The Social Consequences Problem in Health Insurance and How To Solve It

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This Article identifies a problem with contemporary U.S. health care that contributes to "balance billing," the absurd complexity of medical bills, and other visible and invisible health care consumer harms. Casting medical providers as bill collectors misaligns incentives for both health insurers and providers in ways that make the market for health insurance particularly bad at trading off health care's medical consequences with its often severe social, financial, and psychological consequences. As a result, such "social consequences" go unchecked or even exacerbated by an entity—the health insurer—who controls when, where, why, and how insureds must pay medical bills.

This "social consequences problem" in health insurance provides a much-needed normative foundation for existing and proposed health insurance consumer financial protections. But the social consequences problem infects all aspects of medical billing for insureds and existing reforms address only its most visible symptoms. The Article therefore calls for and proposes systemic solutions.

"Financial distress corridors" would reward or penalize insurers based on the relative financial hardship suffered by their insureds, giving insurers "skin in the game" of their insureds' financial distress and unleashing competition-driven innovation over patient-friendly medical billing. "Automatic insurer collection and financing" would require insurers (rather than providers) to bill for, collect, and finance insureds' share of their medical costs, removing providers from the adversarial role of bill collector and greatly simplifying medical billing for those with insurance. After proposing and evaluating these systemic reforms, the Article identifies ways existing ad hoc consumer financial protections should be tailored to better address the social, financial, and psychological consequences of health insurance.

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* Assistant Professor of Law, Pennsylvania State University, Dickinson School of Law. For helpful feedback at various stages of this project the author wishes to thank Glenn Cohen, Barry Friedman, Erin Fuse Brown, Rob Gatter, Timothy Greaney, Mark Hall, Allison Hoffman, Medha Makhlouf, Elizabeth McCuskey, Kevin Outterson, Nicholson Price, Christopher Robertson, Ben Roin, Rachel Sachs, Bill Sage, Martin Skladany, Jeff Skopek, Sydney Watson, Nancy Welsh, Lindsay Wiley, and participants in the 2017 Health Law Scholars Workshop hosted by the American Society for Law, Medicine, and Ethics ("ASLME") at Saint Louis University School of Law, the 2018 ASLME annual conference, and Harvard Law School's Health Law Workshop.

INTRODUCTION

> *"We have a post office box. I would routinely stop and get the mail and not even take it in the house. I'd bring it here to work. I did not want my husband to see the [medical] bills. The doctor had been emphatic with me to keep his stress level down."*[1]

Journalists, scholars, and policymakers in contemporary U.S. health care have focused tremendous attention on health insurance consumer abuses such as "balance billing" and respectively called for, evaluated, and adopted a wide range of ad hoc legislative mandates protecting insureds from particular outrageous billing practices.[2] Largely missing from this discussion has been an effort to understand what about our insurance-based health care financing system leaves insureds exposed to such abuses in the first place.

This Article identifies an underlying problem in health care financing in the United States of which highly visible consumer abuses like huge balance bills are merely symptoms. The root problem is that the contemporary U.S. health insurance market is even worse at making tradeoffs regarding the social, financial, and psychological consequences of health insurance (like how and when insureds must pay medical bills) than it is at making tradeoffs about the medical consequences of health insurance (like what is covered)—and it notoriously struggles to make medical tradeoffs.

The market for health insurance is particularly bad at making tradeoffs about these "social consequences" of health insurance (shorthand for social, financial, psychological, or other non-medical consequences) for two reasons.[3] First, in a system that makes providers responsible for assessing and

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[1] CAROL PRYOR ET AL., THE ILLUSION OF COVERAGE: HOW HEALTH INSURANCE FAILS PEOPLE WHEN THEY GET SICK 57 (2007), http://www.lindsayresnick.com/Resource_Links/the_illusion_of_coverage.pdf [https://perma.cc/MMZ3-TEKA] (quoting Lynnette, a widow whose family accrued $9,000 in medical liability primarily through her health insurance plan's cost-sharing requirements when her husband was dying of cancer).

[2] *See infra* Part I.A (collecting recent policy, newspaper, and scholarly surveys).

[3] This Article uses the umbrella term "social consequences" to describe the social, financial, and psychological consequences of health care (*see infra* Part II.A) and health insurance (*see infra* Part II.B) in order to analogize to the concept of "social determinants of health," which itself includes social, legal, educational, financial, cultural, housing, and other non-medical variables that research shows can have a significant impact on a person's health separate from the actual medical treatment she receives. Just as the concept of "social determinants of health" has become a widely utilized shorthand term for the myriad non-medical determinants of health, it is helpful to use the shorthand "social consequences of health care" to focus on and

collecting insureds' medical bills by default, the cost to such providers of billing and absorbing the bad debt of insured patients is an externality of health insurance. This externality discourages insurers from innovating to develop and offer patient-friendly policies that reduce the pain of medical bills for their insureds to the extent that doing so would force insurers to pay for collection and financing costs that otherwise are borne, uncompensated, by providers. Why invest in helping your insureds avoid medical bankruptcy if someone else is left holding the bag when they go bankrupt?

Second, an expert intermediary that mitigates the well-explored failures in the market for health insurance (which include adverse selection and behavioral biases) when it comes to medical consequences is absent when it comes to social consequences, or worse. Doctors generally have the training, competence, and incentive to help patients make the "right" decisions when it comes to medical consequences, but doctors are neither trained nor incentivized to help patients make the "right" decisions about where, when, and how to pay their medical bills. To the contrary, doctors' incentives in this context are in conflict with patients'; a doctor has a financial interest in her patient paying his bill as soon as possible without regard to whether doing so is in the patient's best interest, and that is what doctors are often trained to do.

Isolating this social consequences problem with health insurance points the way to solving it: To truly fix health insurance, regulators should consider ways to replace the incentive the market fails to give insurers to reduce the social consequences of health insurance on their enrollees, that is, to give insurers "skin in the game" of their enrollees' financial, familial, and psychological distress. This would enlist insurers in shielding their insureds from abusive billing practices both seen and unseen by regulators; enlist insurers in innovating "patient friendly" insurance product features to make predicting, managing, and paying bills easier; and tend to reduce our problematic reliance on health care providers as bill collectors.

Based on this insight, the Article proposes a novel, algorithmic, competition-based reform with the potential to mitigate or even solve the social consequences problem systemically, throughout health insurance. "Financial distress corridors" would penalize insurers whose insureds suffer greater financial distress relative to other insurers' insureds while rewarding those whose insureds suffer less financial distress. This would give insurers reason not only to protect insureds against the worst billing abuses but also to innovate to develop and implement new ways to make medical bills more man-

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call attention to the myriad non-medical consequences of the health care system. *See* Matthew B. Lawrence, *Deputizing Family: Loved Ones as a Regulatory Tool in the 'Drug War' and Beyond*, 11 NORTHEASTERN L. REV. 195 (2019) (employing "social consequence" shorthand to refer to non-medical consequences of deputizing family members in substance use disorder prevention and treatment); *see also* Frank I. Michelman, *Property, Utility, and Fairness: Comments on the Ethical Foundations of "Just Compensation" Law*, 80 HARV. L. REV. 1165, 1214 (1967) (defining related concept of "demoralization cost"); *cf.* GUIDO CALABRESI, THE COST OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS at 27 (2008) (describing such collateral harms as "secondary costs").

ageable. It would also force insurers to internalize the externality of their insureds' bad debt—removing the disincentive insurers now have to help their insureds avoid insolvency or make billing easier. The Article offers this reform as a serious proposal in its own right and as an illustration of the sort of algorithmic tool that holds the potential to actually fix health insurance's social consequences problem rather than merely put a band-aid on its most outrageous symptoms.

The Article also draws from its study of the social, financial, and psychological consequences of health care a normative framework for evaluating more paternalistic, mandatory reforms such as those adopted by several states. It employs this framework to propose a systemic reform intended to remove providers from their problematic current role as bill collectors. "Automatic insurer collection and financing" would shift responsibility for billing insureds for their share of medical expenses from the many doctors a patient sees during a typical spell of illness to her single insurer. Such a reform—which could potentially entail requiring insurers to both collect medical bills and offer financing for such bills to their insureds—has the potential to reduce the complexity of medical bills, make bills easier to manage, facilitate cost-effective financing, and purify the doctor-patient relationship without causing countervailing adverse medical consequences. Finally, the Article applies its normative framework to offer needed normative support for existing and proposed state laws, but also to identify ways such laws should be altered.

The Article proceeds in seven parts. Part I describes the recent controversy about health care consumer abuses and explains that a fuller understanding of the problem giving rise to such abuses is needed in order to ensure that the current slate of reforms really cures what ails health insurance and is worth its economically predictable side effects: increased insurance premiums (and so less affordable health care) or new and different cost-cutting insurance practices (which might be even more abusive).

Part II isolates the social consequences problem. Our current market system for making tradeoffs between health care's social and medical consequences is particularly bad at that task because of the misaligned incentives that come with making doctors bill collectors. It does so by integrating and building upon three strands of existing scholarship: recent reform literature on consumer financial protection in health care, decades of empirical work on "medical bankruptcy" and associated financial distress, and a literature exploring market failures in health insurance developed around the "Patient's Bill of Rights" in the 1990s.[4]

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[4] The consumer financial protection literature includes, for example, Christopher T. Robertson & David V. Yokum, *The Burden of Deciding For Yourself: The Disutility Caused by Out-of-Pocket Healthcare Spending*, 11 IND. HEALTH L. REV. 611, 622–33 (2014) (discussing "decisional burden" associated with cost-sharing) and Christopher T. Robertson et al., *Get Sick, Get Out: The Medical Causes for Home Mortgage Foreclosures*, 18 HEALTH MATRIX 65 (2008) (discussing frequency of medical foreclosure). The empirical literature includes Melissa B. Jacoby, *The Debtor-Patient Revisited*, 51 ST. LOUIS U. L.J. 307 (2007) (discussing medical bankrupt-

Part III explains the need for systemic solutions to the social consequences problem in health insurance. Ad hoc mandates that require or prohibit particular insurance product features do not alter insurers' underlying perverse incentives. They therefore risk addressing only the most visible symptoms of the social consequences problem. They also push insurers to channel those perverse incentives into plan features that are invisible to regulators but nonetheless problematic for insureds.

Part IV offers the "financial distress corridors" program introduced above as a novel competition-based solution to the social consequences problem. This algorithmic reform has the potential not only to curb abuses but also to promote greater innovation by insurers to develop and implement "patient friendly" plan designs that reduce the pain of medical billing in ways that regulators and scholars may not conceive of or have the levers to put into practice.

Part V recognizes that despite the potential of financial distress corridors, more paternalistic mandates may be desirable to some (including some policymakers) as an interim or permanent approach to addressing the social consequences problem. Accordingly, it draws from the study of the social consequences problem a framework for evaluating regulatory mandates intended to curb health care consumer abuses. The Article then applies that framework in Parts VI and VII.

Part VI proposes regulators experiment with the "automatic insurer collection and financing" mandate introduced above. This would entail forcing insurers to collect their insureds' medical bills rather than leave doctors to do so and to offer financing for such bills to their insureds. These integrated reforms would take doctors out of the business of bill collecting and "nudge" patients into default financing arrangements to help them manage their medical bills.

Part VII applies the Article's framework for evaluating mandates directed at medical billing to the ad hoc reforms that legislators have adopted and scholars have endorsed. It shows that such reforms are normatively justifiable, but that they are limited and should be tailored to better account for social, financial, and psychological consequences. Last, a brief conclusion offers summary remarks and collects suggestions for future research.

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cies) and Melissa B. Jacoby & Elizabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 Nw. U.L. Rev. 535 (2006) (discussing medical bankruptcy and associated financial distress). The mandated benefits literature includes Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 Cornell L. Rev. 1 (1999) (analyzing case for proposed "Patients' Bill of Rights") and David A. Hyman, *Regulating Managed Care: What's Wrong with a Patient Bill of Rights*, 73 S. Cal. L. Rev. 221 (2000) (same).

I. CONCERNS ABOUT HEALTH INSURANCE CONSUMER ABUSES

A. *A Wave of Health Insurance Consumer Financial Protection Mandates*

A recent, growing wave of concern about health insurance focuses on particular ways in which insureds come to bear back-breaking medical costs that seem outrageous in light of the treatment received. Front-page news reports have taken aim at "out of network" charges (that an insured pays because she did not go to an insurer-approved provider), in particular for emergency room care, and associated "balance billing" for such care by providers (who demand the insured pay the balance when insurance reimbursement does not cover charges); at other "surprise billing" situations such as facility fees; and at aggressive (and often galling) efforts to collect such bills by providers.[5] The New York Times has published a resource compiling heart-wrenching quotes from insured readers who wrote in to share their own stories of pain, frustration, and financial devastation.[6] And Sarah Kliff

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[5] *See, e.g.*, MARK A. HALL ET AL., BROOKINGS, SOLVING SURPRISE MEDICAL BILLS 9 (Oct. 2016), https://www.brookings.edu/research/solving-surprise-medical-bills/ [https://perma.cc/LH9L-34BL] (citing to academic literature, research studies, and media accounts documenting the surprise billing phenomenon); *see generally* Margot Sanger-Katz, *Even Insured Can Face Crushing Medical Debt, Study Finds*, N.Y. TIMES: THE UPSHOT (Jan. 5, 2016), https://www.nytimes.com/2016/01/06/upshot/lost-jobs-houses-savings-even-insured-often-face-crushing-medical-debt.html [https://perma.cc/P2RQ-829K] (reporting struggles associated with medical debt borne by the insured); LIZ HAMEL ET AL., KAISER FAMILY FOUND., THE BURDEN OF MEDICAL DEBT: RESULTS FROM THE KAISER FAMILY FOUNDATION/ NEW YORK TIMES MEDICAL BILLS SURVEY (Jan. 5, 2016), https://www.kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey/ [https://perma.cc/T2K7-Z6EB] (same); KAREN POLLITZ, KAISER FAMILY FOUND., MEDICAL DEBT AMONG INSURED CONSUMERS: THE ROLE OF COST SHARING, TRANSPARENCY, AND CONSUMER ASSISTANCE (Jan. 8, 2015), https://www.kff.org/health-costs/perspective/medical-debt-among-insured-consumers-the-role-of-cost-sharing-transparency-and-consumer-assistance/ [https://perma.cc/T22U-TNK5] (same); Sarah Kliff, *The madness of American medical billing, in one woman's tweets*, VOX (Jan. 23, 2018, 8:30 AM), https://www.vox.com/policy-and-politics/2018/1/23/16920768/medical-billing-prepay-surgery [https://perma.cc/XS6H-TZ5Z] (describing example of a woman asked to pre-pay her deductible before surgery); Allison Kodjak, *Medical Bills Still Take A Big Toll, Even With Insurance*, NAT'L PUB. RADIO (Mar. 8, 2016, 1:37 PM), http://www.npr.org/sections/health-shots/2016/03/08/468892489/medical-bills-still-take-a-big-toll-even-with-insurance [https://perma.cc/6MRX-AXW7].

[6] *See, e.g.*, Margot Sanger-Katz, *'I am Drowning.' The Voices of People With Medical Debt.*, N.Y. TIMES: THE UPSHOT (Jan. 11, 2016), https://www.nytimes.com/interactive/2016/01/11/upshot/12up-medicaldebt.html [https://perma.cc/3WJ2-2D2F] ("I have gotten a second job to pay for my children's medical expenses, which means that I am not able to spend as much time as I need to monitoring . . . my son's Type 1 diabetes. I am in debt and need to sell my house. I don't go to the doctor to save money."); *id.* ("Nonemergency home repairs and maintenance don't happen, our only vacation is to visit relatives in other states and our kids have no college fund."); *id.* ("My children haven't had Christmas in two years, and some weeks we barely eat."); *id.* ("I used up almost every penny of retirement savings for out of pocket and deductibles, meds."); *id.* ("Health costs have killed my dream of having a child."); *id.* ("We had insurance we could afford and still wound up with huge medical bills after a sickness and hospital stay. . . . [W]e divorced so that the kids and father could be on Medicaid. . . . We had no choice[.]"); *id.* ("I have maxed out my credit cards and will soon be filing for bankruptcy.

of Vox has collected more than 1,300 examples of surprise medical bills, many of which are described in widely disseminated feature stories.[7]

Because such stories are told fully and well in these other sources, they need not be elaborated upon here.[8] It suffices to say that these reports tell the story of people who are in many ways hurting badly *because of* their health insurance—because they relied on it to cover their medical bills only to learn its coverage was incomplete in surprising ways.

Moreover, the numbers that we have show that the stories recounted in these reports are not mere anecdotes. In one study conducted by Zachary Cooper and Fiona Scott Morton, twenty-two percent of in-network emergency department visits involved out-of-network care, with correspondingly high balance billing rates.[9] And a Kaiser survey showed that one in four non-elderly adults is burdened by medical debt.[10]

In light of these concerning stories and statistics, legislators have been motivated to look for ways to lessen the hurt. Concern about abusive practices has produced a slate of new statutory reforms targeting particular practices at the state level. As surveyed by Erin Fuse Brown,[11] as of 2017 five large states (New York, Connecticut, California, Florida, and Texas) had enacted laws prohibiting added cost-sharing on out-of-network care received in an emergency,[12] and many other states had proposed such laws.[13] The National Association of Insurance Commissioners had promulgated a model law prohibiting health insurers from increasing cost-sharing for out-of-network care unless the consumer chose to go out-of-network.[14]

Legal scholars have thus far expressed enthusiasm for these reforms. Valarie Blake applauds the state reforms and calls for their adoption by other states and at the federal level.[15] Erin Fuse Brown does so as well, also pro-

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This week, I'm hiding my car because it's about to be repossessed. My medical bills have destroyed my life.").

[7] *See, e.g.*, Sarah Kliff, *He went to an in-network emergency room. He still ended up with a $7,924 bill.*, VOX (May 23, 2018, 6:00 AM), https://www.vox.com/2018/5/23/17353284/emergency-room-doctor-out-of-network [https://perma.cc/6543-KE6F].

[8] For example, Erin C. Fuse Brown leads her invaluable treatment with the story of a man who opted for back surgery on the assumption that his bills would be fully covered because his hospital was "in-network." *See* Erin C. Fuse Brown, *Consumer Financial Protection in Health Care*, 95 WASH. U.L. REV. 127, 129 (2017). He did not anticipate that while his hospital was in-network, his surgeon was not, so he unexpectedly found himself "on the hook for the six-figure difference between the surgeon's full charges and what his insurance covered." *Id.*

[9] Zachary Cooper & Fiona Scott Morton, *Out-of-Network Emergency-Physician Bills—An Unwelcome Surprise*, 375 NEW ENGL. J. MED. 1915, 1916 (2016).

[10] HAMEL ET AL., *supra* note 5, at 2.

[11] Fuse Brown, *supra* note 8, at 127. Several of these laws feature private rights of action under which patients who receive such surprise bills can sue under their states' unfair business practices laws. *Id.* at 180–81.

[12] *Id.* at 148–53.

[13] For example, Pennsylvania is considering a law, similar to the enacted state laws, that would ensure that insureds pay no more for surprise out-of-network bills than they pay for in-network bills, among other requirements. S. 678, 2017 Gen. Assemb., Reg. Sess. (Pa. 2017).

[14] *See* Fuse Brown, *supra* note 8, at 153–54.

[15] *See* Valarie K. Blake, *Narrow Networks, the Very Sick, and the Patient Protection and Affordable Care Act: Recalling the Purpose of Health Insurance and Reform*, 16 MINN. J.L. SCI. & TECH. 64, 130–36 (2015).

posing a model reform prohibiting certain cost-sharing practices.[16] Mark Hall and his co-authors express concern about the practices targeted by these laws as problematic and support their prohibition by federal administrative agencies including the Departments of Labor and Health and Human Services.[17] Finally and relatedly, George Nation and Barak Richman *et al.* argue that contract law should be utilized to reign in balance billing by labeling excessive price terms unenforceable.[18]

B. The Need for a Fuller Understanding of the Problem with Health Insurance

Health insurance plans could protect insureds from every one of the abuses addressed by the contemporary wave of health care consumer financial protection legislation. Insureds need not be exposed to medical bills for surprise out-of-network bills, balance bills, or the like; insurance plans could cover such bills, or otherwise protect their insureds from such practices.[19] So why have health insurance plans failed to protect insureds?

Outrageous anecdotes and troubling statistics can certainly motivate reform, but they should begin rather than end the inquiry. A fuller understanding of the problem with health insurance that has left insured individuals so vulnerable—and apparently needing statutory or judicial protection—is needed for four overlapping reasons.

Far enough? First, we cannot tell whether proposed and enacted health care consumer financial protection laws go far enough unless we understand the problem they seek to solve. It would be a happy result if now-visible, outrage-inducing examples like huge balance bills were the only problem with health insurance today. But there is reason to believe such abuses are merely the most visible symptoms of a larger underlying problem with health insurance.

The years since the enactment of the ACA have seen a dramatic across-the-board increase in cost-sharing that cannot be explained by abusive practices alone.[20] (Cost-sharing refers to medical expenses that are technically

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[16] *See* Fuse Brown, *supra* note 8, at 129.

[17] *See* HALL ET AL., *supra* note 5, at 24.

[18] *See generally* George A. Nation III, *Healthcare and the Balance-Billing Problem: The Solution is the Common Law of Contracts and Strengthening the Free Market for Healthcare*, 61 VILL. L. REV. 153 (2016); Barak D. Richman et al., *Battling the Chargemaster: A Simple Remedy to Balance Billing for Unavoidable Out-Of-Network Care*, AM. J. MANAGED CARE (Apr. 28, 2017), https://www.ajmc.com/journals/issue/2017/2017-vol23-n4/battling-the-chargemaster-a-simple-remedy-to-balance-billing-for-unavoidable-out-of-network-care [https://perma.cc/5EZG-QJYK]. *See also infra* Part II.B.3.

[19] *See infra* Part II.B.3 (elaborating on ways insurers can reduce social, financial, and psychological consequences).

[20] *See, e.g.*, Jon R. Gabel et al., *Changes in Consumer Cost-Sharing for Health Plans Sold in the ACA's Insurance Marketplaces, 2015 to 2016*, COMMONWEALTH FUND (May 12, 2016), https://www.commonwealthfund.org/publications/issue-briefs/2016/may/changes-consumer-cost-sharing-health-plans-sold-acas-insurance [https://perma.cc/EZ48-B4VB] (discussing increases in out-of-pocket costs); GARY CLAXTON ET AL., KAISER FAMILY FOUND., HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS—2015 ANNUAL SURVEY

"covered" by a patient's insurance plan but that she has to pay herself, *see infra* Part II.B.2.) Insured families can unexpectedly be hit with out-of-pocket costs (deductibles, copays, and the like) that would cover the sticker price on a new car but come with threatening demands for immediate payment rather than years of subsidized dealer financing.[21] Ad hoc consumer protections do nothing to help families manage meeting high deductibles when they are triggered by ordinary, "covered" in-network care. Relatedly, it is far from self-evident that the unhappy linkage between insureds' medical liability and medical bankruptcy that has been explored by Elizabeth Warren, Melissa Jacoby, and others is explained by the practices targeted by current state mandates, either.[22] And last, hospital visits come with a double-barrel attack of paperwork from insurers (sending "explanations of benefits") and doctors (sending invoices) that makes it almost impossible for an insured to figure out what she owes and why (let alone pay the bills on time). Whatever problem with health insurance that has left enrollees vulnerable to outrageous billing situations may also be causing less-visible (or at least less-well-covered) harm across the increasingly complex and costly-to-patients spectrum of health insurance.

Regulatory Whack-a-Mole? Moreover, in a market-driven financing system it may well be impossible to identify and regulate away every problematic health insurance practice one-by-one without curing the underlying problem with health insurance that leads to plans that permit abuses in the first place. Insurers whose apparently-problematic incentives are unchanged may simply replace the practices regulators identify and prohibit with new, potentially worse ones that are either less visible to regulators or just not

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21–38 (2015), http://files.kff.org/attachment/report-2015-employer-health-benefits-survey [https://perma.cc/EMQ6-5ZV5]; *Measuring the generosity of employer-sponsored health plans: an actuarial value approach,* BUREAU OF LABOR STAT.: MONTHLY LABOR REVIEW (June 2015), https://www.bls.gov/opub/mlr/2015/article/measuring-the-generosity-of-employer-sponsored-health-plans.htm [https://perma.cc/BG9S-BJZF] (also reporting a significant increase); *see also* Sanger-Katz, *supra* note 5 ("The Affordable Care Act . . . allowed or even encouraged increases in deductibles."); *id.* (reporting "underlying trend towards higher cost sharing"); Nathan Nascimento, *The Latest Problem under the Affordable Care Act: Deductibles*, NAT'L REVIEW (Apr. 12, 2016, 8:00 AM) https://www.nationalreview.com/2016/04/obamacare-deductibles-are-skyrocketing-affordable-care-act-health-insurance-anything/ [https://perma.cc/B5S7-ZK3F]; Tracy Jan, *Critics say high deductibles make insurance 'unaffordable'*, BOS. GLOBE (Nov. 16, 2015), https://www.bostonglobe.com/news/politics/2015/11/16/high-deductible-health-plans-make-affordable-care-act-unaffordable-critics-say/eaWZZJNrFhm6vVPDBcdZ0I/story.html [https://perma.cc/PUN5-QP6A]; Robert Pear, *Many Say High Deductibles Make Their Health Law Insurance All but Useless*, N.Y. TIMES, (Nov. 14, 2015) https://www.nytimes.com/2015/11/15/us/politics/many-say-high-deductibles-make-their-health-law-insurance-all-but-useless.html [https://perma.cc/5A6T-LD2U].

[21] *Compare* 42 U.S.C. § 18022 (2012 & Supp. II 2014), *and* HHS Notice of Benefit and Payment Parameters for 2018, 81 Fed. Reg. 94058, 94140 (Dec. 22, 2016) (finalizing maximum out-of-pocket limit for family for 2018 of $14,700), *with* Cody Trotter, *2018 Nissan Versa Review*, U.S. NEWS & WORLD REPORT (Sept. 28, 2018), https://cars.usnews.com/cars-trucks/nissan/versa [https://perma.cc/6JHF-8TTD] (suggested retail price for four-door sedan of $12,110).

[22] *See infra* Part II.A.

regulated yet.[23] Health insurers can better understand and predict the behavior of patients, providers, and other insurers than either legislators, bureaucrats, journalists, or scholars; they have more staff, better data, and more resources. Treating the symptoms of an underlying problem without treating the problem itself can put regulators in the position of playing a game of regulatory whack-a-mole that they will inevitably lose.

Indeed, as discussed in Part II.D, the ACA's limitations on cost-sharing themselves may be an example of this issue with top-down regulation of the health insurance market. The ACA attempted to control cost-sharing by setting an out-of-pocket, total cost-sharing limit on in-network care, but this may have pushed insurers to increase the costs borne by typical insureds when they incur claims in order to make up for lost cost-sharing on the highest-cost individuals who reach the new cap.[24]

Worth it? Third, a fuller understanding is needed to make sure that enacted and proposed consumer financial protections do not cause more harm than good. Scholars analyzing President Clinton's proposed "Patient's Bill of Rights" and associated state laws in the 1990s understood this challenge. That era saw concern not about the bills health insurance left to enrollees but rather what treatments and services health insurance covered in the first place, as determined by "managed care" health insurance entities that had been proposed by some legal scholars.[25] Managed care insurance plans closely controlled the care enrollees could receive, such as limiting the nights in a hospital permitted to a mother after childbirth, which reduced costs but generated a massive consumer backlash. Fueled by concern that managed care caused people to forego treatments that were, in fact, medically necessary, states passed "as many as 1,000 patient protection laws" and President Clinton made a major push for national managed care reform.[26]

At first, commentators in this earlier wave of concern about health insurance consumer abuses "treat[ed] the need for a patient bill of rights as a self-evident truth, provid[ing] an anecdotal horror story or two to justify particular provisions."[27] So, too, "the legal academy has engaged in no real debate over the general efficacy" of managed benefit laws.[28]

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[23] *See* Thomas G. McGuire, *Achieving Mental Health Care Parity Might Require Changes in Payments and Competition*, 35 HEALTH AFF. 1029 (2016) (describing tendency of insurers faced with top-down regulation to shift problematic behavior from means that are visible to regulators to means that are not).

[24] *See infra* Part II.D.

[25] In managed care the decider was a combination of the insurer and providers who were incentivized to cut costs. "Managed care" reflected ideas developed in the legal scholarship of Alan Enthoven and Clark Havighurst. *See* Mark A. Hall, *Managed Competition and Integrated Health Care Delivery Systems*, 29 WAKE FOREST L. REV. 1, 11 (1994) (discussing work of Enthoven and Havighurst).

[26] Korobkin, *supra* note 4, at 2–3 (describing "perhaps as many as 1,000 patient protection laws" passed nationwide addressing managed care practices, along with federal efforts toward a patients' "Bill of Rights").

[27] Hyman, *supra* note 4, at 223.

[28] Korobkin, *supra* note 4, at 4.

Ultimately, however, a literature developed conducting "a detailed examination of the benefits and costs of the proposed provisions and their alternatives."[29] Scholars, including Russell Korobkin and David Hyman, recognized that this was necessary because of the tendency of mandated benefits laws to increase health insurance premiums and thereby reduce the affordability of health insurance, adding to the ranks of the uninsured.[30]

Specifically, any insurer must bring in enough through the premiums it charges to offset the claims it pays for care received by its insureds. That means that in a competitive market a law requiring an issuer to cover expenses it otherwise would not cover forces the insurer either to increase its premiums, to increase its cost-sharing, or to deny coverage for some other treatment. And increases in premiums "inevitably cause some consumers . . . to drop out of the private insurance system entirely."[31] The legal requirement would increase the generosity of insurance plans for those able to afford them, but would also—by increasing premiums—tend to leave others unable to afford any insurance plan.

Health insurance consumer financial protection laws present the same challenge. The share of medical costs that an enrollee bears and the premiums she pays for coverage are economically intertwined. An insurer must charge enough in premiums to cover its share of insureds' anticipated covered costs, which means insureds' costs in full (themselves a function of provider charges and consumption) minus whatever liability the insured bears. This is why in a competitive market premiums and cost-sharing operate like a sort of see-saw; if cost-sharing goes down, premiums must go up.

Because of the economic inter-relationship between premiums and cost-sharing, any law limiting insureds' medical expenses in a particular way without changing patient behavior will tend to prompt either a corresponding increase in insureds' expenses elsewhere or an increase in the plan's premiums (which might leave some unable to afford insurance altogether).[32] We

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[29] Hyman, *supra*, note 4, at 223. *See also* Frank A. Sloan & Mark A. Hall, *Market Failures and the Evolution of State Regulation of Managed Care*, 65 L. & CONTEMP. PROBS. 169, 171 (2002) ("[W]hat is the conceptual basis for managed care patient protection laws?"); Korobkin, *supra* note 4, at 1; Marc A. Rodwin, *Consumer Voice and Representation in Managed Care*, 34 J. HEALTH L. 223, 233 (2001). *See generally* Timothy Stoltzfus Jost, *Managed Care Regulation: Can We Learn From Others? The Chilean Experience*, 32 U. MICH. J.L. REFORM 863 (1998).

[30] *See* Korobkin, *supra* note 4, at 65 ("Benefits mandates will cause the cost of health care coverage to increase."); *see also* Hyman, *supra* note 4, at 226 ("[T]he specification of . . . coverage necessarily implies a series of trade-offs within the common pool, with significant distributional implications with and across identifiable groups."); Hyman, *supra* note 4, at 253 ("Those who are uninsured gain nothing from a bill of rights, and their ranks will actually increase if the bill of rights raises the cost of health insurance . . . .").

[31] Korobkin, *supra* note 4, at 65.

[32] This tendency is illustrated in the transition from managed care to consumerism. Backlash against managed care's efforts to limit coverage itself was one factor that fueled the adoption of high cost-sharing plans, as insurers turned from themselves (and providers) to consumers in the effort to find someone to occasionally say "no" to care. *See* James C. Robinson, *Renewed emphasis on consumer cost sharing in health insurance benefit design*, 21 HEALTH AFF. 139 (2002) ("A recognition of medical inflation and the continuing backlash against managed care are stimulating interest among purchasers and health plans in cost-control

need to understand the problem underlying recent reforms in order to ensure that their benefit justifies their costs.

Rebut presumption that market knows best: Fourth, and relatedly, given that insurers and insureds may have more information and flexibility than regulators, those who subscribe to economic theories would presume that the market comes to the most desirable insurance plan when left to its own devices.[33] The understanding of the problem with health insurance offered below contributes to rebutting this presumption; doing so is rhetorically and descriptively helpful even to those who subscribe to other normative approaches, such as distributive justice or egalitarian theories.[34]

II. HEALTH INSURANCE HAS A SOCIAL CONSEQUENCES PROBLEM

This Part identifies and develops a larger problem underlying health care consumer financial abuses that permits dysfunctional practices to flourish unchecked in our insurance-based health care financing system. It does so in four Sections. Section A explains that health care dramatically reduces the physical toll of illness but does so at a price that is itself potentially ruinous for patients and their families. Section B explains how contemporary health insurance controls and calibrates the burden of these financial costs—whether covered or uncovered, subject to cost-sharing or not—by setting the terms of where, when, and how insureds are forced to shoulder bills. Section C explains that insurers currently have a perverse incentive due to the interaction of classical and behavioral market failures and incentive misalignments related to doctors' role as bill collectors to design plans that increase rather than decrease these hidden costs, undermining the manageability of consumer health care expenses. Finally, Section D addresses alternative explanations for health insurance consumer abuses offered by other scholars.

A. Health Care Carries Social, Financial, and Psychological Consequences

Miracles cost money. Health care reduces the direct costs of illness—incapacity, death, pain, and loss—but in a market-based financing system it

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mechanisms for consumers, including thinner benefits, increased copayments, and higher deductibles.").

[33] *See generally* CHARLES SILVER & DAVID A. HYMAN, OVERCHARGED: WHY AMERICANS PAY TOO MUCH FOR HEALTH CARE (2018); Amy B. Monahan, *Fairness Versus Welfare in Health Insurance Content Regulation*, 2012 U. ILL. L. REV. 139, 141 (2012) (discussing economic presumption that regulations of the content of health insurance plans should be permitted only when justified by market failure); TIMOTHY STOLTZFUS JOST, HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER-DRIVEN MOVEMENT 31, 32 (2007) (describing how the presumption that "economics . . . provides the most reliable and accurate explanation of human behavior, pervades the [consumer-directed health care] literature . . . [and how] health care market advocates believe that [o]nly when consumers 'vote with their dollars' can an industry be run efficiently").

[34] *See generally* Blake, *supra* note 15, at 156–58 (discussing normative theories, including egalitarian theories and welfare economics, that can be applied to insurance product design).

also carries a huge price tag for the patient. A burst appendix is no longer lethal (thank goodness) but paying for an appendectomy can itself turn a patient and her family's lives upside down.

Medical bankruptcy is a prominent example of how our health care finance system can trade one type of harm (physical or mental) for another (financial). Research links a high percentage of consumer bankruptcies to medical debt, capturing the attention of policymakers and legal scholars.[35] Medical bankruptcy affects people across a "cross-section of society"[36] but is largely a "middle-class phenomenon."[37]

Medical bankruptcy is just the "tip of the iceberg" of the serious non-medical harms health care can cause.[38] The literature discussing (and often critiquing) "consumerism" in health care has documented a wide variety of such harms,[39] though some such harms have been better documented than others. These non-medical harms caused by market-based health care financing can be broken down into three categories: social, financial, and psychological consequences, or "social consequences" for short.[40]

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[35] This phenomenon has been the focus of many newspaper articles, editorials, and law journal articles. *See generally* Jacoby & Warren, *supra* note 4, at 536 ("Featured stories [in media] described how big hospital bills turn families' lives upside down, sometimes costing them their homes, their credit ratings, access to their bank accounts, and occasionally even their liberty."). President Obama made addressing the problem of medical bankruptcy a core component of his argument in favor of his signature legislative accomplishment, the Affordable Care Act. *See, e.g.*, Melissa B. Jacoby & Mirya Holman, *Managing Medical Bills on the Brink of Bankruptcy*, 10 YALE J. HEALTH POL'Y L. & ETHICS 239, 241–42, n.8 (2010) (describing role of medical bankruptcy in President Obama's advocacy of the ACA). Numerous studies link consumer bankruptcy to medical bills, even among those who have insurance. *See* Tal Gross & Matthew J. Notowidigdo, *Health insurance and the consumer bankruptcy decision: evidence from expansions of medicaid*, 95 J. PUB. ECON. 767 (2011) (concluding that medical costs were "pivotal" in twenty-six percent of personal bankruptcies among low income households); David Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741, 742 (2009) (reporting that 62.1% of bankruptcies in study sample have a medical cause); Robertson et al., *Get Sick, Get Out*, *supra* note 4 (linking medical debt to foreclosure). *See generally* Jacoby, *The Debtor-Patient Revisited*, *supra* note 4. *But see* David Dranove & Michael L. Millenson, *Medical Bankruptcy: Myth Versus Fact*, 25 HEALTH AFF. 74 (Feb. 2006) (expressing skepticism that medical expenses actually contribute to bankruptcy).

[36] TERESA A. SULLIVAN ET AL., THE FRAGILE MIDDLE CLASS: AMERICANS IN DEBT 27 (2000).

[37] *Id.*

[38] *See generally* Robert W. Seifert & Mark Rukavina, *Bankruptcy is the Tip of a Medical-Debt Iceberg*, 25 HEALTH AFF. 89 (Feb. 28, 2006).

[39] While much of this literature has questioned the core claim of consumerism, namely, that patients will make health care consumption choices that reduce cost while improving quality, *see, e.g.*, Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 651 (2008), the strand discussed above has reported on the financial distress suffered by insurers as a byproduct of cost-sharing (whether or not it makes medicine better).

[40] *See supra* Part I.A.

1. Social Consequences

A first category of non-medical impacts is impacts on loved ones, *i.e.*, social or relational impacts. Family members often assist in tracking, managing, and paying medical bills as just one component of their role as critical supports for a loved one coping with illness.[41] Moreover, when insurance coverage utilization review requirements or other barriers stand in the way of needed or recommended coverage, the taxing job of navigating administrative appeals or other mechanisms to overcome such barriers often falls to family members, especially parents and partners.[42]

As previously documented in this journal, it is a systemic problem in policy making that family care worker burdens are often invisible, unrecognized, and (so) unstudied.[43] It is therefore not surprising that the burdens that health care imposes on family members are not as well documented as some other collateral consequences of health care discussed below; existing studies focus for the most part on the ultimate impacts of such care work on the *health* of the involved family member rather than other costs such as time or missed work.[44] The extreme case of "medical divorce" is part exception and part illustration. This extreme example of social consequences—a couple getting divorced to reduce health care bills associated with Medicaid—"has been discussed by attorneys and widely reported on in the media,"[45] but the

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[41] *See generally* Lawrence, *supra* note 3 (discussing this role); Allison K. Hoffman, *Reimagining the Risk of Long-Term Care*, 16 YALE J. HEALTH POL'Y L. & ETHICS 239 (2016) (discussing the risk-shifting aspect of long-term care given prominent role played by family caregivers); CHLOE SILVERMAN, UNDERSTANDING AUTISM: PARENTS, DOCTORS, AND THE HISTORY OF A DISORDER 94 (2011) (describing efforts of parents of children with autism to obtain health care). *Cf.* Una Stenberg et al., *Review of the literature on the effects of caring for a patient with cancer*, 19 PSYCHO-ONCOLOGY 1013 (2010).

[42] *See, e.g.*, Lawrence, *supra* note 41 (discussing conscription of family in advocating for coverage and accessing treatment); LaToya Baldwin Clark, *Beyond Bias: Culture in Anti-Discrimination Law*, 53 HARV. CIV. RTS.-CIV. LIBERTIES L. REV. 381 (2018) (describing efforts of parents of children with special needs in advocating for social services); Traci, Comment to *Insurance Has Denied Coverage for Growth Hormone*, CHILDREN WITH DIABETES (Aug. 8, 2012, 5:55 PM), https://forums.childrenwithdiabetes.com/threads/insurance-has-denied-coverage-for-growth-hormone.70915/ [https://perma.cc/KE3P-M7TZ] ("[T]hey killed a whole forest of trees with their denial letters when I had premature triplets in the NICU . . . they denied routine things for all kinds of crazy reasons. I learned to appeal . . . early and often.").

[43] Noah Zatz, *Supporting Workers by Accounting for Care*, 5 HARV. L. & POL'Y REV. 45, 46 (2011) (identifying "child-care invisibility" as underlying "patholog[y] in contemporary anti-poverty policy"). *See generally* MARTHA ALBERTSON FINEMAN, THE AUTONOMY MYTH: A THEORY OF DEPENDENCY (2004).

[44] *See* Lawrence, *supra* note 41, at 2 ("Scholarship addressing specifically the role of family in fighting disease . . . has appropriately focused on the crucial and pressing question of whether family involvement helps or hurts patients' (or, sometimes, caregivers') health outcomes, with some exceptions."). *But see* Hoffman, *supra* note 41 (exemplifying one such exception).

[45] David Slusky & Donna Ginther, *Did Medicaid Expansion Reduce Medical Divorce*? 3 (Nat'l Bureau of Econ. Research, Working Paper No. 23139, 2018) (economic model estimating that ACA reduced medical divorce rates by 11.6%); *see* Eve Kaplan, *Divorce Due to Medical Bills? Sometimes It Makes Sense*, FORBES (Aug. 21, 2014, 10:57 AM), https://www.forbes.com/sites/feeonlyplanner/2014/08/21/divorce-due-to-medical-bills-sometimes-it-makes-sense/#7a71fea574b8 [https://perma.cc/ADK3-DRWG] (explaining why Medicaid rules can create

term does not appear in published legal scholarship covered by Westlaw's Journals and Law Reviews database as of this writing.[46]

2. *Financial Consequences*

Financial distress, a second category of harms, refers to the collateral impacts on a patient's finances of a medical bill, *i.e.*, its opportunity cost.[47] This category of impacts is paramount in consumerism literature. Financial distress can manifest in foregone health care,[48] but can also result in, for example, a foregone vacation, an insured being rendered unable to borrow due to an adverse impact on the insured's credit,[49] or a lost home or other possessions due to foreclosure or repossession.[50] Medical bankruptcy, discussed just above, is an example of such financial distress. The subject has

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significant financial benefit to divorce as a way to protect family assets); *see also* Jean P. Hall et al., *Medicaid Expansion as an Employment Incentive Program for People With Disabilities*, 108 AM. J. PUB. HEALTH 1235 (Sept. 2018); Nicholas Kristof, *Until Medical Bills Do Us Part*, N.Y. TIMES: OPINION (Aug. 29, 2009), https://www.nytimes.com/2009/08/30/opinion/30kristof.html [https://perma.cc/5SN5-247V] (same).

[46] Author's Westlaw search of Journals and Law Reviews & Journals database for "medical divorce" run August 30, 2018 at 7:49 AM.

[47] *See* Robertson & Yokum, *supra* note 4, at 613 ("financial distress" exists among patients who "cannot afford the cost-sharing burden imposed by their health insurance problems," and therefore "effectively lose access to the healthcare, or they stretch and find themselves in bankruptcy or foreclosure."). To elaborate on this definition as used here, the "financial distress" associated with a cost-sharing liability is equal to the opportunity cost to the insured of bearing the liability. Despite the fact that prior work discussing "financial distress" in health care has been faulted for failing to define "financial distress," *see, e.g.*, Stephen G. Ware, *"Medical-Related Financial Distress" and Health Care Finance: A Reply to Professor Melissa Jacoby*, 55 U. KAN. L. REV. 1259, 1263–64 (2007), this definition can be understood to be implicit in scholarship describing medical bankruptcy or other high-opportunity-cost phenomena. The related term "underinsurance" is often used to describe the problem of too much cost-sharing. *See* Rashid Bashshur et al., *Defining Underinsurance: A Conceptual Framework for Policy and Empirical Analysis*, 50 MED. CARE REV. 199, 208–09 (1993). The analysis above reflects an economic definition of underinsurance, *i.e.*, one that asks, in part, "when out-of-pocket expenses for necessary medical care exceed a specified percent of the person's income within a given time frame, or when a person delays health care due to out-of-pocket costs associated with the services." Donald P. Oswald et al., *Defining Underinsurance Among Children with Special Health Care Needs: A Virginia Sample*, 9S MATERNAL & CHILD HEALTH J. S67, S68 (2005) (discussing economic, attitudinal, and structural definitions of underinsurance). So understood, "financial distress" is synonymous with the concept of "financial toxicity" used predominantly in cancer research. *See generally, e.g.*, S. Yousuf Zafar et al., *Financial Toxicity Part II: How Can We Help With the Burden of Treatment-Related Costs?*, 27 ONCOLOGY 253 (Apr. 2013) (describing opportunity costs of out-of-pocket costs as "financial toxicity"); S. Yousuf Zafar et al., *Financial Toxicity of Cancer Treatment: A Pilot Study of Out-of-Pocket Expenses and the Insured Cancer Patient's Experience*, 18 ONCOLOGIST 381 (Apr. 2013). *See generally* Jim Hawkins, *Regulating on the Fringe: Reexamining the Link Between Fringe Banking and Financial Distress*, 86 IND. L.J. 1361, 1367 (2011).

[48] *See* Seifert & Rukavina, *supra* note 38, at 90; *see also* JOST, *supra* note 33, at 106 (2007) ("Clinical evidence amply demonstrates that the uninsured forgo a great deal of medical care that is vitally important in reducing mortality and morbidity.").

[49] *See* Jacoby, *The Debtor-Patient Revisited*, *supra* note 4, at 311 ("Medical debt is among the notations on credit reports that debt collectors make most.").

[50] *See* Robertson et al., *Get Sick, Get Out*, *supra* note 4 (linking medical debt to foreclosure).

received extensive empirical study and discussion in legal scholarship, but controversy remains about how it can most accurately be measured.[51]

Financial distress can theoretically far exceed the dollar value of a liability itself.[52] For example, imagine a person with $5,000 in the bank and a one-day option to pay $5,000 cash for a $10,000 house. A primary cost of one dollar in liability imposed upon that person on that day, if the person is unable to secure additional financing, will carry with it a $5,000 opportunity cost because it will prevent the person from securing a significant profit. (If the person is able to obtain financing, the opportunity cost will be equal to the cost of interest on the one-day loan.)

3. *Psychological Consequences*

In addition to financial distress and impacts on family, medical bills can bring with them real stress and frustration. The epigraph that leads this Article is one example (and is also an illustration of social consequences). Emotional distress—adverse effects on a patient's wellbeing, broadly understood[53]—has been documented in qualitative studies.[54] Quantitative

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[51] *See* Margot Sanger-Katz, *Elizabeth Warren and a Scholarly Debate Over Medical Bankruptcy that Won't Go Away*, N.Y. TIMES: THE UPSHOT (June 6, 2018), https://www.nytimes.com/2018/06/06/upshot/elizabeth-warren-and-a-scholarly-debate-over-medical-bankruptcy-that-wont-go-away.html [https://perma.cc/E97F-ESNR].

[52] *See* CALABRESI, *supra* note 3, at 27 (describing such costs as "secondary costs"). *See generally* Stanley Ingber, *Rethinking Intangible Injuries: A Focus on Remedy*, 73 CAL. L. REV. 772 (1985); Michelman, *supra* note 3, at 1214 (long-time homeowner whose property is seized through eminent domain may suffer zero primary cost if she is paid the market price for her home but carries associated anguish that constitutes a substantial additional cost of its own).

[53] The normative framework advanced by this Article incorporates emotional distress, broadly understood, on the assumption that laws should be designed to maximize not just wealth but wellbeing, broadly understood. It is in some sense an application of "therapeutic jurisprudence" to the rules and policies that govern liability for health care costs. *See* Peter Johnsen & Elia Robertson, *Protecting, Restoring, Improving: Incorporating Therapeutic Jurisprudence and Restorative Justice Concepts into Civil Domestic Violence Cases*, 164 U. PA. L. REV. 1557, 1571–73 (2016) (offering overview of therapeutic jurisprudence, which "involves the use of various social sciences to determine 'the extent to which a legal rule or practice promotes the psychological and physical well-being of the people it affects'" (quoting Christopher Slobogin, *Therapeutic Jurisprudence: Five Dilemmas to Ponder*, 1 PSYCHOL. PUB. POL'Y & L. 193, 196 (1995)). This is also consistent with recent developments in cost-benefit analysis. *See* John Bronsteen et al., *Well-Being Analysis vs. Cost-Benefit Analysis*, 62 DUKE L.J. 1603 (2013) (arguing in favor of incorporating hedonic measures into cost-benefit analysis). *But cf.* Matthew D. Adler, *Happiness Surveys and Public Policy: What's the Use?*, 62 DUKE L.J. 1509 (2013) (surveying normative hedonic literature and expressing skepticism about incorporating hedonic measures into public policy). While some have argued that the emotional distress associated with cost-sharing itself harms a patient's health by impeding healing, that claim is not a premise of this Article. *See generally* PRYOR ET AL., *supra* note 1.

[54] *See* KAREN POLLITZ ET AL., KAISER FAMILY FOUND., MEDICAL DEBT AMONG PEOPLE WITH HEALTH INSURANCE (Jan. 7, 2014), https://kaiserfamilyfoundation.files.wordpress.com/2014/01/8537-medical-debt-among-people-with-health-insurance.pdf [https://perma.cc/9SFW-BDRM] (summarizing in-depth interviews with 23 insured individuals struggling with medical debt); Jacoby & Holman, *supra* note 35, at 247 (surveying adverse consequences of medical debt, including over-rationing of care and self-rationing of non-medical expenses); PRYOR ET AL. *supra* note 1, at 56–57 ("Most of our interviewees said that their unpaid medical bills contributed to increased stress and tension in their families."); Wilhelmine Miller et al.,

work documenting the emotional costs of health insurance is harder to find, though one example may be the Oregon Medicaid study insofar as it demonstrated that the financial security associated with health insurance reduced the incidence of depression.[55]

Moreover, another harm fitting within the category of "psychological costs" is the concept of psychological "decisional burden" that has been explored in the context of health insurance by Robertson and Yokum.[56] Melissa Jacoby uses a related phrase: "consolation costs."[57] As Robertson and Yokum explain, this refers to the disutility associated with being forced to make decisions about health care and having to keep track of complicated (often bewilderingly complicated) medical bills. Such stress can not only cause harm on its own but lead to "choice overload," "depletion of cognitive capacity," and "facilitation of regret."[58] These, in turn, can all increase other costs of insurance by causing insureds to make poor choices or feel greater remorse about the choices they have made.

B. Health Insurance Reduces but Does Not Eliminate the Social, Financial, and Psychological Consequences of Health Care

As explained below, for most patients in the United States the social, financial, and psychological consequences of health care are largely shaped by the terms and administration of their health insurance plans. Among other things such plans influence when, where, why, how, and for what individuals are subject to medical bills.

1. Health Insurance Exists in Part to Reduce Social Consequences

The goal of insulating patients from significant medical expenses is a primary reason government mandated the purchase of health insurance through the Affordable Care Act (until the mandate was repealed); incentivizes the purchase of health insurance through the tax code and subsidies; and largely gives away health insurance (through Medicare, Medicaid, and

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Covering the Uninsured: What Is It Worth?, 4 HEALTH AFF. 157, 162 (Mar. 2004) ("The social stigma and psychological stresses of medical indigency, health care debt, and bill collection efforts are themselves burdensome."); JACOB S. HACKER, THE GREAT RISK SHIFT: THE NEW ECONOMIC INSECURITY AND THE DECLINE OF THE AMERICAN DREAM 138–40 (2006) (describing "America's crumbling infrastructure of health financing"). *Cf.* Seifert & Rukavina, *supra* note 38 ("Medical bankruptcy . . . is an extreme example of a much broader phenomenon."); Robertson et al., *Get Sick, Get Out*, *supra* note 4 (indicating medical debt as a cause of home foreclosures); Sanger-Katz, *supra* note 5 (reporting example of factory worker who cashed in his IRA to pay $4,000 in cost-sharing on knee replacement).

[55] *See generally* Katherine Baicker et al., *The Oregon Experiment—Effects of Medicaid on Clinical Outcomes*, 368 NEW ENG. J. MED. 1713 (2013).

[56] *See generally* Robertson & Yokum, *supra* note 4.

[57] Jacoby, *supra* note 4, at 319 (defining "consolation costs" as "the exhaustion from fighting a disease and the bureaucracy associated with insurers and providers").

[58] Robertson & Yokum, *supra* note 4.

CHIP health insurance).[59] Reducing liability borne by patients by making an insurer responsible for some health care costs reduces all social consequences, though the goal of reducing financial distress associated with health care costs is ordinarily paramount in discussions of the purposes of insurance.[60] This goal is also a significant reason we closely regulate the cost and content of health insurance.[61]

2. *Derivative Social Consequences Are Inevitable Even For Insureds*

The insulation that insurance provides against medical bills is usually incomplete. Insureds ordinarily bear significant medical liability through "cost-sharing," *i.e.*, medical expenses that are technically "covered" by a patient's insurance plan but that she has to pay herself. It is important to understand cost-sharing's many forms and its potential affordability and health care quality impacts in order to understand how health care's social consequences are influenced by health insurance and may be balanced against medical consequences.

Form of bills. From the insured's perspective, cost-sharing can take a bewildering array of forms.[62] An annual deductible is an amount that a patient must pay (herself or for her family) before insurance kicks in; these often run in the thousands of dollars. Coinsurance refers to a percentage

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[59] *See* ACA § 1501, 42 U.S.C. § 18091 (2012 & Supp. II 2014) ("The individual responsibility requirement."); Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012) (discussing purposes of mandate that individuals purchase health insurance; holding that Tax Power authorized Congress to promulgate mandate); Allison K. Hoffman, *Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1873, 1908–11 (2011) (discussing financial security as one of three conceptual purposes of ACA's insurance expansion); *cf.* MICHAEL J. GRAETZ & JERRY L. MASHAW, TRUE SECURITY (1999) (focusing on financial stability purposes of social insurance). Another primary reason for making health insurance widely available is to facilitate access to health care even to those who could not otherwise afford big-ticket health care expenses. *See* 42 U.S.C. § 1315 (2015) (discussing medical assistance-providing purposes of Medicaid).

[60] Health insurance's capacity to improve wellbeing by insulating consumers from financial distress is perhaps its most well-established benefit. *See, e.g.*, Baicker et al., *supra* note 55, at 1721 ("We found that insurance led to increased access to and utilization of health care, substantial improvements in mental health, and reductions in financial strain, but we did not observe reductions in measured blood-pressure, cholesterol, or glycated hemoglobin levels."). It is actually unclear whether health insurance reduces or increases health care costs. *See generally* RAND HEALTH, THE HEALTH INSURANCE EXPERIMENT: A CLASSIC RAND STUDY SPEAKS TO THE CURRENT HEALTH CARE REFORM DEBATE (2006), https://www.rand.org/content/dam/rand/pubs/research_briefs/2006/RAND_RB9174.pdf [https://perma.cc/UA38-LKXB]; TERESA A. SULLIVAN ET AL., THE FRAGILE MIDDLE CLASS: AMERICANS IN DEBT (2008). For an overview of health insurance's access, equality, solidarity, and financial-security-promoting benefits, see generally Allison K. Hoffman, *Health Care Spending and Financial Security after the Affordable Care Act*, 92 N.C. L. REV. 1481, 1497–526 (2013); Tom Baker, *Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1577 (2011).

[61] *See* Amy B. Monahan, *Fairness Versus Welfare in Health Insurance Content Regulation*, 2012 U. ILL. REV. 139 (2011) (surveying and assessing welfare economic case for state health insurance content regulations).

[62] *See* Hoffman, *supra* note 59 (describing forms of cost-sharing and ways in which health insurance regulation can promote financial security).

contribution that a patient must contribute toward certain sorts of care such as hospital stays, out-of-network care, or pharmaceuticals. For example, Medicare outpatient care carries a twenty-percent coinsurance requirement. And copays are fixed point-of-service charges for visiting the doctor, a minute clinic, and so on. The ACA sets an annual out-of-pocket maximum—a cap on how much an insured must pay in cost-sharing for essential health benefits in a given year—of $6,700 for an individual and $12,700 for a family, but this cap does not apply to cost-sharing on out-of-network care or certain non-standard benefits.[63] Finally, although not traditionally thought of as a form of cost-sharing,[64] ordeals that an insured must complete in order to obtain coverage—like being forced to obtain a referral from a primary care doctor before receiving specialty care—ought to be considered in evaluating means insurers use to shift costs to insureds and combat moral hazard.[65]

Social, financial, and psychological consequences. The liability cost-sharing passes to insureds can impose the very financial harms that drive us to get people insured in the first place (as well as related social and psychological consequences).[66] That is why medical bankruptcy is common for the insured as well as the uninsured.[67] Indeed, the dramatic stories that have motivated the recent wave of state health insurance reforms are dramatic precisely be-

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[63] *See* ACA §1302, 42 U.S.C. § 18022 (2012 & Supp. II 2014).

[64] *See* JOST, *supra* note 33, at 65 (describing six forms of cost-sharing: deductible, coinsurance, copay, balance-billing, "costs that an insured incurs when medical bills exceed maximum coverage," and out-of-pocket payments "for health care services not covered by insurance").

[65] *See* Benjamin A. Olken, *Hassles Versus Prices*, 353 SCIENCE 864 (Aug. 26, 2016) (describing intentional use of hassles as a "cost" patients must pay in order to obtain care).

[66] *See* Jacoby, *supra* note 4; Sanger-Katz, *supra* note 5 (reporting on a poll in which "roughly 20 percent of people under age 65 with health insurance nonetheless reported having problems paying their medical bills over the last year"); HAMEL ET AL., *supra* note 5; POLLITZ, *supra* note 5 ("Cost-sharing levels under many health plans now exceed the resources that most families have on hand."); Sara R. Collins et al., *The Problem of Underinsurance and How Rising Deductibles Will Make It Worse*, COMMONWEALTH FUND, (May 20, 2015), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2015_may_1817_collins_problem_of_underinsurance_ib.pdf [https://perma.cc/8DNP-6BB3] (stating that "23 percent of 19-to-64-year-old adults who were insured all year—or 31 million people—had such high out-of-pocket costs or deductibles relative to their incomes that they were underinsured"); BD. OF GOVERNORS OF THE FED. RESERVE SYS., REPORT ON THE ECONOMIC WELL-BEING OF U.S. HOUSEHOLDS IN 2013 3 (July 2014), https://www.federalreserve.gov/econresdata/2013-report-economic-well-being-us-households-201407.pdf [https://perma.cc/E8BP-LR5V] ("Only 48 percent of respondents said that they would completely cover a hypothetical emergency expense costing $400 without selling something or borrowing money.").

[67] The sources collected *supra* Part II.A describe high rates of medical bankruptcy among both the uninsured and the insured. *See also* Jacoby & Warren, *supra* note 4, at 553–54 ("nationwide and local studies by groups such as the Commonwealth Fund, the Center for Studying Health System Change, the Kaiser Family Foundation, and the Access Project have observed significant financial vulnerability and medical indebtedness even among the insured"); Himmelstein, *supra* note 35, at 744 (study reporting that seventy-eight percent of medical bankruptcy filers had health insurance). *See generally* Nation, *Healthcare and the Balance-Billing Problem*, *supra* note 18 (noting distress caused by unexpected medical bills associated with care at out-of-network hospitals).

cause the patients involved had health insurance that was supposed to protect them but failed to do so.[68]

Health insurance enrollment impacts. While at first glance cost-sharing seems to contradict insurance's purpose of insulating patients from health care costs, there is a reason it is a common feature of insurance. By giving patients "skin in the game," cost-sharing combats "moral hazard," encouraging patients to shop for quality doctors, avoid wasteful health care expenditures, and so on.[69] Research supports the theory that cost-sharing reduces health care consumption.[70] It thereby makes health insurance itself more affordable in a competitive market, trading increased health care uncertainty for those who have insurance (but must pay for some medical bills) for decreased health care uncertainty for those who can afford health insurance thanks to the lower premiums enabled by cost-sharing (but would not be able to afford the premiums of a cost-sharing-free plan). As a result, cost-sharing is a key element of the currently dominant "consumerist" approach to bending the cost curve by finding someone (in the case of consumerism, the patient) to say "no" to some treatments and services.[71]

Medical impacts. In addition to impacts on costs, cost-sharing also has the potential to improve or reduce the quality of care (and so health outcomes) by changing the behavior of doctors and patients.[72] The potential for

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[68] *See supra* Part I.A.

[69] Ryan Sugden, *Sick and (Still) Broke: Why the Affordable Care Act Won't End Medical Bankruptcy*, 38 WASH. U. J.L. & POL'Y 441, 469 (2012) ("Consumer-driven plans rely on out-of-pocket expenses and deductibles to drive consumer behavior"); *see also supra* Part I.A (collecting sources).

[70] *See e.g.*, JOSEPH P. NEWHOUSE, INS. EXPERIMENT GRP., FREE FOR ALL?: LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT 339–72 (1996) (finding cost-sharing reduced medical expenditures). *See generally* JONATHAN GRUBER, KAISER FAMILY FOUND., THE ROLE OF CONSUMER COPAYMENTS FOR HEALTH CARE: LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT AND BEYOND 1 (Oct. 2006), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7566.pdf [https://perma.cc/VT8E-QCFB] (discussing findings that cost-sharing reduces expenditures); Christopher T. Robertson, *Scaling Cost-Sharing to Wages: How Employers Can Reduce Health Spending and Provide Greater Economic Security*, 14 YALE J. HEALTH POL'Y L. & ETHICS 239, 255–57 (2015) (discussing evidence that cost-sharing reduces medical expenditures).

[71] JOST, *supra* note 33, at 17 ("[Consumer-driven health care] has become to the middle of the first decade of the twenty-first century what managed care was to the 1980s and 1990s and health planning to the 1970s"); *see* Mark A. Hall, *Making Medical Spending Decisions: The Law, Ethics, and Economics of Rationing Mechanisms*, 19 J. LEG. MED. 143 (1997) (discussing need to limit some care). *See generally* Hoffman, *supra* note 60 (surveying potential enrollee liability under Medicare, under employer-based insurance, and in the individual and small group marketplaces).

[72] *See* Geoffrey Hoffman, *Cost-Sharing, Physician Utilization, and Adverse Selection Among Medicare Beneficiaries with Chronic Conditions*, 72 MED. CARE RES. REV. 49, 50 (Feb. 2015) ("While cost-sharing is generally known to reduce consumption of a number of different health services, the normative question of whether utilization differences . . . reflect overutilization or underutilization . . . has not been resolved."). *Compare* Amitabh Chandra et al., *Impact of patient cost-sharing in low-income populations: Evidence from Massachusetts*, 33 J. HEALTH ECON. 57 (2014) (moderate adverse health effects from cost-sharing), *and* Collins et al., *The Problem of Underinsurance*, *supra* note 66; Michael T. Eaddy et al., *How Patient Cost-Sharing Trends Affect Adherence and Outcomes*, 37 PHARMACY & THERAPEUTICS. 45 (Jan. 2012) (review of 160 articles demonstrated reduction in adherence to drug regimen due to cost-sharing,

improvement comes from the fact that cost-sharing is a vehicle through which patients can be prompted or incentivized to seek preventive care and adhere to treatment protocols, and through the fact that cost-sharing empowers insurers to use network participation as a carrot (and stick) to force providers to coordinate care among specialists, hospitals, and other providers or ensure doctors are informed of the latest developments, drugs, and devices or incentivized to increase their own quality. The potential for reduction in quality comes from the fact that cost-sharing encourages doctors to short-cut some patients' treatment, creates paperwork that prevents doctors from doing their job, interferes with the doctor-patient relationship, and may discourage consumption of necessary care that would have been worth its cost.[73]

This Article does not take a position on whether cost-sharing is ultimately desirable or not in light of these conflicting financial and medical impacts. Whatever the merit of cost-sharing, the Affordable Care Act locked it in as a critical component of a contemporary healthcare system based around health insurance,[74] and that aspect of our health care system does not appear to be going anywhere, "repeal and replace" or not; indeed the role of insurance and of cost-sharing is growing, not shrinking.[75] So for present purposes, cost-sharing is an inevitable and significant part of U.S. health care. As the next section will explain, however, the fact that we must accept that even insured individuals will have significant medical bills does not mean we should accept all of the social, financial, and psychological consequences those bills create.

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with corresponding adverse health outcomes), *with* Hitoshi Shigeoka, *The Effect of Patient Cost-sharing on Utilization, Health, and Risk Protection*, 104 AM. ECON. REV. 2152 (July 2014) (finding little effect on mortality but significant effect on spending due to cost-sharing in Japan).

[73] *See, e.g.*, Aetna Health Inc. v. Davila, 542 U.S. 200 (2004) (insurer pushed patient to take cheaper alternative to drug recommended by doctor, resulting in harmful side effects).

[74] *See* ACA § 1302(c), 42 U.S.C. § 18022 (2012 & Supp. II 2014) (permitting cost-sharing in the individual and small group markets subject to a maximum out-of-pocket limit).

[75] A central focus of policymakers at the federal level has continued to be legislation directed at enrollment in insurance through the individual and small group marketplaces. For example, consider enacted legislation to repeal the "individual mandate" that required the purchase of health insurance coverage. *See* Tax Cuts and Jobs Act of 2017, Pub. L. No. 115-97, 131 Stat. 2054 (to be codified at 26 U.S.C.A. §5000A) (repealing tax penalty associated with ACA's mandate that individuals buy health insurance). In 2016, 22 million of the 244 million Americans with health insurance obtained it through these marketplaces, or less than one in ten. *See* CONG. BUDGET OFFICE, FEDERAL SUBSIDIES FOR HEALTH INSURANCE COVERAGE FOR PEOPLE UNDER AGE 65: 2016 TO 2026 (Mar. 2016), www.cbo.gov/publication/51385 [https://perma.cc/GC23-5FQD]. Regardless of what Congress, the Executive, or states might do with these marketplaces, the affordability of health insurance for the hundreds of millions who have it through them or other sources will be a central issue for the future of the American health care system. *See generally id.* (predicting a continued dominant role for health insurance in American health care through at least 2026).

C. The Social Consequences of Health Care Are Consequences of Health Insurance

An insured's share of her medical bills due to cost-sharing or other limitations of her plan is commonly understood as if she did not have insurance at all for those bills. This reflects the common scholarly understanding that cost-sharing is "just the absence of insurance for certain costs."[76] As elaborated upon below, while understanding cost-sharing as the absence of insurance is a helpful simplification in other contexts, it is incorrect as applied to the social consequences of medical bills because (a) the social consequences of a medical bill depend critically on its context and (b) the context of an insured's medical bills depends critically on the terms and administration of her health insurance plan.

1. The Social Consequences of a Medical Bill Depend on Context

Behavioral law and economics has highlighted that the context of a cost significantly influences its real-world impact. That is why, for example, cell phone companies fold the costs of shiny new smartphones into monthly service contracts rather than requiring large, separate, up front payments.[77] And, on the other hand, it is why those same companies require a customer hoping to cancel her plan to pay a large fee before termination—to increase the pain of the termination.[78] Such research helps survey the theoretical landscape of ways in which the social, financial, and psychological consequences of medical bills are not constant across individuals and contexts but may tend to vary predictably:

Budgetability: The financial distress (opportunity cost) associated with a medical bill depends not just on the size of the bill but more fundamentally on the bill's impact on the patient's budget, *i.e.*, the likelihood that the insured is able to pay the bill without having to make financial sacrifices in any given budget period (presumably a month). Such budgetability, in turn, depends not just on the overall magnitude of the bill but also: (1) the insured's wealth as reflected in her available monthly assets,[79] (2) the bill's foreseeability, because an insured is better able to (and has greater reason to) plan ahead and thereby spread over several months *ex ante* a foreseeable bill than a sur-

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[76] Robertson, *supra* note 70; *see also* Christopher T. Robertson, *Should Patient Responsibility for Costs Change the Doctor-Patient Relationship?*, 50 WAKE FOREST L. REV. 363, 364 (June 2015) ("cost-sharing is simply the absence of insurance for the out-of-pocket costs"); Jessica L. Roberts, *An Alternative Theory of Burwell v. Hobby Lobby*, 22 CONN. INS. L.J. 85, 109 n.145 (2016) (endorsing this characterization).

[77] *See, e.g.*, Oren Bar-Gill & Rebecca Stone, *Mobile Misperceptions*, 23 HARV. J.L. TECH. 49, 81–92 (2009).

[78] *Id.* at 90; *see also* Oren Bar-Gill, *The Behavioral Economics of Consumer Contracts*, 92 MINN. L. REV 749 (2007) (describing corporate adaptation).

[79] *See, e.g.*, Jacoby, *supra* note 4, at 310 ("the financial burden of medical expense is in part a function of income"); *see* THE HEALTH INSURANCE EXPERIMENT, *supra* note 60; Jacoby & Holman, *supra* note 35, at 239.

prise bill; (3) the interaction of the bill's due date and the availability and cost of financing for the bill; and (4) the ease (or difficulty) to the insured of securing such financing and thereby spreading the liability over several months *ex post*.[80]

Complexity: Research in behavioral economics indicates that a person's "cognitive load"—the relative demands to make decisions at a given time—can systematically influence how she processes new information and makes decisions.[81] The psychological consequence of "decisional burden" described by Robertson and Yokum is itself a function not only of the health care choices we ask the patient to make but the volume and complexity of medical bills we send her. As a Kaiser Family Foundation survey of those struggling with medical debt due to cost-sharing reported:

> Nearly all those interviewed emphasized how the sheer volume of bills during a major health event was overwhelming. They had trouble tracking what had been paid, what was owed, and what had been transferred to collections.[82]

Furthermore, an insured who cannot keep track of what she owes—or whose spare time is all devoted to answering that question—is less able to search for and find efficient, low-cost financing that might be available to satisfy the bill, increasing the likelihood of ultimate default and an adverse impact on her credit and future prospects. Thus, the complexity (including the volume) of bills through which liability is imposed on the insured may itself exacerbate its consequences.

Timing: Sickness makes a person more vulnerable. Shuttling to appointments, learning about an illness, researching doctors, coordinating with loved ones, and managing medications all take up the patient's (and her family's) time and energy and impose stress, decreasing a person's (and her family's) ability to cope with and manage an unexpected (or even an expected) financial obligation. "Someone who is ill and seeking help—unlike someone who is purchasing a pair of socks or a pound of sausages—is often vulnerable, certainly worried, sometimes uncomfortable, and frequently frightened."[83] These emotional demands may tend to exacerbate the social consequences of medical bills forced upon a patient in the midst of illness—

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[80] These theoretical points are drawn from the larger trend in behavioral economics and finance to reduce the magnitude of any individual payment and defer payments into the future because such consumer installment plans featuring monthly (or otherwise periodic) payments are or appear to be more manageable for consumers. *See* Cass R. Sunstein, *Boundedly Rational Borrowing*, 73 U. CHI. L. REV. 249, 251–53 (2006) (noting that monthly payments appear smaller, more manageable).

[81] *See generally* Robertson & Yokum, *supra* note 4 (providing overview of behavioral research into cognitive load); Michael S. Barr et al., *Behaviorally Informed Regulation*, *in* THE BEHAVIORAL FOUNDATIONS OF PUBLIC POLICY (E. Shafir ed., 2012).

[82] POLLITZ ET AL., *supra* note 54.

[83] Hall & Schneider, *supra* note 39, at 650–51 ("Illness disables. . . . Illness pains. . . . Illness exhausts. . . . . Illness erodes control. . . . Illness enforces dependence. . . . Illness disorients. . . . Illness baffles. . . . Illness terrifies. . . . Illness isolates.").

many hospitals present bills on a patient's way out the door—as opposed to after the insured has had the opportunity to recover and adjust.[84]

Relatedly, the cognitive burden of a liability depends not only on the bill's complexity but also the recipients' relative ability to understand and process the liability. This will depend on the presence of other demands on the insureds' time—such as job or care work obligations—as well as the insureds' familiarity with billing and financing practices.

Framing and source: Furthermore, the framing of cost-sharing bills could further influence the associated social consequences. "[R]e-framing a situation in subtle ways that would be irrelevant from the perspective of the standard economic model can have large effects on behavior."[85] Two framing considerations are of particular note for the way we bill for cost-sharing: First, the perceived source of a liability may be important. In most plans today cost-sharing on covered care is technically billed for and collected by the provider, even though it is actually an aspect of the insurance product. As discussed further below, this may damage the doctor-patient relationship, make it harder for the insured to understand her cost-sharing obligations, increase the salience of such bills, and further undermine insurers' incentive to compete on the quality of their cost-sharing arrangements.[86] Second, research in procedural justice reveals that a person's perception of the fairness of a liability—their sense of whether it is "just" or "unjust" that they have been assigned a liability—can influence its psychological impact.[87]

2. *The Context of an Insured's Medical Bills Depends on Her Health Insurance Plan*

Some of the variables that influence the social consequences of medical bills are not subject to the control of the health insurance contract; the patient's wealth certainly is not in the insurer's control, and the amount of a bill charged by an out-of-network provider for uncovered care is also not neces-

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[84] The Access Project's reported interviews with patients dealing with cost-sharing offer anecdotal support. *See* PRYOR ET AL., *supra* note 1, at 56 (summarizing interviews of families after medical events; "[f]or lower income families who are trying to live on tight budgets, medical expenses added to the overall stress of trying to make do with limited resources"); *id.* at 57 ("A number of interviewees similarly commented that the increased stress and tension affected their health and ability to heal.").

[85] Colin Camerer et al., *Regulation for Conservatives: Behavioral Economics and the Case for Asymmetric Paternalism*, 151 U. PA. L. REV. 1211, 1230 (2003). *See also* Russell Korobkin, *Libertarian Welfarism*, 97 CAL. L. REV. 1651, 1658 (2009) (a "thread of research in the field of judgment and decision making demonstrates that preferences are not fixed and invariant to context, as rational choice theorists usually assume. Rather, people often construct preferences at the point of decision making based, at least in part, on contextual cues"). These cues include a person's perception of the status quo and the reference point (which impacts whether a cost is viewed as a loss). *Id.* at 1658.

[86] *See* Hall & Schneider, *supra* note 39, at 652 (discussing challenges, given doctor-patient relationship and doctors' training, of doctors acting strictly as sellers); *id.* ("The patient's bond with the doctor is not easily created nor lightly sacrificed.").

[87] *See generally* Matthew J.B. Lawrence, *Mandatory Process*, 90 IND. L.J. 1429 (2015) (describing literature).

sarily in the insurer's control (though the insurer could contract with the provider, include her in its network, or help the insured negotiate or litigate over price). But many other determinants of a bill's social consequences are within the complete control of a health insurance plan, and others are at least subject to the plan's influence.

First, the context in which an insured individual comes to face medical liability is ultimately set by the terms of the insurance contract. By dictating what care is covered by which providers and setting cost-sharing forms and amounts, the insurance contract shapes the liability the insured might come to bear. Even liabilities that are in some sense beyond the insurer's control, like high rates charged by a stubborn tertiary provider who provides an experimental service, are ultimately subject to and could themselves be covered by the insurance contract. Insureds must bear their own medical expenses only when and where their insurance plan requires them to do so.

Second, insurers are very well suited to manage, monitor, and assist in their enrollees' health care consumption decisions, shopping experiences, and bills, regardless what care they technically cover.[88] While an individual's own experiences finding an emergency room or an in-network surgical team may seem unique and hard to predict, the experience of enrollees in an insurance plan generally is not unforeseeable to the insurer.[89] Quite the opposite, a core function of an insurance company is to predict the claims experience of its enrollees—whether they will get sick, who they will see, what treatments they will receive, and what those treatments will cost—and insurers increasing access to "big data" about their insureds is making them better and better at doing that. As recently surveyed by PBS:

> With little public scrutiny, the health insurance industry has joined forces with data brokers to vacuum up personal details about hundreds of millions of Americans . . . . The companies are tracking

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[88] For example, reports indicate that a change in insurers in one state led to a spike in balance billing in that state by providers. *See* Olga Khazan, *The Agony of Medical Bills*, ATLANTIC (May 21, 2015), https://www.theatlantic.com/health/archive/2015/05/the-agony-of-surprise-medical-bills/393785/ [https://perma.cc/3QPU-LGZ3] (reporting that balance billing rates for state employees spiked after United Healthcare began running the state's health plan).

[89] Examples of apps built to help insured populations understand medical costs and shop among providers illustrate the potential for health insurers to make up for patients' lack of knowledge and difficulty asking and learning prices. *See* Robin Gelburd, *You Can Negotiate Costs with Doctors? A New Mobile App to Improve Health Insurance Literacy*, CONN. HEALTH FOUND. (Sept. 6, 2016), https://www.cthealth.org/latest-news/blog-posts/you-can-negotiate-costs-with-doctors-a-new-mobile-app-to-improve-health-insurance-literacy/ [https://perma.cc/6HK2-C954] (describing Connecticut-focused app designed to help insured populations understand medical costs for out-of-network lab tests); Joel Ario & Stuart M. Butler, *How Mobile Apps Will Empower Health Care Consumers*, BROOKINGS (Apr. 20, 2015), https://www.brookings.edu/blog/health360/2015/04/20/how-mobile-apps-will-empower-health-care-consumers/ [https://perma.cc/5ZFV-D4T8] (describing "Stride Health," a startup offering technology to help consumers with cost-sharing decisions); *cf.* Melissa Blair, *Apps to Use When Shopping for Health Insurance Win National Competition*, ROBERT WOOD JOHNSON FOUND. (Mar. 19, 2015), http://www.rwjf.org/en/library/articles-and-news/2015/03/apps-to-use-when-shopping-for-health-insurance-win-national-comp.html [https://perma.cc/92JJ-LJ52] (describing apps designed to help consumers choose health plans).

> your race, education level, TV habits, marital status, net worth. They're collecting what you post on social media, whether you're behind on your bills, what you order online. Then they feed this information into complicated algorithms that spit out predictions about how much your health care could cost them. . . . Insurers contend they use the information to spot health issues in their clients—and flag them so they get the services they need.[90]

This summary raises diverse issues, some downright dystopian and reaching beyond the scope of this Article. The point here, more modestly, is simply that insurers have the capability and the information necessary to predict and spot not just health issues in their clients, but social, financial, and psychological issues associated with the care they receive and the bills they incur, as well. If anyone can spot a balance bill before it happens, it is a person's insurer.

Third, having health insurance in some ways increases (but could decrease) the likely social consequences of the bills a patient receives due to cost-sharing. When an insured patient is completely surprised by a bill because she assumed that she wouldn't have to pay at all due to her health insurance—as often happens today—she is left worse off as to that bill, not better, because she will have had no opportunity to budget for the bill or arrange for payment. Similarly, by making coverage for certain treatments like applied behavioral therapy for autism practically available only through the pursuit of time- and labor-intensive appeals processes, health insurance simultaneously increases access to such care and creates social consequences for the parents or partners involved in pursuing such appeals. Finally, were an insurance plan to coordinate financing for such a bill the patient would be better off, not worse, than she would have been were she left to manage the expense on her own.

Thus, cost-sharing is *not* merely the absence of health insurance when it comes to social consequences; the fraction of her health care costs that an insured bears might bring with it outsized or undersized social consequences, depending on the terms of her plan. Health insurance plans can do much more than just cover claims; they can (and, through cost-sharing, usually do) also govern how and when an insured bears liability for her medical care, significantly altering the context of that liability and, with it, the social consequences. While cost-sharing represents a hole in the health insurance safety net, it can be designed to cushion—or exacerbate—the impact of medical bills on the patient and her family.

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[90] Marshall Allen, *Why health insurers track when you buy plus-size clothes or binge-watch TV*, PBS (July 17, 2018, 10:18 AM), https://www.pbs.org/newshour/health/why-health-insurers-track-when-you-buy-plus-size-clothes-or-binge-watch-tv [https://perma.cc/2NVF-AW4T].

D. Health Insurance Markets Fail to Account for Social, Financial, and Psychological Consequences

1. Presumption of Efficient Tradeoffs

In a world of scarcity, tradeoffs are inevitable. Health insurance's social, financial, and psychological consequences may be undesirable in and of themselves but, as discussed in Part I.B, it does not necessarily follow that there is a feasible way to reduce them without causing countervailing harms.

This section identifies a problem with the way social consequences of health insurance are calibrated in U.S. health care today that tends to increase their costs unnecessarily, *i.e.*, a reason to believe such consequences are not currently calibrated "efficiently" (and so a reason that regulatory changes to reduce them could produce net benefits from the normative standpoint of welfare economics). The following Parts will utilize this explanation, which is grounded in evidence-based theorizing about the behavior of providers, patients, and insurers, to develop ways that social consequences can be reduced using law.

2. Market Failures in Health Insurance Generally

Like other aspects of the health insurance product, the social consequences of health insurance in the U.S. today are calibrated largely through the market for health insurance. Individuals purchase health insurance contracts from insurers or their employers; these contracts and insurers' performance pursuant to them, in turn, determine when, where, and how patients will face social, financial, housing, and psychological consequences associated with medical bills.[91] Social consequences are like the miles-per-gallon of a new car: an aspect of a product consumers buy that is largely determined by the seller but subject to the control (or at least influence) of the buyer through her purchasing decisions insofar as sellers want buyers to purchase their products.

Our current market-based approach to calibrating the social consequences of health insurance reflects the economic view of how best to make difficult tradeoffs under conditions of scarcity. Classical economics holds that, under certain critical assumptions, a well-functioning market makes tradeoffs "efficiently," *i.e.*, buyers and sellers agree to prices and products that maximize their net expected utility.[92] In other words, economics makes the

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[91] The providers that patients see—who may or may not be under a separate contract with the insurer—also shape social consequences for insureds to the extent that the insurance plan leaves providers with responsibility for billing cost-sharing and discretion to impact its magnitude, but that responsibility is itself derivative of and subject to the antecedent health insurance contract between insurer and insured. *See supra* Part II.B.3.

[92] *See, e.g.*, Tom McGuire, *Demand for Health Insurance*, *in* 2 HANDBOOK OF HEALTH ECONOMICS 317, 375 (Mark V. Pauly et al. eds., 2012) (discussing interaction between economic efficiency and choice in health insurance).

normative assumption that the best way to make tradeoffs between competing values (like cost and function, or health and finances) is to let people make those tradeoffs for themselves and predicts that a well-functioning market is usually an effective (and perhaps the most effective) way to engage people to make those tradeoffs.

The economic approach to making difficult tradeoffs has over the last several decades attained prominence in health insurance and increasingly penetrated into health care as well. Whereas health care was for many years exempt from the antitrust laws under the assumption that the market paradigm did not apply to the behavior of doctors, "consumerism" in health care—the market-based approach to making hard health care tradeoffs—is influential in scholarship and simply dominant in policymaking in the United States.[93]

The economic approach accepts that there may be contexts in which its assumptions and predictions do not apply. That is, the economic approach accepts that "market failures" are possible and can deprive markets of their optimality for making tradeoffs, opening the door to regulation. On the economic approach the first-best option in such a case is to use such regulation to fix the market failures and allow the market to make the tradeoffs as it should.[94] The second-best option is to use regulation to make or promote the better making of tradeoffs.

The managed benefits literature of the late 1990s took this economic approach on its own terms—albeit in some cases merely *arguendo*[95]—but pointed out a number of features of the health insurance market that can force health insurers to offer inefficient products from the standpoint of medical or health consequences. That is, the managed benefits literature identified problems (and so made arguments for regulation) that were internal to the classical economic approach, identifying potential failures in health insurance markets that rebut the presumption that the market is the best way to calibrate access to and quality of health insurance products. To generalize, these health insurance market failures identified in the managed benefits literature are adverse selection, incomplete contracting, and behavioral biases.

Adverse selection: "Adverse selection" is the economic term for the behavioral prediction, "borne out in practice,"[96] that people who most need

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[93] *See* Hall, *Managed Competition*, *supra* note 25, at 1, 11 (discussing the work of Enthoven and Havighurst developing market-based approach to medical spending decisions). The fact that the three most prominent recent reforms of our health care system—Medicare Part C, Medicare Part D, and the ACA's subsidized marketplaces—have all employed market mechanisms is evidence of the dominance of such thinking in health care policymaking. *See generally* 42 U.S.C. § 1395w-23 (West 2018) (prescribing rules for Part C); 42 U.S.C. § 1395w-115 (2012) prescribing rules for Part D; ACA § 1343, 42 U.S.C. § 18063 (2012) prescribing rules for ACA.

[94] *See infra* Part III.A (discussing assumption that competition-based reforms are preferable to mandates).

[95] *See, e.g.*, Korobkin, *supra* note 4, at 8.

[96] Baker, *supra* note 60, at 1610 ("High-risk people tend to prefer more complete health insurance coverage, fewer restrictions on their choice of doctors, and other plan features that

insurance are most motivated to seek it out and buy it and have greater information about their need than do insurers. This means that self-selection of insureds into insurance is "adverse" from the standpoint of the insurer (and the functioning of the market) because the riskiest (and so costliest to insure) potential insureds are the ones most likely to enroll in a plan or be attracted by patient-friendly features.[97] Indeed, in some circumstances adverse selection can lead to a "death spiral" in which selection of the sickest individuals into insurance drives up premiums, which in turn further discourages enrollment by healthy, cheap-to-enroll individuals, which in turn drives up premiums still higher, until only sick, costly-to-insure enrollees are willing to buy and the insurance available to them is so expensive that it can hardly be called insurance.[98]

The threat of adverse selection encourages insurers to find ways to discourage enrollment by less-healthy enrollees, including designing plans to be unattractive to sicker-than-average potential enrollees. As Rodwin explains, in light of adverse selection insurers "are better off deterring [those with chronic, high-cost illnesses] from joining rather than attracting them."[99]

"Adverse tiering" is one example of how the threat of adverse selection can cause insurers to design plans to be unattractive to the sick. Adverse tiering can entail constructing a formulary (a drug-by-drug list of cost-sharing and other requirements for pharmaceutical drugs) that makes drugs for certain chronic illnesses disproportionately and unnecessarily costly. For example, insurers in Florida were charged with engaging in "adverse tiering" by

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make it easier to consume more health care."); *cf.* Jost, *supra* note 33, at 143–44 (describing survey data on health insurer efforts to assist patients in shopping for care: "most of the tools made available by health plans to compare prices are still quite crude").

[97] *See* Korobkin, *supra* note 4, at 41–44 ("[T]here are two unique features of the market for health insurance . . . (1) the seller does not wish to retain some of its customers, and (2) in most cases, these unwanted customers are the only ones who will have become informed about the quality of the [managed care organization's (MCO)] services after contracting."); *see also id.* at 62 ("MCOs lack the incentive that sellers usually have to compete for the business of the more sophisticated" because "[u]nhealthy consumers . . . have a stronger incentive to incur the search and analysis costs involved in making the optimal choice among competing managed care plans."); Jacob Glazer & Thomas G. McGuire, *Optimal Risk Adjustment in Markets with Adverse Selection: An Application to Managed Care*, 90 Am. Econ. Rev. 1055, 1055 (2000) ("Selection-related incentives threaten the efficiency and fairness of [plans] . . . by inducing plans to distort the quality of the services they offer to discourage high-cost persons from joining the plan.").

[98] *See* Abigail R. Moncrieff, *King, Chevron, and the Age of Textualism*, 95 B.U. L. Rev. Annex 2, 1–2 (2015) (discussing pervasive concerns about "death spirals" surrounding legal challenges to aspects of the ACA).

[99] Rodwin, *supra* note 29; *see also 47 Million and Counting: Why the Health Care Marketplace is Broken: Hearing Before the S. Comm. on Fin.*, 110th Cong. 6 (2008) (statement of Mark A. Hall, Fred D. and Elizabeth L. Turnage Professor of Law and Public Health, Wake Forest University), https://www.finance.senate.gov/download/2008/06/10/mark-a-hall [https://perma.cc/5HWB-QKH4] ("The natural dynamics of risk segmentation are so strong that risk selection occurs even without overt [screening by insurers]. Subscribers naturally sort themselves by risk to some extent, according to the covered benefits and plan features they find most attractive. *Insurers and employers have learned that features such as deductibles, managed care, and particular benefits that are covered or excluded appeal differently to people with lesser versus greater health care needs. . . . Risk selection practices flow directly from the very nature of how competitive markets should and must respond to highly concentrated health risk.*") (emphasis added).

placing particularly high cost-sharing requirements on HIV medication for the purpose of discouraging enrollment by HIV-positive individuals.[100]

Incomplete contracting: A separate challenge for health insurance markets is that the health insurance contract cannot reasonably spell out every minute detail of how the plan will operate (what it will cover, the precise magnitude of cost-sharing that will apply in certain circumstances, etc.) in advance. This leads to "incomplete contracting" which, in turn, puts pressure on the insured either to learn about or trust the insurer's decision-making processes.[101]

Behavioral biases: Health care consumers are not perfect automatons but vulnerable humans who may make mistakes. Korobkin and Robertson have discussed predictable sorts of mistakes drawn from behavioral economics that can influence the insurance contract.[102] One such bias they discuss is optimism about the likelihood of good events (or bad events) in the future, which where present would lead individuals to underestimate the likelihood that they will actually become sick and need their health insurance and incur cost-sharing. Another is salience (or myopia), a focus on a few particular characteristics (especially near-term consequences) to the exclusion of other important characteristics, which could lead individuals to focus on premiums, cost-sharing amounts, or network status to the exclusion of other service-level aspects of the insurance plan or its operation. And a third, additional consideration is projection bias, individuals' tendency to predict their future mental state correctly and incorporate it into present-day decisions, which could lead individuals to focus too much on a plan's premiums or absolute cost-sharing limits and not enough on the extent of its coverage or likely cost-sharing experience under the plan.[103]

Insurer market power: Finally, insurer market power where present may contribute to market failures preventing competition from pushing insurers to appropriately account for financial, social, and psychological costs in their plans. In the absence of a competitive insurance market insurers have diminished incentive to offer plans that reduce net costs for insureds.

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[100] *See Aetna Agrees to Make HIV Medications More Affordable After Complaint*, NAT'L HEALTH LAW PROGRAM, http://www.healthlaw.org/index.php?option=com_content&view=article&id=342:critical-civil-rights-victory-for-lep-beneficiaries-in-new-york&catid=45 [https://perma.cc/WJ3C-T348] (describing complaint filed with HHS Office for Civil Rights charging four health plans with adverse tiering).

[101] *See* Korobkin, *supra* note 4, at 27–28 (discussing "search," "experience," and "credence" goods); Sloan & Hall, *supra* note 29, at 193.

[102] *See* Korobkin, *supra* note 4; Robertson, *Scaling Cost-Sharing to Wages*, *supra* note 70, at 275–76, 278 (concluding that adverse selection is the "most fundamental" impediment to individual choice regarding cost-sharing; citing optimism and salience as potential behavioral market failures).

[103] *See generally* Lawrence, *supra* note 87. Projection bias is why, for example, a hungry person may order a larger dinner than she will actually want or will purchase too much food at the grocery store. Projection bias could apply in health insurance to two aspects of the insurance product that may impact the insured when she is in a weakened emotional state, *i.e.* when she is sick, or that may pose emotional costs, such as the dissatisfaction associated with a perception of injustice in an unfair coverage decision-making process. *Id.*

3. *Market Failures Also Apply to Social Consequences*

In some ways, social consequences are similar to medical consequences (such as what health care is covered and at what level of quality), and so subject to the same sorts of market failure concerns as medical consequences. The magnitudes of both sets of consequences depend on whether a person gets and incurs claims or not, so adverse selection applies to both. This is because patient-friendly cost-sharing features, whether generous health benefits or billing assistance, would be most valuable to those who expect illness or have a chronic illness and so have the greatest interest in researching a plan to find out its cost-sharing and related requirements.[104] Similarly, as both sets of consequences depend on an uncertain risk developing, they are both subject to the behavioral bias of optimism which, where present, will lead insureds to under-estimate the likelihood they will get sick and therefore under-value aspects of the insurance product that will become relevant only if they do (and over-value aspects that are relevant regardless such as the monthly premium).

In other ways, the aspects of insurance products that impact social consequences most directly (cost-sharing provisions and coverage of care-related activities) are different from those that impact medical consequences (coverage of care). Like law practice, health care itself is largely an "experience" or "credence" good, in the sense that an insured has no way of assessing quality unless she experiences treatment.[105] This exacerbates incomplete contracting and the associated lemon problem.[106] Cost-sharing, on the other hand, is a "search good"—buyers can assess it in advance, with some effort—that is less susceptible to this particular concern. Similarly, a person's likelihood of getting sick is largely outside her control, which diminishes the risk of "regret" when she does get sick. Cost-sharing is in some ways within the insured's control (who in many contexts can pay for a more generous plan), so the behavioral phenomenon of "regret avoidance," if present in purchasing insur-

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[104] *See* JOST, *supra* note 33, at 140 ("the attractiveness of a health plan to persons with high health care expenses is determined by several factors in addition to the size of the deductible" including "the out-of-pocket limit" and "the size and applicability of co-payments and coinsurance"); *see also id.* at 139–40. One difference between cost-sharing and health care coverage is that cost-sharing is a subject of concern to all enrollees who expect to incur health care costs, though it may not be the paramount concern (coverage of their particular illness). On the other hand, coverage of any particular benefit is of extreme concern to people who expect to utilize that benefit, but is of no concern to others. For example, people with diabetes and HIV both are impacted by the size of a plan's deductible and how billing for such cost-sharing operates under the plan, but people who only have diabetes are not impacted by how a plan covers HIV (and vice versa). Further research might helpfully explore how this difference affects the strength of adverse selection in health insurance markets.

[105] Korobkin, *supra* note 4, at 27–28 (describing aspects of health care as credence goods). *See also* JOST, *supra* note 33, at 97 ("many health care products and services are 'credence' goods").

[106] Korobkin, *supra* note 4, at 38.

ance, could push enrollees to purchase health insurance that has *too little* cost-sharing for them.[107]

That said, social consequences differ from health consequences in two ways that exacerbate concerns about market failure across the board. First, social consequences are tied to externalities beyond the insurer and the insured—billing costs, including non-payment, are borne by doctors who are not party to the insurance contract—which inhibits efficient agreements between insurer and insured for plan features that reduce such costs. Second, providers serve as crucial intermediaries mitigating market failures when it comes to the health consequences of health insurance, but they are neither positioned nor incentivized to play this intermediary role when it comes to health insurance's social consequences. Thus, an important check on market failures in health insurance—doctors—is missing or even counter-productive when it comes to social consequences.

4. *Externality of Patient Bad Debt*

The costs associated with insured patient bad debt for providers in the United States are substantial. In fact, in recent years bad debt associated with *uninsured* patients has remained steady but bad debt associated with *insured* patients' cost-sharing requirements has increased.[108] In 2017, "patient balances after insurance"—the share of insureds' medical bills due to cost-sharing that went unpaid—was twelve percent.[109] That means that, all else being equal, when the average patient (assuming patients are average) and an insurer agree to a plan with a $6,000 deductible rather than no deductible, they are in effect agreeing to pass $650 in insolvency costs on to whichever providers the patient might come to see.[110] Meanwhile, administrative costs on providers associated with coding, billing for, and collecting medical bills under governing insurance reimbursement schemes have also stretched well into the double digits.[111] And on top of all this, numerous billion-dollar gov-

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[107] *See generally* K.P.M. van Winssen, R.C. van Kleef, & W.P.M.M. van de Ven, *Potential determinants of deductible uptake in health insurance: How to increase uptake in The Netherlands?*, 17 EUR. J. HEALTH ECON. 1059, 1059–61 (2016) (exploring six phenomena with potential to reduce take-up of high deductible plans, including loss aversion, risk attitude, ambiguity aversion, debt aversion, omission bias, and liquidity constraints; suggesting that high deductible plans could be offered by default).

[108] *See* Jack O'Brien, *Hospital Bad Debt Rising as Patients Shoulder Bigger Share of Medical Bills*, HEALTHLEADERS (June 26, 2018), https://www.healthleadersmedia.com/finance/hospital-bad-debt-rising-patients-shoulder-bigger-share-medical-bills [https://perma.cc/6DCD-4FJA]; *see also* Brooke Murphy, *Beating the patient-pay problem with 3 point-of-service collection strategies,* BECKER'S HOSPITAL REVIEW (Aug. 1, 2016), https://www.beckershospitalreview.com/finance/beating-the-patient-pay-problem-with-3-point-of-service-collection-strategies.html [https://perma.cc/G7ER-HGBF].

[109] O'Brien, *supra* note 108.

[110] Of course, this insolvency risk varies greatly from patient to patient in ways that insurers and providers may be able to predict and, to some extent, control. *See supra* Part II.C.3.

[111] *See e.g.*, Phillip Tseng et al., *Administrative Costs Associated with Physician Billing and Insurance-Related Activities at an Academic Health System*, 319 JAMA 691, 695 (2018) (de-

ernment programs seek to compensate providers for the patient bad debt they bear under our current system in recognition of its significance.[112]

Patient bad debt has its origins in legal requirements, physician ethical obligations, and medical community norms that compel providers to treat patients whether they want to or not. This creates costs for providers associated with patient bad debt—not all patients can pay for their treatment, so providers incur costs both collecting outstanding bills and providing treatment that is never paid for.[113] (Scholars currently debate the extent to which costs associated with such bad debt are passed on to other patients through higher prices.)

Reducing patient bad debt is a well-known positive externality of health insurance. Insured patients are more likely to pay their bills, so when an insurer and an insured enter a health insurance arrangement, they reduce the likelihood that the insured will ultimately incur medical bills she does not pay—which benefits providers.

Indeed, this positive component of the bad debt externality was instrumental to the development of health insurance in the United States. The first health insurance plan was offered by a provider, not an insurer—Baylor Hospital.[114] Concerned that patients increasingly could not afford to pay after-the-fact for the full range of hospital services available and provided to them in the event of an illness, Baylor created a comprehensive health insurance plan for local teachers as a way for them to pre-pay for and share the risk of hospital stays.[115] A modified version of Baylor's business model caught on, and groups of state or regional hospitals across the country began offering comprehensive health insurance plans that became known as "Blue Cross" plans, which were followed by "Blue Shield" plans offered by groupings of outpatient providers.[116] In years since, the fact that reduced insolvency (and with it, patient bad debt) is a positive externality of health insurance has been key to fundamental developments in health policy, including individual mandates to purchase health insurance in the Massachusetts plan and the Affordable Care Act.[117]

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pending on context administrative costs for processing a bill could account for up to twenty percent of total revenues).

[112] *See generally* Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 42 U.S.C. § 1395ww(d)(5) (1985) (disproportionate share hospital (DSH) adjustment).

[113] The risk of being required to treat a patient is not constant across providers. It is greater for some providers, like hospitals, than others, like primary care doctors. *See* 42 U.S.C. § 1395dd (2012) (provision of Emergency Medical Treatment and Labor Act requiring *hospitals* to stabilize individuals who come to the emergency department regardless of ability to pay). Further research might helpfully explore whether balance billing and related practices are more common among provider groups that are subject to higher rates of unavoidable patient bad debt.

[114] JOST, *supra* note 33, at 56 ("The first 'hospital service plan' was stated by Baylor Hospital in Dallas in 1932.").

[115] *See id.*

[116] *See id.* at 56–57.

[117] *See* 26 U.S.C. § 36B (2012 & Supp. V 2018); Melissa B. Jacoby, *Individual Health Insurance Mandates and Financial Distress: A Few Notes from the Debtor-Creditor Research and*

While the fact that reduced insolvency is a positive externality of health insurance has been both recognized by scholars and influential in policymaking, the flip side of that externality has not yet generated the attention of regulators or scholars. Yes, health insurance itself is a *positive* externality for providers because it reduces bad debt as well as collection costs, but that means that health insurance cost-sharing is a *negative* externality for providers because it increases these costs. Moreover, so do any aspects of the insurance plan that shift to providers the cost of billing for and collecting insureds' medical debt.[118]

This negative externality of insured patient bad debt associated with cost-sharing creates an economic disincentive for insurers and insureds to agree to patient-friendly plan features that increase plan costs in ways that reduce either the risk of insolvency or the administrative cost associated with medical billing for providers. This market failure tends to undermine the availability and provision of such features in the marketplace and could exacerbate social consequences. An innovative billing, cost-sharing, or medical debt financing mechanism that reduced the burden of bills on patients might be well worth it on the whole, but nonetheless be undesirable to insurers and insureds in crafting insurance plans because it would entail internalization of bad debt and administrative costs otherwise borne by providers. The same economic logic that justifies mandates forcing individuals to purchase health insurance also justifies regulation of the way insurance plans make their insureds liable for health care costs and provide for the assessment and collection of such liability.[119]

Debates, 55 KAN. L. REV. 1247, 1251 (2007) (discussing reduction of patient bad debt as a justification for mandatory health insurance). *Cf.* Michael Faure & Veronique Bruggeman, *Catastrophic Risks and First-Party Insurance*, 15 CONN. INS. L.J. 1, 33 ("The classic economic rationale behind compulsory liability insurance is the externality argument: in the absence of adequate insurance, injurers could, through their insolvency, externalize risk."). *See generally* Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012).

[118] If doctors could price discriminate among patients, charging some patients more or less depending on the billing expenses presented by those patients, then the administrative costs of medical billing would be mitigated as an externality in the insurance contract; they would matter to the patient and she would have reason to engage her insurers' assistance. But to the extent that any practical or other considerations prevent such price discrimination by doctors, both patients and insurers will be oblivious to billing costs, making such costs an externality of the insurance contract as discussed above. Further research might helpfully explore the legal and practical viability of doctors price discriminating among different patients based on the billing costs they present, that is, of billing for billing. For example, the author's dentist offers a five-percent discount for patients able to pre-pay for significant dental work.

[119] In theory, those subject to a negative externality could address it without government intervention by paying the source to mitigate the externality, if doing so would maximize the utility of the parties. *See generally* RONALD COASE, THE PROBLEM OF SOCIAL COST (1960). Such resolution of the negative externality that cost-sharing and medical billing pose to providers might be difficult to correct via such private ordering insofar as (1) the identity of providers who bear this externality were not ascertainable until after the patient has obtained care or (2) the cost of the externality were spread out over several providers who encounter a given patient, creating a collective action problem that providers could overcome in negotiating with insurers only by engaging in joint negotiation that would run the risk of raising antitrust concerns.

5. *Intermediaries and Adversaries*

A second reason for concern that markets fail in particular to make appropriate tradeoffs when it comes to health insurance's social, financial, and psychological consequences is simply that such consequences are not traditionally "medical" consequences, and so are outside of doctors' traditional domain. The underlying problems with the market for health care and health insurance are checked somewhat by the paramount role of doctors as intermediaries in safeguarding the health of their patients. Adverse selection, incomplete contracting, behavioral biases, and the other market failures discussed above are mitigated by the obvious but important fact that providers play a dominant role in patient's health care decisions.[120] Also important in mitigating health insurance market failures is the related fact that provider lobbies play an influential role in identifying, giving voice to, and lobbying for change of health insurance product features that are harmful to health.[121]

In short, in economic terms, market failures in health insurance or health care are mitigated by the presence of an expert intermediary with training and incentives to help patients make the "right" decisions for their health.[122] This salutary effect of physician intermediaries is absent when it comes to social, financial, and psychological impacts of health insurance, however. Indeed, when it comes to medical billing physicians are more like adversaries than allies: Physicians want to be paid, despite the fact that paying a bill is rarely in a patient's interest.

The "physician is not the patient's financial advisor."[123] Indeed, quite the contrary, a recent movement within medicine has emerged seeking to change the way providers approach billing and cost questions to be more attentive to patient needs. This would entail providers considering financial

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[120] *See, e.g.*, Ezekiel J. Emanuel & Victor R. Fuchs, *The Perfect Storm of Overutilization*, 299 JAMA 2789, 2789–90 (2008) (describing the important role of the physician in making decisions about care); Wendy Netter Epstein, *The Health Insurer Nudge*, 91 S. CAL. L. REV. 595, 612–14 (2018) (collecting sources discussing influence of physicians in treatment decisions); Christopher Robertson & Victor Laurion, *Tip of the Iceberg II: How the Intended-Uses Principle Produces Medical Knowledge and Protects Liberty*, 11 N.Y.U. J.L. & LIBERTY 770, 774–75 (2017) (describing how "physicians help patients make evidence-based consumption decisions" about new drugs and devices); Hall & Schneider, *supra* note 39, at 652 ("Patients rely so much on their doctors that their purchasing choices are severely constricted, so constricted that it is hardly too much to say that doctors wield something like monopoly power over their patients.").

[121] *See* Cristine Nardi, *When Health Insurers Deny Coverage for Breast Reconstructive Surgery: Gender Meets Disability*, 1997 WIS. L. REV. 777, 808–12 (1997) (describing efforts of doctors in lobbying for "mandated coverage laws at both the state and federal level" for mastectomy surgery); William M. Sage, *Physicians as Advocates*, 35 HOUS. L. REV. 1529, 1537 (1999) (describing role of physician in advocating on behalf of patient to force insurance coverage of particular treatments and services); *see also* Robertson, *Should Patient Responsibility for Costs Change the Doctor-Patient Relationship?*, *supra* note 76, at 379 (arguing that "physicians may have a duty to lobby Congress for better health care coverage").

[122] *But see* Sage, *supra* note 121, at 1551–74 (discussing various conflicts of interests that tend to undermine physicians' incentives to advance their patients' best interest, particularly in the context of managed care).

[123] Moore v. Regents of the University of California, 51 Cal. 3d 120, 131 n.10 (1990).

and related consequences as a sort of "toxicity" internal to rather than external from the provider's ethical obligations to serve the patient's interests.[124] That such arguments are necessary and novel is evidence that many "physicians may be resigned to a reality that financial adverse effects are a known and unavoidable harm of medical care."[125] So is the instruction in provider guides and manuals to seek to collect bills early and often in furtherance of the singular goal of maximizing the likelihood of payment.[126]

The question whether physicians *should* "first do not harm" to patients' finances as well as their health is beyond the scope of this Article. Rather, the point here is a more narrow one: Whereas physicians stand as an expert intermediary both trained and positioned to help patients when it comes to the health consequences of their health insurance and health care decisions, physicians are neither trained nor well positioned to help patients when it comes to the social consequences of such decisions. Indeed, financially speaking, physicians' interests are in conflict with patients' when it comes to paying medical bills as discussed in the prior subpart. Thus, a significant check on underlying market failures that frustrate consumerism in health care—the physician intermediary—is missing when it comes to health insurance's social consequences.

6. *Limitations of Employers as Intermediaries*

Nearly half of Americans get their health insurance through their employers, and those employers could in theory serve as an additional expert intermediary mitigating insurance market failures.[127] "[I]t is typically employers, not employees, that decide which . . . health insurance plan to offer to employees,"[128] and scholars have noted that the officials and staff in a human resources office bring expertise and attention to the decision that tends to promote the selection of the "best" plan for employees.[129]

There is surely truth to the proposition that, where present, employers acting as intermediaries tend to improve some aspects of the functioning of the market for health insurance. Incomplete contracting is simply less of a concern when a human resources office negotiates a plan for hundreds, thousands, or tens of thousands of enrollees than when an individual picks a plan for herself. And behavioral biases such as optimism, too, are less of an influence on the considered, group decisions of the professionals who make

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[124] *See* Peter A. Ubel et al., *Full Disclosure—Out-of-Pocket Costs as Side Effects*, 369 NEW ENG. J. MED. 1484 (2013) ("financial toxicity"); Christopher Moriates, et al., *First, Do No (Financial) Harm*, 310 JAMA 577, 577 (2013) ("'First, do not harm' is a well-established mantra of the medical profession, but it may need to be reconceptualized [to include consideration of financial consequences] in an era of unsustainable health care spending.").

[125] Moriates, et al., *supra* note 124, at 577.

[126] *See* Murphy, *supra* note 108 (encouraging hospitals to "capitalize on all contact opportunities" in collecting bills and ensure "active participation by all levels of staff").

[127] Brendan Maher, *Unlocking Exchanges*, 24 CONN. INS. L.J. 125, 131 (2017).

[128] Rodwin, *supra* note 29.

[129] *See* Korobkin, *supra* note 4, at 25–26.

them for employers than they are for the individuals who make them for themselves, all else being equal.[130]

That said, it is doubtful that employers truly "fix" the market failures discussed above, particularly insofar as they apply to social consequences. Russell Korobkin reviewed many of the reasons for doubt years ago in discussing the case for mandated benefits laws.[131] Two considerations are particularly relevant here.

First, employers prefer healthy employees just as insureds prefer healthy insureds. That, at least, has been the perception of Congress in twice enacting legislation prohibiting employers from discriminating against employees who are sick or have sick family members: the Family and Medical Leave Act (which protects employees from termination for taking time off for their or their family members' illness) and the Americans with Disabilities Act (which prevents employers from discriminating against potential employees based on health status, or even asking many health status questions during the interview process).[132]

This tendency for employers to prefer healthy employees provides a disincentive to employers to select health insurance plans that are particularly attractive to the sick. It also makes the complaints of an ill employee about dissatisfaction with medical billing under her plan less likely to carry weight with the employer, insofar as the employer will be relatively less concerned about retaining that employee than about other goals: maximizing profits, recruiting new employees, and so on.[133]

Second, to the extent employers seek to obtain plans that will be attractive to (*i.e.*, seen as most valuable to) current and prospective employees, they may "pass through" errors in those employees' consideration of plans. Korobkin noted a series of studies showing that employers "are extremely sensitive to price when choosing among health plans."[134] That makes sense—potential insureds tend to focus on highly salient price aspects of health insurance plans such as premiums and cost-sharing,[135] and employers wishing to appeal to individuals exhibiting such biases would be motivated to focus on the visible "price" of the plans they select as well.

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[130] On the relative likelihood of corporate entity decisions and individual decisions in health care to be influenced by behavioral biases, *see* Matthew J.B. Lawrence, *Procedural Triage*, 84 FORDHAM L. REV. 79, 85 (2015).

[131] *See* Korobkin, *supra* note 4, at 25–26 (discussing limitations of employers in choosing coverage); *see also* Hyman, *supra* note 4, at 226–27 (discussing role of employer in selecting insurance policies and corresponding disjunction with individual preferences).

[132] *See generally* JESSICA L. ROBERTS & ELIZABETH WEEKS, HEALTHISM: HEALTH-STATUS DISCRIMINATION AND THE LAW (2018) (discussing discrimination on the basis of health status, including by employers, and legislative efforts to curb such discrimination).

[133] *See* Rodwin, *supra* note 29, at 44 ("a firm's loyalty and obligations are primarily to shareholders or other owners, not employees"); *see also id.* (expressing doubt that employers are responsive to the needs of employees who are frustrated with their health insurance plans).

[134] *See* Korobkin, *supra* note 4, at 132.

[135] For a discussion of Monahan's study showing insurers in crowded markets compete primarily on high-salience aspects of the insurance product including premium and cost-sharing amounts, *see* JOST, *supra* note 33.

Ultimately, further research could helpfully tease out the extent to which employers "cure" the social consequences problem despite these concerns. For example, researchers might compare the relative prevalence of balance billing or other consumer abuses between large group employer, small group employer, and individual market insurance plans; evidence of significant differences would tend to show that employer involvement has some effect. Existing studies using insurers' data to explore out-of-network charges have not sought to make this differentiation, which is itself perhaps some anecdotal evidence that from an insurer's perspective the aspects of a health plan that impact the "how" and "when" of cost-sharing are not markedly impacted by the presence of an employer intermediary.[136] In any event, they have found extensive balance billing in employer-sponsored insurance, further undermining the possibility that employers solve the social consequences problem.[137]

E. Alternative Explanations for Health Insurance Consumer Abuses Are Incomplete

Three recent scholarly treatments have discussed alternative explanations for outrageous health care consumer abuses: lack of competition among providers (in Silver and Hyman) and indefensibly high "chargemaster" rates charged by hospitals (Nation and Richman).[138] These explanations are not inconsistent with understanding the social consequences problem discussed above as an explanation for such abuses. Both focus on issues that might permit providers to charge especially high rates in certain circumstances, but neither offers a reason that insurers have failed to shield patients from such rates when providers do charge them.

1. Lack of Competition Among Providers

Silver and Hyman ultimately offer lack of competition among providers as an explanation for the prevalence of outrageous billing situations. In their view such competition would prevent providers from charging insureds outrageous rates if present, but it is impeded by various regulatory and market disruptions.[139] This explanation is limited primarily in that it does not ex-

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[136] *See* Zack Cooper et al., *Surprise! Out-of-Network Billing for Emergency Care in the United States* 3 (Nat'l Bureau of Econ. Res., Working Paper No. 23623, 2017) (analyzing data from "a large insurer that covers tens of millions of lives annually").

[137] *See generally* Christopher Garmon & Benjamin Chartock, *One In Five Inpatient Emergency Department Cases May Lead To Surprise Bills*, 36 HEALTH AFF. 177, 177 (2017) (finding that twenty percent of hospital admissions to the ER resulted in a surprise bill in a sample of employer market data).

[138] *See* SILVER & HYMAN, *supra* note 33, at 187.

[139] *See id.* ("balance billing continues to be a problem because neither doctors nor hospitals have a financial interest in ending the practice"). Silver and Hyman initially offer site of service differentials and self-referrals as playing a role in outrageous billing situations, *see id.* at 173–86, but ultimately recognize that these phenomena are actually reasons that an external corrective (in-house hiring) does not prevent balance billing in some situations (such as anes-

plain why insurers do not insulate patients against the most outrageous billing scenarios. Where present, provider market power may allow providers to extract high costs from patients, but it is up to an insurance plan to calibrate whether such costs are borne by all insureds in small amounts (through increased premiums) or some insureds in extremely high amounts (through, for example, balance bills). The mere possibility of provider market power is not an explanation for why insurers have failed to dampen the impact of balance bills on their patients by spreading costs among insureds or through other financing or management innovations. Indeed, Hyman and Silver recognize that where they wish to do so, insurers can insulate patients against the practice of balance billing despite provider market power.[140]

2. *High Chargemaster Rates*

Nation and Richman *et al.* have pointed the blame for outrageous medical bills to the prices listed in hospital "chargemasters"—documents spelling out "prices" for various treatments and services that are dramatically inflated over actual reimbursement rates and charged only to those unlucky enough to seek treatment without in-network insurance. Indeed, they have argued that "providers have no legal authority to collect chargemaster charges that exceed market prices . . . and thus neither patients nor payers are under any obligation to pay such chargemaster prices. . . . [J]udges, public law enforcement officials, and private attorneys can use this interpretation to combat abusive or harassing efforts that providers pursue to collect such charges."[141]

Again, this explanation does not offer an account of why insurers do not intervene to protect their insureds from the consequences of the chargemaster system, broken though that system might be. In fact, it only points the way to another route by which insurers could, if properly incentivized, protect their insureds against outrageous billing situations. If hospitals lack legal authority to charge patients chargemaster rates and attorneys could argue as much in court, then insurers set on helping to protect their

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thesiology) but does in others (such as hospitalists), not a root cause of balance billing, *id.* at 187.

[140] *See id.* at 177 (describing effort by Aetna to discourage patients from going to in-network Allegheny Health Network emergency room because it employed out-of-network physicians). Silver and Hyman do assert that insurers have little leverage to force unwilling providers to join their networks. *See id.* at 188. Assuming this is true, it does not explain why insurers do not opt to protect insureds from balance billing by covering out-of-network surprise bills, steering patients away from such bills with less financial investment, or even helping patients bring claims against out-of-network providers. *See supra* Part II.

[141] Richman et al., *Battling the Chargemaster*, *supra* note 18, at e103 ("providers do not have a legitimate claim to collect chargemaster charges . . . [t]his analysis is in line with a growing chorus of legal scholars"). *See also* Nation, *supra* note 18, at 175–76 (2016) ("Contracts entered into between healthcare providers and patients are not knowingly and freely entered into with respect to price, and therefore the courts should not enforce the ridiculous prices alleged to be due pursuant to these contracts"). *But see* Wendy Netter Epstein, *Price Transparency and Incomplete Contracts in Health Care*, 67 EMORY L.J. 1, 21 (2017) ("Courts almost always enforce agreements between patients and providers that lack a specific price term . . . [m]ost courts read in an implied term referencing the chargemaster.").

insureds against outrageous chargemaster rates could offer subsidized and centralized legal services to bring such claims, just as automobile insurers help their insureds manage claims against other drivers (even when the damage at issue is uncovered, *e.g.*, within the deductible of the underlying plan). Such services could leverage economies of scale in legal services to challenge unenforceable out-of-network balance bills *en masse,* a valuable risk-reducing service for insureds. Their absence in the marketplace may be an additional "dog that didn't bark" that evidences the social consequences problem in health insurance—the market does not properly incentivize insurers to take available measures to reduce the social, financial, and psychological consequences of medical bills for their insureds.[142]

III. Systemic Solutions to the Social Consequences Problem Are Needed

This Part takes a step back from the social consequences problem itself, and solutions thereto, to discuss how regulators should go about addressing the problem. Section A explains that regulatory interventions that promote competition over the social consequences of health insurance are as a matter of economic theory preferable to mandates that simply prohibit or require particular insurance product features. Section B then offers the ACA's mixed results when it comes to health insurance affordability as an example of the risks entailed in trying to solve a systemic problem with ad hoc mandates. Section C briefly discusses potential categories of systemic reforms: improved disclosure, empowered intermediaries, algorithmic tools, and mandates.

A. Limitations of Ad Hoc Mandates

The recent wave of state health care reforms has consisted primarily of specific prohibitions of particular health care consumer financial abuses such as out-of-network emergency room charges or balance billing, as discussed in Part I. Normative economic theory in general argues that such "paternalistic" regulations that require or prohibit particular practices should be seen as an imperfect last resort, implemented only when and where competition-promoting reforms fail.[143] This view, to those who subscribe to it, counsels in favor of finding a "fix" to the social consequences problem, rather than treating its symptoms. In the case of health care, it would favor ensuring that

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[142] *See* Arthur Conan Doyle, The Memoirs of Sherlock Holmes (1892) ("The Adventures of Silver Blaze").

[143] *See* Korobkin, *supra* note 4, at 21–26 (surveying the argument that the market should be left to govern the content of insurance contracts); Rodwin, *supra* note 29, at 226 ("Underlying all these legislative provisions is one question. Which issues should be left to the market and which should be decided by public policy through some kind of representative process?").

insurers themselves seek to strike the optimal balance between the social consequences and medical consequences of their plans.

There are of course skeptics who do not subscribe to normative economic theories. Even for such skeptics, however, reforms that promote competition or change incentives may nonetheless hold promise as an alternative to mandates. Such incentive-based reforms have five advantages over directly prohibiting or requiring certain insurance or provider practices.

First, accurately measuring social consequences and designing regulations to reduce them without imposing unintended adverse consequences is very hard to do. Exposing insureds to medical costs is ultimately an effort to regulate behavior: its motivation, success, and failure all hinge on the effect of the threat of liability on patients' and doctors' behavior. It might improve medicine by encouraging preventive care, encouraging price-shopping among providers, improving patients' selection of providers, or sparking healthy behaviors, among other mechanisms.[144] And it might harm medicine by causing insureds to avoid or delay needed care or creating awkwardness and conflicts in the doctor-patient relationship.[145] But it can be difficult to assess the extent to which cost-sharing impacts medicine for good or ill.[146] Measuring the causal effect of cost-sharing on social, financial, and psychological consequences is still harder.[147] This empirical challenge for assessing the desirability of regulatory mandates governing the design of health insurance plans reflects the broader behavioral "knowledge problem."[148]

Behavioral law and economics offers theoretical tools for evaluating behavioral impacts that can guide our understanding of available data or provide a bridge where data is lacking, but even such tools produce predictions that are at best tentative.[149] The resulting predictions are merely predictions and may best be used to guide research, structure our understanding of quali-

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[144] *See* Dahlia K. Remler & Jessica Greene, *Cost-Sharing: A Blunt Instrument*, 30 ANN. REV. PUB. HEALTH. 293, 296–97 (2009) (reviewing literature and collecting sources).

[145] *Id.*

[146] While randomized empirical studies link cost-sharing to reduced health care consumption, many still debate whether people forego unnecessary care, or care that would have helped. *See, e.g.*, Baicker et al., *supra* note 55; NEWHOUSE, *supra* note 70; *see also supra* notes 69–73 and accompanying text (collecting sources debating impact of cost-sharing on health).

[147] What quantitative research we have provides insight into the frequency of financial distress and medical bankruptcy, *see, e.g.*, *supra* notes 37–50 and accompanying text, but does not begin to assess the marginal impact of particular practices on that distress or attempt to quantify the associated "cost" for insureds. And while qualitative assessments tell us that real people are really hurt by financial distress, emotional distress, and decisional burden, they do not tell us for sure what insurance practices tend to increase or decrease that hurt or how much to weigh that hurt, either. Finally, disagreement in the medical bankruptcy literature about which bankruptcies should really be classified as such illustrates the difficulty of measuring social consequences empirically. *See* Sanger-Katz et al., *supra* note 51.

[148] *See generally* Jennifer Arlen, *Comment: The Future of Behavioral Economic Analysis of Law*, 51 VAND. L. REV. 1765 (1998) (noting general difficulty of predicting real-world behavior).

[149] *See generally* Matthew J.B. Lawrence, *Chapter Introduction*, *Behavior, Theory, and the Problem of Healthcare Spending*, *in Nudging Health* (Cohen, Lynch, & Robertson, eds. 2016) (explaining that knowledge problem afflicting study of health care costs renders predictions tentative).

tative evidence, and inform interim policy steps that are themselves designed to serve as experiments that lead to concrete evidence.

This leads to a second, substantial benefit of reforms that change insurers' incentives. The benefit of giving insurers cause to reduce the social consequences of medical bills for their enrollees goes far beyond stopping abusive practices. When incentivized to reduce social, financial, and psychological consequences for their insureds, insurers will have reason to innovate to develop creative social consequence-reducing practices that regulators and academics would not possibly be able to imagine, engineer, and mandate themselves. In other words, the ad hoc prohibition approach, even where perfectly executed, merely stops the worst abuses. A market-based approach, on the other hand, can spur the development of new financial protections.

Third, and relatedly, insurers are obviously much more adaptable in their business practices than are state or federal administrators or legislators in their regulatory mandates. It might be that a particular practice is in one time or place problematic, but in another is the best way to minimize social consequences overall. An incentive-based approach permits adaptation and flexibility in a dynamic and changing marketplace; a mandatory approach does not.

Fourth, as discussed above, a mandatory approach that forbids particular abuses without changing the underlying incentives and structures that give rise to such abuses risks losing at the game of regulatory "whack-a-mole." That is, insurers whose incentives are unchanged may respond to a law prohibiting a particular abusive practice by implementing a different, less visible practice. Regulators may find they have trouble keeping up. This risk is not present, however, if regulators are able to counteract the underlying perverse incentives that allow abuses to flourish in the insurance market in the first place.

A fifth reason that promoting competition over social consequences can be preferable to regulatory mandates is that even if we can tell which mandates are the "right" ones, regulators may not adopt those mandates. Regulators are subject to special interests that may use the regulatory opportunity to obtain changes in the law that help them rather than consumers. This political economy issue dilutes the promise of regulatory mandates issued by political entities—federal or state legislators or executive agencies—as a category.[150]

A last note on the usefulness of such reforms: incentivizing insurers to reduce the social consequences of health care could have benefits beyond competitive insurance markets. In health care programs that do not feature competition, regulators and politicians are forced to craft health coverage designs as best they can based on the limited information they have. They often use private sector insurance products as a model. Medicaid, for example, permits cost-sharing benchmarked to cost-sharing requirements utilized

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[150] *See* Hyman, *supra* note 4, at 425; Korobkin, *supra* note 4, at 80–83.

in states' private marketplaces.[151] More affordable insurance products in such marketplaces would mean more affordable health coverage for the government programs they influence.

B. The ACA's Ad Hoc Reforms as Cautionary Tale

The Patient Protection and Affordable Care Act offers a cautionary tale about the risks of ad hoc reforms in addressing health insurance consumer abuses. The law doubled down on private health insurance, implementing a variety of measures to expand access and the enrolled population.[152] By so doing, it undoubtedly reduced financial distress by increasing insurance rolls by millions.[153] At the same time, however, the ACA's insurance market reforms have tended to exacerbate the social consequences problem in health insurance markets for those who do have insurance.

First, the ACA increased insurers' incentive to cherry-pick healthy individuals (or "lemon drop" the sick) by forbidding lifetime and annual coverage limits.[154] Previously, insurers could limit their exposure on the highest-cost individuals by setting maximums on annual and/or lifetime coverage. Such limits, of course, were extremely challenging for those sick individuals who became subject to them, but they also mitigated insurers' incentive to discourage enrollment by less-healthy individuals. By increasing insurers' exposure for the most-costly individuals, the ACA increased their incentive to design plans that discourage enrollment by such individuals.

Second, the ACA also removed several alternatives to social consequence-maximizing plan design that insurers otherwise had to seek to limit enrollment by less-healthy individuals, leaving billing and cost-sharing de-

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[151] *See* Sidney D. Watson, *The View from the Bottom*: *Consumer-Directed Medicaid and Cost-Shifting to Patients*, 51 ST. LOUIS U. L.J. 403, 417–18 (2007) (describing benchmarking to private insurance in Medicaid).

[152] *See, e.g.,* ACA § 1401, 26 U.S.C. § 36B (2012 & Supp. V 2018) (providing for premium tax credit subsidy); Brendan S. Maher, *Regulating Employment-Based Anything*, 100 MINN. L. REV. 1257, 1266–70 (2016) (discussing role of tax subsidy for employer-sponsored health insurance). Its most comprehensive (and controversial) reforms were aimed at leveraging private health insurance to bring coverage to most of the 44 million who lacked any form of health insurance at the time of the law's enactment. These included not just the now-repealed "individual mandate" that everyone buy health insurance, but also the still-in-place premium tax credit that subsidizes the purchase of health insurance for any eligible individual who makes less than four hundred percent of the Federal Poverty Level, or $47,000 for a family of four. *See* ACA § 1501, 42 U.S.C. § 18091 (2012) ("individual responsibility requirement"); *see also* Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012) (discussing purposes of mandate that individuals purchase health insurance; holding that Tax Power authorized Congress to promulgate mandate).

[153] The ACA's Medicaid expansion and individual market reforms have insured millions of individuals who would without them be uninsured. This has brought corresponding social, financial, and psychological benefits. *See, e.g.,* Slusky & Ginther, *supra* note 45 (estimating reduction in medical divorce in states that expanded Medicaid); *supra* Part II.A (discussing social consequences-reducing functions of having health insurance).

[154] *See* Baker, *supra* note 60, at 1607–08 (describing "risk classification by design" generally as a major challenge to the ACA but expressing hope that the law's insurance market reforms might mitigate that challenge).

sign as a remaining, relatively untouched replacement means for insurers to respond to adverse selection. Many of the ACA's insurance market reforms were directly targeted at limiting insurers' ability to discriminate against the sick, especially in the individual and small group markets. These include the prohibition on pre-existing condition exclusions and limitations (rules that postponed or prohibited enrollment by sick individuals), the prohibition against taking health status into account in setting premiums (by increasing premiums for the sick or offering the healthy discounted premiums), and the mandate of coverage of "essential health benefits" (thereby limiting insurers' ability to cherry pick by tailoring coverage packages to attract lower-cost, healthier populations).[155]

Furthermore, while the ACA included reforms meant to control out-of-pocket costs, these reforms are focused exclusively on the primary costs of health insurance—the magnitude of premiums and out-of-pocket requirements—and incompletely check the growth of financial consequences.[156] The ACA capped premium rates based on insurers' administrative expenses through its "medical loss ratio" requirements. And it explicitly capped the absolute magnitude of out-of-pocket costs for in-network care, setting "maximum out-of-pocket limits." But insurers are free to re-arrange their products within these limits, creating pressure for them to design plans that increase the actual out-of-pocket burden experienced by the average enrollee even while respecting the absolute caps on primary costs created by the ACA.[157]

The growth in deductibles is an example. The ACA's out-of-pocket maximum ($13,700 for a family plan) is blind to the likelihood that an average family will incur such an expense. In order to keep their total costs the same, insurers could redistribute out-of-pocket expenses from the few families who exceeded the cap to typical families who fell below the cap. So, for example, the insurer could increase its deductible from $1,500 to $5,000, dramatically increasing the costs borne by the average family without running afoul of the ACA's magnitude-focused caps. Or it could impose cost-sharing on services that people are more likely to utilize, rather than only those for which combating moral hazard is most necessary or effective.

It is not surprising, then, that average deductibles have continued to increase since enactment of the ACA despite the law's ostensible limit on

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[155] *See* ACA §1302(b), 42 U.S.C. § 18022 (2012 & Supp. II 2014) (mandating coverage of "essential health benefits" and describing categories of such benefits).

[156] *See* Nation, *supra* note 18, at 165 ("[T]he out-of-pocket limits established by the ACA do not apply to balance billing.").

[157] In the "Exchange" marketplaces created by the ACA, plans are ranked into metal-levels according to their actuarial generosity. In a "bronze" plan the insured will wind up having to pay 40% of her medical costs, in a "silver" plan her share would be 30%, in a "gold" plan it would be 20%, and in a "platinum" plan the insured is responsible for 10% of her expected medical costs. ACA § 1301(d)(1), 42 U.S.C. § 18022(c) (2012 & Supp. II 2014). But even these metal levels focus only on the primary costs borne by insureds, not the relative financial distress, emotional distress, and decisional burden associated with those costs under a particular plan.

out-of-pocket costs.[158] The ACA's insurance market reforms exacerbated the social consequences problem, and its primary-cost-focused constraints on insurance plan design simultaneously left wide latitude for social consequences to grow unchecked.

To be sure, once again, the ACA's insurance market reforms reflect laudable goals like preventing pre-existing condition discrimination; the fact that they exacerbate the social consequences problem does not mean that these reforms do not bring worthwhile salutary effects or are themselves individually or collectively undesirable. But whatever the overarching benefits of these reforms, the growth in financial consequences under the law has undercut its affordability-promoting purposes.

C. Intermediaries and Disclosure

Intermediaries and disclosure are two categories of systemic solutions for incentive distortions in the marketplace. Such solutions are additive to (rather than mutually exclusive with) systemic reforms proposed below because they improve the functioning of the marketplace. They should therefore be kept in mind.[159]

That said, both categories of solutions pose challenges that would need to be overcome. Empowering intermediaries can be costly and, as discussed above, the two most apparent potential intermediaries who could help patients manage medical bills—providers and employers—are subject to their own incentive distortions.

As for mandated disclosure, it comes with serious limitations that can undermine its effectiveness. Often, it either does not work or does not work well.[160] These limitations are more pronounced when it comes to health insurance, not less, as addressed in the extensive literature exploring the limitations of consumerism in health care.[161] Moreover, a more fundamental problem with disclosure as a solution to the social consequences problem in health insurance flows from the nature of the problem. As discussed above, adverse selection—the tendency for a patient-friendly plan feature to attract sicker patients—is a well-established underlying failure in health insurance markets. Disclosure could make adverse selection worse because disclosed information would disproportionately influence the decisions of the enrollees who most expect to incur significant cost-sharing liability. As a result, the benefit of improved enrollee consideration of the disclosed information in

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[158] *See generally supra* note 20.

[159] Insurers might be required to disclose information designed to educate consumers about the social consequences of the products they choose. Insurers might, for example, be required to disclose their own predictions about a potential enrollee's incurred cost-sharing under a plan given demographic and other considerations, typical enrollee family caregiver burdens, out-of-network costs borne by consumers in a given plan, patient satisfaction with the insurance plan, financial distress experienced by enrollees in the plan, and the like.

[160] *See* Lawrence, *supra* note 130, at 111 n.157 (collecting sources).

[161] *See generally* Hall & Schneider, *supra* note 39; Jost, *supra* note 33.

picking plans could be outweighed by the costs of increased adverse selection.[162]

IV. ALGORITHMIC PROPOSAL: FINANCIAL DISTRESS CORRIDORS

Section A will show how the ACA effectively utilized algorithmic tools to change insurer and provider incentives. Sections B, C, and D will build on that innovation and introduce a novel, incentive-based approach to addressing health insurance's social consequences problem: "financial distress corridors." Section B discusses financial distress corridors in concept, Section C discusses the logistics of financial distress corridors, and Section D discusses regulatory pathways for implementation and experimentation.

A. Algorithmic Tools in the ACA

Health insurance regulation increasingly comes in the form of algorithmic tools that systematically alter insurer incentives rather than merely prohibit or require particular practices. For example, the ACA's risk adjustment program seeks to alter insurer behavior through payments and charges based on the health risk profile of their enrollees in order to make insurers indifferent to the health status of their enrollees and so dampen or eliminate the effect of adverse selection on plan offerings.[163] And under the ACA's three-year risk corridors program, insurers received payments or were assessed charges based on the difference between their premium revenue and the actual costs they incurred in the first three plan years of the ACA's reforms.[164] This risk corridors program provided additional insulation to insurers against the pronounced risks of adverse selection in a new marketplace above and beyond risk adjustment alone, thereby encouraging insurers to innovate both by participating in the marketplace's first three years and in the design of the plans they offered.[165] It was successful in that goal, notwithstanding the fact that insurers ultimately sued the government for failing to make good on its alleged risk corridor obligations.[166]

Medicare's readmission penalty program is another example of an algorithmic tool used in the ACA to improve health care by changing the incentives of health care market participants rather than by directly mandating or prohibiting particular behaviors. A major source of wasteful health

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[162] *See* Benjamin R. Handel et al., *Information Frictions and Adverse Selection: Policy Interventions in Health Insurance Markets* 3 (Nat'l Bureau of Econ. Research, Working Paper No. 21759, 2015); *see also* Korobkin, *supra* note 4, at 71 ("It is highly probable that sicker consumers would be systematically more likely than healthier consumers to factor benefits ratings into their purchasing decisions, thereby creating a perverse incentive for MCOs to attempt to earn bad grades.").

[163] *See* ACA § 1343, 42 U.S.C. § 18063 (2012).

[164] *See* ACA § 1341, 42 U.S.C. § 18061 (2012).

[165] *See id.*

[166] *See, e.g.*, Moda Health Plan, Inc. v. United States, 892 F.3d 1311 (Fed. Cir. 2018); Land of Lincoln Mut. Health Ins. Co. v. United States, 892 F.3d 1184 (Fed. Cir. 2018).

care spending, and one of the greatest sources of frustration for families, is the discharge of patients from the hospital before they are really well. When a person is discharged only to be readmitted days or weeks later, it not only causes them and their families significant stress but entails significant unnecessary treatment expense. Yet, under Medicare reimbursement rules, hospitals historically had an incentive to discharge patients prematurely because they were paid separately for treating a person with a given diagnosis regardless of whether she stayed in the hospital five days or fifteen.[167]

To combat this perverse incentive, the Affordable Care Act provided for a readmission penalty program to be implemented by the United States Department of Health and Human Services.[168] To simplify, HHS tracks readmission rates and adjusts downward slightly the Medicare reimbursement of hospitals with relatively high rates. The results of Medicare's readmission policy have been dramatic. In response to the actuarial incentive created by the program, hospitals have changed their practices and reduced readmissions by the tens of thousands.[169] The program went from an idea to making a significant and measurable positive change to health care in only a few short years.[170]

B. Financial Distress Corridors in Concept

Algorithmic tools could also be used to address health insurance's social consequences problem. Regulators might implement a "financial distress corridors" program through which insurers whose enrollees suffer medical-related financial distress relatively more often than demographically similar

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[167] *See* Medicare Program Hospital Inpatient Prospective Payment Systems, 82 Fed. Reg. 37990, 38219 (Aug. 14, 2017) (describing program).

[168] ACA § 3025, 42 U.S.C. § 1395ww (2010 & Supp. II 2014). Through this program HHS first tabulates hospital readmission rates, *i.e.*, the rate at which patients from a given hospital wind up being readmitted after discharge. HHS then compares the relative readmission rates from hospital to hospital and imposes a penalty on those hospitals who have relatively high readmission rates, all else being equal. This way hospitals are not penalized for uncontrollable readmissions, but those hospitals whose practices produce unnecessary readmissions are incentivized to stop doing so. *See generally* Medicare Program Hospital Inpatient Prospective Payment Systems, 82 Fed. Reg. 37990 (Aug. 14, 2017); CRISTINA BOCCUTI & GISELLE CASILLAS, KAISER FAMILY FOUND., AIMING FOR FEWER HOSPITAL U-TURNS: THE MEDICARE HOSPITAL READMISSION REDUCTION PROGRAM (Mar. 2017), http://files.kff.org/attachment/Issue-Brief-Fewer-Hospital-U-turns-The-Medicare-Hospital-Readmission-Reduction-Program [https://perma.cc/V8DX-FBXM].

[169] *See, e.g.*, Jason H. Wasfy et al., *Readmission Rates After Passage of the Hospital Readmissions Reduction Program: A Pre-Post Analysis*, 166 ANNALS OF INTERNAL MED. 324 (2017).

[170] *See generally* Nihar R. Desai et al., *Association Between Hospital Penalty Status Under the Hospital Readmission Reduction Program and Readmission Rates for Target and Non-Target Conditions*, 316 J. AM. MED. ASS'N 2647 (2016) (longitudinal study finding significant reduction in readmissions due to program); Jennifer Mellor et al., *Does It Pay to Penalize Hospitals for Excess Readmissions? Intended and Unintended Consequences of Medicare's Hospital Readmissions Reductions Program*, 26 HEALTH ECON. 1037 (2017) (study showing significant readmission reductions in Virginia due to program); Robert A. Berenson et al., *Medicare's Readmissions-Reduction Program—A Positive Alternative*, 366 NEW ENG. J. MED. 1364 (2012) (describing adoption of readmission penalty program in ACA in 2010).

enrollees of other plans could be assessed a charge, and insurers whose enrollees suffer such distress relatively less often could be given a payment.[171] Such transfers would effectively reward insurers for having fewer enrollees suffer medical-related financial distress and punish those that had more enrollees suffering medical-related financial distress. This would encourage insurers to take measures to reduce the social consequences of their insurance products and internalize the externality to the health insurance contract otherwise presented by patient bad debt and collection costs. The governing formula could include adjustments for social and psychological consequences, too, to the extent that the measure for financial distress did not capture these.

Moreover, while not an essential feature of such a program, to the extent that the government has an interest in stimulating innovation to reduce the social consequences of health insurance, such transfers could be subsidized—weighted more heavily toward rewarding payments—in order to further promote innovation in this area by insurers and prevent abuses. Funding for such a subsidy could be drawn in part from any reduction in hospital Medicare or tax subsidies or insurer reimbursement rates generated by the program. As long as government is footing some of the bill for patient bad debt, it might as well do so in the circumstances where taxpayer money tends to decrease the prevalence of such bad debt in the first place. All else being equal, it is better from the standpoint of social, financial, and psychological consequences to pay insurers to prevent their insureds from going bankrupt due to medical bills in the first place than to pay providers for bearing the brunt of medical bankruptcy when it happens.

For example, imagine that one insurer, Green Cross, saw three medical bankruptcies per one thousand enrollees in a demographic category who were subject to $5,000 in aggregate medical bills. And imagine another insurer, White Cross, saw ten medical bankruptcies per one thousand enrollees within the same group. White Cross would be assessed a charge that would be paid to Green Cross. This would both encourage White Cross to make efforts to reduce the rate of medical bankruptcy among its population in the future and reimburse Green Cross for any adverse selection it may encounter as a result of its apparently patient-friendly cost-sharing practices. And it would not increase the anticipated cost of claims in the risk pool—and therefore overall premiums in the insurance marketplace—because charges and payments among insurers would cancel out (or even net positive as suggested in the previous paragraph).

Conceptually, such financial distress corridors would have two significant benefits. First, they would give insurers a stake in their insureds' financial distress, encouraging them to harness their expertise to innovate to design patient-friendly practices into their plans that reduce the burden of

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[171] An important consideration in crafting a financial distress corridors program would be to avoid giving insurers an incentive to discriminate against financially vulnerable individuals. *See infra* Part III.C.3 (proposing use of consumer credit report trend information and adjusting based on demographics to reduce risk of creating such an incentive).

medical debt. Second, because the charges and payments would directly impact insurers' bottom lines, insurers would have this incentive to reduce social consequences regardless whether patients efficiently or correctly made choices among plans. So financial distress corridors would be a competition-based solution that would be resistant to critiques that the power of enrollee choice to produce efficient plan design by insurers is illusory.[172]

C. Logistics of Financial Distress Corridors

Financial distress corridors would pose significant logistical challenges, as have other algorithmic health care reforms. The ACA's risk adjustment and risk corridors programs have faced a wide range of implementation challenges, both logistical and legal, many flowing from the difficulty of obtaining reliable data to assess risk and calculate transfer amounts. Mandated transfers among insurers (or to insurers) based on the social, financial, and psychological consequences experienced by enrollees would face analogous challenges. Two key questions would be the data source to use to assess such consequences and the magnitude of charges or payments.[173]

Data source. As for the data source, it would be most feasible to start by focusing on financial distress with the possibility of adjustments based on survey data regarding social or psychological consequences. The empirical literature on medical bankruptcy rates provides a comprehensive and well-considered overview of the methodological pathways (and challenges) for measuring medical bankruptcy rates.[174] That literature would give regulators a head start that supports incorporating medical bankruptcy rates in some form into any transfer formula for financial distress corridors. That said, medical bankruptcy is an imperfect proxy for medical distress.[175] That is not an impediment if the measures insurers would take to reduce medical bankruptcy would tend to reduce all medical-related financial distress, but would be an impediment to meaningfully addressing the real problem if insurers took a more targeted approach.

The impact of significant illness on insureds' credit scores would be perhaps the most straightforward additional data source to use for financial

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[172] *See generally* Hall & Schneider, *supra* note 39 (expressing skepticism about consumers' ability to make decisions among health care treatments and services). Several sources provide empirical support for this critique of consumerism. *See, e.g.,* Zarek C. Brot-Goldberg et al., *What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics* (Nat'l Bureau of Econ. Research, Working Paper No. 21632, 2015); Saurabh Bhargava et al., *Do Individuals Make Sensible Health Insurance Decisions? Evidence from a Menu with Dominated Options* (Nat'l Bureau of Econ. Research, Working Paper No. 21160, 2015).

[173] *Cf.* Mark A. Hall, *Risk Adjustment Under the Affordable Care Act: Issues and Options*, 20 KAN. J.L. & PUB. POL'Y 222, 232–33 (2011) (describing question whether to include prescription drug data in ACA risk adjustment programs).

[174] *See, e.g.*, Dranove & Millenson, *supra* note 35, at 75 (disputing whether medical expenses actually contribute to bankruptcy).

[175] *See generally* Seifert & Rukavina, *supra* note 38 and accompanying text (describing medical bankruptcy as the "tip of the iceberg").

distress corridors. Regulators could assess for each insurer the extent to which insureds who faced significant health care claims in a given year saw a dip, increase, or no change in their credit score that year. They could then compare insurers based on their relative performance on this metric to determine which offered plans that made medical bills more manageable in practice and which had offered plans whose insureds most struggled to keep up when they got sick. This approach has the benefit of relying on easily available data; state and federal regulators may access credit reports under the Fair Credit Reporting Act.[176] Moreover, by focusing on *trends* in credit scores, this approach would tend to mitigate the risk that financial distress corridors would encourage insurers to avoid enrollment by financially distressed individuals—but additional demographic and/or community adjustments in calculating transfers would likely be necessary to further minimize this risk.

Finally, a third potential data source to consider as the basis or part of the basis for transfers would be collection actions for medical bills against enrollees in a particular plan. These actions are common and a strong proxy for medical-related financial distress. Of actions reported to credit companies, "[t]he majority of collection actions (about 52 percent) are associated with medical bills."[177]

Magnitude. With a stable data source based on one of these variables or a blending of several, regulators could then explore the magnitude of transfers, which would depend both on the stability of the data source and policy judgments about how strongly we want to encourage innovation to reduce the social consequences of health insurance. Again, it would be most feasible to start with patient financial distress in determining the size of transfers and, in particular, patient bad debt total amounts in a particular market.

For providers, insured patient bad debt represents an increasingly large fraction of administrative costs.[178] As discussed above, this bad debt—including bills that go unpaid due to medical bankruptcy or simple non-payment, as well as associated collection costs—is an externality of the health insurance contract; dollars spent by insurers to reduce these impacts shift costs from providers to insurers. Medicare recognizes this shifting effect and permits participating providers to seek reimbursement for patient bad debt, but only after they have engaged in good faith collection efforts.[179]

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[176] 15 U.S.C. § 1681 (2012).

[177] Robert B. Avery et al., *An Overview of Consumer Data and Credit Reporting*, FED. RES. BULL. 47, 69 (Feb. 2003). Surveys show twenty-five to thirty percent of enrollees self-report as having medical debt problems in a given year. *See* Jacoby, *supra* note 4, at 311–12. Similar surveys of enrollees conducted by a third-party are an additional option to use as a basis for transfers, but would require generating data that does not presently exist.

[178] *CBO Estimate of the Effects of Medicare, Medicaid, and other Mandatory Health Provisions Included in the President's Budget Request for Fiscal Year 2013*, CONG. BUDGET OFFICE (Mar. 16, 2012), http://cbo.gov/sites/default/files/cbofiles/attachments/FY2013ReestimateofthePresidentsBudget-Health.pdf [https://perma.cc/Y4Z9-7XDJ] (estimating reducing coverage for Medicare bad debts would save $23.6 billion over ten years).

[179] 42 C.F.R. 413.89 (2015). In Medicare Advantage, as compared to fee-for-service Medicare, bad debt reimbursement is optional, *i.e.*, the insurer can decide whether to provide it or not. *See Medicare Cost Reporting*, TRANSUNION (2018), https://www.healthcarepayment

A simple financial distress corridors program would be analogous to Medicare's bad debt reimbursement, simply mandating that insurers reimburse providers for patient bad debt in the applicable private health insurance marketplace just as the government does in fee-for-service Medicare. Such a simple program would pose three difficulties that counsel in favor of a more nuanced approach.

First, reimbursing providers for patient bad debt would shift the cost of such debt from providers to insurers. This would be desirable to the extent that it would cause insurers to internalize the cost of such debt, but it may well be desirable for providers to bear some of the cost of bad debt as well, in order to also engage them in helping to reduce insureds' financial distress.[180] This possibility counsels against fully reimbursing providers for patient bad debt; Medicare's bad debt reimbursement, for example, generally reimburses providers for fifty to sixty-five percent of bad debt.[181]

Second, creating a new, additional cost for insurers would tend to increase premiums across the board. This is likely to be politically controversial—and unpopular with insurers. This consideration counsels in favor of starting off with a budget neutral system in which some insurers pay in but others receive payment, rather than a provider reimbursement regime. This is the mechanism that the risk adjustment program uses in the ACA; so long as net payments and charges among insurers in a market are zero sum, the program need not increase premiums across the board even as it reprograms insurer incentives.

Third, basing charges and payments on the bad debt of insureds would create an incentive for insurers to discriminate against insureds who pose a particularly high financial risk. While insurers are not permitted to base insurability or premiums on credit scores in health insurance (unlike other forms of insurance), they may find ways in their plan administration to engage in service-level selection to deter enrollment by such individuals. This consideration counsels in favor of adjusting charges and payments to be based on the experience of insureds in a plan and not their creditworthiness at enrollment. This could be done by credit-adjusting bad debt charge and payment amounts as described above using changes in credit scores among insurers' enrollee populations even while actual transfer amounts were based on market-wide bad debt outcomes.

.com/intro-medicare-bad-debt-medicare-advantage/ [https://perma.cc/CY7F-FGR3]. Some do. *Id.* Further research could helpfully explore whether hospital collection practices differ for Medicare FFS beneficiaries versus Medicare Advantage beneficiaries with bad debt, or between MA plans based on whether they have a bad debt policy. As an aside, HHS has suggested reducing or eliminating reimbursement for Medicare bad debts to align with private health insurance, but the analysis herein suggests one reason that such alignment in itself may not be a desirable goal. *See also* HEALTH HUMAN SERV., OFFICE INSPECTOR GEN., COMPENDIUM OF UNIMPLEMENTED RECOMMENDATIONS 5 (2012), https://oig.hhs.gov/reports-and-publications/compendium/files/compendium2012.pdf [https://perma.cc/Z9VQ-UNXW] (same).

[180] *But cf. infra* Part IV.E (discussing problems with bill collectors at the bedside).

[181] 42 C.F.R. 413.89 (2015).

These challenges and nuances would necessarily complicate any financial distress corridors program, but are not different in kind from the challenges that regulators have had to address and work through in operating other modern actuarially based incentive modification programs in health care. Regulators experimenting with or implementing such a program would surely use statistical regression or machine learning[182] to identify the best proxies for financial distress upon which to base transfers, mitigate the risk that transfers would themselves encourage insurers to avoid high-financial-risk insureds, and calculate the magnitude of transfers. Finally, and again as with major shifts in other algorithmic health care programs, regulators might ease in a financial distress corridors program, providing for reduced payments and transfers in the first year or years of operation.

D. Legal Pathways for Experimentation

State experimentation with a financial distress corridors program would be encumbered in the self-insured employer market by the need to avoid ERISA preemption.[183] However, state and federal regulators have substantial discretion to experiment with or implement a financial distress corridors program in the individual and small group marketplaces and in Medicare. States are free under the ACA to adopt their own reforms for the individual and small group markets under their general police power. The ACA does not make exclusive the market stabilization programs it mandates states run—reinsurance, risk corridors, and risk adjustment.[184] Moreover, if states or the federal government were concerned that they lacked authority to implement financial distress corridors directly, they could do so through a state innovation waiver under section 1332 of the ACA. Section 1332 permits waiver in whole or in part of several ACA provisions, including the risk adjustment provision (section 1343).[185]

Medicare Parts C and D (privatized Medicare health insurance and pharmaceutical coverage, respectively) also offer a promising administrative route for experimentation with financial distress corridors through the Centers for Medicare and Medicaid Innovation's (CMMI) demonstration pro-

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[182] *See generally* Akritee Shrestha et al., *Mental Health Risk Adjustment with Clinical Categories and Machine Learning*, 53 HEALTH SERVS. RES. 3189 (2018).

[183] *See generally* Fuse Brown, *supra* note 8.

[184] *See* ACA §§ 1341–1343, 42 U.S.C. §§ 18061–18063 (2012 & Supp. II 2014). The reinsurance program mandated by the ACA is provided for only three years but includes provisions addressing coordination between the mandated reinsurance program and any further, longer-term reinsurance program the state might choose to operate. ACA § 1343. This indicates Congress's expectation that states would and could operate their own premium stabilization programs beyond those mandated by the ACA.

[185] There is a chance that a financial distress corridors program could run afoul of the requirement that section 1332 of the ACA waivers not increase the federal deficit. This would happen if the program caused insurers to raise their premiums (and so premium tax credits) in order to lower their cost-sharing (and so cost-sharing reduction payments), but the resulting increase in premium tax credits were somehow greater than the corresponding increase in cost-sharing reduction payments.

ject authority.[186] This authority permits broad waiver of Medicare statutory provisions, including those governing Parts C and D,[187] and has been used by HHS before to test changes in enrollee cost-sharing structure intended to improve health outcomes and reduce cost.[188]

V. A FRAMEWORK FOR DECIDING WHEN A MANDATE IS WARRANTED

Financial distress corridors hold the potential to address the social consequences problem by changing insurers' underlying incentives. Such a solution would require time and political will to implement, however, and would be particularly difficult to implement for health coverage products designed entirely by government actors. As a result, regulators must consider mandating patient-friendly insurance designs even if an algorithmic reform might in theory be preferable. This requires an assessment of the pros and cons of potential insurance product designs. While this is difficult in any circumstance, it is especially so when it comes to any effort to reduce the emotional and financial toll of medical bills. As discussed in Part III, the social consequences of medical bills are difficult to quantify and to measure, as are the medical consequences associated with a particular cost-sharing practice that imposes such bills.[189] That a cost is difficult to quantify, however, means neither that it does not exist nor that particular reforms cannot predictably reduce costs (or increase benefits).

This Part offers a straightforward framework for evaluating regulatory mandates intended to make health care bills more affordable. This analysis draws on the normative considerations for evaluating health insurance plan designs developed in Part II.[190] To synthesize those considerations into a framework, in evaluating any actual or potential affordability-focused health insurance product reform we should ask (1) whether any social, financial, or psychological costs associated with a practice are (2) justified by its medical benefit, *i.e.*, its tendency to either reduce health care costs or improve health

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[186] *See* 42 U.S.C. § 1315a (2015).

[187] 42 U.S.C. § 1315a permits waiver of Titles 11 & 18 of the Social Security Act, among other authorities; Medicare Part C and D payment is governed by Title 18.

[188] *See* Letter from Sheila Hanley, Dir., Policy & Programs Grp., Ctr. for Medicare & Medicaid Innovation, to All Medicare Advantage Organizations (Sept. 1, 2015) (available at https://innovation.cms.gov/Files/x/mavbid-announcement.pdf [https://perma.cc/DMG4-9BKU]) (announcing test of changes to enrollee cost-sharing structure in Medicare Advantage intended to improve health outcomes and reduce cost for individuals with chronic illnesses).

[189] *See supra* Part III.A.

[190] This medical-social consequences framework employs a welfarist perspective on insurance design, *i.e.*, it analyzes insurance practices with the goal of maximizing the welfare of the insured. Other normative perspectives are also relevant to insurance design, such as fairness or justice theories. *See generally* Robertson & Yokum, *supra* note 4 (discussing luck egalitarian arguments against cost-sharing). Further work might usefully continue to develop such theories to offer normative insight on the "how" of health insurance and, especially, whether any such process-focused theories dictate policies different than those dictated by the welfarist account above.

care quality (if any).[191] We should also consider any pronounced distributional impacts, even if some might argue that such impacts should not counsel in favor of or against any particular policy intended to influence behavior as long as we provide for offsetting transfers through the tax system.[192] In short, in assessing a particular health insurance practice, we must focus on its social consequences, if any, as well as its medical costs or benefits, if any.[193]

An analysis that focuses only on medical costs or benefits is blind to other impacts and can lead to high levels of financial distress, emotional distress, or decisional burden that are not justified by countervailing medical benefits; the analysis that follows suggests that several current health insurance product features do so. But at the same time, focusing only on social consequences could lead us to prohibit practices that may be desirable even though they impose significant such costs because of their power to create medical benefits; some of the consumer financial protections in the current wave appear to fall into this trap as currently structured. Only by weighing social, financial, and psychological consequences with health consequences can we begin to determine whether a mandate is really worthwhile.

VI. Mandatory Proposal: Automatic Insurer Collection and Financing

One systemic change to the way medical billing works that would largely address the social consequences problem would be to mandate insurers collect and finance their insureds' medical bills. To be sure, for reasons discussed in Part III, it is impossible to say for sure whether such automatic insurer collection and financing would be an improvement over our current lump sum, provider-sourced approach to billing for cost-sharing without further research and experimentation. But in light of the promise for this or other reforms to the way we bill for cost-sharing to reduce patients' financial and emotional distress, such research and experimentation is warranted.

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[191] It might be that cost-sharing never has a medical benefit, because the harm to health associated with forgone care is greater than any cost-savings benefit. *See* JOST, *supra* note 33, at 106–07 ("if cost sharing discourages welfare-increasing care as well as low-value care, increased cost sharing might well cause more harm than good") (citing JOHN A. NYMAN, THE THEORY OF DEMAND FOR HEALTH INSURANCE 146–51 (2003)). The analysis above is based on one of two assumptions: (1) that some cost-sharing does produce a medical benefit or (2) that cost-sharing is here for the immediate future and improving it would be preferable to the status quo.

[192] *See generally* LEWIS KAPLOW & STEVEN SHAVELL, FAIRNESS VERSUS WELFARE (2002) (making such an argument).

[193] As discussed *supra*, if we put to one side a practice's impact on medicine (either medicine's cost or its quality) and its impact on social consequences (financial distress, emotional distress, and decisional burden), the primary costs of health insurance (premiums and cost-sharing) effectively cancel out across plan enrollees. Assuming either a competitive market or serious rate controls, any increase in cost-sharing will reduce premiums, and any increase in premiums will support a reduction in cost-sharing.

The paramount role of insurers in the how, when, where, and why of medical billing is obscured by the fact that by default most insurance contracts remain silent about the subject of collections and, so, leave it to each individual provider to assess and collect cost-sharing bills.[194] It does not have to be this way. Insurers could be required to bill for and collect their insured's medical costs themselves. In short, this would reduce the complexity of medical bills and their impact on the insured's monthly budget without necessarily reducing the insured's ultimate out-of-pocket costs and her corresponding economic incentive to avoid wasteful health care. To borrow an analogy from the cell phone market, which has been the subject of more searching behavioral economic analysis: patients would pay for surgery or other big-ticket medical expenses in manageable installments, like a new cell phone, rather than (as they do by default now) in one painful payment, like a cancelled cell phone contract.[195]

Section A offers background on medical billing and collections. Section B discusses advantages of automatic insurer collection and financing. Section C discusses potential disadvantages.

A. Background on Medical Billing and Collections

In a typical cost-sharing collections case, a patient receives a bill from her medical provider immediately or soon after treatment for the component of the bill subject to cost-sharing, demanding payment in full for whatever share of her expenses her insurer refuses to pay.[196] This may come before or after an "explanation of benefits" from her insurer describing the insurer's cost-sharing liability determination. Many patients lack the funds to pay or the organization to understand the bill when it is received, leading the provider to send follow-up bills or initiate collection efforts.[197] Indeed, provider manuals recommend demanding payment as soon as possible in a way that is

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[194] *See* Jacoby & Warren, *supra* note 4, at 573–78 (discussing doctors' extensive involvement in medical debt collection).

[195] *See* Bar-Gill & Stone, *supra* note 77, at 75–76 ("Historically, the same termination fees were charged regardless of when the agreement was broken meaning that a consumer would have paid the entire termination fee for ending a two year contract one month early."). *See generally* Sunstein, supra note 80, at 249–70 (monthly payments appear smaller, more manageable).

[196] *See generally* Jacoby, *supra* note 4. Although such demands are typical, they are not the rule. Some providers offer installment plans or easy payment options themselves, in an effort to increase the chances of payment. *See* Mitch Patridge & Doug Barry, *Compassionate Patient Financing Can Cure a Hospital's Financial Ills*, 32 J. HEALTH CARE FIN. 168, 171 (2006). *See generally* Jacoby & Holman, *supra* note 35 (quoting newspaper sources).

[197] CONSUMER FIN. PROT. BUREAU, CONSUMER CREDIT REPORTS: A STUDY OF MEDICAL AND NON-MEDICAL COLLECTIONS (Dec. 2014) https://files.consumerfinance.gov/f/201412_cfpb_reports_consumer-credit-medical-and-non-medical-collections.pdf [https://perma.cc/2VNS-96D5] ("Roughly half of all collections tradelines that appear on credit reports are reported by debt collectors seeking to collect on medical bills claimed to be owed to hospitals and other medical providers. These . . . affect the credit reports of nearly one-fifth of all consumers. . . .").

as visible as possible—the best practice is to demand payment in person immediately after treatment, or at the time of discharge.[198]

This is odd. Cost-sharing *could* easily be conceptualized as a monthly expense—as simply a part of purchasing health insurance, akin to a premium—just as many consumers conceptualize the cost of their cell phone as a part of their cell phone plan. Indeed, that is effectively how cost-sharing operates for some patients with chronic illnesses, as these patients tend, in the years after learning of their illness, to enroll in a more generous (and more expensive) plan with lower cost-sharing.[199] In theory, framing cost-sharing bills to consumers in the same way—as part of the underlying expense of health insurance, payable along with the monthly premium—could make those bills more manageable.

Moreover, doctors are unlikely bill collectors. The extent of an insured's liability for health care she receives is set in advance by the health insurance plan. The specific amount of such liability applicable to a treatment is determined by the insurer in the first instance. What's more, an insured's relationship with her insurer is fundamentally a financial one, in stark contrast with the doctor-patient relationship that is defined by trust and vulnerability. And logistically, patients see many providers but have one insurer, so that provider billing necessarily compounds the volume and complexity of bills. Why, then, is the job of assessing and collecting cost-sharing liability left to providers in contemporary health insurance?

B. Advantages of Automatic Insurer Collection and Financing

Automatic insurer collection and financing would entail a law mandating that insurers be the source of cost-sharing bills, rather than a patient's many providers. And rather than seeking a lump sum payment at the point of service, such a law could also require that insurers automatically place patients in an installment plan whereby more manageable periodic cost-sharing payments would be required over a span of months or years (unless the patient chose to pay in full up front). The medical-social consequences framework indicates that the current approach to collecting for cost-sharing exacerbates the social consequences of health insurance without creating medical benefit, so that regulators should consider requiring insurers to take such a primary role in billing for cost-sharing. Such a regime would have several benefits.

First, automatic insurer collection and financing would mitigate a concern with consumerism by taking doctors out of the role of bill collectors and

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[198] *See*, *e.g.*, Jacoby & Holman, *supra* note 35, at 249 (quoting Coker Group Report: "The manager should take the patient to a private room to discuss payment. . . . It's your money—ask for it!"); *id.* at 250 (discussing design of bills to maximize visibility).

[199] For example, a person with diabetes might opt for a "platinum" plan, on which they are responsible for only ten percent of their health care costs through cost-sharing, rather than a silver plan, through which they are responsible for thirty percent. This is adverse selection in action.

bankers. The doctor-patient relationship is defined by the trust it necessarily entails.[200] Consumerism creates conflicts of interest and interferes with this relationship.[201] These problems stem in part from making doctors responsible for disclosing costs of care and encouraging a more entrepreneurial approach to caregiving. But they also stem from making doctors responsible for considering an insured's ability to pay her bills before delivering care and from tasking doctors with collecting the payment, which they may do in the treatment setting itself, and forcing them to negotiate payment plans and the like.[202]

Second, by concentrating responsibility for assessing and collecting cost-sharing liability in a single entity, automatic insurer collection and financing would greatly simplify the experience of medical bills from the consumers' perspective. Today billing for an episode of care entails a minimum of two letters (an explanation of benefits from the insurer explaining the liability and a bill from the provider seeking payment) and two entities to contact regarding any questions (the provider and insurer) compounded by the number of providers involved in an episode of care. Instead, insureds would receive a single bill from a single source. This would reduce the social and psychological costs associated with our current blitz approach to medical billing.

Third, automatic insurer collection and financing would entail nudging the consumer into a financing arrangement likely to be preferable to the alternatives of the status quo (nonpayment, after which bills are sent to collections) or high-cost credit cards. Indeed, insurers could subsidize financing costs by increasing premiums—effectively insuring enrollees not only against

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[200] *See* JOST, *supra* note 33, at 154 ("[T]he physician-patient relationship has been understood to be a relationship of trust.").

[201] *See* Hall & Schneider, *supra* note 39, at 652 ("Patients want a therapeutic relationship with their doctors, a relationship which produces and prospers on reliance, attachment, and mutual confidence."); *id.* (describing "a taboo in official American health culture: namely, a prohibition upon allowing the physician to appear concerned with financial matters") (internal quotation marks omitted); JOST, *supra* note 33, at 150 ("legal and ethical issues" posed by changing relationship of doctors and patients through consumerism "are only beginning to be identified and may not be resolved for some time"). *See generally* Jim Hawkins, *Doctors as Bankers: Evidence from Fertility Markets*, 84 TUL. L. REV. 841 (2010) (noting conflict of interest created where doctors offer financing arrangements and proposing regulatory framework to address those problems); Robertson, *Should Patient Responsibility for Costs Change the Doctor-Patient Relationship?*, *supra* note 76, at 363 (discussing ways that cost-sharing can complicate the doctor-patient relationship).

[202] *See* Mark A. Hall & Carl E. Schneider, *The Professional Ethics of Billing and Collections*, 15 JAMA 1806, 1806 (Oct. 2008) ("[C]harging and collecting for health care unavoidably affects physicians' duties to serve patients' best interests."). *See generally* Hawkins, *supra* note 201; Robertson, *Scaling Cost-Sharing*, *supra* note 70. Moreover, the fear that doctors may avoid treating uninsured individuals because of the lack of reimbursement should also apply to doctors' treatment of under-insured individuals. A doctor who expects to be on the hook in the event of a patient's potential inability to pay for cost-sharing, or to incur significant collections expense, would also have an incentive to avoid providing that patient with necessary but expensive health care. Assigning the risk of insolvency and responsibility for collections to the insurer instead of the provider would take away that problematic incentive.

the risk of sickness but the risk of associated financial distress, at least due to medical bills—permitting them to provide low-cost financing.[203]

C. Disadvantages of Automatic Insurer Collection and Financing

To be sure, insurer collection of and automatic financing for insured patients' medical liability would come with costs, but it is not apparent that these costs outweigh the benefits just discussed. A first cost would be that such an approach would make insurers rather than doctors bear the costs of patient insolvency. It might be argued that this risk is better placed on doctors, to give them a stake in minimizing patient financial distress. However, many objected to managed care on the ground that it could give a doctor a financial conflict of interest that interfered with her judgment about what is best for her patient.[204] Presumably, such concerns would apply with even greater force to our current practice of giving doctors a particular financial reason to avoid treating the most financially vulnerable patients. Moreover, it would be possible to assign partial liability for patient insolvency to providers even while making insurers responsible for assessment and collection.

A second cost would be that this reform might decrease the salience of medical bills—and so their power to influence patients' consumption decisions—by making medical bills less financially painful. As discussed above, by changing *how* cost-sharing is billed without changing the *amount* of cost-sharing, automatic insurer collection and financing has the potential to reduce the emotional and financial impact of cost-sharing without reducing patients' liability. But it is possible that, although not changing patient liability, automatic insurer collection and financing would reduce a patient's response to the incentive that liability provides to avoid wasteful health care

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[203] The above analysis does not pinpoint the expense of financing itself, *i.e.*, the potential risk of patient default and associated interest rate on installment payments, as a "cost" of automatic insurer collection and financing. *Cf.* Vahid Montazerhodjat et al., *Buying Cures Versus Renting Health: Financing Health Care With Consumer Loans*, 8 SCI. TRANSLATIONAL MED. 327, 330 (Feb. 2016) (presenting analysis, based on student loan default rates, of likely nine-percent interest rate for installment loans to pay un-insured costs of newly-developed, big-ticket curative pharmaceuticals). While the impact of automatic insurer collection and financing on this financing cost is uncertain, there are several reasons that such an approach would reduce rather than increase this cost. First, unsatisfied cost-sharing liability due to patient insolvency is already present in our current system—it is borne by providers and usually passed on to insurers, and so into insureds' premiums. Second, to the extent that automatic insurer collection and financing makes medical bills more manageable, it would *reduce* the likelihood of patient insolvency and so the extent to which cost-sharing liability is passed on to third parties. Third, as discussed above, making collections for cost-sharing liability part of an insurance plan itself would cause enrollees to pool the risk of both getting sick and being unable to afford their resulting cost-sharing obligations *ex ante*, paying marginally increased premiums as part of their health plan in order to subsidize low-interest or no-interest financing of medical bills *ex post*. This possibility of using automatic insurer collection and financing as a way to provide insurance against the risk of being unable to timely pay medical bills offers an additional potential "financing" benefit, not cost, of the automatic insurer collection and financing approach.

[204] *See, e.g.*, Pegram v. Herdrich, 530 U.S. 211, 213 (2000) (discussing possible conflict of interest).

spending by reducing the apparent cost, from the patient's perspective, of a particular expenditure.

For example, imagine a patient deciding whether or not to schedule a minor (and potentially unnecessary) outpatient surgery. And assume that without automatic insurer collection and financing, the surgery would cost the patient $3,000 in cost-sharing at the time of treatment, but with automatic insurer collection and financing, the surgery would increase her monthly health insurance bill by $150 a month for 20 months, plus interest. To a calculating patient, well aware of the cost in advance and with no monthly limits on her budget, the degree to which that cost-sharing would cause the patient to think hard about whether the surgery is worthwhile would be the same with or without automatic insurer collection and financing. But if the patient were subject to certain behavioral biases—like the tendency to under-account for future costs—then the patient's incentive to scrutinize the surgery in the first instance might be diminished in the presence of automatic insurer collection and financing, even though the amount of actual liability was unchanged.

It is not clear that this result—diluted incentives in some cases to avoid wasteful health care spending—would actually be a cost of automatic insurer collection and financing. Some have complained that cost-sharing discourages not wasteful but necessary health care spending, because patients without room in their monthly budget for a large expense might forego needed care.[205] To the extent that is true, changing the way enrollees think about their cost-sharing obligations would be a benefit of automatic insurer collection and financing, not a cost.

More importantly, any such dilution would affect a minority of patients. Patients who do not consider the precise cost of health care before deciding to obtain it and patients who fully realize the cost but are calculating (and so free of behavioral bias) would be completely unaffected. The former group would not reduce its spending in response to cost-sharing no matter how presented, and the latter group would not be influenced by the way cost-sharing is billed in making its consumption decisions. Rather, such dilution would only impact those people who are calculating enough to (1) learn the price of health care before consuming it and (2) understand the availability of automatic insurer collection and financing ahead of time, but who are simultaneously (3) subject to behavioral biases causing them to under-estimate deferred costs. It is not possible to do more than speculate at this time about what fraction of individuals would join the author in exhibiting this particular blend of calculation, information, and behavioral bias. But the fact that any dilution depends on the size of that fraction is further reason to doubt the magnitude of this potential cost of automatic insurer collection and financing. Under plausible assumptions elaborated in the footnote below, break-even analysis suggests that automatic insurer collection and fi-

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[205] *See supra* notes 72–73.

nancing would carry benefits justifying even a modest, indirect, adverse effect on health care spending.[206]

VII. EXISTING AND PROPOSED AD HOC CONSUMER FINANCIAL PROTECTION MANDATES ARE JUSTIFIED BUT SHOULD BE ALTERED

This Part applies the medical-social consequences framework to evaluate existing and proposed ad hoc health insurance consumer financial protections. Section A discusses mandates addressing the events that can trigger liability for an insured for her own medical bills. Section B discusses mandates addressing the amount of such liability. Section C discusses mandates addressing the form of liability.

A. Mandates Regarding the Trigger for Medical Bills

Recent health insurance consumer financial protection proposals and enactments at the state level have called out particular triggering events for medical bills, *i.e.*, elements of an episode of care that give rise to cost-sharing. These reforms have focused on four triggers as potentially problematic. First, the out-of-network status of a provider has received scrutiny as a trigger for liability.[207] Second, the *mens rea* or state of mind of the insured and specifically whether she knew she would be subject to cost-sharing or not has

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[206] Based on published research, it is plausible to assume that twenty-five percent cost-sharing reduces health care spending by roughly twelve percent per patient. *See* RAND, A CLASSIC RAND STUDY, *supra* note 60, at 3 (twenty-five percent additional coinsurance reduced expenditures, in 2005 dollars, from $1,250 to $1,100). In terms of the average per capita health expenditure in the United States today, which is $10,300, this would be about $1,230 in savings per year. *See Health Expenditures*, CTRS. DISEASE PREVENTION & CONTROL: NAT'L CTR. HEALTH STATISTICS (2017), https://www.cdc.gov/nchs/fastats/health-expenditures.htm [https://perma.cc/9W4P-J9HK]. On conservative assumptions, mandatory insurer spending would wipe out more than sixteen percent of this cost savings by changing the way cost-sharing liability is presented to a patient after the fact. This number reflects the assumptions that forty percent of consumers exhibit the mix of information, calculation, and behavioral bias that could lead automatic insurer collection and financing to dilute the incentive effect of cost-sharing and that automatic insurer collection and financing would reduce the perceived cost of care to such individuals by forty percent. If it did so, then the nonquantifiable benefits of automatic insurer collection and financing—primarily reduced emotional and financial distress and avoided conflicts of interest—would need to equal $182 (sixteen percent of $1,140) per beneficiary per year in order to be worth the expense. That may be a small price to pay for the benefit of changing the way people experience cost-sharing and thereby dampening the financial and emotional toll of medical bills. The ACA, which was largely motivated to expand health insurance in order to achieve the latter goal, will reportedly cost roughly $5,000 per beneficiary per year for every person it adds to the insurance rolls. This estimate is based on one analysis of the Congressional Budget Office's official budget scorekeeping of the ACA. *See* David Martosko, *Obamacare program costs $50,000 in taxpayer money for every American who gets health insurance, says bombshell budget report*, DAILY MAIL (Jan. 26, 2015, 4:28 PM), http://www.dailymail.co.uk/news/article-2927348/Obamacare-program-costs-50-000-American-gets-health-insurance-says-bombshell-budget-report.html [https://perma.cc/D3VE-RWHC].

[207] *See* Fuse Brown, *supra* note 8, at 136, 149–54.

received attention.[208] Third, reforms have focused on the setting in which care is delivered and specifically whether it is delivered in an emergency setting.[209] Fourth, and perhaps related to the *mens rea* and emergency triggers as discussed below, reforms have focused on the voluntariness of the care received, that is, whether the insured opted to decline an alternative treatment or service that involved less cost-sharing liability.[210] For example, the balance billing laws passed in New York, Connecticut, California, and Florida all limit insureds' liability for emergency out-of-network care to their in-network cost-sharing amounts, except where the insured has actual knowledge of the out-of-network status before receiving treatment.[211]

As discussed above, legal scholars have endorsed these trigger-based reforms. Erin Fuse Brown supports a federal reform to "prohibit surprise billing for covered emergency services (whether in- or out-of-network) and medically necessary services at in-network facilities where the patient was not provided a meaningful option to receive care from an in-network provider."[212] And Fuse Brown argues that "all out-of-pocket payments for involuntary out-of-network bills should count toward a patient's out-of-pocket limit and in-network deductible."[213] Similarly, Mark Hall and his coauthors recommend that reforms "hold[ ] patients financially harmless when they take reasonable steps, or have no reasonable opportunity, to avoid out-of-network billing," which means "charge them only in-network deductibles and cost-sharing."[214] And Valarie Blake concludes that "essential health benefits" delivered out-of-network "should not result in any additional costs to the patient beyond what the patient would have paid in-network."[215]

Applying a medical-social consequences framework, it is not clear that these triggers should really be subject to the regulatory mandates that scholars have endorsed. To be sure, "surprise" undermines foreseeability, and so makes it less likely an insured can budget for a bill in advance. And "surprise" or involuntariness may make a bill seem unfair, increasing the associ-

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[208] *Id.* at 136 ("One of the most prominent examples of health care consumer harm is the surprise medical bill . . . charges that arise when an insured patient *inadvertently* receives care from an out-of-network provider.") (emphasis added); *see also* HALL ET AL., *supra* note 5, at 16 ("Patients who knowingly agree to incur extra costs cannot complain of mere surprise.").

[209] *See* Fuse Brown, *supra* note 8, at 149–53.

[210] *See* HALL ET AL., *supra* note 5, at 5 ("Surprise medical bills result from providers . . . that patients reasonably assumed would be in-network, but actually are out of network, or when patients have no real choice over the network status of their provider."); *id.* at 16 (discussing problems of "coercion or undue pressure"); Fuse Brown, *supra* note 8, at 137 ("the three common characteristics of a surprise medical bill are that it is unanticipated, involuntary, and out-of-network").

[211] *See* Fuse Brown, *supra* note 8, at 148–53.

[212] *See id.* at 177 ("If choosing an in-network alternative would delay the patient's receipt of care by more than twenty-four hours, such alternative would not be considered meaningful.").

[213] *See id.* at 178–79.

[214] HALL ET AL., *supra* note 5, at 25.

[215] Blake, *supra* note 15, at 130.

ated emotional distress.[216] As for emergency care, insureds are relatively less likely to have budgeted for it than other types of care and its costs are likely to be highly concentrated in time; both these considerations tend to reduce the budgetability of associated liability and so increase social consequences. In short, these triggers may tend to pose a greater risk of social consequences than other triggers for cost-sharing liability which does counsel in favor of their prohibition.

On the other hand, however, there are potential downsides in terms of foregone medical benefits associated with proposed and enacted trigger prohibitions. The new *mens rea* requirements are most concerning; by limiting liability to cases where the insured has actual knowledge she is incurring enhanced cost-sharing, Pennsylvania's and other states' proposed balance billing laws could encourage insureds headed to the emergency room or for surgery to remain willfully ignorant of the network status of their providers and avoid receiving a meaningful disclosure from the provider. This would undercut patients' ability to exercise choice among providers or facilities and, along with it, the insurers' ability to use network status to encourage providers to reduce costs or coordinate care.[217]

Moreover, it is not beyond dispute that a patient who signs a consent form before receiving out-of-network care should be subject to liability as a result. "Coercive aspects are difficult to avoid once a course of treatment has begun,"[218] so a patient may be under tremendous pressure to sign such a form, making it a poor signal of voluntariness.[219] Prior scholarly treatments have not explained whether some consideration other than the possibility that consent serves as a signal of voluntariness counsels in favor of penalizing patients who sign what their doctor puts in front of them.

In light of these concerns with a *mens rea* trigger, reforms that permit enrollees to bear full liability for out-of-network care if they have actual knowledge should at least include the requirement featured in a minority of current laws that written consent be granted twenty-four hours before the treatment in order to minimize the likelihood of coercion. Such a provision

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[216] This possibility for increased social consequences attaches to cost-sharing that comes as a surprise to the patient regardless whether the trigger for the cost-sharing was network status or some other consideration. That is to say, if out-of-network surprise bills pose increased social consequences, then that increase is associated with the fact that they come as a surprise and not that they are for triggered by out-of-network care or providers' out-of-network status.

[217] The insurer's power to bargain over price and to insist on coordination of care depends in large part on the insurer's ability to use cost-sharing to direct the behavior of its patients. The price paid by the insurer is in this sense secondary. The primary stick and carrot the insurer has at its disposal is the ability through cost-sharing to affect the consumption decisions of its patients. As a result, a law that holds patients harmless for out-of-network care could undermine both the providers' carrot for in-network providers and its stick for out-of-network providers. For a further discussion of potential medical benefits and costs of narrow networks, see generally Blake, *supra* note 15.

[218] HALL ET AL., *supra* note 5, at 16.

[219] *See* Matthew J.B. Lawrence, *In Search of an Enforceable Medical Malpractice Exculpatory Agreement: Introducing Confidential Contracts as a Solution to the Doctor-Patient Relationship Problem*, 84 N.Y.U. L. REV. 850, 864–66 (2009) (discussing signaling pressure on patients to waive malpractice liability for fear of indicating a lack of trust to their doctor).

would tend to decrease concerns about willful blindness, because an enrollee could freely learn about the status of her provider without triggering liability.

It also may be problematic to limit emergency room care as a trigger for liability. Emergency room visits are thought by some to be an often avoidable and particularly costly form of health care, the sort of health care consumption cost-sharing has been shown to encourage patients to avoid.[220] Yet, recent reforms would limit insurers' ability to expose patients to liability in particular for this sort of care, undermining that cost-cutting purpose.

Recognizing this concern with focusing on emergency room care, Mark Hall and his co-authors argue that rather than focus on emergency room care, consumer financial protections should expand their limitation to the larger category of which emergency room visits may by (imperfectly) emblematic: involuntary care.[221] The theory behind limiting patients' liability for receiving unavoidable treatments may be that such liability is of dubious medical benefit: a threat of liability cannot alter an insured's behavior if she has no choice but to engage in that behavior in any event.

While sound in principle, a potential theoretical objection to this logic is that many treatments that appear involuntary in the moment may not truly be involuntary in the sense that enhanced liability could not deter their consumption. Emergency room care is a good illustration. In some cases, emergency room care is involuntary in every sense; take the example of a person transported to the closest ER after a car accident. But in other cases, a patient's failure to seek out alternative care earlier in the course of an illness or to maintain a treatment regimen might ultimately generate an emergency that could have been avoided even if the patient is ultimately left with no choice on the day she visits the ER. For example, proper diabetes management and early identification and care can prevent and manage foot ulcers before they become problematic. But left untreated, such ulcers can quickly progress to emergencies that necessitate amputations. A prohibition on liability for involuntary treatments may undercut insurers' ability to incentivize insureds to prevent emergencies from arising in the first place.

None of this is to say that balance billing on emergency room care or other out-of-network visits is not problematic or should not be considered as a basis for regulation. As discussed in the next section, however, reformers should consider capping the extent of insureds' liability for out-of-network or emergency room care rather than forbid these triggers as bases for increased liability altogether.

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[220] *See* Remler & Greene, *supra* note 144, at 301 (reviewing several studies of the impact of cost-sharing on emergency department usage and concluding "[t]he studies have consistently found that ED cost-sharing reduces ED utilization" and "the studies showed no increases in hospitalizations, intensive care unit admissions, or mortality rates").

[221] *See* HALL ET AL., *supra* note 5, at 16 (forcing insurers to reimburse providers for out-of-network emergency care would "tie the hands of insurers attempting to negotiate network participation with emergency facilities and physicians, and likely would lead to even higher charges").

B. Mandates Regarding the Amount of Medical Bills

One problem with surprise liability for out-of-network care may be its amount. Under the ACA there is an out-of-pocket limit on in-network cost-sharing. But this limit does not apply to out-of-network cost-sharing, which is part of the reason that the amount of the liability associated with surprise out-of-network bills is often in the thousands or tens of thousands of dollars.

The magnitude of a cost-sharing liability is itself a prime determinant of its tendency to impose financial distress.[222] The larger a bill, the higher the likelihood that it taps the patient's liquidity and puts the patient into increasingly costly arrears. The marginal benefit for health care cost or quality of extreme liability for surprise or emergency out-of-network care as compared to more modest liability for the same triggers is particularly likely to be limited and insufficient to justify the increased financial distress.

To the extent that the problem with surprise or emergency balance bills on out-of-network care is not just the trigger for liability but its magnitude, reformers and further scholarship should consider whether laws regulating such practices should be altered from outright trigger prohibitions to liability caps. Reforms could limit the magnitude of increased liability that may be imposed on the insured on the basis of triggers thought to be problematic by a percentage based on either the cost of treatment or the insureds' income (or both), or a set amount per day, visit, or procedure. Doing so could both deal with the social consequences problem posed by balance bills and other apparent abuses and also permit insurers to appropriately incentivize patients to find in-network providers and avoid unnecessary emergency room visits.

Legal scholars including Richman *et al.* have argued that existing rules of contract law could in many cases operate as caps on the most outrageous out-of-network bills.[223] If successful, this approach would be consistent with the recommendation here that reformers focus on amount caps instead of outright trigger prohibitions as a way to limit the social consequences of particular consumer abuses.

Turning from the size of medical bills associated with particular triggers, we might also explore varying the overall amount of cost-sharing, and so of medical bills, under a plan. Indeed, Chris Robertson has advocated varying cost-sharing amounts with an insured's income based on the insight that the impact of cost-sharing on an insured's incentive to avoid wasteful care and ability to bear the cost of medical bills both depend to a significant degree on her income.[224] In a nuanced analysis of this particular aspect of health insurance product design that was an inspiration for this Article, Robertson offers a persuasive account in favor of current federal benefits programs that scale cost-sharing amounts to wages and their expansion to new

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[222] *See supra* Part II.B.3.a.

[223] *See supra* Part II.B.3; *see also* Richman et al., *supra* note 18, at 101 ("payers and patients can invoke rudimentary common law principles to challenge inflated chargemaster charges").

[224] *See* Robertson, *supra* note 70, at 244.

contexts.[225] Such programs can be understood alongside trigger-focused reforms as mandatory efforts to address symptoms of the social consequences problem.

C. *Mandates Regarding the Form of Medical Bills*

Another source of large, often unexpected liability associated with health insurance is the deductible. While some enrollees anticipate cost-sharing and plan ahead, for many, $5,000 in liability flowing from a deductible is every bit as unanticipated as $5,000 in liability flowing from a surprise out-of-network bill.[226] Take the hypothetical of an apparently healthy individual who suffers an unexpected hospitalization for gallbladder surgery. That bill is not apparently any less surprising, burdensome, or worrying than a "surprise" out-of-network bill, so it is also worthy of regulatory attention.[227]

In general, the social consequences associated with deductibles may be larger than the social consequences for cost-sharing incurred through copays or coinsurance, for the simple reason that this form of cost-sharing entails liability that is particularly concentrated. In seeking to justify this increased financial impact, it is hard to argue that deductibles necessarily reduce costs or increase quality better than more staggered forms of cost-sharing.[228] Deductibles are uniquely targeted to discourage the insureds' first dollar of consumption; yet often costs are increased, not decreased, by a patient choosing to delay care. Moreover, once deductibles run out, patients lose any further financial incentive to reduce costs.[229] As a result, a large fraction of all spending occurs in a small percentage of high-cost cases.[230] It may be medically preferable to extend a patient's incentive to reduce costs over a fuller share of her medical spending.

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[225] *See id.* at 269.

[226] Surely there is a subset of insureds for whom the secondary cost of a $5,000 deductible is less than the secondary cost of a "surprise" out-of-network bill of $5,000 because they plan ahead. An insured with a chronic illness who anticipates spending her deductible ever year will have budgeted for the expense as if it were a monthly premium, perhaps even contributing an equivalent amount to a tax-deductible health savings account. But just as surely, there is a subset of insureds who do not plan ahead in this way.

[227] Particular thanks to Nancy Welsh for this point.

[228] One possible benefit of deductibles as compared to other forms of cost-sharing is that they exhaust applicable out-of-pocket limits faster, simplifying the experience of treatment for an insured with high expenditures and so reducing decisional burden, but it seems doubtful that this benefit is worth the associated cost or that it is the best way to simplify the patient experience.

[229] *See* JOST, *supra* note 33, at 135 ("[o]nce a [high deductible health plan] enrollee hits the deductible, incentives for controlling expenditures are considerably reduced;" "once the out-of-pocket maximum is reached (which will happen after a few days of hospitalization for most) all further health care is free"). *See also id.* at 78 (questioning usefulness of deductibles based on insight that they do not impact spending choices beyond their limits) (citing ALAIN ENTHOVEN, HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COSTS OF MEDICAL CARE 32–36 (1980)).

[230] *See id.* at 135 ("10 percent of the population is responsible for 70 percent of healthcare expenditures").

Cynical explanations for the fact that insurance plans increasingly devote a significant share of their allowable out-of-pocket expenses to deductibles are not as elusive. In the individual marketplace, turnover between plans is high; deductibles may be a way to encourage patients who become ill toward the end of a plan year to delay their care into the new year and a new plan's costs.[231] Furthermore, deductibles are highly salient, clear cost-sharing features likely to attract the notice in particular of potential enrollees expecting to incur medical expenses during the plan year. So insurers may opt for cost-sharing in the form of deductibles over coinsurance or copays as a way to discourage enrollment by the sick and segment plans. Finally, the ACA caps total out-of-pocket spending on in-network care, without regard to form. By so doing, it is possible that the ACA pushed insurers to adopt particularly painful forms of cost-sharing within their allowable maximum and actuarial limits.

In light of these potential concerns, regulators should consider addressing the form that cost-sharing takes as well as its amount and trigger. For example, Medicaid cost-sharing is capped on a monthly or quarterly basis, and such periodic deductibles have been employed in Canadian provincial drug benefit programs.[232] Regulators could mandate that private insurance deductibles be subject to such periodic caps. This could smooth financial impacts, encourage learning and enrollment in health savings accounts (after a first painful deductible experience), prevent year-end delays, and maintain appropriate incentives to avoid wasteful care throughout the year even after a significant illness in a particular quarter.

CONCLUSION

Regardless whether it is wise or unwise to build a hole into the health insurance safety net, we have the power to cushion the impact of the bills that fall through. Prohibiting particular health care consumer "abuses" outright is not the only or best regulatory tool we have to mitigate the social, financial, and psychological consequences that medical bills cause insureds. Rather, this Article has pointed to other tools to reduce such consequences by incentivizing insurers to vary the way health insurance structures and collects cost-sharing liability or mandating such systemic changes.

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[231] *Cf.* Jeffrey T. Kullgren et al., *Health Care Use and Decision Making Among Lower-Income Families in High-Deductible Health Plans*, 170 ARCH. INTERN. MED. 1918 (2010) (study finding, based on survey, that lower-income families in high-deductible health plans were more likely to delay or forego care than higher-income families); Alison A. Galbraith et al., *Delayed and Forgone Care for Families with Chronic Conditions in High-Deductible Health Plans*, 27 J. GEN. INTERNAL MED. J. 1105 (2012) (study finding, based on survey, that families with chronic conditions in high-deductible health plans were more likely to delay or forego care than such families in traditional health plans).

[232] *See* Watson, *supra* note 151, at 415; Jamie R. Daw & Steven G. Morgan, *Stitching the gaps in the Canadian public drug coverage patchwork? A review of provincial pharmacare policy changes from 2000 to 2010*, 104 HEALTH POL'Y 19 (2012).

In addition to insights regarding the case for existing and proposed health care consumer financial protection laws, this Article has made the case for novel competition-based and mandatory reforms designed to address health insurance's social consequences problem: financial distress corridors and automatic insurer collection and financing. Giving insurers "skin in the game" of their enrollees' financial distress through financial distress corridors would prompt them to innovate on plan designs that make bills more manageable for patients while reducing the sticker shock for patients just recovering from (or still battling) an illness. And making insurers, rather than doctors, responsible for billing for cost-sharing through automatic insurer collection and financing could reduce the salience of bills, purify the doctor-patient relationship, and nudge patients into a low-cost, low-stress financing arrangement that fits into their monthly budget. In any event, states or federal regulators considering following the latest wave of state-based health care consumer financial protections should not assume that these protections fully address the social consequences problem and should tailor new reforms to better account for social consequences.

Finally, this Article has called out various empirical questions on which further research would be helpful. In addition to the possibility of policy development and experimentation raised by the new financial distress corridors and automatic insurer collection and financing reform proposals offered in Parts IV and VI, these include: (1) whether balance billing or other consumer abuses are more common in large group, small group, or individual market health insurance (which could illuminate the extent to which employers play a salutary role in preventing such abuses);[233] (2) whether adverse selection is a more influential challenge for plan features that are highly attractive to a small subset of insureds (like coverage for HIV treatment) or for plan features that are moderately attractive to a larger subset (like cost-sharing);[234] (3) whether balance billing or other insurance consumer abuses are more common among provider groups that are subject to higher rates of patient bad debt (like providers who work in the emergency room versus dermatologists);[235] (4) whether providers could feasibly and legally, and should, price discriminate among different patients based on the billing costs they present;[236] and (5) whether hospital collection practices for Medicare beneficiaries differ based on whether they are enrolled in traditional Medicare or Part C in light of the promise of bad debt reimbursement in the former program. Answering these questions would help to refine our understanding of the social consequences problem in health insurance and how to solve it.

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[233] *Supra* note 137 and accompanying text.
[234] *Supra* note 104 and explanatory text.
[235] *Supra* note 113.
[236] *Supra* note 118.