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Health Law's Sheathed Sword

Why Hasn't Civil Litigation Dented Health Care Costs?

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16.1 INTRODUCTION

It is generally agreed that health care costs in the United States are unreasonably high and unsustainably growing, and that these problems are attributable to prices that are excessive, relative to those in peer industrialized nations.[1] High prices, in turn, are frequently attributed to consolidated markets for provider services[2] and other aggressive, extractive practices by providers.[3]

Generally, one might say that three categories of action are available for stakeholders to push back on prices. Health care purchasers – primarily, employers and insurers, can use the carrot of inclusion in a health plan's network to negotiate lower prices.

A second course is seeking legislative or regulatory action to tamp down prices. This can include options such as state-imposed rate setting,[4] or less onerous measures aimed at bolstering purchasers' negotiating leverage.[5]

A third course to pursue is litigation – either initiated by a purchaser or through defense of provider collection suits when a purchaser is willing to challenge bills because it believes the prevailing law is favorable to it.

[1] Gerard F. Anderson et al., It's the Prices, Stupid. Why the United States Is So Different from Other Countries, 22 Health Affs. 89, 102 (2003).

[2] Zack Cooper et al., The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured, 134 Q. J. Econ. 51 (2019).

[3] Atul Gawande, The Cost Conundrum, The New Yorker (June 1, 2009), https://www.newyorker.com/magazine/2009/06/01/the-cost-conundrum.

[4] Ezekiel Emanuel et al., A Systemic Approach to Containing Health Care Spending, 367 New Engl. J. Med. 949 (2012); Gerard Anderson & Bradley Herring, The All-Payer Rate Setting Model for Pricing Medical Services and Drugs, 17 AMA J. Ethics 770 (2015).

[5] A Tool for States to Address Health Care Consolidation: Prohibiting Anticompetitive Health Plan Contracts, Nat'l Acad. for State Health Pol'y (Apr. 12, 2021), https://nashp.org/a-tool-for-states-to-address-health-care-consolidation-prohibiting-anticompetitive-health-plan-contracts/.

What might be called "cost containment litigation" is not unusual but has been fairly infrequent. One of the most audacious provider overreaches was addressed in an antitrust lawsuit, *UEBT v. Sutter Health*,[6] which was settled in 2019 resulting in a US$575 million disgorgement and injunctive relief to curb the underlying anti-competitive conduct. But this outcome remains an outlier, and the circumstances that make it unique exemplify the dynamics surrounding this type of litigation.

Another practice that provoked an outsize amount of outrage and attention in the second decade of this century was balance billing and other machinations by out-of-network (OON) providers. In particular, hospital-based physicians were able to opt out of all insurance plans because they serve captive clientele within in-network facilities.[7] In 2020, Congress enacted the No Surprises Act in an attempt to finally resolve the problem. But during this period, some modest efforts to invoke private law against rogue providers also proceeded in the courts. As I will explain below, conditions seemed favorable for a litigated solution to the surprise billing problem, yet the coalition of payers and consumer advocates formed to end the abuses chose to concentrate on securing a legislative solution.

Why might it be that this coalition would not, or could not, pursue a coordinated litigation strategy? An impracticability or unwillingness to invoke private-law remedies would give providers and suppliers an edge over purchasers in the struggle to contain the excessive costs of the US health care system. This research project surveyed private-law approaches that have been applied to challenge provider opportunism. The overview of the litigation studied will be presented elsewhere. This article confronts the question of missing-in-action litigation, from political science and economic perspectives.

16.2 WHY TAKE HEALTH CARE COST CONTAINMENT TO COURT?

Two types of provider opportunism seem amenable to court-adjudicated resolution: attempts to collect exorbitant "billed charges," and anticompetitive conduct.

16.2.1 *Background on Billed Charges versus Market Prices*

As a basic framework for understanding legal disputes over healthcare prices, it is helpful to consider the distinction between billed charges and market prices. Billed charges can be thought of as a provider's optimal price for a service free from market constraints, a provider's default "asking price" or "list price." Market prices can be thought of as those prevailing in a competitive market for health care services,

[6] UEBT v. Sutter Health, No. CGC 14-538451 (Cal. Super. Ct.).

[7] Elisabeth Rosenthal, Costs Can Go Up Fast When E.R. Is in Network but the Doctors Are Not, N.Y. Times (Sept. 28, 2014), https://www.nytimes.com/2014/09/29/us/costs-can-go-up-fast-when-er-is-in-network-but-the-doctors-are-not.html.

emerging from network contracts negotiated by insurers or cash payments by consumers.

While the author strongly believes that patient liability for billed charges has little legal support under the common law, there is admittedly enough legal ambiguity about their status, as well as logistical difficulty in challenging them, that they have had compelling power over payers and consumers.[8] Further, some providers have been able to obtain fees close to their idealized maximum price through consolidation or other anticompetitive practices, reaping amounts that resemble billed charges more than prices that would result from vigorous competition. The following two sections summarize the rationales for challenging these practices in the courts.

16.2.2 *The "Common Law Solution" to Billed Charges*

The substantive law case for litigating billed charges has been articulated by Prof. Barak Richman, who argues that "consumers are already protected by current law – bedrock, rudimentary contract law – and require only its proper application to end harmful chargemaster practices."[9] According to Richman and colleagues, "providers have no legal authority to collect chargemaster charges that exceed market prices for OON services, and thus neither patients nor payers are under any obligation to pay such chargemaster prices."[10]

Richman and colleagues are referring to the doctrine of implied contract, or *quantum meruit*. The Pennsylvania Superior Court applied this doctrine in its decision in *Temple University Hospital, Inc. v. Healthcare Management Alternatives, Inc.*[11] The case involved services provided by a hospital to a health plan's enrollees following expiration of the parties' network contract. The hospital sought its chargemaster rates from the insurer. The court noted testimony from the hospital's CFO that the hospital seldom received its published rates.

The court held that when "there is no express agreement to pay, the law implies a promise to pay a reasonable fee for a health provider's services. Thus, in a situation such as this, the defendant should pay for what the services are ordinarily worth in the community. Services are worth what people ordinarily pay for them."[12] Because the controlling question is "what healthcare providers actually receive for those services," the chargemaster "cannot be considered the value of the benefit conferred

[8] See the eleven cases from various jurisdictions holding that paperwork signed by patients can incorporate hospital chargemaster rates cited in Centura Health Corp. v. French, 2020 COA 85, 490 P.3d 780.

[9] Barak D. Richman et al., Battling the Chargemaster: A Simple Remedy to Balance Billing for Unavoidable Out-of-Network Care, 23(4) Am. J. Managed Care e100 (2017).

[10] Id. at e103.

[11] Temple Univ. Hosp. v. Healthcare Management, 832 A.2d 501 (Pa. Super. Ct. 2003).

[12] Id. at 508.

because that is not what people in the community ordinarily pay for medical services."[13]

16.2.3 *Private Antitrust Enforcement*

The case for increased private antitrust enforcement in the health care sphere is articulated by Anne Marie Helm, who argues that it "can restore competition, deter antitrust violations, and compensate victims in the markets for health care services and insurance ... accordingly, the United States should be looking for ways to optimize it."[14]

Helm acknowledges that plaintiffs face a challenging legal environment. Nevertheless, some supportive case law indicates judicial appreciation of the importance of private enforcement.

Messner v. Northshore Univ. HealthSystem[15] involved a putative damages class action following up on the FTC's unwinding of a hospital merger. The District Court denied class certification on predominance grounds.[16] Observing that "it is important not to let a quest for perfect evidence become the enemy of good evidence," the Seventh Circuit reversed.[17]

Another decision, *Palmyra Park Hospital, Inc. v. Phoebe Putney Memorial Hospital*,[18] permitted a challenge by a competing hospital shut out by a large hospital system's market power. Palmyra had been an in-network provider for Blue Cross Blue Shield of Georgia but lost its in-network status allegedly because Phoebe Putney leveraged its power as sole Certificate of Need permittee for three medical services "to force Blue Cross (and other insurers) to exclude Palmyra from their provider networks. Specifically, Phoebe Putney threatened to demand significantly higher reimbursement rates for those services in its contracts with Blue Cross if Blue Cross included Palmyra in its provider network. Palmyra attempted to contract with Blue Cross on several occasions" but was turned down due to Blue Cross's contract with Phoebe Putney.[19]

The issue in the case was whether a competing hospital is an efficient enforcer of the antitrust laws for purposes of antitrust standing. The district judge believed that the health insurers or consumers were the appropriate plaintiffs. The Eleventh Circuit reversed, observing that such scenarios were unlikely, particularly the former:

[13] Id.
[14] Anne M. Helm, Optimizing Private Antitrust Enforcement in Health Care, 11 St. Louis U. J. Health L. & Pol'y 5, 7 (2017), https://ssrn.com/abstract=3157878.
[15] Messner v. Northshore Univ. HealthSystem, 669 F.3d 802 (7th Cir. 2012).
[16] In re Evanston Northwestern Healthcare Corp. Antitrust Litig., 268 F.R.D. 56 (N.D. Ill. 2010).
[17] Messner, supra note 15, at 808.
[18] Palmyra Park Hosp. v. Phoebe Putney Memorial Hosp., 604 F.3d 1291 (11th Cir. 2010).
[19] Id. at 1296.

> [T]he insurance companies are likely able to pass a large percentage of the higher reimbursement rates on to their policy holders in the form of higher premiums. Thus, they bear relatively little of the cost imposed by the tying scheme. Moreover, an insurance company would risk losing its goodwill with Phoebe Putney if it sued; given that an insurer must include Phoebe Putney in its network to be competitive in southwest Georgia, insurers would be understandably reluctant to anger Phoebe Putney by suing it.[20]

The denouement of this saga, however, shows the weakness of relying on competitors to challenge market power. Phoebe Putney acquired and absorbed Palmyra Hospital over Federal Trade Commission (FTC) objections.[21]

16.3 THE PROMISE AND LIMITS OF COST CONTAINMENT LITIGATION

Victory in litigation over an opportunistic provider can have two types of benefits: a private benefit for the party that brought the suit, and a collective benefit for consumers and payers – that is, the public at large – if the wins change business practices. When a case involves a unique, unusual, or payer-specific practice, the private benefit predominates, and success in the suit, such as a damages award or an injunction, suffices to satisfy the plaintiff's goals.

Use of litigation to achieve a collective benefit is more complex, and when it comes to health care costs that are increasing for every employer, worker, and consumer, due to the same common and pervasive practices, it is the collective good that is implicated. Ideally, success would involve discrete entities subject to controlling legal authority that prohibits an abusive business practice (e.g., the outcome of the recent BCBS antitrust litigation).[22] Realistically, it would more likely result in a few impactful judgments, creating a body of law that convinces the losing litigant that continuing the practice would be economically futile (e.g., the litigation that ended production of the Ford Pinto automobile).[23] To be sure, through the availability of punitive damages in tort suits, treble damages in antitrust suits, and Rule 11 sanctions in civil suits, private law has tools to confront social costs and address collective relief in addition to individual relief; however, no attorney would suggest that these tools are easy for litigants to access.

In the case of the out-of-network hospital-based physician or air ambulance business models, true victory would have meant a sequence of victories spelling out the rights of consumers so explicitly as to make further assertions of balance billing claims frivolous and subject to sanctions. It would have required an

[20] Id. at 1305.
[21] In the Matter of Phoebe Putney Health System et al., No. 9348 (F.T.C. 2015).
[22] In re Blue Cross Blue Shield Antitrust Litig. (MDL No. 2406), 2015 WL 10891632 (N.D. Ala. 2015).
[23] Grimshaw v. Ford Motor Company, 174 Cal. Rptr. 348 (Cal. Ct. App. 1981).

orchestrated effort to defend consumers in collection cases (as the author proposed prior to passage of the No Surprises Act).[24]

16.3.1 *The Collective Action Problem in Cost Containment Litigation*

But who, exactly, would bear the costs to achieve this widespread, dispersed collective benefit? A health care system that functions properly in spite of efforts by rogue actors is truly a public good that would be enjoyed by scores of insurers, many thousands of employers, and hundreds of millions of individuals. Some sort of cooperative effort would be needed to achieve it.[25]

Mancur Olson articulated what is known as the Collective Action Problem.[26] While conventional wisdom expects that groups of individuals with common interests would act on behalf of those interests, since they would gain from such cooperation, "they will not act to advance their common or group objectives unless there is coercion to force them to do so," or some separate, distinct incentive is offered to group members individually, conditioned on their help in pursuing the collective aim.[27] Olson's argument is that individual group members, while having common interests, also retain purely individual interests such as saving money, so if it is possible to drop out of paying dues toward a cooperative effort, "the loss of one dues payer will not noticeably increase the burden for any other one dues payer, and so a rational person would not believe that if he were to withdraw from an organization he would drive others to do so."[28]

Consider the sprawling variety of entities that encompass the latent "group" concerned with surprise bills: consumers, who, as patients receive balance bills and as workers experience a significant, but usually invisible, reduction in take-home pay as health benefit costs rise; employers, who in the short run must pay the bills (if self-insured) or higher premiums (if fully insured) but who, over the long run, may be indifferent as to the proportion of employee compensation paid in cash versus health benefits; and insurers, who are most directly on the hook for increased payments but also have interests that may diverge from those of enrollees and clients.

Creating a body of law that would render impotent the out-of-network business model for physician staffing companies would be a public good – a benefit from which no payer or consumer could be excluded.

[24] Jackson Williams, The Persistence of Opportunistic Business Models in Health Care and a Stronger Role for Insurance Regulators in Containing Health Care Costs, 41 Nova L. Rev. 3 (2017), https://nsuworks.nova.edu/nlr/vol41/iss3/3.

[25] Of course, a critical mass of litigation generated for private benefit could have the secondary, incidental effect of deterring a business practice and accomplishing a public benefit, as occurred with the Ford Pinto.

[26] Mancur Olson, The Logic of Collective Action (1971).

[27] Id. at 2.

[28] Id. at 12.

Nevertheless, these diverse interests came together in a Coalition Against Surprise Medical Billing that successfully lobbied Congress to curb balance billing, but they did not jointly pursue a litigation strategy. A fair amount of political science theory and research is available to analyze why groups choose to, or choose not to, seek redress from the courts, which will be discussed *infra*.

16.3.2 *Are Payers Effective Agents of Their Enrollees?*

It is apparent that, unlike other rivalrous dyads in the US economy, providers and payers generally lack an aggressive, two-sided contentiousness. When one compares their network contracting and other interactions to other famously antagonistic dyads – labor versus management, the Association of Trial Lawyers of America and its members versus the US Chamber of Commerce and its members, bulk purchasers for resale versus suppliers – the relationship looks rather amicable. To Dennis Scanlon, "it is somewhat of a mystery as to why insurers and third party administrators (TPAs) have not been able to achieve price reductions through contracting" and "not serving as better agents for their customers."[29]

Surely, a large influence is payers' desire to offer broad provider networks. According to the Kaiser Family Foundation's 2019 Employer Health Benefits Survey,[30] employers were asked what they considered the most important factor in constructing their provider networks. Thirty percent of employers identified the number and convenience of providers as most important.[31] Thirty-nine percent of employers said that they would not reduce network size for cost savings, with 36 percent saying that they would need to realize savings of at least 20 percent to narrow their network.[32] Only 2 percent of firms reported that they or their insurer eliminated a hospital or health system from their provider network during the past year to reduce costs.[33]

Clearly, payers worry about imposing inconvenience on enrollees and see broad networks as attractive to workers. Notably, private insurers have not embraced the role of challenging questionable or fraudulent claims the way that federal health programs have.[34] In Washington, DC, during federal employees' open enrollment

[29] Dennis P. Scanlon, If Reference-Based Benefit Designs Work, Why Are They Not Widely Adopted? Insurers and Administrators Not Doing Enough to Address Price Variation, 55 Health Serv. Res. 344, 344–47 (2020).

[30] 2019 Employer Health Benefits Survey, Kaiser Fam. Found. (Sept. 25, 2019), https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/#:~:text=The%202019%20survey%20included%202%2C012,the%20cost%20of%20their%20coverage.

[31] Id.

[32] Id.

[33] Id.

[34] Marshall Allen, We Asked Prosecutors if Health Insurance Companies Care about Fraud. They Laughed at Us, ProPublica (Sept. 10, 2019), https://www.propublica.org/article/we-asked-prosecutors-if-health-insurance-companies-care-about-fraud-they-laughed-at-us.

period in 2022, city buses were emblazoned with advertisements from Blue Cross Blue Shield boasting that 96 percent of hospitals and 95 percent of doctors were included in their network. But Amazon and Walmart emphasize broad arrays of products, and this does not deter them from bargaining hard with suppliers. As Scanlon notes, payers should be able to negotiate away unwarranted variations in provider prices until they converge at an appropriate level,[35] as do prices for paper towels negotiated by Walmart.

What incentive do payers have to emphasize provider price reductions over other considerations?

Employers are the largest category of payers in the United States, and many participate in organizations such as Catalyst for Payment Reform and Purchaser Business Group on Health that emphasize cost containment. But one prominent school of thought predicts employers will be largely indifferent to whether compensation is paid in the form of cash wages or health benefits.

> Under traditional economic theory, employer contributions to health insurance premiums are one of many parts of workers' total compensation, and employers offer the combination of wages and benefits that will best help them attract and retain employees … When health care costs rise, employers can respond … by increasing worker premium contributions, increasing deductibles or copayment amounts, reducing employment, or increasing their own premium contributions while reducing or limiting wage growth accordingly.[36]

As such, health care costs "come out of workers' wages or other compensation over the long-run," rather than out of employers' profits.[37]

Insurers, meanwhile, may have even less incentive to contain medical costs. Recall the Eleventh Circuit's observations about insurance companies' ability to pass along higher reimbursement rates through higher premiums. Further, insurers are subject to the Affordable Care Act's medical loss ratio (MLR) floor. This regulation requires insurers to issue rebates if claim expenses are less than 80 to 85 percent of premiums. The intention of the law, of course, was to reduce premiums by reducing administrative costs and profits; but the requirement can also be met by holding those elements constant and increasing claim payouts. One study found an increase in claim costs after the MLR law took effect, concluding it was "likely that insurers raised their claims costs from a combination of more comprehensive

[35] Scanlon, supra note 29, at 345.

[36] Laurel Lucia & Ken Jacobs, Increases in Health Care Costs Are Coming out of Workers' Pockets One Way or Another: The Tradeoff between Employer Premium Contributions and Wages, UC Berkeley Labor Ctr. Blog (Jan. 29, 2020), https://laborcenter.berkeley.edu/employer-premium-contributions-and-wages/.

[37] Id.

coverage and reduced cost-containment effort, such as negotiations with providers or claims utilization management practices."[38]

At the other end of the continuum, union health plans established under the Taft-Hartley Act surely have the greatest incentive to curb provider costs since they bargain for the complete compensation package and can quantify the wage/health benefit trade-off literally to the penny per hour worked.[39] Funds that go to high-cost providers can be directly reallocated to wages if the union plan is willing to sacrifice access to some providers.[40] Unlike the situation when the employer alone stewards the health benefit, union leaders can promise definite monetary benefits to be reaped in exchange for dropping, or threatening to drop, a high-cost provider.[41]

And so we see that in the *Messner* antitrust litigation, the Painters District Council No. 30 Health & Welfare Fund was a named plaintiff, while Blue Cross Blue Shield of Illinois filed an affidavit stating that it "did not pay artificially inflated prices" and did not suffer "any injury or damage."[42] This continuum of incentives is concerning, because the payer category with the least incentive has the greatest resources, while the payer category with maximum incentives serves only a small proportion of health insurance enrollees. Payer participation in cost containment activities may rely more on insurers' and employers' executives' sense of unfairness or outrage at excesses than on economic incentives.

The Eleventh Circuit, in the *Phoebe Putnam* decision, also mentioned insurers' incentive to retain goodwill with provider partners.[43] Outside of extreme and exploitative circumstances, insurers surely feel inhibited from confronting providers they need to maintain adequate networks, especially in an era when insurers are asking providers to take on risk. Conversely, unions' mission encompasses vigilance against oppressive business practices, and confrontation is central to their *modus operandi*.

Finally, federal antitrust law prefers plaintiffs to be the direct purchaser of the overpriced service.[44] The victorious cocounsel in *UEBT v. Sutter Health* argues that one reason they secured a settlement in their state-court litigation while a similar federal case yielded a verdict for the defendant was that they sought "direct damages for amounts that self-insured entities allegedly overpaid Sutter for health care services; in the federal case, by contrast, the insured class members sought indirect

[38] Steve Cicala et al., Regulating Markups in US Health Insurance, 11 Am. Econ. J. Applied Econ. 71, 101 (2019).

[39] Cost Containment and Price Transparency: Hearing before the California Senate Committee on Health (Mar. 5, 2014) (testimony of Ken Stuart).

[40] Martha Hostetter & Sarah Klein, In Focus: How Unions Act as a Force for Change in Health Care Delivery and Payment, Transforming Care (newsletter) (Mar. 21, 2019), https://doi.org/10.26099/mx4c-qc89.

[41] Noam N. Levey, Not Everyone Has Eye-popping Deductibles: How One Union Kept Medical Bills in Check, L.A. Times (Dec. 17, 2019), https://www.latimes.com/politics/story/2019-12-17/one-union-kept-medical-bills-in-check.

[42] Messner, supra note 15, at 822.

[43] Palmyra Park Hosp., supra note 18, at 1305.

[44] See Illinois Brick Co. v. Illinois, 431 U.S. 720 (1977).

damages for the increased insurance premiums resulting from Sutter's alleged overcharges. Such indirect damages can be harder to prove."[45]

16.3.3 *Examples of Potentially Effective Collective Efforts*

Economic and political science doctrines offer insights into how collective action problems can be solved, and these insights illuminate three categories of litigation, which we might expect to better facilitate challenges to excessive health care costs.

16.3.3.1 Class Actions

Olson argued that one solution to the collective action problem is compulsory participation. Olson cites the tremendous growth of labor unions following enactment of the Wagner Act, which requires that once a majority of workers in a bargaining unit vote for union representation, employers must bargain collectively with the union and that the contract will bind all the workers in the unit.[46]

A certified class action is analogous to a certified bargaining unit – both involve representation of a community of interest, on a mandatory basis, by an entity that will be compensated on a mandatory basis. As with collective bargaining, representation depends upon entrepreneurial activity by that entity, which in turn is conditioned on the union organizer's or plaintiff's attorney's confidence in prevailing.

16.3.3.2 State Attorneys General as Advocates of Lower Costs

Standard neoclassical welfare economic analysis holds that collective benefits, which are non-rivalrous and non-excludable, are public goods that can't be provided by the market and must be provided through government. Successful cost containment litigation that prospectively ends abusive practices fits this description. As such, the most logical plaintiff is not an insurer or a class representative, but the government agencies such as attorney general's offices.[47]

But there are drawbacks to relying on political officeholders to enforce cost containment, including the complexity of health care issues which may intimidate lawyers, the broad range of responsibilities that an Attorney General (AG) must meet with limited resources, and the possibility of regulatory capture of AGs by health care interest groups.

[45] Daniel G. Bird & Emilio E. Varanini, Deciphering Sutter Health's State-Court Settlement and Federal-Court Win in Parallel Antitrust Cases, Health Affs. Forefront (May 10, 2022), https://www.healthaffairs.org/content/forefront/deciphering-sutter-health-s-state-court-settlement-and-federal-court-win-parallel.

[46] Olson, supra note 26, at 79.

[47] Robert A. Berenson et al., Addressing Health Care Market Consolidation and High Prices: The Role of the States, Urban Institute (2020), https://www.urban.org/research/publication/addressing-health-care-market-consolidation-and-high-prices.

16.3.3.3 Patron-Sponsored Litigation

Political scientist Jack Walker charted and analyzed the growth of US interest groups that Olson's theory predicts should not have happened.[48] He found that 60 percent of nonprofit groups and 89 percent of citizen sector groups received startup funding from an outside source.[49] Among nonprofit sector groups, 30 percent reported receiving support from foundations and 29 percent reported support from individual patrons.[50] Among citizen sector groups, 48 percent reported receiving support from foundations and 78 percent reported support from wealthy individuals.[51] Walker concluded: "Patrons stand at the center of a common solution to Olson's collective goods dilemma."[52]

As such, it is not surprising that philanthropies have emerged as a supporter of cost containment litigation in the absence of other collective efforts. The *Wall Street Journal* reported that Arnold Ventures, a foundation with health care costs as a key focus area, is among patrons supporting a number of lawsuits spearheaded by Fairmark Partners LLP.[53]

Note that these collective efforts, with consumers, employers, or the state as plaintiffs, do not implicate the partnership inhibition that seems to neutralize insurers as effective plaintiffs.

At several points *supra*, this article referenced the *UEBT v. Sutter Health* case. This case stands alone as the most – perhaps only – significant victory for payers and consumers over providers. Three notable traits of this case illustrate some of the bolstering elements of cost containment litigation discussed above: (1) a union health plan as plaintiff; (2) structured as a class action; and (3) the AG as a coplaintiff which, according to Bird and Varanini, "may have been significant to the settlement of the state case. Jury research has shown that some jurors are more likely to credit assertions that are backed by an attorney general or similar official."[54]

16.3.4 *Political Science Insights into Collective Litigation*

Walker's study of interest groups included a chapter on their litigation strategies. Interest groups do, said Walker, "file lawsuits to safeguard the interests of their members, promote test cases or class action suits … and file amicus briefs …,"

[48] Jack L. Walker, Mobilizing Interest Groups in America: Patrons, Professions, and Social Movements (1991).
[49] Id.
[50] Id.
[51] Id.
[52] Id.
[53] Melanie Evans, The Billionaire behind a Big-Hospital Battle, Wall St. J. (June 11, 2022), https://www.wsj.com/articles/the-billionaire-funding-a-battle-against-hospital-monopolies-11654920006.
[54] Bird & Varanini, supra note 45.

but litigation is generally *ad hoc* and a departure from organizational routines and repertoires.[55]

Over the years, political science scholars have propounded theories explaining why some groups use the courts more than others.[56] Two of these theories suggest that coalitions of payers are unlikely candidates for litigants. The political disadvantage hypothesis holds that groups seek remedies through the courts primarily when they see no way forward via the political branches. Employers and insurers are hardly "out-groups" and their judgment that they could succeed in persuading Congress to curb surprise billing was vindicated. The rights consciousness theory predicts that groups "see[ing] themselves in terms of uncompromising rights" are more likely to seek recourse in the courts.[57] Payers are not citizen groups with this mindset, though some of their coalition partners on surprise billing are.

Meanwhile, two other theories predict that payer groups, having considerable organizational resources and having claims (common law and antitrust) that are quite compatible with and conducive to judicial resolution, would choose to bring litigation.[58]

Walker's own research conclusions suggest several reasons why the payer coalition did not prioritize private-law remedies. First, Walker concluded, litigation is "one of the least popular forms of advocacy pursued by interest groups."[59] Second, "groups engaged in policy areas characterized by intense disputes" – groups with "recurring opponents" or "natural enemies" – are more likely to carry those disputes to court.[60] As noted, payers and providers are opponents only intermittently; more often they are partners. Finally, Walker says, "[G]roups that operate in policy areas that are sensitive to changes in outcomes of national elections are also more likely to resort to litigation."[61] The parties to the "Network Wars" were not aligned with any particular political party or ideology that would complicate passage of a surprise billing law.

16.4 CONCLUSION

It should be noted that, in spite of the foregoing considerations, payer-initiated cost containment litigation *does* take place, albeit not systematically.[62] There seems to be a point at which insurers' frustration can boil over, and a decision is made to invoke

[55] Walker, supra note 48, at 158.
[56] See id. at 160–61 (summarizing work by Susan Olson, Frank Sorauf, and Karen O'Connor).
[57] Id. at 160.
[58] Id. (citing Susan Olson).
[59] Id. at 171.
[60] Id. at 173.
[61] Id. at 174.
[62] See, e.g., Blue Cross & Blue Shield United of Wis., 152 F.3d 588 (7th Cir. 1998); Bay Area Surgical Management LLC v. Aetna Life Insurance Co., Case No. 15-cv-01416-BLF (N.D. Cal. July 18, 2016); Envision HealthCare Corp. v. United HealthCare Ins. Co., 311 F. Supp. 3d 1322 (S.D. Fla. 2018), French v. Centura Health, 509 P.3d 443 (Colo. 2022).

private law to remedy overreaching. Could these urges be harnessed and institutionalized in some way? Ideally, private law would be a tool to tamp down on provider opportunism that purchaser-side stakeholders utilize as readily as, and complementary to, legislative advocacy or hardball contract negotiations. The author's view, as a lawyer who has advocated before all three branches of government, is that litigation *can* (though not necessarily *does*) produce change more quickly than lobbying Congress.

We would also want insurers and employers deputized as unambiguously committed agents of consumers and workers, and to establish structures to investigate, conceptualize, and prosecute common-law and statutory violations by providers. And we would want employers and insurers to hold themselves to a duty to enrollees similar to that embraced by union health plans.

Not all excessive prices will rise to the level of legal violations, of course, but some instances will merit scrutiny: where provider prices are attributable to antitrust violations, upcoding, claims for excessive billed charges that TPAs paid without regard to prevailing prices, and, perhaps, facility fees and similar mark-ups and upcharges.

One option would be for payers to contribute to a joint legal fund. This could take the form of a small assessment (or "check-off" as it is sometimes called) analogous to those levied on agricultural producers of commodities to support the promotion of their product. Such a fund might be operated under the auspices of existing employer coalitions, which would relieve individual payers from poisoning relationships with providers. It could hire staff to investigate and develop cases or provide grant funding for dedicated positions in state AG's offices. It could ensure that damage awards or settlements are returned to enrollees, and operate as, and be perceived as, a more public-minded litigant than insurers. Seed money from a foundation might help build momentum for such an effort.

Private law could be a powerful sword to wield against health care costs, if an appropriate champion comes forward.