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Most of the legal commentary regarding mobile health has focused on direct regulation leveraging existing laws and regulators such as HIPAA privacy through the Office for Civil Rights at the U.S. Department of Health & Human Services (OCR) or device regulation by the Food and Drug Administration (FDA). However, much of the mobile health revolution likely will play out in lightly regulated spaces bereft of most of the privacy, security, and safety rules associated with traditional health care. This article examines the potential for common law liability models to bridge these gaps (even on a temporary basis). The article provides an introduction to the terminology used, and presents a brief typology of the apps appearing in the health care space. It discusses the potential liability of physicians and other health care professionals and the potential liability of institutional health care providers. The article further examines the applicability of product liability to mobile health developers and vendors and explains some of the issues that may arise when patients or consumers seek damages following privacy or security breaches. The survey concludes by noting that regulation by litigation may be a significant force in the app and wearable space during a period of light regulation by traditional regulators. This is a conclusion that is unlikely to cheer either health care providers or app developers given that the indeterminacy associated with common law litigation is only exacerbated when applied to novel or emerging technologies.

The current unprecedented surge of consolidation in the health care market continued when two large health insurance company mergers were announced in 2015. If approved, these transactions would consolidate the health insurance market into three main players ¯ threatening competition and disrupting the traditional health insurance market. Part I examines the merger frenzy occurring within the health care industry, including its drivers and effects. Part II outlines the impact on consumers and the market. Part III discusses antitrust laws and their role in evaluating, and potentially limiting, proposed health insurance mergers. Part IV proposes that the arms race between providers and insurers to gain negotiation power will subside because through consolidation, health systems will acquire the infrastructure, network, and risk-managing expertise necessary to implement a provider-owned insurance company. By articulating the advantages and disadvantages, this Article explains the effect of a provider health system entering the health insurance business. After the enactment of the Affordable Care Act, providers are taking on more financial risk for their patients under the value-based reimbursement model. Through provider-sponsored health plans, providers control premium dollars through a patient˘s continuum of care, sparking financial and quality advantages for the health system. This Article˘s proposed provider-sponsored health insurance company can reshape the industry to better align stakeholder incentives and enable the delivery of high-quality, low-cost care within a value-based reimbursement model.