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## The Private Option

Brendan S. Maher

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# THE PRIVATE OPTION

*Brendan S. Maher\**

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## ABSTRACT

*Health care reform is once again in the air. Virtually all Democrats favor some meaningful expansion of public insurance, whether through single payer or the creation of a “public option” that would allow consumers dissatisfied with the private market to buy into a public program. Republicans, not surprisingly, have pushed back, not only against single payer, but also against the public option, saying it will drive private payers to extinction. All the political jousting implicates a larger and serious policy question; namely, what should be the role of private payers in the nation’s health care system?*

*Arguments to date on that subject have largely overlooked two crucial realities. First, payers (public and private) perform multiple functions regarding health care delivery. That the government is better at one function does not mean, or even imply, that the government is better at all of them. By disaggregating the services payers render in connection with health care financing, debates about the ideal roles for public and private payers—as well as whether one of them will or should compete the other into extinction—can be had on understandable terms.*

*Second, although frequent references to the competitive virtues of a public option have been made, insufficient thought has been given to the conceptual specifics of why and how private payers faced with a public option might evolve. In terms of improving care delivery, observers have underexamined how private payers might serve as welfare-enhancing big data digesters, care evaluators, choice intermediaries, and incentive innovators—all proficiencies that not only rate to improve the cost and quality of care, but are entirely harmonious with modern experience about where private actors often*

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create value: by collecting, analyzing, packaging, presenting, and deploying information.

Once these two significant theoretical refinements are brought to bear, a richer analysis of the public–private question emerges—one that supplies good reason to doubt that private payers should or will, at least in the short term, be put to the sword by either Congress or public-option-armed consumers.

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## INTRODUCTION

Health care reform is once again in the air. Virtually all Democrats favor some meaningful expansion of public insurance, whether through single payer or the creation of a “public option” that would allow consumers dissatisfied with the private market to buy into a public program.<sup>1</sup> Republicans, not surprisingly, have pushed back, not only against single payer, but also against the public option, saying it will drive private payers to extinction.<sup>2</sup>

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1. See, e.g., Peter Sullivan, *Democrats Spar over Electoral Appeal of ‘Medicare for All,’* HILL (Sept. 14, 2019, 2:10 PM), <https://thehill.com/policy/healthcare/461383-democrats-spar-over-electoral-appeal-of-medicare-for-all> [https://perma.cc/L3F5-69UU]. Senator Sanders, for example, favors a “Medicare for All” approach and envisions a health care system free of private payers. See *id.* Mayor Buttigieg, in contrast, favors a “Medicare for All Who Want It” public option approach where anyone unhappy with the private market can buy into Medicare. See Scott Simon & Heidi Glenn, *‘Just the Right Policy’: Pete Buttigieg on His ‘Medicare for All Who Want It’ Plan*, NAT’L PUB. RADIO (Nov. 8, 2019, 5:00 AM), <https://www.npr.org/2019/11/08/774716877/just-the-right-policy-pete-buttigieg-on-his-medicare-for-all-who-want-it-plan> [https://perma.cc/LK67-C2C5].

2. Among those Republicans is Seema Verma, the Administrator of the Centers for Medicare & Medicaid Services. See Seema Verma, *I’m the Administrator of Medicaid and Medicare. A Public Option Is a Bad Idea.*, WASH. POST (July 24, 2019, 4:37 PM), <https://www.washingtonpost.com/opinions/a-public-option-for-health-insurance-is-a-terrible-idea/2019/07/24/fb651c1a-ae2e-11e9-8e77->

All the political jousting implicates a larger and serious policy question; namely, what *should* be the role of private payers in the nation's health care system?<sup>3</sup> Arguments to date on that subject have largely overlooked two crucial realities.

First, payers (public and private) perform *multiple* functions regarding health care delivery. That the government is better at one function does not mean, or even imply, that the government is better at all of them. By disaggregating the services payers render in connection with health care financing, debates about the ideal roles for public and private payers—as well as whether either of them will or should compete the other into extinction—can be had on understandable terms.

Second, although frequent references to the competitive virtues of a public option have been made, insufficient thought has been given to the conceptual specifics of why and how private payers faced with a public option might evolve. In terms of improving care delivery, observers have underexamined how private payers might serve as welfare-enhancing big data digesters, care evaluators, choice intermediaries, and incentive innovators—all proficiencies that not only rate to improve the cost and quality of care, but are entirely harmonious with modern experience about where private actors often create value: by collecting, analyzing, packaging, presenting, and deploying information.

Once these two significant theoretical refinements are brought to bear, a richer analysis of the public–private question emerges—and one that supplies good reason to doubt that private payers should or will, at least in the short term, be put to the sword by either Congress or option-armed consumers. And there is an additional satisfying consequence of thickening and stratifying the framework with which we assess the optimal role of private players: Doing so allows us to more readily locate *non-health* arguments in favor of continued private participation, rationales that may transcend a future empirical verdict about the degree to which, or whether, private payers improve care or not.

The ultimate conclusion one reaches about optimal private payer participation will, in significant part, turn on one's priors as well as what empirical research one chooses to credit. But that does not mean

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03b30bc29f64\_story.html [https://perma.cc/6C22-4TX4] (“[T]he public option is a Trojan horse with single-payer hiding inside.”).

3. Private payers can be traditional insurers, but they can also be employers, HMOs, physician associations, or other organizations. For convenience, I use *payer* and *insurer* interchangeably throughout.

consideration of the question need be hopelessly diffuse and freewheeling. This Article seeks to structure that debate and propose a path forward for policymakers and scholars.

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Part I sets the stage.<sup>4</sup> No fruitful discussion can occur without recognizing that private payers perform *multiple* functions with respect to health care delivery. We can categorize those functions in any number of ways, but one particularly useful way is to think about the risk, cost, and quality of care. Risk refers to who pays; cost refers to how much; and quality refers to care effectiveness. Payer behavior implicates all three. To assess whether the government should or will replace private payers, one should analyze whether the government is better with regard to all those aspects or just some. If the former is true, then the clock is ticking on private payers. If not, then regulators should take note of the areas in which private payers can serve welfare-enhancing ends.

Part II considers risk.<sup>5</sup> A tour of American health care history reveals that the United States has settled upon a clear risk strategy with respect to the private market. Make the insurable unit a group—whether a workplace group (ERISA) or the community group (ACA)—and charge individuals a premium based upon the average risk within that group. The American polity almost certainly settled on that approach because either out-of-pocket financing or individualized-risk financing would have excluded a majority of people from accessing care. In contrast, if one is charged a premium that corresponds to the average group member risk, many more can afford insurance, and thus care. Nor, obviously, does Medicare care about individualized risk; it is financed through broad-based taxes.

But if the Nation's private risk strategy is to insure a group and charge individuals the group premium, observers asked: Why use private players at all? The government could pursue the same approach by making the insurable group the entire country and "charge" the average cost to every taxpayer. Indeed, as Section II.B explains, in terms of risk bearing, the government has enormous advantages over private players—and that is reason enough to justify a "public option."<sup>6</sup> Were private payers *only* offering a risk-bearing

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4. See *infra* Part I.

5. See *infra* Part II.

6. See *infra* Section II.B.

service, it is hard to see how they could do better than the government. That reality is something, interestingly, that *both* “Medicare for All” advocates and Republican opponents of “Medicare for All Who Want It” stress: the former to justify the elimination of private payers, and the latter to argue that a public option will cause private players to go extinct.<sup>7</sup>

Part III explains why the ideal role of private payers, and their ultimate fate, defies a sound-bite answer.<sup>8</sup> Whatever the government advantage regarding risk, on cost and quality of care, the verdict is less clear. Part of the challenge arises because both private and public payers offer the same promise to their insureds; namely, that “medically necessary” care will be provided. This promise—made for reasons of both moral and cognitive appeal—leaves unsolved, and likely exacerbates, the challenge of minimizing costs, maximizing quality, and making tradeoffs in between.

Part IV considers the potential virtues of private payers on cost and quality, particularly when faced with a public option.<sup>9</sup> First, private payers can promote safety and quality in ways the government is unlikely to, and consumers may be willing to pay for that service. Second, private payers are more likely to adopt explicit cost-effectiveness metrics in the insurance promise, which would have positive effects for both individuals and society at large. More generally, it seems highly unlikely that the very hard problem of optimizing health care delivery will be solved if the federal government alone is pursuing solutions; private payers can engage in helpful data deployment and paradigm experimentation. Third, private payers can serve to fund a cross-subsidy for better health care, hold information some do not wish the government to have, and serve as the alternative option for those philosophically opposed to larger government.

In Part V, I consider objections and concede some ground.<sup>10</sup> Payers will seek rents; they may be worse at innovating than is hoped; and even the best result might be a tiered system of care. But those downsides, although meaningful, can likely be ameliorated with thoughtful regulatory intervention. Finally, I note that keeping available the “private option” is not only the superior political strategy because it pleases those who are skeptical of a larger government role;

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7. See Sullivan, *supra* note 1; Simon & Glenn, *supra* note 1; Verma, *supra* note 2; *supra* note 3 and accompanying text.

8. See *infra* Part III.

9. See *infra* Part IV.

10. See *infra* Part V.

it is also a superior political strategy because it will produce valuable information about what works. Either having private payers at the table will be welfare enhancing to society or not. Better to preserve them until that verdict is clear, particularly when there are sensible reasons to be optimistic, and especially if doing so is the price to pay for obtaining true universal coverage.

## I. CONCEPTUALIZING HEALTH CARE FINANCING

Health care finance is extraordinarily complicated, and people who say otherwise are usually selling something.<sup>11</sup> But discussion of the details is more fruitful when some organizing principles are offered first. The motley nature of the American health care system, the rise of the public option, and the ever-present urge to improve health care delivery makes disciplined thinking by reformers essential—particularly with respect to the role of private payers in the American health care future.

In Part I below, I suggest a conceptual path forward: that we assess the optimal role for private payers by thinking about how they can affect the risk, cost, and quality of health care, and then by identifying the advantages and disadvantages, private actors may have vis-à-vis the government.

### A. American Health Care Basics

As scholars have noted, the United States has simultaneously adopted multiple health care delivery systems, depending on one's status.<sup>12</sup> The elderly and poor have access to public insurance in the

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11. For example, while Candidate Trump boasted that under his administration Americans were “going to have such great healthcare at a tiny fraction of the cost, and it is going to be so easy,” President Trump admitted that “[n]obody knew that health care could be so complicated.” Compare Tim Hains, *Trump: Repealing and Replacing Obamacare Is Going to Be “So Easy,”* REAL CLEAR POL. (Oct. 25, 2016), [https://www.realclearpolitics.com/video/2016/10/25/trump\\_repealing\\_obamacare\\_is\\_going\\_to\\_be\\_so\\_easy.html](https://www.realclearpolitics.com/video/2016/10/25/trump_repealing_obamacare_is_going_to_be_so_easy.html) [https://perma.cc/8VCD-L9ZM], with Graham Lanktree & James Lillywhite, *Watch Donald Trump Change His Tune from Easy to Difficult on Repealing Obamacare*, NEWSWEEK (July 20, 2017, 12:57 PM), <https://www.newsweek.com/easy-difficult-watch-donald-trump-change-his-tune-repealing-obamacare-639782> [https://perma.cc/8JNZ-MLM3].

12. See, e.g., Brendan S. Maher & Radha A. Pathak, *Enough About the Constitution: How States Can Regulate Health Insurance Under the ACA*, 31 YALE L. & POL'Y REV. 275, 282 (2013) (discussing different legal regimes under which health care is financed and delivered in the United States).

form of Medicare and Medicaid.<sup>13</sup> The nonelderly have access to private insurance in the form of employment-based (ERISA) or exchange-based insurance (ACA).<sup>14</sup> Thus, being old, poor, employed, or none of the above is what drives what type of health care financing arrangement one can obtain, with only a very limited ability to choose between options.<sup>15</sup>

The so-called public option aimed to change that, by the expedient of offering all Americans the opportunity to “buy-in” to public insurance (generally Medicare).<sup>16</sup> Among the offered rationales for the pre-ACA proposal, popularized by Yale political scientist Jacob Hacker, were that it would ensure that everyone who wanted coverage could have it, while also curbing bad payer behavior by making insurance markets more competitive.<sup>17</sup>

The public option failed to make it into the ACA.<sup>18</sup> Yet fascination with the notion of giving each American a choice between public and private insurance has grown ever stronger. Indeed, whatever the virtues and vices of specific public option proposals currently being bandied about, the idea of the public option has changed the geography of the health debate. In under ten years, it has become roughly the conservative position in Democratic policy debates with the more progressive wing of the party now urging the abolition or near abolition of private insurance in favor of a single payer approach.<sup>19</sup> Required more than ever is the development of a

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13. See Social Security Amendments of 1965, Pub. L. No. 89-97, §§ 101, 111, 79 Stat. 286, 290, 340–43 (codified as amended in scattered sections of 42 U.S.C.).

14. See Maher & Pathak, *supra* note 12, at 282–84.

15. See *id.* at 282.

16. See, e.g., Helen A. Halpin & Peter Harbage, *The Origins and Demise of the Public Option*, 29 HEALTH AFFS. 1117, 1117–19 (2010).

17. See *id.* (tracing the political history of the public option). Discussion of the public option’s competitive virtues generally focused on giving consumers an option to avoid bad payer behavior, as opposed to comprehensively analyzing the specifics of how the option would promote competition, along what lines, and whether such competition was salutary or would promote rent-seeking. See *id.* This Article offers a framework that, as they say, fills that gap.

18. See Brendan S. Maher, *The Benefits of Opt-in Federalism*, 52 B.C. L. REV. 1733, 1751 (2011) (explaining that Congress, in enacting the ACA, rejected both the creation of a “Medicare for All” health program and multiple versions of a “public option”).

19. See *Eliminate Private Insurance: Where 2020 Democrats Stand*, WASH. POST, <https://www.washingtonpost.com/graphics/politics/policy-2020/medicare-for-all/private-insurance/> [https://perma.cc/VNA7-M3SA] (last visited Nov. 16, 2020).

methodical framework to carefully analyze the ideal role of private payers.

### B. A Tri-Partite Heuristic

Conceptually, health care financing arrangements—whether called “insurance” or not—have three parties: the insured, the payer, and the provider. The insured offers a small sum of money in return for care; the payer accepts that money while promising to pay for care; and the provider strikes deals with either the insured or the payer in connection with diagnosing and offering care.

The simplest version of such a multilateral arrangement is the indemnity fee-for-service model.<sup>20</sup> There the payer bears the risk and pays for the cost of care, while the provider bears the duty to identify the need for and provide effective care.<sup>21</sup> That arrangement can get considerably more complicated, such that multiple parties share duties with respect to risk, cost, and quality. But there is nonetheless a useful takeaway, which is that the point of any health care financing arrangement is to establish *some* distribution of responsibility with respect to risk, cost, and quality in connection with the ultimate aim of delivering care.

Health care is a fundamentally important good. Optimizing health care finance arrangements is therefore a subject about which society cares *enormously*: particularly with respect to who bears the risk, how much providers get paid, and how good the provided care is. Reliance on ill-conceived arrangements can, among other things, exclude too many people from access, result in allocative inefficiencies regarding care, and provide care of wildly varying quality. We can thus productively evaluate different health care financing arrangements—as well as regulatory schemes that promote or prohibit them—by asking if the arrangement in question is likely to give the “right” parties the “right” amount of responsibility with respect to the risk, cost, and quality of care.<sup>22</sup>

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20. See 22 Ill. Prac. 3d § 23:60 n.1. “Indemnity” simply means the insurance payout is based on the size of loss. Non-indemnity insurance is when the payout is not based on the loss, such as life insurance.

21. See *id.*

22. Cf. Thomas R. McLean & Edward P. Richards, *Health Care’s “Thirty Years War”*: *The Origins and Dissolution of Managed Care*, 60 N.Y.U. ANN. SURV. AM. L. 283, 285 (2004) (“Medical insurance does not just pay for medical care—it shapes the medical care delivery system, determines what treatments are developed, and formulates our view of what constitutes medical care.”).

This analysis will be brought into crisper focus if one imagines, as I do in Parts II–V, how private payers might behave in a world where a public option has been enacted.

## II. THE RISK OF CARE

Americans favor markets but not so much as advertised. For a certain set of socially desirable goods—i.e., goods most agree make society better off if all have access to them—Americans have long tolerated, if not applauded, government intervention in the market.<sup>23</sup> Health care, as perhaps *the* classic example of a socially desirable good, is no different.<sup>24</sup>

Indeed, even though the fractious American polity has so far rejected the level of public financing adopted in other developed countries, it has nonetheless greenlit a kludge of massive legislative interventions—chiefly Medicare, Medicaid, ERISA, and the ACA—in order to ensure that medical care is available to more than the very few that could pay for it directly. And whatever the intimidating intricacies of those colossal schemes, they share the common notion that *individual* risk should be largely removed from the financing equation. That acknowledges a fundamental financing reality: that asking individuals to directly bear their own expected health costs will inevitably leave many—in particular those with high needs—unable to afford access to care. The regulatory response has been to price health care access at no more than the expected cost of some average member of a larger group.

### A. Risk Averaging as Care Access

The problem of “access” to health care is, in a key sense, a secondary one. The antecedent problem, which took most of human history to satisfactorily address, was figuring out how to effectively treat sick people, as opposed to administering “treatments” that make things worse.<sup>25</sup> Hence Hippocrates’ time-honored admonition to do no

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23. See Brendan S. Maher, *Regulating Employment-Based Anything*, 100 MINN. L. REV. 1257, 1276 (2016) [hereinafter Maher, *REBA*] (“Such goods are commonly held to have special significance because of supra-economic concerns such as fairness, opportunity, dignity, compassion, and so on.”).

24. See *id.*

25. See, e.g., McLean & Richards, *supra* note 22, at 286 (citing PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 156–57 (1982)) (“In the late

harm. So long as medicine was doing more harm than good, figuring out how to pay for it was far from pressing. But things began to meaningfully change in the nineteenth century.<sup>26</sup> A number of developments served to situate the practice of medicine as an important societal and commercial player in the decades to come.<sup>27</sup> As health care moved from folk medicine to a science-based approach, both consumers and legislators became more interested in its use and regulation.<sup>28</sup>

Interested consumers buy things, and in the simplest of arrangements, a sick person simply pays a doctor out of pocket.<sup>29</sup> But as medical care became more sophisticated, it was soon apparent that not nearly enough people could afford to pay for care out of pocket.<sup>30</sup> And so, the first device the United States (organically) relied on to get more people care was a familiar type of contract: insurance.<sup>31</sup>

### 1. Health Insurance

Health insurance made medical care accessible to more people because it is a risk-trading device that smooths the cost obligation: the insured accepts the risk of a small, recurring loss that he can afford (the premium) in return for the insurer assuming the risk of a large loss (the cost of needed care) that the insured would, even if he had saved his money, not have been able to afford.<sup>32</sup> Ambitious politicians realized that the government could perform that same function, but the

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1800s, for the first time in history, a patient's chances of survival were improved by seeing a physician and going to a hospital.”)

26. See STARR, *supra* note 25, at 156–57. Starr's book is the seminal work about the history of American health care.

27. See *id.* at 160–62.

28. See *id.*

29. See JAN GREGOIRE COOMBS, THE RISE AND FALL OF HMOs: AN AMERICAN HEALTH CARE REVOLUTION 3–6 (2005) (discussing paying for health care in the early 1900s); see also William D. White, *Market Forces, Competitive Strategies, and Health Care Regulation*, 2004 U. ILL. L. REV. 137, 141 (2004) (explaining that in the early part of the twentieth century, the “vast majority of care was purchased directly by consumers out-of-pocket on a fee-for-service basis in the private market place”).

30. See White, *supra* note 29, at 143.

31. See *id.*

32. See Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 959 (1963). Arrow's article is essentially the foundation of modern health economics.

success of the New Dealers in enacting social welfare legislation did not include the successful passage of national health insurance.<sup>33</sup>

The health insurance device, however, grew in popularity and particularly in connection with employment.<sup>34</sup> As the nation pulled itself out of the Great Depression and readied for and fought World War II, an increasingly larger percentage of workers obtained insurance through the workplace.<sup>35</sup> Indeed, in the post-war years, having a good car, a good job, a good home, and a good doctor were considered to be the signs of middle-class success, and increasingly health insurance became something that employers chose to offer.<sup>36</sup>

## 2. Group Health Insurance

The rising popularity of employment-based health insurance was attributable to something more fundamental than post-war glow.<sup>37</sup> A group policy makes the insurable unit the group, and insuring a group is an easier and less risky task than insuring an individual.<sup>38</sup> The reason is adverse selection, for which we will take a brief detour.<sup>39</sup>

For an insurer to make money, it must accurately “underwrite” the risk a would-be insured presents. Underwriting is how insurers determine the premium they should charge an insured. To oversimplify: insurers have vast stores of data about (1) the risk an average member of the community poses and (2) the additional increment or decrement of risk that various particular characteristics pose, should those characteristics be present in an individual. The insurer can accordingly adjust upward or downward what the premium

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33. Supporters of national health insurance have counted among their number historical figures observers generally do not associate with big government liberalism. *See, e.g.*, F. A. HAYEK, *THE ROAD TO SERFDOM: TEXT AND DOCUMENTS* 148 (Bruce Caldwell ed., 2007) (describing the appeal of a “comprehensive system of social insurance”); *see* COOMBS, *supra* note 29, at 3–6 (explaining the failure of New Deal reformers).

34. *See* Laura A. Scofea, *The Development and Growth of Employer-Provided Health Insurance*, 117 MONTHLY LAB. REV. 3, 3–4 (1994).

35. *See id.* at 5.

36. *Cf.* Kathryn L. Moore, *The Future of Employment-Based Health Insurance After the Patient Protection and Affordable Care Act*, 89 NEB. L. REV. 885, 891 (2011) (describing factors, such as unions, contributing to spread of health benefits after World War II).

37. *See id.* at 892.

38. *See* Maher, *REBA*, *supra* note 23, at 1282.

39. *See id.*

should be for a potential insured with certain risk-relevant characteristics.<sup>40</sup>

But the information available to the insurer is not perfect.<sup>41</sup> As a result, the insurer will be concerned that a seeker of insurance is doing so *because* he is more likely than average to get sick—and thus make a claim—but that the applicant’s ascertainable characteristics will not allow the insurer to know that.<sup>42</sup> One way the insurer can avoid that danger—namely, the risk of writing a premium that is too low given a would-be insured’s unascertainable likelihood to consume substantial care—is by instead writing policies for a large group of people.<sup>43</sup> Groups of people (that are organized for a reason other than to buy insurance) are less likely to pose an adverse selection problem, i.e., they are more likely to pose a risk that matches the risk of the *average* community member, for whom insurers have a reliable ability to properly risk-price.<sup>44</sup> Thus, the rise of employment-based health insurance, even prior to meaningful federal regulation on the subject, happened because doing so was a way to offer health insurance while minimizing the risk of profit-destroying adverse selection.

### 3. Medicare

As should be obvious, the widespread use of employment-based insurance to ensure people had access to health care leaves out many, in particular the elderly. In response to that problem, Great Society reformers created Medicare in 1965, which was simply government

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40. See generally *id.*

41. See generally Michael Rothschild & Joseph Stiglitz, *Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information*, 90 Q.J. ECON. 629 (1976).

42. See generally George A. Akerlof, *The Market for “Lemons”: Quality Uncertainty and the Market Mechanism*, 84 Q.J. ECON. 488 (1970) (providing the first formal treatment of adverse selection); Rothschild & Stiglitz, *supra* note 41 (explaining the first formal model of adverse selection insurance markets); see also Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125, 134 (2011) (explaining adverse selection, risk-differentiation, and premium pricing).

43. See Maher, *REBA*, *supra* note 23, at 1282–84.

44. See *id.*; see also Allison K. Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 AM. J.L. & MED. 7, 28 (2010) (noting that adverse selection rarely imperils large, employer-sponsored group insurance).

health insurance for those sixty-five and over.<sup>45</sup> Unlike private insurers, the federal government had no need to “underwrite” anybody or make any effort to price individual risk. Its aim was to pay for a certain level of care for all seniors, and finance that through taxes, on the assumption that the latter would pay for the former.

Thus, while this is a bit of an oversimplification, the two largest “devices” the American policymaking community was using to ensure access to care—namely, group insurance for workers and public insurance for the elderly—both rejected using individualized risk as the risk-pricing mechanism. Indeed, after ERISA was enacted in 1974, Congress enacted a series of amendments to ensure that, while insurers writing employment-based policies could underwrite *between* employee groups—e.g., charging coal mining companies more than colleges—they could not underwrite *within* employee groups.<sup>46</sup>

#### 4. *Affordable Care Act*

The Affordable Care Act was the final step in abandoning any meaningful societal use of risk-differentiation in health care financing. For the nonpoor–nonelderly who did not have health insurance through the workplace, obtaining health insurance—and thus health care—was difficult, precisely because these unaffiliated individuals were potentially subject to serious adverse selection concerns. To solve that problem, the ACA adopted regulatory measures to artificially create—through an underwriting bar, guaranteed access, and a mandate to buy insurance—a pool of insureds that was sufficiently representative of the community, i.e., not just sick people to whom insurers could sell community-rated policies.<sup>47</sup>

The fact that the United States had thus moved, in different times and settings, away from using individualized risk assessments with respect to health care financing led some to suggest that the private insurance industry—facially perceived as being *solely* in the business

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45. See Julian E. Zelizer, *How Medicare Was Made*, NEW YORKER (Feb. 15, 2015), <https://www.newyorker.com/news/news-desk/medicare-made> [https://perma.cc/B2CW-XPKM].

46. See 29 C.F.R. § 2590.702(b) (2014); see also Timothy Stoltzfus Jost & Mark A. Hall, *Self-Insurance for Small Employers Under the Affordable Care Act: Federal and State Regulatory Options*, 68 N.Y.U. ANN. SURV. AM. L. 539, 541 (2013) (explaining how changes to federal law that protect individuals nonetheless permit insurers to “charg[e] higher premiums depending on the health status of the group”).

47. See Brendan S. Maher, *Unlocking Exchanges*, 24 CONN. INS. L.J. 125, 145 (2017) (explaining ACA reforms to ensure a stable pool).

of risk differentiating—was not necessary at all.<sup>48</sup> Perhaps the best approach, observers noted, would be to have the government insure the entire community and simply collect a tax equivalent to the average cost of care it decided to provide.<sup>49</sup> Let us briefly consider the government's risk advantages.

## B. Government Advantages

The risk aspect of care itself involves at least two sub-tasks: identifying the risk of a potential insured and bearing it. One can imagine a world in which society determined that the best way to handle the risk of care would be to charge individuals a premium that closely matched their individual risk.<sup>50</sup> In that world, granular underwriting capabilities would be of significant importance and private payers—particularly traditional insurers—might have a significant advantage, via competition or otherwise, compared to the government.

But that does not resemble the approach the American polity has favored, which is to move away from an individualized risk model. In that world, where individualized risk assessment is moot and indeed poses a threat of cherry-picking, the government has meaningful advantages with respect to its ability to serve as the risk-bearer. These advantages are well-known, and I will recapitulate them only briefly, although one in particular bears some additional emphasis given the big data revolution currently overtaking all modern economies.

### 1. Risk-Neutral

First, the government is risk-neutral in that it is indifferent to fluctuations around the expected value of any given bet; cost volatility is economically irrelevant to a financial actor as large as the United States government, even setting aside its ability to tax or print

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48. See, e.g., Scott Detrow & Josh Rogers, *On the Trail with Bernie Sanders*, NAT'L PUB. RADIO (July 1, 2019, 6:10 AM), <https://www.npr.org/2019/06/30/737495980/on-the-trail-with-bernie-sanders> [<https://perma.cc/52AS-34JM>].

49. See *id.*

50. One theory for doing so is that individuals should be incentivized to modify their choices, i.e., eat healthy, exercise, stop smoking, to reduce their unhealthy behaviors. Many have challenged that notion as unfair and ineffective. See generally Hoffman, *supra* note 44; Nicole Huberfeld & Jessica L. Roberts, *Health Care and the Myth of Self-Reliance*, 57 B.C. L. REV. 1 (2016).

money.<sup>51</sup> As a result, the government can likely insure any given risk at a lower cost than a private insurer.<sup>52</sup>

## 2. Profit-Neutral

Second, the government is profit-neutral: not only does it not need to make money to continue to perform an insurance function, it can lose money to the extent voters believe doing so promotes some public interest better than would spending those lost dollars on something else. But even voters demanding a budget-neutral public insurance operation would be creating a competitor with a distinct advantage over its private rivals; namely, one with no need to add a profit margin—or, in a public-only world, comparative advertising expenses—to its risk-bearing service.<sup>53</sup>

## 3. Risk-Indifferent

Third, the government is risk-indifferent, which is different than risk neutral. By risk-indifferent, I mean that the government *fundamentally* is unconcerned about the risk profile of individuals. It cares only about the collective risk of the pool it insures so that it can properly determine the taxes it needs to collect.<sup>54</sup> But the individual risk of a given insured is irrelevant. That is not so for private payers.<sup>55</sup> To the extent they can attract better risks and discourage worse risks from buying their product, they stand to make money.<sup>56</sup> Only regulation neuters that impulse.

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51. See Christopher Serkin, *Insuring Takings Claims*, 111 NW. U. L. REV. 75, 82 (2016).

52. The government's unique ability to assume risks of immense proportion also differentiates it from individual private insurers. See, e.g., Jeffrey C. Dobbins, *Promise, Peril, and Procedure: The Price-Anderson Nuclear Liability Act*, 70 HASTINGS L.J. 331, 341 (2019) (discussing government insurance for nuclear accidents).

53. Generally speaking, an insurer is going to charge a premium equal to the sum of (1) an actuarially fair premium equal to the expected loss of the insured during the term, (2) the administrative costs associated with running an insurance business, and (3) a profit margin. See 39 Cal. Jur. 3d § 120. The third does not exist for the government and the second is lower (in theory) because of scale and the size of the government's pocketbook.

54. See COMM. ON EMP.-BASED HEALTH BENEFITS DIV. OF HEALTH CARE SERVS., *EMPLOYMENT AND HEALTH BENEFITS: A CONNECTION AT RISK* 178 (Marilyn J. Field & Harold T. Shapiro eds., 1993).

55. See Monahan & Schwarcz, *supra* note 42, at 134.

56. See *id.* at 134–36 (discussing economic gains from risk classification).

The big data revolution makes effective regulation along those lines harder.<sup>57</sup> As information becomes less costly and the ability to analyze information becomes much better, a vastly more granular picture of a would-be insured's risk profile can be developed.<sup>58</sup> And the power to risk-differentiate is ever-enhanced by the degree to which people voluntarily produce, in a noninsurance-application setting, information about themselves—whether as an incident to commerce or gratuitously via public media sites like Facebook.<sup>59</sup>

This sort of risk analysis can largely sidestep attempts to stop it, in part because of the use of proxy variables.<sup>60</sup> Even where, like with the ACA, insurers were sharply regulated in terms of how they could explicitly underwrite, shadow underwriting is a continuing risk.<sup>61</sup> The big data revolution thus burdens regulators with a complicated task to the extent that insurers are expected to play a salutary role in health care access, as opposed to simply collecting easy money insuring low risks. None of these problems, of course, exist when the government completely assumes the insurance function.

The policy consequences as to the government's risk advantages are two-fold. First, the federal government is best situated to tolerate bearing the riskiest and most unprofitable insureds; for that reason alone, a public option makes sense. Second, were risk bearing alone

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57. See Rick Swedloff, *Risk Classification's Big Data (R)evolution*, 21 CONN. INS. L.J. 339, 340 (2014).

58. See *id.* at 340–41, 353 (explaining the promise and peril of big data in insurance).

59. Indeed, the cultural casualness and frequency with which information is handed over or left unguarded, and the ever-improving ability of data scientists and machine algorithms to make predictions based on any given set of data, has led to routine reports by data researchers about surprising things they can predict about people merely from analyzing their “digital exhaust” or other innocuous information—including health-related predictions. See, e.g., Johannes C. Eichstaedt et al., *Facebook Language Predicts Depression in Medical Records*, 115 PROC. NAT'L ACAD. SCI. 11203, 11207 (2018); see also Sharona Hoffman, *What Genetic Testing Teaches About Predictive Health Analytics Regulation*, 98 N.C. L. REV. 123, 133–34 (2019) (discussing the use of nontraditional information to make medical predictions); see also James Vincent, *Google's New AI Algorithm Predicts Heart Disease by Looking at Your Eyes*, VERGE (Feb. 19, 2018, 12:04 PM), <https://www.theverge.com/2018/2/19/17027902/google-verify-ai-algorithm-eye-scan-heart-disease-cardiovascular-risk>.

60. Cf. Anya E.R. Prince & Daniel Schwarcz, *Proxy Discrimination in the Age of Artificial Intelligence and Big Data*, 105 IOWA L. REV. 1257, 1261–62 (2020) (discussing the inevitable use of proxy variables when AI is deployed).

61. Cf. Monahan & Schwarcz, *supra* note 42, at 167–71 (discussing how an employer might indirectly risk classify, even under the ACA).

the function of private payers, the case for public payers and public payers only would be very strong. But that is not the whole story.

### III. THE COST AND QUALITY OF CARE

Health care payers do more than deal with risk; most importantly, they also influence the cost and quality of care. On those fronts the government as payer has powerful tools to promote desirable outcomes, but the government's advantages are not so profound as to make private payers—either from the perspective of an individual consumer or society—unreasonable alternatives.

At the heart of the cost and quality of care challenge is the core promise that *both* public and private payers make; namely, that the insureds will receive “medically necessary” care. This promise does little to define quality beyond a minimum and nothing to address cost, and in fact, may stand as an obstacle to the efficient pursuit of both.

#### A. Medical Necessity as the Care Promise

Both public and private payers promise to provide “medically necessary” care.<sup>62</sup> Intuitively, there are at least two reasons why. First, it accords with certain moral intuitions about what people should be able to get if they are sick: whatever care is medically necessary to address their condition.<sup>63</sup> Second, and relatedly, it acknowledges the complicated reality of health care as a good. The health care that one needs varies depending upon the affliction from which one suffers. It is thus difficult to define the bounds of health care promise in a simple way *ex-ante*.<sup>64</sup> Medical necessity is what fills the gap.

Consider insuring against the loss of an “easier” good: jewelry, for example. One knows much of the time precisely what one will need, *i.e.*, the replacement of the jewelry, and how much one will need to address the loss event, *i.e.*, the replacement cost of the jewelry. Alternatively, to the extent that the jewelry is damaged, the insurance

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62. See Nicholas Bagley, *Bedside Bureaucrats: Why Medicare Reform Hasn't Worked*, 101 GEO. L.J. 519, 526 (2013) (describing medical necessity in Medicare).

63. Cf. Einer Elhauge, *Allocating Health Care Morally*, 82 CAL. L. REV. 1449, 1452–53 (1994) (discussing moral intuitions that underlie health care debates).

64. See John V. Jacobi, Tara Adams Ragone & Kate Greenwood, *Health Insurer Market Behavior After the Affordable Care Act: Assessing the Need for Monitoring, Targeted Enforcement, and Regulatory Reform*, 120 PENN. ST. L. REV. 109, 130 (2015) (describing how “the infinite complexity of human medical conditions” makes *ex-ante* specification impossible).

promise will not include fixes that cost more than the price of the original jewelry, nor fixes that will use component parts that are worth more than the original components.

Health insurance is much more complicated. It is difficult to know in advance, and therefore explicitly incorporate into the promise, what one will need. Trouble breathing, for example, does not mean that one needs a replacement lung; an expert is needed to figure out what the “fix” even is.<sup>65</sup> The way to resolve whether one needs a lung transplant or an inhaler is by asking a physician what is medically necessary to address the breathing difficulty. Moreover, because individuals are not accustomed to financially valuing human life—particularly their own—and are indeed repeatedly told in art, culture, and politics that human life is priceless, the assumption is that, unlike jewelry, the *only* question that should matter is whether the “fix” is medically needed or not. Given that psychological starting point, as well as the opacity of medical pricing, “medical necessity” is a natural outgrowth of how underinformed and inexpert consumers would demand that an insurance promise be made and priced, as I have argued in a previous work.<sup>66</sup>

It is thus unsurprising that both private and public insurance use the medical necessity concept as the core of the care promise. It describes both what people believe they are morally entitled to and how people assume health insurance should work.

## B. The Cost Problem of Medical Necessity

The first difficulty with the medical necessity standard is that it does not incorporate cost. Medical necessity, in effect, asks whether a particular treatment will do a peppercorn of good; a treatment that does five peppercorns of good is arguably more necessary than one that does four peppercorns of good, even if the marginal cost of the fifth peppercorn is ten times the additional cost. One covered by a medical necessity promise—whether an insured capable of filing a lawsuit or a voter capable of going to the ballot box—will seek the latter.<sup>67</sup>

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65. See Peter Diamond, *Organizing the Health Insurance Market*, 60 *ECONOMETRICA* 1233, 1234 (1992) (recognizing the importance of diagnosis).

66. See Brendan S. Maher & Peter K. Stris, *ERISA & Uncertainty*, 88 *WASH. U. L. REV.* 433, 461–63 (2010) (explaining how “medical necessity” is an organic market outgrowth of the moral intuitions and cognitive limitations of consumers).

67. Insurers will use categorical exclusions regarding experimental or cosmetic procedures, of course. See *generally* John Bronsteen, Brendan S. Maher &

More abstractly, an indemnity promise that is not perfectly experience-rated presents a problem of ex-post demand-side moral hazard; insureds facing a loss event will choose the “fix” most consistent with their preferences without regard to cost.<sup>68</sup> The standard account is that such actions will lead to far higher consumption levels of the insured good than would occur in the absence of insurance and ultimately increase its cost.<sup>69</sup> Indemnity also creates supply-side moral hazard, i.e., medical providers engaging in service provision—or creation—without regard to cost.<sup>70</sup> Where doctors receive pay for the amount of services provided, and innovators know new care products—drugs, procedures, technology—that offer only an additional peppercorn of positive health outcome will be covered, overproduction is likely.<sup>71</sup> As I have written elsewhere, I believe “moral hazard” is a widely misunderstood term that can carry inaccurate connotations; I instead prefer the term “discretionary cost pressure.”<sup>72</sup> The point is the same: Where an insured or a provider is in a position where he is indifferent to cost, that indifference is likely to result in higher cost at the micro and macro level.<sup>73</sup>

Moreover, health care is particularly susceptible to cost growth from supply side discretionary cost pressure because there is no robust noninsured market, i.e., a market where nonindigents make purchasing decisions based on ability to pay, to exert cost-containment pressure. The individual and the market demand curve for repairing most goods will be generally constrained in some fashion by the

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Peter K. Stris, *ERISA, Agency Costs, and the Future of Health Care in the United States*, 76 *FORDHAM L. REV.* 2297 (2008) (discussing categorical health insurance exclusions). But the point is that if those exclusions do not apply, there is no explicit cost constraint at work.

68. See Mark V. Pauly, *The Economics of Moral Hazard: Comment*, 58 *AM. ECON. REV.* 531, 535–37 (1968). Pauly’s work is the foundational work in the field.

69. See *id.*; see also D. Ward Kallstrom, *Health Care Cost Control by Third Party Payors: Fee Schedules and the Sherman Act*, 1978 *DUKE L.J.* 645, 647–48 (1978) (identifying inflationary incentives of both patients and providers).

70. See, e.g., McLean & Richards, *supra* note 22, at 293.

71. See *id.* (“[M]any new drugs offer marginal or no benefits to most patients when compared with existing remedies . . . [yet] cost much more than existing drugs.”); see also Lawrence J. Appel, *The Verdict from ALLHAT—Thiazide Diuretics Are the Preferred Initial Therapy for Hypertension*, 288 *J. AM. MED. ASS’N* 3039, 3039–42 (2002) (explaining the superior effectiveness for treating hypertension of inexpensive diuretics over more costly patented drugs).

72. See Maher & Stris, *supra* note 66, at 463 n.142 (arguing in favor of “discretionary cost pressure” as the superior term).

73. See *id.* at 462 (explaining that the lack of an explicit marginal cost limitation creates a “relentless upward cost pressure on the promise”).

object's market value, as determined in a pure market. Tailors charge less than mechanics because clothes cost less than cars. It makes no sense to develop a business repairing objects of a certain type if the cost of performing the repairs exceed the value of the good. One would not expect that owners of the subject good would be willing to pay more than the value of the good to fix it; they would choose to replace it instead. But there is no independent market for health.

Accordingly, the supply-side discretionary pressure on the price of medical services—roughly, those services for which the primary aim is to restore health—are not constrained by noninsured market values.<sup>74</sup> The obvious incentive for medical innovators is to attempt to create services that are marginally more effective without regard for cost, and for treating physicians to recommend more costly procedures.<sup>75</sup> Hence the worry about the “cost-spiral” in health care and constant talk by policymakers about how to “bend the cost-curve.”<sup>76</sup>

### C. The Quality Problem of Medical Necessity

The second problem of the medical necessity promise is the consequences it has for quality of care. It does not cover treatments that are worthless, as those treatments are unnecessary. But it is often the case that more than one potential treatment could “work,” and the medically necessary promise on its own does not speak to how to choose among worthy options.

Put slightly more formally, medical necessity can be thought of as requiring some decisionmaker to answer two questions. The first (threshold) question is whether a given treatment will do *any* good, i.e., whether it is worthless. The second (comparative) question is which is the better option between two non-worthless treatment choices, i.e., which salutary treatment option will do more peppercorns of good.

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74. See Pauly, *supra* note 68, at 535–37.

75. See *id.*

76. See Ehsan U. Syed, *Will We Ever Bend the Cost Curve in Healthcare?*, 12 AM. HEALTH & DRUG BENEFITS 186, 187 (2019); see also Ezra Klein, *Does Health-Care Reform Bend the Cost Curve Up?*, WASH. POST (Sept. 10, 2010, 12:30 PM), [http://voices.washingtonpost.com/ezra-klein/2010/09/does\\_health-care\\_reform\\_bend\\_t.html](http://voices.washingtonpost.com/ezra-klein/2010/09/does_health-care_reform_bend_t.html) [https://perma.cc/CY82-5DRE]; Girard Miller, *Bending the Medical-Cost Curve*, GOVERNING (Oct. 21, 2010, 4:30 PM), <https://www.governing.com/columns/public-money/Bending-Medical-Cost-Curve.html> [https://perma.cc/4N57-K8D5].

In both cases, the original approach to applying the medical necessity standard was to utilize the judgment of the patient's physician: She would determine what was necessary in the first instance, i.e., the threshold issue, ruling out worthless treatments. She would likewise determine which of the potential treatment options was better, i.e., the comparativeness issue, choosing among worthy treatments. That approach, however, posed several interrelated problems.

First, in the original fee for service model, a physician might find herself in the following situation: She will have correctly determined that there are two treatments that will both actually help the patient, i.e., neither treatment is worthless. Yet she finds it also to be true that decisively resolving *which* treatment is in fact better for this particular patient is challenging, while nonetheless knowing for sure that one of those methods is more lucrative for her than the other.<sup>77</sup> Because the patient himself has no meaningful ability to compare treatments, the temptation for the physician to simply choose the more costly treatment will be high.<sup>78</sup> In other words, the pursuit of effectiveness might be abandoned due to the siren of dollars.

Second, the individual physician is not a reliable assessor of her own quality. Locating the necessity inquiry in her, with no overview, meant tolerating some likelihood that she would not make the right choice with respect to either the threshold aspect or the comparativeness aspect, as well as the likelihood that she would, even if she chose the optimal treatment option, not implement it as well as a more competent physician.

Both problems were further compounded by the fact that patients are not sophisticated consumers of medical care: They choose their providers by virtue of proximity, bedside manner, or happenstance, not after a searching review of the physician's past performance.<sup>79</sup>

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77. See, e.g., Ira L. Burney et al., *Medicare and Medicaid Physician Payment Incentives*, 1 HEALTH CARE FIN. REV. 62, 68–70 (1979) (describing empirical study of physician incentives in fee-for-service model).

78. See John P. Bunker, *Surgical Manpower: A Comparison of Operations and Surgeons in the United States and in England and Wales*, 282 NEW ENG. J. MED. 135, 139 (1970). Nor are patients hard to sway. See Shannon Brownlee, Vikas Saini & Christine K. Cassel, *When Less Is More: Issues of Overuse in Health Care*, HEALTH AFFS. (Apr. 25, 2014), <https://www.healthaffairs.org/doi/10.1377/hblog20140425.038647/full/> [<https://perma.cc/38SU-3UWX>] (“Patients often believe implicitly that there’s always one more test, one more treatment to try, and that their doctor would never recommend a procedure or a stay in the ICU that was not in their best interest.”).

79. See, e.g., Katherine M. Harris, *How Do Patients Choose Physicians? Evidence from a National Survey of Enrollees in Employment-Related Health Plans*,

Thus, the relevant actor with regard to determining and supplying medically necessary care was a physician chosen and trusted by the patient using a decision process unrelated to the actual quality of the physician's diagnostic or performance abilities. Under such circumstances, care deemed "medically necessary" would only loosely correlate with the most effective care.

#### D. Cost and Quality Approaches

It took payers, both private and public, some time to recognize the theoretical and practical limitations of the medical necessity promise. Private health insurance first spread in the 1930s, but it was not until the late 1970s that private payers adopted significant efforts to control costs.<sup>80</sup> As for the government, the first meaningful effort to control Medicare's costs, in 1983, occurred almost twenty years after its enactment.<sup>81</sup> The reality is that, in contrast to risk, no societal consensus has been reached on how to best address challenges inherent in a health care financing arrangement that hinges on promising medically necessary care.

Countless pages have since been written on the different approaches taken by both private and public payers to constrain cost and promote quality. For our purposes, however, only a general overview is necessary. The most-frequently tried approaches are (1) bulk buying power, (2) discretion allocation, (3) internalization, (4) evidence-based treatment constraints, and (5) quality metrics.<sup>82</sup>

##### 1. Bulk Buying Power

The first way to tamp down costs is neither complicated nor specific to health care: keep costs lower by having big payers refuse to pay more than a certain amount for the medical services being provided. The larger the buyer, the more power it has to negotiate low

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38 HEALTH SERVS. RSCH. 711, 712 (2003) (summarizing the literature as supporting the notion that patients do not rationally search for or choose physicians).

80. See, e.g., Kallstrom, *supra* note 69, at 647–49 (discussing now-common cost-control measures that most insurers in 1978 had not yet adopted); Sara Rosenbaum et al., *Who Should Determine When Health Care Is Medically Necessary?*, 340 NEW ENG. J. MED. 229, 230 (1999).

81. See Social Security Amendments of 1983, Pub. L. No. 98-21, §§ 601–07, 97 Stat. 65, 149–72 (codified as amended at 42 U.S.C. § 1395 (2018)).

82. As will become clear in the discussion below, several of these approaches address both cost and quality. The order in the text begins with the most-cost focused and ends with the most-quality focused.

prices. Large private insurers use this power to negotiate lower reimbursement rates for their in-network doctors who they attract by promising volume. The government, as the largest buyer of health care of all, has long since adopted a payment schedule that uses its buying power to dictate lower prices still.<sup>83</sup> Providers sign up to be Medicare providers not because they are compelled to, but because the government controls such a volume of patients that, even with Medicare's low reimbursement rates, most physicians opt to do so.

## 2. Discretion Allocation

As discussed in Section III.C, a promise to pay for medically necessary treatment requires a judgment on the part of *someone* that a sought treatment is, in fact, medically necessary.<sup>84</sup> Originally, such judgment was wholly exercised by the patient's physician. But payers soon realized that, for the reasons discussed above, physicians often have different goals than (1) the patient or (2) the payer, and accordingly may exercise their discretion in a way that is financially advantageous to the physician but that optimizes neither cost nor quality of care.<sup>85</sup>

Accordingly, one mechanism to control cost was for the payer to arrogate to itself some discretion to determine, either prospectively or retrospectively, what services are or were medically necessary and thus reimbursable. By locating some discretionary power with regard to medical necessity determinations in the payer, both physician-inspired and patient-inspired care choices that disregarded either cost or quality could, in theory, be curbed by payer judgment. Note that this approach, in theory, could lead to quality improvements by deterring suboptimal but more lucrative care choices. Private payers pursued this approach through a number of mechanisms, including

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83. See §§ 601–07. I am referring to hospital and provider reimbursement. Drug purchases are another matter.

84. See discussion *supra* Section III.C.

85. See, e.g., Jonathan Gruber & Maria Owings, *Physician Financial Incentives and Cesarean Section Delivery*, 27 RAND J. ECON. 99, 99, 120 (1996) (suggesting physicians substituted Cesarean delivery for natural delivery in order to make up for negative income shocks from decreased fertility rates). Doctors, in contrast, tend to cast the issue in terms of obviously-we-should-have-it physician autonomy. See, e.g., Zhiping Walter & Melissa Succi Lopez, *Physician Acceptance of Information Technologies: Role of Perceived Threat to Professional Autonomy*, 46 DECISION SUPPORT SYS. 206, 208 (2008) (reporting that almost 70% of physicians “agreed or strongly agreed that clinical freedom was essential to the practice of medicine and physicians should fight against any constraints upon it”).

gag rules, precertification requirements, and utilization review procedures.<sup>86</sup> The government has implicitly done so by the promulgation of comprehensive codes that a provider need choose when providing treatment for which he hopes to obtain payment.<sup>87</sup> To the extent that no applicable code exists, that amounts to the government's judgment that the contemplated treatment is not medically necessary and therefore not reimbursable.<sup>88</sup>

### 3. *Internalization*

Internalization describes the universe of approaches intended to promote the efficient provision of care by making providers internalize the cost of failure or reap the benefit of success.<sup>89</sup> At their heart, the original wave of internalization approaches rested upon the notion that there is some level of care that the ideal provider—let's call him Dr. Hercules—would provide to a given patient.<sup>90</sup> Dr. Hercules will never prescribe unnecessary care, nor would he provide poor care that would, by virtue of its ineffectiveness, lead to the need for additional care. The payment scheme for providers should be based on what Dr. Hercules would charge, and to the extent that more care than that was provided, the physician should solely or largely bear that cost of provision. Note that, like discretion allocation above, this approach could improve quality of care because it will theoretically incent providers to avoid unnecessary care, as well as to choose care options likely to reduce the need for future care. Both private and public payers have attempted variants of the internalization approach;

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86. See Bronsteen, Maher & Stris, *supra* note 67, at 2311–27 (discussing cost-control measures).

87. See CTRS. FOR MEDICARE & MEDICARE SERVS., EVALUATION AND MANAGEMENT SERVICES GUIDE 4 (2020) (explaining how matters not included in codes are not reimbursable).

88. See *id.*

89. A separate set of cost-internalization approaches was designed to curb overconsumption of care by consumers. See, e.g., Amy B. Monahan, *The Promise and Peril of Ownership Society Health Care Policy*, 80 TUL. L. REV. 777, 792 (2006) (“The theory behind CDHPs [consumer-driven health plans] is that individuals should be incentivized to act as consumers when they purchase medical services.”). A problem with that approach is that consumers are unsuited to make care decisions, and particularly so in a world of opaque prices. See *id.* at 818–20; see also Robert H. Brook et al., *Does Free Care Improve Adults' Health? Results from a Randomized Controlled Trial*, 309 NEW ENG. J. MED. 1426, 1432 (1983) (finding that cost sharing leads to patients avoiding obtaining needed care).

90. Cf. Ronald Dworkin, *Hard Cases*, 88 HARV. L. REV. 1057, 1101–02 (1975). The joke will be lost if I include a parenthetical.

modern versions are more sophisticated and structure compensation using more advanced internalization models, such as those structured around health outcomes.<sup>91</sup>

#### 4. Evidence-Based Treatment Constraints

If medicine is more art than the science, evidence-based treatment constraints are efforts to bring more science to the art. Physicians are educated about best practices in medical school and during their residencies, and they engage in professional reading and ongoing clinical education thereafter, but the degree and speed to which the latest validated findings filter into the treatment they recommend to their patients is the opposite of overnight: Some observers have suggested it takes 15–20 years before the care we should get becomes the care we do get.<sup>92</sup>

Evidence-based treatment constraints are payer-generated efforts to (1) identify when clinical practice is not adhering to the latest findings and (2) get physicians to so adhere. A common approach is through the use of “clinical guidelines,” which often incorporate and agglomerate the guidelines generated by various players that advise

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91. The idea behind value-based care approaches is that physicians should be in part compensated based on the outcome delivered. The ACA added to Medicare’s reimbursement system several value-based modifiers to the traditional Medicare fee schedules. See *Medicare FFS Physician Feedback Program/Value-Based Payment Modifier*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Sept. 12, 2016, 8:47 AM), <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index> [<https://perma.cc/7PHX-YJJC>] (“The Value Modifier provides for differential payment under the Medicare Physician Fee Schedule (PFS) based on the quality of care furnished compared to the cost of care during a performance period.”); CTRS. FOR MEDICARE & MEDICAID SERVS., SUMMARY OF 2015 PHYSICIAN VALUE-BASED PAYMENT MODIFIER POLICIES 3 (2015) (explaining that the program is budget neutral, meaning some physicians will effectively get bonuses and others debited). See generally Kenneth W. Field & Douglas E. Litvack, *Health Care Merger Analysis in the Era of Payment Reform*, 24 J. ANTITRUST, UCL & PRIV. SECTION ST. BAR CAL. 42 (2015) (describing several broad types of risk-based payment approaches in private settings). The evidence on the success of value-based incentive structures is mixed. See Wendy Netter Epstein, *Revisiting Incentive-Based Contracts*, 17 YALE J. HEALTH POL’Y, L., & ETHICS 1, 46–48 (2017) (examining empirical studies evaluating success of value-based compensation structures).

92. Paul H. Keckley, *Evidence-Based Medicine in Managed Care: A Survey of Current and Emerging Strategies*, 6 MEDSCAPE GEN. MED. 56, 56–58 (2004) (paraphrasing the Institute of Medicine’s description of the problem).

providers what the latest evidence supports—and in some cases, what the payer customarily or exclusively reimburses.<sup>93</sup>

### 5. *Quality Metrics*

Outside of the extremes, neither the physician's skill (when compared to other physicians performing the same treatment) or the treatment's effectiveness (when compared to the same physician performing the alternative treatment) are readily ascertainable by a current or prospective patient. Indeed, because of the multifactorial challenge inherent in evaluating provider performance—i.e., the difficulty in figuring out whether a doctor's results were worse because he saw people with more serious ailments to begin with or because he is a worse doctor—ex-post evaluation of provider performance, even by experts, is far from easy. The idea behind quality metrics is to analyze information that can serve the latter purpose—and thus give payers the power to act accordingly to incent or penalize good performance—with the hope of someday translating those insights into metrics usable by consumers.<sup>94</sup> Both private and public payers are accordingly pursuing quality-driven approaches.<sup>95</sup>

## E. Government Advantages

### 1. *On Cost*

One might be tempted to conclude that the government—as a nonprofit actor not making a contractual promise—is not susceptible to the cost problem. But that is not so. To the extent that the public promise of health care turns on medical necessity without explicit reference to marginal cost, the government will face discretionary cost pressure politically—i.e., voters insisting that as taxpaying citizens, they deserve every peppercorn of care and medical innovators predicting the government will give in to voters.

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93. See, e.g., Ronen Avraham, *Clinical Practice Guidelines: The Warped Incentives in the U.S. Healthcare System*, 37 AM. J.L. & MED. 7, 16–18, 28 (2011) (discussing clinical practice guidelines).

94. See *infra* Part IV.

95. See Kristin M. Madison, *From HCQIA to the ACA: The Evolution of Reporting as a Quality Improvement Tool*, 33 J. LEGAL MED. 63, 78–82 (2012) (explaining how states, the federal government, and private actors are pursuing quality recording and reporting efforts). Professor Madison observes, however, that “the pervasiveness of quality reporting does not guarantee its usefulness as a quality improvement mechanism for individual physicians.” *Id.* at 80; see also *infra* Part IV.

The chief tool the American government has used to control cost to date is buying power. Because Medicare participation is voluntary, its reimbursement rates and fee schedule (discussed in more detail below) are better thought of as an incident of the government's market power as the largest buyer of health care, rather than its regulatory power as sovereign.<sup>96</sup> It is worth a brief detour to consider the evolution of Medicare's payment scheme, which is famously complicated and jargon-filled.<sup>97</sup> Abstraction will spare us engagement with those mind-numbing particulars.

Medicare originally adopted a payment approach using a fee-for-service model for providers and a cost-incurred model for hospitals (which is a rough analog to the fee-for-service model but in which the hospital's time and effort was reimbursed on a cost basis).<sup>98</sup> By the early 1980s, Congress became concerned that its original approach was too expensive and highly susceptible to cost growth.<sup>99</sup> It thereafter moved to a "prospective payment system," which amounted to a broadly comprehensive fee schedule that spelled out how much particular acts with respect to particular conditions would get

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96. In effect, the government has announced, "We will pay X and no more to any physician who accepts our offer." That more resembles private buying behavior than a sovereign flexing its regulatory muscles. The government could, of course, use its regulatory power to set prices for certain goods independent of whether the government was buying the good or not. But it has not broadly done so, and that exercise would, in any event, be subject to the same allocative efficiency concerns described in the text.

97. As the Fourth Circuit once acidly observed:  
There can be no doubt but that the statutes and provisions in question, involving the financing of Medicare and Medicaid, are among the most completely impenetrable texts within human experience. Indeed, one approaches them at the level of specificity herein demanded with dread, for not only are they dense reading of the most tortuous kind, but Congress also revisits the area frequently, generously cutting and pruning in the process and making any solid grasp of the matters addressed merely a passing phase. *Rehab. Ass'n of Va., Inc. v. Kozlowski*, 42 F.3d 1444, 1450 (4th Cir. 1994). If anything, that understates the matter. *See id.*

98. Nicole Huberfeld, Elizabeth Weeks Leonard & Kevin Outterson, *THE LAW OF AMERICAN HEALTH CARE* 60 (2d ed. 2018) (describing Medicare's original payment approach).

99. *See, e.g.*, Robert M. Gibson, Daniel R. Waldo & Katharine R. Levit, *National Health Care Expenditures, 1982*, 5 HEALTH CARE FIN. REV. 1, 1 (1983) (documenting cost growth and congressional "concern over the survival of government entitlement programs").

reimbursed, regardless (mostly) of the actual time and effort expended to treat.<sup>100</sup>

When, for example, the Diagnostic-related Group (DRG) system was introduced with respect to hospital reimbursement in the 1980s, observers complained that the result was that hospitals were simply discharging patients “quicker and sicker.”<sup>101</sup> The reason was the way the original DRG system worked: It spelled out the amount of money a hospital would be reimbursed for certain conditions, and no more.<sup>102</sup> As a result, patients would be discharged even if they were not well enough to be, and, to the extent they were readmitted, the hospital would seek a new DRG reimbursement.<sup>103</sup> The DRG system was subsequently overhauled, with a more comprehensive DRG list—that more accurately reflected the care realities of more serious conditions—as well as the inclusion of readmittance penalties, to deter system gaming.<sup>104</sup>

Similar adjustments were made to Medicare Part B (provider) reimbursements.<sup>105</sup> Medicare Part B provider reimbursement for most services is based on the annually produced Medicare Physician Fee Schedule.<sup>106</sup> There is some flexibility in the codes one can fill out for reimbursement based on the amount of time taken, but largely the fees

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100. 22 Ill. Prac. 3d § 23:21. The fee schedules for both hospitals and physicians (discussed later in the text) attempt to bake in intensity and effort, *see* 2 Health L. Prac. Guide § 25:25 (describing how reimbursement base is compensated for a given treatment act), but in practice there are limited reimbursement options to the extent a doctor is more aggressive than the codes contemplate. *See* 2 Health L. Prac. Guide § 25:29 (discussing coding); *see also* 22 Ill. Prac. 3d § 23:21 (noting limited options for additional payment). *But see supra* note 91 and accompanying text (describing ACA’s efforts to add incentive-based compensation to Medicare).

101. Bagley, *supra* note 62, at 544 (explaining the 1983 reforms); *see also* Jacqueline Kosecoff et al., *Prospective Payment System and Impairment at Discharge: The ‘Quicker-and-Sicker’ Story Revisited*, 264 J. AM. MED. ASS’N 1980, 1982 (1990) (discussing quicker and sicker phenomenon). DRG stands for “diagnosis-related group.” The idea is to comprehensively categorize conditions and the corresponding treatment, such that one can determine what the expected cost of treating the condition will be.

102. *See* 22 Ill. Prac. 3d § 23:22.

103. *See* Jacqueline Kosecoff et al., *Prospective Payment System and Impairment at Discharge: The ‘Quicker-and-Sicker’ Story Revisited*, 264 J. AM. MED. ASS’N 1980, 1982 (1990) (discussing early challenges of DRG system).

104. *See, e.g.*, 22 Ill. Prac. 3d § 23:22 (“Within each DRG, hospital payment is fixed, with the possible exception of outlier payments in a limited number of circumstances.”).

105. *See* Bagley, *supra* note 62, at 540–41 (explaining adjustments to Medicare’s compensation of physicians).

106. *See id.*

are fixed without regard to the actual effort expended or the difficulty thereof.<sup>107</sup>

Those adjustments to the Medicare payment approach represented a deliberate and meaningful reduction in reimbursable unit cost and reimbursable volume, compared to what was and is available from private payers, for hospitals and providers.<sup>108</sup> The government's buying power and payment discipline, in other words, have seemingly allowed it to outperform its private rivals on cost.

But the government's cost advantage might not be costless. A market with overly powerful buyers—the most extreme of which, a single buyer market, is a monopsony—risks driving down the price of the good in question so low that society risks allocative inefficiency in two classic ways. The first is an underinvestment in human capital, i.e., too few people will choose to be doctors rather than bankers. The second is an underinvestment in medical advances, i.e., too little resources will be devoted to developing medical breakthroughs.<sup>109</sup>

In a world where the government is paying considerably less for care than private players, it is unclear, and probably unknowable, as to what the additional monies spent by private payers were or are “buying” society—or, conversely, what the saved government dollars were “costing” society.<sup>110</sup> Was every additional dollar spent for better care? Was every additional dollar spent a waste? Was every dollar the government saved one that contributed to too few medical advances? Was every additional dollar spent a cross-subsidy that made the

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107. *See id.*

108. *See, e.g.,* JARED LANE MAEDA & LYLE NELSON, AN ANALYSIS OF HOSPITAL PRICES FOR COMMERCIAL AND MEDICARE ADVANTAGE PLANS (2017); DARIA PELECH, AN ANALYSIS OF PRIVATE-SECTOR PRICES FOR PHYSICIAN SERVICES (2017); Gary N. Nugent et al., *Value for Taxpayers' Dollars: What VA Care Would Cost at Medicare Prices*, 61 MED. CARE RSCH. & REV. 495, 501 (2004) (finding that services provided by the Veterans Health Administration would have cost about 21% more if those services had been delivered through the private sector at Medicare's payment rates).

109. *See, e.g.,* Mark V. Pauly, *Managed Care, Market Power, and Monopsony*, 33 HEALTH SERVS. RSCH. 1439, 1459 (1998) (warning about risks of monopsony); *see also* Mark V. Pauly, *U.S. Health Care Costs: The Untold True Story*, 12 HEALTH AFFS. 152, 153–54 (1993) (arguing that the higher cost of health care in the United States is not because of waste and inefficiency).

110. *See, e.g.,* H.E. FRECH III, COMPETITION AND MONOPOLY IN MEDICAL CARE, at ix, 84 (1996) (“Making sense of the sprawling literature and disparate empirical results requires theoretical and empirical judgment.”); Gerald E. Anderson et al., *It's the Prices Stupid: Why the United States Is So Different from Other Countries*, 22 HEALTH AFFS. 89, 90 (2003) (arguing that higher relative price of care in the United States is not justified).

collective expenditure for medical care by public and private payers allocatively efficient?<sup>111</sup>

There is certainly reason to think that the government's cost control efforts are on balance salutary, particularly given how much other governments around the world pay for care—namely, less.<sup>112</sup> Yet that there appears to be some room for the government's purchasing power to reduce the cost of medical care without destroying entry and innovation incentives does not mean that the existence of a more-costly private market is wasteful or suboptimal.

## 2. On Quality

As the historical efforts to improve care show, quality-promoting efforts generally pursue one of three conceptual objectives: (1) identifying quality providers, (2) identifying effective and comparatively effective treatments, and (3) creating incentive payment structures that encourage physicians to make decisions that lead to effective care.<sup>113</sup> Here, the government's advantages are considerably less obvious than on risk and cost.

The government certainly can and should gather information and sponsor research that makes the first two objectives easier, but it can do so regardless of whether it serves as a payer or not. As to the creation of incentive structures, it is difficult to see why or how the government will do a better job innovating incentive structures than private competitive players.

Simultaneously, the risks of having the government as the sole actor of this task seem acute. I noted above that incentive measures to control cost can implicitly have positive effects on quality, serving as discouragements for physicians to provide suboptimal care that breeds the need for more care. Yet the converse is also true: Cost control measures can also lead to worse or no care. The Health Maintenance Organization (HMO) was the recipient of much theoretical praise for using capitation and similar mechanisms to deter physicians from overproviding care, but the practical result was widespread patient unhappiness and "stinting," i.e., the under-provision of care.<sup>114</sup> The

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111. See *infra* Subsection IV.C.1.

112. See Anderson et al., *supra* note 110, at 90.

113. See *supra* Section III.D.

114. See, e.g., Randall P. Ellis & Thomas G. McGuire, *Optimal Payment Systems for Health Services*, 9 J. HEALTH ECON. 375, 375–76 (1990) (discussing a theory of stinting); Randall P. Ellis & Thomas G. McGuire, *Provider Behavior Under*

analog to that with a public payer is that some doctors simply will not take Medicare patients because the fee schedules either do not cover the needed care or (more likely) will not economically justify the amount of time and effort the doctor believes is necessary to treat patients with certain difficult conditions. In short, payment strictures virtuous from a cost perspective might repel superior practitioners. Having multiple payers using different incentive and payment structures seems to be the safer course.

The foregoing, importantly, does *not* mean the government is a hidebound incompetent incapable of pursuing meaningful quality-promoting initiatives. To the contrary, the federal government has attempted numerous programs on this score, several of which observers believe have reasonable promise.<sup>115</sup> But two points are worth noting. First, to the extent that the government is serving as an information gatherer and promulgator, it can do that without being a payer. Second, whatever the government's nascent successes in promoting quality, the results are not so overwhelming as to suggest private payers could not do better.<sup>116</sup>

### 3. *On Cost and Quality Tradeoffs*

None of the government's potential advantages with respect to cost and quality aid it with the thorniest problem of all: cost-effectiveness.<sup>117</sup> Let us first define the relevant terms.

A treatment that is "effective" is one that does at least one peppercorn of good.<sup>118</sup> A treatment that is "comparatively effective" is one that does more peppercorns of good than a competing treatment.<sup>119</sup> Reliably identifying what treatments are effective and then, among

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*Prospective Reimbursement: Cost Sharing and Supply*, 5 J. HEALTH ECON. 129, 148 (1986) (examining a theory of stinting).

115. See, e.g., Epstein, *supra* note 91, at 18–22 (2017) (remarking that "[b]y some measures, the ACA includes forty five different provisions aimed at reforming health-care delivery to either improve the quality and/or the efficiency of health care in some way" of which the three biggest are ACOs, physician incentive pay, and bundled payments). Both the ACA and the Medicare and CHIP Reauthorization Act of 2015 required the government to pursue quality-evaluating (e.g., the Physician Quality Reporting System) and quality-communicating (e.g., the creation of a website entitled "Physician Compare") initiatives. See *id.* at 19.

116. See *id.* at 45–46.

117. See Peter J. Neumann, Allison B. Rosen & Milton C. Weinstein, *Medicare and Cost-Effectiveness Analysis*, 353 NEW ENG. J. MED. 1516, 1516 (2005).

118. See, e.g., Sarah J. Whitehead & Shehzad Ali, *Health Outcomes in Economic Evaluation: The QALY and Utilities*, 96 BRIT. MED. BULL. 5, 5 (2010).

119. See Neumann, Rosen & Weinstein, *supra* note 117, at 1517.

effective treatments, reliably identifying which is the most comparatively effective are important and difficult tasks.<sup>120</sup> But the tools brought to bear on resolving those hard questions cannot answer the final question: Which treatment is the most cost-effective? *That* is the ultimate question in a world of limited resources because there is some price above which society does *not* believe that either its private or public payers should be obligated to pay for an additional peppercorn of good; those dollars are better spent on something else.

As a conceptual matter, cost-effectiveness is easy enough to define. It is the treatment that restores the most amount of “health units” per dollar.<sup>121</sup> The intuitive way to measure health outcomes, and then determine whether a marginal increase is worth the additional cost, is to measure epidemiological outcomes specific to the particular treatment; for example, the amount blood pressure drops after a course of hypertension medication, the degree to which range of movement returns after shoulder surgery, or the five-year survival rate for certain cancer treatments.<sup>122</sup> One would see how much better Treatment A scores than Treatment B along the relevant outcome vector, and then ask whether that increase in health outcome is worth the higher cost of Treatment A.

The value of that type of cost-effectiveness approach, however, is limited for general payers—whether private or public—because the analysis is not fungible.<sup>123</sup> One cannot meaningfully compare blood pressure declines with increases in shoulder movement.<sup>124</sup> Thus, one cannot determine whether one should spend additional dollars on the blood pressure medicine that is better but more costly than *its* next best treatment option or on the shoulder surgery that is better but more costly than *its* next best treatment option.<sup>125</sup> To solve that problem—to allow payers to compare health outcomes with different epidemiological characteristics—health economists developed a variety of ways to measure health outcomes in a fungible manner, i.e., to effectively calculate health units.<sup>126</sup>

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120. See *supra* Section III.C.

121. See Matthew D. Adler, *QALYs and Policy Evaluation: A New Perspective*, 6 YALE J. HEALTH POL’Y, L., & ETHICS 1, 8–9 (2006).

122. See MICHAEL F. DRUMMOND ET AL., METHODS FOR ECONOMIC EVALUATION OF HEALTH CARE PROGRAMMES 103 (3d ed. 2005).

123. See Arti Kaur Rai, *Rationing Through Choice: A New Approach to Cost-Effectiveness Analysis in Health Care*, 72 IND. L.J. 1015, 1050 (1997).

124. See *id.*

125. See *id.*

126. See Whitehead & Ali, *supra* note 118, at 17–19.

The Quality Adjusted Life Year (QALY) is the most well-known example, but there are others.<sup>127</sup> QALYs assign a quality of life value of “1” to a year of perfect health and “0” to death; adverse health states in between perfect health and death are assigned fractional values between zero and one.<sup>128</sup> The QALY value of a particular treatment is determined by multiplying the expected post-treatment quality of life value by the years spent in that state, minus the QALY calculation for no treatment.<sup>129</sup> QALY calculations thus combine both the morbidity (quality of life) consequences and mortality consequences of a given treatment and permit comparison of vastly different epidemiological outcomes.<sup>130</sup>

With sufficiently robust QALY (or similar) data, a meaningful alteration could be made to the coverage promise. Instead of a promise of all “medically necessary care,” one can imagine a promise that offers to provide all medically necessary treatments less costly than X thousand dollars per QALY. Such a promise—call it a cost-effectiveness promise—excludes not only ineffective treatments (waste), but also treatments that offer a marginal benefit below a certain predetermined ratio (caviar).<sup>131</sup>

An explicit cost-effectiveness constraint is enormously valuable because it directly constrains discretionary cost pressure of both the demand and supply side variety—at least regarding those services who fall outside the threshold.<sup>132</sup> Demand side players will be unable to obtain a “necessary” treatment if the marginal benefit is smaller than the minimum threshold set forth in the promise; supply side players will have less incentive to prescribe or develop treatments outside the threshold.<sup>133</sup>

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127. There are a variety of ways the quality of life values can be determined. For an involved discussion, see generally DRUMMOND ET AL., *supra* note 122.

128. See Rai, *supra* note 123, at 1050.

129. See *id.*

130. See Adler, *supra* note 121, at 1–2. To be sure, QALYs are not perfect; scholars have discussed their shortcomings and discussed alternative metrics. See, e.g., *id.* at 43–53 (discussing QALY limitations); Philip G. Peters, Jr., *Health Care Rationing and Disability Rights*, 70 IND. L.J. 491, 501 (1995) (considering whether QALYs impermissibly discriminate against the disabled); Ani B. Satz, *The Limits of Health Care Reform*, 59 ALA. L. REV. 1451, 1485–87 (2008) (discussing ethical concerns regarding QALYs); Whitehead & Ali, *supra* note 118, at 17–19 (discussing alternatives to QALYs, including Disability Adjusted Life Year (DALY) that respond to various criticisms).

131. See Peters, *supra* note 130, at 495–96.

132. See *id.* at 496.

133. See Rai, *supra* note 123, at 1048–49. Buying power alone does not resolve this problem. Even in a monopsony market, there will be a treatment that does

Ultimately, any payer who makes the “medically necessary” promise of care is bound by the reality that it has limited resources to make good on that promise.<sup>134</sup> For a private payer, that limit is equal to premiums collected plus the returns it earns on investing those premiums; for the government, it is taxes collected for that purpose plus whatever other percentage of the federal fisc it wishes to draw upon.<sup>135</sup> But everything has a limit, and thus there is some line on expenditure that must be drawn. Limiting the coverage promise to care that has met some threshold of cost-effectiveness, i.e., to treatments that will restore some minimum amount of health per dollar, is the only way to transparently, explicitly, and squarely bound discretionary cost pressure.<sup>136</sup> It is precisely what health scholars have been urging for many years.<sup>137</sup>

Americans, however, have not reacted well to attempts to incorporate cost-effectiveness metrics into coverage decisions made by governments.<sup>138</sup> Any hint of a QALY-like constraint being considered by the government has been criticized as unacceptable “rationing” equivalent to reliance on “death panels.”<sup>139</sup> Medicare is

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five peppercorns of good for \$100, and a competing treatment that does six peppercorns of good for \$500. The existence of the latter will politically push doctors to suggest it, the government to cover it, and innovators to prioritize a peppercorn of good over the marginal value of the innovation.

134. See Peters, *supra* note 130, at 496.

135. See Satz, *supra* note 130, at 1459–62.

136. See Rai, *supra* note 123, at 1048–49. Consider a silly but illustrative example: video game characters. In many video games, player-characters have “health points” or “health level” or something similar. When, during the course of the game, the character is injured by a video adversary or obstacle, his health points decrease by a discrete amount. In the video game world, a cost-effectiveness insurance promise would cover all treatments for the character that restored X or more number of health points for Y or less number of dollars (or gold pieces, or star credits, or whatever the currency in the game).

137. See Muriel R. Gillick, *Medicare Coverage for Technological Innovations—Time for New Criteria?*, 350 NEW ENG. J. MED. 2199, 2201 (2004); Rai, *supra* note 123, at 1018; Neumann, Rosen & Weinstein, *supra* note 117, at 1520. The British government uses cost-per-QALY largely, although not exclusively, in connection with its coverage recommendations. See Steven D. Pearson & Michael D. Rawlins, *Quality, Innovation, and Value for Money: NICE and the British National Health Service*, 294 J. AM. MED. ASS’N 2618, 2619 (2005).

138. See Neumann, Rosen & Weinstein, *supra* note 117, at 1516.

139. Elizabeth Weeks Leonard, *Death Panels and the Rhetoric of Rationing*, 13 NEV. L.J. 872, 885–86 (2013) (enumerating and explaining federal law prohibitions against using cost-effectiveness metrics). In the early 1990s, Oregon famously attempted to use QALYs in regard to Medicaid coverage decisions; the episode was a political disaster. See Robert M. Kaplan, *Utility Assessment for Estimating Quality-Adjusted Life Years*, in VALUING HEALTH CARE: COSTS, BENEFITS, AND

explicitly barred from considering cost-effectiveness with respect to coverage decisions.<sup>140</sup> As a result, the government is politically unable to openly use an extremely powerful tool. Instead, in the view of knowledgeable observers, it has resorted to considering cost-effectiveness in a disorganized and *sub rosa* fashion.<sup>141</sup>

#### IV. LEVERAGING PRIVATE PAYERS

In the previous Parts, I have argued that the government has an overwhelming advantage on risk; a meaningful but bounded advantage on cost; no advantage on quality; and a seeming disadvantage on cost-effectiveness. Given that, as well as the uncertainty around what the right answers are with respect to cost, quality, and cost effectiveness, there is good reason to imagine that, in the right regulatory scheme, private payers could be welfare enhancing. To sharpen the analysis, I imagine how private payers might evolve if confronted with a private option.<sup>142</sup>

##### A. Care Delivery Positives

As scholars have increasingly recognized, private insurers perform functions in connection with the insurance promise that resembles regulation, and they do so in ways or places where the government is unlikely to act as well or at all.<sup>143</sup> A similar species of rationale, as well as intuitive insights regarding the ability of private actors to create value as information intermediaries, suggests that private payers could serve that function in the health care context—and in a way that will attract consumers.<sup>144</sup>

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EFFECTIVENESS OF PHARMACEUTICALS AND OTHER MEDICAL TECHNOLOGIES 31, 53–59 (Frank A. Sloan ed., 1996) (describing the political failure of Oregon’s experimentation with implementing QALYs).

140. See Neumann, Rosen & Weinstein, *supra* note 117, at 1516.

141. See *id.* at 1519–20.

142. This Part does not aim to consider every reason why it might be desirable to not have the government be the only player in health care financing. Rather, it highlights some underrecognized practical reasons why private insurer involvement could make everyone better off.

143. See Omri Ben-Shahar & Kyle D. Logue, *Outsourcing Regulation: How Insurance Reduces Moral Hazard*, 111 MICH. L. REV. 197, 200–01 nn.8–10 (2012) (setting forth list of scholarship concerning insurers serving as regulators in a variety of fields).

144. See *id.* at 201.

### 1. Safety

The provision of care can be worse than ineffective; it can be harmful—sometimes for reasons as simple as poor instrument hygiene. As risk bearers, insurers generally have a long history of offering risk-reduction advice to insureds concerning safety procedures or practices that will reduce the odds of a loss event occurring.<sup>145</sup> Sometimes insurers require compliance as a condition for coverage; other times they offer premium reductions or rebates to promote preventative behavior; and other times they simply make recommendations.<sup>146</sup>

In the health care setting, insurers interact with both the insureds and the providers who treat them. In order to avoid rent-seeking on risk, regulators may choose to sharply limit what an insurer can ask or demand an insured to do.<sup>147</sup> But payers also interact with providers and thus can retain considerable discretion to regulate the practices of providers in ways that could provide a higher safety floor than government regulation alone.<sup>148</sup>

Insurers have two incentives to deploy this expertise. First, poor safety practices can increase the cost of a care episode.<sup>149</sup> Second, consumers might be willing to pay more for an insurer with a reputation as one requiring the hospitals, doctors' offices, and labs it uses to employ safety procedures that exceed federal government standards, e.g., the Volvo of health insurance.<sup>150</sup> Even if extra care caused by lax safety standards is entirely covered by insurance, avoiding the time and psychic cost associated with additional remedial care could be something for which many consumers would willingly pay a higher premium.

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145. See Victor P. Goldberg, *Tort Liability for Negligent Inspection by Insurers*, 2 RSCH. L. & ECON. 65, 72–73 (1980) (discussing examples).

146. See Ben-Shahar & Logue, *supra* note 143, at 210–13.

147. See *infra* Part V.

148. See Ben-Shahar & Logue, *supra* note 143, at 201.

149. See PA. HEALTH CARE COST CONTAINMENT COUNCIL, HOSPITAL-ACQUIRED INFECTIONS IN PENNSYLVANIA 2 (2006) (detailing how, in 2006, the Pennsylvania Health Care Cost Containment Council found that the “average payment for a hospitalization in which a patient acquired an infection was \$53,915, while the payment when a hospital-acquired infection was not present averaged \$8,311”).

150. See Ben-Shahar & Logue, *supra* note 143, at 210–11 (discussing how safety improvements can consist of both education regarding practice improvements in specific situations and the creation of safety codes that can apply writ large).

## 2. Provider Quality

There is little evidence that patients choose providers based on quality.<sup>151</sup> Yet because there is no doubt that patients are interested in quality, the problem is likely that patients cannot easily ascertain which provider is better than another. That is unsurprising because actually identifying a doctor's quality is a challenging exercise, even for experts.<sup>152</sup> Merely sifting through the existing information to extract actionable information as a consumer seems to be an insurmountable challenge, particularly given the vast array of federal, state, and association databases that speak to some aspect of physician quality.<sup>153</sup>

One way payers might add value is to gather and develop their own ways to assess quality and then strike deals with those providers.<sup>154</sup> But more likely is that the relevant innovation by insurers will be to synthesize information in a way that enables consumers, in addition to the payer itself, to understand whether a doctor is highly rated or not: through grades, stars, thumbs up, or so on.<sup>155</sup> One thing that the behavioral economics revolution has made clear is that decision-making is difficult, particularly in complicated, multifactorial settings—such as choosing a provider.<sup>156</sup>

Metrics that render intelligible to a consumer quality data are *highly* valuable.<sup>157</sup> The extraordinary twenty-first century rise of information companies, such as Google and Facebook, make readily apparent in general the massive value that can be gained by gathering, synthesizing, and extracting usable information from an otherwise staggering ocean of data.<sup>158</sup> And note that a profound portion of the value-creating impact of identifying quality in both physicians (and treatments) will come from translating those quality conclusions into

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151. See generally Harris, *supra* note 79.

152. See *id.* at 715–17.

153. See William M. Sage, Joshua Graff Zivin & Nathaniel B. Chase, *Bridging the Relational-Regulatory Gap: A Pragmatic Information Policy for Patient Safety and Medical Malpractice*, 59 VAND. L. REV. 1263, 1284–91 (2006) (discussing various sources of information regarding physician quality and safety).

154. See *id.* at 1305.

155. See *id.* at 1281–82.

156. See Harris, *supra* note 79, at 712–13.

157. See, e.g., Jullanar Alwazir, *Google and Facebook, the Data Collecting Companies*, MEDIUM (May 14, 2019), <https://medium.com/jullanar-alwazir/google-and-facebook-the-data-collecting-companies-42dd5cb0e016> [<https://perma.cc/9XP2-WQC7>].

158. See *id.*

intelligible metrics.<sup>159</sup> Whatever a payer may have concluded about the superior skill of one physician or treatment, quality improvement will be vastly easier if that conclusion can be readily understood by both actual and prospective patients: The former will increase the likelihood that patient autonomy principles do not frustrate quality gains, and the latter will drive patients to the right place.<sup>160</sup>

Such innovation is more likely to come from a private payer—rather than from a free-standing public or private service—because the payer can not only make available its quality tools to its insureds to promote choice, but can also strike deals with quality providers that justifiably pay them more and thus offer their insureds heightened access to superior practitioners.<sup>161</sup> Finally, private payers have greater freedom in making quality assessments than does the government, which faces both legal and equitable constraints about what it, as the government, can say about private physicians.<sup>162</sup>

In sum, private payers are well suited to identify quality physicians, using both proprietary and public information; to develop metrics comprehensible to consumers regarding such quality; and to take action with respect to those providers who do well, such as by only including in their network doctors who rate above a certain floor.<sup>163</sup> All of which is a fancy way of saying private payers can likely intelligibly differentiate on quality—an attractive value proposition to a significant set of consumers when they are faced with a choice between a cheaper public option and a more expensive private plan.

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159. See Sage, Zivin & Chase, *supra* note 153, at 1268–79.

160. See *id.* at 1268.

161. See JOSEPH P. NEWHOUSE, *THE ECONOMICS OF MEDICAL CARE* 62 (Michael L. Wachter & Susan M. Wachter eds., 1978).

162. See Sage, Zivin & Chase, *supra* note 153, at 1277–78 (responding to the claim that the government can do analysis that is close enough to as good and as actionable on safety and quality as private players). Perhaps. But there is little reason to believe the government will act so quickly, so definitively, and so intelligibly on safety and quality that another take on the subject—by private parties whose key pitch for their product is that they are doing a worthwhile job on those fronts—is unnecessary or dilatory.

163. See NEWHOUSE, *supra* note 161, at 58–66 (explaining the importance of accurate information in making rational care decisions); Sage, Zivin & Chase, *supra* note 153, at 1282 (arguing that the “quality of physicians under contract is a distinction worthy of aggressive marketing to consumers”).

### 3. *A Special Type of Quality: Personalized Medicine*

A great deal has been written about the promise of “personalized medicine” and its potential to improve radically health outcomes.<sup>164</sup> Less has been written about what financing structures are most likely to promote its development and adoption. Most scholarship focuses (understandably) on matters such as FDA approval.<sup>165</sup>

Generally speaking, the quality of care a physician can render improves the more the physician knows about the patient.<sup>166</sup> In some cases, additional information will not be helpful: A doctor need not know a person’s DNA in order to use the Heimlich maneuver to stop him from choking. But in many other cases, additional information about the patient is useful to both prevent the doctor from doing something harmful and to improve the effectiveness of a proposed treatment. For decades, physicians have secured information by having patients provide medical histories and symptom descriptions in varying amounts of detail. But recent improvements in both medical and data science suggest that the nation is on the precipice of a *profound* personalization trend in health care; namely, the widespread use of “personalized” or “precision” medicine.<sup>167</sup>

The idea is that making available to physicians biological information much more granular and reliable than a person’s self-reported medical history will result in treatment recommendations that will be vastly more effective—or have less side effects.<sup>168</sup> If armed with their patients’ biomarker specifics, a physician could check the relevant research to see that drug X works better on people with characteristic A, whereas drug Y works better on people with characteristic B, and thus prescribe the former to Patient A and the latter to Patient B.

The original basis for personalized medicine was the expected treatment gains that would result from human genome sequencing.<sup>169</sup>

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164. See, e.g., U.S. FOOD & DRUG ADMIN., PAVING THE WAY FOR PERSONALIZED MEDICINE: FDA’S ROLE IN A NEW ERA OF MEDICAL PRODUCT DEVELOPMENT 2 (2013) [hereinafter FDA].

165. See, e.g., W. Nicholson Price II, *Black-Box Medicine*, 28 HARV. J.L. & TECH. 419, 423–24 (2015).

166. See FDA, *supra* note 164, at 6.

167. See Price, *supra* note 165, at 420.

168. “The goal of personalized medicine is to streamline clinical decision-making by distinguishing in advance those patients most likely to benefit from a given treatment from those who will incur cost and suffer side effects without gaining benefit.” FDA, *supra* note 164, at 6.

169. See Price, *supra* note 165, at 424.

But additional bases for personalized medicine have since been developed, and personalized medicine's promise has been enhanced farther when combined with data science and artificial intelligence algorithms.<sup>170</sup> As leading commentator Nicholson Price observed in a now widely cited work, there are two types of personalized medicine.<sup>171</sup> There is "standard" personalized medicine where one relies on "scientific and clinical research to identify and explain relatively simple biological relationships" between the individual's known characteristics and treatment outcomes.<sup>172</sup> But there is also "black-box" personalized medicine, where highly advanced machine algorithms analyze enormous sets of health information to identify treatment improvements that are, by their very nature, neither replicable by unaided humans or practically susceptible to clinical trial.<sup>173</sup>

As Price also correctly observed, the Medicare payment system is not designed to accommodate rapid advancements in the deployment of personalized treatment protocols.<sup>174</sup> The current reimbursement approach relies largely on broad-based clinical studies and expert commissions to make large-scale determinations about appropriate treatments, and is generally skeptical of aggressive biomarker testing.<sup>175</sup> And while one expects—or at least hopes—that will change, given the tremendous promise of personalized medicine, it should not be controversial to say that the government as payer is unlikely to be as nimble or aggressive as private payers might be.

Private insurers—and certainly to the extent that they cannot compete with the public option on cost—are better suited than the government to incent physicians to adopt cutting edge personalized medicine treatments, such as by incorporating into treatment planning and clinical practice guidelines the recommendations of health analysts well-versed in the latest "standard" and "black-box" personalized medicine developments. More abstractly, one suspects

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170. See *id.* at 420–21.

171. See *id.* at 427, 429.

172. *Id.* at 427.

173. See *id.* at 429–30.

174. See *id.* at 462–65. Price proposes government reimbursement approaches be modified to more readily find personalized medicine treatments to be reimbursable. See *id.* One hopes that will occur. But that is more likely to do so in a world where private payers are aggressive in their own reimbursement strategies.

175. See *id.*; see also Lisa M. Meckley & Peter J. Neumann, *Personalized Medicine: Factors Influencing Reimbursement*, 94 HEALTH POL'Y 91, 97 (2010) (anticipating adoption of personalized medicine will be slowed until a "long overdue" "revised reimbursement system" occurs).

that private players—whether acting alone or as a part of an industry association—can develop and adopt any number of coverage-decision structures that could promote or incent the adoption of personalized medicine treatments during the lag period before Medicare’s own coverage wheels have turned.<sup>176</sup> That an insurance company offers more aggressive reimbursements regarding cutting edge, bespoke medicine than does public insurance seems to be a salient characteristic for which consumers could rationally pay more.<sup>177</sup>

#### 4. Employers

There is an additional positive wrinkle regarding safety and quality on the private market: employer involvement. As many have argued elsewhere (including me), the policy merit of providing health insurance through the workplace is at best mixed.<sup>178</sup>

Yet there are some positives associated with employer involvement, including (1) reducing adverse selection risk and (2) the fact that the employer, as a more sophisticated player with meaningful buying power, is likely a better evaluator of insurance products than a single worker.<sup>179</sup> This is, in part, why, for example, employment-based insurance policies tend to be more robust than those that individuals select on their own. In a world where the public option becomes a reality, i.e., a world where workers know the employer could not offer insurance and simply let employees obtain it through a (cheaper) Medicare buy-in—that puts genuine pressure on the employer to use its sophistication to *actually* secure for its workers a superior insurance product. Put differently, if one worries that payers might promise safety, quality, and cutting-edge personalized medicine but not deliver, sophisticated employers may be incented to deter, monitor, and prevent such behavior.<sup>180</sup>

#### B. Paradigm Positives

Private payers, if competing with a public option, may be willing to take bold steps that amount to paradigm shifts in how the health care financing promise is defined. I consider one possibility in some

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176. See Price, *supra* note 165, at 465–66.

177. That the government may someday modify its own decisional processes to match those of private payers is a positive.

178. See generally Maher, *REBA*, *supra* note 23.

179. See *id.* at 1278–79.

180. See *id.*

detail and then make the larger point that health care financing might benefit from paradigm experimentation.

### 1. *Explicit Cost-Effectiveness*

In part to combat claims that the government should not be involved in rationing care, Medicare cannot consider the cost or cost-effectiveness of a technology or service when making coverage decisions.<sup>181</sup> Yet the “rationing” concern may be surmountable to the extent that private insurers explicitly incorporate a cost-effectiveness metric into their insurance promise, particularly where Americans may enter such a regime by choice.<sup>182</sup>

As any sophisticated health commentator will explain, being opposed to “rationing” in a world of limited resources is conceptually incoherent.<sup>183</sup> One may oppose rationing being done by a certain party, or the way in which the rationing is done, but when there is more care to be purchased than money available to buy it, some form of rationing will occur—whether in the form of pretextual denials, longer waiting periods, or some other way.<sup>184</sup> Where resources are not infinite, rationing will occur.<sup>185</sup>

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181. See generally Jacqueline Fox, *Medicare Should, but Cannot, Consider Cost: Legal Impediments to a Sound Policy*, 53 BUFF. L. REV. 577 (2005) (analyzing and explaining historical and legal basis as to why Medicare cannot consider cost in its coverage decisions).

182. One might wonder why explicit or QALY-like metrics are not broadly used in insurance contracts today. The health care cost crisis is more recent than is commonly understood: It has only been in the last few decades that the problem was big enough to be worth solving. And employing explicit cost effectiveness constraints as a solution is more challenging than other alternatives (1) because of the cognitive and moral attachment to medical necessity, and (2) because doing so as a practical matter requires more sophisticated data analysis and effort. The former problem recedes when private insurers are competing against the government; in that instance cost effectiveness only governs those who choose it. The latter problem is not insignificant, but the incredible amount of information available and the incredible advances in data science analysis and health economics make widespread QALY analysis possible by properly capitalized private players. See generally Peter J. Neumann et al., *Comparing the Cost-Per-QALYs Gained and Cost-Per-DALYs Averted Literatures* [version 2; peer review: 3 approved], GATES OPEN RSCH., Mar. 5, 2018 (describing thousands of cost-effectiveness studies).

183. See, e.g., David Leonhardt, *Health Care Rationing Rhetoric Overlooks Reality*, N.Y. TIMES (June 17, 2009), <http://www.nytimes.com/2009/06/17/business/economy/17leonhardt.html> [<https://perma.cc/78FG-E586>] (“The choice isn’t between rationing and not rationing. It’s between rationing well and rationing badly.”).

184. See *id.*

185. See *id.*

A world in which some number of private insurers explicitly specify the basis on which they ration—whether by use to a dollars per QALY approach or some similar cost-effectiveness metric—could very well persuade some that opting-in to an explicit rationing regime is better than the alternative.<sup>186</sup> Under even a moderately restrictive cost-effectiveness promise, numerous extremely costly treatments would not be covered. That could lower the premiums needed to buy that policy. Alternatively, an innovative insurer could take the savings from the use of a cost-effectiveness metric and use them to pay its doctors more, and thus likely attract better doctors, or pay its doctors a premium to reserve spots for its patients, which insureds who are concerned about waiting periods might find especially attractive.

The existence of such policies might have positive spillover effects—in societal terms—in two potential ways. First, while it may take some time to find equilibrium, one expects that some level of dollars per QALY, whether \$25,000 or \$50,000, would become the most popular choice in the private market. Assuming the market was large enough, that would be a relevant signal to innovators regarding which medical advances to pursue; namely, those that have a marginal return better than the median QALY per dollar promise made. Put more formally, even a signal from a portion of the market is likely to reduce the odds that the health care market is allocatively inefficient. Second, the adoption of an explicit cost-effectiveness metric in a private setting by willing players—as opposed to being imposed on anyone via public insurance—will yield useful information about how to implement such an approach without the hysteria that attends sweeping government changes upon the unwilling.<sup>187</sup>

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186. Some observers have expressed concern that the use of QALYs discriminates against the disabled in potential violation of the Americans with Disabilities Act. I do not resolve that debate here, but merely suggest there likely exists a cost-effectiveness metric (whether QALY, DALY, or something else) that furthers resource allocation without violating the law. *Cf. supra* note 130 and accompanying text (discussing conceptual and legal limits of QALY-like approaches).

187. See Russell Korobkin, *Comparative Effectiveness Research as Choice Architecture: The Behavioral Law and Economics Solution to the Health Care Cost Crisis*, 112 MICH. L. REV. 523, 556 (2014) (arguing that when consumers can choose the terms of the coverage contract, “rationing” type concerns will have less salience). Korobkin’s very interesting paper proposed “relative value” insurance, but the insight about choice carries the same weight here. *See id.* at 523.

## 2. Paradigm Experimentation

The American polity has made little progress regarding the tradeoffs it wishes to make regarding cost and quality or the financing structures most suitable to get there. Given the relative recency of the problem, this is not surprising. Consider the following timeline.

Prior to the 1970s, few believed the fee-for-service model of health insurance to be a problem; it was assumed by many observers that the profession of medicine behaved largely independently of organizational and financing incentives.<sup>188</sup> Only in the late 1970s did now traditional cost-containment measures—like clinical guidelines, utilization review, and network rates—begin to be proposed and then adopted.<sup>189</sup> Only in the late 1990s and early 2000s did health scholars begin to propose that treatments and health outcomes be addressed in evidence-driven ways that could not only improve treatment but also allow choices to be made about where to put limited dollars.<sup>190</sup> And only in the last few years has the cost of information and the power to analyze it grown substantially enough to design and extract truly valuable cost and effectiveness metrics from the data we have and will get.<sup>191</sup> It was only this decade, for example, that most medical records began to be kept electronically.<sup>192</sup>

There is thus little reason to believe that we have discovered all there is to know about how to finance and deliver care, with the only question left being what model to pick and who to drive it.<sup>193</sup> We are

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188. See Kallstrom, *supra* note 69, at 657–58.

189. See *id.* at 672.

190. See, e.g., Kathleen N. Lohr, Kristen Eleazer & Josephine Mauskopf, *Health Policy Issues and Applications for Evidence-Based Medicine and Clinical Practice Guidelines*, 46 HEALTH POL'Y 1, 7 (1998).

191. Cf. Swedloff, *supra* note 57, at 341 n.6 (remarking that insurers are only just beginning to adopt big data analytics).

192. See JAWANNA HENRY ET AL., ADOPTION OF ELECTRONIC HEALTH RECORD SYSTEMS AMONG U.S. NON-FEDERAL ACUTE CARE HOSPITALS: 2008-2015 (2016) (showing increasing adoption of electronic health records); see also Karen B. DeSalvo & Vindell Washington, *By the Numbers: Our Progress in Digitizing Health Care*, HEALTH IT BUZZ (Sept. 29, 2016), <https://www.healthit.gov/buzz-blog/electronic-health-and-medical-records/numbers-progress-digitizing-health-care> [<https://perma.cc/4DBH-AALE>].

193. For example, we still have not determined how to decrease the lag time from when studies reveal that certain treatments are ineffective (or super effective) to when physicians actually adopt them. See Wendy Netter Epstein, *The Health Insurer Nudge*, 91 S. CAL. L. REV. 593, 599–600 (2018) (decrying the fact that a majority of providers “adhere to out-of-date practices long after the evidence mandates change”). Nor have we determined whether the new generation of risk-internalization models

still in the experimentation phase and have not yet meaningfully attempted to engage, for example, on the question of how to integrate cost-effectiveness into our financing arrangements.<sup>194</sup> Better than to let our variegated pursuit to continue, with private players competing with the government—and the federal government permitting state governments to promote in-state experimentation along the same lines.<sup>195</sup>

## C. Other Positives

### 1. Health Care Cross-Subsidy

During the run-up to the passage of the Affordable Care Act, opponents of the bill complained bitterly about the Act's use of "cross-subsidies" in creating exchange pools, with the implication being that cross-subsidies were a particularly nefarious brand of government-meddling. Yet, as I have written elsewhere, cross-subsidies are *far* more ubiquitous than even expert commentators realize, appearing in all manner of regulatory settings, sometimes intentionally and sometimes incidentally, but frequently and at least arguably advantageously.<sup>196</sup>

A cross-subsidy exists when one segment of the purchasing pool pays more for a good so another segment can enjoy it for less.<sup>197</sup> In health care, private payers pay more than public payers for care.<sup>198</sup> While some of that excess payment may be attributable to other causes, there is a distinct possibility that some portion of the higher

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have been successful in driving down cost without reducing quality (although the evidence so far is positive).

194. *See id.* at 600.

195. Health scholars have proposed numerous promising ideas that have yet to be adopted. *See, e.g.,* Rai, *supra* note 123, at 1048, 1052 (discussing QALY-based insurance); *see* Avraham, *supra* note 93, at 25 (detailing clinical guidelines as safe harbors); Korobkin, *supra* note 187, at 556 (discussing relative value insurance); Epstein, *supra* note 193, at 600 (proposing the use of nudges to prevent unnecessary care). Some, admittedly, may require changes in federal or state law. That may be warranted, but it is also likely that some application of the core idea is applicable even absent the express sanction of the relevant sovereign.

196. *See* John R. Brooks, Brian D. Galle & Brendan S. Maher, *Cross-Subsidies: Government's Hidden Pocketbook*, 106 GEO. L.J. 1229, 1235–36 (2018).

197. *See id.* at 1235.

198. *See supra* note 108 and accompanying text.

cost paid by private players cross-subsidizes public payers.<sup>199</sup> This raises two concerns for policymakers.

First, a shrinking or elimination of the private market could result in providers demanding higher prices from the government, which means the cost savings promised by public payer advocates will be less than promised. Second, to the extent the government uses its buying (or regulatory) power to resist those price demands, the result may be allocatively inefficient in the form of too few doctors and too few medical innovations, i.e., a worse health care system for everyone.

There are a number of counters to this argument, including wondering whether it is efficient or fair to ask a portion of the citizenry, i.e., those who have private insurance, to pay for better care for everyone. As a practical matter, however, to the extent that consumers preferring private payers are *willing*—by refusing the choice of a public option—to continue to fund the cross-subsidy that is likely present in the current system, one wonders whether eliminating that choice makes sense. To the contrary, depending on how strongly one believes the private payer cross-subsidy to exist, that would be a reason to *incent* people to choose private financing—whether through subsidies, rebates, or tax credits.<sup>200</sup>

## 2. Non-Health Value Preferences

Worth considering briefly are additional reasons why the existence of a private market may—even apart from the immediate

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199. There has been considerable academic disagreement over whether reforms that result in Medicare paying less will simply result in providers charging private payers more (thus wiping out any cost-savings on a system level). Some studies conclude yes, while others conclude no. Compare David M. Cutler, *Cost Shifting or Cost Cutting?: The Incidence of Reductions in Medicare Payments*, 12 TAX POL'Y & ECON. 1, 18 (1998), with Austin Frakt, *Hospitals Don't Shift Costs from Medicare or Medicaid to Private Insurers*, JAMA NETWORK (Jan. 4, 2017), <https://jamanetwork.com/channels/health-forum/fullarticle/2760166> [<https://perma.cc/6FW2-FMF8>] (surveying the more recent literature to conclude no cost shift). But a cross-subsidy can exist regardless of whether or not *direct* cost-shifting occurs. In a segmented market, where one type of payer pays more, top providers (and innovators, as well as builders of physical plant medical infrastructure) will have decent reason to believe their work will get those dollars. But those providers, innovations, and buildings will, in practice, also be available to the consumers who use the cheaper payer. They will be available less, and maybe after a longer wait, but the result is still that the higher payer creates a better overall product that the lower payer consumers have access to.

200. Cf. Brooks, Galle & Maher, *supra* note 196, at 1249 (describing how some cross-subsidies are worth incenting).

question of whether payers can improve health care delivery—be attractive to consumers and voters. Whatever the improvements (or non-improvements) that the existence of payers can effect with respect to health care *qua* health care, it is important to acknowledge that those costs or benefits might not outweigh various systemic concerns stakeholders may otherwise find important.

a. Information

The age of big data has made scholars, and increasingly consumers, concerned about how personal information might be gathered, stored, transferred, and used. Medical information is a subset of information about which observers are acutely concerned, for obvious reasons.<sup>201</sup> While anyone can potentially misuse private information, some tremble at the idea that the government would have their health information in a Medicare for All system, and would thus likely be inclined to not choose a public option if available.

b. Small Government

A related version of the concern about the government misusing information would be a general aversion to an increased government role in everyday life. Such may lead, in the minds of some, to a passive, dependent populace, lacking the virtues of a citizenry that must be more self-reliant.<sup>202</sup> Sometimes philosophical objections vanish when the bill for fidelity thereto—namely, higher premiums for a private plan—is presented, but sometimes they do not. And to the extent that there are people willing to pay more to not rely on the government and preserve an alternative, one would imagine people with such strong preferences will be particularly committed to mobilizing in the public sphere.

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201. See, e.g., Bradley A. Areheart & Jessica L. Roberts, *GINA, Big Data, and the Future of Employee Privacy*, 128 *YALE L.J.* 710, 759–61 (2019) (describing risks of misuse of genetic and health information of employees); see also Wendy K. Mariner, *Reconsidering Constitutional Protection for Health Information Privacy*, 18 *U. PA. J. CONST. L.* 975, 978 (2016) (exploring privacy protection from a constitutional perspective).

202. See, e.g., *Mitt Romney Suspends Campaign*, *N.Y. TIMES* (Feb. 7, 2008), <http://www.nytimes.com/2008/02/07/us/politics/08romney-transcript.html> [<https://perma.cc/E9JZ-A7TH>] (“Dependency is death to initiative, risk-taking and opportunity. Dependency is culture killing. It’s a drug. We’ve got to fight it like the poison it is.”).

## c. Choice

Choice can be instrumentally valuable to the extent that the absence of options frustrates preferences, or because the exercise of choice makes more likely that one's preferences will be satisfied. For others, the existence of choice is a virtue in itself. Choice acknowledges and promotes through its exercise fundamental truths about individuals' dignity, autonomy, worth, and rights, leading to a salutary and robust free society.<sup>203</sup> Adherents to this view would thus prefer, even if they ended up choosing the public option, a world in which that choice was theirs to make.

## V. SKEPTICISM

I have argued there is little reason to expect payers to add value on risk but better reason to believe they could do so on cost and quality. In this concluding Part, I consider objections and propose an incremental path forward. I again imagine a world where a public option exists.

A skeptic might offer three general objections to the analysis offered in Part IV above. First, private actors are inclined to seek rents, and therefore what private payers are likely to do—rather than innovate in a salutary fashion—is innovate new ways to engage in welfare-reducing rent-seeking and profiteering.<sup>204</sup> Second, private payers have not already engaged in the welfare-enhancing behaviors I have proposed, including in a setting in which something resembling a public option already exists: Medicare Advantage. There is therefore little reason to believe they will do so in the future. Third, the private payer best case may be a tiered system of care, which undermines social justice.

## A. Avoiding Rent-Seeking

Payers make money by collecting more money in premiums—plus investment returns on those premiums—than they pay out in claims. And because there are several ways to make money that are not welfare-enhancing—cherry-picking healthy insureds, stinting on

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203. See, e.g., DAVID BOAZ, *LIBERTARIANISM: A PRIMER* 16–17 (1997) (praising choice as furthering numerous fundamental values).

204. See Michael Hiltzik, *Health Insurance Companies Are Useless. Get Rid of Them*, L.A. TIMES (Aug. 5, 2019, 11:25 AM), <https://www.latimes.com/business/story/2019-08-05/health-insurance-useless>.

care, engaging in strategic coverage denials, and so on—keeping private payers as a part of the system will mean more of that.

To be clear, there *is* significant merit to this criticism. Regulators *will* need to heavily regulate private payers. One cannot set up a system, for example, where payers can easily prosper by skimming off healthy insureds and collecting community-rated premiums. But the good news is that existing regulatory structures, e.g., in the ACA and ERISA, do a reasonable enough job in preventing rent-extracting such that additional tweaks to combat rent-seeking would be incremental rather than monumental.<sup>205</sup>

Moreover, the existence of a public option as competition would limit some types of classic rent-extraction techniques, e.g., strategic denials. Consider what a private payer would face: A public option that costs less run by a payer (the government) whose bottom line (unlike the private payer) is indifferent to care denials. The private payer would need to convince the would-be insured—or, more likely, the insured's employer—that the higher priced coverage option offered by the payer was worth it, whether through some proof that its denials were no more frequent or unjustified than the government's or some offsetting affirmative advantage of the plan. More generally, the public option's ability to serve as a competitive check on *bad* private payer behavior is a key aspect of its appeal.<sup>206</sup>

In sum, to the extent one hopes to leverage private payers as forces to generate welfare gains that would be lost if government was the sole health care payer, regulators must be mindful of ways in which insurers could continue to economically exist by merely extracting rents. But that risk seems addressable.

## B. Private Bureaucrats, Not Innovators

If the above criticism equates to the accusation that one should not underestimate how bad payers will be, a related criticism might be not to overestimate how good they will be.<sup>207</sup> Put differently, it is

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205. This is not to say there will not be opportunities for rent-extraction. It is only to say the risk of that is—at least in the short term—a tolerable one given the potential advantages of private payer participation.

206. I have not focused on that in this Article because—in contrast to how the private option might lead to *salutary* behavior—the bad behavior deterrence argument is easier to intuitively understand. Less developed are the hows and whys an option might lead to affirmatively better behavior.

207. It is true that private payers take significant cues from how Medicare behaves. But that is in today's environment, when Medicare is not truly a competitor.

possible that the salutary behaviors I identify will not in fact materialize, leaving us simply with a private sector that charges more to deliver no additional value.<sup>208</sup>

In furtherance of this point, a specific example might be raised: Medicare Advantage. Medicare Advantage, so the argument goes, currently resembles what I envision throughout. Those eligible for Medicare can choose either traditional Medicare or Medicare Advantage; with respect to the latter option, private insurers (1) provide Medicare benefits (2) plus, if they choose, additional benefits. And to the degree that the Medicare Advantage program has suffered critiques, so too do my arguments. Like the criticism above, this is most certainly an important point—but its consequences in my mind favor the use of private payers.

Medicare Advantage was enacted by Congress in 1997 under a different name to “enable the Medicare program to utilize innovations that have helped the private market contain costs and expand health care delivery options.”<sup>209</sup> Since then, the popularity of Medicare Advantage plans has steadily grown.<sup>210</sup> Part of the appeal of Medicare Advantage plans is additional coverage, such as vision and dental, and starting in 2019, coverage of benefits—such as social support and healthy food—that more broadly promote health.<sup>211</sup> That last change reflects the insight of scholars who have long urged that “social determinants of health” are extremely important to positive health

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208. Cf. Katharine Cooper Wulff, Franklin G. Miller & Steven D. Pearson, *Can Coverage Be Rescinded when Negative Trial Results Threaten a Popular Procedure? The Ongoing Saga of Vertebroplasty*, 30 HEALTH AFFS. 2269, 2273 (2011) (describing how private insurers prefer to wait for Medicare coverage decisions); see also CHRISTOPHER M. WHALEY ET AL., NATIONWIDE EVALUATION OF HEALTH CARE PRICES PAID BY PRIVATE HEALTH PLANS, at viii (2020) (finding that private payers pay hospitals significantly more than does Medicare for the same services).

209. H.R. REP. NO. 105-217, at 585 (1997), as reprinted in 1997 U.S.C.C.A.N. 176, 205–06.

210. See Gretchen Jacobson, Anthony Damico & Tricia Neuman, *Medicare Advantage 2019 Spotlight: First Look*, KAISER FAM. FOUND. (Oct. 16, 2018), <https://www.kff.org/medicare/issue-brief/medicare-advantage-2019-spotlight-first-look/> [<https://perma.cc/PG8H-575D>] (finding that one third of Medicare beneficiaries are now enrolled in Medicare Advantage plans).

211. See 42 C.F.R. § 422.100 (2005) (authorizing supplemental benefits beyond what Medicare covers); see also Ann Connelly et al., *A New Look at Medicare Advantage: What Lawyers Need to Know to Advise or Contract with Medicare Advantage Plans Now*, 12 J. HEALTH & LIFE SCI. L. 1, 11–13 (2018) (describing a new scope of permitted coverage).

outcomes. While traditional Medicare does not cover such interventions, numerous Medicare Advantage plans will.<sup>212</sup>

Medicare Advantage plans that offer additional benefits pay for those benefits in two ways. First, Medicare Advantage plans, which receive a flat fee from the government for each enrollee, are allowed to directly charge enrollees an additional premium for additional services.<sup>213</sup> Second, Medicare Advantage plans use provider networks to reduce costs, and thus can, in theory, provide additional benefits even without a one-for-one premium raise.<sup>214</sup> That trade—more benefits in return for slightly higher premiums and the inconvenience of a network—will be worth it to some and not others. From a cost perspective, the government is indifferent because it pays no more than the flat fee. That leaves private payers to experiment with packages that (1) strike the right balance between cost and benefit for (2) sub-audiences with different preferences. Some do not choose that option, and others still disenroll and return to traditional Medicare, typically as a result of unhappiness associated with network restrictions.<sup>215</sup>

But the Medicare Advantage experience illustrates two points that cut in favor of private payer participation. First, it confirms the

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212. See Connelly et al., *supra* note 211, at 12.

213. See Mary West, *How Is Medicare Advantage Funded?*, MEDICALNEWS TODAY (May 21, 2020), <https://www.medicalnewstoday.com/articles/how-is-medicare-advantage-funded> [https://perma.cc/QP6S-K76T] (“Medicare pays [Advantage Plans] a fixed monthly amount for each beneficiary’s expected healthcare costs.”); see also *Costs for Medicare Advantage Plans*, MEDICARE, <https://www.medicare.gov/your-medicare-costs/costs-for-medicare-advantage-plans> [https://perma.cc/Z7UT-82U8] (last visited Nov. 16, 2020) (explaining, generally, costs and premiums in Medicare Advantage plans). The flat fee Medicare Advantage plans receive is subject to a risk-adjustment given the health of the enrollee pool. See MEDPAC, REPORT TO THE CONGRESS: MEDICARE AND HEALTH CARE DELIVERY SYSTEM 99 (“Each capitated payment is the product of two general parts: a base rate, which reflects the payment if an MA enrollee has the health status of the national average beneficiary, and a risk score, which indicates how costly the enrollee is expected to be relative to the national average beneficiary.”) That Medicare Advantage plans might attempt to game the risk-adjustment system is one form of rent-seeking regulators need be mindful of. See, e.g., Erika Kelton, *The Risk Adjustment Scoring Scam—A Medicare (Dis) Advantage*, FORBES (June 17, 2015, 12:46 PM), <https://www.forbes.com/sites/erikakelton/2015/06/17/the-risk-adjustment-scoring-scam-a-medicare-dis-advantage/?sh=32bc4bc93d45> [https://perma.cc/V5B5-QFD4] (reporting on examples of risk-adjustment gaming).

214. See CTRS. FOR MEDICARE & MEDICAID SERVS., UNDERSTANDING MEDICARE ADVANTAGE PLANS 5–7 (2019).

215. See MEDICARE RTS. CTR., WHY CONSUMERS DISENROLL FROM MEDICARE PRIVATE HEALTH PLANS 2 (2010).

virtues of experimentation from an individual choice perspective; namely, that there is good reason to believe that payers will develop benefit–cost tradeoffs that will appeal to some set of beneficiaries, thus presumably leading to welfare-enhancement compared to the lack of that option. Second, it confirms the existence of a demand for private alternatives.

One might counter that the Medicare Advantage shows the *limits* of private payer participation; namely, the ho-hum offer of some additional benefits and traditional networks. This argument would insist that none of the major innovations suggested in the preceding pages of this Article have appeared: no intelligible quality metrics; no personalized medicine innovations; no cost-effectiveness constraints. To that final (important) point, several rejoinders can be made.

First, it is not clear that the pressure on private payers has yet been significant enough to exhaust the innovation of which they may be capable. Medicare Advantage is but a small part of what many payers do, and generally early attempts to develop new lines of business will leverage existing knowledge about how to attract customers and make money.<sup>216</sup> Additional services plus networks is a fairly simple application of what payers already know. A public option would immediately put under threat retention of a much larger percentage of an insurer's business, i.e., all employment-based group insurance and exchange-based insurance that it sells. As a threat (and incentive) to the market, Medicare Advantage is marginal, whereas a public option for primary coverage strikes at the core of a payer's business.

Second, the harm of waiting before taking some form of regulatory action against private payers seems small: Either private payers will innovate in significant ways in the aftermath of a public option, or they will not. If they do, their continued participation is easily justified. If they do not, the question becomes whether the alternative reasons for their involvement—the health care cross-subsidy, non-health value preferences, as a check against government poor performance—are worth the extra financial and regulatory cost they impose upon the system. One need not assess those costs and benefits now, in the abstract, as opposed to when experience provides information and data currently hypothetical.

Third, to the extent that one believes private payer participation is particularly salutary, that might be reason to subsidize their

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216. See MARSHA GOLD ET AL., MEDICARE ADVANTAGE 2013 SPOTLIGHT: PLAN AVAILABILITY AND PREMIUMS 1 (2012).

existence even if organic forces do not prompt payers to take the initiative themselves. Example one: To the extent one believes private payers generate a cross-subsidy that leads to better care overall, a series of inducements to either private payers or insureds might be justified. Example two: To the extent that certain innovations are worthwhile but unlikely to be pursued by private payers without a push, the government could take action to promote private development of those innovations.<sup>217</sup>

### C. Tiered Care

A final objection might target a world in which the arguments advanced here are largely *right*; namely, the potential inequity of a system in which private payers do in fact develop ways to deliver a better care product than the government. Although sometimes a better health care product costs less because wasteful aspects are eliminated, generally speaking, better products cost more. That could lead to a world where most have the public plan while a wealthier minority gets better care. Such a result, the argument goes, would perpetuate the very type of inequality that national health insurance is supposed to end.<sup>218</sup>

While I do not dispute that severe inequality writ large is a problem in the United States—and for that matter an unsustainable one—I would make two arguments in response. First, the current health care system itself is worse than whatever could happen in the world this Article conceives. Today millions of people do not have health care coverage. If the political cost of a public option is that private payers continue to play a meaningful role in American health care, virtually any suboptimality occasioned by the continued

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217. For example, to the extent that the creation of a sufficiently comprehensive database to permit the widespread implementation of a cost-effectiveness constraint is too costly or faces a free rider problem, the government could offer inducements to those who successfully adopt—and build a paying audience for—such approaches. Alternatively, the government could require that any private payer wishing to offer a policy need develop a metric that allows its consumers to evaluate the quality of any doctor that is in network or otherwise contracted with the insurer.

218. See, e.g., Gordon D. Schiff, Andrew B. Bindman & Troyen A. Brennan, *A Better-Quality Alternative: Single-Payer National Health System Reform*, 272 J. AM. MED. ASS'N 803, 804 (1994) (“[U]niversally available lowest-tier coverage, such as that proposed under managed competition, with more or better services only for those able to afford to upgrade their benefits, violates this principle and would perpetuate inequalities in health care.”).

involvement of private payers is worth the gain of truly universal coverage.

Second, given that something like Medicare will be the floor, tiered care does not seem particularly unpalatable. Capitalism has virtues and vices; the former leads to a larger pie and the latter to unequal slices. If the existence of private payers results in a segment of the market paying medical providers more—even if the “more” is likely an overpayment—to the extent a society is going to overpay anyone, best that we overpay the sector capable of restoring capabilities and extending life. Whatever else is reducible to fungible bits in the information age, those two things are not.

#### CONCLUSION

Whatever its tolerance for market interventions, the American polity has long been and remains skeptical of the direct government provision of goods, as well as the elimination of choice. Those two preferences and the inclination to punish politicians who ignore them might constitute good political reason enough to not instantiate a “Medicare for All” approach. But policy might also counsel against “Medicare for All,” and instead in favor of some form of a public option—a piece of policy that last great spasm of American health reform, the still-controversial Affordable Care Act, rejected.

There is reason to believe that private payers can serve welfare-enhancing functions with respect to cost and quality, and those possibilities seem more likely to obtain where the public option provides competitive pressure. At a minimum, payers should be given time to prove themselves on that score, and their value proposition is not so fragile as to suggest that no consumers will be interested in the “private option.” To the extent that private payers fall comparatively short, there could still be good reason to preserve a system with both public and private payers, and to perhaps even offer carrots to the latter. Even absent a persuasive argument in favor of private payers contributing to improved health care delivery, non-health value preferences might justify the continued role of private payers, particularly if a significant percentage of Americans are willing to pay for those values. Given those various possibilities—the contours of which are only likely to become clear after some period of experimentation, trial, and error—the prudent course appears to be the incremental one: public and private options both.