Annals of Health Law and Life Sciences

Volume 32
Issue 2 *Summer 2023*

Article 1

Summer 2023

Table of Contents

Annals of Health Law and Life Sciences

ANNALS OF HEALTH LAW AND LIFE SCIENCES

THE HEALTH POLICY AND LAW REVIEW OF
LOYOLA UNIVERSITY CHICAGO SCHOOL OF LAW

Beazley Institute for Health Law and Policy

VOLUME 32, ISSUE 2 SUMMER 2023

CONTENTS

This article expands upon past research by showing how ERISA hinders existing state efforts to reform the health care delivery system through multi-payor alignment initiatives (MPAIs). To address challenges, states are seeking to harmonize the payment rules adopted by a state's payors. Specifically, state-led MPAIs involve collaborations among public and private payors with the goal of reducing variation among their payment approaches, and, ultimately, lowering the administrative and financial barriers that deter providers from participating in alternative payment models. While participation in most state-led MPAIs is voluntary, some states mandate that all private plans participate in order to ensure state-wide payment standardization. However, these participation mandates cannot reach one key group of payors – self-insured employers.

ERISA exempts from state insurance regulations self-insured employer plans, where employers pay for all or a portion of their employees' health expenses from an employer fund rather than purchasing insurance policies from a commercial insurer. States therefore cannot mandate the sixty percent of employer plans that are self-insured participate in state-led MPAIs. This means a significant segment of payors are free to disregard a state's efforts to harmonize payment approaches across payors. ERISA thereby diminishes states' ability to promote health care delivery reform that improves the health of a state's citizens, lowers health care spending, and reduces health disparities. In doing so, ERISA stymies states' fundamentally important role as laboratories of health reform. This article therefore calls on Congress to amend ERISA and exempt from ERISA preemption state-led MPAIs.

In this paper, the authors consider an important strategy for containing hospital charges—limits on charges for out-of-network care. Ordinarily, a non-contracting hospital can charge patients its out-of-network rates, so its willingness to reduce its in-network rates for an insurer diminishes as its out-of-network rates rise. If the government places limits on what a hospital can charge for out-of-network patients, then the government reduces the hospital's leverage when negotiating in-network rates. This paper discusses an alternative approach to government directly limiting out-of-network charges through legislation—application of common law contract principles for deciding a price when the contract itself leaves the price unspecified. This article proposes implementation via an official opinion of a state's attorney general.

Since January 2022, the authors have been working with state officials in Nevada to elicit an official opinion by the attorney general. In Nevada, requests for official attorney general opinions must come from the executive branch, so the authors are collaborating with the Nevada Department of Health and Human Services (DHHS) to draft a request. Nevada DHHS staff have analyzed hospital charge data and documented the extent to which hospitals bill out-of-network patients well above their in-network rates. Accordingly, DHHS can demonstrate the need for an attorney general opinion on the obligation of hospitals to bring their out-of-network rates in line with contract law principles. In this article, the authors discuss (1) the theory of containing hospital costs via limits on out-of-network charges, (2) using contract law principles to limit out-of-network charges, and (3) their Nevada case study.