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Reference Pricing in Health Care: An Inventory of Techniques, and Practical and Policy Implications

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INTRODUCTION

Reference-based pricing (RBP) is a new and intriguing concept in health care cost containment.[1] For purposes of this article, RBP is defined as any announced policy by a payor (or benefit administrator) to place a firm limit on payment for a service or product based upon some reference point.[2] Over the past decade, this strategy has evolved from a fairly simple beginning to iterations involving more complex legal and market leverage considerations.[3] This article describes the various versions of reference pricing and discusses the different legal and practical considerations that apply. The recent announcement by CVS Caremark Pharmacy Benefit Management Services (PBM) that it will marshal the employers it represents to place a limit on prices of new drugs raises the possibility of payors acting collectively to impose a reference pricing regime.[4] Needless to say, such an escalation implicates new questions while offering great promise.

For decades, the dominant model of paying health care providers has been network contracting, through which payors offer patient referrals in exchange for an ostensibly discounted price.[5] In many regional markets providers have an edge in contract negotiations.[6] In rural areas, a single hospital may have

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[1] Kenneth B. Berry & Ryan Day, *The Evolution of Reference Based Pricing*, 56 BENEFITS MAG. 20, 22 (2019).

[2] Jason Shafrin, *What is Reference Pricing?*, HEALTHCARE ECONOMIST (July 28, 2014), https://www.healthcare-economist.com/2014/07/28/what-is-reference-pricing/. Reference-based pricing should be distinguished from reference-based contracting. The latter could be the outcome of the former, i.e., the provider accedes to the reference price proffered by the payor and signs a contract on those terms; or could result when a reference price is proposed by a payor without taking the form of an ultimatum. As will be apparent *infra*, reference-based contracting does not implicate the legal and practical issues raised by pure reference-based pricing and is not discussed in this article.

[3] *See* Berry & Day, *supra* note 1, at 23-24 (discussing the four generations of RBP beginning in 2009).

[4] CVS Health Introduces New Approach to Pricing of Pharmacy Benefit Management Services, CVS HEALTH (Dec. 5, 2018), https://cvshealth.com/newsroom/press-releases/cvs-health-introduces-new-approach-pricing-pharmacy-benefit-management.

[5] A J. CULYER, & J.P. NEWHOUSE, HANDBOOK OF HEALTH ECONOMICS (2000).

[6] NAT'L ACAD. OF SOC. INS., ADDRESSING PRICING POWER IN HEALTH CARE MARKETS: PRINCIPLES AND POLICY OPTIONS TO STRENGTHEN AND SHAPE MARKETS 12 (2015).

a natural monopoly.[7] In other areas, provider consolidation increasingly confers monopoly or near-monopoly power on the provider.[8] Some providers intentionally stay out of networks, perceiving greater negotiating power when they can hold a balance bill over consumers' heads.[9] Finally, insurers and employers that want to offer enrollees a broad network, or perceive a need to include "must-have" providers, essentially handicap themselves in network negotiations.[10]

RPB is seen as a way of overcoming such disadvantages in payor/provider negotiations.[11] In an era of political gridlock, where legislative action is hard to achieve even under the best circumstances, RBP can be a purely private-sector activity initiated without legislation.[12] RPB holds the promise of "bending the cost curve" without the need to enact the global budgets or all-payor rate setting that have been necessary to contain health care costs in other countries, or to pursue complex antitrust litigation.[13] Perhaps most importantly, it addresses the factor that most health care experts believe is responsible for America's high health care costs relative to similarly situated nations—excessive provider prices.[14]

In a news account describing the state of Montana's use of referenced pricing for hospital services, a prominent benefits consultant was quoted as saying, "why wouldn't every single employer do that?"[15] This article explores exactly that question and concludes that further experimentation is warranted. The analysis will focus on three dimensions on which the legal and practical difficulties of imposing reference pricing increase as a payor moves from a position of safety and security toward more daring challenges to providers. These are summarized in the table below.

Scope: RBP can be applied to specific procedures or products, or across the board to a given provider type, e.g., hospital services.

Origin of reference: Prices can be set with reference to market conditions,

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[7] *Id.* at 11.

[8] *Id.*

[9] *Id.* at 10.

[10] SABRINA CORLETTE ET AL., ASSESSING RESPONSES TO INCREASED PROVIDER CONSOLIDATION IN THREE MARKETS: DETROIT, SYRACUSE, AND NORTHERN VIRGINIA 3 (2018).

[11] *Id.*

[12] *See generally* Berry & Day *supra,* note 1, at 25 (stating increasing relevance of RBP simultaneously increased hospitals willingness to negotiate prices or risk losing market share).

[13] Mike Miesen, *Bending the Cost Curve with Reference Pricing*, HEATH CARE BLOG (June 27, 2013), https://thehealthcareblog.com/blog/2013/06/27/bending-the-cost-curve-with-reference-pricing/.

[14] Gerard F. Anderson et al., *It's The Prices, Stupid: Why the United States is so Different From Other Countries*, 22 HEALTH AFFS. 89, 102 (2003).

[15] Julie Appleby, *'Holy Cow' Moment Changes How Montana's State Health Plan Does Business*, KAISER HEALTH NEWS (June 20, 2018), https://khn.org/news/holy-cow-moment-changes-how-montanas-state-health-plan-does-business/.

at a level that a known number of providers will accept in full, or with regard to a normative judgment as to what constitutes an appropriate price.

Payor strength: RBP can be imposed by a small individual payor, a large payor, or collectively by a payor alliance.

Dimension	Less Complexity	More Complexity
Scope	Shoppable or commodity services	All services for provider type
Origin of Reference	Market-referenced	Normative-referenced
Payor Strength	Large payor	Small Payor Multiple Payors

I. EXPERIENCE WITH REFERENCE PRICING TO DATE

A. Single-commodity, market-referenced pricing, individual payor: The CalPERS Initiative

The California Public Employees' Retirement System (CalPERS), in association with Anthem Blue Cross in California, introduced the first RBP program in 2011.[16] CalPERS purchases coverage for 1.3 million employees of the state of California and its governmental subdivisions.[17] The program initially focused on single hip and knee joint replacement surgery— an elective, non-emergency procedure that can be scheduled in advance.[18] CalPERS set a payment threshold of $30,000, an amount set with reference to existing market prices and sufficient to cover the procedure at forty-one hospitals across the state.[19] Hospitals that were able to provide these services for a cost at or below the threshold were identified and communicated to the group's enrollees.[20]

Enrollees are liable for the difference between the hospital contracted charges and the $30,000 threshold should they choose a facility with a price above it (prices for joint replacement surgery negotiated by CalPERS ranged from $12,000 to $75,000), which is to say, they can be balance billed.[21] The

[16] Berry & Day, *supra* note 1, at 22; *see also* Austin Frakt, *How Common Procedures Became 20 Percent Cheaper for Many Californians,* N.Y. TIMES (Aug. 9, 2016), https://www.nytimes.com/2016/08/09/upshot/how-common-procedures-got-20-percent-cheaper-for-many-californians.html (discussing how California has reduced pricing for common procedures for those insured by the public employees retirement system).

[17] Amanda E. Lechner et al., *The Potential of Reference Pricing to Generate Health Care Savings: Lessons from a California Pioneer*, HEALTH SYS. CHANGE RES. BRIEF NO. 30 (2013), http://hschange.org/CONTENT/1397.

[18] Barry & Day, *supra* note 1, at 22.

[19] James C. Robinson & Timothy T. Brown, *Increases In Consumer Cost Sharing Redirect Patient Volumes And Reduce Hospital Prices For Orthopedic Surgery*, 32 HEALTH AFFS. 1392, 1393 (2013).

[20] *Id.*

[21] *Id.*

CalPERS program operates within a preferred provider network, not in lieu of it as would a narrow network design.[22] CalPERS exempts enrollees who live more than fifty miles from a facility offering the service below the price limit, or if the patient's physician cites a clinical justification for using a higher-priced facility.[23]

Hip or knee replacements were thought to be good candidates for RBP programs since they vary in cost within markets without any measurable difference in quality, their status as "commodities," which is to say, interchangeability with procedures of the same type, and crucially, the fact that they are scheduled in advance.[24] CalPERS later added arthroscopic surgery, cataract surgery, and colonoscopies.[25] Other payors have applied a similar methodology to other health care commodities: prescription drugs (RETA Trust, limiting payment to the price of the cheapest medication in seventy-eight therapeutic drug classes)[26] and imaging (Safeway, limiting reimbursement to approximately the 60th percentile of the distribution of prices in 2010).[27]

Evaluations of these programs have found that:

> When faced with paying the excessive rates charged by high-priced providers, most consumers shift towards lower-priced providers. For CalPERS, this has occurred for both inpatient and ambulatory surgery. Other employers have obtained analogous changes in consumer choices for laboratory tests, imaging procedures, and drugs.
>
> These changes in consumer choices result in reductions in prices and payments. Some high-priced providers reduce their prices so as to mitigate the threatened loss of volume. Payments by employers and insurers decline as consumers shift to providers that charge lower prices.
>
> The application of reference pricing to inpatient orthopedic surgery led to significant price reductions from some of the hospitals whose initial prices were above the CalPERS payment limit. The number of California hospitals charging prices below the CalPERS reference limit ($30,000) rose from forty-six in 2011 to seventy-two in 2015.[28]

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[22] *Id.* at 1394.

[23] James Robinson & Kimberly MacPherson, *Payers Test Reference Pricing And Centers Of Excellence To Steer Patients To Low-Price And High-Quality Providers*, 31 HEALTH AFF. 2028, 2033 (Sept. 2012).

[24] Barry & Day, *supra* note 1, at 22.

[25] *Reference Pricing: Diagnostic Tests and Procedures*, BERKELEY CTR FOR HEALTH TECH., https://bcht.berkeley.edu/reference-pricing-diagnostic-tests-and-procedures (last visited Nov. 11, 2019).

[26] *Id.*

[27] *Id.*

[28] Ann Boynton & James C. Robinson, *Appropriate Use of Reference Pricing Can Increase Value*, HEALTH AFFS.: HEALTH AFFS. BLOG, (July 7, 2015),

Practical considerations: RBP for shoppable commodities represents the easiest of the techniques discussed in this article. The price is "safe" for enrollees because there are providers available with prices below the reference amount.[29] Limiting application to shoppable services guarantees an opportunity for the consumer to obtain services without a balance bill, although consumers might be unpleasantly surprised by a balance bill if they do not understand the special coverage rule.[30] Providers would not want to be excluded from CalPERS business given its large enrollment. The arrangements raise minimal legal concerns because, as self-funded ERISA plans, the state's network adequacy requirements (time, distance) governing insurance products do not apply.[31]

B. All-Provider Type, Market-Referenced Pricing, Individual Payor: Montana's Employee Health Plan

Montana's Health Care and Benefits Division (HCBD) implemented RBP for all hospital services in July 2016.[32] HCBD's goal was to bring all hospitals to a narrow range based on the pricing of the lower cost hospitals.[33] The result was an average of 234 percent of Medicare rates for blended inpatient and outpatient services.[34] While HCBD's RBP is stated as a multiple of Medicare's prices, in fact its true reference, like CalPERS', is previously negotiated commercial network rates. However, by linking future rate increases to Medicare, the price trend is significantly decreased moving into the future.

As the largest self-funded plan in the state, with 31,000 covered lives, HCBD's bargaining leverage is comparable to CalPERS'.[35] Five of the hospitals due for a haircut resisted for a while, but all but one capitulated before the implementation date; the remaining holdout signed on shortly thereafter.[36]

Practical considerations: This scenario introduces the "game of chicken" dynamic. This game-theory concept takes its name and inspiration from the

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https://www.healthaffairs.org/do/10.1377/hblog20150707.049155/full/.

[29] Robinson & MacPherson, *supra* note 23, at 2029.

[30] *See generally* Lechner et al., *supra* note 17 (noting few respondents of a survey of CalPERS enrollees were surprised with the balance on their hospital bill).

[31] *See generally* Appleby, *supra* note 15 (using Montana as an illustration of the success of reference pricing when changing state contract with hospitals).

[32] *Id.*

[33] *See id.* (reporting that prior to the program all hospitals within the state charged state employees a varied amount for the same service).

[34] *See id.*; *see also* Marilyn Bartlett, Direct Administrator of Montana's Health Care and Benefits Division, Presentation to Colorado Business Group on Health (June 14, 2018) (Available at http://cbghealth.org/wp-content/uploads/2018/06/CBGH-June-2018-Monthly-Packet.pdf).

[35] Bartlett, *supra* note 34.

[36] Appleby, *supra* note 15.

mid-20th century hot-rodders' dare: two vehicles hurtle toward each other on a collision course, each driver publicly vowing not to be the first to swerve. The driver to swerve first loses face; in the event that neither driver swerves, both will lose their lives.

Here, the payor has publicly stated an intention not to "swerve" from the reference price. If providers do not swerve, the payoff is stalemate: plan enrollees will not have access to non-participating facilities, or will be met with balance bills. There are enough well-publicized instances of stalemates between providers and payors in far less fraught circumstances to give one pause at this possibility.[37] If the providers swerve, they communicate weakness that other payors may be able to exploit. If the payor swerves, the reference pricing program collapses. As such, the success of this RBP technique is entirely dependent on provider capitulation.

The inference we can draw from the Montana experience is that the HCBD, as a large payor representing a sympathetic constituency, had the greater leverage, both economically and in the court of public opinion. The providers with above-average prices were disadvantaged by a need to explain and justify their higher costs.[38] Further, not-for-profit hospitals are vulnerable to allegations that they do not provide a community benefit commensurate with the revenue that local taxing bodies forego, and officials can challenge their tax exemptions.[39] Hospitals that do not capitulate also face the likelihood of losing lucrative shoppable services to other providers.[40] Ultimately, Montana hospitals felt unable to lock out patients on whose behalf a seemingly reasonable offer was made.[41] However, a similar scenario in North Carolina led to a different result, discussed in Section I.E. *infra*.[42]

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[37] *See, e.g.*, Courtney Tompkins & Melissa Evans, *Long Beach Memorial is no Longer In-Network for Anthem Blue Cross, Stunning Patients*, LONG BEACH PRESS-TELEGRAM, (updated Sept. 1, 2017, 12:05 PM), https://www.presstelegram.com/2017/08/23/long-beach-memorial-is-no-longer-in-network-for-anthem-blue-cross-stunning-patients/ (reporting thousands of customers with Anthem Blue Cross insurance lost in-network health services after contract negotiations ended in a stalemate); *see e.g.*, Matthew Nojiri, *Tower Health, Independence Blue Cross contract stalemate leaves customers in limbo*, READING EAGLE (Oct. 3, 2017, 10:35 AM), http://www.readingeagle.com/news/article/tower-health-independence-blue-cross-contract-stalemate-leaves-customers-in-limbo (reporting Independence Blue Cross and Tower Health stalled negotiations leaving over 100,000 customers in limbo over health care).

[38] *See* Marshall Allen, *In Montana, a Tough Negotiator Proved Employers Don't Have to Pay So Much for Health Care*, PROPUBLICA (Oct. 2, 2018, 5 A.M.), https://www.propublica.org/article/in-montana-a-tough-negotiator-proved-employers-do-not-have-to-pay-so-much-for-health-care (discussing how consumers should be demanding the health care industry justify seemingly arbitrary rising costs).

[39] *Id.*

[40] *Id.*

[41] *Id.*

[42] Mark Tosczak, *No More Negotiations: State Health Plan Wants Clearer Process, Lower Prices*, N.C. HEALTH NEWS (Nov. 1, 2018), https://www.northcarolinahealthnews.org/2018/11/01/no-more-negotiations-state-health-plan-wants-clearer-process-lower-prices/.

C. Single-Commodity, Normative-Referenced Pricing, Individual Payor: Per-Service Price Caps for Targeted Services in The Oscar Winski Health Plan

Billing by some providers in particular has raised the ire of payers, including hospital-based physician practices and air ambulance services, which often decline to negotiate network contracts; and dialysis facilities..[43] All three of these provider types have been the subject of proposed legislation to cap prices,[44] but some payors have marshaled self-help through reference pricing for targeted services.[45]

By happenstance, the author obtained a document describing the health benefits offered by the Oscar Winski Company,[46] a scrap metal processer in Lafayette, Indiana with about 250 employees.[47] After a long list of fairly ordinary exclusions, page twenty-seven contains provisions that essentially use the Medicare Fee Schedule as reference prices for several services:

> 55. for charges due to renal dialysis, payment by this Plan will not exceed 100 percent of the Medicare allowance for such incurred expenses;
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> 56. for Hospital Inpatient charges exceeding $25,000, payment will be limited to the Medicare DRG Rate. If a Medicare DRG Reimbursement Rate is not available, then reimbursement will be limited to the Rate of the next closest Hospital;
>
> 57. for Outpatient Hospital charges exceeding $10,000, payment will be limited to the Medicare APC Reimbursement Rate. If a Medicare APC Reimbursement Rate is not available, then reimbursement will be limited to the Rate of the next closest Hospital;
>
> 58. for Out-of-Network Ambulatory Surgical Center charges exceeding $5,000, payment will be limited to the Medicare ASC reimbursement fee schedule;
>
> 59. for ambulance (ground and air) charges exceeding $5,000, payment by this Plan will not exceed 100 percent of the Medicare allowance for such incurred expenses. Charges include those which relate to 1) transportation

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[43] Elizabeth Davis, *Balance Billing in Health Insurance*, VERYWELL HEALTH (Aug. 28, 2019), https://www.verywellhealth.com/balance-billing-what-it-is-how-it-works-1738460.
[44] Susannah Luthi, *Senate Health Bill Includes Pay Cap for Surprise Bill Disputes*, MOD. HEALTHCARE (June 19, 2019, 11:16 A.M.), https://www.modernhealthcare.com/politics-policy/senate-health-bill-includes-pay-cap-surprise-bill-disputes.
[45] *Id.*; *see* Sammy Mack, *Fed Up With Traditional Health Insurance, South Florida Company Tries Something Radical*, WLRN (Jan. 3, 2018), https://www.wlrn.org/post/fed-traditional-health-insurance-south-florida-company-tries-something-radical (explaining how employer uses reference-based pricing to save money on the rising cost of health insurance).
[46] OSCAR WINSKI CO., OSCAR WINSKI CO. HEALTH PLAN, SUMMARY PLAN 27 (2015) (on file with author) [hereinafter OSCAR WINSKI CO. HEALTH PLAN].
[47] OSCAR WINSKI COMPANY, http://www.oscarwinski.com/company (last visited Nov. 14, 2019).

> and 2) medical supplies used during transport, including those for BLS (basic life support) only services and ALS (advanced life support) services/supplies;
>
> 60. For charges billed on a Form CMS-1500 exceeding $10,000, payment will be limited to the Medicare fee schedule;
>
> 61. For infusion therapy charges exceeding $1,500 (including, but not limited to, chemotherapy), payment by this Plan will not exceed 100 percent of the Medicare allowance for such incurred expenses. (Infusion therapy encompasses intravenous and/or intramuscular injections, as well as drugs administered through other non-oral routes, such as epidural routes).[48]

These provisions will have different impacts. At one extreme, dialysis clinics do not typically balance bill; at the other, air ambulance companies are notorious for aggressive balance billing and a payor may deem any effort to avoid it futile.[49] It would seem that in the other instances, this employer may expect the worker to individually search for providers who will accept the Medicare amounts or negotiate some type of discount based on the cap amount.[50] One wonders whether the plan administrator assists the workers in this task. (Note that Lafayette appears to have two competing hospitals).

1. Legal considerations: The MOOP limit

Guidance issued jointly by the U.S. Departments of Labor, Health and Human Services (HHS), and the Treasury in 2014[51] addressed the question of whether reference pricing under the CalPERS model squared with the Affordable Care Act's Maximum Out-of-Pocket Limit (MOOP).[52] Network adequacy requirements governing fully-insured products do not apply to self-insured plans, but the Departments read the MOOP limit as implying a quasi-network adequacy requirement, articulated as ensuring that a plan "is using

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[48] OSCAR WINSKI CO. HEALTH PLAN, *supra* note 46, at 27.

[49] *See generally* Jenny Gold, *They May Owe Nothing – Half-Million-Dollar Dialysis Bill Cancelled*, KAISER HEALTH NEWS (July 26, 2019), https://khn.org/news/bill-of-the-month-half-million-dollar-kidney-dialysis-bill-fresenius-now-zero/ (providing an example of a dialysis clinic cancelling a patient's bill); Harris Meyer, *Air Ambulance Charges Study Could Boost Senate Surprise Bill Legislation*, MOD. HEALTHCARE (July 1, 2019), https://www.modernhealthcare.com/payment/air-ambulance-charges-study-could-boost-senate-surprise-bill-legislation (noting that in 2016, the national median charges for air ambulance services were 4.1 to 9.5 times what Medicare paid for the same services).

[50] *See generally* Grace M. Carter, *Use of Diagnosis-Related Groups by Non-Medicare Payers*, 16 HEALTH CARE FIN. REV. 127, 29 (explaining that the most consistent variation among types of payers concerns how the payment rates are set Medicaid programs which tend to announce prices according to a fixed rule and that commercial insurers and self-insured employers tend to negotiate payment rates).

[51] DEP'T OF LABOR ET AL., FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART XXI) 1-4 (2014).

[52] *Id.* at 2.

a reasonable method to ensure adequate access to quality providers at the reference price."[53] Elements of this requirement are:

1. "Plans should have standards to ensure that the network is designed to enable the plan to offer benefits for services from high-quality providers at reduced costs and does not function as a subterfuge for otherwise prohibited limitations on coverage." The Departments opined that "reference-based pricing that treats providers that accept the reference amount as the only in-network providers should apply only to those services for which the period between identification of the need for care and provision of the care is long enough for consumers to make an informed choice of provider," that is, to shoppable services. "Limiting or excluding cost-sharing from counting toward the MOOP with respect to providers who do not accept the reference-based price would not be considered reasonable with respect to emergency services."[54]

2. "Plans should have procedures to ensure that an adequate number of providers that accept the reference price are available to participants and beneficiaries. For this purpose, plans are encouraged to consider network adequacy approaches developed by States, as well as reasonable geographic distance measures, and whether patient wait times are reasonable."[55]

3. "Plans should have procedures to ensure that an adequate number of providers accepting the reference price meet reasonable quality standards."[56]

4. "Plans should have an easily accessible exceptions process," allowing departures when a provider that accepts the reference price is unavailable within a reasonable wait time or travel distance or "the quality of services with respect to a particular individual could be compromised with the reference price provider."[57]

5. Automatic disclosures to enrollees of the pricing structure, "including a list of services to which the pricing structure applies and the exceptions process" in the Summary Plan Description; as well as information upon request about providers accepting the reference price for each service and about the "process and underlying data used to ensure that an adequate number of providers accepting the reference price meet reasonable quality standards."[58]

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[53] *Id.* at 3.
[54] *Id.*
[55] *Id.*
[56] *Id.* at 4.
[57] *Id.*
[58] *Id.*

Essentially, the ruling means that when these conditions are met, providers that are otherwise in-network can be considered out-of-network for reference-priced services and the in-network MOOP does not apply.[59] In a subsequent "Frequently Asked Questions" release,[60] the agencies clarified that if these requirements cannot be met, a "plan that merely establishes a reference price without using a reasonable method to ensure adequate access to quality providers at the reference price will not be considered to have established a network,"[61], and the plan is "required to count an individual's out-of-pocket expenses for providers who do not accept the reference price toward the individual's MOOP limit."[62] This essentially forces the plan to cover costs beyond the limit.[63]

Let us imagine an unplanned hospitalization occurring that implicates paragraph fifty-six of the Winski Summary Plan Description (SPD), involving hospital inpatient charges exceeding $25,000.[64] Per paragraph fifty-six, payment is to be limited to the Medicare DRG Rate, but this language is only a starting point.[65] Suppose the hospital's charges are $50,000 and the Medicare fee for the DRG is $10,000. The plan offers to settle the bill in full for the scheduled amount: $10,000. Under the ACA, the enrollee is entitled to an annual maximum out-of-pocket cost of around $7,000.[66] Under the common law doctrine of *quantum meruit*, the hospital is entitled to its usual, customary and reasonable fee,[67] which depends on local market conditions. Let us say that the hospital's prevailing negotiated rate for this DRG is $30,000.

The plan cannot leave the enrollee with a balance bill of more than $7,000,[68] nor, likely, would it want to. The plan will pay something between $17,000 and $30,000 (the UCR should cap the patient's responsibility) with the precise amount depending on whether the hospital wants to be paid right away or is willing to pursue litigation. If the hospital is not-for-profit and has

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[59] *Id.* at 1-4 (explaining that when the conditions outlined within the FAQs are met, in-network providers can be considered out of network and the in-network MOOP does not apply).

[60] DEP'T OF LABOR ET AL., FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART 31, MENTAL HEALTH PARITY IMPLEMENTATION, AND WOMEN'S HEALTH AND CANCER RIGHTS ACT IMPLEMENTATION (2016) [hereinafter HHS ACA FAQS PART 31].

[61] *Id.* at 9.

[62] *Id.*

[63] *Id.* at 9-10.

[64] OSCAR WINSKI CO. HEALTH PLAN , *supra* note 46, at 27.

[65] *Id.*

[66] HHS ACA FAQS PART 31, *supra* note 60, at 8.

[67] Temple Univ. Hosp. Inc. v. Healthcare Mgmt. Alts., Inc., 832 A.2d 501, 508 (Pa. Super. Ct. 2003).

[68] Timothy Jost, *Implementing Health Reform: Reference Pricing and Network Adequacy*, HEALTH AFF. (Oct. 12, 2014), https://www.healthaffairs.org/do/10.1377/hblog20141012.041924/full/.

a tax exemption to preserve, and if it does not want to reveal inside billing information through court discovery, it may accept an amount at the lower end of the range.

2. Legal considerations: Special rules for dialysis.

Medicare secondary payor (MSP) requirements under section 1862(b) of the Social Security Act and its implementing regulations restrict health plans from carving out dialysis for special treatment.[69] These requirements arise from the status of end-stage renal disease (ESRD) patients as eligible for Medicare coverage regardless of age; and its interaction with Congress' policy of maintaining private insurance coverage of ESRD patients for the first thirty months of their illness.[70] In other words, Congress has explicitly established a regime in which Medicare expenditures are to be reduced by an offsetting contribution from the private sector.[71] Later in Section 2A of this article the author discuss a related concept, the implicit regime of commercial insurance reimbursements cross-subsidizing providers for whom Medicare pays less.

The author, as an advocate for patients with end-stage renal disease, has seen a proliferation of plan provisions similar to Paragraph 55 of the Winski SPD, limiting payment for dialysis to 100 percent of the Medicare allowance.[72] Such treatment is clearly unlawful under section 1862(b).[73] Section 1395y(b)(1)(C)(i) of the Social Security Act provides that a group health plan "may not take into account that an individual is entitled to or eligible for" Medicare benefits based upon end-stage renal disease "during the [thirty]-month period which begins with the first month in which the individual becomes entitled to" Medicare hospital benefits or "would have been entitled to benefits . . . if the individual had filed an application for such benefits."[74] Further, section 1395y(b)(1)(C)(ii) provides that a group health plan "may not differentiate in the benefits it provides between individuals having [ESRD] and other individuals covered by such plan on the basis of the existence of [ESRD], the need for renal dialysis, or in any other manner" during said thirty-month period.[75]

Pursuant to 42 C.F.R. § 411.108 and 42 C.F.R. § 411.161, actions by group health plans that take into account "that an individual is entitled to Medicare

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[69] 42 U.S.C. § 1395y (2018).

[70] SUZANNE KIRCHHOFF, MEDICARE COVERAGE OF END-STAGE RENAL DISEASE (ESRD) 11 (Congressional Research Service, 2018).

[71] *See id.* at 11 (explaining that a patient with ESRD may remain on private insurance for the first 30 months after qualifying for Medicare). Later in this article the author discusses a related concept, the implicit regime of commercial insurance reimbursements cross-subsidizing providers for whom Medicare pays less.

[72] OSCAR WINSKI CO. HEALTH PLAN, *supra* note 46, at 27.

[73] 42 U.S.C. § 1395y (2018).

[74] *Id.*

[75] *Id.*

on the basis of ESRD" are prohibited.[76] These actions include "[i]mposing limitations on benefits for a Medicare entitled individual with ESRD that do not apply to others enrolled in the plan,"[77] such as "[p]aying providers and suppliers less for services furnished" to an individual entitled to Medicare than for the same services furnished to a group health plan enrollee who is not entitled to for Medicare.[78]

42 C.F.R. § 411.161(b) also mandates that group health plans "may not differentiate in the benefits [they] provide between individuals who have ESRD and others enrolled in the plan, on the basis of the existence of ESRD, or the need for renal dialysis, or in any other manner."[79] Unlawful conduct includes actions cited above to the extent they are taken based on the ESRD health condition.[80]

In February 2018, at the urging of the author, the Centers for Medicare and Medicaid Services' Office of Financial Management sent letters to a number of plan administrators whose SPDs include language similar to the Winski plan's Paragraph 55.[81] These letters reminded the plan administrators of the MSP statute and regulations and admonished them to review their plan benefits to ensure compliance with MSP.[82]

D. All-provider type, normative-referenced pricing, individual payor: Medicare Plus Pricing by small/medium-size employers

A growing number of smaller self-insured employers, working through independent third party administrators, are unilaterally defining reimbursements with "scheduled benefits" pegged to the Medicare Fee Schedule.[83] How these plans operate is still unclear—their administrators view them as proprietary products and are more interested in communicating their virtues to employers than to the public at large.[84] Enough information is available to describe this alternative reimbursement paradigm and analyze its legal and policy implications.

This model travels under the names of Medicare-Plus and Cost-Plus (on the assumption that Medicare fees represent facilities' input costs) as well as

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[76] 42 C.F.R. § 411.108 (1995); 42 C.F.R. § 411.161 (1995).
[77] 42 C.F.R. § 411.108 (1995).
[78] 42 C.F.R. § 411.161 (1995).
[79] *Id.*
[80] 42 C.F.R. § 411.108 (1995); 42 C.F.R. § 411.161 (1995).
[81] *See* Letter from Steve Forry, Director, Division of MSP Operations, to Kauffman Engineering Health Plan (Feb. 16, 2018) (on file with author).
[82] *Id.*
[83] Melissa Shimizu, *Reference-Based Pricing: Another Self-Insured Option for Employers*, SOC'Y HUM. RESOURCE MGMT. (June 5, 2018), https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/reference-based-pricing-is-self-insured-option.aspx; Mike Dendy, *The Rise of Reference-Based Pricing*, BENEFITSPRO (Nov. 1, 2017), http://www.benefitspro.com/2017/11/01/the-rise-of-reference-based-pricing.
[84] Dendy, *supra* note 83.

Reference-Based Pricing.[85] As of the publication of this article, only one journalistic account,[86] and none from health services researchers, of this trend are available, but the facts can be pieced together from vendor materials that are fairly candid.[87] The premise of the model is that employers are usually paying about 300 percent of Medicare in a PPO, but that, as one TPA put it, "hospitals readily accept 130 percent to 150 percent of what Medicare would pay (sometimes less) for those willing to make cash-based payments."[88]

The Medicare-Plus model relies upon a novel additional infrastructure. The plan must retain lawyers to defend patients in billing litigation, analogous to the lawyers deployed by liability insurers to defend tort lawsuits.[89] The plan must also employ "patient advocates" who try to arrange care within the price parameters of the scheduled benefit.[90]

Ideally, the model is accompanied by advance agreements with at least some facilities to accept the scheduled fees in exchange for referrals,[91] and a preferred provider network of physicians that leaves the Medicare-Plus pricing to facilities.[92] The latter PPO would be important because it would impose some accountability among physicians, who, if sympathetic to an affiliated facility, could undermine cost savings by increasing referral volume.[93]

Practical Considerations: A Negotiating Advantage From an Inaccessible, Limited Pot of Money?

In Section B, I suggest that one reason Montana was successful in

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[85] Russell Riebeling, *The Fundamental Problem with Reference Based Pricing*, REVIVE HEALTH BLOG (Feb. 14, 2019), https://www.thinkrevivehealth.com/blog/fundamental-problem-reference-based-pricing; Jeff Long, *A Different Tactic in the War on Medical Costs: Reference-Based Pricing*, LOCKTON (Mar. 2018), https://www.lockton.com/whitepapers/Long_Reference_Based_Pricing_External_March_18_-_FINAL.PDF.

[86] Mack, *supra* note 45.

[87] *See* Dendy, *supra* note 83 (discussing the rise of reference-based pricing); *see also* Melissa Shimizu, *Reference-Based Pricing: Another Self-Insured Option for Employers*, SOC'Y FOR HUM. RESOURCE MGMT. (June 5, 2018), https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/reference-based-pricing-is-self-insured-option.aspx (generally describes how reference-based pricing works).

[88] Chris Elvidge, *Industry Trends: Reference-Based Plan Models,* KISTLER TIFFANY BENEFITS (Nov. 16, 2017), https://ktbenefits.com/2017/11/industry-trends-reference-based-plan-models/.

[89] Jon Jablon, *You Down with RBP? (You May Already Be!)*, THE PHIA GROUP BLOG (Nov. 28, 2018), https://www.phiagroup.com/Media/Posts/PostId/794/you-down-with-rbp-you-may-already-be.

[90] *Id.*

[91] Len Strazewski, *Relieving the Squeeze,* ROUGH NOTES (June 28, 2016, 12:44 PM), http://roughnotes.com/relieving-the-squeeze/.

[92] *Id.*

[93] *What is Reference Based Pricing?*, HOLLOWAY BENEFITS CONCEPTS BLOG (May 15, 2019), www.hollowaybenefitconcepts.com/what-is-reference-based-pricing.

implementing its reference-based pricing was its large enrollment.[94] But it is worth considering that the opposite circumstance might be true as well—that small employers with limited resources have negotiating advantages.

The author's own experience negotiating payments to hospitals came two decades ago as a plaintiff's personal injury attorney trying to settle a tort claim and a medical bill at the same time. My clients often had no health insurance and, in such cases, the proceeds from the injury claim had to compensate the providers for medical care, my client for lost wages, and my law firm for our legal work. In these circumstances, I found hospitals willing to accept a greatly discounted amount in full settlement in order to expedite payment from a limited fund over which I was the gatekeeper.[95]

The Medicare-Plus model exploits this same circumstance—a limited pot of money to which the provider has no immediate access—because there is no network contract and no assignment of benefits.[96] These pioneering payors are daring providers to forego immediate payment for care already rendered, or to leave a bed unfilled so that they can collect their full charges. The calculation is that if 120 percent of the Medicare rate is dangled before them, most providers will not leave the money on the table.[97] Because the employers are relatively small and smaller employers are not typically thought of as sources of generous coverage, providers may feel they are not telegraphing weakness by agreeing to the reference price.[98]

When comparing the Medicare-Plus model with traditional health insurance, it is apparent what is being sacrificed to save money: the convenience and peace of mind associated with a provider network and predictable out of pocket costs.[99] In a Medicare-Plus plan, a consumer must sweat out the process of billed charges being negotiated down by the plan administrator; this could mean delays in arranging necessary procedures, or calls from bill collectors and adverse credit reports following emergency encounters.[100] The recent hue and cry over balance billing by out-of-network

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[94] *See generally* Allen, *supra* note 38 (discussing that providers with above-average prices were disadvantaged by a need to explain and justify their higher costs).

[92] Harris Meyer, *Hospital develops package prices to lure cash-paying patients*, MOD. HEALTHCARE (Feb. 2, 2019), www.modernhealthcare.com/article/20190202/TRANSFORMATION04/190129925/hospital-develops-package-prices-to-lure-cash-paying-patients.

[96] Riebeling, *supra* note 85.

[97] *See generally* Allen, *supra* note 38 (writing that Montana hospitals did not want to lose patients to competitors based on a refusal to accept the reference based pricing plan).

[98] *See generally id.* (explaining that the subject of the article, Bartlett, chose the pricing that she thought was fair and allowed providers to decide whether to work with them rather than agreeing to the original, high price offered).

[99] *See generally id.* (discussing that employers have historically handed this process over to insurers to avoid navigating the complicated system of getting in-network discounts and figuring out pricing).

[100] Shimizu, *supra* note 83.

physicians at in-network facilities[101] and over inaccurate provider network directories[102] exemplifies the extent to which consumers have come to expect that their medical bills will be "taken care of," out of their view. Some providers, most notably air ambulance services and hospital-based physician staffing companies, have been more than willing to exploit consumer angst over bills to pressure insurers.[103] One can imagine the trepidation that the first employee to become ill might feel after his or her company adopts Medicare-Plus pricing, not knowing whether a local hospital will agree to the plan's terms. The plan administrator, who would be in the same situation, would not be able to offer much reassurance.

The employer adopting this approach must inculcate a new mind-set among employees, that they should not fear pricing confrontations with providers, but rather embrace them in order to control costs.[104] For the many consumers with high-deductible health plans, hassle-free insurance is already a distant memory.[105] By asking enrollees to shop among providers and negotiate prices, Medicare-Plus requires more than the typical HDHP, but by offering assistance in such negotiations, consumers are perhaps better protected than they are in making other big-ticket purchases such a car and a home mortgage.[106]

It is interesting that the Medicare-Plus approach has originated with a few unheralded benefit advisors and medium-sized businesses, far from America's elite coastal enclaves and not from the "sophisticated" purchasers such as CalPERS whose innovations draw regular attention.[107] One wonders if business owners in struggling rural areas have a different insight into the level of health care pricing that is realistic for a population of low- and middle-income workers, or if the experience of seeing health care emerge as the dominant industry in a small community provokes a unique perspective on cost growth sustainability. Note that Oscar Winski is in Indiana, which is said to have among the highest hospital prices of any state.[108]

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[101] Zack Cooper & Fiona Scott Morton, *Out-of-Network Emergency-Physician Bills — An Unwelcome Surprise*, 375 NEW ENGLAND J. MED. 1915, 1915 (Dec. 19, 2016).

[102] Michael Adelberg & Michelle Strollo, *From Machine-Readable Provider Directories, A Preview Of A Revolution*, HEALTH AFFS. BLOG (Feb. 27, 2017), www.healthaffairs.org/do/10.1377/hblog20170227.058937/full.

[103] Kevin Schulman et al., *Resolving Surprise Medical Bills*, HEALTH AFFS. BLOG (July 10, 2019), www.healthaffairs.org/do/10.1377/hblog20190628.873493/full.

[104] Lisa Rapaport, *Consumers with High-Deductible Health Plans Could Be Smarter Shoppers*, BUS. INSIDER (Nov. 27, 2017, 1:32 PM), https://www.businessinsider.com/r-consumers-with-high-deductible-health-plans-could-be-smarter-shoppers-2017-11.

[105] *Id.*

[106] *Id.*

[107] INST. HEALTH POL'Y SOLUTIONS, COST MANAGEMENT STRATEGIES AND EXAMPLES FOR THE POOL C- 31 (2005).

[108] Shari Rudavsky, *High health care costs leave some businesses saying anywhere but Indiana*, INDIANAPOLIS STAR (Apr. 29, 2019), www.indystar.com/story/news/2019/04/29/health-care-costs-indiana-exceed-what-nearby-states-pay-study-says/3513795002.

Alternative paradigms such as Medicare-Plus pricing challenge an implicit assumption made by providers who aggressively apply leverage in contract negotiations—that the pool of money available to pay them is virtually unlimited, and infinitely replenishable. In the long run, of course, that is not the case. By unilaterally limiting the size of the pool, these payors are forcing the issue.

Legal considerations: Medicare-Plus implicates the same legal considerations surrounding MOOPS described in the preceding section.

E. All-provider type, normative-referenced pricing, individual payor: The North Carolina State Health Plan Clear Pricing Project

In October 2018, North Carolina State Treasurer Dale Folwell notified hospitals of an initiative under which the State Health Plan (SHP) would pay reference prices set at 155 percent of Medicare for inpatient care, 200 percent of Medicare for outpatient services, and 160 percent of Medicare for professional services.[109]

Folwell stated that SHP had been paying an average of 158 percent of Medicare rates for inpatient care (ranging from 85 percent to 318 percent), 291 percent of Medicare for outpatient care (ranging from 145 percent to 803 percent), and 126 percent of Medicare for professional services (ranging from 65 percent to 994 percent).[110] Across provider types, reference-based payments would be approximately 177 percent of what Medicare pays.[111] *Modern Healthcare* reported that the figure was calculated by actuaries, expecting that it would "save the taxpayer-funded state health plan about $300 million in the first year alone, while reducing plan members' co-payments and deductibles another $60 million."[112] Previously, Folwell expressed a desire to reduce program expenditures by fifteen percent.[113] On average, the RBP plan would result in a fourteen percent reduction.[114] What is interesting about this initiative is its assumption of a normatively "correct," if perhaps arbitrary, level of overall spending for a state program—in a sense, a global budget; as well as a normatively correct level of expenditures on primary care, which would be increased.

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[109] Letter from Dale Folwell, Treasurer, State of N.C, to Provider Organizations 1,2 (Oct. 3, 2018) (available at https://files.nc.gov/ncshp/documents/shp-documents/provider_reimbursement_at_a_percentatge_of_medicare_letter.pdf); *see also* Rose Hoban, *Treasurer moves forward with health care pricing plan despite uncertainty*, N.C. HEALTH NEWS (May 17, 2019), www.northcarolinahealthnews.org/2019/05/17/folwell-state-health-plan-pricing-changes-uncertainty.

[110] *Id.*

[111] Shelby Livingston, *Setting the bar for hospital prices*, MOD. HEALTHCARE (Mar. 2, 2019, 1:00 AM), www.modernhealthcare.com/hospitals/setting-bar-hospital-prices.

[112] *Id.*

[113] Tosczak, *supra* note 42.

[114] Bobby Burns, *Battle brewing over state health plan*, THE DAILY REFLECTOR (Dec. 3, 2018), www.reflector.com/News/2018/12/03/Battle-brewing-over-state-health-plan.html.

Practical considerations: The North Carolina Hospital Association actively opposed the initiative and a bill was offered in the legislature to delay it.[115] Individually, most hospitals held firm against the Treasurer, refusing to sign the proffered contracts; in the end, the Treasurer was unwilling to subject employees to balance billing and "swerved."[116] One major difference between the Montana and North Carolina situations was that Montana officials had data on hospitals' negotiated rates while North Carolina officials did not, but it is impossible to say whether this led to the difference in outcomes.[117] What can be said is that the economic and political strength of hospitals, which are often the largest employers in their communities, and the fear of balance billing, constitute potent forces and give hospitals leverage.[118] We will not know if hospitals might have refrained from balance billing after the reference price was tendered had the Treasurer not folded his cards months before scheduled implementation.[119] Journalists covering stories on "surprise medical bills" have observed that providers frequently back down in the face of media scrutiny of their billing practices.[120] The Treasurer elected not to test their resolve on this front.[121]

F. All-provider type, normative-referenced pricing, insurer: Medicare Plus Pricing in the BCBS North Carolina "myChoice" Plan.

In 2019, BlueCross BlueShield of North Carolina (BCBS-NC) introduced a Medicare Plus insurance product dubbed "myChoice."[122] The product is offered in partnership with ACS Benefit Services, one of the vendors behind Medicare-Plus plans in the employer market.[123]

While the ACA's Qualified Health Plans—those eligible for subsidies and

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[115] Shelby Livingston, *N.C. walks back reference-based pricing plan for state workers*, MOD. HEALTHCARE (Aug. 9, 2019, 4:41 PM), www.modernhealthcare.com/hospitals/nc-walks-back-reference-based-pricing-plan-state-workers.

[116] Peyton Upchurch, *State Treasurer Opposes Bill that Would Stop Clear Pricing Project*, THE CAROLINIAN (Mar. 13, 2019). www.carolinianuncg.com/2019/03/13/state-treasurer-opposes-bill-that-would-make-health-care-affordable-for-state-employees.

[117] *See id.* (discussing North Carolina's system); *see also* Appleby, *supra* note 15, at 1 (discussing Montana's system).

[118] Appleby, *supra* note 15.

[119] Upchurch, *supra* note 116, at 1.

[120] *See, e.g.*, Nisarg A. Patel, *Journalism Shouldn't Be a Safeguard Against Unreasonably High Health Care Bills*, SLATE (Oct. 18, 2018, 9:00 AM), www.slate.com/technology/2018/10/surprise-billing-health-care-journalism.html (discussing how media backlash should not be the driving factor behind lowering high health care bills).

[121] Upchurch, *supra* note 119, at 1.

[122] Julie Appleby, *New Health Plans Expose The Insured To More Risk*, KAISER HEALTH NEWS (Mar. 13, 2019), www.khn.org/news/new-health-plans-expose-the-insured-to-more-risk.

[123] Press Release, Blue Cross and Blue Shield of North Carolina, New, Lower Cost Plan Available for Small Businesses and Individuals (Oct. 25, 2018), http://mediacenter.bcbsnc.com/news/new-lower-cost-plan-available-for-small-businesses-and-individuals.

sale in exchanges—are required to have a provider network, the ACA permits the off-exchange, unsubsidized sale of indemnity-type products.[124] The myChoice product sets reimbursement at 140 percent of Medicare.[125] BCBS-NC asserts that "premium savings will equal an average of thirty-three percent, or $230 per member per month, for individual plans. Premium savings will equal thirty percent, or $140 per member per month, for small group plans."[126]

In its promotional materials, BCBS-NC does not guarantee that any medical provider will accept the Medicare Plus pricing but asserts that enrollees will receive "personalized support from myChoice Advisors before and after your doctor visits."[127] The plan's Summary of Benefits and Coverage states that "not included in the out-of-pocket limit" are "charges over the maximum allowable cost" and "balance billing charges."[128] In its press release announcing the product, BCBS-NC states that,

> [i]f a provider charges more than 140 percent of Medicare for a particular service, including emergency care, the member may be billed the difference by the provider and will be responsible for paying the balance owed. While approved claims go towards satisfying deductibles and out of pocket maxes, balance billing does not count towards the plan's deductible or out of pocket max.[129]

Legal considerations: The author disagrees that this accurately states the plan's obligations under the Patient Protection and Affordable Health Care Act (ACA). While CMS has not weighed in on the legality of this specific approach, Section 2707 of the Public Health Service Act, "Comprehensive Health Insurance Coverage,"[130] requires that any "health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 1302(a) of the Patient Protection and Affordable Care Act," which in turn sets an out-of-pocket limit.[131]

We should first note that as the product pertains to employee coverage, Section 1302(b) of the ACA, "Cost-Sharing Under Group Health Plans"[132] would certainly impose the MOOP, making applicable the tri-agency guidance discussed in Section I.C. above.

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[124] *Id.*
[125] *Id.*
[126] *Id.*
[127] *More affordable health care that puts you in control,* MYCHOICE, www.mychoicehealth.com (last visited Nov. 14, 2019).
[128] *Id.*
[129] Blue Cross BlueShield of North Carolina, *supra* note 123, at 1.
[130] Patient Protection & Affordable Health Care Act, 42 U.S.C. § 300gg-6 (2014) [hereinafter ACA].
[131] 42 U.S.C. § 1302 (a) (2006).
[132] 42 U.S.C. § 1302 (b) (2006).

It would appear that BCBS-NC is relying on a creative interpretation of one or both of two exceptions to the MOOP in asserting that bills above the 140 percent of Medicare threshold are solely the responsibility of the consumer. Section 1302(c)(3) of the ACA provides that the term "cost sharing" "does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services."[133] At the time the ACA was enacted, reference pricing did not exist, so balance billing as understood by the statute's framers would be defined as the difference between a provider's billed charges and the "usual, customary, and reasonable"[134] amount that insurers typically tender in an indemnity situation. With the myChoice product, balance billing encompasses not only that difference, but also the additional difference between the UCR and the reference price of 140 percent of Medicare.[135] The intent of the ACA was to require comprehensive coverage of essential health benefits with a hard limit on cost sharing for such benefits.[136] As such, BCBS-NC's blanket disavowal of liability for this difference cannot be read as complying with Section 2707 of the Act.

In 2013, the Department of Health and Human Services issued a final rule promulgating a number of regulations interpreting the ACA.[137] One of these regulations, 45 CFR § 156.130(c), permitted qualified health plans to count only in-network utilization toward the out-of-pocket limit.[138] With regard to the individual market, there is no support in the text of 45 CFR § 156.130(c) for the proposition that an indemnity insurer can unilaterally disavow liability for balances over a reference price.

First, the title of § 156.130(c) is "Special rule for network plans."[139] Second, by its own terms, § 156.130(c) has applicability only to "a plan using a network of providers;"[140] BCBS-NC expressly states that the myChoice product has "no provider network limitations" and "no restrictions on which providers a customer can see."[141] Finally, in its discussion of § 156.130(c) in the 2013 Final Rule, HHS said its rationale for § 156.130(c) was that its "research has shown that generally, health spending occurs in-network."[142] This rationale does not apply to a Medicare-Plus indemnity product.

As such, the author's view is that BCBS-NC must make the same efforts

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[133] 42 U.S.C. § 1302 (c)(3) (2006).

[134] UCR (Usual, Customary, and Reasonable), HEALTHCARE.GOV, www.healthcare.gov/glossary/ucr-usual-customary-and-reasonable (last visited Nov. 14, 2019).

[135] MyChoice, *supra* note 127, at 1.

[136] ACA, *supra* note 130.

[137] ACA, *supra* note 130; 78 Fed. Reg., 12833-47. (Feb. 25, 2013).

[138] 78 Fed. Reg., 12833-47. (Feb. 25, 2013).

[139] *Id.*

[140] *Id.*

[141] Blue Cross Blue Shield of North Carolina, *supra* note 123.

[142] ACA, *supra* note 130.

to negotiate, and if necessary, litigate lower provider bills on the enrollee's behalf that are described in Section I.C. above, and that North Carolina's insurance commissioner erred in approving BCBS-NC's forms' assertions with regard to balance billing.

Practical considerations. While the author believes that this product must provide full MOOP protection, the fact that it is marketed without promising such protection will discourage its purchase by consumers with assets to protect. North Carolina's homestead exemption is limited to $35,000;[143] a consumer with a lot of home equity, or who owns business or agricultural property, would be a tempting target for a hospital inclined to file a lawsuit pursuing its full chargemaster rates in the event of an unplanned inpatient episode.

G. Single commodity, normative-referenced pricing, multiple payor: The CVS Caremark Initiative

In August 2018, the pharmaceutical benefit manager (PBM) CVS Health announced a program that allows self-funded plan sponsors "to exclude from coverage medications that have launch prices of greater than $100,000 per quality-adjusted life-year (QALY)" as determined by the Institute for Clinical and Economic Review (ICER).[144] CVS Health states that a "pharmaceutical company will know exactly where the price must be set for a drug to be included as a covered benefit," so therefore, under the policy it will be

> [T]he pharmaceutical manufacturer that is determining access to the medication by its choice of a launch price. Some pharmaceutical manufacturers may initially prefer to price high and risk limiting access. But over time, as more payors adopt this program or ones similar to it, the logic of the market will dictate more reasonable launch pricing overall.[145]

In effect, the program sets a QALY-referenced price.

This concept differs from the reference pricing programs described above in that it uses neither a Medicare price nor a point on a range of commercial prices for its benchmark. The concept introduces three new elements: first, rather than action by an individual payor, an action by multiple payors acting collectively through an agent (the PBM); second, a cost-effectiveness concept, the QALY, in which the price is tethered to a unit of health outcome rather than the unit sold; and third, an assessment by a party other than government or markets. Each of these elements represents a new milestone on the march of reference pricing. Taken together, they suggest a bold new

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[143] N.C. Gen. Stat. § 1C-1601(a)(1).

[144] Troyen Brennan & Surya Singh, *Why CVS Is Giving Plans A New Tool To Target High Launch Prices*, HEALTH AFF. (Sept. 17, 2018) https://www.healthaffairs.org/do/10.1377/hblog20180913.862850/full/.

[145] *Id.*

future for the concept that some might see as logical next steps and others might see as oppressive or presumptuous.

1. Collective Action By Payors

A reference pricing program in which multiple payors participate is more likely to be effective in bending the cost curve, but is also more likely to draw a legal challenge on antitrust grounds.

Practical Considerations: Multi-Payor Cooperation.

As a PBM, CVS Health is in a position to coordinate the effort of multiple client-employers to force down drug prices.[146] No individual payor need stick out its neck as the first mover and potentially scare off risk-averse incumbent or prospective employees. CVS Health can sign up employers and unions conditionally and confidentially before going live and ensure that a critical mass of payors are participating. Since there is nothing stopping other PBMs, payors, or groups of payors from independently adopting the same strategy, the mere fact of the CVS announcement sets in motion a powerful collective dynamic that empowers payors to force drug prices down. The "game of chicken" between individual drivers is replaced by the equivalent of a squadron of tanks barreling toward a lone, very vulnerable, drag racer. The ability of drug manufacturers to charge exorbitant prices is almost entirely dependent on their access to the large sums of money pooled within insurance plans.[147] If access is denied, very few Americans could be expected to purchase them with their own money.[148]

Legal considerations: Antitrust issues

What CVS Health proposes is in the nature of a joint purchasing cooperative. The author, as a health policy generalist, claims no expertise in antitrust law so the discussions of this topic below will be relatively brief and perhaps superficial.

Antitrust rulings to date have been favorable to the PBM business model,

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[146] *See* Cole Werble, *Pharmacy Benefit Managers*, HEALTH AFF. (Sept. 14, 2017), https://www.healthaffairs.org/do/10.1377/hpb20171409.000178/full/ (stating ". . . from the payer perspective, PBMs have standing with pharmaceutical industry in price negotiations").

[147] *See* NAT'L ACAD. SCI. ENG'G, & MED., MAKING MEDICINES AFFORDABLE: A NATIONAL IMPERATIVE 89 (Norman R. Augustine, et al. eds., 2018) (writing that "[Drug] [m]anufacturers commonly sell their products at discounted prices . . . In concept these discounts are passed through (at least in part) from the PBMs to the consumer via the consumer's prescription drug insurance plans . . . However, it is not clear that this occurs in practice.").

[148] *Cf. id.* at 15-16 (providing an example of how much an individual with healthcare insurance pays for a medication); Laura Entis, *Why Does Medicine Cost So Much? Here's How Drug Prices Are Set*, TIME MAG. (Apr. 9, 2019), https://time.com/5564547/drug-prices-medicine/ (stating "as it exists today, the system is not designed to prioritize savings for patients").

brushing aside suggestions that monopsony or oligopsony purchasing by PBMs violates the law.[149] These rulings rejected allegations of antitrust injury by pharmacies that distribute drugs and as such are not entirely on point with the potential grievance of a drug manufacturer. Nevertheless, the rulings' rationales offer considerable support for the CVS Health proposal.

In approving the Medco/Express Scripts merger in 2012, the Federal Trade Commission "considered whether the acquisition would confer monopsony power on the merged company when it negotiates dispensing fees with retail pharmacies."[150] The Commission stated: "As a general matter, transactions that allow firms to reduce the costs of input products have a high likelihood of benefitting consumers, since lower costs create incentives to lower prices. Only in special circumstances does an increase in power in negotiating input prices adversely impact consumers."[151] The Commission found that the resulting larger PBM would not have sufficient market share to constitute a monopsony, but even

> [I]f the transaction enables the merged firm to reduce the reimbursement it offers to network pharmacies, there is no evidence that this would result in reduced output or curtailment of pharmacy services generally. Furthermore, for contractual and competitive reasons, it is likely that a large portion of any of these cost savings obtained by the merged company would be passed through to the PBM's customers. Although retail pharmacies might be concerned about this outcome, a reduction in dispensing fees following the merger could benefit consumers by lowering health care costs.[152]

Similarly, the U.S. District Court for the Northern District of Illinois expressed approval of PBMs' purchasing power in finding that it did not constitute a "naked horizontal price-fixing agreement" and therefore a per se violation of the Sherman Act.[153] In *North Jackson Pharmacy v. Caremark Rx Inc.*, the court found that Caremark (predecessor to CVS Health) "is essentially a cooperative purchasing group," and analyzed its activities under the "ancillary restraints" doctrine—that is, were Caremark's restraints on trade "part of a larger endeavor whose success they promote."[154] While naked restraints "are unlikely to have any redeeming value and so are usually accorded per se treatment…ancillary restraints that may contribute to the success of a cooperative venture that promises greater productivity and

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[149] *See generally*, PHARM. CARE MGMT. ASSOC., ANTITRUST CONSIDERATIONS OF PROPOSALS TO LIMIT REBATES 3-5 (2018) (stating that the court did not "condemn the use of rebates" which led to current use of rebates) [hereinafter PCMA].

[150] Statement Concerning the Proposed Acquisition of Medco Health Solutions by Express Scripts, Inc., FTC File No. 111-0210, F.T.C., (2012).

[151] *Id.*

[152] *Id.*

[153] N. Jackson Pharmacy, Inc. v. Caremark Rx, Inc., 385 F. Supp. 2d 740, 745 (2005).

[154] *Id.* at 746-47.

output" will be upheld if reasonable.[155] The question was framed as "whether [a PBM acts] in a procompetitive, efficiency-enhancing manner that benefits consumers, or whether instead that goal is accomplished through unlawful collusion that drives prices below competitive levels and thereby reduces social welfare."[156]

While the decision discussed here was not a ruling on the merits, the pharmacies' litigation has petered out and it would be fair to say that PBMs' general business model is lawful. Does this imply that using the PBM structure to coordinate reference pricing is also lawful? At least two elements of the rulings raise distinctions that drug manufacturers could point to.

First, the Northern District observed that Caremark's contracting with pharmacies was one of ostensibly interrelated functions in the administration of Plan Sponsors' drug benefit plans "includ[ing] not only the negotiation of reimbursement rates with retail pharmacies but also the processing of reimbursement claims, maintenance of patient records, design and management of drug formularies, negotiation of manufacturer rebates and maintenance of a mail order pharmacy.[157] A drug manufacturer could argue that reference pricing represents a significant departure from these functions. Second, the FTC has observed that:

> In conventional monopsony and oligopsony models, all sales take place at a single price. A reduction in price is associated with a movement downward along the supply curve to a lower quantity. By contrast, each contract between a PBM and a pharmacy company is subject to individual negotiation. Both the PBM and the pharmacy have the incentive to contract for the efficient quantity, while bargaining on the price in order to determine how the gains from the transaction are divided between them. In this situation, an increase in the bargaining power of the buyer may lead to a lower price, but there is no reason to expect a lower price to lead to a lower quantity.[158]

Drug manufacturers could argue to a court or to the FTC, as they have argued to Congress and the public, that forced price reductions will lead to the development of fewer new drugs.[159] However, because CVS will merely be trying to impose the same QALY-based restrictions in the US that are ubiquitous in the rest of the world, Pharma would be placed in the awkward position of telling courts and regulators that higher prices in the US, alone,

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[155] *Id.* at 747.
[156] *Id.* at 749.
[157] *Id.* at 748.
[158] Statement In The Matter Of Caremark Rx, Inc./Advancepcs, File No. 031 0239, F.T.C. (2004) 1, 3 n.4.
[159] Ezekiel J. Emanuel, *Big Pharma's Go-To Defense of Soaring Drug Prices Doesn't Add Up*, THE ATLANTIC (Mar. 23, 2019), https://www.theatlantic.com/health/archive/2019/03/drug-prices-high-cost-research-and-development/585253/.

are necessary to guarantee innovation.

Finally, we should take note of what might be called the "healthcare-is-complicated" disclaimer that is found in the joint DOJ-FTC antitrust statement: "These principles are sufficiently flexible to take into account the particular characteristics of health care markets and the rapid changes that are occurring in those markets,"[160] as well as Justice Breyer's observation that "the subject matter of the present agreement—medical costs—is an area of great complexity where more than solely economic values are at stake."[161] Clearly, judges and regulators understand the intractability of the health care cost problem and seem reluctant to step in to protect any entity from purchasing techniques that might curb those costs.

2. QALY As The Unit of Pricing.

RBP to date has assumed that items' prices will be stated in the units sold,[162] e.g., $30,000 for a joint replacement procedure,[163] $1,500 for a colonoscopy,[164] or $12.30 for a thirty-day supply of statins.[165] While price may be set at percentile of a negotiated commercial reimbursement range or multiple of Medicare prices, the denominator in each instance is the unit by which the item is usually sold.[166]

The denominator in a QALY is the gain in a patient's longevity adjusted by reduced quality-of-life.[167] ICER evaluations produce prices at which treatments would be considered cost-effective at willingness-to-pay thresholds of $50,000/QALY, $100,000/QALY, and $150,000/QALY.[168] ICER states a "value-based benchmark price for a drug," defined as the "care value price range that would achieve cost-effectiveness ratios between $100,000 and $150,000 per QALY gained."[169] CVS Health is applying its own value judgment in choosing the $100,000/QALY benchmark.[170] It notes

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[160] STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, DOJ & FTC (Aug. 1996).

[161] Kartell v. Blue Shield of Mass., Inc., 749 F.2d 922, 931 (1st Cir. 1984).

[162] PCMA, *supra* note 149, at 5.

[163] Ralph Weber, *Reference Based Pricing in 2018*, MEDIBID (Nov. 2, 2018), https://www.medibid.com/blog/2018/11/reference-based-pricing-in-2018/.

[164] Berry & Day, *supra* note 1, at 22.

[165] Ross J. Simpson et al., *Cardiovascular and Economic Outcomes After Initiation of Lipid-Lowering Therapy With Atorvastatin vs Simvastatin in an Employed Population,* 84 MAYO CLINIC 1065, 1071 (2009).

[166] PCMA, *supra* note 149, at 5.

[167] Franco Sassi, *Calculating QALYs, comparing QALY and DALY calculations*, 21 HEALTH POL'Y PLAN. 402, 403 (Sept. 2006).

[168] INST. FOR CLINICAL & ECON. REVIEW, PCSK9 INHIBITORS FOR TREATMENT OF HIGH CHOLESTEROL: EFFECTIVENESS, VALUE, AND VALUE-BASED PRICE BENCHMARKS 20 (2015).

[169] *Id.* at 77.

[170] Ami Gopalan, *CVS Announcement of Cost-Effective Benchmark Puts ICER in the Spotlight,* STAT NEWS (Aug. 22, 2018), https://www.statnews.com/2018/08/22/cvs-cost-effectiveness-benchmarks-puts-icer/.

that this is approximately double the benchmark applied by European nations,[171] preserving a measure of "American exceptionalism" with this judgment.

Value-based insurance designs (V-BID) that align a patient's cost sharing to a normative judgment of the value of the underlying service are currently undergoing testing.[172] Pricing per QALY for drugs suggests the possibility of V-BID pricing for procedures in the future.

3. Independent Body as Evaluator of Value

Institute for Clinical and Economic Review (ICER) describes itself as:

> [A]n independent and non-partisan research organization that objectively evaluates the clinical and economic value of prescription drugs, medical tests, and other health care and health care delivery innovations. ICER conducts rigorous analyses of all clinical data and publicly convenes key stakeholders – including patients, doctors, life science companies, private insurers, and the government – to translate this evidence into policy decisions that lead to a more effective, efficient, and just health care system.[173]

As a creature purely of civil society, not the government, its authority and legitimacy must be earned by the expertise of its staff and independent voting committees, and the fairness and representativeness of its processes. To the extent that ICER is viewed as a fair and neutral arbiter its valuations could be perceived as more legitimate and less capricious than those set unilaterally by a payer.

II. THE FUTURE OF REFERENCE BASED PRICING

From a modest beginning nine years ago, reference pricing techniques have evolved to encompass more services, more providers, more payors, and more dollars of health care expenditures. In particular, the three new elements introduced by the CVS Health initiative, if brought to scale across the full landscape of US health care delivery, could bring paradigmatic change to the leverage of payors vis a vis providers.

To quote the prominent benefits consultant from Montana, "Why wouldn't everyone do it?"[174] Could large payors use reference pricing to ratchet reimbursements down to 125 percent of Medicare as some small payors have done? Could small payors combine to force reference pricing on high-cost

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[171] Brennan & Singh, *supra* note 144, at 2.

[172] *See* Mark A. Fendrick et al., *Value-Based Insurance Design: More Health at Any Price*, 47 HEALTH SERVS. RES. 404, 407-8 (2012) (stating that "[t]here is a dearth of data . . . of evaluations of V-BID programs").

[173] *About ICER*, INST. FOR CLINICAL & ECON. REVIEW, https://icer-review.org/about/ (last visited Nov. 14, 2019).

[174] Appleby, *supra* note 15.

providers?

A. Reference-Based Prices and Administered Prices

The Medicare-Plus model superficially resembles proposals from Robert Berenson and from Dartmouth researchers to set government-mandated upper limits on reimbursements pegged to a multiple of the Medicare Fee Schedule. Berenson's version contemplates a ceiling in the range of 200 to 250 percent of Medicare, intended as a backstop to negotiations rather than a final price.[175] The Dartmouth proposal would give "every patient and every insurance company…the option of paying 125 percent of the Medicare price for any service."[176] Such proposals are calls for all-payor rate setting, a form of administered prices.

RBP share some similarities with administered pricing systems. Medicare's system of administered prices uses formulas loosely based on input costs to set fees on a "take-it-or-leave-it" basis for providers wishing to serve Medicare beneficiaries.[177] Because the Medicare population represents the vast majority of patients for certain types of care—in particular, hospital inpatient and dialysis services—essentially all providers of such services must accept these fees. A minority of physicians decline to participate in Medicare, but not enough to threaten beneficiaries' access to care.[178] Medicare's Prospective Payment Systems are designed to cover input costs for an "efficient" provider, not for *any* provider, an arrangement intended to encourage lean operations.

The state of Maryland has a system of all-payor rate-setting for hospitals, to which has recently been added a global budget for all hospital services in the state.[179] Rates are set by the state Health Services Cost Review Commission.[180] As with Medicare, hospitals are required to file cost reports and rates are updated annually.[181]

Britain has what amounts to an administered pricing system for drugs since all of its citizens receive health coverage through the government-run

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[175] Robert Berenson, *Addressing Pricing Power in Integrated Delivery: The Limits of Antitrust*, 40 J. HEALTH POL. POL'Y & L. 711, 738 (2015).

[176] Jonathan Skinner et. al., *The 125 Percent Solution: Fixing Variations In Health Care Prices*, HEALTH AFF. (Aug. 26, 2014), https://www.healthaffairs.org/do/10.1377/hblog20140826.041002/full/.

[177] MEDICARE PAYMENT ADVISORY COMM'N, PAYMENT BASICS: HOSPITAL ACUTE INPATIENT SERVICES PAYMENT SYSTEM 3 (2018) [hereinafter MEDPAC PAYMENT BASICS].

[178] MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 110 (2017) [Hereinafter MedPAC MPAC REPORT].

[179] Gerard Anderson & Bradley Herring, *The All-Payer Rate Setting Model for Pricing Medical Services and Drugs*, 17 AMA J. ETHICS 770, 772 (2015).

[180] *Id.*

[181] *See id.* ("Maryland has used a prospective annual global budget that requires each hospital to monitor both the number of admissions and the cost per admission").

National Health Service (NHS).[182] Britain's National Institute for Health and Care Excellence (NICE) makes recommendations on which drugs NHS must cover based upon clinical effectiveness and cost-effectiveness analysis.[183] NICE generally will not approve drugs with a value of less than £30,000 per QALY.[184]

Reference pricing resembles administered pricing in that it purports to offer a "take-it-or-leave-it" price.[185] It can further resemble administered pricing if it uses an administered price, such as Medicare's, as a reference point, or if it purported to set prices based upon input costs as do Medicare and Maryland. Ultimately, if all payors used the same reference pricing system, the RBP could become a *de facto*, virtual administered price.

It is important to note that a government-mandated administered price offers a consumer protection that reference pricing does not: as part of the take-it-or-leave-it terms, a government entity can require that the provider accept the payment in full satisfaction of the patient's obligations, thereby prohibiting balance billing.[186] Effective in 2019, Oregon imposed a system of administered prices on hospitals serving the 136,000 state employees and dependents covered by its Public Employees Benefit Board (PEBB) pegged at 200 percent of Medicare.[187] In testimony to the House Committee on Health Care, Speaker Tina Kotek noted that "the current average inpatient/outpatient cost for the self-insured plans is approximately 237 percent of Medicare.[188] The bill targets 200 percent for in-network claims because it is an achievable benchmark that still moves us in the right direction."[189] She further observed:

> [A recent study] found the cost of health care in Oregon is seventeen percent higher than neighboring states with no correlating increase in the quality of care. In 2016, there was an 8.1 percent increase in medical costs across all PEBB plans compared to the previous plan year. Mercer actuaries determined that 3.4 percent of the self-insured cost increases were due to simple increases in the service cost—not increases in

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[182] David A. Wong, *Rationing Treatments Based on Their Cost per QALY*, 13 VIRTUAL MENTOR 220, 221 (2011).
[183] *Id.*
[184] *Id.*
[185] Pamela Rich, *Reference-Based Pricing: Creating Health Care Shoppers*, 30 BENEFITS Q. 25, 27 (2014).
[186] MPAC PAYMENT, *supra* note 178, at 110.
[187] Oregon Legislative Assembly, *Staff Measure Summary: SB 1067 A*, 5 (2018), https://www.oregon.gov/oha/PEBB/docs/OEBB-PEBB%20Innovation%20Workgroup/20181016/IW%20Attachment%204c-SB106-HB3418%20summaries%20and%20testimony.pdf; Julie Appleby, *Health Plans For State Employees Use Medicare's Hammer On Hospital Bills*, KAISER HEALTH NEWS (Mar. 21, 2019), https://khn.org/news/health-plans-for-state-employees-use-medicares-hammer-on-hospital-bills/.
[188] Oregon Legislative Assembly, *supra* note 187, at 5.
[189] *Id.*

utilization or risk.[190]

Other efforts to impose administered prices have faltered. In 2019, Colorado Insurance Commissioner Michael Conway's office proposed a reinsurance program to reduce premiums in the individual market by, among other things, cutting $215 million to $245 million in hospital costs by limiting claims to low multiples of Medicare rates.[191] Both the state legislature and the Trump Administration rejected the plan in April 2019.[192] Just days earlier, the Montana legislature rejected House Bill 747, which would have set a ceiling on hospital rates pegged to the Health Care and Benefits Division's reference-based pricing.[193]

In arguing for a cap on payments at 125 percent of Medicare rates, Skinner, Fisher, and Weinstein note several advantages to using Medicare as a benchmark: while "not perfect . . . it is uniform across regions, with a cost-of-living adjustment that pays more in expensive cities and less in rural areas."[194] With a twenty-five percent premium added there would be sufficient incentives for providers "to see new patients and help offset the inadequate Medicaid payments provided in many states.[195] Furthermore, most negotiated payments are already under the 125 percent of Medicare cap, so those payments would be entirely unaffected by this new policy."[196]

As noted earlier, the Medicare-Plus approach assumes that Medicare fees reflect facilities' input costs. Many providers would disagree with this proposition, and indeed prospective payments are supposed to be set at the level of an "efficient" provider.[197] The Medicare Payment Advisory Commission (MedPAC) acknowledges that most hospitals have negative Medicare margins and thrive based upon more generous commercial reimbursements, but has identified a subset of efficient hospitals that deliver high-quality care with positive Medicare margins.[198] MedPAC summarizes its conclusions in a pithy formulation, "high pressure = low cost,"[199] that is, facilities facing fiscal pressure due to low commercial reimbursements will evolve to deliver care at lower costs. Noteworthy in this regard is survey findings from consultancy firm Kaufman, Hall & Associates, which reports

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[190] *Id.* at 5-6.

[191] LEWIS & ELLIS ACTUARIES, COLORADO REINSURANCE PROGRAM ANALYSIS PREPARED FOR COLORADO DEPARTMENT OF REGULATORY AGENCIES 6 (2019).

[192] *Remarks of Commissioner Michael Conway to the NAIC Regulatory Framework Task Force*, Apr. 6, 2019. CMS would have had to approve a State Innovation Waiver.

[193] *Montana House Bill 747 (Adjourned Sine Die)*, LEGISCAN, https://legiscan.com/MT/bill/HB747/2019 (last visited Nov. 14, 2019); *See* H.B. 747, 66th Leg., Reg. Sess. (Mont. 2019) (detailing H.B 747).

[194] Skinner et al., *supra* note 176.

[195] *Id.*

[196] *Id.*

[197] *Id.*

[198] MPAC REPORT, *supra* note 178.

[199] *Id.* at 87.

that sixty percent of hospital executives say their internal cost-cutting goal is, or should be, "achieving revenue/expense breakeven with Medicare."[200]

B. How Could Payors Lawfully Coordinate a Joint Reference-Based Pricing Regime?

1. Joint Purchasing Monopsony Antitrust Considerations

The collapse of the Clinton Administration's 1993-94 Health Security Act proposal, which featured mandatory state-based purchasing alliances as its primary cost containment mechanism, spurred a boomlet of legal scholarship inquiring whether private-sector analogs to those purchasing alliances would pass antitrust muster or be struck down as unlawful monopsonies. Ironically, joint purchasing at the scale discussed in these works never came to pass over the succeeding quarter-century. Nevertheless, the analyses they presented are helpful to understanding the legal ramifications of collective purchaser action to impose reference pricing.

Both authors discussed hereafter were sanguine about legal prospects for employer collective action.[201] Havighurst noted that antitrust enforcement officials "have evinced a positive disposition toward collective purchasing of health care…[b]ecause joint purchasers are generally perceived as fighting battles to control the cost and improve the quality of health care and as seeking to bring a semblance of price competition to markets that have long lacked it."[202] He concluded that "few employer coalitions or purchaser cooperatives are likely to cross the lines laid down by antitrust law,"[203] and that "courts could be persuaded to tolerate some monopsonistic joint purchasing in the health care sector."[204] Miller concluded:

> Properly structured and analyzed, collective action by health insurance buyers need not present significant antitrust risk… In point of fact, courts have generally treated large health sector purchasers or purchasing coalitions quite leniently in antitrust cases, even in the absence of facilitating legislation. This coincides with a legal perception that, notwithstanding pure economic theory (which tends to treat monopsony and monopoly as two sides of the same anticompetitive coin), buyer power does not generally present the

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[200] LANCE B. ROBINSON ET AL., 2018 STATE OF COST TRANSFORMATION IN U.S. HOSPITALS AND HEALTH SYSTEMS: TIME FOR BIG STEPS 26 (2018).

[201] Clark C. Havighurst, *Antitrust Issues in the Joint Purchasing of Health Care*, 1995 UTAH L. REV. 409 (1995); Frances Miller, *Health Insurance Purchasing Alliances: Monopsony Threat or Procompetitive Rx for Health Sector Ills?*, 79 CORNELL L. REV. 1546 (1994).

[202] Havighurst, *supra* note 201, at 412.

[203] *Id.* at 413.

[204] *Id.* at 424.

same risks to consumer welfare as does seller domination.[205]

Havighurst's article suggests several questions relevant to a court's or regulator's inquiry, each of which he suggests can be answered with facts favoring permissive treatment.[206]

Would the exercise of monopsony power exploit providers and extract "producer surplus" they rightfully earned? Havighurst argues that a case can be made that employers collectively purchasing health care "truly represent community interests, including the interests of consumers concerned about the quality and accessibility as well as the cost of health care,"[207] and would likely be viewed "sympathetically by antitrust enforcers, juries, and judges if they appeared to be acting as agents of their workers."[208]

Could the collective action achieve allocative efficiency, that is, reduce prices without unduly reducing output? Havighurst notes that:

> [T]he policy objections to the exercise of monopsony power are somewhat weaker in the case of health services than in other markets. Indeed, it cannot be assumed that any output reductions resulting from health care purchaser collaboration would represent a loss of efficiency in resource allocation…As it currently operates, the market for health coverage is widely suspected of causing an overcommitment of resources to health care uses. . . . Purchasers may therefore actually desire to reduce supply and to discourage of new investment."[209]

With regard to private antitrust enforcement, would aggrieved providers be able to prove an "antitrust injury"? "[It] might be argued that health care providers challenging joint purchasing of health services have suffered no antitrust injury because they are seeking only to restore the uncompetitive conditions that generally prevail with respect to price and utilization in markets for insured fee-for-service health care."[210]

The Havighurst article lays out a sort of road map for organizing and justifying a collective action project to make it more likely to survive legal challenges:

- Avoiding a naked agreement to fix prices.[211]
- Preserving employer and patient choice. Havighurst notes the approval given by the U.S. Department of Justice Antitrust

[205] Miller, *supra* note 201, at 1551.
[206] Havighurst, *supra* note 201.
[207] *Id.* at 446.
[208] *Id.* at 420.
[209] *Id.* at 422-23.
[210] *Id.* at 418.
[211] *Id.* at 425.

> Division to a joint purchasing proposal by the Bay Area Business Group on Health. The employers, rather than "promis[ing] providers exclusive access to its members' employees as a reward for agreeing to the group's terms…left each employer free to choose the specific HMOs (among thirty-five with which the coalition proposed to negotiate) that it would offer its employees at coalition-negotiated prices...In addition, the group would not boycott HMOs that refused to negotiate or did not come to terms."[212]

- Retaining point-of-service options, such as "a preferred-provider strategy to ensure consumer choice would not be limited unnecessarily," permitting employees to pay extra for higher-priced providers.[213]

- Asserting a "market-failure remedy" defense that "efficiencies outweigh modest anticompetitive effects."[214] The project could claim "that the restraint was well calculated to overcome a demonstrable market failure not readily correctable by other (including legislative) means. While such a market 'failure' defense has no real support in case law, courts have never declared all naked restraints to be illegal per se. If in fact the law permits some purposeful interferences with competition, the question arises: which ones? It is at least arguable that a restraint should be allowed if it could reasonably be expected to produce results actually closer to the efficient result that the market would yield if it functioned smoothly, unimpaired by market failure."[215]

2. A Concept for Bringing Reference Pricing to Scale in a High-Cost Market: The Local Healthcare Market Payment Advisory Commission

I introduce here a concept that could operationalize the Havighurst prescriptions: a Local Healthcare Market Payment Advisory Commission. Like the Medicare Payment Advisory Commission, it would bring data-driven economic analysis to bear in recommending prices that lower payor costs while remaining adequate to ensure access to care. Like the community health planning model that is used in Rochester, NY,[216] it would be a cooperative, multi-stakeholder, civil-society venture. It could have greater legitimacy in the public's mind than efforts by individual, powerful payors

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[212] *Id.* at 440.
[213] *Id.* at 441.
[214] *Id.* at 436-37.
[215] *Id.* at 445.
[216] Jackson Williams, *Non-governmental health planning: Is the Rochester approach an alternative to regulatory certificate of need?*, 3 HEALTH POL'Y TECH. 185, 191 (2014).

and avoid the perception that it is choosing arbitrary benchmarks.

Because the commission (hereinafter, LoHMPAC) would have the charge of ensuring payment adequacy, it would meet the antitrust law's mandate that a monopsony not result in output reductions that reduce access. Like the Rochester model, it would not involve naked restraints or an agreement to fix prices,[217] but it would be expected that payors will individually implement its recommendations.

A LoHMPAC would have access to information on prices that prevail in other localities and would therefore have some empirical guidance into the parameters of price adequacy. Suppose for instance that a LoHMPAC is convened in a community like Denver, where prevailing prices overall are, according to Health Care Cost Institute (HCCI), three percent above the national average.[218] HCCI's Healthy Marketplace Index compendium indicates that, at the extreme, in Baltimore, prices are thirty-three percent below the national average.[219] The LoHMPAC could set a target based upon Baltimore or any other metropolitan area with prices below average, adjusting for geographic differences in input costs (such as wages). A LoHMPAC would also have access to cost reports that hospitals submit to Medicare. The panel could also request additional data from providers, though, as a private-sector body, it would be in no position to demand it.

Like MedPAC, a LoHMPAC could have full-time professional staff reporting to its voluntary governing body, or it could retain consultants. Economists would conduct data analysis and make recommendations to volunteer panel members. They would present their analysis and document any trade-offs required by lower prices, have to certify no likely material reduction in output at the recommended prices, and be available to testify in an antitrust lawsuit. The governing body could hold hearings and give providers the opportunity to present evidence justifying their current prices. It may be wise from a legal standpoint to structure the governing body so that its members do not represent more than thirty-five percent of purchasing power in the community. However, because reference prices do not imply a refusal to deal with sellers, only an assertion that the balance between the RBP and charges must be collected from the patient, the arrangement should pass legal muster. Reference prices set by a commission would still face the obstacles confronting RBP by an individual payor, most notably the threat of balance billing. But the groundwork laid by a commission in recommending an appropriate price could be recapitulated by the commission's staff or

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[217] *Id.*

[218] *Healthy Marketplace Index*, HEALTH CARE COST INST., https://www.healthcostinstitute.org/research/hmi (last visited Nov. 16, 2019) (select "Discovery Health Care Prices and Use In your Area >>", scroll down new page, select drop-down "How does your area stack up?", select "Your Area", then Select "Denver-Aurora-Lakewood").

[219] *Id.*

consultant in defense of a balance billing lawsuit.

Imagine that the commission's review of data concludes that prevailing prices of 400 percent of Medicare are due to provider concentration and market power, and that an efficient hospital could function well while receiving 200 percent. An enrollee is admitted to the hospital in an emergency, without signing papers agreeing to pay the charges in full. A participating provider tenders 200 percent, and the hospital brings suit against the enrollee for the balance. A coalition of payors could arrange to defend the suit as a test case, and call commission personnel to testify. The defense could present a virtual antitrust case in miniature against the hospital without having to prove all elements; as a plaintiff, the hospital would have the burden of proving the balance due. Clearly, the commission could give payors an advantage they don't have in a pure, unilateral RBP scenario.

A LoHMPAC would be most effective if convened to settle an antitrust lawsuit by consumers or payors (or government officials) against providers. Like a Certificate of Public Advantage remedy, it would have the power of a court or regulator behind it. Hiring staff or consultants for a LoHMPAC would put at payors' or state attorney generals' disposal experts who could help prepare, and testify in, proactive antitrust litigation.

C. Reference Pricing and Insurance

Efforts to impose reference pricing on providers are complicated by the bifurcated nature of health insurance. Self-insured employer health plans are regulated under ERISA which, as noted earlier, does not have network adequacy requirements. Fully insured plans are regulated by states, and in the case of Qualified Health Plans[220] in the ACA's individual market, by the federal government. State laws and the ACA impose network adequacy requirements. Under the ACA, individual market QHPs are explicitly structured as network-based products, that is, the consumer is purchasing access to healthcare within a PPO or HMO network, and there is no provision for indemnity-style insurance.[221]

The upshot is that under current law governing insurance, there is limited latitude for reference pricing to supplant network contracting with providers. Changes in state and federal law could permit reference prices to further spread within the fully insured market, but without such revisions, some providers would have the option of shifting costs onto insurer-payors.

If unified employers were to impose reference pricing on providers, one presumes that their intent would be for that pressure to lower providers' overall costs and for lower prices to spill over into fully insured products. But because of network adequacy laws, insurers would still have to come to

[220] 42 U.S.C. § 18021 (2010).
[221] 42 U.S.C. § 18003 (2010).

terms with providers on prices, permitting providers to mount resistance and pass on costs to insurers and, ultimately, on to the federal government.

This scenario would be most likely to occur in markets where a single hospital or health system predominates. A dominant provider would have two options other than capitulation on reference pricing (option one being to balance bill members of ERISA plans). The cost-shifting option would be to demand higher prices from insurers. This in turn would increase health insurance premiums. The reaction of employers might be to drop out of the small-group market. Some might be able to self-insure or join Association Health Plans to take advantage of RBP, but others might leave their employees to the ACA individual market. In the ACA market, the majority of consumers have been subsidized and are held harmless for premium increases; instead, the government absorbs the higher prices.

While structural and legal factors favor the provider in this scenario, public relations and political factors might not. A provider refusing to accede to pressure would face a backlash from middle- and upper-class consumers ineligible for subsidies. Not-for-profit hospitals, whose tax exemptions always place them in a somewhat adversarial position with local governments and state revenue departments, would be vulnerable to complaints addressed to those entities arguing that the provider is deviating from its not-for-profit mission. Further, a drop in insurance enrollment could result in a hospital providing more uncompensated care.

The dynamics would be somewhat different in markets with multiple providers. An insurer could contract with a narrow network yet permit enrollees to use other providers, as a point-of-service option, at the reference price. For non-network providers, this arrangement would resemble a unilateral contract offering by the insurer that providers could accept on either a blanket or ad-hoc basis if they decided, after rejecting a network contract offer, to undercut their in-network competitor to win back volume. Such providers could advertise to enrollees their willingness to provide services and accept the reference price as payment in full.

D. Reference Pricing's Incompatibility With Payment Reforms

In recent years, public and private payors, including employers, have been implementing alternative payment models (APMs). In APMs, providers, or groups of providers, assume responsibility for the total costs of care for a population (as in an accountable care organization, or ACO) or for an episode of care (called a bundled payment).[222] These arrangements presuppose a significant level of cooperation and trust between provider and payor. They involve a commitment by the payor to direct all, or much, of their health care expenditures to the provider group in exchange for that group's willingness

[222] Jackson Williams, *The CMS Innovation Center's Expansion Authority and the Logic of Payment Reform Through Rulemaking*, 40 J. HEALTH HUM. SERVS. ADMIN. 3, 6-7 (2017).

to take on risk. They require a joint dedication to move away from the paradigm of fee-for-service billing that is lucrative for providers and broad access to providers that many, if not most, American workers have come to expect from their employer health plans. Under APMs, savings in health care costs arise from reduced utilization.

Imposition of reference pricing upon providers would surely undermine the spirit of cooperation necessary to implement APMs. A decision to pursue RBP almost certainly implies a decision to continue fee-for-service medicine. In turn that implies some ability of providers to generate more procedures and patient encounters to replace lost income, meaning that RBP may also require managed care techniques such as prior authorization and utilization review that both providers and patients can find onerous. A decision to pursue RBP presumes a determination that prices, not utilization, are the culprit in high health care costs (a determination that would square with the opinion of most health care experts)[223] and that cooperative efforts to reduce utilization can be sacrificed.

CONCLUSION

To pursue RBP means accepting trade-offs and risking unintended consequences; the potential for impasses impacting patient access is only the tip of the iceberg. But RBP is also a way that employers can send a strong message that business-as-usual will not be tolerated and perhaps begin a movement toward lower health care costs. Private sector initiatives in this area, by shaking up the status quo, could force the hand of policymakers and stakeholders in addressing high costs. In the author's view, it is certainly worth experimenting with collective payor action to lower prices in appropriate high-cost localities.

"Why wouldn't everyone do it?" Clearly, the appetite for RBP is weaker than one might have expected. In Montana, county and municipal employee health plans have imposed the same terms on hospitals that the state Health Care and Benefits Division did, but other payers and third party administrators have not, despite the fact that hospitals seemingly revealed a willingness to accept those rates.[224] A 1992 *Wall Street Journal* article reported that the Memphis Business Group on Health planned to evolve its group purchasing cooperative to encompass the establishment of "its own 'fair and reasonable' price schedule,"[225] but this appears not to have come to pass. Harvard researchers who interviewed a dozen benefit executives for large employers reported "Four key themes characterized employer

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[223] HEALTH CARE COST INST., 2017 HEALTH CARE COST AND UTILIZATION REPORT 3 (2019).
[224] *Montana House Bill 747 (Adjourned Sine Die)*, LEGISCAN, https://legiscan.com/MT/bill/HB747/2019 (last visited Nov. 14, 2019); *See* H.B. 747, 66th Leg., Reg. Sess. (Mont. 2019) (detailing H.B 747); Bartlett, *supra* note 193.
[225] Ron Winslow, *Strong Medicine: How Local Businesses Got Together to Cut Memphis Health Costs,* WALL ST. J., Feb. 4, 1992, at A1.

perspectives on adoption of RBP: (1) Although cognizant of its potential, very few employers have implemented RBP; (2) There are concerns about the complexity of RBP, employee risk of catastrophic out-of-pocket costs, and need for significant communication and decision support; (3) The business case for RBP is not compelling; and (4) Adoption of RBP may hinder retention of and competition for workers."[226] Note that the informants expressed these sentiments with regard to the more conservative CalPERS model, not the expansive, riskier Montana model.

Some state insurance commissioners have expressed curiosity about the applicability of reference pricing to plans under their jurisdiction. Regulators should tread carefully in carving out exceptions to network adequacy requirements since doing so risks impasses, confusing consumers with unfamiliar plan designs, and gaming by providers. However, state regulators should consider participating alongside employers in coordinated localized demonstration projects.

[226] Anna D. Sinaiko et al., *Why Aren't More Employers Implementing Reference-Based Pricing Benefit Design?,* 25 AM. J. MANAGED CARE 85, 86 (2019).