

ARTICLES

Mastering the Chargemaster: Minimizing Price-Gouging and Exposing the Structural Flaws in the Healthcare "Market"

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INTRODUCTION

In his seminal article, *Bitter Pill: Why Medical Bills Are Killing Us*,¹ Steven Brill recounts stories of Americans of modest to comfortable means, whose lives were turned upside-down, not just by tragic illness; but, by the cost of the cure. Sean and Stephanie Recchi, owners of a small start-up technology firm, discovered that his policy's \$2,000/day cap did not come close to defraying six days in the hospital to develop a treatment plan (\$48,900) and the initial doses of chemotherapy (\$35,000) for his non-Hodgkin's lymphoma treatment.² Feeling chest pains, Janice, a sixty-four (64)-year-old unemployed and uninsured woman, endured a four-mile ambulance trip, three hours of tests, and "some brief encounters with a

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¹ Steven Brill, *Bitter Pill: Why Medical Bills Are Killing Us*, TIME, Feb. 22, 2013, at 17-55.

² *Id.* at 18.

doctor," to learn she had indigestion.³ The \$21,000 bill⁴ could have caused a recurrence of the indigestion or, even, the feared heart attack.⁵ Plagued by back problems, Steve, a thirty-something blue-collar worker, required a neurostimulator to be surgically implanted in his back. Sanguine that a day of the requisite outpatient care could not exceed the \$45,000 remaining of his insurance benefits, he was sadly disabused of the illusion when he received a bill of \$86,951.⁶

Brill goes on to document multiple tales of patients' undergoing a variety of procedures, some routine, some not so routine.⁷ Despite the technical variety of their procedures, the suffering patients display striking similarities in their financial experience: First, the "unbundled"⁸ hospital charges for supplies were dramatically higher than what the patient would pay if he/she had purchased them at a local drugstore, even though the patient could hardly marshal the hospital's purchasing power. Second, patients are often double and triple-charged for items used in their care. Third, the price charged the patient for supplies and services was driven by the healthcare provider's "chargemaster," the hospital's "internal price list,"⁹ which appears to have no connection to the realities of cost accounting. Fourth, not every patient pays the chargemaster rates. Indeed, most do not.¹⁰

³ *Id.* at 22.

⁴ *Id.*

⁵ *Id.*

⁶ *Id.* at 32–34.

⁷ *Id. passim.*

⁸ *Id.* at 18.

⁹ *Id.* at 22.

¹⁰ *Id.* at 23.

This paper, however, will focus on the approximately 43 million persons who *are* or *will be* charged the chargemaster price.¹¹ They are distinguished by their having no health insurance coverage or limited coverage. In either case, they have no public or private carrier to negotiate a lower "price" for their medical care. Only they are held to the Disneyland price structure of the chargemaster, a price structure that is increasingly invoked to explain our spiraling healthcare costs.¹² Because they lack any institutional muscle to deal with healthcare providers, these individuals face horrific decisions of life, death, and poverty for themselves and their families.

Focusing on this relatively large group of patients will underline both the larger market failures in healthcare and their potential solution. Because this population is uniquely and disastrously affected by those market failures, addressing their concerns first serves both the demands of education and the demands of justice. We conclude that multiple failures in the healthcare market make it irresponsible to rely on market mechanisms to allocate healthcare resources. Reliance on price to clear the market fails miserably because only this vulnerable population is even remotely price-sensitive. Instead, we propose to limit that population's healthcare costs to the price allowed by Medicare. In doing so, the grossest excesses found in the system are curbed, without reducing the incentives for that population to seek the healthcare insurance that is more broadly available under the Patient

¹¹ In its most recent report, the U.S. Census Bureau states that approximately 48 million individuals reported being without healthcare coverage for all or part of 2012. The number is statistically unchanged from 2011. CARMEN DENAVAS-WALT ET AL., INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2012, U.S. DEPT. OF COMMERCE (Sept. 2013). On March 11, 2014, CNN reported that 4.2 million individuals had signed up for healthcare coverage through the ACA. CNN further reported that it was uncertain that enrollment would reach the CBO projected number of 6 million by March 31, 2013. The number of individuals still not covered by the ACA would approximate 42 to 44 million.

¹² *E.g.*, Hamilton Moses III et al., *The Anatomy of Health Care in the United States*, 301 JAMA 1947, 1949 (Nov. 13, 2013), available at <http://jama.jamanetwork.com/article.aspx?articleid=1769890>.

Protection and Affordable Care Act ("ACA").¹³ The proposed remedy has the added feature of testing a promising method to control the country's still rising healthcare costs. By comparison to other institutional players (namely, insurance companies), Medicare and Medicaid have been remarkably successful at reducing most healthcare costs.¹⁴ Applying their systems and methods to the vulnerable population would provide a useful laboratory for testing how we can constrain healthcare costs.

I. PATIENTS CAUGHT IN THE COST TRAP

Blessed with an embarrassment of riches, Brill unpacks the charges found in bill after patient bill. Just one example will highlight the looking glass quality of the "market." Returning to Steve Recchi's eight (8)-page invoice, Brill details how each product and service enjoyed a 400 to 1500% markup from their retail prices. Paradigmatically, a generic acetaminophen tablet (325 mg), currently priced on Amazon at 2.59 cents,¹⁵ cost Recchi, \$1.50.¹⁶ In truth, you can't buy a single tablet on line. You must have the buying power sufficient to purchase in bulk; namely, a bottle of 1,000 tablets, which costs \$19.12, or less than 2 cents per tablet.¹⁷ Apparently, the hospital could not avail itself of the volume discounts that Recchi enjoys at Amazon. Recchi's experience is hardly unique.¹⁸

¹³ Patient Protection and Affordable Care Act, Pub. Law No. 111-148 124 Stat. 11 (2010) (codified as amended in sections of 42 U.S.C. and 26 U.S.C.).

¹⁴ Brill, *supra* note 1, at 43, 46–47.

¹⁵ A 100-pill bottle costs \$2.59. Brill reports that he could purchase a 100-pill bottle for \$1.49 on Amazon.com. Brill, *supra* note 1, at 18.

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ A billing advocate for another patient, Scott S., determined that Texas Southwestern Medical had triple-billed him for portions of his ICU treatment:

The hospital's chargemaster, its ultimate billing source, appears to bear little, if any, relation, to the hospital's actual cost structure; rather, it appears to be simply an assessment of what the market will bear, like a "hypersteroidal rack rate."¹⁹ Brill describes the document as an embarrassment to hospital officials, who "treat it as if it were an eccentric uncle living in the attic."²⁰ Nevertheless, with one important exception, it drives price for most healthcare consumers. That one exception is the government healthcare programs. Because of their market power and extensive cost databases, Medicare²¹ and Medicaid,²² pay only a tiny fraction of the chargemaster rate. In fact, the government does not even use the chargemaster as a guide, relying instead on its own assessment of the provider's cost structure. Large insurers, having less leverage than the government, pay a significantly higher price, usually discounted from the chargemaster rates. Smaller insurers, with still less leverage, enjoy smaller discounts off the chargemaster list. Individual patients, not covered by insurance, Medicare, or Medicaid receive the "special" chargemaster price. Incredibly, only those least able to pay, those without insurance or a

First they charge more than \$2,000 a day for the ICU, because it's an ICU and has all this special equipment and personnel. . . . Then they charge \$1,000 for some kit used in the ICU to give someone a transfusion or oxygen. . . . And then they charge \$50 or \$100 for each tool or bandage or whatever that there is in the kit. That's triple billing.

Brill, *supra* note 1, at 17.

¹⁹ Tina Rosenberg, *The Cure for the \$1000 Toothbrush*, N.Y. TIMES, Aug. 13, 2013, at 4, available at <http://opinionator.blogs.nytimes.com/2013/08/13/the-cure-for-the-1000-toothbrush/>.

²⁰ Brill, *supra* note 1, at 22.

²¹ Rosenberg, *supra* note 19, at 4; Brill, *supra* note 1, at 43, 46–49.

²² Brill, *supra* note 1, at 46–49.

government-sponsored program, are singled-out to pay the exorbitant chargemaster rates.²³

If cost structure does not explain the hospital's price list, what does? One might expect healthcare competitors to be the key driver. Again, however, analysis leads only to mystification. Recently, the federal government has released the amounts hospitals charge for various procedures.²⁴ A joint replacement in Ada, Oklahoma, will cost \$5300; in Monterey Park, California, \$223,000. However lovely it is in Monterey Park, it is unlikely that the hospital's cost structure would be 42 times greater than it would be in Ada, Oklahoma. One might, nevertheless, be seduced by the notion that the two hospitals are simply in different markets. Being in the same geographic market does not, however, rationalize price. The same study reports that, in New York City, the charge for treating a blood clot on a lung can range from \$29,869 to \$51,580.²⁵ Admittedly, the range is dramatically less than the national range for joint replacement. However, it is still much greater than one expects in a truly competitive market. The seeming irrationality is not even readily explained by hospital's willingness to charge what the "market" will bear. "At Suburban Hospital in Bethesda, Maryland—serving an affluent community at the gates of the National Institutes of Health—the average charge for simple pneumonia was \$5,284. Compare that to \$79,365 at Hahnemann University Hospital in Philadelphia." A quick look at some of the comparable data²⁶ suggests that the much more affluent zip code of the Bethesda, Maryland, hospital is getting an incomprehensible deal:

²³ *Id.* at 22.

²⁴ Connie Cass & Luran Neergaard, *High hospital bills go public, but will it help*, SEATTLE TIMES, May 8, 2013, available at http://seattletimes.com/html/health/2020944456_apushospitalcostsdisparity.html.

²⁵ *Id.*

²⁶ CITY-DATA.COM, <http://www.city-data.com/zips> (last visited May 3, 2014) (for the zip codes of both hospitals).

IRS Category from 2004 (most recent available)	Bethesda, MD 20814	Philadelphia, PA 19102
Avg. Adjusted Gross Income	123,634	72,894
Avg. Taxable Dividends	9,064	6,217
Avg. Net Capital Gains	33,934	12,466
Avg. Self-Employment Pension	22,529	14,680

Most of our 2010 healthcare debate revolved around *who* would pay for what kinds of care. Only at the margins did we begin to address the problem of *how much* we should pay for the care we receive.²⁷ Studies show that our national healthcare costs are dramatically higher than all other countries and our results are just as dramatically uneven.²⁸ For significant populations within the country, access to healthcare is more limited than it is for populations in some developing countries.²⁹ Evening out access to healthcare is directly related to the extraordinary costs of that care. If nothing is done about cost, the 48 million individuals who have become eligible for healthcare under the ACA promise to severely strain national resources.³⁰ However salutary it may be to assure (almost) universal access to healthcare, containing costs remains an unaddressed and potentially crippling reality. Remarkably, it has yet to be addressed.

Analytically, controlling costs is pretty straightforward. "Cost" has only two components: price and quantity (Cost = price x quantity). In our current system, most of our feeble cost containment efforts have focused on

²⁷ See Brill, *supra* note 1, at 20.

²⁸ See, e.g., *id.* at 18; Elisabeth Rosenthal, *American Way of Birth, Costliest in the World*, N.Y. TIMES, June 30, 2013, available at <http://www.nytimes.com/2013/07/01/health/american-way-of-birth-costliest-in-the-world.html>.

²⁹ Tina Rosenberg, *Revealing a Healthcare Secret: The Price*, N.Y. TIMES, July 31, 2013, available at <http://opinionator.blogs.nytimes.com/2013/07/31/a-new-health-care-approach-dont-hide-the-price/> (citing Brill, *supra* note 1).

³⁰ Rosenberg, *supra* note 19.

controlling the quantity of medical resources consumed. Typically, insured patients are limited to acquiring prescriptions or healthcare services for only limited periods of time: an annual check-up, enough prescription medicine to last 30 days. Routine exams and tests similarly must meet some periodic limitation. Indeed, one can even view the "copay" as a quantity constraint, a disincentive to use medical services. Obviously, for the uninsured, both price and quantity do matter. For reasons discussed below, and alluded to above, they cannot do much about price. Many try to self-limit quantity, with potentially devastating consequences when the malady, easily addressed in its early stages, becomes expensive (and possibly untreatable) in its late stages.

Controlling quantity, however, has clearly not worked. While Brill reports of some incidents where patients appeared to "over-consume" medical resources,³¹ that particular problem appears marginal. Most people do not find their lives so empty and lonely that they look forward to having it filled up with medical attention. Just living precludes that "luxury." Similarly, few of us are tempted by an inordinate desire to over-consume ordinary prescription drugs for diabetes, high blood pressure, cholesterol and other common maladies. They just don't taste that good; nor, do they promise much recreational value, prescription narcotics excepted.

II. PRICE IS THE PROBLEM AND A SYMPTOM OF A DEEPER PROBLEM

Brill is hardly alone in concluding that prices for medical resources are out of control.³² Healthcare providers charge prices that would prod Alan

³¹ Brill, *supra* note 1, at 49.

³² See e.g., *That CT scan costs how much?*, CONSUMER REPORTS (July 2012), <http://www.consumerreports.org/cro/magazine/2012/07/that-ct-scan-costs-how-much/index.htm>, *passim*; Matthew Yglesias, *America's Overpaid Doctors*, SLATE (Feb. 25, 2013), *passim*, http://www.slate.com/articles/business/moneybox/2013/02/american_doctors_are_overpaid_medicare_is_cheaper_than_private_insurance.html; Ezra Klein, *High health-care costs: It's all in the pricing*, WASH. POST, Mar. 2, 2012, *passim*, http://www.washingtonpost.com/business/high-health-care-costs-its-all-in-the-pricing/2012/02/28/gIQAtbhimR_story.html; David Belk, *The True Cost of*

Greenspan to mutter anew about "irrational exuberance." The singularly high cost of healthcare in this country is not attributable to the quantity of healthcare products and services consumed. All evidence supports the proposition that the high cost of healthcare is driven by the price of healthcare. High prices and wild price variance³³ reflect some profound failures in the healthcare market. That prices vary so much within the same market testifies to the absence of expected market restraints, as will be discussed below.³⁴ The existence of (comparatively) low-price options only underscores the seeming irrationality. Yet, there remains a fundamental rationality to the exuberance. Providers charge those prices because they can. Some may just be more giddy (greedy?) than others. Moreover, providers can charge whatever they want, because every other player in the system (except one, the federal government) does not have to care about the price. While most patient-buyers cannot shop around, the uninsured patient is even more restricted to simply taking the random price demanded by the provider. As will also be discussed more directly below,³⁵ the inability to control price is rooted in major (and irremediable) market failures.

In an article written over fifty years ago, Kenneth Arrow³⁶ pointed out how ill-suited are patient/consumers to be the leading spear for price control. They are (by definition) sick, unschooled in the subject matter (which is why they have turned to a professional), unschooled in the risks they confront (just by being human), uncertain whether any particular protocol will be successful, scared, and wholly ignorant of price. Rare is the patient who receives an array of possible remedies, each with an identified probability of success and an actual price. Indeed, it would be almost boorish to discuss cost

Healthcare: A view of Healthcare Costs from the Inside, passim, <http://www.truecostofhealthcare.org> (last visited July 2, 2014).

³³ Klein, *supra* note 32, at 4.

³⁴ See *infra* Section III.

³⁵ See *infra* Section III.

³⁶ Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 948–49 (1963).

in such a vitally personal matter.³⁷ As discussed below,³⁸ even the loutish patient who might ask will find little reliable (and useful) data applicable to his situation.

Patients have generally ceded price control responsibility to their insurance companies, who have only a limited concern to control price. Typically, patients worry (some) about their deductible, and (less) about their co-pay. They expect that their insurance company will pick up the rest of the tab. Ultimately, however, insurance companies have no dog (or only a very tiny dog) in the price fight. If, in any current year, insurance payouts compromise profit expectations, the resulting difference becomes the basis for raising premiums the following year. Any one year's loss can be made up the following year.³⁹ With the implementation of the ACA, the incentive structure doesn't really change. If anything, it removes any remaining incentive for insurance companies to care. So long as their allowed 20% margin (for administrative costs and profit) is protected, any further savings, via negotiated price reductions, will be returned to the rate payer. If claims eat into the 20%, they simply provide the basis for a higher premium the following year. Underscoring how perverse the incentive structure remains, 20% of a larger number (i.e., increased costs) will only generate a larger revenue stream and, presumably, even greater profit in the following year.

One might look to the individual physician, who generally orders the care via prescription or referral, to serve as the bulwark against excessive prices. For a variety of reasons, some benign, some malignant, that hope is similarly misplaced. Even though physicians bill patients for services, the social norms preclude their acting simply as self-interested business owners. The norms themselves are unsurprising, given the fiduciary character of the relationship. The patient goes to a physician to get both a diagnosis and a treatment. Virtually ignorant of the elements of either prong of the consultation, the patient must rely on the physician's expertise and integrity.

³⁷ *Id.* at 964–66.

³⁸ *Infra* notes 40–45 and accompanying text.

³⁹ Rosenberg, *supra* note 19, at 2.

For that reason, physicians are typically forbidden (or discouraged) from advertising or engaging in overt price competition.⁴⁰ Their medical advice must be devoid of self-interest.⁴¹ Treatment prescriptions are presumed driven by case requirements and ought not to be limited by financial considerations. These long-standing norms reinforce a level of physician-patient trust that makes discussions of price almost unseemly and, not surprisingly, give birth to acts of individual medical charity for the indigent and the related price-discrimination among affluent patients.⁴²

Other factors also limit the physician's role in cutting costs. Not surprisingly, physicians want to have available as broad an array of remedies for their patients' ailments as is possible.⁴³ Considering cost limits that array. Consistent with a disdain for and/or discomfort with money being interjected into considerations of care, physicians, not unlike their patients, are often wholly ignorant of the price of their various healthcare remedies.⁴⁴ Indeed, they may be as ignorant of costs as are their patients. One physician, David Belk, MD, chronicling his own epiphany, captures the problem of physician ignorance in his opening statement on why medical costs are so high.

Why didn't we know [why medical costs were so high]?
To start with, unlike any other business in America,
almost all of the financial transactions in healthcare are
hidden from the providers as well as the patients. We
order test, procedures and medications to manage our
patients, but very few doctors, or other healthcare
providers, have any idea how much any of those things
cost. Patients only rarely pay directly for these services
and payment for any service varies substantially from
different payers. Hospitals have separate billing

⁴⁰ Arrow, *supra* note 36, at 949.

⁴¹ *Id.*

⁴² *Id.* at 953.

⁴³ Belk, *supra* note 32, at 4.

⁴⁴ *Id.*

departments that are far removed from anyone ordering or performing tests or procedures. No one directly involved with patient care has any notion of the charge or reimbursement for their service. Even most private doctor's offices contract billing companies, who just send them a check each month from the total amount collected, leaving them no notion of the actual charge or reimbursement for an individual service they provided.⁴⁵

In summary, none of the principal sources of consumption—neither the patients, their families, nor their immediate healthcare providers (their own physicians)—are in a position even to know what the costs are of a procedure, let alone control those costs. The insurance company is in a slightly more advantaged position, having likely negotiated prices for specific procedures, as well as prescriptions and equipment. That, however, is not the same as knowing the *cost* of the procedure. Indeed, for most insurance companies, the price is simply a "discounted" chargemaster price.⁴⁶ However, if, as is usually the case, the chargemaster is a multiple of 10–15 times the provider's actual cost,⁴⁷ a "whopping" 50% discount is something less than a negotiating coup. The healthcare system is like a rigged game of poker,⁴⁸ where the patient, especially if not insured through either his employer or the government, is the ultimate patsy.

Notwithstanding these obvious flaws in the system, there are still many who advocate that the real cure for healthcare is to allow the free competitive marketplace to work its magic.⁴⁹ This would assure resolution of both our

⁴⁵ *Id.*

⁴⁶ Brill, *supra* note 1, at 23

⁴⁷ See Rosenberg, *supra* note 19, at 4.

⁴⁸ Brill, *supra* note 1, at 54 (calling it "a crapshoot").

⁴⁹ See, e.g., Ron Paul, *Ron Paul: We Need Free-Market Healthcare, NOT Obamacare*, RONPAUL.COM (Mar. 22, 2010), <http://www.ronpaul.com/2010-03-22/we-need-free-market-healthcare-not-obamacare/>; Ron Paul, *Ron Paul on Free Markets, Regulation, Auditing the Fed & Healthcare*,

cost and access issues.⁵⁰ Prices would drop and quantity is unlikely to rise, given the low marginal utility of overconsumption.⁵¹ If prices drop and quantity remains stable, costs must also drop. However, as opponents of the ACA pointed out, the second element of the healthcare issue, access, dramatically affects the first element, costs. Quantity cannot remain stable if somewhere between 35 and 45 million citizens⁵² are to be provided healthcare under the enactment. Even after accounting for the efficiencies resulting from early diagnoses and treatment of potentially serious and expensive illnesses, filling the system with that many "new" consumers has to increase quantity and, ultimately, cost.

One suggested answer is simply to bar the door. It was captured succinctly in the 2012 Republican primary debates, when Rep. Ron Paul was asked whether society should pay for the emergency care of a young man in a coma who had chosen not to purchase insurance. To make the hypothetical work, one has to assume that the man now had no assets (money or insurance) to enable him to purchase the needed treatment. Paul was asked how he would address the dilemma of the uninsured comatose patient. The candidate stumbled⁵³ a bit, as he said that people make decisions and need to expect to live (presumably, no pun intended) with the consequences of those decisions. Obviously, in the non-hypothetical world, few adults "choose" to go without healthcare coverage, except when they cannot afford it. To extend Paul's comments to the broader societal question of indigent healthcare, Paul would be referring to the Everyman's "decisions" that had left him without

RONPAUL.COM (Nov. 6, 2009), <http://www.ronpaul.com/2009-11-06/ron-paul-on-free-markets-regulation-auditing-the-fed-and-healthcare/>.

⁵⁰ Grace-Marie Turner, *Toward Free-Market Healthcare*, THE HERITAGE FOUNDATION (May 4, 2007), available at <http://www.heritage.org/research/lecture/toward-free-market-health-care>.

⁵¹ See *supra* note 31 and accompanying text.

⁵² See *supra* note 11 and accompanying text.

⁵³ *Should society let the uninsured die?*, YOUTUBE (Aug. 28, 2013), <https://www.youtube.com/watch?v=8T9fk7NpgIU>.

assets and not his "decision" to have a heart attack. When Wolf Blitzer pressed him, would Paul "let him die?" a number of his (presumably) supporters shouted "Yes," to general applause from the audience.⁵⁴

However problematic are the ethics underlying such an ethos, the law has already addressed the policy issue. If the man did not have the resources, he would, depending on his age, be covered under either Medicare or Medicaid. Moreover, as a matter of federal law, no one may be turned away from a hospital simply for lack of funds.⁵⁵ Such a longstanding statutory expression of public policy, makes it unlikely that the Paul supporters could rally public support for their chilling view of public policy. As it stands now, the indigent and the elderly have affordable healthcare through the government, who successfully sets prices for healthcare services. The next large group of healthcare consumers is "protected," at least to some extent, by employer provided health insurance companies. A much smaller segment purchases its own insurance. Unlike the government "carriers," insurance companies are not as successful at controlling prices. While Medicare and Medicaid, armed with an incomparable database and genuine market power, can simply ignore the chargemaster, insurance companies exploit their more limited leverage to reduce the amount of chargemaster-based prices.⁵⁶ The most vulnerable population is the one group that is neither protected by the government nor by an insurance company. Only that group's members are caught up in a completely rigged "free" market.

III. THE MARKET IS THE PROBLEM; NOT THE SOLUTION

Given the political attractiveness for those who would "set the market free," it serves to recall some basic conditions for the existence of a competitive free market. The list is short:

⁵⁴ *Id.*

⁵⁵ Emergency Medical Treatment and Active Labor Act § 9121, 42 U.S.C. § 1395dd (1986).

⁵⁶ Brill, *supra* note 1, at 43–44, 46–49.

- A. There are numerous buyers and sellers, all of whom are "price-takers";
- B. There are no barriers to entry or exit;
- C. Every buyer and seller has full and perfect knowledge of the market, including the knowledge of what every other buyer and seller is doing, as well as knowledge of the price, quantity, and quality of the goods bought and sold in that market;
- D. The goods/services are fungible;
- E. There are no externalities;
- F. All buyers are utility-maximizers; and
- G. No external parties regulate price, quality, or quantity.⁵⁷

A. NUMEROUS BUYERS AND SELLERS AS PRICE-TAKERS

Clearly, the healthcare market fails on most or all of these component parts. Depending on how one looks at the "market," one can argue that there are numerous buyers and sellers; but, it cannot be said that all of the players are price-takers. Certainly, Medicare and Medicaid patients are protected by a price-maker. Depending on the financial strength of their respective carriers in the relevant local and national markets, privately insured patients enjoy a modest protection from healthcare providers by dint of their carriers' ability to negotiate some price concessions. While the uninsured, non-government protected patient-buyer is a price-taker, the same cannot be said of the correlative provider-seller. Whether it is a pharmacy, a private physician, or a hospital/medical institution, the provider alone (if then) sets the price. Moreover, as medical care providers, especially hospitals merge and

⁵⁷ These are pretty standard conditions to be found in just about any college economics text. See PAUL A. SAMUELSON & WILLIAM D. NORDHAUS, *ECONOMICS passim* (McGraw-Hill Irwin, 19th ed. 2010).

incorporate more private physicians into their networks, their market power increases. As that process accelerates, the market power of their primary foil, insurance companies, diminishes.⁵⁸ The effect of this consolidation is to reduce the number of providers, affording the remaining ones the leverage to more closely approximate their chagemaster wish list.

B. BARRIERS TO ENTRY AND EXIT

Depending on one's place in the market, there are multiple barriers to entry and exit. For the patient, death is the only "viable" exit strategy. While some health problems may be ignored for a while, few of them ever age well. Only those who suffer a quick and untimely death can actually exit the market. That, however, is a one-time only option. Nevertheless, even most in that select population entered the market upon entering life. By any definition, patients form a captive market. For providers, also, there are certainly barriers to entry. One of the most profound barriers is represented by the strict rationing of places in medical school, which constricts the number of physicians in the marketplace,⁵⁹ leading to a consequent oligopoly. With increasing consolidation of healthcare facilities, via mergers and acquisitions, the healthcare industry (at the institutional level) further raises the barriers to competitive entry, while reinforcing its oligopolistic (and even monopolistic) systems.⁶⁰

C. PERFECT INFORMATION

As virtually every writer has observed,⁶¹ buyers have almost no information about market conditions. For most patients, knowledge about

⁵⁸ Rosenberg, *supra* note 19, at 2, 3; Brill, *supra* note 1, at 40, 55.

⁵⁹ Arrow, *supra* note 36, at 952.

⁶⁰ See Brill, *supra* note 1, at 40.

⁶¹ *E.g.*, *id.* at 40, 54; Belk, *supra* note 32, at 4; Arrow, *supra* note 36, at 962 (noting that insurance removes even the incentive for the central players—physicians and patients—to price shop); Rosenthal, *supra* note 19, at 4.

price, quantity, and quality is virtually inaccessible. There is no price transparency whatsoever. Typically, patients are never advised of price until after the transaction has taken place.⁶² However, even if the patient were to be told in advance of the price of a procedure, it would not help much. More likely than not, the patient would be given the chargemaster rate, unadjusted for discounts negotiated by the patient's public or private carrier.⁶³ Even if such price information were available, it is unlikely that similar information would be available from competing providers that would make the information relevant to a decision. Finally, even if such information were available from both the expected provider and competitors, the typical patient has no means to evaluate the information and is often too stressed to evaluate it.⁶⁴ Alternatively, the patient is too ill, even unconscious, to engage in comparison shopping, whether of the on-line or on-foot variety. Finally, it may well be that the patient's physician probably only has privileges at one, or maybe two, institutions available for the procedure.⁶⁵

The problem of knowledge in and of the marketplace actually is even more acute. In the case of services, the physician may not have much knowledge about the comparative merits of the available institutional choices.⁶⁶ Moreover, he/she may have familiarity with or be restricted to practicing in only one of the available choices, creating an implicit conflict of interest between physician and patient. Further, the physician may well be as clueless about the cost-benefit analysis as is his/her patient.⁶⁷ Finally, most

⁶² Brill, *supra* note 1, *passim*.

⁶³ *E.g., id.* at 22.

⁶⁴ Arrow, *supra* note 36, at 949, 964–65.

⁶⁵ The rise of medical tourism, borne of high U.S. surgical costs, has created a cottage industry abroad. *See, e.g.,* Elisabeth Rosenthal, *The Growing Popularity of Having Surgery Overseas*, N.Y. TIMES, Aug. 5, 2013, available at <http://www.nytimes.com/2013/08/07/us/the-growing-popularity-of-having-surgery-overseas/>.

⁶⁶ *See* Belk, *supra* note 32, at 28.

⁶⁷ *Id.* at 28; Rosenberg, *supra* note 19, at 4.

institutional providers, as well as individual providers, cannot say what a procedure/remedy will cost, without first knowing the patient's specific insurance plan. Obviously, if there is no patient insurance, that complication is removed; but, at an enormously greater cost; that is, by ready reference to the chargemaster.⁶⁸ In many cases, the attending physician may be just as unaware of price and quality when it comes to prescriptions or medical equipment.⁶⁹ Moreover, even if the physician knows what the list price is for the goods, he/she would almost certainly not know what the carrier's particular discount is, or even if the patient is covered by insurance at all. Below, we discuss specifically how physicians compromise their judgment by holding a financial interest in the remedy prescribed—whether pharmaceuticals, devices, or equipment.⁷⁰

D. FUNGIBLE GOODS AND SERVICES

With regard to the fungible quality of healthcare goods and services, the results are mixed. With regards to services, it would appear that the softer qualities of the physician-patient relationship argue for lack of fungibility. Nevertheless, the entire medical industry has relied for decades on an elaborate encoding system for payments related to each medical procedure, a system which argues for greater fungibility.⁷¹ Both government and private carriers have embraced the coding system.⁷² One would expect that there be greater fungibility among healthcare goods such as prescriptions and medical equipment. On the surface, that is actually true. In practice, the situation is more complicated. For a variety of reasons, doctors prescribe different medications, medical equipment, and therapies. The variance can be attributed in part to physician awareness of a patient's unique health

⁶⁸ Brill, *supra* note 1, at 54

⁶⁹ Belk, *supra* note 32, at 4.

⁷⁰ *Infra* notes 73–76 and accompanying text.

⁷¹ Brill, *supra* note 1, at 48.

⁷² *Id.*

requirements, to physician familiarity and comfort with certain protocols (with attendant efficiencies), or just availability in a particular region.

More troubling, however, is the growing practice of physicians' receiving significant compensation from companies whose medical devices (e.g., joint replacements, heart "parts," such as defibrillators, valves, etc.) they adopt.⁷³ The compensation can take the form of "stock options, royalty agreements, consulting agreements, research grants, and fellowships."⁷⁴ Whatever the form, it raises serious conflict-of-interest issues that certainly could direct patient "choices" and even lead to over-prescription.⁷⁵ Rarely, however, would the patient even know the price of the prescribed equipment, how it compares to similar types of equipment, or the nature of his physician's financial interest in the "choice."⁷⁶ In any event, the argument for fungibility is seriously compromised.

E. NO EXTERNALITIES

The requirement that there be no externalities in a perfectly competitive market (or even a "tolerably" competitive market) may be the element least often found in healthcare. An externality is any cost or benefit from a transaction that is borne or enjoyed by a party who is not a participant in the transaction.⁷⁷ With the one possible exception that is the ultimate focus of this examination, virtually every provider-patient transaction involves third-parties, and consequent externalities. Patients receive treatment and, only rarely, pay for it (or for most of it). The federal government, with state support, pays for the treatment of the elderly and indigent patient. Similarly,

⁷³ *Id.* at 34.

⁷⁴ Brill, *supra* note 1, at 34.

⁷⁵ *Id.*; Robert Pear, *Doctors Who Profit From Radiation Prescribe It More Often*, N.Y. TIMES, Aug. 19, 2013, *passim*, available at <http://nytimes.com/us/doctors-who-profit-from-radiation-prescribe-it-more-often.html>.

⁷⁶ Pear, *supra* note 75, *passim*.

⁷⁷ *See, e.g.*, JEFFREY M. PERLOFF, MICROECONOMICS 603 (4th ed. 2007).

insurers guarantee (some) payment; but, do not receive treatment. Both the government and the private insurer are affected by cost. The government is accountable ultimately to tax payers. The insurance company is accountable to shareholders. Because of data and leverage, the government can positively (from its perspective) affect the cost of the transactions.⁷⁸ Insurance companies have less leverage; but, an obvious escape hatch. If they cannot match their costs stream with their premium stream, they can always raise premiums in the next year.⁷⁹ Unlike the government, which is loath to raise taxes, insurance companies can always raise their rates, forcing employers and the insured to absorb the price increases. Employers continue to pay for insurance; but, do not receive the treatment. For them, healthcare expenses are a source of worry and concern, without much of a lever to control either element of cost price or quantity.⁸⁰

That leaves only the providers and the patient. While some providers are as uninformed as are their patients,⁸¹ others are just happy to provide as much care at as high a cost as possible. Their motivation is uncomplicated in the extreme. Patients also fall into two, albeit different groups. Virtually all patients are ignorant of pending costs. Most insured patients, however, simply do not care what the cost is. After paying their deductible (and, usually, small co-pays), they know only that someone else will pick up their remaining tab.

What remains are those patients without either public or private insurance, or are insufficiently insured. Their experience of externalities is primarily negative. Unlike their insured counterparts, they care intensely about cost. Like their insured counterparts, however, they neither know the price of what they are buying nor have the emotional temperament to rationally weigh obscurely defined options in major life or death decisions or,

⁷⁸ See Rosenberg, *supra* note 29, at 4.

⁷⁹ Rosenberg, *supra* note 19, at 2 and 4; e.g., Brill, *supra* note 1, at 4, 37–38.

⁸⁰ Rosenberg, *supra* note 19, at 4.

⁸¹ See Belk, *supra* note 32, at 4 and accompanying text.

less dramatically, major health decisions.⁸² Moreover, as pointed out above, even if they could know their costs for each option in advance of purchase, and even if they could rationally assess those options, they lack the bargaining power of either the insurance companies or the federal government.⁸³ The ultimate perversity in the system is that providers look to this last pool of consumers to subsidize the profits they have relinquished to those with significantly more market power; namely, the government and insurance companies. In effect, this population subsidizes the rates of the variously insured populations. As a result of their lack of market power, they forgo much preventive care, and with it, early diagnosis. As observed above,⁸⁴ undiagnosed health problems seldom improve with age. When those problems can no longer be ignored, they require very expensive attention and frequently a consequent bankruptcy.⁸⁵ Unplanned and expensive healthcare issues represent the largest single cause of Chapter 7 filings.⁸⁶ Bankruptcy is the final externality. For the patient it offers of the hope of a "fresh start:" albeit one, without their former assets, often accumulated over a lifetime. For the hospital, it represents a loss of a peculiar nature. It is a loss calculated at the bloated chargemaster rate and then written-down as bad debt for tax-purposes. Given the nature of the chargemaster, the tax recovery is typically greater than the original cost (or even "retail" value) of the medical services provided.

F. BUYERS ARE UTILITY MAXIMIZERS

Economists assume that consumers, including healthcare consumers, make their market choices by opting for the most preferable bundle of goods,

⁸² Brill, *supra* note 1, at 23; Arrow, *supra* note 36, at 949, 964–65.

⁸³ Brill, *supra* note 1, at 22.

⁸⁴ *Supra* at text between notes 30 and 31.

⁸⁵ Ryan Sugden, *Sick and (Still) Broke: Why the Affordable Care Act Won't End Medical Bankruptcy*, 38 WASH. U. J. L. & POL'Y 441, 468 (2012).

⁸⁶ *Id.* at 444 (noting that, in 2007, 62% of individual bankruptcies could be traced to a medical event).

given their resource constraints.⁸⁷ Perhaps the shakiest part of the assumption is that healthcare consumers are capable of rationally maximizing their utility. Given the opaqueness of the market,⁸⁸ healthcare consumers have ceded considerable control to their physicians and, for the more fortunate with insurance, to their insurance providers. Nevertheless, one can consider the unavoidably ignorant, and frequently anxious, patient as maximizing his utility by simply relying on the counsel of his physician, who may well share the patient's ignorance of the cost of medical goods going into the market basket.⁸⁹ In the case of the uninsured, it is simply a matter of foregoing the "luxury" of a diagnosis, or the resulting prescriptions for, say, high blood pressure or incipient diabetes, to assure that the patient and her family remained fed, clothed and housed. To the onlooker, it appears a Hobson's choice; to the patient, it is utility maximization. For purposes of this analysis, however, the writers assume that the healthcare market meets the condition of utility maximization.

G. NO EXTERNAL PARTIES REGULATE PRICE, QUANTITY OR QUALITY OF THE GOODS AND SERVICES EXCHANGED IN THE "MARKET"

It would seem to go without saying that there exist a number of sources of external regulation in the healthcare markets. While free market advocates might want to look first at fixing this market "deficiency," the problem is neither simple nor easily resolvable. No one seriously disputes that the development of drugs (prescription and non-prescription) and medical devices is highly regulated. Reducing that regulation might produce greater efficiencies in getting drugs and devices to market. However, the benefits of such a policy would need to be weighed against the prospect of more tainted

⁸⁷ SAMUELSON & NORDHAUS, *supra* note 57, at 87.

⁸⁸ *See supra* notes 61–70 and accompanying text.

⁸⁹ Belk, *supra* note 32, at 4.

drugs, drug frauds, and quack remedies.⁹⁰ Given the complexity of the products available, it is hard to fathom how the market (made up either of attending physicians or their patients) could begin to evaluate the claims of competing manufacturers. Dissecting that problem (or promise?) goes beyond the scope of this paper. However, regulation, actual and potential, does not end there.

Currently, the market "regulates" physician malpractice with individual and class actions. A patient's claim is tested in a court of law, usually by a jury. Plaintiffs' personal injury attorneys, compensated by contingent fees, represent the most market-driven portion of the bar. Because every case represents a major investment of time and money, attorneys have to prudently assess which cases have merit and which are black holes. Imprudent assessments make for hungry attorneys. Nevertheless, the process is cumbersome, idiosyncratic, costly, and time-consuming. For all these reasons, there is a growing movement for malpractice reform. One proposal is to provide a "safe-harbor" defense to physicians. Physicians and hospitals could invoke the defense by showing that the symptoms presented did not call for the unreasonable expense avoided.⁹¹ The test for "reasonableness" would be established by peers within the medical community; not by experts in the courtroom.⁹² The proposal could reduce incentives to overuse expensive testing and diagnostic procedures merely to avoid later claims that a case would not have had the unfortunate result that gave rise to the suit.⁹³ Of course, the proposed reform does not address the other incentive to overuse diagnostic protocols; namely, that they are such an easy and lucrative way to increase revenues for hospitals and for private practices.⁹⁴

⁹⁰ ROBERT I. FIELD, HEALTH CARE REGULATION IN AMERICA: COMPLEXITY, CONFRONTATION, AND COMPROMISE 114–24 (1st ed. 2007).

⁹¹ *Id.*

⁹² *Id.*

⁹³ Brill, *supra* note 1, at 55.

⁹⁴ *Id.*

There is, however, another form of external regulation designed expressly to keep healthcare costs high. While Medicare and Medicaid have been enormously successful in keeping their per-patient payout to a (comparative) minimum,⁹⁵ with regard to healthcare services⁹⁶ the same cannot be said for the purchase of prescription drugs. The two government programs are prevented by law from restraining prices for drugs, as is commonly done in other countries.⁹⁷ Indeed, the two programs are even prohibited from using their considerable buying power (Medicare is the single largest buyer⁹⁸) to negotiate lower drug prices. Instead, Medicare is required to pay 106% of the average sales price for prescription drugs.⁹⁹ The catch is that the pharmaceutical companies set the price.¹⁰⁰ This is especially problematic when patents guarantee a monopoly-pricing opportunity. If the patient only has a copay of five (5) to thirty (30) dollars, the patient will rarely complain. If the insurance company overpays on a new drug, it can recover with higher premiums the following year.

Quite possibly, the most expensive example of protective legislation comes from Congress' barring Medicare from getting into the comparative effectiveness debate. If exhaustive comparative studies show that one drug, which costs dramatically less than a second drug, actually has the same or better results, Medicare should be able to say it will only cover the less expensive drug, forcing an efficiency that does not compromise care.¹⁰¹

⁹⁵ Estimates of cost structures suggest that even Medicare and Medicaid could tighten up their compensation for services, without throwing the medical profession to the wolves. Brill, *supra* note 1, at 55.

⁹⁶ *E.g., id.* at 46–49.

⁹⁷ *Id.* at 46.

⁹⁸ *Id.*

⁹⁹ 42 C.F.R. § 414.904 (the lesser of the actual charge or 106% of average sales price).

¹⁰⁰ Brill, *supra* note 1, at 43.

¹⁰¹ *Id.* at 46.

However, that option is precluded by the Medicare requirement to reimburse patients at 106% of average sales price for any FDA-approved Part B drug.¹⁰² Part of the so-called "death panel" debate had to do with efforts by ACA proponents to incorporate "comparative effectiveness" principles into the legislation, which would give Medicare more leverage to control costs.¹⁰³ The principles were not incorporated. Brill observes that private hospitals, such as Sloan-Kettering, have successfully induced at least one pharmaceutical to reduce by half its colorectal-cancer drug originally priced at \$11,063/month. It did so by pointing out that a competitive drug cost only \$5,000 and was just as effective.¹⁰⁴ By congressional fiat, Medicare is forbidden to similarly exploit its considerably greater market power.¹⁰⁵

H. SUMMARY: TO THE EXTENT HEALTHCARE IS EVEN A MARKET, IT IS NEITHER FREE NOR COMPETITIVE

In summary, with or without the ACA, the healthcare market is a sellers' market; indeed, it is a sellers' captive market. There are numerous (desperate and ignorant) buyers and relatively few sellers. From the day each patient is born, the only way to exit the market is by death; *that* is an unmistakable barrier to exit. Necessarily, buyers have little real knowledge about the market and many sellers cynically exploit that vulnerability,¹⁰⁶ while other sellers enjoy only a limited superiority to their patient-buyers' ignorance of market conditions.¹⁰⁷ While there are elements of fungibility in the market,¹⁰⁸ much of the central physician-patient relationship is highly personal and

¹⁰² 42 C.F.R. § 414.904; Brill, *supra* note 1, at 43 & 46.

¹⁰³ Brill, *supra* note 1, at 46.

¹⁰⁴ *Id.*

¹⁰⁵ 42 C.F.R. § 414.904; Brill, *supra* note 1, at 43.

¹⁰⁶ Brill, *supra* note 1, *passim*; Pear, *supra* note 75; Arrow, *supra* note 36, at 946.

¹⁰⁷ Belk, *supra* note 32, at 4.

¹⁰⁸ *Supra* note 71 and accompanying text.

idiosyncratic.¹⁰⁹ Multiple externalities make cost-control almost meaningless.¹¹⁰ Insured patients (that is, "fully insured") can afford the luxury of not attending to cost. Insurance companies can recover in the following year and providers can ratchet up price on the uninsured to cover lost profits resulting from having to bargain with the "market's" stronger players. While one can attempt to argue that patients are utility-maximizers, they remain so stressed and unavoidably ignorant that the necessary qualifier "rational" is oxymoronic. Given enormous constraints of knowledge, access, and resources, patients make the best of what they can with their limited options. Acknowledging those constraints compromises any characterization of patients as utility maximizers.

Finally, this market has been and will remain heavily regulated.¹¹¹ Protecting the life and health of the public is both an individual and corporate concern.¹¹² Primarily, healthcare regulation has focused on quality assurance, expanding access, and cost control.¹¹³ It is hard to imagine policy makers eschewing any one of those three goals. Obviously, the expected expansion of access to the healthcare system presents challenges to other two goals of quality assurance and cost control. Given that healthcare will continue to have an outsized presence¹¹⁴ in the American economy, both economic and policy reasons make significant deregulation unlikely.

Because it involves the exchange of goods and services, the healthcare system can be called a "market." By almost every indicia (making some allowance for the fungibility and utility maximization conditions), however, it is not, and has not been for decades, a *competitive* market. It is much more

¹⁰⁹ Arrow, *supra* note 36, at 949–51, 964–66.

¹¹⁰ *Supra* notes 77–87 and accompanying text.

¹¹¹ *Supra* notes 92–96 and accompanying text.

¹¹² FIELD, *supra* note 91, at 3–4.

¹¹³ *Id.* at 4.

¹¹⁴ *E.g., id.* at 235–49.

like a casino, in which only the patient does not get to see the cards being played. This is especially true when one considers the plight of the uninsured patient. As healthcare expenditures approach a quarter of our GDP, getting a handle on cost is critical for society at large.¹¹⁵ For the uninsured, the situation is more dire. For many, it represents a choice between death and bankruptcy.

IV. RESPONDING TO THE PLIGHT OF THE UNINSURED PROVIDES A LABORATORY FOR TESTING THE BROADER CHALLENGES OF REGULATING THIS MARKET

The economic conditions surrounding healthcare call for some major intervention. As long as conditions remain as described herein, the United States will continue to see healthcare costs soar, without a parallel improvement in quality of the results. One remedy, to universalize Medicare coverage, was hinted at during the ACA debates.¹¹⁶ At the time, it was politically untenable and probably remains so.¹¹⁷ Given almost catastrophic market failure, the problem calls out for a legislative solution. While our current Congress may simply blink in the face of this public policy challenge, it could try a "small-bore" response to a much graver individual problem.

The one truly vulnerable "player" in the market is the uninsured patient. With virtually no institutional forces to provide cover, the patient is a ready mark for profit and "non-profit"¹¹⁸ healthcare providers, especially if

¹¹⁵ *E.g.*, Rosenberg, *supra* note 19, at 4.

¹¹⁶ Sam Stein, *Lieberman's Medicare Flip-Flop Leaves Democrats Fuming*, THE HUFFINGTON POST (last updated May 25, 2011, 3:55 PM), http://www.huffingtonpost.com/2009/12/14/liebermans-medicare-flip_n_391732.html (chronicling Sen. Joseph's Lieberman's recantation of his healthcare proposal to expand Medicare coverage to those as young as 55).

¹¹⁷ *See* Sudgen, *supra* note 85, at 443.

¹¹⁸ Brill, *supra* note 1, at 24–28 (on the structure and success of so-called "non-profit" hospitals).

unplanned emergency¹¹⁹ requires hospitalization. Having no market power, he/she can only hope for service provider largess. That largess, however, appears to becoming ever more scarce.¹²⁰ Indeed, only the uninsured face the surrealism of the chargemaster, unaware that the hospital expects them to simply negotiate some small discount.¹²¹ For Sean and Stephanie Rechi, Janice, and Scott S.,¹²² negotiation is a chimera. Indeed, the ruthlessness of medical provider billing practices only confirms the experience of these patients.¹²³ The "almost poor" uninsured represent the sweet spot in provider practice—the one population that the provider can charge the full chargemaster price. Even if the provider cannot ultimately wring every last charge out of the patient, it knows it got as much as it could and passes the remaining "loss" on to the taxpayer.¹²⁴

There is something cynically exploitative about these bill collection practices. Providers have singled out the one slice of the population that lacks any large institutional protection; namely, the working poor.¹²⁵ Providers do

¹¹⁹ Rare (births excepted) would be the hospitalization that was planned.

¹²⁰ Sugden, *supra* note 85, at notes 44–48 and related text.

¹²¹ Brill, *supra* note 1, at 22–24, 36.

¹²² *Id.* at 1–6, 16–18 and accompanying text.

¹²³ See KAY STANLEY, COKER GROUP, MAXIMIZING BILLING AND COLLECTIONS IN THE MEDICAL PRACTICE 42–43 (2007); see also Sugden, *supra* note 85, at 447–48.

¹²⁴ To the extent the for-profit provider cannot recover from the impecunious patient, it seeks a tax deduction for the uncollected chargemaster-priced debt.

¹²⁵ Remember, those who are the most desperately poor are protected by Medicare and Medicaid. We are talking here of those who employment does not provide healthcare insurance at all. Even after full implementation of ACA, it is expected that this population will diminish; but not disappear. Sugden, *supra* note 85, at 443.

not do it solely to recover their costs and a reasonable profit.¹²⁶ They are not floundering institutions desperately trying to survive. Indeed, the most aggressive appear to be enormously profitable institutions.¹²⁷ To make up for the chargemaster discounts afforded private insurance companies and the deeper discounts afforded federal insurance companies, they squeeze the so-called "working poor." They continue to do it simply because they can. It is the naked exercise of market power against the most vulnerable in our society. Cursed with bad genes, bad health decisions, bad employment situations, bad luck, or a combination of all four factors, the victims are left with two choices—forego medical attention or risk personal bankruptcy. While this dysfunction may be tolerable (or even desirable) to Ron Paul supporters,¹²⁸ it cannot be justified in any religious or ethical system currently accepted. Even if one could isolate those victims whose medical requirements were the consequence solely of bad health decisions, protecting the "market" against this seeming "moral hazard" would appear callous, at best.

Nevertheless, it is not the focus of this paper to discuss the ethics of healthcare coverage. Its primary focus has been how to control the increasingly high cost of the product. If controlling quantity can only trim costs at the margins,¹²⁹ an effort all the more belated when so many millions of new patients are to now be covered under the ACA, it is time to look at controlling price, the second element of "cost." "Controlling price" requires both a determination of pricing standards and a mechanism for applying the standards. It appears that the Medicare standards offer a readily available pricing standard. It has been tested for years and appears to assure that

¹²⁶ Brill, *supra* note 1, at 22.

¹²⁷ *Id.* at 26, 50–51.

¹²⁸ *Should society let the uninsured die?*, *supra* note 53, and accompanying text.

¹²⁹ *See, e.g., supra* note 31 and accompanying text.

providers are sufficiently well-compensated that they do not routinely turn away Medicare patients.¹³⁰

Some may argue that the idea of price controls has no place in our free market system. As detailed above, that argument fails to address the market failures in our current system of healthcare,¹³¹ especially for the "less poor" uninsured. A related argument is that this limited proposal raises the specter of "moral hazard." What incentive will such individuals have to purchase insurance, even the subsidized insurance available under the ACA? However, the fear of moral hazard is misplaced. This particular group of patients is not getting an incredibly attractive deal that would make paying premiums a "bad deal." Under our proposal, they would be paying far more than their insured counterparts for a medical procedure. Paying the Medicare price for just about any procedure would reduce the patient's financial obligation by eighty (80) to ninety (90) percent,¹³² while assuring a reasonable compensation to the provider.¹³³ That might still raise the specter of bankruptcy for the patient; but, the chance is reduced by that eighty (80) to ninety (90) percent. Further, as noted above,¹³⁴ these patients do not find themselves in desperate straits because of their profligacy, nor for their lack of planning. Most of us do not have the wherewithal to save for the calamity of sudden accident or illness. For most of us, smokers perhaps excepted, a cancer diagnosis is not the result of poor planning or bad decisions. In the vast majority of cases, going uninsured is the result of not being fortunate enough to find employment that provides adequate (or any) insurance. To the extent the diagnosis is the result of bad decisions, insurance insulates us from the worst consequences of our all too human follies. Asking someone to place in jeopardy all their assets in

¹³⁰ Brill, *supra* note 1, at 43.

¹³¹ *See, passim*, Section III.

¹³² Rosenberg, *supra* note 19, at 4–5 (a colonoscopy costing \$4,158 in Seattle would bear a Medicare price of \$531)

¹³³ Brill, *supra* note 1, at 43.

¹³⁴ *See, passim*, Section I.

the face of an adverse medical diagnosis is to worry way too much about "moral hazard" in the face of genuine human tragedy.

Maryland has actually taken this idea much farther than we have proposed here. Since 1971, its independent Health Services Cost Review Commission (HSCRC) has regulated rates that its state hospitals could receive from *anyone* paying for a patient's medical care (Medicare, Medicaid, private insurer, or individual).¹³⁵ With numerous safeguards to assure regulatory independence, the HSCRC has successfully controlled the hospital care cost spiral, while the rest of the country has only talked about it.¹³⁶ Moreover, the system also successfully expanded access to hospital care.¹³⁷ One observer has proposed expanding the system to include setting physicians' rates.¹³⁸ The point here, however, is only to note that a proposal similar to the one presented here has been successfully implemented for over 40 years. Indeed, at both the state and federal level, It is unnecessary to recreate the Maryland mechanism. The administrative machinery is already in place. Medicare and Medicaid have developed enormous databases that make them singularly appropriate to implement the proposal.¹³⁹

If this country has reached a level of development such that healthcare is deemed as essential as water, then we need to think more smartly about how we deliver that care. There was a time when it was not a necessity, simply

¹³⁵ John A. Dastor & Eli Y. Adashi, *Maryland's Hospital Cost Review Commission at 40: A Model for the Country*, 306 JAMA 1137, 1137 (Sept. 14, 2011), available at <http://jama.jamanetwork.com.proxy.seattleu.edu/article.aspx?articleid=1104315>.

¹³⁶ *Id.* at 1138.

¹³⁷ *Id.*

¹³⁸ Barry F. Rosen, *What if the HSCRC Set Doctors' Rates?*, MID-ATLANTIC HEALTH LAW TOPICS (2009), <http://www.gfrlaw.com/pubs/GordonPubDetail.aspx?xpST=PubDetail&pub=745> (last visited Apr. 20, 2014 5:22 PM).

¹³⁹ *E.g.*, Brill, *supra* note 1, at 47–48.

because it could offer so little relief.¹⁴⁰ Those days are clearly gone. With great opportunity, however, comes great cost. Getting control of that cost is one of the major public policy issues of the next decade(s). If Medicare provides the price-setting standards, it also can provide the mechanisms. Amending Medicare would provide the statutory and related administrative framework for such a limited test as proposed here. One might also invoke the Independent Payment Advisory Board (IPAB), charged under the ACA with bending the cost curve of healthcare expenses, as a possible mechanism for this task. Obviously, whichever statutory framework was employed, there would be a huge political battle over both the extension of "coverage" to the uninsured and the invocation of price controls. If past is prologue, however, there would be no significant discussion of alternatives to the proposal.

¹⁴⁰ Consider the difference between the healthcare George Washington could enjoy and that of his slaves. Given a cancer diagnosis, possible only in the later stages of its development, about the only difference between the treatments available to master and slave would be the quality of the alcohol used to numb the pain. Washington's only other "advantage" might be the more frequent bloodlettings that would unintentionally hasten his end.