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Health Care Finance Law's Relational Bias

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18.1 INTRODUCTION

Private health insurers have long played a vital role in financing the US health care system. Yet private insurers' modern role transcends simply paying providers for patient care. Growing recognition of how payment methodologies shape care delivery has generated tremendous interest in leveraging payment reform to address longstanding inefficiencies and quality issues in health care. These problems include health inflation that outpaces general inflation, excessive utilization, fragmented patient care, and preventable medical errors and complications.[1] In response, private insurers increasingly are embracing value-based payment models (VBPMs)[2] that incentivize providers to increase efficiency and better manage patients' health care needs.[3]

[1] See generally Council on Health Care Spending & Value, A Road Map for Action: Recommendations of The Health Affairs Council on Health Care Spending and Value, Health Affs. 18–23 (2023), https://www.healthaffairs.org/pb-assets/documents/CHS_Report/CHS_Report_2022_R5–1675432678.pdf (recommending continued development of value-based payment models).

[2] The term "value-based payment models" and "alternative payment models" often are used interchangeably. In general, VBPMs refer to the broad array of approaches public and private payers use to align financial incentives with approaches to improving efficiencies and patient outcomes, whereas alternative payment models refer to the specific payment mechanisms for implementing these approaches. See Athena Chapman & Samantha Pellón, Medi-Cal Explained: What Are Alternative Payment Models?, Cal. Health Care Found. (May 2022), https://www.chcf.org/publication/medi-cal-explained-what-are-alternative-payment-models/. For purposes of this chapter, the author uses the term "VBPMs" to include alternative payment models.

[3] See Mark B. McClellan et al., Payment Reform for Better Value and Medical Innovation, Nat'l Acad. of Med. (Mar. 17, 2017), https://nam.edu/payment-reform-for-better-value-and-medical-innovation/.

VBPMs reward providers who both improve the quality of care delivered to patients and lower health care spending.[4] For example, pay-for-performance models link providers' payments to their performance on select quality and efficiency measures, rewarding high performers with bonuses or higher payment rates and penalizing poor performers with downward payment adjustments or other penalties.[5] Shared savings and bundled payments reward providers who effectively manage a set of procedures, an episode of care, or all health care services by sharing with the providers all or a portion of any cost savings they generate, coupled with upward or downward adjustments for high or poor performance on quality measures.[6] More advanced population-based payment models, such as per-member-per-month payments or capitation, replace fee-for-service's volume-based payments with fixed prospective payments that cover all or a range of services, with potential adjustments for a provider's quality-related performance.[7]

VBPMs have prompted some providers to pivot to care delivery models that emphasize evidence-based protocols, care coordination, and preventive care, such as accountable care organizations and medical homes.[8] Providers are also exploring care delivery models that take a holistic view of patients' health and consider not only patients' physical needs but also social, economic, and behavioral health needs that impact well-being.[9]

Numerous examples of VBPMs successfully incentivizing quality improvements and efficiency gains have generated confidence that VBPMs can drive providers toward more effective care delivery models.[10] Consequently, private insurers' utilization of VBPMs can increase society's general welfare by improving the overall performance of the health care delivery system. So although private insurers are

[4] See U.S. Dep't of Health and Hum. Servs., Assistant Sec'y for Planning and Evaluation, Common Alternative Payment Model (APM) Approaches: Reference Guide (2021) (explaining key features of alternative payment models include financial incentives for providers who meet certain objectives).

[5] See Health Care Payment Learning & Action Network, Alternative Payment Model Framework, 23–24, The MITRE Corp. (2017), http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf (describing the effects of performance on payments received by providers in an APM framework).

[6] See id. at 25–27.

[7] See id. at 23, 27–29.

[8] See Mark W. Friedberg et al., Effects of Health Care Payment Models on Physician Practice in the United States: Follow-Up Study, AMA-RAND 12 (2018), https://www.rand.org/pubs/research_reports/RR2667.html (summarizing the strategies implemented by physician practices in response to VBPMs) (hereinafter "Friedberg Follow-Up Study").

[9] See Jessica Mantel et al., Developing a Health Care Workforce that Supports Team-Base Models that Integrate Health and Social Services, 15 St. Louis U. J. Health L. & Pol'y 239 (2022); Nat'l Acad. of Sci., Eng'g, & Med., Implementing High-Quality Primary Care: Rebuilding the Foundation of Healthcare 163 (2021) (discussing interprofessional teams based in primary care practices).

[10] See Rachel Werner et al., The Future of Value-Based Payment: A Road Map to 2030 6 (2021) ("The past decade of experimentation with APMs … has provided proof-of-concept that if designed well, APMs are capable of driving cost savings and value improvements").

private actors, they arguably undertake a quasi-public role when they employ VBPMs to achieve health care delivery reform.

Yet unlike elected officials and regulators, private insurers perform this role outside the policymaking apparatus of democratically accountable institutions. This state of affairs raises a fundamental question – do the laws overseeing private insurers facilitate their successfully steering the health care system toward improved patient outcomes and reduced spending? This chapter contends that the answer to this question is no. Specifically, it explains that health care finance laws are shaped by private law norms that narrowly focus on relational concerns between marketplace participants and that this results in misaligned payment approaches that hinder providers' adoption of new patient care models. Consequently, policymakers should shift to a public law framework that would mandate coordinated action across payers when acting as value-based purchasers. Alternatively, payment alignment could be achieved through a single-payer health care system.

18.2 THE PRIVATE LAW UNDERPINNINGS OF HEALTH CARE FINANCE

Although the line separating private and public law can be blurred, generally speaking private law governs relationships between private individuals or entities while public law pertains to relations between the state and individuals. Private law thus focuses on the horizontal associations among individuals within familial, commercial, or communal contexts, defining the rights, powers, and duties of private parties vis-a-vis one another.[11] It encompasses not only common law subjects such as tort, contract, and property law but also statutes and regulations that similarly delineate rights and obligations in interpersonal interactions.[12] Conversely, public law's object is vertical, addressing individuals as subjects of the state with individual rights and shared responsibilities. It therefore both defines the state's powers and obligations and individuals' rights against the state, and promotes collective action by obliging individuals to act in concert with one another.[13]

Despite operating in a web of private contracts with patients, providers, employers, and others, private insurers' actions have broad social impact by shaping the contours of the health care delivery system. Consequently, we might expect that the laws governing private insurers would encompass both public and private law principles. The laws of health care finance, however, largely reflect private law norms, namely facilitating cooperative endeavors while securing relational justice.

[11] See Hanoch Dagan & Benjamin C. Zipursky, Introduction: The Distinction between Private Law and Public Law, in Research Handbook on Private Law Theory 2–3 (Hanoch Dagan & Benjamin C. Zipursky eds., 2020); Jeffrey A. Pojanowski, Private Law in the Gaps, 82 Fordham L. Rev. 1689, 1704 (2014).

[12] See Dagan & Zipursky, supra note 11, at 13.

[13] Id. at 2, 12.

In a nod to the influential law-and-economics movement, many twentieth-century scholars argued that private law should structure interpersonal interactions in a manner that maximizes efficiency.[14] Consistent with this aim, numerous laws are designed to support a robust health insurance market. Specifically, they generate market confidence in insurers' willingness and capacity to both provide financial protection for insureds and compensate providers. This is exemplified by strict financial standards for insurers that prevent insolvency, such as minimum capital and reserve requirements. Contract law similarly ensures that health insurers deliver covered benefits to insureds and pay providers promised payments, while consumer protection laws address insurers' unfair trade and claims practices. Health care finance laws also target market failures hampering the efficient functioning of the health insurance sector. For example, various state and federal laws address information asymmetries between private insurers and consumers by requiring clear disclosure of insurance policies' terms and conditions.[15]

The emergence of managed care provoked a public backlash that ushered in a new era of health care finance laws. This backlash coincided with various legal commentators questioning private law's narrow focus on efficiency aims. Scholars such as Hanoch Dagan and Avihay Dorfman argued that private law's interpersonal focus includes structuring private actors' duties, rights, and obligations so that parties relate to one another as equals.[16] Accordingly, private law should remedy significant power imbalances between parties to a transaction and prohibit discriminatory conduct.[17] This in turn ensures that both parties to an interaction can be "self-determining individuals" who "realize their respective freedoms."[18]

The "patient rights" mantra similarly framed managed care debates in relational terms.[19] Proponents emphasized protecting patients from managed care practices deemed unfair, a violation of patient dignity, or an unwarranted interference with the physician–patient relationship. States responded by enacting laws targeting managed care practices that limit patients' access to needed care. These laws include coverage mandates, standards for utilization review, appeal and grievance processes, and network adequacy requirements. Some state laws also protect the physician–patient relationship from interruption or outside influence by requiring that private insurers contract with "any willing" provider or prohibiting insurers use of contractual "gag orders" that restrict the treatment options physicians can discuss

[14] See id. at 7–9.

[15] See, e.g., 29 C.F.R. §2502.102-3 (disclosure requirements for employee group health plans); 42 C.F.R. §156.220 (disclosure requirements for state exchange plans); 28 Tex. Admin. Code § 3.3075 (2014).

[16] Hanoch Dagan & Avihay Dorfman, Just Relationships, 116 Colum. L. Rev. 1395, 1410–17 (2016).

[17] See id.

[18] Id. at 1417.

[19] See William M. Sage, Relational Duties, Regulatory Duties, and the Widening Gap between Individual Health Law and Collective Health Policy, 96 Geo. L.J. 497, 514 (2008) (managed care opponents "frame[d] the debate in relational terms").

with patients. Various state laws also protect providers from unfair insurer practices, such as laws requiring prompt claims payment.

The Affordable Care Act (ACA)[20] took further steps in support of relational justice goals. Notably, the ACA targeted practices that stemmed from private insurers' power advantage over consumers, practices that left many individuals uninsured or underinsured. For example, the ACA prohibits private insurers from rejecting insurance applicants based on their health status, varying premiums based on health status or gender, or excluding preexisting conditions.[21] The ACA also mandates that individual and small group policies cover a comprehensive bundle of "essential health benefits."[22]

The laws addressing private insurers' role as value-based purchasers likewise prioritize relational considerations, namely promoting insureds receiving their promised financial protection against high medical expenses. For example, some states restrict insurers from shifting insurance risk to providers that cannot meet minimum financial viability or solvency standards.[23] Other state laws dictate that private insurers retain ultimate financial risk for covered benefits, thereby protecting insureds from failed risk-sharing arrangements.[24]

This review of health care finance laws reveals a legal regime primarily shaped by private law norms. Its chief aims are relational – keep the economic wheels turning by generating market confidence in health insurers and ensure that their interactions with consumers and providers are fair and just. The law thus regulates private insurers in their *individual* capacity and focuses on their discrete, one-on-one interactions with consumers and providers. Private insurers are not regulated as a *several* engaged in a joint endeavor to reform the health care delivery system through VBPMs.

This narrow focus results in a legal regime that affords private insurers tremendous autonomy in their role as value-based purchasers, as the components of VBPMs – the specific financial incentives and performance measures, patient attribution and benchmarking methodologies, data sharing requirements, and other factors – rarely implicate relational considerations. This leaves the specific terms of VBPMs to private insurers' independent judgment and the voluntary processes of the marketplace. Consequently, while US payment policy is based in part on publicly adopted Medicare and Medicaid payment rules, it also encompasses thousands of decentralized decisions made by private insurers.

In theory, a legal regime that grants private insurers the freedom to develop their own payment policies promotes the public good through market competition. After

[20] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010).
[21] 42 U.S.C. §§ 300gg, 300gg-1, 300gg-4 (2023).
[22] 42 U.S.C. §18022 (2023).
[23] 11 N.Y. Comp. Codes R. & Regs. §101.5; Cal. Code Regs. tit. 28, § 1300.75.4.2; Conn. Gen. Stat., ch. 700c, § 38a-479bb(b).
[24] 11 N.Y. Comp. Codes R. & Regs. § 101.4(b); Conn. Gen. Stat., ch. 700c, § 38a-479bb(j).

all, a free-market economy encourages producers of products and services to achieve a competitive advantage through quality improvements, cost reductions, and innovation. Section 18.3, however, shows that in practice, market competition among private insurers undermines the health reform goals of VBPMs.

18.3 VARIATION AMONG PAYMENT MODELS AND ITS ADVERSE EFFECTS

In a competitive marketplace, a private insurer's success depends on it differentiating its health plans from competitors' plans, particularly on factors related to price and quality of care. Payment methodologies are an important source of this competitive differentiation. Individual payers regularly experiment with new and innovative payment approaches as part of their competitive strategies, aiming to achieve for their insureds both lower health care spending and superior quality care relative to their rivals.[25] In theory, then, competition among payers and their experimentation with VBPMs should, over time, propel the health care system toward cost savings and better patient outcomes. In reality, however, VBPMs have yielded mixed results,[26] as few health care providers have fundamentally changed how they care for patients.[27]

Paradoxically, a legal regime that allows private insurers to pursue different payment approaches creates obstacles to VBPMs advancing provider-level reforms. As explained below, a competitive, multi-payer health insurance market results in providers operating in a sea of confusing and conflicting payment rules and incentives. This imposes significant administrative burdens on providers and weakens the business case for their investing in new patient care models.

18.3.1 *Administrative Complexity*

With the US population insured by numerous public and private insurers, health care providers routinely contract with multiple payers. Providers therefore must manage a range of disparate rules, performance measures, and reporting requirements across numerous payment arrangements. As explained below, this creates a

[25] See Kristof Stremikis, All Aboard: Engaging Self-Insured Employers in Multi-Payer Reform 3 (2015) (noting that a health care system with "multiple public and private insurer entities facilities experimentation with a variety of payment structures and quality measurements").

[26] Marina A. Milad et al., Value-Based Payment Models in the Commercial Insurance Sector: A Systematic Review, 41 Health Affs. 540, 546 (2022).

[27] See Hannah L. Crook et al., A Decade of Value-Based Payment: Lessons Learned and Implications for the Center for Medicare and Medicaid Innovation, Part 1, Health Affs. Forefront (June 9, 2021), https://www.healthaffairs.org/do/10.1377/forefront.20210607.656313/ (VBPMs have had only modest impacts because providers have not invested in care transformation).

heavy administrative burden for providers that complicates their operations under VBPMs.[28]

Understanding VBPMs and devising strategies for success requires significant staff time and other resources.[29] Payers' VBPM specifications often are lengthy and require a provider to adjust their workflow and infrastructure.[30] For example, providers may need to redesign their patient care models to incorporate evidence-based protocols, emphasize more preventive care, and integrate behavioral health or social determinants of health interventions. Providers also may be expected to develop new care teams of both licensed and nonlicenced care providers.[31] In addition, providers must redesign their electronic health records systems to accommodate new workflows and build the internal capacity to both analyze their performance under multiple VBPMs and track their numerous requirements.[32] Finally, providers must develop coherent strategies that promote success across VBPM arrangements. Not surprisingly, many providers report confusion and uncertainty over how best to modify their operations.[33]

Providers cite managing an expanding array of performance measures as a particular source of frustration.[34] With each payer adopting distinct performance measures, providers must comply with hundreds of metrics.[35] Doing so complicates providers' data collection and management efforts, including having to configure

[28] See generally Jessica Mantel, An Overlooked Argument for a Single-Payer Healthcare System: Eliminating Misalignment among Payment Models, 32 Annals Health L. and Life Scis. 101 (2023).

[29] See MedPAC, Report to Congress: Medicare and Healthcare Delivery System 57 (2021) (providers describe VBPMs as requiring "significant investments of time or consultants to understand").

[30] See id.

[31] See Friedberg Follow-Up Study, supra note 8; see also Mannatt Health, Supporting the Future of Primary Care in California through Aligned Hybrid Payment Models 5 (2021).

[32] See Mark W. Friedberg et al., Effects of Health Care Payment Models on Physician Practice in the United States, AMA-RAND 58 (2015), https://www.rand.org/pubs/research_reports/RR869.htm (discussing customizing systems to meet new workflows); MedPAC, supra note 29, at 53 (noting that practices of all sizes reported investing significant resources in building internal capabilities to analyze VBPMs); Friedberg Follow-Up Study, supra note 8, at 12 (commenting on the challenge of keeping track of payment performance details that vary from payer to payer).

[33] See Friedberg Follow-Up Study, supra note 8, at 14; Friedberg et al., supra note 32, at 102–03 (providers expressed uncertainty about best strategies for responding to multiple VBPMs).

[34] See Friedberg et al., supra note 32, at 64 (physician practices reported "heavy administrative burdens from the growing cacophony of metrics"); Stephanie M. Kissam et al., States Encouraging Value-Based Payment: Lessons from CMS's State Innovation Models Initiative, 97 Milbank Q. 506, 532 (2019) (same).

[35] See Tricia McGinnis & Jessica Newman, Advances in Multi-Payer Alignment: State Approaches to Aligning Performance Metrics across Public and Private Insurers, Milbank Mem'l Fund Issue Brief (2014), https://www.milbank.org/publications/advances-in-multi-payer-alignment-state-approaches-to-aligning-performance-metrics-across-public-and-private-payers/ (providers must collect and report "hundreds" of different performance measures).

electronic health records systems to capture all relevant data.[36] In addition, because providers cannot simultaneously tackle numerous metrics, they must decide which ones to focus on and which to ignore.[37] Many providers report struggling with these requirements.[38]

These administrative challenges have slowed providers' adoption of value-based care models.[39] For some providers, the time, effort, and expertise needed to manage disparate payment requirements and performance measures is simply beyond their capacity.[40] For others, the associated administrative costs can outweigh VBPMs' potential financial rewards.[41] These challenges have dissuaded many providers from participating in VBPMs.[42]

For providers who do enter into VBPMs, the administrative challenges can complicate efforts to fundamentally transform their operations. As explained by a practice administrator:

> We're so constrained on staff that the time to investigate [each new payment program], the time to do the thinking, the time to ask questions is hard to come by. And so because of that, I don't think we're doing it as efficiently as we could A) we're not getting everything done that we could get done, and B) we don't have the time to really think about how to do it better.[43]

Relatedly, the administrative cost of participating in VBPMs weakens the business case for providers making significant investments in practice transformation.[44]

18.3.2 *Diluted and Conflicting Financial Incentives*

When providers participate in multiple VBPMs, interactions among payment models can weaken each model's effectiveness in two ways. First, covering only a portion of a provider's patient panel dilutes the financial incentives under each

[36] See Friedberg et al., supra note 32, at 52, 102–03 (discussing the investments in data management capabilities made by providers participating in VBPMs).

[37] See Friedberg Follow-Up Study, supra note 8, at 64, 93 (explaining that providers filter performance metrics).

[38] See id. at 63–64, 95 (confusion over managing many performance metrics is common among small primary care or single-subspecialty practices).

[39] See Werner et al., supra note 10, at 8–9 (administrative complexity "dissuades adoption" of VBPMs).

[40] See Friedberg et al., supra note 32, at 63 (tracking payment program details "could be beyond the capacity of some practices").

[41] See id. at 22, 64 (managing multiple payers' reporting requirements is "a major reason for rising practice expenses," and the cost of complying with certain performance measures can be disproportionate to the financial reward).

[42] See Friedberg Follow-Up Study, supra note 8.

[43] Id. at 48.

[44] Cf. McGinnis & Newman, supra note 35, at 2 (explaining that the "chaos" of facing multiple performance measures "greatly limits the business case for providers to improve specific performance outcomes").

payer's VBPM.[45] For example, if a payment arrangement only covers 15 percent of a provider's patient panel, the arrangement's prospective financial rewards may be of insufficient magnitude to prompt the provider to transform their practice. Now, in theory, alignment across multiple VBPMs could yield sufficiently large financial incentives in the aggregate to motivate practice transformation. Unfortunately, in markets with "many competing payers all going it alone, these conditions are seldom met,"[46] as payers vary in their own readiness to implement specific VBPMs.[47]

Second, when providers treat a combination of patients attributed to VBPMs and fee-for-service arrangements, they face conflicting financial incentives that complicate their transitioning to value-based care models.[48] Fee-for-service incentives that encourage higher volume and care intensity can blunt VBPM incentives to reduce costs, utilization, and intensity.[49] For example, VBPMs that reward a health system's physicians for reducing hospital admissions and ER visits can harm the financial well-being of the system's hospital.[50] Fee-for-service and VBPM arrangements also encourage different clinical care approaches. Specifically, fee-for-service's volume-driven incentives encourage seeing patients quickly,[51] whereas advanced VBPMs require longer patient visits that allow for fully exploring patients' needs and

[45] Sean Cavanaugh & Gregory Burke, A Multipayer Approach to Health Care Reform 4 (2010).

[46] Id.

[47] See Friedberg et al., supra note 32 (describing how practices interested in certain risk-based payment models faced difficulties negotiating contracts with payers who were less interested in those models, especially among payers still focused on fee-for-service payment models).

[48] See Assistant Sec'y for Planning and Evaluation, U.S. Dep't of Health and Hum. Servs., Environmental Scan on Issues Related to the Development of Population-Based Total Cost of Care (TCOC) Models in the Broader Context of Alternative Payment Models (VBPMs) and Physician-Focused Payment Models (PFPMs) 16 (Mar. 3, 2022), https://aspe.hhs.gov/sites/default/files/documents/871a839c1771919499e415b2dae8700a/TCOC-Escan.pdf (noting that it is difficult for providers to "strike a balance" between the incentives under fee-for-service arrangements and VBPMs that shift significant financial risk to providers); Friedberg et al., supra note 32, at 100 ("Some physicians face the 'two-canoe' problem of depending on [fee-for-service] and accompanying incentives to a significant portion of their revenues while working to transition to alternative payment models with conflicting incentives").

[49] See Friedberg et al., supra note 32, at 63 (explaining that when practices participate in both fee-for-service and risk-based contracts, they "faced fundamentally conflicting incentives to increase volume under the FFS contract while reducing costs under the risk-based contract"); see also Nat'l Acad. of Sci., Eng'g, & Med., supra note 9, at 298–99 (explaining that among practices' participating in patient-centered medial home arrangements, their "underlying focus on visit volume" under fee-for-service made it more difficult for them to shift their focus to reducing total spending).

[50] Friedberg et al., supra note 32, at 63.

[51] Collin Couey, Value-Based Care vs Fee-for-Service: The Ins and Outs You Need to Know, Software Advice (Aug. 1, 2022), https://www.softwareadvice.com/resources/value-based-care-vs-fee-for-service/.

providing in-depth patient education.[52] These considerations can greatly weaken the financial rewards of transitioning to new patient care models, as providers who do so may incur declining revenue under their fee-for-service arrangements. Finally, rather than investing in practice transformation, providers with both fee-for-service and VBPM contracts can simply make up any lower VBPM revenue by increasing care volume or intensity for fee-for-service patients.[53]

In sum, while a decentralized approach to health care finance has facilitated payment innovation, this experimentation has not spurred meaningful health care delivery reform. True change instead requires a coordinated approach that harmonizes payment models across payers.

18.4 EFFORTS TO HARMONIZE PAYMENT APPROACHES THROUGH VOLUNTARY ALIGNMENT

Policymakers increasingly recognize the need for payment alignment. Yet this recognition has not produced a public law paradigm for health care finance, with legal mandates used as a tool for coordinating payers' payment approaches. Federal and state agencies instead have developed multi-payment alignment initiatives (MPAIs) that facilitate payers *voluntarily* aligning their VBPMs.[54] For example, payers participating in MPAIs could adopt a common set of performance measures or a uniform patient attribution methodology. Regulators believe that MPAIs can increase the percentage of patients covered by similar payment rules and incentives, thereby lowering providers' administrative burden and improving the business case for participating in VBPMs.[55] Unfortunately, MPAIs are unlikely to achieve these objectives.[56]

[52] See Friedberg et al., supra note 32, at 28–30, 65–66 (quoting a physician practice leader explaining the competing time pressures under fee-for-service and medical home arrangements).

[53] Friedberg Follow-Up Study, supra note 8, at 35–36.

[54] See Stremikis, supra note 25, at 3 ("Multipayer initiatives involve collaboration among public (e.g., Medicaid) and private (e.g., commercial insurance) payers participating in value-based payment and delivery system reforms . . ."). Although non-governmental entities can convene MPAIs, collaborations led by private actors risk running afoul of antitrust laws that prohibit coordinated action among competitors, whereas government-led MPAIs can invoke the state action doctrine to protect coordinated action taken pursuant to a clearly articulated state policy and under state supervision. See Barbara Wirth & Mary Takach, State Strategies to Avoid Antitrust Concerns in Multipayer Medical Home Initiatives, Commonwealth Fund (July 2013), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2013_jul_1694_wirth_state_strategies_avoid_antitrust_ib.pdf.

[55] See Assistant Sec'y for Planning and Evaluation, supra note 48, at 12 (MPAIs can simplify administrative and financial planning for providers, thereby increasing their engagement with VBPMs).

[56] For a more in-depth discussion of factors that frustrate MPAIs' achieving their goals, see Mantel, supra note 28, at 120–25.

MPAIs may appeal to payers seeking to amplify their individual efforts to reform the health care delivery system.[57] Successfully doing so could lead to lower health care spending and higher quality care, boosting participating insurers' profit margins and giving them a competitive advantage over nonparticipating insurers. However, because providers generally treat their patients similarly, any patient care improvements stemming from greater payment alignment would benefit *all* payers, including those not participating in an MPAI. Private insurers participating in MPAIs therefore may derive little if any competitive advantage over other insurers.[58]

Additional considerations may dissuade private insurers from joining MPAIs. The benefits of MPAIs are limited when the participating payers collectively cover too few patients to nudge providers toward practice transformation. This concern can deter potential MPAI participants, creating a vicious cycle. A private insurer also may doubt whether MPAI participants can reach consensus, given marketplace rivalries and likely disagreement over payment strategies.[59] Finally, logistical and financial constraints, such as the burden of switching to new payment methodologies, can further erode the case for MPAI participation.[60] Consequently, MPAIs have had limited success in lowering the barriers to providers adopting value-based care models due to limited payer participation in MPAIs.

18.5 CONCLUSION

Health care finance law, with its private law foundation, largely centers on ensuring that private insurers honor their financial commitments and treat insureds and providers fairly. This narrow relational focus leaves insurers free to develop divergent payment policies based on their own individual priorities and self-interest. In particular, private insurers have embraced a range of value-based payment approaches designed to nudge providers toward more effective patient care models. Unfortunately, these efforts have failed to produce meaningful health care delivery

[57] See Stremikis, supra note 25, at 3 ("Successful multi-payer alignment can amplify the impact of payment and delivery reforms by sending consistent incentives to health care providers and aligning performance measurement").

[58] See Kissam et al., supra note 34, at 531 (one reason cited by commercial insurers for not aligning with Medicaid VBP models were concerns "that if they invested in a payment model that succeeded in reducing overall utilization and expenditures for a practice's entire patient panel, they would end up subsidizing the care of patients covered by free-riding payers who were not making similar investments in a new payment model").

[59] See Mantel, supra note 28, at 121–22 (noting that insurers with a history of competition may struggle to cooperate with and trust one another); Cavanaugh & Burke, supra note 45, at 6 (explaining that a payer's willingness to participate in an MPAI may be influenced by the fact that "[p]ayers differ in their outlook on different models of service delivery reform").

[60] See Mantel, supra note 28, at 123 (explaining that some payers may be unwilling to invest in or lack the capacity to adopt new payment methodologies, and that regional or national payers may prefer to standardize their operations across all service areas rather than conform to multiple state MPAIs).

reform, as payers' misaligned payment strategies create obstacles to practice transformation at the provider level. Moreover, various competitive and logistical considerations have impeded attempts to harmonize payment approaches through voluntary payer collaborations.

Efforts to improve the quality and efficiency of patient care through payment reform will prove futile absent greater alignment across VBPMs. Yet a private law approach, with its emphasis on individual rights and bilateral relationships, falls short of eliciting the necessary coordinated action among payers. Public law, however, can transcend this collective action problem by using the law to coordinate payment policies across the health care sector. In addition, a public law paradigm would take a holistic view of the health care system and promote payment policies rooted in collective goals rather than private insurers' self-interest.

A public law approach to health care finance could be achieved in one of two ways. First, regulators could follow the lead of Rhode Island and implement a mandatory cooperative scheme that requires private insurers to operate in concert with one another and with public payers. For example, in order "to ensure consistency in the use of quality measures" across payer-provider contracts, Rhode Island limits insurers to a common set of performance measures.[61] Rhode Island similarly mandates that all insurers pay primary care practices that meet regulatory guidelines for patient-centered medical homes a per-member-per-month fee for care management services and infrastructure.[62] Alternatively, a single-payer system built around a government insurance plan would, by definition, apply uniform payment rules and processes across a provider's patient panel.[63] Choosing between these two options raises complex issues beyond the scope of this chapter, such as questions about comparative institutional competence, value trade-offs, federalism concerns, and political and economic feasibility. Nevertheless, reforming the health care delivery system demands a paradigm shift in our regulatory approach to private insurers, one that moves beyond traditional private law norms. It is thus imperative that future policy conversations about health care finance occur within a public law framework.

[61] 230 R.I. Code R. §20-30-4.10(D)(5).
[62] 230 R.I. Code R. §20-30-4.10(C).
[63] See Mantel, supra note 28, at 127–29 (describing how a single-payer system could address the current payment misalignment under a multi-payer system by paying an individual provider in the same manner across their entire patient panel).