DATA ANALYTICS, THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, MEDICARE FEE-FOR SERVICE PROVIDER UTILIZATION AND PAYMENT DATA INPATIENT PUBLIC USE FILE: A METHODOLOGICAL OVERVIEW 3 (2014), <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Inpatient.html>; accord Editorial, *The Murky World of Hospital Prices*, N.Y. TIMES (May 16, 2013), <http://www.nytimes.com/2013/05/17/opinion/the-murky-world-of-hospital-prices.html>; Sarah Kliff & Dan Keating, *One Hospital Charges \$8,000 — Another, \$38,000*, WASH. POST WONKBLOG (May 8, 2013, 12:01 AM), <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/05/08/one-hospital-charges-8000-another-38000/>.

10. OFFICE OF THE ATT'Y GEN. MARTHA COAKLEY, EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS PURSUANT TO G.L. C. 118G, § 61/2(B): REPORT FOR ANNUAL PUBLIC HEARING 3, 16–27 (2010), <http://www.mass.gov/ago/docs/healthcare/2010-hcctd-full.pdf> [hereinafter MASSACHUSETTS AG 2010 REPORT].

11. See Reinhardt, *supra* note 8, at 62; Gerard Anderson, *From 'Soak the Rich' To 'Soak the Poor': Recent Trends in Hospital Pricing*, 26 HEALTH AFF. 780, 781 (2007).

12. Melissa B. Jacoby & Elizabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 NW. U. L. REV. 535, 548–49 (2006); Christopher Tarver Robertson et al., *Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures*, 18 HEALTH MATRIX 65, 66–68 (2008).

13. See, e.g., *Competition in the Healthcare Marketplace: Hearing Before the Subcomm. On Consumer Protection, Prod. Safety & Ins. of the S. Comm. on Commerce, Sci., & Trans.*, 111th Cong. 15 (2009) (statement of Len M. Nichols, Dir., Health Policy Program, New America Foundation); Thomas L. Greaney, *Chicago's Procrustean Bed: Applying Antitrust Law in Health Care*, 71 ANTITRUST L.J. 857, 862–63 (2004); Bruce C. Vladeck & Thomas Rice, *Market Failure and the Failure of Discourse: Facing up to the Power of Sellers*, 28 HEALTH AFF. 1305, 1306 (2009); Bruce C. Vladeck,

asymmetries where price and quality information are virtually undiscoverable to patients; noncompetitive markets in which providers with market power charge supracompetitive, monopoly prices; moral hazard created by third-party financing of health care; principal-agent problems arising from the web of intermediaries standing between a patient and her health care; and financial and health-related externalities from unmanageable medical debt that are borne by individuals and society as a whole. Of these, the single most important factor driving our health care pricing problem is a noncompetitive provider market.

The failure of the market for health care services invites regulatory intervention, and there is an array of legal and policy solutions policymakers may pursue to control health care prices and spending. These solutions fall into several categories: (1) market solutions that focus on consumerism, price competition, and transparency to discipline health care prices; (2) antitrust enforcement to protect competition in the provider market; (3) health care payment and delivery reforms that alter financial incentives of providers to reduce overutilization and improve efficiency; (4) consumer protections that protect financially vulnerable patients from unconscionable prices and onerous debt collection practices; and (5) rate regulation in the form of all-payer rate setting, price caps, or global budgets.

Considerable scholarship from health law and policy literature, as well as health economics, delve into the evaluation of some of these approaches to solve our health care pricing and spending problem. The literature, however, reflects the fragmentation and complexity of our health care system¹⁴ because each study tends to focus on individual solutions in isolation, such as evaluations of health care price transparency,¹⁵ recommendations for accountable care organizations (“ACOs”),¹⁶ critiques

Paradigm Lost: Provider Concentration and the Failure of Market Theory, 33 HEALTH AFF. 1083, 1083 (2014).

14. See, e.g., THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS 3–6 (Einer Elhauge ed., 2010).

15. See David Cutler & Leemore Dafny, *Designing Transparency Systems for Medical Care Prices*, 364 N. ENG. J. MED. 894 (2011); Morgan A. Muir et al., *Clarifying Costs: Can Increased Price Transparency Reduce Healthcare Spending?*, 4 WM. & MARY POL’Y REV. 319 (2013); Anna D. Sinaiko & Meredith B. Rosenthal, *Increased Price Transparency in Health Care—Challenges and Potential Effects*, 364 N. ENG. J. MED. 891 (2013); Andrew Steinmetz & Ezekiel Emanuel, *What Does a Hip Replacement Cost? The Transparency Imperative in 2013*, 173 JAMA INTERNAL MED. 432 (2013); Peter A. Ubel, *Can Patients in the United States Become Savvy Health Care Consumers?*, 92 N.C. L. REV. 1749 (2014).

16. See, e.g., Rudy Douven et al., *Avoiding Unintended Incentives in ACO Payment Models*, 34 HEALTH AFF. 143, 143–47 (2015); see Elliott S. Fisher et al., *A Framework for Evaluating the Formation, Implementation, and Performance of Accountable Care Organizations*, 31 HEALTH AFF. 2368 (2012); Thomas L. Greaney, *Regulators as Market-Makers: Accountable Care Organizations and Competition Policy*, 46 ARIZ. ST. L.J. 1 (2014).

of health care antitrust enforcement,¹⁷ or analysis of contract-based approaches to control health care prices.¹⁸

This Article is the first to consider all the policy approaches simultaneously and comprehensively, using one overarching analytic framework. Using this framework, this Article systematically evaluates the viability of each of the policy solutions to discipline health care prices by assessing the degree to which each strategy addresses the various health care market failures. This policy-against-market-failure approach reveals each policy's relative strengths and blind spots, and the comprehensive consideration of all of the approaches together tells a story of a dynamic system where fixing one market failure may exacerbate others, and ultimately undermine the goals of restraining health care prices and spending. It is critical for policymakers to consider the dynamic interplay between the different market failures and menu of solutions to craft a legal or policy approach that actually has a chance of correcting a failed market of the size, complexity, and importance of the U.S. health care system.

In applying the policy-against-market-failure framework, this Article accepts each of the legal and policy solutions to control health care prices on its merits, construing each solution in a light most favorable to the proponents who typically advance the policy. The conclusions from the analysis are sobering. When evaluating the strategies to control health care prices for their ability to address market failures, all except rate regulation fall short when applied to noncompetitive health care provider markets. In particular, the policy approaches that are most politically popular—market approaches and payment and delivery reforms—will not control health care prices in concentrated markets. For the increasing preponderance of noncompetitive health care provider markets, the only policy capable of addressing the market power of providers is rate regulation, because no amount of competitive pressure will create choices for consumers where none exist. The primary conclusion of this analysis is that for the vast majority of jurisdictions with concentrated provider markets, health care rate regulation must be a central part of any

17. David M. Cutler & Fiona Scott Morton, *Hospitals, Market Share, and Consolidation*, 310 JAMA 1964, 1968–69 (2013); Thomas L. Greaney, *Night Landings on an Aircraft Carrier: Hospital Mergers and Antitrust Law*, 23 AM. J.L. & MED. 191, 192–200 (1997); Clark C. Havighurst & Barak Richman, *The Provider Monopoly Problem in Health Care*, 89 OR. L. REV. 847, 868–71 (2011); Barak D. Richman, *Antitrust and Nonprofit Hospital Mergers: A Return to Basics*, 156 U. PA. L. REV. 121, 140–48 (2007).

18. See Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643 (2008); Barak D. Richman et al., *Overbilling and Informed Financial Consent — A Contractual Solution*, 367 N. ENG. J. MED. 396 (2012); Carl E. Schneider & Mark A. Hall, *The Patient Life: Can Consumers Direct Health Care?* 35 AM. J.L. & MED. 7 (2009).

policy strategy to control health care spending. The analytic framework and this conclusion are summarized visually in Figure 1, set forth below.

FIGURE 1: POLICY SOLUTIONS MEASURED AGAINST HEALTH CARE MARKET FAILURES

Market Imperfection	Market Solutions (CDHC, transparency, reference pricing, tiering)	Antitrust	Payment & Delivery Reforms (ACOs, bundling)	Consumer Protections (contract enforcement, fair pricing laws)	Rate Regulation (all-payer rate setting, global budgets, caps on prices)
Information Asymmetry	☑	--	☑	--	☑
Monopoly/ Concentrated Market	--	☑ (but cannot address extant monopoly)	-- (increases concentration)	--	☑
Moral Hazard	☑	--	--	--	--
Principal-Agent	--	--	☑	--	--
Externalities	--	--	--	☑	☑

The second conclusion from this policy-against-market-failure analysis is that no single solution or approach is sufficient to address all the market failures, and a combination of approaches is necessary to correct the manifold health care market imperfections. What this means is that for noncompetitive provider markets, rate regulation should be augmented by payment and delivery reforms, because rate setting alone will not address the principal-agent problem of demand inducement by physicians and overutilization of health care. Noncompetitive markets could also benefit from the infusion of market forces to reward high-quality and high-value hospitals and ensure adequacy of supply of needed services.

Part I describes the failures of the market for health care services. Part II sets forth the range of legal and policy solutions typically offered to discipline health care costs, and uses the policy-against-market-failure framework to evaluate each solution for its effectiveness at addressing

the various market failures. Part III then discusses the main conclusions from the comprehensive analysis and implications for choosing which policy solutions to deploy in a particular health care market to discipline prices in that market.

I. HEALTH CARE PRICES AND MARKET FAILURE

Health care prices in the United States are excessive and inexplicable, and they matter tremendously to any effort to control our health care spending. Health care spending consumes more than seventeen percent of our GDP.¹⁹ Inpatient and outpatient hospital prices are the largest contributors to excess spending in U.S. health care.²⁰ Moreover, high prices are the main reason we spend so much more in the United States for health care than other wealthy and developed countries, whether measured per capita or as a percentage of the economy.²¹ For the higher prices we pay, we do not get more or better quality care or better health outcomes.²² Health care prices account for most of the growth in U.S. health care spending, eclipsing the effects of increasing utilization, the aging or sickness of the population, the supply of health care services, or malpractice litigation and defensive medicine.²³ Hospital prices are a key driver of the larger health care pricing problem in the United States, and the lack of market discipline of hospital prices is a prominent manifestation of what is wrong with the health care market as a whole.

Evidence of the market failure for hospital services is borne out in what we can observe of the unwarranted variations in hospital prices. In a functioning market, price variations would relate to differences in costs,

19. CTRS. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH EXPENDITURES 2013 HIGHLIGHTS (2013), <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf> (noting that in 2013, national health expenditures in the United States comprised 17.4% of the gross domestic product, totaling \$2.9 trillion or \$9255 per person).

20. Anderson et al., *supra* note 2, at 101; Lorenzoni et al., *supra* note 1, at 89 (“Higher health sector prices explain much of the difference between the USA and other high-spending countries.”); DIANA FARRELL ET AL., MCKINSEY GLOBAL INST., ACCOUNTING FOR THE COST OF US HEALTH CARE: A NEW LOOK AT WHY AMERICANS SPEND MORE 13–19, 21 (2008) (estimating, in 2008, that the United States spends \$650 billion more on health care than would be expected for a country with its wealth, with inpatient and outpatient costs accounting for \$476 billion, or seventy-three percent of the excess spending).

21. Anderson et al., *supra* note 2, at 103; Vladeck & Rice, *supra* note 13, at 1305–06.

22. See Vladeck & Rice, *supra* note 13, at 1306.

23. Anderson et al., *supra* note 4, at 904 (“We conclude that supply constraints and waiting lists do not appear to translate into significant savings in other countries and that malpractice and defensive medicine are responsible for only a small portion of the U.S. spending differential.”); Moses et al., *supra* note 4, at 1949 (“Between 2000 and 2011, increase in price (particularly of drugs, medical devices, and hospital care), not intensity of service or demographic change, produced most of the increase in health’s share of GDP.”).

quality, the sickness of the population, or patient preferences.²⁴ Instead, variations in hospital prices are dictated by market power of the hospital, not the hospital's costs, payer mix, quality, or whether it is a teaching hospital.²⁵ Hospitals routinely engage in price discrimination, charging different prices to different payers for the same service.²⁶ Hospital price discrimination is inefficient because the highest prices are charged to those with the least bargaining power and ability to pay, such as the uninsured or out-of-network patient. This health care price discrimination differs from the price discrimination practices in other industries like airlines or hotels, which are calibrated according to willingness to pay.²⁷ Indeed, the market for hospital services is rife with features of market failure: information asymmetries, noncompetitive markets, moral hazard, principal-agent problems, and externalities.

A. INFORMATION ASYMMETRY

The health care market overall, and the more limited market for hospital services, are shot through with information asymmetries. Kenneth Arrow famously identified information asymmetry in the form of “uncertainty in the incidence of disease and in the efficacy of treatment” as the primary reason for the health care market's departure from the neoclassical competitive model.²⁸ Health care information regarding diagnosis or treatment options is so specialized, the theory goes, that the patient lacks the information to assess the quality, cost, and nature of health care necessary to make a purchasing choice.²⁹

The information asymmetry problem goes beyond assessing the efficacy of a particular treatment. For hospital care, many informational deficits accumulate: the patient typically lacks the clinical knowledge to identify the items and services she will need; the price is nearly always inaccessible until after the service is rendered;³⁰ the quality of the hospital

24. PAUL B. GINSBURG, CTR. FOR STUDYING HEALTH SYS. CHANGE, WIDE VARIATION IN HOSPITAL AND PHYSICIAN PAYMENT RATES EVIDENCE OF PROVIDER MARKET POWER 6 (2010).

25. See MASSACHUSETTS AG 2010 REPORT, *supra* note 10, at 3.

26. Uwe Reinhardt, Commentary, *The Many Different Prices Paid to Providers and the Flawed Theory of Cost Shifting: Is It Time for a More Rational All-Payer System?*, 30 HEALTH AFF. 2125, 2128–29 (2011).

27. N.J. COMM'N ON RATIONALIZING HEALTH CARE RES., N.J. DEP'T OF HEALTH, FINAL REPORT 92–93 (2008).

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

29. See David Dranove & Mark A. Satterthwaite, *The Industrial Organization of Health Care Markets*, in 1B HANDBOOK OF HEALTH ECONOMICS 1093, 1095 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000).

30. Jaime Rosenthal et al., *Availability of Consumer Prices from US Hospitals for Common Surgical Procedure*, 173 JAMA INTERNAL MED. 427 (2013) (finding that only sixteen percent of hospitals studied could provide a full price quote for a total hip replacement for a fictitious sixty-two-year-old uninsured grandmother).

and various clinicians involved in the care (such as experience and track record or hospital error or infection rate) is notoriously difficult to measure and compare;³¹ and patients rarely are aware of the financial incentives for physicians involved in their care to order certain items or services or refer to particular providers.³² All of this information would be necessary for a patient to make informed health care decisions.

Patients simply have inadequate information about the substance, quality, cost, and provider incentives to make informed choices about consuming hospital services. Information asymmetry with high search costs continues to drive market failure for hospital services.

B. NONCOMPETITIVE PROVIDER MARKETS

Monopolies and excessive market power are another type of market failure that plagues health care provider markets.³³ Loss of competition in health care is probably the most important driver of our health care pricing problem. Hospital markets in the United States are highly concentrated and are getting increasingly noncompetitive.³⁴ To measure the competitiveness of a given health care market, antitrust agencies and economists use the Herfindahl-Hirschman Index (“HHI”).³⁵ Under this measure, half of all hospital markets in the United States are considered highly concentrated, and no hospital market is highly competitive.³⁶ The vast majority of large metropolitan areas in the United States have a highly concentrated hospital market,³⁷ meaning most of the population lives in a noncompetitive market. The problem is worse in many rural areas, where hospitals have few if any competitors.³⁸ The typical hospital market is noncompetitive: it has one dominant hospital system and two to three smaller systems that

31. Reinhardt, *supra* note 8, at 65–66 (noting that information on price and quality are rarely available to the patient).

32. Greaney, *supra* note 13, at 864.

33. See Vladeck & Rice, *supra* note 13, at 1306.

34. See Cutler & Scott Morton, *supra* note 17, at 1966.

35. HHI is the sum of the squared market share of each hospital or hospital system in a given market multiplied by 10,000. Market share is calculated as proportional share of inpatient admissions or patient days possessed by a hospital relative the rest of the market. Thus, a market with only one hospital (a pure monopoly) would have an HHI of 10,000 and a market with two hospitals (a duopoly) would have an HHI of 5000. Typically, a market is considered “highly concentrated” if the HHI is greater than 2500, which means there are about four equal sized hospital owners in a given market. A market is “moderately concentrated” if its HHI is between 1500 and 2500. *Herfindahl-Hirschman Index*, U.S. DEP’T OF JUST., <http://www.justice.gov/atr/public/guidelines/hhi.html> (last updated July 29, 2015).

36. See Cutler & Scott Morton, *supra* note 17, at 1966.

37. STEPHEN ZUCKERMAN & JOHN HOLAHAN, URBAN INST. HEALTH POLICY CTR., *DESPITE CRITICISM, THE AFFORDABLE CARE ACT DOES MUCH TO CONTAIN COSTS 2* (2012), <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412665-Despite-Criticism-The-Affordable-Care-Act-Does-Much-to-Contain-Health-Care-Costs.PDF> (noting that as of the mid-2000s, eighty-eight percent of hospital markets in large metropolitan areas is highly concentrated).

38. See Ginsburg, *supra* note 24, at 3.

together account for a large preponderance of hospital admissions in the area.³⁹ The concentration of hospital markets has been increasing over time, with an ongoing wave of hospital mergers resulting in horizontal concentration, and hospital acquisitions of physician groups resulting in vertical integration.⁴⁰

The excessive concentration found in the provider market drives up prices to supracompetitive levels.⁴¹ Empirical studies have demonstrated that increasing concentration in hospital markets significantly raises hospital prices, by some estimates as much as twenty percent to forty percent.⁴² In concentrated markets, “must-have” hospitals have significantly more bargaining power than health insurers because the health plan needs the hospital to satisfy its individual and employer-customers and to provide sufficient access to necessary services.⁴³ Hospitals with market power can resist health insurers’ pressures to constrain prices when they know the insurer cannot walk away from the negotiation.⁴⁴

Hospital markets are also characterized with dramatic variations in price. Within the same geographic area, there can be a sixty percent difference between the highest and lowest priced hospitals for the same inpatient services, and a twofold difference in prices for outpatient services.⁴⁵ Price variations in the hospital market are driven largely by differences in market share and cannot be explained by differences in the hospitals’ costs, quality, the sickness of the patients, or whether the hospital is an

39. See Cutler & Scott Morton, *supra* note 17, at 1966.

40. *Id.* (“The extent of hospital concentration has increased over time. The hospital HHI has increased by [forty percent] since the mid-1980s, changing from a market with on average [five] independent firms (there were [more than five] independent hospitals, but approximately [five] major ones) to a market with approximately [three] independent firms.”)

41. MARTIN GAYNOR & ROBERT TOWN, ROBERT WOOD JOHNSON FOUND., *THE IMPACT OF HOSPITAL CONSOLIDATION—UPDATE I* (2012), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261; Glenn A. Melnick, Yu-Chu Shen & Vivian Yaling Wu, *The Increased Concentration of Health Plan Markets Can Benefit Consumers Through Lower Hospital Prices*, 30 HEALTH AFF. 1728, 1731 (2011).

42. GAYNOR & TOWN, *supra* note 41, at 2 (“The magnitude of price increases when hospitals merge in concentrated markets is typically quite large, most exceeding 20 percent.”); Martin Gaynor, *Competition Policy in Health Care Markets: Navigating the Enforcement and Policy Maze*, 33 HEALTH AFF. 1088, 1089 (2014) (“Hospital mergers that create a dominant system can lead to very large price increases, even as high as 40–50 percent.”); Leemore S. Dafny, *Estimation and Identification of Merger Effects: An Application to Hospital Mergers*, 52 J.L. & ECON. 523, 544 (2009).

43. CHAPIN WHITE, AMELIA M. BOND & JAMES D. RESCHOVSKY, CTR. FOR STUDYING HEALTH SYS. CHANGE, *HIGH AND VARYING PRICES FOR PRIVATELY INSURED PATIENTS UNDERSCORE HOSPITAL MARKET POWER 2* (2013), <http://www.hschange.com/CONTENT/1375/1375.pdf>; 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, 973 (2012).

44. See Robert A. Berenson et al., *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, 29 HEALTH AFF. 699, 702 (2010).

45. White et al., *supra* note 43, at 4.

academic medical center.⁴⁶ In other words, when we pay more at a high-price hospital, we are not getting more or better care. Rather, we are simply paying for the hospital's monopoly rents.⁴⁷

Barriers to entry for new competitors exacerbate the problem of hospital market concentration. State certificate of need ("CON") laws were originally designed to control supply of health care services in an effort to control spending.⁴⁸ However, CON laws pose barriers to entry, making it difficult or impossible for new competitors to enter a market.⁴⁹ CON laws persist in more than two-thirds of states,⁵⁰ but even in states without CON laws, state licensure, accreditation, and certification to participate in Medicare and Medicaid, make it difficult for competitors to enter the market.⁵¹ It is much easier for an existing hospital to buy up and merge with its competitors than it is to open a new hospital.

The current landscape reveals a hospital market that is highly concentrated and trending toward more consolidation of market power among the large hospital systems. Although localities vary in their degree of concentration, in most of the United States, hospital markets are failing due to a lack of competition.

C. MORAL HAZARD AND THIRD PARTY PAYMENT

The uncertainty of illness or accident and the expense of acute medical care leads most people to finance their health care through third party insurance.⁵² The presence of the third party payer can lead to moral hazard, another feature of market failure, where individuals consume more health care than they would if they had to bear the full costs of health care.⁵³ Even if an individual knows her excess use of health care

46. MASSACHUSETTS AG 2010 REPORT, *supra* note 10, at 2; Joseph P. Newhouse & Alan M. Garber, *Geographic Variation in Health Care Spending in the United States: Insights from an Institute of Medicine Report*, 310 JAMA 1227, 1227–28 (2013) (“[P]rice variation is responsible for an estimated 70% of the total geographic variation in spending among privately insured persons. Variation in wage levels and variation in the quantity of services delivered are almost equally responsible for the remaining estimated 30% of spending variation.”).

47. See, e.g., Paul Krugman, *Profits Without Production*, N.Y. TIMES (June 21, 2013), <http://www.nytimes.com/2013/06/21/opinion/krugman-profits-without-production.html> (defining monopoly rents as “profits that don’t represent returns on investment, but instead reflect the value of market dominance”).

48. *Certificate of Need: State Health Laws and Programs*, NAT’L CONF. ST. LEGISLATURES, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx#Program> (last visited Dec. 18, 2015).

49. Gaynor, *supra* note 42, at 1090–91; William M. Sage, *Getting the Product Right: How Competition Policy Can Improve Health Care Markets*, 33 HEALTH AFF. 1076, 1080 (2014).

50. *Certificate of Need: State Health Laws and Programs*, *supra* note 48 (identifying, as of 2011, thirty-six states with active CON law or program, twenty-eight of which regulate acute hospital beds).

51. See Greaney, *supra* note 13, at 865; Vladeck & Rice, *supra* note 13, at 1307.

52. See Arrow, *supra* note 28, at 945.

53. See Mark Pauly, Comment, *The Economics of Moral Hazard*, 58 AM. ECON. REV. 531, 533–35 (1968).

services will result in increased health insurance premiums, the magnitude of her gain from the additional services is greater than the premium increase, which is spread across all policyholders.⁵⁴ The tax subsidy that employers receive to provide health insurance for employees exacerbates this moral hazard by allowing more insurance to be purchased than would be with after-tax dollars.⁵⁵ One correction to moral hazard is to impose price rationing at the point of service in the form of individual cost-sharing through copays, coinsurance, or deductibles.⁵⁶

In the case of hospital care, it is particularly difficult to strike the balance between the overconsumption from moral hazard and underconsumption of necessary care by those who cannot afford it. Most hospital stays are so expensive that even modest coinsurance rates can make hospital care unaffordable to most people, which may be one reason the Affordable Care Act places a limit on annual out-of-pocket expenses.⁵⁷ Because hospital treatment is so expensive, it is likely to exceed an individual's annual deductible and the statutory out-of-pocket limit, which protects the patient from financial risk, but makes her insensitive to hospital costs above the deductible.⁵⁸ Health insurance may also exacerbate the market failure from hospital monopolies—by shielding individuals from prices, insurance allows monopolist hospitals to charge even more than the price that would be enabled by the monopoly.⁵⁹

Some have questioned the degree to which moral hazard produces inefficiency in health care.⁶⁰ In the case of treatment for serious illness characteristic of acute hospital care, it is far from clear how much additional health care is consumed because of insurance coverage.⁶¹ Almost no one would elect to undergo unnecessary major surgery simply

54. *Id.* at 534.

55. See Mark Pauly, *Taxation, Health Insurance, and Market Failure in the Medical Economy*, 24 J. ECON. LIT. 629, 641 (1986).

56. See JOSEPH P. NEWHOUSE & THE INSURANCE EXPERIMENT GROUP, FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT 40–42 (1986); Pauly, *supra* note 53, at 534.

57. Patient Protection and Affordable Care Act § 1302(c), 42 U.S.C. § 18022(c)(2010); see also Allison K. Hoffman, *Health Care Spending and Financial Security after the Affordable Care Act*, 92 N.C. L. REV. 101, 121 (2014).

58. ANN TYNAN ET AL., CTR. FOR STUDYING HEALTH SYS. CHANGE, A HEALTH PLAN WORK IN PROGRESS: HOSPITAL-PHYSICIAN PRICE AND QUALITY TRANSPARENCY 7 (2008); James C. Robinson & Kimberly MacPherson, *Payers Test Reference Pricing and Centers of Excellence to Steer Patients to Low-Price and High-Quality Providers*, 31 HEALTH AFF. 2028, 2029 (2012).

59. Havighurst & Richman, *supra* note 17, at 863.

60. John A. Nyman, *Is Moral Hazard Inefficient? The Policy Implications of a New Theory*, 23 HEALTH AFF. 194, 196 (2004).

61. *Id.* Contrast this with the known waste and welfare loss that results from excess care that is ordered because of principal-agent problems, discussed *infra* in Part I.D.

because insurance covers it.⁶² Thus, cost-sharing strategies to control health care prices by targeting moral hazard may have reduced value or effect, especially for hospital services. Nevertheless, the existence of third-party financing does make individuals less sensitive to price differences among hospitals or providers, which dampens incentives for providers to compete on price.

In sum, hospital prices are so high that we need insurance to finance even ordinary hospital services, but the presence of insurance creates moral hazard by shielding patients from the costs of their own care and making them insensitive to price signals. Consumers who are insensitive to price are less likely to impose market pressure on hospitals to constrain costs or prices. In this manner, moral hazard contributes to the market failure for health care services. However, as among the various health care market failures, moral hazard may be a less serious problem than others, such as provider monopolies, information asymmetry, or principal-agent problems.

D. PRINCIPAL-AGENT PROBLEMS

Hospital markets also suffer from principal-agent problems. Agency problems lead to inefficient economic results when the agent makes decisions on behalf of the principal, but the agent's interests are misaligned with that of the principal.⁶³ Tim Greaney described the "triple-agency" problem that arises between the patient, physician, and payer in many health care transactions.⁶⁴ For hospital services, the hospital is yet another party, creating a quadruple-agency web of relations between the hospital, physician(s), patient, and payer. Worse, for most nonelderly patients in the United States, there is a quintuple-agency relationship, when you add the employer who purchases the insurance on behalf of the individual.

The classic principal-agent relationship in health care is the physician-patient relationship.⁶⁵ It is well-documented that physicians' medical decisions on behalf of their patients are often influenced by financial incentives, practice habits, and norms that may be at odds with

62. *Id.* at 197–98 (“[F]ew if any people would frivolously choose to endure coronary bypass surgery just because the price had dropped to zero. Therefore, imposing any coinsurance payment (let alone a 50 percent copayment) on the patient with coronary heart disease to limit . . . her purchases of bypass procedures simply does not make sense. Insurance contracts should be restructured so that this type of care is completely covered.”).

63. Paul A. Pautler & Michael G. Vita, *Hospital Market Structure, Hospital Competition, and Consumer Welfare: What Can the Evidence Tell Us?*, 10 J. CONTEMP. HEALTH L. & POL’Y 117, 120 (1994).

64. Thomas L. Greaney, *Economic Regulation of Physicians: A Behavioral Economics Perspective*, 53 ST. LOUIS U. L.J. 1189, 1191 (2009).

65. Pautler & Vita, *supra* note 63, at 120; Vladeck & Rice, *supra* note 13, at 1306–07.

the patients' interests in obtaining the appropriate care at the right price.⁶⁶ Physicians have legal and ethical obligations to put their patient's interests first, but they have a difficult time ascertaining what the patient's interests are.⁶⁷ And even though cost is a significant concern to many patients, physicians generally do not know the price of the items and services they prescribe, so they cannot guide a patient to a cost-effective choice.⁶⁸

In the context of hospital services, the physician often stands between the patient and the hospital, being the one to order as well as perform the hospital service. Physicians drive demand for services, such that it is often quipped that the most expensive piece of equipment in the hospital is the doctor's pen.⁶⁹ The principal-agent problem between the physician and the patient is exacerbated by the incentives created by the way we pay for health care, which generally rewards ordering more services and more complex, highly paid services.⁷⁰ Thus, the practical manifestation of the principal-agent problem in health care is a push toward overutilization of health care.

The physician may be both the agent of the hospital (as an employee or contractor) and of the patient, with misaligned incentives existing between all three. For example, Medicare's differing payment methodologies for hospitals (based on a lump sum payment) and physicians (based on fee-for-service) creates an inherent tension between providing less care or more care.⁷¹ Nevertheless, hospitals need physicians to maintain their business, both to perform services and to drive patient volume through referrals. To attract a physician's "book of business," hospitals bend over backwards to attract and curry favor with physicians, often competing for physician referrals more than they

66. See Greaney, *supra* note 64, at 1199–1200.

67. See E. Haavi Morreim, *A Dose of Our Own Medicine: Alternative Medicine, Conventional Medicine, and the Standards of Science*, 31 J.L. MED. & ETHICS 222, 222–25 (2003).

68. See Kanu Okike et al., *Survey Finds that Few Orthopedic Surgeons Know the Cost of the Devices They Implant*, 33 HEALTH AFF. 103, 103 (2014).

69. See, e.g., Atul Gawande, *The Cost Conundrum*, NEW YORKER, June 1, 2009, at 36, 43 (“Health-care costs ultimately arise from the accumulation of individual decisions doctors make about which services and treatments to write an order for. The most expensive piece of medical equipment, as the saying goes, is a doctor’s pen.”).

70. See, e.g., Robert Murray, *Maryland’s Bold Experiment in Reversing Fee-for-Service Incentives*, HEALTH AFF. BLOG (Jan. 28, 2014), <http://healthaffairs.org/blog/2014/01/28/marylands-bold-experiment-in-reversing-fee-for-service-incentives/>.

71. For inpatient care, Medicare pays hospitals a lump sum payment based on diagnosis under the Medicare Severity-Adjusted Diagnostic Related Group (“MS-DRG”), which puts financial pressure on the hospital to use fewer resources and discharge the patient sooner for a given admission. The physicians who perform the “professional component” of the hospital services are separately paid on a fee-for-service basis, which provides incentives to order more tests and services. See Fuse Brown, *supra* note 7, at 56; Greaney, *supra* note 16, at 15; Uwe E. Reinhardt, *How Medicare Sets Hospital Prices: A Primer*, N.Y. TIMES ECONOMIX (Nov. 26, 2010, 6:00 AM), <http://economix.blogs.nytimes.com/2010/11/26/how-medicare-sets-hospital-prices-a-primer/>.

compete on price through generous compensation and upgrades in equipment and facilities.⁷² The patient's interests and values are quickly lost in the complicated forces and powerful interests pushing care decisions.⁷³

Further complicating this web of agency relationships are the payers and employer-purchasers of health insurance. Just as the patient relies on the physician to make diagnostic and treatment decisions, the patient also relies on the third-party payer to negotiate prices with the provider and evaluate provider price and quality.⁷⁴ The interests of the health insurance plan, attracting customers, and ensuring medical claims do not exceed premium revenue, often run against those of the patient-enrollee.⁷⁵ And for the majority of nonelderly Americans, the employer acts further as an agent by purchasing health insurance for employees. The employer has dampened incentives to bargain aggressively with providers because of the employer's ability to pass on higher prices to employees in the form of reduced wages and higher premiums.⁷⁶ Each agent has incomplete information about the patient's preferences and has financial incentives that may be contrary to the interests of the patient.

The quadruple or quintuple-agency problem creates barriers to efficient purchasing and selling of hospital services. It is nearly impossible for the patient's interests to be served effectively when hospitals view physicians and payers, not patients, as their primary

72. *United States v. Rockford Mem'l Corp.*, 717 F. Supp. 1251, 1283 (N.D. Ill. 1989) ("Traditionally, hospitals competed on the basis of their attractiveness to physicians. Hospitals recognized that, in most cases, physicians controlled inpatient admissions to hospitals. Consequently, attracting competent physicians became a means to maintain and expand inpatient admissions."), *aff'd*, 898 F.2d 1278 (7th Cir. 1990); see also Peter J. Hammer, *Antitrust Beyond Competition: Market Failures, Total Welfare, and the Challenge of Intramarket Second-Best Tradeoffs*, 98 MICH. L. REV. 849, 864-65 (2000).

73. See, e.g., Albert G. Mulley et al., *Stop the Silent Misdiagnosis: Patients' Preferences Matter*, 345 BMJ 6572 (2012) (describing the problem of misdiagnosis of patient preferences and values in treatment, which leads to excess provision of unwanted treatment).

74. See Paul B. Ginsburg, *Shopping for Price in Medical Care*, 26 HEALTH AFF. W208, W209 (2007); Reinhardt, *supra* note 8, at 61.

75. See C. Paul Wazzan et al., *An Economic Analysis of the Impact of Pay-for-Performance Initiatives on Physicians, Patients and Insurance Providers*, 3 IND. HEALTH L. REV. 357, 358 (2006).

76. Gaynor, *supra* note 42, at 1089 ("[P]rice increases by hospitals are fully passed through to consumers. When prices go up, health insurance premiums go up. When premiums go up, employers simply reduce workers' total compensation dollar for dollar by the amount of the premium increase. This can come in the form of lower pay; increased cost-sharing for premiums; or lower benefits, including dropping coverage entirely in some cases."); Uwe E. Reinhardt, *The Culprit Behind High U.S. Health Care Prices*, N.Y. TIMES: ECONOMIX (June 7, 2013, 12:01 AM), <http://economix.blogs.nytimes.com/2013/06/07/the-culprit-behind-high-u-s-health-care-prices/> ("One reason for the employers' passivity in paying health care bills may be that they know, or should know, that the fringe benefits they purchase for their employees ultimately come out of the employees' total pay package. In a sense, employers behave like pickpockets who take from their employees' wallets and with the money lifted purchase goodies for their employees.")

customers, because physicians and payers drive demand for their services.⁷⁷ Hospitals then make pricing and economic decisions to maximize bargaining leverage over health plans.⁷⁸ As a result, information about price and product are communicated in a way that is impenetrable to the patient, spoken in the disaggregated and incomprehensible language of CPT codes,⁷⁹ DRGs,⁸⁰ case rates, per diems, facility fees, and professional components.⁸¹ For every hospital interaction, the patient may be represented simultaneously and imperfectly by multiple physicians, the health insurer, and employer, and the patient's interests quickly get lost in the complicated web of quadruple or quintuple-agency relationships.

The principal-agent problems in health care are interrelated with both moral hazard and information asymmetry. A person may consume more health care than he would if he were bearing the full cost of the services because the decision to order the services is made by an agent (the physician). Moreover, there is substantial information asymmetry between the principals and agents in health care. An easy example is that the physician might happen to know that an alternative item or service might be similarly effective, but does not tell the patient that the physician has a greater financial incentive to recommend one choice over another. These types of market failures are best thought of as conceptual overlapping categories rather than as crisply defined phenomena. However, it remains useful to think about principal-agent problems in health care as its own category, because the policy interventions to address them may be different than those that address moral hazard or imperfect information.

77. Peter J. Hammer, *Questioning Traditional Antitrust Presumptions: Price and Non-Price Competition in Hospital Markets*, 32 U. MICH. J.L. REFORM 727, 734 (1999) (describing hospital competition for loyalty of physicians for referrals or payers for volume of patients, because both physicians and payers are sources of demand for hospital services).

78. See Anderson, *supra* note 11, at 784–85 (describing hospitals' incentives to inflate charges, including to improve negotiating power against health plans); Berenson et al., *supra* note 43, at 976.

79. CPT codes, or Current Procedural Terminology, are "the most widely accepted medical nomenclature used to report medical procedures and services under public and private health insurance programs." *About CPT®*, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt.page?> (last visited Dec. 18, 2015).

80. DRGs, or Diagnosis-Related Groups, refers to a payment classification system that groups similar clinical conditions by diagnosis and includes all procedures furnished by the hospital during the inpatient stay. Hospitals are paid a fixed rate for all inpatient services according to the DRG assigned to the patient, adjusted for severity and comorbid conditions. See DEP'T OF HEALTH & HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., ACUTE CARE HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM (2013), <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AcutePaymtSysfctsh.pdf>.

81. See Sage, *supra* note 49, at 1077–78.

E. EXTERNALITIES OF IRRATIONAL HOSPITAL PRICES

Elsewhere I have written about the externalities of our current hospital pricing system: the harms imposed on individuals who face unaffordable and incomprehensible hospital bills.⁸² Though hospitals may believe they internalize the costs of uncompensated care by shifting these costs to other payers, there are many costs externalized by the hospital to individual patients and society as a whole. The externalities of excessive hospital prices and harsh debt collection practices include the costs of personal bankruptcy, home foreclosure, wages garnished, legal fees and interest paid, loss of creditworthiness, and self-rationing of necessary items like food, shelter, or medical care.⁸³

Hospital bills are often unaffordably high, especially for the uninsured or underinsured individual.⁸⁴ When a person cannot pay his or her hospital bill, the hospital typically uses aggressive debt collection practices to pursue the debt, including reporting the debt to credit agencies, seeking garnishment of wages, placing a lien on or seeking foreclosure on the patient's home, or assigning the debt to collection agencies that use harsh tactics to hound a person to pay the debt.⁸⁵ Even if the hospital ultimately only collects a small fraction of the debt, the patients suffer significant financial and health-related costs from having an unpaid hospital debt.⁸⁶ The externalities of irrational hospital prices affect a broad range of patients and are not just a problem for the uninsured.⁸⁷ In a 2012 survey, forty-one percent of adults aged nineteen to sixty-four reported they had trouble paying off medical debt, and of

82. See Fuse Brown, *supra* note 7, at 40.

83. See Jacoby & Warren, *supra* note 12, at 548 (estimating that about forty-six percent of personal bankruptcy filers had self-identified a medical reason for their bankruptcy); Melissa B. Jacoby, *The Debtor-Patient: In Search of Non-Debt-Based Alternatives*, 69 BROOK. L. REV. 453, 477 (2004); Melissa B. Jacoby & Mirya Holman, *Managing Medical Bills on the Brink of Bankruptcy*, 10 YALE J. HEALTH POL'Y L. & ETHICS 239, 247 (2010); Katherine Porter, *The Damage of Debt*, 69 WASH. & LEE L. REV. 979, 1006-08 (2012); Robertson et al., *supra* note 12, at 66-68 (concluding from survey data that forty-nine percent of home foreclosures were caused in part by a medical problem, and twenty-three percent were caused by unmanageable medical bills).

84. See Reinhardt, *supra* note 8, at 62.

85. See, e.g., Marsha Austin, *Uninsured Pay Higher Price: Hospital Collection Agents Demand Full Cost of Care*, DEN. POST, Jan. 28, 2003, at 1A (noting that hospitals in the Denver area have sued at least 210 individuals for unpaid bills); Cullen Browder, *Wake Woman May Lose Home to Cover Late Husband's Medical Bills*, WRAL.COM (July 12, 2004), <http://www.wral.com/news/local/story/112201/>; Liz Kowalczyk, *Hospital Using Liens to Collect from Patients*, BOSTON GLOBE, Oct. 17, 2004, at A1; Lucette Lagnado, *Twenty Years and Still Paying—Jeanette White Is Long Dead but Her Hospital Bill Lives On*, WALL ST. J., Mar. 13, 2003, at B1; Elisabeth Rosenthal, *When Health Costs Harm Your Credit*, N.Y. TIMES, Mar. 8, 2014, at SR.4.

86. Hospitals typically only recover about ten percent of the bill from self-pay patients. See *A RelayHealth White Paper: Improving Self Pay at All Points of Service*, RELAYHEALTH 8 (2010), http://ndha.org/image/cache/ImprovingSelf-PayAtAllPointsofService_RelayHealth_2_.pdf; Anderson, *supra* note 11, at 787.

87. See Fuse Brown, *supra* note 7, at 41-51.

those reporting difficulty with medical debt, forty-two percent (or approximately thirty-two million people) reported lower credit ratings as a result.⁸⁸

Health care markets are replete with forms of market failure. Like a textbook example, the U.S. hospital market exhibits the types of information asymmetries, market concentration, moral hazard, principal-agent problems, and externalities that interfere with a market's efficient and effective functioning.

II. POLICY SOLUTIONS EVALUATED AGAINST MARKET FAILURES

The type of market failure and magnitude seen in the health care market invites a regulatory solution. This Part describes the variety of legal and policy solutions generally put forth to discipline health care prices: (1) market solutions, including transparency and other efforts to heighten the consumer behavior of patients to discipline prices through competition; (2) antitrust enforcement to protect competition in the hospital market; (3) payment and delivery reforms, such as accountable care organizations or bundled payments that aim to control health care costs through improved care coordination and aligned provider financial incentives; (4) consumer protection solutions where courts use tools from contract law or consumer protection statutes to protect vulnerable patients from the extremes of hospital pricing; and (5) rate regulation in the form of all-payer rate setting, price caps, or global budgets.

Part II uses an analytic framework to evaluate each policy approach to controlling health care prices by measuring the policy for its effectiveness at addressing the various market failures identified in Part I. This policy solution-against-market-failure approach reveals much about the strengths, weaknesses, and blind spots of each proposed solution and allows policymakers to select the policy approaches that will have the best chance of controlling health care prices, and therefore, health care spending. A depiction of this analytic framework and its conclusions is set forth in Figure 1.⁸⁹

A. MARKET SOLUTIONS

Market solutions are the most popular solutions among health policymakers to address the problem of excess and wildly variable health care prices.⁹⁰ Market solutions include price transparency, consumer-

88. SARA COLLINS ET AL., COMMONWEALTH FUND, INSURING THE FUTURE: CURRENT TRENDS IN HEALTH COVERAGE AND THE EFFECTS OF IMPLEMENTING THE AFFORDABLE CARE ACT xii (2013), http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Apr/1681_Collins_insuring_future_biennial_survey_2012_FINAL.pdf.

89. See *supra* Figure 1.

90. Meredith Rosenthal & Norman Daniels, *Beyond Competition: The Normative Implications of Consumer-Driven Health Plans*, 31 J. HEALTH POL. POL'Y & L. 671, 671 (2006).

directed health care, reference pricing, and tiered or narrow networks, and they rely on competition and market forces to reduce price variations and to scale prices to reflect value.

I. Price Transparency

Price transparency promotes the notion that health care purchasers, whether individuals or employers, ought to be able to find and compare the price of a given service between hospitals. Price transparency has broad political and intuitive appeal by attempting to lift the veil of secrecy that shrouds hospital prices.⁹¹ So the argument goes, consumers need access to accurate, understandable, and comparable information regarding hospital price and quality for market forces to discipline prices and improve quality.⁹² Armed with such information, consumers will shop for health care and select the lower cost, higher quality providers and pressure the others to bring their prices and quality levels in line.⁹³

Health care price transparency initiatives are being pursued at both the state and federal levels. A majority of states have passed some form of legislation to improve hospital price transparency.⁹⁴ According to 2014 data from the Catalyst for Payment Reform, thirty-five states only require that hospitals post or make available their chargemaster data;⁹⁵ fifteen states require the reporting of the prices hospitals receive from private payers, whether actual claims data or average amounts paid (several of which also require reporting of chargemaster data);⁹⁶ and two states (New Hampshire and Massachusetts) make available more detailed, plan-specific price information.⁹⁷ At the federal level, the Department of Health and Human Services initiated its price transparency efforts by releasing hospital charge data on May 8, 2013, updated annually,

91. Cutler & Dafny, *supra* note 15, at 894.

92. Steinmetz & Emanuel, *supra* note 15, at 433.

93. Sinaiko & Rosenthal, *supra* note 15, at 892.

94. CATALYST FOR PAYMENT REFORM & HEALTH CARE INCENTIVES IMPROVEMENT INST., REPORT CARD ON STATE PRICE TRANSPARENCY LAWS 9–16 (2014), http://www.hci3.org/sites/default/files/files/Report_PriceTransLaws_2014.pdf; *see also* Sinaiko & Rosenthal, *supra* note 15, at 891.

95. CATALYST FOR PAYMENT REFORM, *supra* note 94, at 9–16. These states include: Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, Nevada, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin. *Id.*

96. *Id.* These states include Colorado, Connecticut, Florida, Kansas, Maine, Maryland, Minnesota, New Jersey, North Carolina, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, and West Virginia.

97. MASS. GEN. LAWS ch. 6A, § 16K (2012); MASS. GEN. LAWS ch. 111, § 228 (2014); N.H. REV. STAT. ANN. §§ 420-G:11, 420-G:11-a (2006).

and making available \$87 million in grants to states to create data centers to collect and analyze health care pricing information for consumers.⁹⁸

For transparency efforts, the type of data matters. Publishing chargemaster prices does little to accomplish price transparency.⁹⁹ Chargemasters are too long and incomprehensible to be useful and do not reflect the prices that the majority of individuals with insurance would pay.¹⁰⁰ Average prices negotiated by payers gives a better sense of the relative price differences between hospitals actually paid by health plans in the aggregate, but it does not give an individual a sense of how much she might pay with her particular health plan or the range in prices negotiated by different health plans. Plan-specific data or estimates of a patient's expected out-of-pocket costs are more helpful for consumers to get a sense of what their actual costs might be, but still may fall short if not accompanied by robust quality data, which is much more difficult to measure.¹⁰¹ Most consumers do not want cheaper health care if it is of poorer quality, and without good quality data, patients often assume (incorrectly) that price is a proxy for quality.¹⁰²

It is far from clear whether consumers will use available price and quality data information to make their treatment choices. Generally, the more complex the information, the less consumers utilize it. For example, price information ought to be provided about the whole bundle of services associated with an episode of care rather than a disaggregated list of coded, *a la carte* items, as hospital services are often priced.¹⁰³ Earlier efforts at health plan price transparency using easy-to-read symbols (\$ vs. \$\$\$) were abandoned due to little consumer use and pressure from low-price providers to increase prices.¹⁰⁴ If the patient is shielded from price differences because she has exceeded her deductible,

98. Press Release, U.S. Dep't of Health & Human Servs., Administration Offers Consumers Unprecedented Look at Hospital Charges (May 8, 2013), <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2013-Press-releases-items/2013-05-08.html?DLPage=3&DLEntries=10&DLSort=0&DLSortDir=ascending>; Press Release, Ctrs. for Medicare & Medicaid Servs., Fact Sheet: HHS Releases Hospital Data on Charge Variation to Promote Transparency (May 8, 2013), <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2013-Fact-Sheets-Items/2013-05-08.html>.

99. See Anderson, *supra* note 11, at 786. A chargemaster is a master list of the hospital's undiscounted or full charges, akin to retail list prices, for each of the tens of thousands of items, services, and procedures it provides. ALLEN DOBSON ET AL., LEWIN GROUP, A STUDY OF HOSPITAL CHARGE SETTING PRACTICES I (2005).

100. David Dranove, *The Rest of the Story About Hospital Pricing*, HEALTH CARE BLOG (May 9, 2013), <http://thehealthcareblog.com/blog/2013/05/09/the-rest-of-the-story-about-hospital-pricing/#more-61521>; Muir et al., *supra* note 15, at 326–29.

101. See Anderson, *supra* note 11, at 786.

102. See Sinaiko & Rosenthal, *supra* note 15, at 892.

103. See Ginsburg, *supra* note 74, at w211.

104. *Id.* at w213.

then she has little incentive to choose a hospital based on price information.

Price transparency, though politically popular, has a couple of major pitfalls. First, disclosure of prices does not solve the market failures created by noncompetitive hospital markets. Despite having among the most robust price transparency laws in the country, New Hampshire has not seen a measurable reduction in hospital prices or price variation.¹⁰⁵ There, price transparency has not been able to overcome the tidal force of a noncompetitive hospital market.¹⁰⁶ Where hospitals do not compete on price, transparency does little to constrain prices. Large, “must-have” hospitals can still command high prices without losing patient volume where patients and payers have few alternatives.

The second pitfall is that widespread price transparency may lead paradoxically to higher rather than lower hospital prices.¹⁰⁷ In particular, revelation of the prices that commercial health plans actually pay hospitals—the data most helpful for patients—could create a perverse incentive for hospitals to raise their prices.¹⁰⁸ To illustrate, imagine Hospital A offers a significant discount to Insurer 1 and a smaller discount to Insurer 2. If forced to reveal its prices, Hospital A might be unwilling to offer the deeper discount to Insurer 1, knowing that Insurer 2 will likely pressure it to offer the same discount.¹⁰⁹ This tendency is exacerbated where the hospitals have greater bargaining power than the health plans, which is true in most provider markets.¹¹⁰ In these markets, a lower-priced Hospital B may raise its prices once it sees what Hospital A is charging because the health plans lack the power to keep Hospital B’s prices in check.¹¹¹ Especially in less competitive markets, price transparency might create a magnetic ceiling, where all hospitals converge on higher prices rather than compete to lower them.¹¹² Hence, prices might become more uniform, but uniformly higher.

105. HA T. TU & JOHANNA R. LAUER, CTR. FOR STUDYING HEALTH SYS. CHANGE, IMPACT OF HEALTH CARE PRICE TRANSPARENCY ON PRICE VARIATION: THE NEW HAMPSHIRE EXPERIENCE I (2009).

106. *Id.* at 2.

107. Cutler & Dafny, *supra* note 15, at 894.

108. *See* Ginsburg, *supra* note 74, at w214 (citing a Danish study of the pricing behavior of concrete producers in a concentrated market. Following implementation price transparency policies, the companies raised prices fifteen to twenty percent because of the loss of the ability to offer secret discounts to buyers).

109. *See id.*; Margaret K. Kyle & David B. Ridley, *Would Greater Transparency And Uniformity Of Health Care Prices Benefit Poor Patients?*, 26 HEALTH AFF. 1384, 1388 (2007).

110. Cutler & Dafny, *supra* note 15, at 894.

111. Sinaiko & Rosenthal, *supra* note 15, at 893.

112. Cutler & Dafny, *supra* note 15, at 894; Kyle & Ridley, *supra* note 109, at 1388.

2. Consumer-Directed Health Care

Consumer-directed health care (“CDHC”) is another market-based approach that builds off of price transparency. The typical mechanism to encourage CDHC is through a high deductible health plan coupled with a tax-advantaged health savings account (“HSA”).¹¹³ By giving patients some “skin in the game,” CDHC sensitizes patients to health care costs, which leads the patient to exert market pressure on providers to move toward more uniform prices.¹¹⁴ CDHC attempts to address the moral hazard problem of health insurance by forcing the insured individual to bear the initial cost of her health care expenditure, which will cause her to ration her utilization of services.¹¹⁵

In 2015, a plan is considered a high deductible plan if the deductible is at least \$1300 for an individual and \$2600 for a family.¹¹⁶ Deductibles vary widely, and over a third of family deductibles exceed \$5000.¹¹⁷ The use of high deductible plans is widespread and steadily increasing. In a 2014 survey of large employers, eighty-one percent reported offering a CDHC plan to employees as an option, and thirty-two percent reported offering a CDHC plan as the only option, up from twenty-five percent the previous year.¹¹⁸ As of 2014, twenty percent of covered employees were enrolled in a CDHC plan, compared with just four percent in 2006.¹¹⁹ On the health insurance exchanges, high deductible health plans comprise approximately sixty percent to eighty percent of plans.¹²⁰

In the form of high deductible health plans, CDHC has a limited impact on hospital prices because most hospital services will be so expensive that a patient will “blow through” her deductible, and thus be insensitive to price variations above the deductible.¹²¹ Carl Schneider and Mark Hall identified several barriers to the goals of CDHC that prevent patients from engaging in consumer behaviors.¹²² Patients may lack

113. See N.J. DEP’T OF HEALTH, *supra* note 27, at 99.

114. Gail R. Wilensky, *Consumer-Driven Health Plans: Early Evidence and Potential Impact on Hospitals*, 25 HEALTH AFF. 174, 183–84 (2006).

115. See Rosenthal & Daniels, *supra* note 90, at 672; Timothy Stoltzfus Jost, *Is Health Insurance a Bad Idea? The Consumer-Driven Perspective*, 14 CONN. INS. L.J. 377, 378–79 (2008).

116. Rev. Proc. 2014-30, 2014-20 I.R.B. 1009.

117. GARY CLAXTON ET AL., KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS: 2014 ANNUAL SURVEY 158, Exhibit 8.II (2014), <http://kff.org/health-costs/report/2014-employer-health-benefits-survey/>.

118. Press Release, Nat’l Bus. Grp. on Health, U.S. Employers Changing Health Benefit Plans to Control Rising Costs, Comply with ACA, National Business Group on Health Survey Finds (Aug. 13, 2014), <http://www.businessgrouphealth.org/pressroom/pressRelease.cfm?ID=234>.

119. CLAXTON ET AL., *supra* note 117, at 154, Exhibit 8.5.

120. Bob Herman, *High-Deductible Plans Dominate Next Open Enrollment*, MODERN HEALTHCARE (Nov. 30, 2014), <http://www.modernhealthcare.com/article/20141113/NEWS/311139966>.

121. See Tynan et al., *supra* note 58, at 4; Gail R. Wilensky, *Consumer-Driven Health Plans: Early Evidence and Potential Impact on Hospitals*, 25 HEALTH AFF. 174, 182 (2006).

122. Schneider & Hall, *supra* note 18, at 15.

choices among plans and providers.¹²³ Moreover, despite efforts to promote transparency, patients still lack necessary information about price and quality.¹²⁴ If they lack quality data, patients are likely to opt for the higher-priced hospitals because of the mistaken perception that price is a proxy for quality.¹²⁵ Even with price information, patients are often unable to bargain with the hospital, either because they will not or cannot. Patients place themselves in their doctor's hands, following whatever advice the doctor prescribes, including at which hospital to have a procedure performed.¹²⁶ Acutely sick patients are in a particularly vulnerable position, unable to negotiate on prices for urgently needed care on the way to the emergency room or at the bedside of a gravely ill family member.¹²⁷ Empirical research has cast doubt on patients' financial literacy and ability to process the complex information necessary to make health care choices.¹²⁸

Studies have demonstrated that higher cost-sharing has a disproportionate, negative impact on the poor and those with chronic illness, highlighting questions of distributive justice.¹²⁹ Greater cost-sharing causes people to cut back not just on unnecessary care, but needed care as well.¹³⁰ Privately insured individuals with incomes below 200 percent of poverty are significantly more likely to have deductibles that exceed five percent of their incomes and are more likely to delay needed care as a result.¹³¹ When individuals defer cost-saving preventive and outpatient care, they may later consume more expensive ER and hospital services for poorly controlled illness.¹³² CDHC may contribute to adverse selection, with healthier (and, evidence shows, wealthier and more educated) individuals selecting a CDHC plan and sicker people

123. *Id.* at 18.

124. *Id.* at 20–21.

125. Sinaiko & Rosenthal, *supra* note 15, at 892.

126. Schneider & Hall, *supra* note 18, at 27.

127. Hall & Schneider, *supra* note 18, at 658.

128. Ginsburg, *supra* note 74, at w211; Greaney, *supra* note 64, at 1199–1200; Schneider & Hall, *supra* note 18, at 38–40.

129. See, e.g., Vicki Fung et al., *Financial Barriers to Care Among Low-Income Children with Asthma: Health Care Reform Implications*, 168 JAMA PEDIATRICS 649, 650 (2014); Rosenthal & Daniels, *supra* note 90, at 675, 679; Amal Trivedi et al., *Increased Ambulatory Care Copayments and Hospitalizations Among the Elderly*, 362 N. ENG. J. MED. 320, 320 (2010). Policies can selectively address the problem of the negative impact of cost-sharing on low-income populations. For example, the Affordable Care Act subsidizes cost-sharing for low-income individuals purchasing plans on the exchanges, 42 U.S.C.A. § 18071 (2010), and requires certain preventive care to be covered without cost-sharing, 42 U.S.C.A. § 300gg-13 (2011).

130. See NEWHOUSE & THE INSURANCE EXPERIMENT GROUP, *supra* note 56, at 162.

131. SARA R. COLLINS ET AL., COMMONWEALTH FUND, TOO HIGH A PRICE: OUT-OF-POCKET HEALTH CARE COSTS IN THE UNITED STATES 4–5 (2014), http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/nov/1784_collins_too_high_a_price_out_of_pocket_tb_v2.pdf.

132. See Fung, *supra* note 129, at 652; Trivedi, *supra* note 129, at 321.

opting for plans with lower deductibles.¹³³ Meredith Rosenthal and Norman Daniels explain that among employer-sponsored high-deductible health plans with HSAs, the employer contribution to the HSA tends to redistribute wealth from the unhealthy to the healthy.¹³⁴

3. Reference Pricing

Like high deductibles, reference pricing also puts the individual's own dollars at stake, but reverses who pays the first dollar of coverage.¹³⁵ Instead of making the patient pay for the first few thousand dollars of care, health plans agree to pay the price for a given service charged by a low priced provider, and the individual is free to seek care from a range of other providers but is responsible for the difference between that provider's higher price and the reference price.¹³⁶ Health economist Austin Frakt illustrates the difference between deductibles and reference pricing by analogizing deductibles to being told that insurance will pay for any Toyota you want if you pay the first \$500.¹³⁷ You would likely pick the most expensive car, such as an \$80,000 Land Cruiser. With reference pricing, you are told that insurance will cover the first \$15,000 of any Toyota, but you have to pay the excess price.¹³⁸ In this example, reference pricing will clearly lead to more value and price-sensitive shopping by the consumer who may opt for a Toyota Yaris instead of a Land Cruiser.

Proponents say reference pricing makes patients more sensitive to the differences in price between hospitals than CDHC, where most hospital visits will exceed the patient's deductible.¹³⁹ The increased price sensitivity from reference pricing creates market pressure for high-priced providers to lower their prices closer to the reference price or else lose business. One advantage of reference pricing over CDHC is that it relies on the health plan to gather and report the providers' price information

133. See Jost, *supra* note 115, at 385; Rosenthal & Daniels, *supra* note 90, at 679.

134. See Rosenthal & Daniels, *supra* note 90, at 678.

[I]n contrast to traditional insurance plans, when employers contribute to savings accounts in CDHPs, they are distributing some portion of the healthcare benefit directly to all enrollees (the account), not just those needing care. These account dollars may exceed annual health care spending for healthier workers, while they will quickly be expended by those who are chronically ill. As many have noted, unless savings from CDHPs are realized and redistributed, or other subsidies are given to those who are less healthy, there is an inevitable redistribution in favor of the healthy.

Id.

135. See Robinson & MacPherson, *supra* note 58, at 2029.

136. Reinhardt, *supra* note 76.

137. Austin Frakt, *Is Reference Pricing a Good Deal?*, ACADEMYHEALTH BLOG (May 23, 2013), <http://blog.academyhealth.org/is-reference-pricing-a-good-deal/>.

138. *Id.*

139. Editorial, *The Weird World of Colonoscopy Costs*, N.Y. TIMES (June 9, 2013), <http://www.nytimes.com/2013/06/09/opinion/sunday/the-weird-world-of-colonoscopy-costs.html>.

rather than the individual, who may not have sufficient data or wherewithal to evaluate the different options.¹⁴⁰ Health insurers favor reference pricing because it caps their financial responsibility for a particular service.¹⁴¹

There is early evidence that reference pricing can nudge patients toward more cost-effective choices and cause high-priced providers to lower prices closer to reference price levels.¹⁴² Payers are starting to use reference pricing for hospital or outpatient services, but generally only for certain standardized procedures where there is wide price variation but little variation in quality, such as colonoscopy or hip replacement.¹⁴³ In addition, the service ought to be “shoppable,” that is, a nonurgent service that allows the patient time to shop around, with readily available information regarding price and quality, and for which there are several choices of provider.¹⁴⁴

Reference pricing also has limitations. Most health care spending is for services that are not shoppable and are therefore ill-suited for reference pricing.¹⁴⁵ To make up profits that it loses on reference-priced services, hospitals may simply raise prices for non-reference priced services.¹⁴⁶ One study suggests reference pricing may have a limited impact on total spending because it tends to affect prices only at the highest end of the price distribution.¹⁴⁷ Some of the barriers to CDHC, such as lack of choices, lack of available data, reliance on physician recommendations, and impaired ability to make choices based on information given, could similarly afflict reference pricing initiatives.

140. See Ginsburg, *supra* note 74, at w211.

141. Frakt, *supra* note 137.

142. PAUL FRONSTIN & M. CHRISTOPHER ROEBUCK, EMP. BENEFIT RESEARCH INST., REFERENCE PRICING FOR HEALTH CARE SERVICES: A NEW TWIST ON THE DEFINED CONTRIBUTION CONCEPT IN EMPLOYMENT-BASED HEALTH BENEFITS 5 (2014); see also Sarah Thomson et al., *Value-Based Cost Sharing in the United States and Elsewhere Can Increase Patients' Use of High-Value Goods and Services*, 32 HEALTH AFF. 704, 706 (2013) (showing that reference pricing lead consumers to switch from higher priced brand-name prescriptions to lower priced generics without adverse health impacts). For a discussion of the effects of reference pricing used by CalPERS, which covers California's public retirees, see James C. Robinson & Timothy T. Brown, *Increases in Consumer Cost Sharing Redirect Patient Volumes and Reduce Hospital Prices for Orthopedic Surgery*, 32 HEALTH AFF. 1392, 1393-97 (2013) (showing how reference pricing initiative for hip and knee replacements led to a 21.2% increase in CalPERS patients at low-priced hospitals and a 34.4% decrease at high-priced hospitals, leading many high-priced hospitals reduced their prices for the procedures for CalPERS in response).

143. See Robinson & MacPherson, *supra* note 58, at 2034-35; Fronstin & Roebuck, *supra* note 142, at 4 (“In 2012, 11 percent of employers with 500 or more workers were using some type of [reference pricing], and another 16 percent were considering it.”).

144. See CHAPIN WHITE & MEGAN EGUCHI, NAT'L INST. FOR HEALTH CARE REFORM, REFERENCE PRICING: A SMALL PIECE OF THE HEALTH CARE PRICES AND QUALITY PUZZLE 2 (2014); Ginsburg, *supra* note 74, at w210.

145. WHITE & EGUCHI, *supra* note 144, at 4 (“Using an inclusive definition, all shoppable services accounted for about a third of total spending if both inpatient and ambulatory services are included.”).

146. Fronstin & Roebuck, *supra* note 142, at 5.

147. WHITE & EGUCHI, *supra* note 144, at 1.

Reference pricing comes with a thorny technical problem of how to set the reference price. Set too high, and the cost-savings will be lost, with lower-priced providers raising their prices up to the reference price.¹⁴⁸ Set too low, and the providers may not be able to cover the cost of providing the service, leading providers to drop the service, to cost-shift to more remunerative services, or to seek market power as a method of resisting reference pricing.¹⁴⁹

4. *Tiering and Narrow Networks*

Another market approach relies upon health insurance plans to engage in active purchasing in the form of narrow or tiered networks to pressure hospitals and other providers to restrain prices.¹⁵⁰ In a narrow network, payers selectively contract with a limited group of providers who will agree to lower prices in exchange for patient volume.¹⁵¹ Under a tiering strategy, the health plan sorts contracted providers or service lines into tiers based on price and steers patients to the lower priced providers (the preferred tier) using lower cost-sharing incentives.¹⁵² In their roles curating the narrow or tiered network, the health plan is the one wielding the consumer power on behalf of the patient.

Neither approach is new. Narrow networks and tiering were both strategies widespread during the rise of managed care and HMOs in the 1980s and 1990s.¹⁵³ Consumers and employers vociferously resisted choice-limiting networks then, and it is unclear whether they will accept similarly narrowed choices today.¹⁵⁴ Nevertheless, tiering and narrow networks are gaining renewed attention as solutions to discipline health care prices.¹⁵⁵ The ACA has accelerated the revival of narrow networks because of its limits on health plans' ability to engage in underwriting or to narrow benefits to keep premiums down.¹⁵⁶ Thus, one of the remaining

148. *Id.* at 9.

149. *Id.* at 10.

150. Chapin White et al., *Understanding Differences Between High- and Low-Price Hospitals: Implications for Efforts to Rein in Costs*, 33 HEALTH AFF. 324, 330 (2014).

151. *Id.*

152. Paul B. Ginsburg & L. Gregory Pawlson, *Seeking Lower Prices Where Providers Are Consolidated: An Examination of Market and Policy Strategies*, 33 HEALTH AFF. 1067, 1069 (2014).

153. Robert A. Berenson et al., *supra* note 44, at 975.

154. Muir et al., *supra* note 100, at 339.

155. *See, e.g.*, Cutler & Scott Morton, *supra* note 17, at 1969; Ginsburg & Pawlson, *supra* note 152, at 1069; White et al., *supra* note 150, at 330.

156. 42 U.S.C. § 300gg (2010) (establishing limits on health plan underwriting on the basis of health status); 42 U.S.C. § 18022 (2010) (establishing requirements for health plans to cover the essential health benefits).

strategies for health plans to keep their prices in check is to offer narrow networks of providers.¹⁵⁷

Narrow networks and tiering strategies rely upon the existence of sufficient competition among hospitals, which is lacking in many markets.¹⁵⁸ Without competition, powerful providers use their market power to require anti-tiering provisions in their contracts with health plans, or else require that the plan always include the high-priced hospital in the most preferred tier.¹⁵⁹ To address this issue, Massachusetts passed a law in 2010 prohibiting providers from using anti-tiering provisions in their plan contracts.¹⁶⁰ Even with such a law, health plans may have no choice but to include high priced hospitals in their network or in the best tier because they have unique services, such as a Level I trauma facility or a Neonatal Intensive Care Unit (“NICU”), that lower priced hospitals lack.¹⁶¹ In most places, health plans will be unable to exclude “must-have” providers from the highest tier due to their market power.¹⁶²

5. *Market Approaches Measured Against Health Care Market Failures*

Market solutions to the hospital pricing problem are intuitively pleasing—they attempt to restore market forces to a failed market. Price transparency and reference pricing take aim at correcting information asymmetry and helping patients become informed consumers. It may be technically difficult to implement price transparency or reference pricing, but it is plausible that well-designed programs can prompt effective comparison shopping by patients.¹⁶³ The cost-sharing imposed on individuals by CDHC, especially in the form of reference pricing, attempts to address moral hazard and sensitizes patients to the prices of their care.

The biggest problem with market approaches to discipline hospital prices is that they fundamentally will not work in concentrated markets where there is little choice or competition between providers.¹⁶⁴ And as

157. See David Cusano & Amy Thomas, *Narrow Networks Under the ACA: Financial Drivers and Implementation Strategies*, HEALTH AFF. BLOG (Feb. 17, 2014), <http://healthaffairs.org/blog/2014/02/17/narrow-networks-under-the-aca-financial-drivers-and-implementation-strategies/>.

158. See *supra* Part I.B.

159. Ginsburg & Pawlson, *supra* note 152, at 1070.

160. MASS. GEN. LAWS ANN. ch. 1760, § 9A (West 2012).

161. White et al., *supra* note 150, at 330.

162. Robert Berenson, *Acknowledging the Elephant: Moving Market Power and Prices to the Center of Health Policy*, HEALTH AFF. BLOG (June 3, 2014), <http://healthaffairs.org/blog/2014/06/03/acknowledging-the-elephant-moving-market-power-and-prices-to-the-center-of-health-policy/>.

163. See, e.g., Sze-jung Wu et al., *Price Transparency for MRIs Increased Use of Less Costly Providers and Triggered Provider Competition*, 33 HEALTH AFF. 1391, 1394–95 (2014).

164. Vladeck, *supra* note 13, at 1085 (“If sellers have too much market power, in other words, a policy that supports a shift in the buying function from insurers with some market power to consumers with effectively none is not likely to succeed in imposing discipline on producers from the demand side.”).

discussed above, concentrated hospital markets are the norm, not the exception.¹⁶⁵ Where there is no choice, patients cannot shop around or substitute the lower cost or higher value provider. Where hospital-sellers have disproportionate market power, purchasers (health plans or patients) can exert little discipline on prices through transparency, CDHC, reference pricing, or active purchasing.

Moreover, the stressful nature of most hospital encounters makes it unlikely for transparency plus CDHC to overcome patients' substantial cognitive and behavioral barriers to rational consumer behavior.¹⁶⁶ Even when equipped with sufficient price and quality information, when it comes to serious medical decisions, patients generally defer to their physicians.¹⁶⁷ Buying health care is thus unlike shopping for a car, unless one imagines buying a car while being chased by a gunman, when there are only a couple unfamiliar models to choose from, relying upon the guidance of a trusted car salesman who tells you which car is best for your situation and also serves as your driver as you try to get away. Although market approaches attempt to address information asymmetry and moral hazard, the principal-agent problems persist. Health plans and/or providers are in the best position to gather, report, and translate price and quality information for patients, and thus market approaches build upon the existing web of principal-agent relationships.¹⁶⁸

Finally, market solutions like price transparency or reference pricing are inherently limited because much of health care is not "shoppable."¹⁶⁹ Acute or urgent health care does not lend itself to comparison or price shopping, and patients end up seeking care at the nearest hospital, the one to which the ambulance delivers them, or the one to which they are referred to by their physician.

Market solutions are premised on improving informational deficits and sensitizing consumers to their health care costs to bring competitive forces to bear on health care prices. As an overall strategy to discipline health care prices, however, market solutions are fundamentally limited because they fail to address the underlying lack of competition in hospital markets and barriers to patient consumer behavior.¹⁷⁰

165. See *supra* Part I.B.

166. See *supra* text accompanying notes 123–25.

167. See Greaney, *supra* note 64, at 1200.

168. HEALTHCARE FIN. MGMT. ASS'N, *supra* note 3, at 3 ("Health plans should serve as the principal source of price information for their members. . . . The provider should be the principal source of price information for uninsured patients and patients who are seeking care from the provider on an out-of-network basis.").

169. See WHITE & EGUCHI, *supra* note 144, at 4.

170. Paul B. Ginsburg, *All-Payer Rate Setting: A Response to a 'Modest Proposal' from Uwe Reinhardt*, HEALTH AFF. BLOG (July 24, 2009), <http://healthaffairs.org/blog/2009/07/24/all-payer-rate-setting-a-response-to-a-modest-proposal-from-uwe-reinhardt/>.

B. ANTITRUST ENFORCEMENT

I. Antitrust Strategies to Address Hospital Market Power

If market solutions fail to address the problem of health care market concentration, one response is to use antitrust laws to address provider market power.¹⁷¹ First, the FTC can use its power under section 7 of the Clayton Act to oppose horizontal hospital mergers that “lessen competition, or . . . tend to create a monopoly.”¹⁷² Using this approach, the antitrust agencies can block proposed mergers or, occasionally, seek divestiture of a consummated merger.¹⁷³ The general analytic framework for horizontal mergers requires definition of the geographic and product markets at issue as well as assessment of the potential anticompetitive effects of the merged entity’s increased market share.¹⁷⁴

Second, under section 1 of the Sherman Act, antitrust agencies can police efforts by provider networks to engage in joint contracting with health plans, a form of price fixing among otherwise independent and competing providers.¹⁷⁵ These types of provider networks implicate health care prices when hospitals vertically integrate with physician practices through ACOs, physician-hospital organizations, or physician practice acquisition.¹⁷⁶ Hospitals can use these strategies to increase their market share by “locking up” physician referrals from large networks of physicians and bundling hospital and physician services together for greater bargaining leverage over payers.¹⁷⁷ Antitrust scrutiny of provider networks is fact-specific, weighing the procompetitive efficiencies gained by clinically and/or financially integrating an otherwise disparate and fragmented web of providers against the anticompetitive effects of increased consolidation and market power.¹⁷⁸ In the case of ACOs, the antitrust agencies will afford rule-of-reason treatment (not the stricter

171. Berenson et al., *supra* note 44, at 702 (quoting a health plan executive complaining about providers’ monopoly prices in California: “We’d welcome some regulatory intervention to break up these monopolies, because they are just killing us.”); Gaynor, *supra* note 42, at 1090; Havighurst & Richman, *supra* note 17, at 853.

172. Clayton Act, 15 U.S.C. § 18 (2013).

173. Cutler & Scott Morton, *supra* note 17, at 1969.

174. See U.S. DEP’T OF JUSTICE & FED. TRADE COMM’N, HORIZONTAL MERGER GUIDELINES (2010), <http://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf>; see also Greaney, *supra* note 17, at 193.

175. Sherman Antitrust Act, 15 U.S.C. § 1; see Greaney, *supra* note 71, at 23.

176. Laurence C. Baker et al., *Vertical Integration: Hospital Ownership of Physician Practices Is Associated with Higher Prices and Spending*, 33 HEALTH AFF. 756, 757 (2014).

177. Baker et al., *supra* note 175, at 756–57; Ginsburg & Pawlson, *supra* note 152, at 1072.

178. See DEP’T OF JUSTICE & FED. TRADE COMM’N, STATEMENTS OF ANTITRUST ENFORCEMENT IN HEALTH CARE POLICY, Statements 8 & 9 (1996) (describing antitrust agencies’ policies regarding physician network joint ventures and multiprovider networks).

per se analysis) to joint contracting by providers in ACOs that comply with all of the requirements to be a Medicare ACO.¹⁷⁹

Third, antitrust agencies can police anticompetitive efforts by dominant hospitals—often in combination with dominant payers—to entrench their market power, exclude rivals, and establish price-setting schemes.¹⁸⁰ For example, hospital-payer contracts may undermine price competition through mechanisms such as anti-tiering or most favored nation (“MFN”) clauses.¹⁸¹ As discussed above, powerful providers may insist on anti-tiering or anti-steering provisions to prevent health plans from using different levels of cost-sharing to encourage enrollees to use lower priced providers.¹⁸² MFN provisions are typically used by dominant health plans to extract agreement from hospitals not to accept lower rates from another health plan competitor, thus contractually assuring the dominant plan will receive the best price and preventing price competition from other health plans.¹⁸³ In other contexts, antitrust agencies have pursued collusion between “must-have” hospitals and dominant payers to protect the other from competition,¹⁸⁴ or hospitals’ pricing discounts to payers in exchange for the payers’ agreement not to contract with or accept better prices from the hospital’s competitors.¹⁸⁵ The color and stripe of antitrust abuse vary with the particulars of the market, but successful enforcement is rare and fact-intensive, with the law and outcomes often unclear. As a result, antitrust law is an inherently imperfect strategy to address the widespread monopoly problem in the hospital market.¹⁸⁶

2. *Antitrust Strategies Measured Against Health Care Market Failures*

Aggressive antitrust enforcement may be critical to preserving competition in markets that have not already become highly concentrated.

179. Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67,026, 67,026 (Oct. 28, 2011); see also Greaney, *supra* note 16, at 23 (noting that the ACO antitrust policy statement also establishes safety zones for calculating acceptable levels of market power that are specific to ACOs).

180. See Greaney, *supra* note 16, at 30–31.

181. See Sage, *supra* note 49, at 1080–81.

182. See *supra* text accompanying note 156.

183. See, e.g., Complaint at 1, United States v. Blue Cross Blue Shield of Mich., 809 F. Supp. 2d 665 (E.D. Mich. 2010) (No. 2:10-CV-14155).

184. See, e.g., W. Penn Allegheny Health Sys., Inc. v. UPMC, 627 F.3d 85, 91 (3d Cir. 2010).

185. Complaint at 1, United States v. United Reg’l Health Care Sys., (N.D. Tex. Feb. 25, 2011) (No. 7:11-cv-00030); Cascade Health Sols. v. PeaceHealth, 502 F.3d 895 (9th Cir. 2007). For a good discussion of these cases, see Greaney, *supra* note 71, at 28–31.

186. Greaney, *supra* note 16, at 30–31 (“While antitrust litigation can challenge these tactics, such cases are fact-intensive, require extensive analysis, and fall in areas in which the law remains unsettled. . . . As a result, antitrust law is more paper tiger than bulwark against abuse when dealing with incumbent monopolies.”).

As an overall solution to discipline health care prices, however, antitrust enforcement is significantly limited. There is little the antitrust laws can do to break up or reverse existing monopolies, so antitrust enforcement is little help to the many provider markets where concentration has already occurred.¹⁸⁷ As forcefully stated by Thomas Greaney,

A common misapprehension among legislators and policymakers is that antitrust law provides a reliable counterforce to monopoly. With respect to extant monopolies, legally acquired, the opposite is true: antitrust law tolerates the exercise of market power (which includes charging higher prices, reducing output, and lowering quality) and generally intervenes only where monopolists wrongfully exercise that power to exclude or harm rivals.¹⁸⁸

For a stretch of time from the late 1990s to the early 2000s, antitrust agencies ran into a judicial wall when opposing hospital mergers, with courts dealing the agencies seven consecutive losses.¹⁸⁹ Although the FTC's losing streak subsequently broke, it remains true today that antitrust enforcement to prevent hospital mergers has been largely ineffective at counteracting the wave of consolidation in the industry.¹⁹⁰

Market power gained lawfully is unreachable by antitrust enforcement.¹⁹¹ For example, a hospital may be a "must-have" hospital because it is one of the few providers of unique services such as a Level I Trauma unit, NICU, or transplant service.¹⁹² Or the hospital may be the sole provider in a rural area that cannot support more than one hospital.¹⁹³ Other hospitals, like Cedars-Sinai in Los Angeles, may have a reputation that makes them powerful (in the case of Cedars-Sinai, it is the preferred hospital for Hollywood celebrities).¹⁹⁴ Large, geographically dispersed health care systems may bargain collectively,

187. Cutler & Scott Morton, *supra* note 17, at 1969; Gaynor, *supra* note 42, at 1090; Havighurst & Richman, *supra* note 17, at 871.

188. Greaney, *supra* note 16, at 27.

189. See *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1053 (8th Cir. 1999); *FTC v. Freeman Hosp.*, 69 F.3d 260, 273 (8th Cir. 1995); *California v. Sutter Health Sys.*, 84 F. Supp. 2d 1057, 1085 (N.D. Cal. 2000), *amended by* 130 F. Supp. 2d 1109, 1137 (N.D. Cal. 2001); *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 149 (E.D.N.Y. 1997); *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1302-03 (W.D. Mich. 1996), *aff'd*, No. 96-2440, 1997 WL 420543, at *1 (6th Cir. July 8, 1997); *United States v. Mercy Health Servs.*, 902 F. Supp. 968, 989 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632, 637 (8th Cir. 1997); *Adventist Health Sys./West*, 117 F.T.C. 224, 285 (1994); see also Thomas L. Greaney, *Whither Antitrust? The Uncertain Future of Competition Law in Health Care*, 21 HEALTH AFF. 185, 187 (noting that the cases show a "judicial disdain for applying traditional antitrust principles to health care providers").

190. See Havighurst & Richman, *supra* note 17, at 849 ("[The government's] inability over time to apply antitrust law rigorously and systematically in the big business that health care has become is one important—though not the only—reason why many health care markets are now dominated by firms with alarming pricing power.").

191. See Berenson et al., *supra* note 43, at 973-74.

192. White et al., *supra* note 150, at 327.

193. See Berenson, *supra* note 162.

194. See Berenson et al., *supra* note 44, at 702.

leveraging a flagship hospital for higher prices across the system.¹⁹⁵ But because the system's facilities are spread out across many hospital markets, such collective price negotiation is typically beyond the reach of antitrust law.¹⁹⁶ These types of market power were acquired legally and are not amenable to antitrust enforcement.

Much of the current provider consolidation is occurring in response to payment and delivery reforms like ACOs or bundled payments, which may have many salutary benefits in terms of better care coordination, reduction of fragmentation, and improved quality.¹⁹⁷ Thus, the antitrust agencies have chosen to tread lightly when it comes to these integration efforts despite their attendant risks to competition.¹⁹⁸ Payment and delivery reforms address the principal-agent problem of providers' inherent incentives to create demand for their own services, which antitrust policy does not address. Thus, antitrust policy has a difficult needle to thread: it must be flexible enough to accommodate health care delivery innovations while containing the effects of provider market power.

Because antitrust enforcement can do little to address existing monopolies, antitrust enforcement is an inadequate solution to the problem of provider market power. Additional regulatory efforts are required to promote competition in the concentrated hospital market, such as repeal of state CON law regimes that prevent entry into the hospital market or avoidance of "any willing provider" laws that stymie narrow networks and price competition.¹⁹⁹ However, even these augmented approaches to competition policy do not address providers' motivations to consolidate: to increase bargaining leverage over a fragmented payer landscape.²⁰⁰

Antitrust policy also does not touch many of the other features of market failure in the hospital market, such as information asymmetry, moral hazard, principal-agent problems, or externalities. As discussed in Part III, the theory of "second best" warns that where there are multiple types of market failure, addressing one but not the others might actually result in reduced efficiency and welfare and even worse outcomes than doing nothing at all.²⁰¹

195. *Id.*

196. Berenson, *supra* note 43, at 976; Greaney, *supra* note 16, at 21.

197. Ginsburg & Pawlson, *supra* note 152, at 1067.

198. See Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations, *supra* note 179, at 67,026; see also Greaney, *supra* note 16, at 23–24.

199. See Gaynor, *supra* note 42, at 1090–91.

200. See Berenson et al., *supra* note 43, at 977.

201. Peter J. Hammer, *Antitrust Beyond Competition: Market Failures, Total Welfare, and the Challenge of Intramarket Second-Best Tradeoffs*, 98 MICH. L. REV. 849, 853–54 (2000).

C. PAYMENT AND DELIVERY REFORMS

I. ACOs and Bundled Payments

Payment and delivery reforms are premised on the hope that altering the financial incentives in our health care system will result in structural changes that fix the fragmented, inefficient, poor quality, and costly health care delivery system.²⁰² Of all the payment and delivery reforms set in motion by the ACA, ACOs generated the most anticipation.²⁰³ ACOs are the flagship among an assortment of Medicare reforms in the ACA that all aim at paying for value in health care instead of volume.²⁰⁴

In the early 2000s, researchers at Dartmouth's Atlas of Health Care revealed large variations in Medicare spending across geographic regions and demonstrated that higher spending does not lead to better health outcomes.²⁰⁵ They concluded that approximately thirty percent of the nation's Medicare spending could be eliminated without negative impacts on health simply by reducing geographic variations in spending.²⁰⁶ Because this research was based on Medicare spending, the variations were due to practice patterns and utilization, not differences in price. In the private market, geographic spending variations are compounded by price differences as well as utilization patterns.²⁰⁷

The Dartmouth researchers, led by Elliott Fisher, devised a model now known as an ACO to create financial incentives and structural reforms to move the high-spending regions toward the practices of the more efficient regions.²⁰⁸ The idea of the ACO is to reward groups of physicians and other providers for improving quality and care coordination while reducing unnecessary utilization by paying them a share of the

202. See David Cutler, *How Health Care Reform Must Bend the Cost Curve*, 29 HEALTH AFF. 1131, 1133–34 (2010).

203. Rob Cunningham, *The Payment Reform Paradox*, 33 HEALTH AFF. 735, 735 (2014).

204. See Greaney, *supra* note 16, at 1.

205. Elliott S. Fisher et al., *The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care*, 138 ANNALS INTERNAL MED. 273, 273 (2003) [hereinafter Fisher et al., *Regional Variations of Medicare Spending Part 1*]; Elliott S. Fisher et al., *The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care*, 138 ANNALS INTERNAL MED. 288, 288 (2003) [hereinafter Fisher et al., *Regional Variations of Medicare Spending Part 2*].

206. Fisher et al., *Regional Variations of Medicare Spending Part 1*, *supra* note 205, at 273.

207. Newhouse & Garber, *supra* note 46, at 1227–28 (“Whereas price variation explains almost none of the overall variation in Medicare expenditures (after adjusting for wage variation), price variation is responsible for an estimated 70% of the total geographic variation in spending among privately insured persons.”).

208. Transcript of Proceedings at 280–363, Medicare Payment Advisory Comm’n: Pub. Meeting (Nov. 9, 2006), <http://www.medpac.gov/documents/november-2006-meeting-transcript.pdf> (describing the ACO model variously as “extended hospital staff” and “accountable organization”); see also Elliott S. Fisher et al., *Creating Accountable Care Organizations: The Extended Hospital Medical Staff*, 26 HEALTH AFF. W44 (2006–2007).

amount they save for the payer.²⁰⁹ The model was adopted by the ACA in the form of the Medicare Shared Savings Program, which establishes ACOs for Medicare with the intent that the model will spread to the private market.²¹⁰ The goal is to move the health care market away from the inefficient, highly fragmented, volume-based fee-for-service payment model toward a more efficient, coordinated, and value-based system.²¹¹

In a similar vein, the ACA also created a pilot program to bundle Medicare payments for an entire episode of care for certain conditions, where the hospital receives a single lump sum payment to cover all inpatient, physician, outpatient, and post-acute services involved in the episode of care.²¹² Payment bundling creates incentives for fragmented providers to work together, improve efficiency, and internalize the costs of a poorly managed episode of care.

The strategies underlying ACOs and payment bundling are not new; they are similar to the ways providers assumed financial risks (and benefits) under capitated payments from managed care companies in the 1990s.²¹³ The main differences are that ACO models seek to preserve patients' choice of provider and are designed to be driven by providers rather than by payers.²¹⁴ In their purest form, HMOs with capitation did reduce health care spending and utilization, but patients and providers alike opposed them as blunt instruments of rationing and because of limitations in their choice of providers.²¹⁵

As discussed above, ACOs and bundled payments create pressures for providers to consolidate, particularly through vertically integrated networks of physicians, hospitals, and post-acute providers.²¹⁶ In its benign form, ACOs encourage efficient consolidation because they require providers to come together to coordinate care, assume financial risk, and share and report data.²¹⁷ The consolidation may improve efficiency by reducing duplicative or wasteful services, as well as by aligning the financial and clinical incentives of disparate providers. In the private market, however, vertical integration and ACO formation may be motivated as much or more by the desire to gain market share and bargaining leverage

209. Elliott S. Fisher et al., *Fostering Accountable Health Care: Moving Forward in Medicare*, 28 HEALTH AFF. W219, W222 (2009).

210. See 42 U.S.C. § 1395jii (2013); see also Greaney, *supra* note 16, at 16–17.

211. Fisher, *supra* note 209, at W221.

212. 42 U.S.C. § 1395cc-4 (2013); accord White et al., *supra* note 150, at 2.

213. ROBERT A. BERENSON & RACHEL A. BURTON, URBAN INST., ACCOUNTABLE CARE ORGANIZATIONS IN MEDICARE AND THE PRIVATE SECTOR: A STATUS UPDATE I–2 (2011).

214. See Greaney, *supra* note 16, at 7.

215. See BERENSON & BURTON, *supra* note 213, at 1; see also Muir et al., *supra* note 15, at 339.

216. See *supra* Part I.B.

217. See Baker et al., *supra* note 176, at 762.

against health plans, which may work against the goals of systemic cost-savings or rationalization of care.²¹⁸

2. *Payment and Delivery Reforms Measured Against Health Care Market Failures*

At their heart, payment and delivery reforms are not aimed at disciplining health care prices. ACOs and bundled payments attempt to restrain overall health care spending by reducing unnecessary utilization, not by constraining prices. Simply altering the payment methodology does not have much influence on ultimate prices.²¹⁹ Importantly, these reforms do not address the market concentration problem and in fact exacerbate it by spurring further consolidation among providers.²²⁰

Payment and delivery reforms have some prospect of addressing the informational asymmetries in health care prices. The hope is that measuring ACOs for quality performance and cost-savings will also improve cost and quality transparency of participating providers.²²¹ To the extent that payment bundling groups together disparate parts of an episode of care, it may create a more understandable and comparable product to evaluate for price or quality purposes. For example, it is easier to comparison shop for an entire episode of care, such as the total cost of delivering a baby, than for each unbundled piece of the care.²²² However, there is nothing inherent about the ACO model or bundled payments that encourage patients to deploy consumeristic choices amongst providers. If anything, the incentive runs in the opposite direction, encouraging patients to stay within the ACO or group of providers included in the bundled payment rather than shopping among competitors.

Of all the health care market failures, payment and delivery reforms most directly address the principal-agent problem by attempting to align the incentives of the payer and different providers (hospital, physicians, post-acute care, and so on) involved in the patient's care.²²³ Payment and

218. Cunningham, *supra* note 203, at 737 (“If the object of these alliances is to make more money, they can’t be expected to transform health care.”).

219. See Massachusetts AG 2010 Report, *supra* note 10, at 4 (“Variation in total medical expenses on a per member per month basis is not correlated to the methodology used to pay for health care, with total medical expenses sometimes higher for risk-sharing providers than for providers paid on a fee-for-service basis.”).

220. See Austin Frakt, *Bigger Health Companies: Good for Medicare, Maybe Not for Others*, N.Y. TIMES: UPSHOT (June 23, 2014), <http://www.nytimes.com/2014/06/24/upshot/bigger-health-companies-good-for-medicare-maybe-not-for-others.html>.

221. See Fisher et al., *supra* note 208, at w223.

222. See Elisabeth Rosenthal, *American Way of Birth, Costliest in the World*, N.Y. TIMES (June 30, 2013), <http://www.nytimes.com/2013/07/01/health/american-way-of-birth-costliest-in-the-world.html> (“Only in the United States is pregnancy generally billed item by item, a practice that has spiraled in the past decade, doctors say. No item is too small. Charges that 20 years ago were lumped together and covered under the general hospital fee are now broken out, leading to more bills and inflated costs.”).

223. See Greaney, *supra* note 16, at 4–5, 15–16.

delivery reforms address the central principal-agent relationship between the patient and the physician who directs the patient's care, by dampening the physician's financial incentives to order unnecessary and potentially harmful tests and services.²²⁴ The providers' incentives are also aligned with the payers' because if the providers save the payer money, then the providers share some of the savings.

In the end, the payment and delivery reforms' abilities to discipline health care prices are threatened by their tendency to increase provider market power.²²⁵ Hospitals, physician groups, and other providers are consolidating to form ACOs, which can lead to higher prices in the private market.²²⁶ Perversely, the ACOs' constraints on utilization may create incentives for providers with market power to raise their prices. As bluntly stated by the Urban Institute's Robert Berenson, "[I]t is unlikely that an organization can offset the higher spending resulting from exorbitant prices by decreasing the volume of services. Or put more pithily, higher prices eat decreased volume for lunch."²²⁷

D. CONSUMER PROTECTIONS

Consumer protections take aim at only one aspect of the hospital pricing problem: the externalities of excessive hospital prices and aggressive debt collection on individual patients who may be uninsured or underinsured. Consumer protections can take the form of stronger judicial supervision in favor of the consumer when enforcing contracts for services between hospitals and self-pay patients. Alternatively, consumer protections could take the form of state fair pricing and collection laws that limit the amounts hospitals may charge to financially vulnerable patients and their bill collection actions.²²⁸ Overall, the consumer protection approach does not attempt to rationalize the whole system of hospital pricing, but rather protects the individual patient from the externalities of unreasonable hospital prices.

224. See Fisher, *supra* note 209, at w220–21.

225. See Greaney, *supra* note 16, at 20 ("Provider market power poses the biggest obstacle to the success of the ACO strategy.").

226. See Baker et al., *supra* note 176, at 756–57.

227. See Berenson, *supra* note 162.

228. A third alternative would be for a patient to pursue a claim against hospitals for violating state consumer protection statutes prohibiting unfair and deceptive trade practices ("UDTPs"). Despite the near-perfect fit between the legal conception of unfairness and hospital billing practices toward uninsured or out-of-network patients, courts have generally been hostile to claims by uninsured patients under state UDTP laws. See, e.g., *Kolari v. N.Y.-Presbyterian Hosp.*, 382 F. Supp. 2d 562, 565–66 (S.D.N.Y. 2005), *vacated in part on jurisdiction grounds*, *Kolari v. N.Y.-Presbyterian Hosp.*, 455 F.3d 118 (2d Cir. 2006); *Grant v. Trinity Health-Mich.*, 390 F. Supp. 2d 643, 647 n.6 (E.D. Mich. 2005) (listing twenty-eight other cases in various federal districts where defendant hospitals obtained dismissals in suits presented by uninsured or indigent patients).

I. *Contract Law and Muscular Supervisory Doctrines*

Uninsured or out-of-network patients are generally charged what are known as “full charges,” or the retail list prices for hospital services.²²⁹ These highly inflated prices are more than twice what private insurers pay and three to five times higher than government payers.²³⁰ Largely in response to the problem of the uninsured being charged full, undiscounted hospital prices, Mark Hall and Carl Schneider have advocated that courts adopt a protective stance through muscular use of supervisory doctrines when enforcing contracts between hospitals and uninsured patients for services.²³¹ The supervisory doctrines would allow courts to revise or reject vague or oppressive contracts when, as is the case of uninsured patients, one party lacks any meaningful bargaining power and enters the contract in a vulnerable state.

The supervisory doctrines Hall and Schneider have advocated include: (1) supplying vague or missing price terms, such as when hospital contracts obligate patients to pay a hospital’s “usual charges” or “regular rates,”²³² (2) amending or refusing to enforce unconscionable hospital-patient contracts,²³³ and (3) evaluating the fairness of health care fiduciaries’ pricing in open-ended hospital contracts for services.²³⁴ Courts can deploy these doctrines to substitute a more reasonable price for the ones often charged by hospitals to uninsured or self-pay patients.²³⁵ The larger argument advanced by Hall and Schneider is that courts should not treat as ordinary commercial contracts the essentially nonnegotiable agreements by self-pay patients in a state of medical duress to pay a hospital whatever it wants to charge. Rather, knowing the complexities and failures of health care markets, courts should feel empowered to supervise and adjust these lopsided contract terms as needed to make them more fair and reasonable.

Use of the supervisory doctrines tends to focus on the unequal bargaining power between an uninsured, vulnerable patient and a hospital. Although hospital-patient contracts are arguably equally unconscionable regardless of the patient’s education or means, courts might be less willing to use the supervisory doctrines to protect the more affluent or sophisticated consumers, who might not be perceived to be as vulnerable

229. See MICHAEL E. PORTER & ELIZABETH OLMSTED TEISBERG, *REDEFINING HEALTH CARE* 65 (2006); Anderson, *supra* note 11, at 780.

230. Barry Meier et al., *Hospital Billing Varies Wildly, Government Data Shows*, N.Y. TIMES (May 8, 2013), <http://www.nytimes.com/2013/05/08/business/hospital-billing-varies-wildly-us-data-shows.html>; Uwe E. Reinhardt, *What Hospitals Charge the Uninsured*, N.Y. TIMES: ECONOMIX (Mar. 15, 2013, 6:00 AM), <http://economix.blogs.nytimes.com/2013/03/15/what-hospitals-charge-the-uninsured/>.

231. Hall & Schneider, *supra* note 18, at 671.

232. *Id.* at 673.

233. *Id.* at 678.

234. *Id.* at 681.

235. *Id.* at 684–85.

and worthy of protection as the uninsured poor. For insured patients who receive care out-of-network and are charged inflated prices, courts might be even less willing to use supervisory doctrines because the patient's insurance contract likely specifies that out-of-network care is not covered or that the patient may be charged additional amounts from an out-of-network provider.

When an insured patient receives hospital care out-of-network, the hospital does not have a contractual, negotiated rate with the health plan.²³⁶ If the health plan covers the patient's out-of-network care at all, the plan typically specifies it will pay the noncontracted provider its "usual, customary, and reasonable rates" ("UCR").²³⁷ UCR is indeterminate and often requires litigation to assign a specific dollar value to the rate.²³⁸ In addition, the out-of-network provider will typically charge the patient a "balance bill" for the difference between the UCR amount received from the health plan and the hospital's full charges, which can be a substantial proportion of the bill. Patients are increasingly finding themselves subject to out-of-network billing with the resurgence of narrow networks under the ACA.²³⁹ Even if a patient takes pains to select an in-network hospital, she may be subject to surprise out-of-network prices because the physicians who treated her were out-of-network.²⁴⁰

When adjudicating the amount owed by self-pay patients or non-contracted health plans for hospital services, courts engage in the critical task of assigning a reasonable value to undefined prices. Although assigning value to UCR would appear to be a simple matter of determining the fair market value for specified services in the geographic market, courts struggle with this fact-intensive task and have used myriad, often conflicting, approaches to assigning values to UCR.²⁴¹ Possible methods include calculating UCR based on (1) Medicare rates or a multiplier of Medicare rates;²⁴² (2) administratively determined fee schedules, such as state-based rates for workers' compensation or auto

236. See PORTER & TEISBERG, *supra* note 229, at 65; Anderson, *supra* note 11, at 781.

237. Carol K. Lucas & Michelle A. Williams, *The Rights of Nonparticipating Providers in a Managed Care World: Navigating the Minefields of Balance Billing and Reasonable and Customary Payments*, 3 J. HEALTH & LIFE SCI. L. 132, 138 (2009). UCR or a similar concept may also be used to determine the amount an uninsured patient should pay for her care.

238. *Id.*

239. See *supra* text accompanying notes 152–54.

240. Elisabeth Rosenthal, *Costs Can Go Up Fast When E.R. Is in Network but the Doctors Are Not*, N.Y. TIMES (Sept. 28, 2014), <http://www.nytimes.com/2014/09/29/us/costs-can-go-up-fast-when-er-is-in-network-but-the-doctors-are-not.html?ref=health>.

241. David Stahl, *Health Care Reform: Presumptively Reasonable Rates for Necessary Medical Services*, 35 NOVA L. REV. 175, 181–82 (2010).

242. See, e.g., *In re Adoption of N.J.A.C.*, 979 A.2d 770, 774 (N.J. Super. Ct. App. Div. 2009) (interpreting the reasonable fee to be 130 percent of the Medicare rate).

insurance rates for hospital services;²⁴³ (3) independent third party databases like FairHealth.org;²⁴⁴ (4) the amounts the hospital generally accepts from its other payers, including or excluding Medicare and Medicaid;²⁴⁵ or (5) the hospital's full charges.²⁴⁶

Each methodology has advantages and drawbacks, which further depend on whether one is calculating rates owed by an uninsured patient or a non-contracted health plan. For example, some have advocated using a multiplier of Medicare rates to set a reasonable price for a self-pay patient because Medicare rates are transparent, widely available, and are relatively free from distortions of hospital market power.²⁴⁷ However,

243. Workers compensation and auto insurers typically do not have contracted rates with hospitals because their members make up so little of a hospital's patient volume, so some states have established fee schedules applicable to these payers to avoid them being charged full charges. *See* Fuse Brown, *supra* note 7, at 51; Stahl, *supra* note 241, at 189–90.

244. *FAQs*, FAIRHEALTH.ORG, <http://www.fairhealth.org/CorporateFAQs> (last visited Dec. 18, 2015). FairHealth.org was the result of an investigation by State Attorney General of New York in 2009 into the Ingenix database owned and operated by health insurance giant United Healthcare. The investigation alleged that United had conflicts of interest and used biased data in the Ingenix database to produce inaccurate, lower UCR calculations owed by insurance companies to providers for out-of-network care. The litigation and investigation resulted in a 2009 settlement with health insurers that called for the creation of an independent, not-for-profit database called FairHealth. For more discussions of the Ingenix controversy, see Lucas & Williams, *supra* note 237, at 155–62; Troy J. Oechsner & Magda Schaler-Haynes, *Keeping It Simple: Health Plan Benefit Standardization and Regulatory Choice Under the Affordable Care Act*, 74 ALB. L. REV. 241, 275–79 (2010); Stahl, *supra* note 241, 185–87.

245. *See, e.g.*, Baker Cty. Med. Servs., Inc. v. Aetna Health Mgmt., LLC, 31 So. 3d 842, 845 (Fla. Dist. Ct. App. 2010) (excluding Medicare and Medicaid rates); Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts., Inc., 832 A.2d 501, 509–10 (Pa. Super. Ct. 2003) (including Medicare and Medicaid rates). Data of this sort is not always readily available because negotiated rates may be subject to contractual confidentiality clauses. Thus, obtaining actual payment data requires more administrative digging (or discovery) than reference to an existing fee schedule like Medicare.

246. Some courts recognize that full charges are not “reasonable” rates because they are inflated and no payer with any bargaining clout pays anything close to these rates. *See, e.g.*, Greenfield v. Manor Care, Inc., 705 So. 2d 926, 930–31 (Fla. Dist. Ct. App. 1997); Payne v. Humana Hosp. Orange Park, 661 So. 2d 1239 (Fla. Dist. Ct. App. 1995); Victory Mem'l Hosp. v. Rice, 493 N.E.2d 117, 119 (Ill. App. Ct. 1986); *In re Adoption of N.J.A.C.*, 979 A.2d at 785; Doe v. HCA Health Servs. of Tenn., Inc., 46 S.W.3d 191 (Tenn. 2001). Other courts, however, have concluded that billed charges are “reasonable” because they are what is usually or customarily charged to self-pay patients or noncontracted payers. *See, e.g.*, Allen v. Clarian Health Partners, Inc., 980 N.E.2d 306, 311 (Ind. 2012) (holding that a patient's agreement to pay “the account” in a contract to provide medical services is not indefinite and refers to the hospital's chargemaster); Holland v. Trinity Health Care Corp., 791 N.W.2d 724, 728 (Mich. Ct. App. 2010) (finding that “usual and customary charges” referred to the hospital's chargemaster prices because Black's Law Dictionary defines charge as “to demand a fee; to bill.”); Huntington Hosp. v. Abrandt, 779 N.Y.S.2d 891, 892 (App. Div. 2004); *accord* Kolari v. N.Y.-Presbyterian Hosp., 382 F. Supp. 2d 562, 576 (S.D.N.Y. 2005) (“[U]nder New York law a hospital's charges to an uninsured patient are not unreasonable merely because a lower price is charged to government programs or other insurers.”); Albany Med. Ctr. Hosp. v. Huberty, 428 N.Y.S.2d 746 (App. Div. 1980).

247. Gerard Anderson has proposed that reasonable rates to charge a self-pay patient would be 125 percent of Medicare rates, which is higher than most commercial payers' negotiated rates, but significantly lower than full charges. Medicare rates are based on a methodology that takes into

because they tend to be lower than private rates and typical calculations of UCR, using a multiplier of Medicare for out-of-network care means the health plan pays less and the balance bill for the insured patient increases.²⁴⁸ Regardless of the methodology used to determine UCR for a noncontracted provider, the court ought to keep in mind the harm to the patient that comes from balance billing even if the plan's payment obligation is satisfied. Without legislation prohibiting balance billing, courts might be without power to stop a hospital from balance billing a patient even if the court is able to resolve how much the noncontracted health plan owes.²⁴⁹

2. Hospital Fair Pricing and Balance Billing Laws

Thirteen states have passed laws that limit the amount hospitals may charge to uninsured or self-pay patients who fall below defined income levels.²⁵⁰ Many of these states plus some additional states that do not limit charges to uninsured or underinsured patients, also regulate the debt collection practices hospitals use to recover medical debt from patients,²⁵¹ including limitations on interest rates, liens or foreclosure actions on a patient's home, and wage garnishment, as well as obligations to offer payment plans and defer assigning debt to collection agencies for

account the hospital's costs, geographic variation, and resource intensity of particular services. See Anderson, *supra* note 11, at 787. Mark Hall and Carl Schneider suggested capping rates that providers may charge self-pay patients at 150 percent of Medicare rates or a weighted average of what large private insurers pay in the region. Mark A. Hall & Carl E. Schneider, *Price-Gouging by Doctors and Hospitals*, HEALTH REFORM WATCH (July 19, 2009), <http://www.healthreformwatch.com/2009/07/19/price-gouging-by-doctors-and-hospitals/>.

248. Nina Bernstein, *Insurers Alter Cost Formula, and Patients Pay More*, N.Y. TIMES (Apr. 23, 2012), http://www.nytimes.com/2012/04/24/nyregion/health-insurers-switch-baseline-for-out-of-network-charges.html?pagewanted=all&_r=0 (observing an increasing trend toward insurance companies paying 140 percent to 250 percent of Medicare for out-of-network care, instead of eighty percent of UCR, resulting in lower payments by the insurance plan and large balance-bills for the patient).

249. For discussion of state balance billing bans, see *infra* Part II.D.3.

250. See CAL. HEALTH & SAFETY CODE § 127400-127446 (West 2012); COLO. REV. STAT. § 25-3-112 (2013); CONN. GEN. STAT. § 19a-673 (West 2014); 210 ILL. COMP. STAT. 88/1-88/999 (2013); MD. CODE ANN. HEALTH-GEN. §§ 19-214.2, -214.3 (West 2013); MISS. CODE ANN. § 41-7-35 (West 2014); NEV. REV. STAT. § 439B.260 (2014); N.J. STAT. ANN. § 26:2H-12.52 (West 2013); N.Y. PUB. HEALTH LAW § 2807-k (McKinney 2013); OKLA. STAT. tit. 63, § 1-723.2 (2007); 27-50 R.I. CODE R. § 11.0:31-4-9 (LexisNexis 2011); TENN. CODE ANN. § 68-11-262 (2015); WASH. REV. CODE § 70.170.010-.905 (1998). Although it has not passed a law, Utah has issued administrative guidance outlining standards for property tax exemption that includes a requirement that nonprofit hospitals not charge indigent patients for medically necessary care. UTAH STATE TAX COMM'N, PROPERTY TAX EXEMPTIONS: STANDARDS OF PRACTICE 26-29 (2015), <http://propertytax.utah.gov/library/pdf/standards/standard02.pdf>. See generally HOSP. CMTY. BENEFIT PROGRAM, HILLTOP INST., http://www.hilltopinstitute.org/hcbp_cbl_state_table.cfm?select=lcbc; FAMILIES U.S.A., MEDICAL DEBT: WHAT STATES ARE DOING TO PROTECT CONSUMERS (2009), <http://www.familiesusa.org/assets/pdfs/medical-debt-state-protections.pdf>.

251. KAN. STAT. ANN. § 60-2310(c) (2005); LA. REV. STAT. ANN. § 20:1(A)(2) (2014); ME. REV. STAT. tit. 9-A, § 5-116-A (2009); 114.6 MASS. CODE REGS. § 12.08(1)(b) (2015); N.D. CENT. CODE § 13-01-14.1(4) (2001); OHIO REV. CODE ANN. § 2329.66(A)(1)(a) (West Supp. 2013). See HOSP. CMTY. BENEFIT PROGRAM, *supra* note 250.

specified time periods.²⁵² At the federal level, the ACA created new requirements limiting the amount tax-exempt hospitals may charge to patients who are eligible under the hospital's financial assistance policy as well as requiring such hospitals to make reasonable efforts to determine eligibility before pursuing debt collection actions.²⁵³

An example is California's Fair Pricing Act, passed in 2006, which limits the amounts hospitals may charge uninsured patients below three hundred and fifty percent of the federal poverty limit ("FPL") or insured patients below three hundred and fifty percent of the FPL whose medical bills exceed ten percent of their income.²⁵⁴ Hospitals may not charge these patients more than the highest amount paid by any government program (for example, Medicare, Medicaid, or CHIP). By 2011, most California hospitals had adopted financial assistance policies and gone beyond the bare requirements of the Act, with ninety-seven percent offering free care to those below one hundred percent of the FPL and a significant percentage limiting charges to Medicare rates for those above three hundred fifty percent of FPL.²⁵⁵ New Jersey passed a law in 2008 that limits the amount hospitals may charge uninsured patients who make up to five hundred percent of the FPL to Medicare rates plus fifteen percent and requires hospitals to provide free care to those who make less than two hundred percent of the FPL.²⁵⁶

These laws cap rates for financially vulnerable patients, but they do not eliminate price discrimination among payers or prevent inflated charges to middle class uninsured patients, or insured patients who are out-of-network.²⁵⁷ Nor do they address hospitals' market power and variations in price. These laws seek to reduce the number of people who are billed full charges without actually rationalizing these charges.

Virtually every state has laws restricting balance billing by *in-network* providers to managed care enrollees, but twelve states extend

252. See Erin C. Fuse Brown, *Fair Hospital Prices Are Not Charity: Decoupling Hospital Pricing and Collection Rules from Tax Status*, 53 U. LOUISVILLE L. REV. (forthcoming 2015) (manuscript at 43–44).

253. Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119, 855–58 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (2010) (codified at 26 U.S.C. § 501(r)(2014)). The federal 501(r) rules contain many gaps in protection, including that they do not apply to for-profit or government-run facilities and they leave eligibility for financial assistance to the complete discretion of hospitals. For an in-depth discussion of the 501(r) rules and state fair pricing laws, see Fuse Brown, *supra* note 252, at 42–43.

254. CAL. HEALTH & SAFETY CODE §§ 127400-127446 (West 2012); CAL. CODE REGS. tit. 22, §§ 96000–96150 (2007); see Glenn Melnick & Katya Fonkych, *Fair Pricing Law Prompts Most California Hospitals to Adopt Policies to Protect Uninsured Patients from High Charges*, 32 HEALTH AFF. 1101, 1102 (2013).

255. See Melnick & Fonkych, *supra* note 254, at 1104.

256. N.J. STAT. ANN. § 26:2H-12.52 (West 2013).

257. See Anderson, *supra* note 11, at 768–87.

balance billing restrictions even to *out-of-network* providers.²⁵⁸ These states include California, Connecticut, Delaware, Florida, Maryland, Minnesota, New Jersey, New York, Pennsylvania, Rhode Island, Utah, and West Virginia.²⁵⁹ Although these laws vary in scope and degree, balance billing prohibitions generally protect the patient from receiving bills for the difference between what their health plan pays the out-of-network provider and the provider's full charges.²⁶⁰ Some laws only apply to emergency services, while others apply to a broader range of covered benefits.²⁶¹ Balance billing is a problem in nonemergency care, such as when the hospital is in-network, but the surgeon or anesthesiologist is out-of-network.²⁶² In addition, state balance billing laws may be preempted by ERISA for self-insured employer plans.

258. *State Restriction Against Providers Balance Billing Managed Care Enrollees*, HENRY J. KAISER FAM. FOUND., <http://kff.org/private-insurance/state-indicator/state-restriction-against-providers-balance-billing-managed-care-enrollees/> (last visited Dec. 18, 2015).

259. See CAL. HEALTH & SAFETY CODE § 1379 (West 2013); *Prospect Med. Grp. v. Northridge Emergency Med. Grp.*, 198 P.3d 86 (Cal. 2009) (ruling that HMO members may not be balanced billed); CONN. GEN. STAT. ANN. § 20-7f (West 1998) (protecting an enrollee of a managed care plan from balance billing from “any health care provider”); DEL. CODE ANN. tit. 18, § 3565 (2011) (protecting members of “individual and group health insurance policies” from balance billing); DEL. CODE ANN. tit. 19, § 2322F (2009) (protecting those covered by workers compensation from balance billing); FLA. STAT. § 641.3154, .513 (2015) (protecting HMO members from balance billing for non-network emergency care); FLA. STAT. § 641.513 (2015) (protecting HMO members from balance billing for non-network emergency care); IND. CODE § 32-33-4-3.5 (2013) (prohibiting hospital lienholders from balance billing patients); MD. CODE ANN., HEALTH-GEN. § 19-710(i) (West 2014) (holding HMO subscribers harmless for covered services in and out of network; statute mandates HMO payment to non-contractual providers); N.J. ADMIN. CODE § 11:3-29.6 (protecting “any person” from balance billing by health care providers); 2014 N.Y. Sess. Law § 6914 (McKinney) (protecting individuals insured under a health care plan from balance billing for a “surprise bill” by a “non-participating physician” that knows the individual is insured); 35 PA. STAT. ANN. § 449.34 (West 1990) (prohibiting any primary health care practitioner, or any primary health center, corporation, facility, institution or other entity that employs a health care practitioner from balance billing); R.I. GEN. LAWS ANN. § 27-41-26 (West 2003) (protecting enrollees of an HMO from balance billing by “any provider” for charges for covered health services); UTAH CODE ANN. § 31A-8-501(5) (West 2012) (prohibiting out-of-network providers from balance billing when an HMO or PPO enrollee lives or resides within thirty miles of a federally qualified health center or independent hospital or is in closer proximity to these providers than another contracting hospital); W. VA. CODE § 33-25A-7a (1996) (protecting HMO members from balance billing if the provider is aware patient is HMO subscriber). In addition, Colorado requires managed care companies to hold members harmless for out-of-network balance bills, but it does not prevent the provider from balance billing. COLO. REV. STAT. § 10-16-704(2)(a) (2015).

260. See JACK HOADLEY ET AL., UNEXPECTED CHARGES: WHAT STATES ARE DOING ABOUT BALANCE BILLING 6–9 (2009).

261. See *State Restriction Against Providers*, *supra* note 258.

262. See Ginsburg, *supra* note 24, at 6; Roni Caryn Rabin, *Out-of-Network Bills for In-Network Health Care*, N.Y. TIMES (Nov. 19, 2012, 4:23 PM), <http://well.blogs.nytimes.com/2012/11/19/out-of-network-bills-for-in-network-health-care/>; Tara Siegel Bernard, *Out of Network, Not by Choice, and Facing Huge Health Bills*, N.Y. TIMES (Oct. 18, 2013), <http://www.nytimes.com/2013/10/19/your-money/out-of-network-not-by-choice-and-facing-huge-health-bills.html>.

These balance billing laws shield a subset of patients including insured persons receiving care out-of-network from the harms of excess hospital charges. As with many of these solutions, balance billing laws do not address the fundamental market failures afflicting hospital pricing. Nevertheless, balance billing laws remain an important protection for individuals, especially as the proliferation of narrow networks makes it more likely a patient will find herself out-of-network.²⁶³

3. *Consumer Protections Measured Against Health Care Market Failures*

The consumer protection solutions are not really solutions to discipline health care prices on the whole, but to protect some of the most vulnerable patients from the harms of unrestrained hospital pricing. The main market failure addressed by consumer protection is the externalities imposed on individual patients when they are charged excessive prices because they are uninsured or underinsured.

Judicial supervision of hospital-patient contracts generally proceeds case by case, individualized on the level of the hospital or patient. Under the broader fair pricing laws, hospitals are forced to curtail some of the excessive pricing and collection practices for the financially vulnerable. However, none of the consumer protection approaches address the information asymmetries, the price distortions of provider market power, or principal-agent problems that characterize the health care market. A powerful hospital could still exact supracompetitive prices to the rest of the market even if it must charge fairer prices to the uninsured or underinsured patient.

E. RATE REGULATION

Health economists who study the issue of health care pricing are less sanguine than politicians about the ability of market strategies such as transparency and CDHC to discipline hospital prices and curb health care spending. Antitrust enforcers can do little to address extant provider monopolies. Payment and delivery reforms are increasing provider market consolidation while they try to improve health care quality and efficiency. Consumer protection approaches have limited potential as a systemic policy solution because they only protect a limited segment of the population from excessive hospital prices. Thus, whether enthusiastically or grudgingly, nearly every prominent health economist or policy analyst with expertise in health care pricing ultimately concludes that the only solution that may be effective in a concentrated

263. See *supra* text accompanying notes 152–54.

provider market is regulation of health care prices.²⁶⁴ The best-known example of rate regulation is Maryland's all-payer rate setting model, but other models include a version of rate-setting that allows some price variation between hospitals, caps on rates negotiated by private payers, or global budgets.

I. All Payer Rate Setting

Under an all-payer system, hospitals are paid the same rate for a given service by all payers, whether insurers, government programs, or self-pay patients ineligible for charity care.²⁶⁵ The prices are set by either a governmental agency using a public utility model or by collective negotiation between representatives of hospitals and payers for prices binding on all hospitals.²⁶⁶ Maryland is the only state currently using an all-payer system that sets the prices for all payers through the regulatory, public utility model. Pursuant to legislation enacted in 1971, Maryland established an independent rate setting agency to set hospital rates for all payers, including Medicare and Medicaid.²⁶⁷ The agency collects detailed information about costs, patient volumes, hospital finances, and services at each hospital to inform its rates.²⁶⁸ As for the latter model of collectively negotiated prices, there are no examples from the United States, but there are examples from Japan, Germany, France, Switzerland, and other OECD countries.²⁶⁹ For consistency and administrative ease, the all-payer fee schedule could be based on Medicare DRGs. To the extent that Medicare is not included in the all-

264. See, e.g., Anderson, *supra* note 11, at 786–87; Berenson et al., *supra* note 43, at 979; Cutler & Scott Morton, *supra* note 17, at 1969; Ginsburg, *supra* note 170; Ginsburg & Pawlson, *supra* note 152, at 1073; Thomas L. Greaney, *The Affordable Care Act and Competition Policy: Antidote or Placebo?*, 89 OR. L. REV. 811, 840–41 (2011); Robert Murray, *Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience*, 28 HEALTH AFF. 1395, 1395 (2009); Joseph P. Newhouse, *Assessing Health Reform's Impact on Four Key Groups of Americans*, 29 HEALTH AFF. 1, 10 (2010); N.J. DEP'T OF HEALTH, *supra* note 27; Reinhardt, *supra* note 26, at 2125; Vladeck, *supra* note 13, at 1086; Vladeck & Rice, *supra* note 13, at 1312–13; White et al., *supra* note 147, at 330; Austin Frakt, *Simply Put: All-Payer Rate Setting*, INCIDENTAL ECONOMIST BLOG (Apr. 8, 2011, 8:00 AM), <http://theincidentaleconomist.com/wordpress/simply-put-all-payer-rate-setting/>.

265. NAT'L CONFERENCE OF STATE LEGISLATURES, EQUALIZING HEALTH PROVIDER RATES: ALL-PAYER RATE SETTING (2010), http://www.ncsl.org/portals/1/documents/health/ALL_PAYER_RATES-2010.pdf; Reinhardt, *supra* note 26, at 2129.

266. NAT'L CONFERENCE OF STATE LEGISLATURES, *supra* note 265, at 1.

267. See Murray, *supra* note 264, at 1395–96. Maryland received a waiver in 1971 to allow it to set hospital rates for Medicare and Medicaid patients. A similar waiver from CMS would be required in other states that want to include Medicare and Medicaid in its all-payer rates.

268. *Id.*

269. See Uwe E. Reinhardt, *A Modest Proposal on Payment Reform*, HEALTH AFF. BLOG (July 24, 2009), <http://healthaffairs.org/blog/2009/07/24/a-modest-proposal-on-payment-reform/> [hereinafter Reinhardt, *A Modest Proposal*]; Reinhardt, *supra* note 26, at 2129; Vladeck & Rice, *supra* note 13, at 1313.

payer system, the private rates could be expressed as a simple multiplier of Medicare rates.²⁷⁰

An all-payer system addresses many of the complexities and perversities of hospital pricing. First, all-payer systems reduce or eliminate price discrimination by creating uniform rates for everyone, regardless of whether one is insured by a big health plan, a small plan, a government program, workers compensation, or are a self-pay patient. An all-payer approach flattens the inequities of price discrimination, where those with the least bargaining power pay the highest prices.²⁷¹ Setting uniform rates for all payers also reduces the administrative costs of negotiating with and maintaining separate billing systems for each payer.²⁷² These administrative costs are significant, with U.S. hospitals' administrative costs totaling about twenty-five percent of their total costs.²⁷³ Because of the fragmented payer landscape, U.S. hospitals spend far more on administrative costs than other wealthy countries with all-payer or single-payer systems.²⁷⁴

Most importantly, all-payer rates combat the market power of hospitals that drives price inflation, either because the rates are set by an administrative body or by combining the bargaining power of all the payers to negotiate lower prices.²⁷⁵ By constraining market power and regulating prices, all-payer rate setting also has the potential to control rising health care spending.²⁷⁶ As a result of its all-payer system, Maryland has by far the lowest hospital price markups in the country, almost a hundred times lower than New Jersey's, a state that abandoned its own all-payer system in 1992.²⁷⁷ Maryland's all-payer rate setting has effectively constrained growth in costs per hospital case.²⁷⁸ Skeptics note, however, that the cost-per-case savings in Maryland's system have been

270. See Vladeck & Rice, *supra* note 13, at 1313.

271. Murray, *supra* note 264, at 1400-01.

272. See Reinhardt, *supra* note 26, at 2126.

273. David U. Himmelstein et al., *A Comparison of Hospital Administrative Costs in Eight Nations: US Costs Exceed All Others by Far*, 33 HEALTH AFF. 1586, 1589 (2014).

274. *Id.* at 1591-92.

275. See Frakt, *supra* note 264.

276. NAT'L CONFERENCE OF STATE LEGISLATURES, *supra* note 265, at 2; Graham Atkinson, *State Hospital Rate-Setting Revisited*, 69 COMMONWEALTH FUND 1332, 2 (Oct. 2009); Reinhardt, *supra* note 26, at 2129.

277. See Karan Chhabra, *Chargemaster Tomfoolery, Policy Responses, and Unintended Consequences (In Four Charts)*, PROJECT MILLENNIAL BLOG (May 17, 2013), <http://projectmillennial.org/2013/05/17/chargemaster-tomfoolery-policy-responses-and-unintended-consequences-in-four-charts/>.

278. See Murray, *supra* note 261, at 1399, 1403. Maryland's system is not perfect, however. Murray further notes that although costs-per-admission, hospital length-of-stay, and hospital price inflation have been curtailed, overall hospital cost growth has not been well-controlled due to increases in patient volume.

offset by increases in patient volume, so without other mechanisms to control incentives to boost volume, the cost savings may be ephemeral.²⁷⁹

The fact that Maryland's was the sole rate setting program to survive deregulation was due in part to its unique and valuable Medicare waiver that allowed it to include Medicare prices as part of its rate setting system, but it also resulted in higher than average Medicare rates.²⁸⁰ Maryland's Medicare waiver offset some of the financial pressures exerted on the state's hospitals from the all-payer model and ensured continued cooperation from the hospitals.

To address the volume problem and reign in Medicare spending in the state, Maryland has made adjustments to its rate setting program and negotiated a new Medicare waiver with the Centers for Medicare and Medicaid Services ("CMS") starting in 2014.²⁸¹ Maryland has agreed to impose overall limits on per capita hospital spending to counteract incentives to increase utilization and to contain its relatively high Medicare reimbursements.²⁸² In addition, Maryland must move eighty percent of its hospitals' revenue to population-based payments, the principal method for which is a fixed, global budget for hospitals. Under the fixed budget, the hospital has a low, but stable profit margin.²⁸³ If costs exceed revenue, the agency will increase the hospitals' prices the following year to make up for the loss. But if the hospital comes in under budget, its prices will be reduced the following year.²⁸⁴ In essence, Maryland has moved from hospital rate-setting to rate-setting under a global budget.

Another variation of an all-payer system allows prices to vary between hospitals to preserve competition. This market-based approach to rate-setting permits hospitals to charge different prices from each other, but the hospital is required to charge each of its payers the same price (that is, no price discrimination) and post its percentage markup

279. See Mark Pauly & Robert Town, *Maryland Exceptionalism? All-Payers Regulation and Health Care System Efficiency*, 37 J. HEALTH POL. POL'Y & L. 697, 699 (2012); Kevin Outterson, *All-Payer Rate Setting in JAMA: A "Maryland Miracle?"*, INCIDENTAL ECONOMIST BLOG (Sept. 14, 2011, 6:00 AM) <http://theincidentaleconomist.com/wordpress/all-payer-rate-setting-in-jama-a-maryland-miracle/>.

280. John E. McDonough, *Tracking the Demise of State Hospital Rate Setting*, 16 HEALTH AFF. 142, 145 (1997); Lena H. Sun & Sarah Kliff, *Maryland Already Sets Hospitals' Prices. Now It Wants to Cap Their Spending*, WASH. POST WONKBLOG (May 25, 2013), <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/05/25/maryland-already-sets-hospitals-prices-now-it-wants-to-cap-their-spending/>.

281. *Maryland All-Payer Model*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/> (last updated Feb. 6, 2015).

282. Robert Murray, *Maryland's Bold Experiment in Reversing Fee-for-Service Incentives*, HEALTH AFF. BLOG (Jan. 28, 2014), <http://healthaffairs.org/blog/2014/01/28/marylands-bold-experiment-in-reversing-fee-for-service-incentives/>; Christine Vestal, *Maryland May Be the Model for Curbing Hospital Costs*, USA TODAY (Jan. 31, 2014, 10:37 AM), <http://www.usatoday.com/story/news/nation/2014/01/31/stateline-maryland-hospital-costs/5079073/>.

283. Eduardo Porter, *Lessons in Maryland for Costs at Hospitals*, N.Y. TIMES (Aug. 27, 2013), <http://www.nytimes.com/2013/08/28/business/economy/lessons-in-maryland-for-costs-at-hospitals.html>.

284. *Id.*

above the standard rate to allow price comparisons with other hospitals.²⁸⁵ This approach maintains price competition among hospitals to allow for differences in quality, amenities, or input costs.²⁸⁶ Whatever price is reached by the collective insurance negotiation with each hospital would be the same price charged to self-pay patients, whether on contracted or non-contracted health plans. Like the public utility model, this approach would save hospitals the administrative costs of negotiating different rates and maintaining separate billing procedures for each payer.

In order to counteract hospital market power and keep prices in check for “must-have” providers, insurers combine their bargaining power and collectively negotiate with each provider, even if providers are permitted to bargain separately.²⁸⁷ Balancing hospitals’ supply-side monopolies with insurance buy-side monopsony power could reduce price variations based on hospital market power, and whatever variations in price that remain between hospitals would better reflect differences in quality or amenities. Importantly, allowing insurers to come together to bargain collectively with hospitals and providers is not the same thing as concentrating the insurance market. The individual health plans would still have to compete for their own customers, which would hopefully drive down premiums.²⁸⁸

Outside of Maryland, federal and state efforts to pursue all-payer rate setting have been tentative but may be gaining steam.²⁸⁹ The ACA created the Center for Medicare and Medicaid Innovation, which is tasked with testing various payment and health care delivery approaches for their ability to contain health care costs while improving quality.²⁹⁰ The Center encourages states to test all-payer rate setting models that include Medicare and Medicaid populations, which some economists believe is important to make all-payer systems work well.²⁹¹ Some states have more recently examined all-payer systems, although none have yet moved forward to implement such a system.²⁹²

285. See Frakt, *supra* note 264; Reinhardt, *supra* note 8, at 66; Reinhardt, *A Modest Proposal*, *supra* note 269; N.J. COMM’N ON RATIONALIZING HEALTH CARE RES., *supra* note 27, at 100.

286. See Frakt, *supra* note 264; see also Reinhardt, *A Modest Proposal*, *supra* note 269.

287. Austin Frakt, *All-Payer Rate Setting and Health Reform’s Underpants Gnomes Strategy*, WASH. POST WONKBLOG (June 2, 2011), http://www.washingtonpost.com/blogs/wonkblog/post/all-payer-rate-setting-and-health-reforms-underpants-gnomes-strategy/2011/06/02/AG3SfHHH_blog.html.

288. *Id.*

289. At one time, in the 1970s, many states adopted all-payer rate setting models facilitated by Congress, only to abandon them in the 1980s during the Reagan-era push for deregulation. See N.J. COMM’N ON RATIONALIZING HEALTH CARE RES., *supra* note 27, at 100.

290. Patient Protection and Affordable Care Act, 42 U.S.C. § 1115A (2010) (encouraging development of new patient care models).

291. See Murray, *supra* note 264, at 1396; Reinhardt, *A Modest Proposal*, *supra* note 269.

292. See NAT’L CONFERENCE OF STATE LEGISLATURES, *supra* note 265, at 2 (describing initiatives in Minnesota, Oregon, and Massachusetts to examine some version of all-payer rate setting); N.J.

2. Caps on Negotiated Prices for Private Health Plans

For those who are skeptical about the ability of regulators to actually set hospital prices for all payers, an intermediate option would be to establish caps on the prices hospitals can charge private health plans or self-pay patients. This system would permit hospitals to continue to discriminate amongst payers (charging different payers different rates for the same services) and preserve the ability of hospitals to charge different prices from each other, but it would limit the extent of price variation by imposing a ceiling on prices. A broad cap on private payer rates would improve payer bargaining position to resist price increases by powerful hospitals or at least put a regulatory backstop on the degree to which such hospitals can charge monopoly prices.

Although we do not have any examples within the United States of such a system, Robert Murray, former Executive Director of Maryland's rate setting agency, suggested that the cap could be set as a multiple of Medicare rates, such as 150 percent to 175 percent of Medicare.²⁹³ More recently, health economics and policy experts from Dartmouth suggested that all health care prices should be capped at 125 percent of Medicare prices for all payers.²⁹⁴ Such a cap would particularly benefit uninsured and out-of-network patients who are typically charged the highest prices. The cap would thus have similar effects as the fair pricing laws that are discussed in the previous section, although it would lack the protections against hospital debt collection practices.²⁹⁵

3. Global Budgets

Under a global budget system, states impose total revenue limits on hospitals to control both prices and utilization.²⁹⁶ A global budget is set

COMM'N ON RATIONALIZING HEALTH CARE RES., *supra* note 27, at 100 (recommending that New Jersey consider an all-payer approach).

293. See Robert Murray, *The Case for a Coordinated System of Provider Payments in the United States*, 37 J. HEALTH POL., POL'Y & L. 679, 689 (2012) [hereinafter Murray, *The Case for a Coordinated System of Provider Payments*]; ROBERT MURRAY, NAT'L HEALTH POLICY FORUM, THE COST OF HOSPITAL CARE: EXPERIENCE FROM MARYLAND'S ALL-PAYER RATE SETTING SYSTEM 21 (Oct. 8, 2010), http://www.hsrc.state.md.us/documents/HSCRC_PolicyDocumentsReports/Presentations/TheCostofHospitalCareNHPFR_Murray2010-10-08.pdf.

294. Jonathan Skinner et al., *The 125 Percent Solution: Fixing Variations in Health Care Prices*, HEALTH AFF. BLOG (Aug. 26, 2014), <http://healthaffairs.org/blog/2014/08/26/the-125-percent-solution-fixing-variations-in-health-care-prices> ("If every patient and every insurance company always had the option of paying 125 percent of the Medicare price for any service, we would effectively cap the worst of the price spikes. No longer would the tourist checked out at the ER for heat stroke be clobbered with a sky-high bill. Nor would the uninsured single mother be charged 10 times the best price for her child's asthma care. This is not just another government regulation, but instead a protection plan that shields consumers from excessive market power.")

295. See *supra* Part II.D.2.

296. RACHEL BLOCK, MILLBANK MEM'L FUND, STATE MODELS FOR HEALTH CARE COST MEASUREMENT: A POLICY AND OPERATIONAL FRAMEWORK 7 (2015). Global budgets can also be

prospectively for a hospital or integrated health system to cover the total expected health care costs of a defined population for a given time period.²⁹⁷ If the hospital or health system exceeds its budget, then it must make up for the overrun in the following year's budget, and if it comes in under budget, the hospital can keep the surplus.

As discussed above, Maryland has begun to implement global budgets on top of its rate setting system,²⁹⁸ but a state could move straight to regulatory limits on hospital budgets without first establishing standalone rate setting. Because hospital revenues are the result of a combination of its prices, utilization, and operating costs, regulatory oversight of total hospital revenues is a way to control both rates and utilization by hospitals.

Notwithstanding the demise of Vermont's single payer system,²⁹⁹ in 2012 the state implemented reforms to constrain total health care spending through administrative review of hospital budgets.³⁰⁰ Hospitals must submit their proposed budgets to the state's Green Mountain Care Board for review, and then the Board sets an annual budget for each hospital based on hospital proposals.³⁰¹ The Board may adjust a hospital's budget by ordering changes to a hospital's rates or net revenues, or by allowing hospitals to retain or use cash surpluses.³⁰² The Board may enforce hospital compliance with agreed upon budgets through court-ordered injunction or imposition of civil administrative penalties.³⁰³

Vermont's hospital budget review system is a step toward a global budget system, under which the Board would set total payments and revenues for hospitals from all payers to manage all of the health care for a given population.³⁰⁴ Under the current hospital budget review process,

implemented by private payers, often called "Alternative Quality Contracts" or ACOs with two-sided risk or "Total Cost of Care Contracts." See, e.g., Zirui Song et al., *The 'Alternative Quality Contract,' Based on a Global Budget, Lowered Medical Spending and Improved Quality*, 31 HEALTH AFF. 1885, 1885–86 (2012); ANN ROBINOW, COMMONWEALTH FUND, *THE POTENTIAL OF GLOBAL PAYMENT: INSIGHTS FROM THE FIELD* 1, 3 (2010).

297. See Song et al., *supra* note 296, at 1885.

298. See *supra* text accompanying note 281.

299. 2011 Vt. Acts & Resolves No. 48 (enacting Vermont's single payer system); Sarah Kliff, *How Vermont's Single-Payer Health Care Dream Fell Apart*, VOX.COM (Dec. 22, 2014), <http://www.vox.com/2014/12/22/7427117/single-payer-vermont-shumlin> (describing how Vermont's single payer plan would cost an estimated \$2.5 billion in additional tax revenue, up from earlier estimates of \$1.6 billion).

300. VT. STAT. ANN. tit. 18, § 9456 (2014); 4-7 VT. CODE R. §§ 3:3.100–3:3.500 (2014). See generally, THE GREEN MOUNTAIN GUIDE TO HOSPITAL BUDGET REVIEW (Aug. 2012), <http://gmcboard.vermont.gov/sites/gmcboard/files/GMCB%20Hospital%20Budget%20Review.pdf>.

301. VT. STAT. ANN. tit. 18, §§ 9456(a)–(d) (2014); 4-7 VT. CODE R. § 3:3.300 (2014).

302. 4-7 VT. CODE R. § 3:3.400 (2014).

303. VT. STAT. ANN. tit. 18, § 9456(h) (2014).

304. Zack Budryk, *VT Hospitals Eye "Global Budget" Payment Model*, FIERCE HEALTH FIN. (Apr. 15, 2014), <http://www.fiercehealthfinance.com/story/vt-hospitals-eye-global-budget-payment-model/2014-04-15>; Morgan True, *Vermont to Launch Global Budget Pilot for Hospitals*, VTDIGGER.ORG (Apr. 14, 2014), <http://vtdigger.org/2014/04/14/vermont-launch-global-budget-pilot-hospitals/>.

Vermont hospitals still negotiate rates with each commercial payer, but under the global budget system the Board would set a uniform rate increase for each hospital applicable to all payers, eliminating the hospital's contract negotiations with each payer.³⁰⁵ Both Maryland and Vermont have experienced success under their hospital budget programs: in its first year with global budgets, Maryland saved more than \$100 million,³⁰⁶ and Vermont's hospitals requested a total budget increase of just 3.6% for fiscal year 2016.³⁰⁷ Global budgets as implemented in Maryland or anticipated in Vermont are more comprehensive than rate setting because they incorporate mechanisms to control all the components of total health care spending: prices, utilization, and hospital operating costs.

4. Rate Regulation Measured Against Health Care Market Failures

Rate regulation is the only proposed price-disciplining policy solution that addresses the problem of provider market power. Administrative rate regulation addresses provider market power by administrative price setting through a pure monopsony and removing the element of negotiation from hospital pricing, similar to the way Medicare sets prices for all participating hospitals.³⁰⁸ Alternatively, the rate setting model could combine all payers' market power in an oligopsony to bargain against hospitals on prices.³⁰⁹ By doing away with price discrimination within the hospital, all-payer rate setting would reduce administrative complexity and costs for providers, simplifying billing, and drastically reducing the number of parties with which providers must negotiate prices.³¹⁰

With respect to information asymmetries, rate regulation could promote transparency of price and quality because the prices would be publicly available. Therefore, standardized payments and reporting could

305. RICHARD SLUSKY, DIR. OF PAYMENT REFORM, PROPOSED PILOT PAYMENT REFORM PROJECTS: CONSIDERATION OF HOSPITAL GLOBAL BUDGET PILOT, at Slide 21 (Mar. 27, 2014), http://gmcbord.vermont.gov/sites/gmcbord/files/Global_Budgets032714.pdf.

306. Audie Cornish & Andrea Hsu, *In Maryland, A Change in How Hospitals Are Paid Boosts Public Health*, NPR.ORG (Oct. 23, 2015), <http://www.npr.org/sections/health-shots/2015/10/23/451212483/in-maryland-a-change-in-how-hospitals-are-paid-boosts-public-health>.

307. Nancy Remsen, *Hospitals in Vermont Anticipate Modest Budget Increases Next Year*, SEVEN DAYS (July 23, 2015), <http://www.sevendaysvt.com/OffMessage/archives/2015/07/23/hospitals-in-vermont-anticipate-modest-budget-increases-next-year>. The Chair of the Green Mountain Care Board, Al Gobeille, noted that the average rate increase Vermont hospitals requested from insurers was only 4.3%, the lowest rate increase in fifteen years. *Id.*

308. Vladeck & Rice, *supra* note 13, at 1312.

309. *Id.*

310. See Himmelstein et al., *supra* note 270, at 1593 (noting that if U.S. hospitals' administrative costs were shifted to the levels seen in Canada or Scotland on a per capita basis, the United States would have saved from \$156 billion to \$158 billion in 2011, the equivalent of about one percent of GDP).

result in better and more comparable data on prices, product (bundled episodes of care), and quality. All-payer rate setting can also be augmented with market strategies to address price insensitivity from moral hazard. In the market-based approach to rate setting, hospitals are permitted to charge different prices from one another, and the different prices and quality scores could be used by payers to structure reference pricing or tiering programs.³¹¹

Rate regulation reduces the externalities of hospital pricing, because under both systems the uninsured or out-of-network patient would not be charged unfair or inflated charges. All-payer rate setting eliminates price discrimination, and therefore evens out much of the variability and disparate pricing that harms the financially vulnerable patient. In addition, the prices set through rate setting systems can help hospitals internalize the costs borne by financially vulnerable patients by incorporating the costs of uncompensated care into the price, much the way Medicare adjusts hospital rates.³¹² Nevertheless, the uninsured patient may still struggle to pay her hospital bills even if charged the regulated price, and all-payer rate setting does not necessarily address balance billing, hospital debt collection practices, or financial assistance policies for the most financially vulnerable. Consumer protections could be added to an all-payer approach through state funds to reimburse hospitals for indigent or uncompensated care and fair debt collection laws.³¹³

The biggest blind spot of rate regulation is that it does not fully address the principal-agent problem leading to overutilization of health care. As demonstrated by Maryland's experience, the financial constraints imposed on hospitals from rate regulation on a per case basis create an incentive to drive up the volume of care.³¹⁴ Paradoxically, providing more health care is not necessarily in the patient's interests. Higher rates of health care utilization result in patient health outcomes that are no better, and often worse, than lower utilization.³¹⁵ Thus, a major challenge for designers of systems of rate regulation is to address the need to control incentives toward increased utilization. Maryland is addressing this problem by moving its hospitals to a global budget, which

311. Robert Murray, *The Case for a Coordinated System of Provider Payments in the United States*, 37 J. HEALTH POL. POL'Y & L. 679, 684 (2012).

312. Murray, *supra* note 264, at 1397.

313. See *supra* text accompanying notes 247–48.

314. Murray, *supra* note 264, at 1403; Pauly & Town, *supra* note 279, at 699–700; Outtersson, *supra* note 279.

315. See Fisher et al., *Regional Variations of Medicare Spending Part 2*, *supra* note 202, at 293. More health care is worse for patients because every admission, test, or procedure comes with risks of complications. See, e.g., Gawande, *supra* note 69, at 5; Aaron E. Carroll, *Doing More for Patients Often Does No Good*, N.Y. TIMES (Jan. 12, 2015), <http://www.nytimes.com/2015/01/13/upshot/doing-more-for-patients-often-does-no-good-.html>.

removes the possibility of increasing revenue through increased volume, and creates incentives to keep patients healthy within and outside the hospital.³¹⁶ In essence, rate regulation needs to incorporate payment and delivery reforms like ACOs to address the principal-agent problems in health care.

Establishing global budgets is no simple matter. Measuring per capita spending on a provider basis, creating and reconciling the global budget for each provider, and defining the population for which the health system will be accountable, are complicated, politically fraught, and technically challenging tasks.³¹⁷ In addition, a global budget system inherently shifts risk to health care providers, who may not be equipped to manage this financial risk.³¹⁸

Despite the challenges, if overall health care spending is to be contained, global budgets appear to be an essential component of a rate regulation strategy.³¹⁹ Rate regulation disciplines prices while global budgets constrain volume and utilization.

None of the proposed policy prescriptions in this Part address all of the features of health care market failure. The policy prescription necessarily must include a combination of approaches. The theory of second best posits that if one or more of the market imperfections cannot be addressed, then correcting the other market imperfections will not necessarily improve patient-consumer welfare and in fact make outcomes worse. Fortunately, the policy approaches are mutually reinforcing rather than mutually exclusive. A discussion of the implications of the policy-against-market-failure analysis follows in Part III.

III. RESURRECTING HEALTH CARE RATE REGULATION

Each of the policies has shortcomings, so which policy or combination of policies should be adopted to discipline health care prices? Applying the policy-against-market-failure framework sheds light on the effectiveness of any particular approach to controlling health care prices and reveals a dynamic interplay between the various market imperfections and policy solutions.

A. CONCLUSIONS FOR NONCOMPETITIVE PROVIDER MARKETS

The first and most significant conclusion from a coordinated analysis of all the policy solutions is that all approaches except rate regulation fall

316. *See supra* text accompanying notes 279–81.

317. *See* Porter, *supra* note 283 (describing Maryland's challenge in applying global budgets to metropolitan areas where patients have more than one hospital to choose from, thus complicating patient attribution for budgeting purposes).

318. Song et al., *supra* note 296, at 1885–86.

319. Donald M. Berwick et al., *The Triple Aim: Care, Health, and Cost*, 27 HEALTH AFF. 759, 767 (2008); Vladeck & Rice, *supra* note 13, at 1309.

short when applied in concentrated health care provider markets. The politically popular market approaches (such as price transparency or CHDC) and payment and delivery reforms (such as ACOs) will not control health care prices in concentrated markets. For noncompetitive health care markets, market solutions will be ineffective at disciplining provider prices because market solutions rely fundamentally on some level of choice among competitors.³²⁰ No amount of transparency, network narrowing, or consumer skin in the game will provide choices where none exist. Without choices, market forces will not have much effect on prices. Market strategies have a more limited role for noncompetitive markets: to reward high-quality and high-value hospitals and ensure adequacy of supply of needed services. If hospitals are permitted to charge different rates from each other, then strategies like reference pricing and tiering can be used to reward high-value hospitals and encourage competition on quality and services.³²¹

For the increasing proportion of the country with noncompetitive provider markets, the only policy that can address the market power of providers is rate regulation. There are two policy alternatives to correct monopolies: antitrust laws and rate regulation.³²² As described above, antitrust laws can do little to reverse existing monopolies and bring about a competitive market.³²³ Thus, for noncompetitive provider markets, the only solution remaining is rate regulation. Rate regulation addresses hospital market power by combining the bargaining leverage of all payers together or eliminating price negotiations with payers in favor of administratively established rates.³²⁴ The inescapable implication of this analysis is that for the vast majority of this country with concentrated provider markets, health care rate regulation must be a central part of any policy strategy to control health care spending.

A predictable criticism of rate regulation is that it is less efficient than markets in determining prices because the agencies or bodies charged with setting rates become bogged down in bureaucratic difficulty and are subject to agency capture. These concerns point to the sensible conclusion that rate regulation is difficult to do well, and highlight the importance of institutional design to avoid the capture, bureaucratic inefficiency, and crippling complexity that can make rate regulation ineffective. Another practical challenge with rate regulation is that it is politically unpopular in many jurisdictions, where the tendency is to oppose regulation of any sort in favor of letting the market do the job. The central conclusion of this article is that notwithstanding these

320. See Vladeck, *supra* note 13, at 1085.

321. See *supra* text accompanying notes 282–83.

322. ROBERT COOTER & THOMAS ULEN, *LAW AND ECONOMICS* 40 (3d ed. 2000).

323. See *supra* Part II.B.2.

324. See *supra* Part II.E.3.

challenges, policymakers have few options other than rate regulation to constrain health care prices in concentrated markets. The premise is that the market has failed, and in noncompetitive markets, market approaches are fundamentally unable to restore the competition necessary for market forces to work.

The second conclusion from this policy-against-market-failure analysis is that no single solution or approach is sufficient to address all the market failures, and a combination of approaches is necessary to correct the numerous health care market imperfections. In noncompetitive provider markets, rate regulation should be augmented by payment and delivery reforms to address the principal-agent problem of demand inducement by physicians that rate regulation fails to correct.

The policy prescription to discipline prices in noncompetitive health care markets starts but does not end with rate regulation. Because health care markets suffer from multiple failures, it is insufficient to correct the market power problem but not the other imperfections. The theory of second best posits that where there are multiple market failures, correcting one imperfection but leaving the others unaddressed may not improve social welfare, and in some cases, may make consumers worse off.³²⁵ Rate regulation does not correct the overconsumption of health services through provider-induced demand, and we saw that Maryland had to modify its all-payer system by constraining total hospital spending within global budgets, which creates the financial imperative for hospitals to reduce overall health care costs through strategies that look a lot like ACOs.³²⁶

Just because rate regulation is necessary to control health care prices does not make it easy. Creating an all-payer system that also can accommodate innovations in payment and delivery like ACOs can be extremely complex, and this complexity can be nettlesome enough to sink the entire enterprise.³²⁷ Indeed, many of the rate setting programs in states other than Maryland were abandoned in the 1980s and 1990s due to the inability to incorporate managed care models into the system and the belief that rate setting was no longer necessary or desirable in the managed care era.³²⁸ In addition, rate regulation would almost certainly result in lower payments for the most powerful hospitals, so implementing rate regulation is politically difficult, unless hospitals otherwise facing

325. Richard G. Lipsey & Kelvin Lancaster, *The General Theory of Second Best*, 24 REV. ECON. STUD. 11, 11 (1956) (“The general theorem for the second best optimum states that if there is introduced into a general equilibrium system a constraint which prevents the attainment of one of the Paretian conditions, the other Paretian conditions, although still attainable, are, in general, no longer desirable.”).

326. See Porter, *supra* note 283.

327. See McDonough, *supra* note 280, at 144.

328. *Id.*

financial difficulties see some benefits to rate regulation, such as reduced administrative costs and more stable, if constrained, revenues over time.³²⁹

Although prices would be limited for the most vulnerable, ideally rate regulation should be augmented with laws that limit hospitals' debt collection and balance billing practices for financially vulnerable patients and other consumer protections.³³⁰ Even a regulated health care market produces externalities that could be curbed with stronger protections for individuals who need but cannot afford their health care.

B. WHAT TO DO WITH COMPETITIVE HEALTH CARE MARKETS

Although no health care market remains highly competitive, there are areas scattered throughout the country where the health care provider market remains relatively unconcentrated.³³¹ What policies should be adopted for these markets?

The policy-against-market-failure analysis leads to a different set of policy prescriptions for competitive health care markets. Here, market strategies may be able to constrain hospital prices.³³² To harness the market pressure on prices, private payers and employers would have to collect and report price and quality information in a form that is useful to patients, bargain aggressively to create meaningful price options, and monitor claims data to ensure value and quality within lower-priced options.³³³ Legislation is necessary to force some of these changes, including price and quality transparency requirements at the individual or plan level, formation of all-payer claims databases, and legislation to prohibit powerful providers from putting anti-tiering clauses in their health plan contracts. In order to work, the market approaches for disciplining health care prices require nearly as much regulation as rate regulation.

The second major difference between noncompetitive and competitive health care markets is how to address the provider market

329. Hospitals, especially nonprofit hospitals, are facing significant financial uncertainties as Medicare cuts hospital reimbursement rates. *See, e.g.,* Reed Abelson, *Nonprofit Hospitals' 2013 Revenue Lowest Since Recession, Report Says*, N.Y. TIMES (Aug. 27, 2014), <http://www.nytimes.com/2014/08/27/business/nonprofit-hospitals-2013-revenue-lowest-since-recession-report-says.html>. The political hurdles to effectuating any of these policy solutions are a related issue that is beyond the scope of this Article.

330. *See supra* notes 248–49. Alternatively, a single-payer approach would offer protections against the externalities of hospital prices through universal coverage.

331. Cutler & Scott Morton, *supra* note 17, at 1966 (calculating that one-sixth of hospital markets in the United States are unconcentrated, with an HHI between 100 and 1500).

332. *See, e.g.,* Avi Dor et al., *Medicare's Hospital Compare Quality Reports Appear to Have Slowed Price Increases for Two Major Procedures*, 34 HEALTH AFF. 71, 72 (2015); Pauly & Town, *supra* note 279, at 706 (arguing that in competitive hospital markets, market approaches (supplemented by significant regulatory support, antitrust enforcement, and tax reforms) will be more effective at constraining hospital prices than a rate-setting approach).

333. *See* HEALTHCARE FIN. MGMT. ASS'N, *supra* note 3, at 3.

power problem.³³⁴ In competitive markets, market approaches must be paired with aggressive antitrust enforcement to prevent further concentration or consolidation of the provider market. States could further protect competition by reducing barriers to entry and competition caused by archaic CON law regimes.³³⁵ All of these actions to promote competition would likely be opposed by powerful incumbent hospital systems, and are therefore politically challenging.

Although different policy prescriptions emerge for competitive versus noncompetitive markets, policymaking is generally done at the level of the state, not the individual locality, and no state in the country has an entirely competitive health care market.³³⁶ It may be unworkable to establish a bilateral regulatory system where competitive submarkets are permitted to use market approaches to set prices but noncompetitive neighbors are subject to rate regulation. Should a state implement rate setting where some of its hospital markets remain competitive but others are not?

The answer may depend to what degree the state or its population centers are dominated by concentrated versus unconcentrated markets. Every sign points to a trend of increasing consolidation, so we can expect many of the remaining competitive markets to slide toward concentration, and antitrust enforcement has historically failed to prevent this loss of competition. Providers and payers everywhere are busy implementing ACOs and similar integration strategies to curtail the incentives for overutilization and improve quality in health care, but this effort comes with an accelerated surge in consolidation. Thus, even for the few unconcentrated health care markets remaining, a market-based approach to health care price containment may be elusive in practice.

CONCLUSION

We all experience the harms of unpredictable and uncontrollable health care prices every time we interact with the health care system, but especially when we set foot in a hospital. We hold our breath, wait for the bills and (if we are lucky) the mystifying “explanation of benefits” to accumulate. We try to make sense of the jargon and codes, and even if we have insurance, we have no way of knowing whether we got a good price or just got ripped off. If you happen to be uninsured or out-of-network, the financial nightmare unfolds from there as debt collection commences on your bill, wrecking your credit score, raiding your wages or home, or worse. The individual harms are compounded by the societal

334. The rest of the policy prescription for competitive markets looks a lot like noncompetitive markets, with payment and delivery reforms to address overutilization and consumer protections to correct for externalities imposed on financially vulnerable patients.

335. *See supra* text accompanying notes 48–50.

336. *See* Cutler & Scott Morton, *supra* note 17, at 1966, fig.3.

harms of uncontrolled health care spending (driven in large part by unrestrained prices), which drags down our paychecks, savings, and resources for all other social programs. Our excess and undisciplined health care prices derive from a broken system rife with market failures and beg for a regulatory solution.

So what is a policymaker to do? Policymakers are confronted by a menu of policy solutions of mind-boggling complexity. For this reason, it is difficult to assess which policy approach to pursue in a given jurisdiction. The policy-against-market-failure framework set forth in this article provides a method to evaluate the policy approaches comprehensively and simultaneously and gauge the policies' effectiveness for a particular market. The clearest message of the policy-against-market failure analysis is that any effective solution to discipline health care prices must contend with the problem of the growing market power of the provider.

The majority of the U.S. population lives in a highly concentrated hospital market; for these noncompetitive provider markets, the only policy prescription to discipline health care prices is rate regulation to address provider market power. Rate regulation alone is insufficient, however, and it must be paired with payment and delivery reforms to address principal-agent problems and incentives toward overutilization.

For the minority of the United States that lives in an unconcentrated health care market, market approaches like price and quality transparency may constrain health care prices, but only to the degree that aggressive antitrust enforcement is able to stave off the slide toward consolidation. The reality is that the competitive health care market is an endangered species, living in an increasingly noncompetitive ecosystem. Policymakers at the state level will rarely have the luxury of relying on competition to contain health care prices for all markets within their state's borders. To reap the benefits of increased health care integration and coordination, perhaps the best option is to accept the inevitable consolidation of health care providers but regulate prices like a utility.

The story of our unchecked health care spending in the United States is a story about high and undisciplined prices. Our health care pricing problem is driven at its core by a growing provider monopoly problem. The only policy capable of addressing the provider monopoly problem is rate regulation. The inescapable conclusion is that we must resurrect health care rate regulation and place it in the center of any policy approach to control our health care spending.