PART IV

How Private law Can and Cannot Control Costs

Introduction

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Perhaps more than in any other domain of US health policy, private law is central to who pays for health care at what prices. Remarkably, almost the entire structure is built around the privity of contract. With some narrow exceptions, physicians are generally free to choose whether to provide care to any given patient, and thus free to set the terms of those agreements. This means that physicians can choose whether to join any particular insurer's network, agreeing to their contracts.

State and federal governments provide health insurance coverage for 36 percent of the population directly, and they also pay indirectly for other care through tax subsidies.[1] But the coverage is often incomplete, leaving individual patients bearing substantial cost exposures, in the form of copays, deductibles, and coinsurance, where any obligation to pay (at the point of service, or later as debt) is also governed by contract. And of course, about 11 percent of Americans remain uninsured, leaving them seeking care in *quid pro quo* settings, if at all.

It is important to approach these questions not just at the level of the contract, but with a view for the competitiveness of the entire market, which will set the terms of any contract. The federal government is an important bulk purchaser of health care. This market power allows it to secure lower prices than the private payors, and also to set reimbursement rates in ways that spill over to the private market. In building their networks of providers, private payors tend to haggle over the multiplier over the federal reimbursement rates for particular procedures. We have private law in the shadow of a public giant.

In Chapter 14, "Federalism, Private Law, and Medical Debt," Erin C. Fuse Brown explores the issue of medical debt in the United States, focusing on the interplay between federal and state laws in addressing this problem. Medical debt is a significant burden for millions of Americans, impacting their financial well-being

[1] K. Keisler-Starkey et al., Health Insurance Coverage in the United States: 2022, U.S. Census Bureau (Sept. 12, 2023), https://www.census.gov/library/publications/2023/demo/p60-281.html.

and health outcomes, and it worsens racial and ethnic disparities as well. Federal laws like the Dodd-Frank Act and Affordable Care Act aim to protect consumers from medical debt through the Consumer Financial Protection Bureau (CFPB) and IRS regulations. Yet, these measures are limited in scope and enforcement, leaving gaps in protections for individuals. States have enacted various laws to address medical debt, including setting standards for financial assistance, limiting collection practices, and empowering individuals to sue for violations. Fuse Brown encourages more private enforcement mechanisms like Unfair and Deceptive Acts or Practices (UDAP) laws to increased accountability for health care providers, debt collectors, and government agencies.

In Chapter 15, "Paying for Health Care and Private Law's Internal Point of View," James Toomey explicates the internal logic of legal obligations to pay for health care where the prices are not prespecified, and Toomey uses this as a case study for a larger argument against the idea that legal reasoning is merely a mask for policy-making. Toomey advocates for taking the language and concepts of private law seriously, arguing that it's possible and beneficial to reason about them to address novel situations like opaque health care pricing. Traditional contract law enforces agreed-upon prices, but in cases where no price was agreed upon, courts can determine a "reasonable" price. Toomey argues for a certain conceptual unity behind the various domains of private law, here suggesting that contract law can draw from tort law, which uses "reasonableness" to determine damages. Toomey suggests this approach aligns with the core principles of contract law (enforcing agreements) and promotes consistency with tort law's treatment of reasonableness. It also avoids policy-driven rules that might conflict with basic legal concepts.

Jackson Williams also picks up the theme of litigating health care costs but from a practical rather than conceptual approach. His chapter title reveals the challenge: "Health Law's Sheathed Sword: Why Hasn't Civil Litigation Dented Health Care Costs?" (Chapter 16). Not all excessive prices are legally actionable (since again, they are typically based on freely agreed contracts), but some clear cases exist, like antitrust violations, upcoding, and excessive billed charges.

While some payer-initiated cost containment litigation does happen, it has not been systematic. The payors – private health insurance companies – would be an obvious candidate to pursue this litigation against providers, but they face collective action problems – it's hard for them to coordinate and share the costs of litigation. Williams identifies tools that may help, including class actions, involvement of state attorneys general, and patron-sponsored litigation (e.g., foundations funding lawsuits). In the search for the right champion to wield this "sword," unions and other employee-based groups may have better-aligned interests.

Jamie S. King's Chapter 17 is titled "The Canary in the Coal Mine: Private Antitrust Law and New Dynamics in Health Care Markets." She argues that antitrust enforcement in health care has not kept pace with market changes, leading to insufficient competition and high prices. Public enforcers struggle to address new

consolidation strategies like vertical, cross-market, and cross-industry mergers. Private actors could bring cases challenging restrictive employment contracts or anticompetitive contract terms. Such private cases can illuminate complex market dynamics and gaps in public enforcement, leading to improved guidelines and interventions. For example, in a case involving Sutter Health, private plaintiffs challenged anticompetitive contracting practices, leading to a landmark settlement and influencing public enforcement. Likewise, in a case involving Envision Healthcare, the challenges to restrictive physician contracts brought attention to private equity's role in market consolidation.

Finally, Jessica Mantel's Chapter 18 explains, "Health Care Finance Law's Relational Bias." One classic challenge for contracting generally, and especially health care contracting in particular, is to align incentives of the provider and the payor (who at least theoretically represents the interests of the patient). A simple fee-for-service system may generate more services and more expensive services than patients need. Various payment reforms have been implemented, but Mantel identifies a particular challenge in the fragmentation of our health care system: If one insurer implements a payment reform, but other insurers implement different or no payment reforms, the providers receive mixed signals and may not change their behavior accordingly. Multi-Payer Alignment Initiatives (MPAIs) encourage voluntary coordination but are limited by low participation. Mantel argues for a public law framework to improve health care delivery, which could take the form of a mandatory cooperative scheme or single-payer system.

Altogether, these chapters evince the challenges of making a private law framework achieve its potential as applied in the real world of the US health care system. Whether examined in the pristine conceptual clarity of a 1:1 contract for services, or at the system-level perspective assessing the market power of providers and payors, the issues cannot be ignored.