THE HEALTHCURE SYSTEM: A REGIONAL ACCOUNTABLE CARE MODEL TO REMEDY HEALTHCARE'S PRICING PROBLEM

CHRISTOPHER A.G. LOCASCIO*

TABLE OF CONTENTS

INTRODUCTION 1252
I. BACKGROUND 1257
II. ECONOMIC CHALLENGES AND SOLUTIONS IN HEALTHCARE: FROM ACOS TO HEALTHCARE DISTRICTS 1262
A. DIAGNOSING HEALTHCARE'S MARKET FAILURES 1262
B. FINDING A CURE IN ACCOUNTABILITY 1268
III. ACCESS: ADOPTING A REGIONAL FOCUS TO DELIVER EMPLOYER-STYLE UNIVERSAL COVERAGE 1270
A. EXPANDING THE RISK POOL FROM COWORKERS TO NEIGHBORS: A REGIONAL APPROACH 1271
B. SIMPLIFYING BENEFICIARY HEALTHCARE COSTS TO INDUCE PRICE ELASTICITY AND PROTECT AFFORDABILITY 1273
C. POSSIBLE EQUITY IMPLICATIONS OF A REGIONAL MODEL 1275
IV. COST: INNOVATING A NEW HEALTHCARE DISTRICT GOVERNANCE MODEL WITH PUBLIC AND FINANCIAL ACCOUNTABILITY FROM STAKEHOLDERS 1278
A. PUBLIC GOVERNANCE AS A COUNTERWEIGHT TO CONSOLIDATED PROVIDER MARKET POWER 1281

* Editor-in-Chief, *Southern California Law Review*, Volume 96; J.D. 2023, University of Southern California Gould School of Law; B.A. Political Science and English 2014, University of California, Riverside. Thank you to Professor Ankit Shah, Professor Jonathan Barnett, the editors of the *Southern California Law Review*, my family, friends, and classmates for your support throughout this Note's writing and editing process.

B. DRAWING ON PRIVATE ORGANIZATIONAL FORMS TO BALANCE STAKEHOLDER INTERESTS 1285
1. Allocating Rights and Responsibilities Between Patients and Providers 1286
2. Fiduciary Duties of Directors and Stakeholder Health Maximization 1289
V. QUALITY: ALIGNING THE INCENTIVES OF PROVIDERS AND PATIENTS TO DRIVE COST-EFFECTIVE, VALUE-BASED CARE 1292
VI. PRACTICAL CONCERNS OF IMPLEMENTING HEALTHCARE DISTRICTS 1295
CONCLUSION 1296

INTRODUCTION

The most sinister game show in American life commences every time a hospital provides care, draws up an eye-popping bill, and asks its patient how it will be paid.[1] Imagine waking up from a medically induced coma to the words, "Will that be cash or card?" In its own sick twist of the three-legged race, the healthcare system effectively binds patients' ability to navigate the costs of their care, such that even those with insurance are often left hobbling for answers to the questions, *what must I pay and why?* The stakes are ever graver for those underinsured or uninsured. In this game, the winners are not those who make it out alive, but those who can afford to keep on living.

In a properly functioning market, supply and demand would theoretically prevent a hospital from wildly inflating its prices, such as charging a patient approximately $200.00 for a routine blood test that would otherwise cost $13.00, but the reality is that healthcare is no such market.[2] As Princeton Professor Uwe Reinhart put it, "In effect, [patients] enter that market like blindfolded shoppers pushed into a department store to shop around smartly for whatever item they might want or, in the case of health care, need."[3]

1. *See* Steven Brill, *Bitter Pill: Why Medical Bills Are Killing Us*, TIME (Apr. 4, 2013, 3:36 PM), https://time.com/198/bitter-pill-why-medical-bills-are-killing-us [https://perma.cc/Z7UV-YTW3].
2. *Id.*; Ari Mwachofi & Assaf F. Al-Assaf, *Health Care Market Deviations from the Ideal Market*, 11 SULTAN QABOOS UNIV. MED. J. 328, 330 (2011).
3. UWE E. REINHARDT, PRICED OUT: THE ECONOMIC AND ETHICAL COSTS OF AMERICAN HEALTH CARE, at xviii (2019).

Patients cannot expect to make informed decisions when they lack reliable pricing information before seeking care, but this is just one of the many market failures that drives the ever-skyrocketing costs of American healthcare.[4] Hospital administrators themselves often fail to grasp the true costs of their services, as do doctors when ordering tests and writing prescriptions.[5] In fact, healthcare providers often have financial and legal incentives to overtreat their patients, at the patients' expense.[6] When providers are paid based on the services they render, in what is known as the "fee-for-service" payment model, providers that do more, make more.[7] In the fear of the dreaded medical malpractice lawsuit, providers have an incentive to cover their bases and test for everything, no matter the cost.[8] Even insurance companies, which foot the providers' bills, stand to gain from exaggerated costs.[9] Unlike insurance companies in other sectors, which derive profit by spending as little of policyholders' premiums as possible, health insurance companies have incentives to maximize their spending because regulations cap their profits at a certain percentage of their expenditures.[10] Essentially, insurers earn more when they spend as much of their beneficiaries' premiums as possible.[11] In what is perhaps the most perplexing market failure of them all, individuals continue to pay the rising premiums, copays, coinsurance, and taxes that feed the hungry, hungry healthcare hippo.[12] Yet, the pricing problem snuck up on no one—the

4. *See, e.g.*, Mwachofi & Al-Assaf, *supra* note 2, at 330–34.

5. *See* Brill, *supra* note 1.

6. Atul Gawande, *The Cost Conundrum*, NEW YORKER (May 25, 2009), https://www.newyorker.com/magazine/2009/06/01/the-cost-conundrum [https://perma.cc/AH58-NLTB].

7. *See* Jerry Cromwell & Janet B. Mitchell, *Physician-Induced Demand for Surgery*, 5 J. HEALTH ECON. 293, 294, 311–12 (1986); Christel A. Woodward, Brian Hutchison, Geoffrey R. Norman, Judy A. Brown & Julia Abelson, *What Factors Influence Primary Care Physicians' Charges for Their Services? An Exploratory Study Using Standardized Patients*, 158 CAN. MED. ASS'N J. 197, 197 (1998) ("Physicians seeing comparable patients may earn much more or less than their colleagues because of differences in the services they provide and the way they apply the fee schedule. Quality-assurance techniques are likely needed to reduce the variability in charges seen and increase value for money spent in health care.").

8. Gawande, *supra* note 6.

9. Marshall Allen, *Why Your Health Insurer Doesn't Care About Your Big Bills*, NPR (May 25, 2018, 5:00 AM), https://www.npr.org/sections/health-shots/2018/05/25/613685732/why-your-health-insurer-doesnt-care-about-your-big-bills [https://perma.cc/5D3J-BHE3].

10. *Id.*; *see also* Sarah Kliff & Josh Katz, *Hospitals and Insurers Didn't Want You to See These Prices. Here's Why.*, N.Y. TIMES (Aug. 22, 2021), https://www.nytimes.com/interactive/2021/08/22/upshot/hospital-prices.html [https://web.archive.org/web/20230206220545/https://www.nytimes.com/interactive/2021/08/22/upshot/hospital-prices.html]. *See generally* Michael J. McCue & Mark A. Hall, *Insurers' Responses to Regulation of Medical Loss Ratios*, COMMONWEALTH FUND 1 (2012), https://www.issuelab.org/resources/14212/14212.pdf [https://perma.cc/3TAY-39PZ] (explaining the ACA's creation of medical loss ratios that specify a percentage of insurance premium dollars that insurance companies must spend on care as opposed to retain for profit).

11. Allen, *supra* note 9.

12. Reed Abelson, *Workers with Health Insurance Face Rising Out-of-Pocket Costs*, N.Y. TIMES (Oct. 8, 2020), https://www.nytimes.com/2020/10/08/health/health-insurance-premiums-deductibles.html

rubbery, rotund river beast of a healthcare system has slowly barreled through America's regulatory swamp for a century as landlocked policymakers repeatedly tried and failed to halt its growth by trying different reimbursement models, competition enhancements, and delivery programs.[13]

The most promising opportunity to impose downward cost pressure on the healthcare system came in 2010 with the advent of the Accountable Care Organization ("ACO") concept as part of the Patient Prevention and Affordable Care Act ("ACA").[14] ACOs are networks of healthcare providers that coordinate care, integrate finance and delivery, and share in financial gains and losses.[15] A primary goal of the ACO is to achieve a more cost-efficient system that incentivizes preventive care and integrated treatment while limiting incentives to drive up costs.[16] While they come in many forms, ACOs often accomplish cost savings by allocating a set amount of money to providers for each patient they treat, known as capitated payments, thereby exposing providers to the risk of outspending that amount if they do not keep costs down.[17] In essence, ACOs are financially accountable for the care of a particular population.[18]

ACOs remain a largely underdeveloped concept with as-yet-unsolved complications.[19] For instance, the Center for Medicare & Medicaid Innovation ("CMMI") pilots a wide variety of ACO models, ranging from "one-way risk" models with no downside and modest upside to "two-way risk" models with varying levels of risk and reward.[20] Providers are free to

[https://web.archive.org/web/20221209090035/https://www.nytimes.com/2020/10/08/health/health-insurance-premiums-deductibles.html].

13. *See generally* Terree P. Wasley, *Health Care in the Twentieth Century: A History of Government Interference and Protection*, 28 BUS. ECON. 11 (1993) (tracing the historical development of the law and regulations governing healthcare in the United States).

14. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-48, § 3022, 124 Stat. 119, 395–99 (2010).

15. *ACO Operational Elements Toolkit*, CTRS. FOR MEDICARE & MEDICAID SERVS. 3 (May 2021), https://innovation.cms.gov/media/document/aco-operational-elements-toolkit [https://perma.cc/L3BF-YAQ2].

16. *Accountable Care Organizations (ACOs)*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Dec. 1, 2021, 8:00 PM), https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO [https://perma.cc/BZ7R-5VP7].

17. Tianna Tu, David Muhlestein, S. Lawrence Kocot & Ross White, *The Impact of Accountable Care: Origins and Future of Accountable Care Organizations*, BROOKINGS 3 (2015), https://www.brookings.edu/wp-content/uploads/2016/06/impact-of-accountable-careorigins-052015.pdf [https://perma.cc/TV2H-QR43].

18. *Id.*

19. *See* Thomas L. Greaney, *Regulators as Market-Makers: Accountable Care Organizations and Competition Policy*, 46 ARIZ. ST. L.J. 1, 21–22 (2014).

20. Medicare Program, 42 C.F.R. § 425.600 (2011); *see also* Anne M. Lockner, *INSIGHT: The Healthcare Industry's Shift from Fee-for-Service to Value-Based Reimbursement*, BLOOMBERG LAW (Sept. 26, 2018, 6:30 AM), https://news.bloomberglaw.com/health-law-and-business/insight-the-

choose how much risk of cost overruns they would like to take on, and they get to keep a proportionate amount of any cost savings.[21] For example, one ACO may choose a one-way risk model with a 0% risk of losing money and a 3% share of cost savings, whereas another ACO may choose a two-way risk model that exposes it to a 10% risk of any cost overruns but entitles it to 30% of any cost savings.[22] Naturally, the more risk a provider faces, the greater the incentive to cut costs.[23] The prospect of a greater reward has not proven persuasive for ACOs to adopt riskier models, however, and all but the least risky models have struggled to attract provider participation.[24] Moreover, ACOs fail to address the demand-side concern of consumers' continued payment for health insurance despite increases in rates—a phenomenon known as the price inelasticity of health insurance premiums.[25] Equally alarming among these concerns is the antitrust component.[26] In an environment in which providers are already consolidating, ACOs stand to exacerbate a shrinking market and empower consolidated provider networks to wield unmatched pricing power.[27]

Despite the promise of new models, the healthcare system remains in a precarious position. The ACA has been left on unstable footing following the repeal of the individual mandate tax penalty in 2017[28] and efforts to either fully repeal or replace the law altogether.[29] Meanwhile, insurance premiums

healthcare-industrys-shift-from-fee-for-service-to-value-based-reimbursement [https://perma.cc/Y55Z-9PGC].

21. J. Michael McWilliams & Alice Chen, *Understanding the Latest ACO "Savings": Curb Your Enthusiasm and Sharpen Your Pencils—Part 1*, USC-BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POL'Y (Nov. 12, 2020), https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/11/12/understanding-the-latest-aco-savings-curb-your-enthusiasm-and-sharpen-your-pencils-part-1 [https://perma.cc/2528-E6JV].

22. *See id*.

23. *Accountable Care Organizations (ACOs): General Information*, CTRS. FOR MEDICARE & MEDICAID SERVS. (June 4, 2021), https://innovation.cms.gov/innovation-models/aco [https://perma.cc/R9EM-3N23].

24. Tu et al., *supra* note 17, at 4; *see also Highlights of the 2020 Medicare ACO Program Results*, NAT'L ASS'N ACOS (Nov. 3, 2021), https://www.naacos.com/assets/docs/pdf/2021/NAACOS2020ACOResult%20Summary110321.pdf [https://perma.cc/94SY-MUZR].

25. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 23.

26. Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67026 (Oct. 20, 2011).

27. Greaney, *supra* note 19, at 19.

28. Margot Sanger-Katz, *Requiem for the Individual Mandate*, N.Y. TIMES (Dec. 21, 2017), https://www.nytimes.com/2017/12/21/upshot/individual-health-insurance-mandate-end-impact.html [https://web.archive.org/web/20230215204722/https://www.nytimes.com/2017/12/21/upshot/individual-health-insurance-mandate-end-impact.html?searchResultPosition=1].

29. Sahil Kapur, *Trump Revives Push to Eliminate Obamacare, Sparking Biden Campaign Blowback*, NBC NEWS (Nov. 29, 2023, 9:05 AM), https://www.nbcnews.com/politics/2024-election/trump-revives-push-eliminate-obamacare-sparking-biden-campaign-pushbac-rcna126768 [https://perma.cc/X57N-E7ZE].

have continued to rise.[30]

This Note proposes a novel framework from which to develop pilot programs for future healthcare regulations and legislation. In doing so, this Note will identify certain regulatory factors that contribute to, or at least fail to stop, the upward march of healthcare prices, and propose a novel alternative model that delivers on the three pillars of healthcare: broad access, low cost, and high quality.[31] Here, access refers to both access to coverage of costs and access to care. Quality refers to both the breadth of covered benefits and health outcomes.

This Note takes a law and economics approach to healthcare, focusing on the information asymmetry, moral hazards, principal-agent problems, adverse selection, and misaligned incentives that contribute to healthcare's current market failures.[32] To solve these problems, this Note prescribes a new outcomes-based model that aligns the incentives of patients and providers by tying provider funding to certain health indicators. The proposed healthcare model, titled *the Healthcure System*, achieves universal coverage through regional healthcare districts that draw on the funding model of employer-based insurance, the cost-cutting features of ACOs, the monopoly regulation of public utilities, the accountability of special districts, the mixed public and private partnership of government-sponsored enterprises, and the structure of the corporate form. Under this approach, regional healthcare districts replace private insurance companies, and the districts offer universal coverage to all within the region in return for a direct healthcare tax. The districts pay providers in a capitated payment model, similar to paying a lump sum for each patient, instead of the fee-for-service model that pays per service rendered. The outcomes-based component consists of back-end, per-event incentive payments—which reward providers for each successful treatment—and additional payments that resemble dividends based on the overall health of the region. Providers get additional funding through government adjustment payments if they operate in underserved communities. The result is a synthesis of burgeoning knowledge on finance and governance in healthcare law and economics into the first model of its kind.

30. *See, e.g.*, Leroy Leo & Khushi Mandowara, *US Employers to See Biggest Healthcare Cost Jump in a Decade in 2024*, REUTERS (Sept. 21, 2023, 9:07 AM), https://www.reuters.com/world/us/us-employers-see-biggest-healthcare-cost-jump-decade-2024-2023-09-20 [https://web.archive.org/web/r20231103005554/https://www.reuters.com/world/us/us-employers-see-biggest-healthcare-cost-jump-decade-2024-2023-09-20/]; *Employer Health Benefits: 2021 Summary of Findings*, KAISER FAM. FOUND. 1 (Nov. 10, 2021), https://files.kff.org/attachment/Summary-of-Findings-Employer-Health-Benefits-2021.pdf [https://perma.cc/G3DV-LU6H].

31. Donald M. Berwick, Thomas W. Nolan & John Whittington, *The Triple Aim: Care, Health, and Cost*, 27 HEALTH AFFS. 759, 760 (2008).

32. *See* Mwachofi & Al-Assaf, *supra* note 2, at 330–34.

This Note proceeds in six parts. Part I traces the development of healthcare regulations from their inception in the early twentieth century and outlines the corresponding rise in healthcare costs. Part II discusses the various economic concepts and challenges that underlie the increase in costs. Part III explains how the Healthcure System achieves access by establishing universal coverage risk pools based on region and price elasticity by reducing individual healthcare expenditures to one income-based payment. Part IV describes the model's downward price pressures through a new governance model that combines integrated finance and delivery with public electoral accountability. Part V explores how the Healthcure System enhances quality by aligning the incentives of patients and providers through a capitation and incentive payment model. Part VI considers the legal path and obstacles facing the implementation of the Healthcure System before concluding the Note.

I. BACKGROUND

Healthcare was once an unregulated and uninsured marketplace consisting of independent doctors making house calls in exchange for modest out-of-pocket fees.[33] The low cost of this relatively unsophisticated care sustained a functioning market until the early 1900s, when a combination of increasingly complex medical care, growing demand, and rising quality standards led to a surge in the average family's medical expenses.[34]

An early insurance market grew organically out of a need to spread out costs and risks by making regular payments to guarantee access to care without financial barrier when it was needed.[35] As insurers increasingly became intermediary payers between patients and healthcare providers, a "cost plus" reimbursement methodology emerged that paid doctors whatever "reasonable and customary charges" they set and covered hospital costs plus an additional negotiated rate payment.[36] The cost plus model supercharged the already-upward trend in healthcare costs by creating incentives to treat more and charge more.[37]

The 1940s saw the addition of employers as an integral layer to the increasingly complicated healthcare funding landscape. Amid World War II's labor shortage and inflation, Congress enacted the Stabilization Act in

33. George B. Moseley III, *The U.S. Health Care Non-System, 1908-2008*, 10 AMA J. ETHICS 324, 324 (2008).
34. *Id*.
35. *Id*. at 325.
36. *Id*. at 326.
37. Wasley, *supra* note 13, at 12.

1942 to place limits on wage increases, but it carved out an exception that allowed employers to offer fringe benefits like health insurance up to the value of five percent of wages.[38] In 1951, the Internal Revenue Service ("IRS") adopted a rule making employer-paid insurance premiums a tax-deductible business expense.[39] Health insurance thus became a form of tax-free compensation that employers could offer their employees.[40] Once private health insurers instituted provisions requiring that a substantial majority of employees participate in the employer-sponsored plan, insurers had a risk pool of working-age adults that avoided disproportionate inclusion of higher-risk individuals who tend to consume more in medical expenses, such as those in the general population who are too old or ill to work.[41] Using the employee risk pool as a guide, insurers then set a standardized premium rate for all participants, regardless of participants' individual health histories, under what is known as "community rating."[42] Essentially, an employee with a clean bill of health paid the same premium as an employee who previously battled cancer. At the same time, labor unions negotiated rapidly increased employer-paid percentages of insurance premiums, achieving 100% coverage at some of the largest automobile manufacturers by 1961.[43] In 1974, the Employee Retirement Income Security Act of 1974 ("ERISA") further solidified employer-provided healthcare by creating a nationally uniform regulatory scheme for multistate employers, imposing fiduciary duties on employer health plans, and providing beneficiaries with a positive right to sue for recovery of denied benefits.[44]

The rise in healthcare costs significantly impacted two populations that tend to lack employer-based health insurance: the elderly and the poor. Congress responded with the Social Security Amendments of 1965 that established the Medicare and Medicaid programs, a pair of national insurance programs that positioned the federal government as the single

38. Stabilization Act of 1942, Pub. L. No. 77-729, 56 Stat. 765 (codified in 50a U.S.C. § 961 (repealed 1980)); Wasley, *supra* note 13, at 12; Laura A. Scofea, *The Development and Growth of Employer-Provided Health Insurance*, MONTHLY LAB. REV. (Mar.) 3, 6 (1994).

39. Laxmaiah Manchikanti, Standiford Helm II, Ramsin M. Benyamin & Joshua A. Hirsch, *Evolution of US Health Care Reform*, 20 PAIN PHYSICIAN 107, 108 (2017).

40. COMMITTEE ON EMPLOYMENT-BASED HEALTH BENEFITS, INSTITUTE OF MEDICINE, EMPLOYMENT AND HEALTH BENEFITS: A CONNECTION AT RISK 70–71 (Marilyn J. Field & Harold T. Shapiro eds., 1993).

41. *Id*. at 67.

42. *Id*. at 42, 74.

43. Wasley, *supra* note 13, at 13; BARRY R. FURROW, THOMAS L. GREANEY, SANDRA H. JOHNSON, TIMOTHY STOLTZFUS JOST, ROBERT L. SCHWARTZ, BRIETTA R. CLARK, ERIN C. FUSE BROWN, ROBERT GATTER, JAIME S. KING & ELIZABETH PENDO, HEALTH LAW: CASES, MATERIALS AND PROBLEMS 490 (8th ed. 2018).

44. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified in 29 U.S.C. ch. 18 § 1001–1461); FURROW ET AL., *supra* note 43, at 423.

largest third-party payer in healthcare.[45] Despite its outsize role in the industry, the federal government initially made no changes to the healthcare business model and adopted the same cost plus reimbursement model that had driven up costs in the private insurance industry.[46]

Lawmakers have struggled to reign in the cost of the healthcare fee-for-service model since the 1970s, when they sought to incentivize adoption of the health maintenance organization ("HMO") model that had been pioneered by the Ross-Loos Medical Group and the Kaiser Foundation Health Plan.[47] The HMO is the archetypal organizational form of coordinated care in which a network of providers deliver a comprehensive benefit package for a fixed premium.[48] The primary advantage of HMOs is the integration of finance and delivery of healthcare within the defined network of providers who cut down on costs by managing utilization and provider payments.[49] A key component of the HMO model is "managed care," which comprises of "gatekeeping, capitation reimbursement, utilization review, clinical practice guidelines, and selective physician contracting."[50] The Health Maintenance Organization Act of 1973 encouraged adoption of HMOs by funding the expansion of HMOs and requiring large employers to offer an HMO benefit option in addition to fee-for-service plans.[51] Despite HMOs' success at cutting costs, concerns over provider incentives to reduce access to services or diminish patient control ultimately led to the downfall of most HMOs and a return to healthcare cost inflation within two decades.[52]

The nature of healthcare evolved in the mid-twentieth century as policyholders sought coverage of medical expenses beyond hospital visits and catastrophic illness. Insurers implemented new forms of sharing the increased costs of new "major medical" coverage with individuals through deductibles, an annual dollar amount that a policyholder must pay before insurance begins covering costs, and co-payments, a share of healthcare service costs paid by policyholders each time they use a service.[53] On paper,

45. Social Security Amendments of 1965, Pub. L. No. 89-97, 70 Stat. 286 (amended 42 U.S.C. ch. 7); Wasley, *supra* note 13, at 13.

46. Wasley, *supra* note 13, at 14.

47. Moseley, *supra* note 33, at 327.

48. Nancy De Lew, George Greenberg & Kraig Kinchen, *A Layman's Guide to the U.S. Health Care System*, 14 HEALTH CARE FIN. REV. 151, 156 (1992).

49. *Id*.

50. Moseley, *supra* note 33, at 328.

51. Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (codified in 42 U.S.C. ch. 6A § 300e); Moseley, *supra* note 33, at 327.

52. Tu et al., *supra* note 17, at 2; Moseley, *supra* note 33, at 327.

53. Beatrix Hoffman, *Restraining the Health Care Consumer: The History of Deductibles and Co-Payments in U.S. Health Insurance*, 30 SOC. SCI. HIST. 501, 504 (2006).

insurers had strong reasons for implementing cost sharing in healthcare. As individuals took on more of their healthcare costs, insurers could not only offset some of their expenditures, but also adjust their offerings with lower premiums or higher annual coverage limits.[54] Cost-sharing measures also looked to solve the "moral hazard" problem that arises when individuals seek medical care that they may not need because they do not bear any of the cost.[55] Once individuals had to pay each time they visited a doctor or got an X-ray, they would "think twice" and presumably seek fewer services.[56]

Healthcare coverage reached an inflection point in the 1980s, at which point the rapid growth in access to health insurance and care began to move in the opposite direction. Employer-sponsored health coverage reached its peak in 1980, when it covered 79.4% of the U.S. population under sixty-five.[57] By 2018, employer-sponsored coverage of the same population had fallen to 58.1%.[58] As fewer employers offered insurance, access to private plans did not grow to cover the difference—the rate of uninsured grew from 12% in 1980 to 18.2% in 2010, with the majority of the growth occurring in Medicare and Medicaid enrollment.[59]

Regulators saw an opportunity to cut healthcare costs with market-based interventions that realign competition across the industry. In the early 1990s, President Clinton introduced the Health Security Act that built on economist Alain Enthoven's concept of managed competition.[60] Under managed competition, sponsor agencies or "alliances" (such as employers, Medicare, or Medicaid) act as referees between the competing health plans available to the sponsors' members, determining benefits, prices, enrollment, and more.[61] Sponsors focus competition on the price of annual premiums rather than individual services, with the goal of creating price-elastic demand.[62] Price-elastic demand occurs when individuals reduce demand as

54. *Id*.
55. *Id*. at 505–06.
56. *Id*. at 506.
57. *National Health Interview Survey: Long-Term Trends in Health Insurance Coverage*, NAT. CTR. HEALTH STATS. 1 (2019), https://www.cdc.gov/nchs/data/nhis/health_insurance/TrendHealthInsurance1968_2018.pdf [https://perma.cc/UP75-4ABH].
58. *Id*. at 2.
59. *Id*. at 1–2. Medicaid enrollment grew from 8% in 1980 to 16.9% in 2010, and Medicare enrollment grew from 1.8% in 1980 to 2.3% in 2010. Note, however, that these figures account for the population of individuals under sixty-five, and they do not include Medicare's primary enrollment population of those sixty-five and older. *Id*.
60. Theda Skocpol, *The Rise and Resounding Demise of the Clinton Plan*, 14 HEALTH AFFS. 66, 69 (1995).
61. Alain C. Enthoven, *The History and Principles of Managed Competition*, 12 HEALTH AFFS. 24, 30–31 (supp. 1993).
62. *Id*. at 32.

prices go up, and this incentivizes sellers to keep prices as low as possible.[63] Naturally, regulators try to avoid *price inelasticity*, which occurs when a seller can increase prices without reducing demand.[64] Managed competition also pursues cost cutting by dividing providers into competing economic units and imposing market forces to compel them to become efficient delivery systems.[65] While President Clinton's proposal would have introduced the American healthcare system to a new phase of managed care, the bill failed, and it would be another sixteen years before Congress would pass large-scale healthcare reform.[66]

When President Obama signed the ACA in 2010, it represented the most significant healthcare reform package since President Johnson's Great Society gave Americans Medicare and Medicaid.[67] Rather than deconstructing the healthcare system to cut costs as President Clinton had attempted to do a generation prior, the ACA primarily focused on increasing access to health insurance and improving the quality of health benefits. The ACA created a new marketplace for health insurance plans that aimed to streamline the insurance purchase process and required that plans offer ten essential health benefits to all who sign up.[68]

The ACA took a carrot and stick approach to expanding health coverage in what is known as the "three-legged stool."[69] The first leg required insurance companies to adopt community rating with guaranteed issue of ten essential health benefits for all who seek coverage.[70] Those who did not buy into the health insurance market, either through the marketplace or another avenue such as an employer, were subject to the second leg: a tax penalty known as the "individual mandate."[71] Many who signed up, however, enjoyed tax credits—the third leg—to help cover their premiums and cost sharing, such as co-pays, deductibles, and coinsurance.[72] As a result, twenty million individuals gained health insurance in its first five years.[73]

---

63. *Id*.
64. *Id*.
65. *Id*. at 29.
66. Robert J. Blendon, Mollyann Brodie & John Benson, *What Happened to Americans' Support for the Clinton Health Plan?*, 14 HEALTH AFFS. 7, 8 (1995); Skocpol, *supra* note 60, at 71.
67. Patient Protection and Affordable Care Act, Pub. L. No. 111-48, § 3022, 124 Stat. 119, 395–99 (2010); *see also* FURROW ET AL., *supra* note 43, at 533.
68. *Summary of the Affordable Care Act*, KAISER FAM. FOUND. (Apr. 25, 2013), https://www.kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act [https://perma.cc/2HPE-DY2H].
69. FURROW ET AL., *supra* note 43, at 536.
70. KAISER FAM. FOUND., *supra* note 68.
71. *Id*.
72. *Id*.
73. Bowen Garrett & Anuj Gangopadhyaya, *Who Gained Health Insurance Coverage Under the ACA, and Where Do They Live?*, URB. INST. (Dec. 2016), https://www.urban.org/sites/default/files/publication/86761/2001041-who-gained-health-insurance-coverage-under-the-aca-

More than any other aspect of the ACA, the individual mandate faced intense legal and political scrutiny. An array of court battles culminated in *NFIB v. Sebelius*, a 2012 Supreme Court decision that upheld the constitutionality of the individual mandate.[74] In his opinion, Chief Justice Roberts wrote that although the individual mandate fails as an exercise of Congress's Commerce Clause power, "it is reasonable to construe what Congress has done as increasing taxes on those who have a certain amount of income, but choose to go without health insurance. Such legislation is within Congress's power to tax."[75] Constitutionality was not enough to save the individual mandate, however, and Congress repealed the tax penalty in 2017.[76] The ACA itself came just one Senate vote short of repeal,[77] and there remain efforts to replace it.[78]

II. ECONOMIC CHALLENGES AND SOLUTIONS IN HEALTHCARE: FROM ACOS TO HEALTHCARE DISTRICTS

A. DIAGNOSING HEALTHCARE'S MARKET FAILURES

Healthcare represents not only a lifeline for individuals, but also for the American economy.[79] In 1960, healthcare expenditures accounted for 5% of the nation's gross domestic product ("GDP").[80] By 2022, that figure had risen to 17.3%.[81] Some of the increase can be attributed to positive developments in care and coverage. But economists point out that healthcare spending also results from fundamental problems in the healthcare market. In an efficient healthcare market, rational and fully informed individuals could purchase healthcare services they need from fair, perfectly competing

and-where-do-they-live.pdf [https://perma.cc/3PVS-4Q5H].

74. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 588 (2012).

75. *Id*. at 588.

76. Robert Pear, *Without the Insurance Mandate, Health Care's Future May Be in Doubt*, N.Y. TIMES (Dec. 18, 2017), https://www.nytimes.com/2017/12/18/us/politics/tax-cut-obamacare-individual-mandate-repeal.html [https://web.archive.org/web/20221116231255/https://www.nytimes.com/2017/12/18/us/politics/tax-cut-obamacare-individual-mandate-repeal.html]; Sanger-Katz, *supra* note 28.

77. Robert Pear, Thomas Kaplan & Emily Cochrane, *Health Care Debate: Obamacare Repeal Fails as McCain Casts Decisive No Vote*, N.Y. TIMES (July 27, 2017), https://www.nytimes.com/2017/07/27/us/politics/senate-health-care-vote.html [https://web.archive.org/web/20221108212744/https://www.nytimes.com/2017/07/27/us/politics/senate-health-care-vote.html].

78. Kapur, *supra* note 29.

79. U.S. DEP'T HEALTH & HUM. SERVS. OFF. ASSISTANT SEC'Y PLAN & EVALUATION, THE EFFECT OF HEALTH CARE COST GROWTH ON THE U.S. ECONOMY (2007), https://aspe.hhs.gov/sites/default/files/private/pdf/75441/report.pdf [https://perma.cc/7ST8-4NGJ].

80. Ryan Nunn, Jana Parsons & Jay Shambaugh, *A Dozen Facts About the Economics of the U.S. Health-Care System*, BROOKINGS (Mar. 10, 2020), https://www.brookings.edu/research/a-dozen-facts-about-the-economics-of-the-u-s-health-care-system [https://perma.cc/TS5P-6LRX].

81. *NHE Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Dec. 12, 2023, 4:13 PM), https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet [https://perma.cc/SY28-FL4D].

sellers.[82] Healthcare resources could be allocated efficiently in a world in which people can shop around for healthcare, with the full scope of information on the prices and quality of each provider's services, and the ability to then pay for those services directly. As Americans learned in the early-twentieth century, when complex healthcare emerged and insurance developed to pay for it, such a world is a fiction. The healthcare system that resulted was one fraught with market failures that have driven costs upward, and healthcare reform to this point has failed to stem the tide.

For many, the loss of the individual mandate spelled the end of the ACA.[83] In theory, the less-risky population of younger, healthier individuals could pull themselves out of risk pools and skip health insurance in a phenomenon that economists call "adverse selection." With risk pools more heavily concentrated with older and sicker individuals, as the theory goes, prices would increase.[84] Increased prices would lead more people to withdraw from the health insurance market, and the so-called "adverse selection death spiral" would lead to a collapse of the market altogether. It turns out that one of healthcare's greatest problems is what has propped up the system post-mandate: price inelasticity.

Healthcare suffers from price inelasticity because when healthcare costs go up, individuals do not drop insurance coverage, they just drop going to the doctor. By 2010, the uninsured non-elderly population reached its peak at 17.8% before the passage of the ACA.[85] The law's drafters understandably made it a priority to bring the number of uninsured down, and on that front the law has been largely successful to date.[86] In 2018, the uninsured rate dropped to 11%,[87] and by 2022 the non-elderly uninsured rate reached 9.6%, the lowest level on record.[88]

82. *See, e.g.*, Mwachofi & Al-Assaf, *supra* note 2, at 330–34.

83. Avik Roy, *Want to See a Health Insurance Death Spiral? Visit Washington State*, FORBES (Mar. 30, 2012, 11:17 AM), https://www.forbes.com/sites/theapothecary/2012/03/30/want-to-see-a-health-insurance-death-spiral-visit-washington-state/?sh=6efc68785d09 [https://perma.cc/VRJ9-M8X5]. *Contra* Larry Levitt & Gary Claxton, *Is a Death Spiral Inevitable if There Is No Mandate?*, KAISER FAM. FOUND. (Jun. 19, 2012), https://www.kff.org/health-reform/perspective/is-a-death-spiral-inevitable-if-there-is-no-mandate [https://perma.cc/V3NL-GU62].

84. David M. Cutler & Richard J. Zeckhauser, *Adverse Selection in Health Insurance*, *in* 1 FRONTIERS IN HEALTH POLICY RESEARCH 1 (Alan M. Garber, ed., 1998), https://www.nber.org/system/files/chapters/c9822/c9822.pdf [https://perma.cc/LK6H-MGSP].

85. Jennifer Tolbert, Patrick Drake & Anthony Damico, *Key Facts About the Uninsured Population*, KAISER FAM. FOUND. (Dec. 19, 2022), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population [https://perma.cc/29SR-KYRC].

86. *See supra* notes 69–73 and accompanying text.

87. Tolbert et al., *supra* note 85.

88. Jennifer Tolbert, Patrick Drake & Anthony Damico, *Key Facts About the Uninsured Population*, KAISER FAM. FOUND. (Dec. 18, 2023), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population [https://perma.cc/EG4X-8UNE].

Yet, increased coverage did not spell increased access to care. One survey found that in 2001, 19% of adults reported putting off needed care due to costs, but even with the passage of the ACA, by 2022, that figure had risen to 38%.[89] Another survey reported that 40% of Americans skipped a recommended medical test or treatment due to cost, and 40% of Americans have cited cost as the reason for going without routine physicals or other preventive care.[90]

Not all insurance plans are the same, and the differing approaches to cost sharing exposes the disparity in access to care across the healthcare system and the problems that arise from a lack of reliable pricing information. Cost sharing comes in various forms, including percentages of medical service costs or fixed rates set by insurance companies according to a particular service, such as $20 for a physician visit or $150 for a hospital stay. Alternatively, one might pay $150 or 20% for a hospital stay, depending on the type of plan one has. The disparity in insurance can be seen in the enrollment trends in the ACA insurance marketplace, in which the middle "silver" tier has seen declines in enrollment, the "gold" tier has seen modest gains, and the lowest "bronze" tier has seen significant increases.[91] Whereas set rates, rather than percentages, for healthcare services shields individuals from unexpected costs, it simultaneously hides the complex and mysterious world of medical billing.

The key takeaway is this: price elasticity of demand occurs in the provision of healthcare services, rather than in the provision of insurance coverage.[92] More Americans than ever have health insurance, but a great deal of those with coverage forgo the added out-of-pocket costs that come with seeking healthcare services.[93] And while that reduced demand for services might compel providers to reduce prices in an efficient market, they have made up the difference by continuing to increase prices and extracting more money per service for those who do seek treatment.[94] Individuals with reduced cost sharing, such as set rates for services, face a reduced barrier to

89. Megan Brenan, *Record High in U.S. Put Off Medical Care Due to Cost in 2022*, GALLUP (Jan. 17, 2023), https://news.gallup.com/poll/468053/record-high-put-off-medical-care-due-cost-2022.aspx [https://perma.cc/Y29D-LQE2].

90. *Americans' Views on Healthcare Costs, Coverage and Policy*, NORC U. CHI. 5 (2018), https://www.norc.org/PDFs/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy%20Topline.pdf [https://perma.cc/3HUF-V3Y6].

91. Dan Grunebaum, *Affordable Care Act Enrollment by State and Metal*, HEALTH CARE INSIDER (Sept. 9, 2021), https://healthcareinsider.com/affordable-care-act-enrollment-by-state-and-metal-364584 [https://perma.cc/F752-FPY6].

92. Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey & Varduhi Petrosyan, *It's the Prices, Stupid: Why the United States Is so Different from Other Countries*, 22 HEALTH AFFS. 89, 100 (2003).

93. COMMONWEALTH FUND, *supra* note 89.

94. Anderson et al., *supra* note 92, at 102.

services and do not encounter the prices that keep others away.

Because individuals are not the only payers in the health insurance market, price elasticity could ostensibly come from insurers or employers. In theory, employers ought to balk at rising healthcare costs, but economists have suggested that they pass on the additional costs to employees.[95] In an era of high inflation, employers can pass on healthcare costs easily through smaller nominal wage increases.[96] Between 2009 and 2019, worker contributions to employer-sponsored premiums rose 59% and employer contributions rose 54%, while employers' share of the total premium held steady at 73%.[97] Employees absorb the increased prices charged by providers in a way that is largely hidden from them—employees cannot readily know how much they would earn in the absence of healthcare cost increases.[98] Evidence suggests the passing of these costs to employees, combined with rising wage inequality, "significantly reduced the percentage of compensation."[99] If providers can increase prices that individuals will ultimately bear, without some other market basis like a proportionate loss in demand or increase in value, the provider gets away with earning what economists call "rents," or excess prices beyond the minimum price a seller would otherwise be paid in the market.[100] Not only is this harmful to individuals, in that it represents an inefficient allocation of resources, rent-seeking behavior evinces a level of monopolistic power by providers in the market.[101] Were prices elastic, the number of insured individuals would decrease as prices rose. Over that same period, however, more people have gained insurance.[102] While the growth in healthcare coverage is a positive development, it represents a worrying trend when paired with increased prices. The brakes that traditionally keep prices low—the threat of losing

95. Uwe E. Reinhardt, *Health Care Spending and American Competitiveness*, 8 HEALTH AFFS. 5, 8 (1989).

96. Alain C. Enthoven & Victor R. Fuchs, *Employment-Based Health Insurance: Past, Present, and Future*, 25 HEALTH AFFS. 1538, 1546 (2006).

97. KAISER FAM. FOUND., *supra* note 30; *Premiums and Worker Contributions Among Workers Covered by Employer-Sponsored Coverage, 1999–2022*, KAISER FAM. FOUND. (Oct. 27, 2022), https://www.kff.org/interactive/premiums-and-worker-contributions-among-workers-covered-by-employer-sponsored-coverage-1999-2021/#/?compare=true&coverageTypeComp=worker_contribution [https://perma.cc/E2DU-3Z8N].

98. Reinhardt, *supra* note 95, at 20.

99. Gary Burtless & Sveta Milusheva, *Research Summary: Effects of Employer-Sponsored Health Insurance Costs on Social Security Taxable Wages*, 73 SOC. SEC. BULL. 83, 84 (2013), https://www.ssa.gov/policy/docs/ssb/v73n1/v73n1p83.pdf [https://perma.cc/PF4T-TNFD].

100. Anderson et al., *supra* note 92, at 102.

101. *Id*.

102. Kenneth Finegold, Ann Conmy, Rose C. Chu, Arielle Bosworth & Benjamin D. Sommers, *Trends in the U.S. Uninsured Population, 2010–2020*, U.S. DEP'T HEALTH & HUM. SERVS. (Feb. 11, 2021), https://aspe.hhs.gov/sites/default/files/private/pdf/265041/trends-in-the-us-uninsured.pdf [https://perma.cc/5HY7-QBYN].

paying customers once prices exceed what they are willing to pay—either do not exist or have not been reached.

With market failures taking out downward cost pressures from individuals and employers, insurers stand as the apparent last line of defense against rising healthcare costs. The traditional insurance business model incentivizes cost efficiency—policyholders pay insurers set premiums, and insurers have the incentive to pay as little of those premiums out as reimbursement for services in order to retain the greatest possible profit margin. The ACA turned this model on its head when it mandated a "medical loss ratio"—a requirement that insurance companies spend 80–85% of premium dollars on medical care-related expenses, thereby tying the amount they get to keep (including profits) to a percentage of care dollars spent.[103]

The healthcare marketplace insulates individuals from many of the direct costs of healthcare, and the lack of robust price competition for insurance means that insurers may continue to raise premiums to accommodate the high healthcare prices that net them greater profits.[104] Insurers can take advantage of market failures to pursue the perverse incentives of a medical loss ratio policy that was meant to decrease costs but instead incentivizes them to spend as much as they can.[105] Furthermore, insurers have an additional incentive to keep costs as high as their premiums can bear because high prices set a high barrier to entry for other potential competing insurers.[106] These incentives expose the pitfalls of cost-based regulations instead of incentive-based ones, as proposed here.[107]

Insurers cannot overpay for services if they are not charged such high prices in the first place. Whereas cost sharing effectively curbed the threat of moral hazard when individuals seek out more medical services than they need because they do not bear the cost, another moral hazard problem arose in the form of provider billing and overtreatment.

The cost-sharing measures implemented by insurers essentially traded one moral hazard problem for another. Insurers overcorrected the moral hazard problem by disincentivizing individuals from seeking treatment,

103. McCue & Hall, *supra* note 10.

104. Allen, *supra* note 9; Kliff & Katz, *supra* note 10.

105. *See, e.g.*, Iván Major, *Two-Sided Information Asymmetry in the Healthcare Industry*, 25 INT'L ADVANCES ECON. RSCH. 177, 191–92 (2019), https://link.springer.com/content/pdf/10.1007/s11294-019-09732-9.pdf [https://perma.cc/8M3F-ES4U].

106. Robert A. Berenson, Jaime S. King, Katherine L. Gudiksen, Roslyn Murray & Adele Shartzer, *Addressing Health Care Market Consolidation and High Prices: The Role of the States*, URB. INST. 2 (Jan. 2020), https://www.urban.org/sites/default/files/publication/101508/addressing_health_care_market_consolidation_and_high_prices_1.pdf [https://perma.cc/HQ44-4H7K].

107. Major, *supra* note 105, at 178.

instead incentivizing doctors to overtreat those that do come in.[108] In its worst incarnation, physician-induced demand can rack up healthcare expenses when patients do not know any better, and insurers put few, if any, brakes on unnecessary charges.[109] A major factor that has enabled healthcare providers to charge ever-higher prices is the lack of transparency around the prices of services between patients, insurers, and even providers.[110]

One contributor to healthcare's price inelasticity is the varying difficulty that consumers, providers, employers, and insurers have with understanding the price of healthcare services, or what economists call "information asymmetry." Throughout healthcare, there are discrepancies in the amount of information available to transacting parties.[111] For instance, doctors typically have more information about the care they can provide than patients. Similarly, healthcare providers generally have more information about the costs of their services than insurers. The discrepancies in information create inefficiencies that drive up costs. When patients seek healthcare services, they likely do not know the cost of the services beforehand.[112] Depending on their insurance plan, patients can either anticipate paying their insurance plan's set rate co-pays or face the surprise bill for a percentage of the services they incurred. Information asymmetry gives rise to a principal-agent problem, in which the physician-agent has incentives to use the information asymmetry for the physician's financial benefit.[113]

A primary culprit of increased healthcare prices is the mysterious and unscientific hospital "chargemaster" system. Chargemasters are automated systems traditionally employed by large healthcare providers such as hospitals to set price markups and generate the sticker prices for their various services.[114] Few, if any, in the hospital administration are involved with the setting of the prices, and even doctors generally are not informed of the prices of the services they perform.[115] Here, a type of information asymmetry even occurs *within* providers. Yet, chargemasters set the baseline price from which insurance companies negotiate down to a level the insurer is willing to pay. Those with less bargaining power, such as uninsured individuals, may

108. *See* Cromwell & Mitchell, *supra* note 7.
109. E.M. Johnson, *Physician-Induced Demand*, 3 ENCYC. HEALTH ECON. 77, 80 (2014), https://www.mit.edu/~erinmj/files/PID.pdf [https://perma.cc/K2WG-EHJC].
110. Oswald A.J. Mascarenhas, Ram Kesavan & Michael D Bernacchi, *On Reducing Information Asymmetry in U.S. Health Care*, 30 HEALTH MKTG. Q. 379, 380 (2013).
111. *Id.* at 382.
112. *Id.* at 384–85.
113. *Id.*
114. Brill, *supra* note 1.
115. *Id.*

face the full chargemaster price without the assistance of medical billing consultants to negotiate on their behalf. The result often leads to newsworthy charges such as 675% price hikes.[116]

Providers capitalize on information asymmetry by using chargemasters to extract the highest possible prices, and they have few disincentives to do otherwise. As discussed earlier, many patients never see their medical bills aside from standardized, insurer-set co-pays. One might reasonably expect the other payers in the healthcare system—employers and insurers—to thus bear the sensitivity to providers' exorbitant costs and apply downward price pressures. Unfortunately, the confluence of healthcare's market failures renders those pressures toothless.

Efforts over the past decade to improve price transparency will not likely affect individuals' healthcare decision-making process in a significant enough way because patients are not the ones making many of the decisions about their care.[117] Revealing chargemaster prices, for instance, likely matters more to insurers and employers, as well as smaller hospitals that seek to charge comparable prices to larger competitors, than it would to consumers.[118]

The goals of universal access, low cost, and high quality can be achieved with a model that addresses the information asymmetry, principal-agent problem, misaligned incentives, adverse selection, poor competition, price inelasticity, and antitrust concerns that plague healthcare today.

B. FINDING A CURE IN ACCOUNTABILITY

Enter the Healthcure System, an entirely new healthcare model proposed by this Note that adapts the best features of ACOs, incentive payment models, and employer-provided health plans while abandoning fee-for-service cost plus payments, private health insurers, complexity of multiple payment sources, incentives for providers to overtreat, and the power of providers to increase prices by consolidating and reducing competition.

Historically, healthcare reform has consisted of attempts to achieve two of the three pillars: cost, quality, and access. The ideal healthcare system

116. David Lazarus, *Column: Leaked SoCal Hospital Records Reveal Huge, Automated Markups for Healthcare*, L.A. TIMES (Dec. 10, 2021, 6:00 AM), https://www.latimes.com/business/story/2021-12-10/column-healthcare-billing-markups [https://perma.cc/527D-D5ZA].

117. Sherry Glied, *Price Transparency—Promise and Peril*, 325 JAMA 1496, 1496–97 (2021).

118. Julie Appleby, *Hospitals Forced to Be More Transparent About Pricing. Will That Save You Money?*, NPR (Jan. 5, 2021, 5:00 AM), https://www.npr.org/sections/health-shots/2021/01/05/953340571/hospitals-forced-to-be-more-transparent-about-pricing-will-that-save-you-money [https://perma.cc/4AQP-PTNK].

keeps costs low for individuals and providers (whether someone can afford their healthcare costs and whether providers reign in the costs of their services), maintains high quality by making available a breadth of healthcare benefits with strong outcomes (whether a particular ailment is covered and whether a treatment has a high likelihood of success), and ensures that the greatest possible population has access to care and coverage of costs (whether most are able to easily visit a doctor or hospital and will they have a means of paying for their treatment). Medicare focused on cost and access by providing insurance to all who reach a certain age, but it has historically lacked important quality indicators such as coverage of prescriptions, dental, vision, long-term care, and nursing home care.[119] The proposed Clinton health reforms of the 1990s focused on cost and quality by managing competition and guaranteeing benefits, but they did not address a growing number of uninsured.[120] The ACA focused on quality and access by guaranteeing ten essential health benefits and expanding access to Medicaid and a private insurance marketplace, but it left intact the payment methods that have driven prices upward.[121] The Healthcure System rebuts the presumption that no model can achieve all three.

Under the Healthcure System, all residents within a particular region make payments (essentially a healthcare tax) to a healthcare district—a corporate entity that encompasses all of the healthcare providers in the region. Each region would be determined by the state legislature based on population and concentration of providers and should account for the equitable distribution of resources when doing so.[122] The healthcare district coordinates payment and care for residents of the region, employing a front-end per capita payment and back-end incentive payments system that encourages providers to not rack up unnecessary costs but still have an incentive to provide cost-effective quality care. Healthcare districts largely take the place of private health insurers and employer-paid plans, instead centralizing each individual's healthcare costs into one monthly income-based payment. Each healthcare district's board of directors sets this progressive healthcare tax rate for the region, and if that percentage exceeds what residents are willing to pay, individuals may vote out the directors during staggered biennial elections or, if feasible, avoid living in the district.

119. FURROW ET AL., *supra* note 43, at 17; *What Isn't Covered by Part A & Part B?*, MEDICARE, https://www.medicare.gov/what-medicare-covers/what-isnt-covered-by-part-a-part-b [https://perma.cc/XT6H-ZWWY].

120. Skocpol, *supra* note 60, at 70.

121. Berenson, *supra* note 106, at 1.

122. Matthew J. Parlow, *Equitable Fiscal Regionalism*, 85 TEMP. L. REV. 49, 74 (2012).

This Note makes some acknowledgments from the start. First, healthcare delivery is inherently local—patients are realistically constrained to choosing providers near them, and healthcare costs are significantly influenced by local factors. Rather than share the struggles Medicare has had with accounting for regional differentiation in markets for medical services, products, and employment when calculating reimbursement, each healthcare district only concerns itself with negotiating local pricing with local providers for local beneficiaries. Districts are therefore organized around a large enough population to distribute risk in a risk pool while also encompassing the entirety of a local market (that is, all of the providers that would compete with one another for individuals in the region). In densely populated states, there may be healthcare districts proportionate to the number of counties, but in more rural areas, districts could theoretically be the size of a state. Second, provider consolidation is inevitable and comes with benefits despite its drawbacks. The upside of a fully functional ACO is the imposition of cost sensitivity on the providers who are responsible for the decision-making behind those costs. Providers would need to evaluate, for instance, whether to use an expensive treatment based on its likelihood of success, rather than indiscriminately prescribing costly remedies, because they can no longer rely on a third-party payer to just foot the bill. Such integration of finance and delivery can act as a powerful downward cost pressure that can alleviate the current upward incentives to overtreat and overprice. Although consolidation also breeds upward price pressures in the form of reducing competition, Healthcure makes use of other downward cost pressures such as regional competition, price elasticity, public accountability, and a market for supplemental benefits to counterbalance antitrust pricing concerns. Third, incentive payments must account for both event-specific outcomes (rewarding providers when a particular treatment works, for example) and community outcomes (rewarding providers for overall health gains in a region) in order to fully align the incentives of payments and providers.

III. ACCESS: ADOPTING A REGIONAL FOCUS TO DELIVER EMPLOYER-STYLE UNIVERSAL COVERAGE

In a sense, access is the ultimate aim of healthcare reform: it encompasses both cost and quality to a certain degree. High cost is often a barrier to access to coverage, and poor-quality coverage often keeps people from access to care. Any discussion of access in the healthcare system must account for both coverage (as in an individual's participation in some support system to cover healthcare costs) and care (which accounts for the kinds of healthcare services available to an individual). Both are of major concern in the current United States healthcare system. In early 2023, 7.7% of

Americans did not have access to health insurance.[123] Furthermore, studies have shown that low-income and marginalized communities see a disproportionate decline in access to care from higher odds of losing healthcare facilities.[124] Healthcure addresses access by co-opting one of the original drivers of health insurance adoption: employer-sponsored health plans.

As evidenced by the public concerns over whether individuals would be able to keep their insurance plans at the time the ACA was passed,[125] such employer plans have achieved a level of ubiquity in American society that any reform that upends the status quo would be well-advised to consider. The Healthcure System shares two key elements with employer-sponsored health plans: community rating and income contributions.

A. Expanding the Risk Pool from Coworkers to Neighbors: A Regional Approach

Today's healthcare landscape is filled with geographically mismatched systems and entities. When individuals seek care, they are generally constrained to providers within their immediate vicinity. These individuals may participate in health plans through employers that also provide coverage to employees located in other states. Insurance marketplaces through the ACA, on the other hand, are constrained to markets within each state. Meanwhile, the single largest payer in the country—the Medicare system of the federal government—operates nationwide but uses a litany of processes to account for regional disparities in costs. To put it simply, healthcare is inescapably local, and the first step to crafting an efficient healthcare system is recognizing the value of a regional approach.

At its core, the Healthcure System consists of smaller, regional systems that naturally incorporate the idiosyncrasies of their localities in healthcare finance and delivery. Although healthcare districts do not currently exist as envisioned for the Healthcure System here, the concept of regional healthcare districts is not entirely new. Regional health districts under the

---

123. *New HHS Report Shows National Uninsured Rate Reached All-Time Low in 2023 After Record-Breaking ACA Enrollment Period*, U.S. DEP'T HEALTH & HUM. SERVS. (Aug. 3, 2023), https://www.hhs.gov/about/news/2023/08/03/new-hhs-report-shows-national-uninsured-rate-reached-all-time-low-2023-after-record-breaking-aca-enrollment-period.html [https://perma.cc/9868-957P].

124. *See, e.g.*, Jennifer Tsui, Jana A. Hirsch & Felicia J. Bayer, *Patterns in Geographic Access to Health Care Facilities Across Neighborhoods in the United States Based on Data from the National Establishment Time-Series Between 2000 and 2014*, JAMA NETWORK OPEN (May 15, 2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2766043 [https://perma.cc/5TTD-D67M].

125. Jeffrey Young, *Senate Passes Historic Healthcare Reform Legislation in 60-39 Vote*, HILL (Dec. 24, 2009), https://thehill.com/homenews/senate/73537-senate-passes-historic-healthcare-reform-bill-60-40 [https://perma.cc/E2NA-RG72].

Healthcure System trace their roots to a different kind of healthcare district employed by state governments to coordinate healthcare in rural areas.[126] Funded by either general taxes or special taxes, traditional healthcare districts are local governments that operate healthcare facilities, establish managed care, contract with providers, or take on any other health-related service for a community.[127]

Any third-party payer that collects funds from a population to distribute medical services must consider risk. The delicate balance between risk and ratemaking can have significant implications for access if those with higher health risks face significantly higher rates (or exclusion from the market altogether). Such was the consequence of experience rating, a method used by health insurers to determine eligibility and rates based on an assessment of one's health risks. Insurers engaged in favorable selection, attempting to insure healthier individuals and avoid sicker people. Prior to the ACA, those with certain preexisting conditions would face unaffordable premiums or even exclusion from certain health plans. To avoid locking out those with the most medical need from the insurance system, and thereby exposing them to insurmountable out-of-pocket costs, the ACA banned experience rating in all circumstances except age and tobacco use. To counteract the risk imbalance that would result from removing the experience rating mechanism plans could use to reduce risk, especially on small plans, the ACA promised economies of scale that could accommodate high-risk individuals but spread exposure across a larger risk pool. Insurers had the individual mandate to thank in part for the uptick in larger, healthier risk pools, as it compelled those who might otherwise go without health insurance to do so or face tax penalties.[128]

While the ACA expanded coverage for those who did not otherwise have access, employer-sponsored health coverage still dominates. Employers cover approximately 50% of the U.S. population.[129] Of those who have access to employer-sponsored coverage, 77% participate in the employer's group.[130] In the mid-twentieth century, employer-sponsored

126. *California's Healthcare Districts: A Local Choice for California's Health,* ASS'N CAL. HEALTHCARE DISTS., https://www.achd.org/achd-message [https://perma.cc/6V85-RS8B].

127. *Overview of Health Care Districts*, LEGIS. ANALYST'S OFF. 1, 1–4 (Apr. 11, 2012), https://lao.ca.gov/handouts/Health/2012/Overview_Health_Care_Districts_4_11_12.pdf [https://perma.cc/NRU9-6KU5].

128. MATTHEW FIEDLER, HOW DID THE ACA'S INDIVIDUAL MANDATE AFFECT INSURANCE COVERAGE? 4–5, 27 (May 2018), https://www.brookings.edu/wp-content/uploads/2018/05/coverageeffectsofmandate2018.pdf [https://perma.cc/L6FY-3P99].

129. *Health Insurance Coverage of the Total Population*, KAISER FAM. FOUND., https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0 [https://perma.cc/UB2H-9VYN].

130. KAISER FAM. FOUND., *supra* note 30, at 4.

plans drove rapid growth in health coverage, but today they are fraught with drawbacks. Employer plans are responsible for additional complications in the payment structure, buffering individuals from the cost of their care by passing on the costs through reduced wages, shifting compensation from paychecks to health plan contributions, limiting coverage to those employed, and constraining risk pools. Studies have shown that the upward cost pressure problems of employer plans are exacerbated in markets with fewer insurance carriers because carriers take advantage of the lack of competition by negotiating higher premiums, especially with employers experiencing profit shocks.[131] Moreover, the costs of researching different plans and transitioning to new ones often keep those in employer plans from switching, thereby reducing competition that could impose downward price pressure.[132]

Even before it was mandated by the ACA, individuals were exposed to community rating by their employer health plans. Rather than engaging in experience rating, which evaluates risk based on the individual health histories of each ratepayer and charges them accordingly, traditional employer plans distribute risk across a group and charge each member the same rate.[133] Because community rating does not take into account health histories, the primary mechanism by which to manage risk is to achieve scale.[134] Employer plans are limited by the group of enrollees at a particular firm.

Given the local limitations of healthcare delivery, the Healthcure System's answer to risk distribution is to expand it from the silos of individual employers to the very limits of a particular region. The general wisdom is that when allocating risk, the larger the risk pool, the better. Although community rating across organizations provides some semblance of risk distribution, it pales in comparison to the distribution across an entire region at all employers except for the largest of firms. The Healthcure System's expansion of risk pools enables healthcare districts to enjoy the cost savings of the risk distribution.

B. Simplifying Beneficiary Healthcare Costs to Induce Price Elasticity and Protect Affordability

The "Affordable" in Affordable Care Act may be the most significant undelivered promise of the law. What the ACA did not address is the complex web of payment sources that underlies the entire system. Whereas

131. Leemore S. Dafny, *Are Health Insurance Markets Competitive?*, 100 AM. ECON. REV. 1399, 1426 (2010).
132. Kliff & Katz, *supra* note 10.
133. COMM. ON EMP.-BASED HEALTH BENEFITS, *supra* note 40, at 67.
134. *Id.* at 42.

insurance premiums are the primary focus of the cost debate, and deservedly so, they do not account for the entirety of an individual's healthcare expenses.

It is this mixture of cost types that shields individuals from grasping the full scope of their healthcare expenditures and buffers their sensitivity to the exorbitant charges providers make for their services.[135] The Healthcure System narrows each individual's health expenses to a percentage of one's income—the starkest representation of one's ability to pay. The percentage is set by each healthcare district and may be adjusted annually by its board of directors. Income contributions have a low-income threshold—individuals with an income below a certain dollar amount pay nothing, and as one's income crosses the threshold, the percentage gradually rises up to the base percentage that is broadly applied across the district. All residents in a region have access to the district's health benefits, regardless of income level. To avoid adverse selection of high earners fleeing from risk pools, a high-income cap places a limit on the dollar amount a family may contribute to the healthcare district's base benefits. While healthcare districts adopt the ten essential health benefits as defined by the ACA and offer them to all residents, those who wish to supplement their benefits may purchase a supplemental plan on an open market similar to Medigap supplemental coverage for Medicare.[136]

The extent of the current healthcare system's price inelasticity was tested when Congress repealed the individual mandate. With the flick of President Trump's pen, those who would otherwise leave the market due to high prices could all of a sudden do just that. However, as healthcare costs continued to rise, enrollment did not precipitously decline.[137] Even with the loss of the individual mandate, price inelasticity may still rely on the buffer between individuals and their healthcare costs to insulate them from the price sensitivity that might otherwise drive them from the market.

135. Elena Prager, *Healthcare Demand Under Simple Prices: Evidence from Tiered Hospital Networks*, 12 AM. ECON. J.: APPLIED ECON. 196, 196–97 (2020); Enthoven, *supra* note 61, at 30.

136. *What's Medicare Supplement Insurance (Medigap)?*, MEDICARE, https://www.medicare.gov/supplements-other-insurance/whats-medicare-supplement-insurance-medigap [https://perma.cc/M2FJ-K6LY].

137. *See* Sarah Kliff, *Republicans Killed the Obamacare Mandate. New Data Shows It Didn't Really Matter.*, N.Y. TIMES (Sept. 21, 2020), https://www.nytimes.com/2020/09/18/upshot/obamacare-mandate-republicans.html [http://web.archive.org/web/20221227134009/https://www.nytimes.com/2020/09/18/upshot/obamacare-mandate-republicans.html]; Jeanna Smialek, Sarah Kliff & Alan Rappeport, *U.S. Poverty Hit a Record Low Before the Pandemic Recession*, N.Y. TIMES (Sept. 15, 2020), https://www.nytimes.com/2020/09/15/business/economy/poverty-record-low-prior-to-pandemic.html [http://web.archive.org/web/2022113065933/https://www.nytimes.com/2020/09/15/business/economy/poverty-record-low-prior-to-pandemic.html]; *see also* Molly Frean, Jonathan Gruber & Benjamin D. Sommers, *Disentangling the ACA's Coverage Effects—Lessons for Policymakers*, 375 NEW ENG. J. MED. 1605, 1607 (2016).

The Healthcure System's approach to individual payment achieves price sensitivity by wrapping up all healthcare costs into one tax payment that is broadly applied to all residents in the healthcare district. The current mix of individual premiums, employer contributions, co-pays, deductibles, coinsurance, and government tax credits all obscure the cost of healthcare to the individual. However, when all that individuals must consider is a particular tax, their understanding of health expenses gains a clarity with which they can impose downward price pressures.

Downward price pressures on the demand side of the Healthcure System consist of individual choice between healthcare districts and public election of district boards of directors. Instead of imposing cost sharing through co-pays for each medical service rendered, Healthcure incentivizes individuals to consider healthcare tax costs when choosing where to live. If a particular healthcare district sets too high of an income contribution rate for its residents, individuals may choose not to move to that particular district. But moving may not always be feasible or desirable, so those who reside in the district can express their objection to high income percentages by voting out the board of directors and electing a board committed to cutting costs.

Traditional cost sharing does not sufficiently cause individuals to better consider which healthcare services they should seek because they lack the information needed to make that determination and will always lack that information in the absence of the training of a medical professional.[138] Cost sharing on the service level thus results not in cost savings, but in worse health outcomes when people forgo treatment due to cost. Instead, price sensitivity should be focused on what individuals can make informed decisions about and fully understand. For most, that is the total amount they are able to pay for their healthcare tax.

C. Possible Equity Implications of a Regional Model

The deontological debate over whether healthcare constitutes a commodity, a right, or something in between extends far beyond the scope of this Note. But the law and economics approach taken here does not ignore the ethical implications of equity in its design of a more efficient healthcare system. Policymaking necessarily has ethical and economic consequences, and this Note presents the Healthcure System as a means of compelling providers to become fairer market actors, guaranteeing egalitarian access to

138. Elise Gould, *Uwe Reinhardt on Cost-Sharing*, ECON. POL'Y INST. (Nov. 15, 2013, 4:46 PM), https://www.epi.org/blog/uwe-reinhardt-cost-sharing [https://perma.cc/QK2K-YDV9]; *see also* Uwe E. Reinhardt, *The Disruptive Innovation of Price Transparency in Health Care*, 310 JAMA 1927, 1927–28 (2013).

healthcare, enhancing competition, and reducing costs.

The general thrust of the Healthcure System model is its introduction of new accountability measures into a healthcare landscape where there are currently few. This lack of accountability, whether it be in hospital pricing or insurers' willingness to pay, affects every individual regardless of whether they choose to participate in the insurance market. This is true of any market—the actions of firms do not exist in a vacuum without influencing supply and demand for all market participants.[139] The imperative for broad public accountability in the market for widgets, however, does not measure up to the imperative in a healthcare industry that every individual is likely to transact with at some point. For healthcare providers to be truly accountable, they must be accountable to *everyone*, not just their customers. By bringing all individuals under a universal coverage model, the Healthcure System's accountability measures can internalize the externalities of the healthcare market. In other words, no longer will insurers and providers suscept the uninsured to price inflation.

In its effort to provide universal coverage, the Healthcure System sets forth regional healthcare districts that collect taxes from residents and distribute those funds to providers for the provision of services. Notwithstanding its unique policy prescriptions, the Healthcure System would be wise to adopt some of the innovations of the ACA, such as the guaranteed issue of essential health benefits. All health insurance plans were required to offer ten services as part of their benefit packages under the ACA: (1) ambulance; (2) emergency; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) lab work; (9) preventive, wellness, and chronic disease management; and (10) pediatric services including oral and vision care.[140] Additionally, the ACA ensured that insurers could not turn away or even raise premiums for those with preexisting health conditions. Although the ACA may not have done enough to stem rising costs, it did take significant steps toward improving access to health coverage and the quality of the benefits provided.

A regional, tax-funded healthcare system raises concerns over provider concentration and equity between regions with different income levels. These concerns predate the proposed reforms offered here, but this Note does not seek to entrench an already inequitable system. On the contrary, the

139. Mwachofi & Al-Assaf, *supra* note 2, at 333.

140. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3022, 124 Stat. 119, 395–99 (2010); HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards, 86 Fed. Reg. 24140, 24143 (May 5, 2021) (codified as amended at 45 C.F.R. pts. 147, 150, 153, 155, 156, 158, 184).

Healthcure System can act as a vehicle for identifying areas with inequitable access to healthcare and delivering targeted financial support in the form of supplemental government adjustment payments.

The Health Resources & Service Administration ("HRSA") currently uses two designations to identify areas of need in the healthcare system: Medically Underserved Areas/Populations ("MUA/P") and Health Professional Shortage Areas ("HPSAs").[141] Additionally, Medicaid identifies hospitals that serve large numbers of Medicaid and uninsured individuals and directs supplemental payments through the Disproportionate Share Hospital ("DSH") program.[142] These programs may be rolled into healthcare districts, which can more easily collect data on the community's needs due to the coordinated care of all the providers in the region. Federal and state governments can then issue adjustment payments to those districts with the most need, and the payments can come in the form of block grants, incentives to recruit physicians, infrastructure and capital improvement funding, equipment, and even technical assistance and consultation. Further, government payments could subsidize the costs of patients visiting other healthcare districts to make use of equipment, services, or specialists that their underserved district may lack. The district could evaluate the cost of purchasing access to equipment, services, or specialists in other districts and the demand for them, and if cost-effective, petition the government to subsidize the acquisition of them for the underserved district. In this way, the Healthcure System can play an active role in improving health equity in a given region.

Another concern arises over the district's control over pricing and the potential for monopsony. Whereas monopoly power enables a seller to set prices above what a perfect market would dictate, monopsony power on the buyer side enables one to counterbalance monopoly rent seeking.[143] But a monopsonist need not face a monopoly on the other side of the transaction in order to wield its power, and in the healthcare context, a single-payer such as a government can lead providers to withdraw supply in response to lack of price power.[144] It is not difficult to imagine how low-income districts may be disproportionately susceptible to constrained supply if they pay providers less than neighboring districts. Government adjustment payments are just one way districts can avoid these circumstances.

141. *What Is Shortage Designation?*, HEALTH RES. & SERVS. ADMIN. (Aug. 2022), https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#empu [https://perma.cc/58X8-PJS4].

142. *Medicaid Disproportionate Share Hospital (DSH) Payments*, MEDICAID, https://www.medicaid.gov/medicaid/financial-management/medicaid-disproportionate-share-hospital-dsh-payments/index.html [https://perma.cc/Z4TS-BVKJ].

143. Anderson, *supra* note 92, at 102.

144. *Id.*

Here, the board of a healthcare district also has work to do to protect individuals' access to care. One way to fight the possibility of constrained supply is through the system's per-event incentive payment structure that rewards providers for seeing more patients, rather than rewarding them based on the number of services administered through fee-for-service.

An additional safeguard would be a requirement that providers offer essential health benefits if they are to participate in a supplemental coverage market not subject to price controls by the district. Providers could offer supplemental coverage in a private market for services not otherwise available through the district. The districts must ensure there is no overlap of services between the essential benefits they offer and the supplemental benefits offered by providers because an overlap would open the door for a conflict of interest. If providers' supplemental services competed with those offered by the district, then providers will have incentives to reduce district essential benefits made available to everyone, offer lesser-quality district benefits, or otherwise push individuals toward its supplemental offerings (which would ostensibly be more lucrative for the providers).

IV. COST: INNOVATING A NEW HEALTHCARE DISTRICT GOVERNANCE MODEL WITH PUBLIC AND FINANCIAL ACCOUNTABILITY FROM STAKEHOLDERS

Although not a centerpiece of the ACA, a modest provision in section 3022 now stands as one of the most promising elements of the ACA left standing, one that opened the door to a new organizational form dedicated to accountable care: the ACO.[145] When providers come together to form an ACO, they commit to coordinating care and sharing in the responsibility for financial and quality outcomes for a certain population of patients.[146] Not only can ACOs deliver improved health outcomes by sharing information between doctors, hospitals, and other providers, thereby reducing unnecessary or redundant treatment, but they can also reduce costs.

The healthcare market traditionally imposes on insurers—not providers—the risk of losing money when healthcare costs exceed the amounts collected from individual premiums. As discussed earlier, market failures have led to a system in which healthcare providers face no downside to overtreating patients and often have incentives to charge as high of prices as possible.[147] Thus, the system imposes few, if any, brakes on runaway healthcare costs, and those costs are ultimately passed to individuals in the

145. *See supra* notes 14–18 and accompanying text.

146. Tu et al., *supra* note 17, at 3.

147. *See supra* Section II.A.

form of increased premiums, greater cost sharing, and reduced wage gains.[148] ACOs flip this relationship on its head by shifting risk to the providers who are largely responsible for making decisions about and incurring the costs of care in the first place. Rather than rewarding providers based on the number of services provided, as the traditional fee-for-service model incentivized, ACOs offer providers financial incentives for hitting cost-savings targets and meeting quality benchmarks. In theory, the goal is to align incentives in the healthcare market so that all benefit from low-cost, high-quality care.

In concert with the Medicare Shared Savings Program ("MSSP"), the federal government incentivizes cost cutting by offering providers who organize under an ACO model a share of any cost savings they generate from efficient service delivery.[149] The Centers for Medicare & Medicaid Services ("CMS") offer several levels of shared savings, and the ACO shares a proportionate amount of risk of cost overages according to the level it joins.[150]

The upside of the ACO is so great that it could—with the right adjustments—avoid the upward cost pressures that come with traditional private insurers.[151] MSSP reported $1.8 billion in net savings in 2022 after making incentive payments to participating ACOs.[152] On its face, that number represents a laudable achievement and proof of concept for ACOs, but it does not fully capture the state of the program. The number of participating ACOs shrank from 561 in 2018 to 456 in 2023,[153] and economists point out that the savings figure is largely the product of selective participation.[154] Due to the voluntary nature of MSSP, higher-spending ACOs have disproportionately exited the program and lower-spending ACOs have entered. The result is a skewed program that provides incentive

148. *See supra* Section II.A.

149. *Pioneer ACO Model*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://innovation.cms.gov/innovation-models/pioneer-aco-model [https://perma.cc/C8XW-47K2].

150. *Id*.

151. Ezekiel J. Emanuel & Jeffrey B. Liebman, *The End of Health Insurance Companies*, N.Y. TIMES (Jan. 30, 2012, 9:00 PM), https://opinionator.blogs.nytimes.com/2012/01/30/the-end-of-health-insurance-companies/?smid=pl-share [http://web.archive.org/web/20230215225222/https://opinionator.blogs.nytimes.com/2012/01/30/the-end-of-health-insurance-companies/?smid=pl-share].

152. *Compare Medicare Shared Savings Program Saves Medicare More Than $1.8 Billion in 2022 and Continues to Deliver High-Quality Care*, CTRS. FOR MEDICARE & MEDICAID SERVS., (Aug. 24, 2023), https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-saves-medicare-more-18-billion-2022-and-continues-deliver-high [https://perma.cc/KH3B-LME6] (heralding CMS's claim of $1.8 billion in net savings), *with* McWilliams & Chen, *supra* note 21 (questioning the accuracy of CMS's methodology for calculating savings).

153. *Accountable Care Organizations*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Jan. 2023), https://data.cms.gov/medicare-shared-savings-program/accountable-care-organizations [https://perma.cc/R6A8-NRH2].

154. McWilliams & Chen, *supra* note 21.

payments to smaller, potentially less-efficient providers and falls short of imposing meaningful cost savings on the large providers most responsible for the healthcare system's increasing costs.[155]

A key selling point of ACOs is the integration of finance and delivery among a network of providers, but adverse selection stands in the way of achieving that integration at scale. Healthcare districts may solve the selective participation problem by automatically enrolling all providers and individuals to participate in the district's network. Such a mandate creates a new set of challenges when considering the varying interests of individual, hospital, and physician stakeholders.

On one side, individuals are responsible for paying healthcare taxes to pay for their access to the district's provider network and essential health benefits. In their pursuit of quality care at the lowest possible cost, individuals may voice their preferences through choice of provider, district in which to live, and elected directors of the district. In this regard, districts take on qualities resembling special districts.

On the other side, a mix of independently run private for-profit and not-for-profit healthcare providers compete with one another for patients, and they may make different business decisions in light of that competition. To require these providers to join forces might exacerbate provider consolidation and raise antitrust concerns that they might wield too much pricing power in their regional market. In light of this, healthcare districts could take cues from public utilities in the administration of a regulated monopoly on healthcare.

A reasonable objection to the mandated participation of healthcare providers is the restriction on the freedom of private businesses to transact in an open market. With traditional ACOs, providers choose with whom they would form a network; in contrast, healthcare districts bring together all neighboring providers to coordinate. Concerns over the agency of providers are warranted, and it is precisely these concerns that encourage the consideration of the corporate form as a source of inspiration to protect these interests.

The formation of special districts and regulation of corporations are largely functions of state law.[156] When legislating the creation of healthcare

155. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 152 ("Approximately 63% of participating ACOs earned payments for their performance in 2022. ACOs that earned more shared savings tended to be low revenue. Low-revenue ACOs are usually ACOs that are mainly made up of physicians and may include a small hospital or serve rural areas. With $228 per capita in net savings, low-revenue ACOs led high-revenue ACOs, who had $140 per capita net savings . . . .").

156. *See* Jill E. Fisch, *Leave It to Delaware: Why Congress Should Stay Out of Corporate*

districts, state lawmakers will need to consider an organizational form tailored to the idiosyncrasies of healthcare. Whereas the ACO is the archetypal structure from which healthcare districts are designed, the districts must take on characteristics of both public and private entities to overcome the market failures and regulatory shortcomings that otherwise keep ACOs from achieving the integration of finance and delivery at scale today.

A. Public Governance as a Counterweight to Consolidated Provider Market Power

At the center of the ACO adverse selection problem is the gap between, on the one hand, the good governance principles that CMS inspires through incentives for cost-savings, and on the other, the financial motives for avoiding participation in ACOs due to the risk of cost overages. As a means of broad institutional change, MSSP's ACO program is a portrait in weak governance.[157] In the tripartite scheme of healthcare governance between individuals, providers, and government, the government's role in enacting ACOs is more akin to making a series of suggestions than outright rulemaking.[158]

Despite the federal government's soft touch when it comes to pushing providers to participate in a two-way risk MSSP model, industry watchers have raised antitrust concerns over ACOs' potential to exacerbate provider consolidation.[159] Therein lies an inherent conflict within the very concept of the ACO: while ACOs strive to achieve a reduction in costs, they simultaneously enable increased prices by encouraging providers to join forces and reduce competition.[160] With fewer competitors on price, ACOs can theoretically wield more market power and raise prices with impunity.[161]

A conflict thus arose between CMS's encouragement of ACO formation and the Department of Justice's ("DOJ") antitrust enforcement role. Where the two federal agencies stood diametrically opposed, the DOJ capitulated to CMS and issued a policy statement effectively taking a hands-off approach to antitrust enforcement when providers are organized in an

Governance, 37 DEL. J. CORP. L. 731, 732, 733 n.5 (2013).

157. *See* Derick W. Brinkerhoff & Thomas J. Bossert, *Health Governance: Principal-Agent Linkages and Health System Strengthening*, 29 HEALTH POL'Y & PLAN. 685, 689 (2014) (describing the healthcare governance relationships that enable policy adoption and implementation).

158. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 23 (listing the various ACO programs); *see also* Brinkerhoff & Bossert, *supra* note 157, at 689.

159. Greaney, *supra* note 19, at 27–28.

160. *Id*. at 21–22.

161. *Id*. at 27–28.

ACO.[162] Notwithstanding the multitude of market failures that have largely eviscerated price competition in healthcare, the fact remains that a traditional ACO could adopt a one-sided risk model that imposes no risk for cost overages while enjoying the lax antitrust rule enforcement that comes with participating in MSSP.

Provider consolidation was a growing trend in healthcare even before the ACA took effect, but it has ramped up in the years since.[163] In the two-year span between 2016 and 2018, physician affiliation with vertically integrated health systems jumped 11%,[164] and the number has doubled over the past decade.[165] The movement toward vertical integration, in which entities along a supply chain such as doctors and hospitals align under one entity, can be a positive development for cost efficiencies and care coordination. After all, coordination is a central component of the ACO model. But consolidation inevitably results in price increases in the absence of downward cost pressures such as ACO cost sharing and strong antitrust regulation, especially when entities such as nearby hospitals horizontally integrate and cease competition.[166] With ACOs increasingly opting for one-way risk models and the DOJ relaxing antitrust enforcement, the current system does not pose much of a barrier to increased prices.

The Healthcure System's mandate to form provider networks by region would not mark the first time a government sanctioned a geographic monopoly over a particular market. The regulation of public utilities arose from the recognition that some businesses operate in the public interest and regulations would ensure that "all must be served, adequate facilities must be provided, reasonable rates must be charged, and no discriminations must be made" when the free market alone would not.[167] Historically, sectors of

162. Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67026 (Oct. 28, 2011) (outlining the "antitrust safety zone" that ACOs may fall under to avoid challenge from the Department of Justice and Federal Trade Commission).

163. Michael F. Furukawa, Laura Kimmey, David J. Jones, Rachel M. Machta, Jing Guo & Eugene C. Rich, *Consolidation of Providers into Health Systems Increased Substantially, 2016–18*, 39 HEALTH AFFS. 1321, 1322 (2020).

164. *Id*.

165. Soroush Saghafian, Lina D. Song, Joseph P. Newhouse, Mary Beth Landrum & John Hsu, *The Impact of Vertical Integration on Physician Behavior and Healthcare Delivery: Evidence from Gastroenterology Practices* 1–2 (Nat'l Bureau of Econ. Rsch., Working Paper No. 30928, 2023), https://www.nber.org/system/files/working_papers/w30928/w30928.pdf [https://web.archive.org/web/20230329184025/https://www.nber.org/system/files/working_papers/w30928/w30928.pdf].

166. Karyn Schwartz, Eric Lopez, Matthew Rae & Tricia Neuman, *What We Know About Provider Consolidation*, KAISER FAM. FOUND. (Sep. 2, 2020), https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation [https://perma.cc/G637-28XP].

167. 1 BRUCE WYMAN, THE SPECIAL LAW GOVERNING PUBLIC SERVICE CORPORATIONS AND ALL OTHERS ENGAGED IN PUBLIC EMPLOYMENT xi (1911).

public interest, such as transportation, communications, electricity, and water, invited regulation as utilities when they were dominated by large businesses with enough market power to exploit customers.[168] The similarity of circumstances in healthcare today has raised the question of whether medicine should be regulated as a public utility.

The difficulty with applying public utility regulation to medicine lies with its traditional business model: while its rates and service may be mandated by the government, a utility remains a private business that charges a rate based on use.[169] For instance, an electricity company may be required to supply energy to all homes in a given region. Not all of those homes may choose to purchase that energy, however, and if they do, they pay an amount proportionate to the amount they consume.[170] In healthcare, pay-per-use is fraught with complications, most prominently the information asymmetry problem that keeps patients from fully understanding their healthcare services and costs.[171] Patients are simply not equipped to make many choices about constraining their use of healthcare services, especially when they occur in emergency situations.

In the bargain between public utilities and their regulating agencies is the grant of a monopoly to provide services in a given region in exchange for a duty to serve everyone, often at certain price levels.[172] The monopoly bestows exclusive access to the market and ensures supply to the populace, but it does not compel demand. Consumers are not required to purchase the services or purchase a certain amount. To do so could run afoul of the Supreme Court's Commerce Clause analysis in *Sebelius*, which would have

168. Nicholas Bagley, *Medicine as a Public Calling*, 114 MICH. L. REV. 57, 62 (2015).

169. A.J.G. Priest, *Possible Adaptation of Public Utility Concepts in the Health Care Field*, L. & CONTEMP. PROBS. 839, 840 (1970). There is a burgeoning movement to change the ways in which utilities charge their customers, though, that augments the traditional pay-by-use model. California lawmakers passed legislation, AB 205, that imposes an income-based fee on ratepayers' electricity bills. Jason Fordney, *Legislature Passes Sweeping Energy Bill, Angering Environmentalists, Localities*, CAL. ENERGY MKTS. (Jul. 1, 2022), https://www.newsdata.com/california_energy_markets/regional_roundup/legislature-passes-sweeping-energy-bill-angering-environmentalists-localities/article_903b5ed2-f97a-11ec-8f61-bb515331ac82.html [https://perma.cc/KHP9-8C9N]. In theory, the fixed charges would allow the utilities to charge less per kilowatt-hour, ultimately reducing the total electricity bill of low and middle-income customers. Rob Nikolewski, *A New Charge Is Coming to Your Electric Bill. Will It Make California Rates More Affordable?*, L.A. TIMES (Apr. 11, 2023, 3:17 PM), https://www.latimes.com/business/story/2023-04-11/a-fixed-monthly-charge-is-coming-to-your-electric-bill-will-it-make-caifornia-rates-more-affordable [https://perma.cc/DNB5-9SMR]. There remain questions about how the investor-owned utilities will confirm ratepayer income levels, and the California Public Utilities Commission will consider proposals regarding the dollar amounts of the charges before instituting them in 2025. *Id*.

170. Koichiro Ito, *Do Consumers Respond to Marginal or Average Price? Evidence from Nonlinear Electricity Pricing*, 104 AM. ECON. REV. 537, 553–54 (2014) (describing household price elasticity in the electricity market as a function of reduced consumption in the face of perceived price).

171. Bagley, *supra* note 168.

172. *Id*. at 61.

struck down the individual mandate to purchase health insurance as an overstepping of Congress's authority had it not been deemed a form of taxation.[173] It is in this respect that the public utility model falls short of its usefulness in a healthcare system that provides universal coverage—the model must reckon with the public's expectations of electoral accountability in the face of taxation.

The inextricable relationship between taxation and voting traces its roots to an early moment in American history when colonists protested their lack of electoral representation by turning Boston Harbor into the world's largest teacup.[174] One can imagine the fervor with which Americans might destroy crates of stethoscopes and gauze bandages in protest of healthcare taxes without a say in how those taxes are spent. The establishment of a specialized entity that lays taxes and delivers services to a particular population naturally invokes a governmental structure—in particular, the ubiquitous local public entities such as school districts and water districts. These special districts are generally governed by a board of elected representatives charged with hiring managers, monitoring the quality of services rendered, and tending to the responsible expenditure of public funds.[175] When applied to the concept of a healthcare district, the election of directors carries the potential to apply accountability measures that, in tandem with improved consumer price sensitivity, can impose downward cost pressures that counteract the market power of consolidated providers.

The public election of a district's board of directors is a step toward accountability, but it begs the question: Accountability to whom? In theory, popularly elected directors stand to lose their jobs should taxes exceed what constituents deem acceptable or services fail to meet the desired level of quality. Directors always face the possibility that constituents may vote them out of office. These are conditions under which directors are seemingly

173. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 588 (2012) ("[The Commerce] Clause authorizes Congress to regulate interstate commerce, not to order individuals to engage in it. In this case, however, it is reasonable to construe what Congress has done as increasing taxes on those who have a certain amount of income, but choose to go without health insurance.").

174. *Proportional Representation*, HIST., ART & ARCHIVES, https://history.house.gov/Institution/Origins-Development/Proportional-Representation [https://perma.cc/6RMT-PBDP] ("American colonists, who were used to controlling their local affairs in the directly-elected colonial legislatures, lacked a voice in Parliament and resented the British policies imposed on them. Thus, they rallied behind the now familiar motto: 'No taxation without representation!' . . . Since constitutional framers had to provide for the funding of the new government, they debated the proper relationship between representation and taxation . . . . Delegates [] settled on proportional contributions based on population, and, by extension, the number of Members in the House of Representatives.").

175. MELISSA J. BRAYBROOKS, TINA HIGHFILL & DYLAN G. RASSIER, ACCOUNTING FOR SPECIAL DISTRICT GOVERNMENTS IN THE U.S. NATIONAL ACCOUNTS 1–2 (2018), https://www.bea.gov/index.php/system/files/papers/WP2018-14.pdf [https://web.archive.org/web/20190514222523/https://www.bea.gov/index.php/system/files/papers/WP2018-14.pdf].

incentivized to govern in a manner that is responsive to voter concerns. Indeed, free and fair elections are a hallmark of American democratic governance but so is the pervasive influence of special interests in the electoral process. Individuals do not comprise the entirety of the stakeholder population with an interest in a healthcare district's decision-making. Providers, and the healthcare industry as a whole, will almost assuredly seek political influence to promote their interests. Such influence peddling can range from the standard fare of lobbyists sharing their expertise to financial contributions to candidates. It is the latter activity that concerned Reinhardt and led him to reject a single-payer model at the federal level "because [the United States federal] government is too corrupt. Medicare is a large insurance company whose board of directors (Ways and Means and Senate Finance) accept payments from vendors to the company. In the private market, that would get you into trouble."[176] A purely governmental form does not appear wise when a taxing entity is susceptible to corrupt influence and capable of generating profits. Additional measures are in order to best ensure individuals' interests remain protected.

B. DRAWING ON PRIVATE ORGANIZATIONAL FORMS TO BALANCE STAKEHOLDER INTERESTS

A board of directors elected at the local level can be responsive to the ethical concerns of the electorate and its preferences regarding the allocation of resources.[177] Yet corruption, or even just the undue influence of interests other than that of individual voters, can stand in the way of public accountability.[178] This is only of concern if the interests of the public and the third-parties are not aligned, and providers' interest in financial rewards stand to do just that.

As envisioned here, healthcare districts do not force providers to take on nonprofit status. The Healthcure System takes a general approach of noninterference with for-profit providers, recognizing that the pursuit of profits, when earned legitimately and not by taking advantage of market failures, may incentivize innovation and new efficiencies.[179] In Part IV, this Note instead proposes an aligned incentives payment structure that rewards providers for delivering on cost savings and outcomes measures.

176. REINHARDT, *supra* note 3, at 153.
177. *See* Brinkerhoff & Bossert, *supra* note 157.
178. *See id*.
179. Harold S. Luft, *Economics Incentives to Promote Innovation in Healthcare Delivery*, 467 CLINICAL ORTHOPAEDICS & RELATED RSCH. 2497, 2503 (2009).

While purely governmental entities are not profit-making ventures, it is not as though governments do not transact with private, for-profit entities.[180] Taxpayer dollars provide profits to contractors regularly.[181] Yet, contractors willingly enter the public bidding process for government contracts with some expectation of their profit margins at the outset, and if the business proposition does not meet their business objectives, they can refrain from participating in the competitive bid.[182] Here, a governmental structure does not suffice for healthcare districts because the relationship between districts and providers is not a contractual one entered into voluntarily. To realize the goals of aligned incentives and accountability, the Healthcure System devises that all providers retain their organizational form while uniting under the single healthcare district entity in which they share a financial stake. Because healthcare districts compel providers to provide services (to avoid the adverse selection problem of ACOs) and control their payment, providers lose a great deal of their pricing power. Although the districts can attempt to offset the pricing restrictions with promises of increased scale, it is nevertheless reasonable to expect that providers will seek to maximize their financial reward with the highest possible incentive payments.

Thus, an incentive payment model cannot fully rectify the tension between public interest and provider profit motive. The public utility model excels in accommodating a regulated monopoly that provides services in the public interest, but it fails to fulfill the need for electoral representation of a public taxed for their healthcare costs. The special district model does a better job of incorporating democratic ideals into the provider of specialized public services, but it cannot accommodate the profit-generating motive that some providers inevitably seek, such as individual physicians' practices.

Where public entities fall short of balancing stakeholder interests, state legislators can look to variations on private organizational forms for guidance.

1. Allocating Rights and Responsibilities Between Patients and Providers

The underpinnings of the Healthcure System's financial model are an amalgamation of seemingly conflicting revenue collection and distribution streams that do not lend themselves to a cut-and-dry organizational form. Starting with the residents of a healthcare district, individual tax payments

180. Jody Freeman, *The Private Role in Public Governance*, 75 N.Y.U. L. REV. 543, 595 (2000).

181. *See, e.g.*, Paul Toscano, *The 10 Biggest U.S. Government Contractors*, CNBC (Jan. 29, 2014, 2:57 PM), https://www.cnbc.com/2011/04/08/The-10-Biggest-U.S.-Government-Contractors.html [https://perma.cc/D5SA-WUXR].

182. *Understanding the Government Solicitation Bid Package*, FED. DEPOSIT INS. CORP. 3, 3–4, https://www.fdic.gov/about/diversity/sbrp/52.pdf [https://perma.cc/X9RJ-D55Z].

form the inflow of capital with which a district procures healthcare services. All told, a district's residents are stakeholders as (1) financial supporters, (2) beneficiaries of its services, and (3) electors of its board of directors. Once a healthcare district collects taxes, it distributes funds to private provider entities. All healthcare providers in the region are likewise stakeholders, as they (1) provide services to residents, (2) operate under the governance of the district's board of directors, (3) receive funding from the district, and (4) share in the gains and losses of the district.

Yet, where one party has voting rights to elect a board of directors, and another lacks that right but bears exposure to the financial decisions the board makes, there arises a principal-agent problem.[183] The question then turns to how to legally organize such an entity.

In the private sector, the corporate form offers a number of options for interested parties to organize around a shared mission. Like governments, corporations are governed by representatives elected by a constituency of interested parties.[184] Those parties—the holders of shares of ownership in the corporation—need not retain the same rights and responsibilities as one another.[185] When for-profit corporations wish to assign different rights to different shareholders, they may issue preferred stock or create a dual-class share structure.[186] As such, certain shareholders may have priority over others when it comes to receiving financial distributions from the corporation, or they may have the right to vote on certain business matters that other classes of shareholders do not.

Ultimately, though, shareholders are owners of the corporation, and to regard individuals and providers as "owners" of a healthcare district opens the door to questions about the relative amounts of shares they hold and whether they can be transferred.[187] The concept of owning an entity that has the power to tax and regulate an industry confers power that would undermine electoral accountability to the public.

Other forms also offer distinct benefits but ultimately fail in their application to healthcare districts. A partnership, for instance, offers even more flexibility to cleave apart interested parties into distinct,

183. John Armour, Henry Hansmann & Reinier Kraakman, *Agency Problems, Legal Strategies, and Enforcement*, HARV. JOHN M. OLIN CTR. LAW, ECON. & BUS. 3 (2009).

184. Julian Velasco, *The Fundamental Rights of the Shareholder*, 40 U.C. Davis L. Rev. 407, 417 (2006).

185. Dhruv Aggarwal, Ofer Eldar, Yael V. Hochberg & Lubomir P. Litov, *The Rise of Dual-Class Stock IPOs*, COLUM. L. SCH. BLUE SKY BLOG (Apr. 21, 2021), https://clsbluesky.law.columbia.edu/2021/04/21/the-rise-of-dual-class-stock-ipos [https://perma.cc/BDB6-A9WJ].

186. *Id*.

187. *See* Velasco, *supra* note 184, at 437.

nonoverlapping roles. Hypothetically, a healthcare district could make individuals partners or members of the manager-managed organization. These members can then assign their rights to distributions to providers while retaining their management rights.[188] An analog to the public's role in a corporation might be a limited shareholder with a subscription (accounting for tax payments as the subscribed consideration) and retained voting rights but assigned distribution rights to providers. Another possible route for potential exploration is the treatment of providers as creditors to the healthcare district, or a complex contractual (or "contractarian") relationship that binds individuals, providers, and districts, thereby avoiding the corporate form altogether.[189]

This futile exercise represents a microcosm of an ongoing debate in health law. Clearly, a healthcare district is not conducive to cleanly applying a preexisting public or private form, but in light of the struggle between patient and provider interests, the healthcare industry has grappled with the limits of organizational forms for decades.[190] This is where a public-private partnership delivers useful inspiration.

Federal and state governments have established a variety of instrumentalities that skirt the line between public entity and private business. Although the United States has traditionally shunned the kinds of government-owned corporations that are prevalent in other parts of the world,[191] federal corporations are still prominent fixtures in American life.[192] Amtrak is one such quasi-corporation,[193] as are government-sponsored

188. *See* RUPA § 503(a) (NAT'L CONF. UNIF. STATE L. 2015).

189. *See* Velasco, *supra* note 184, at 443.

190. *See, e.g.*, APRIL HARDING & ALEXANDER S. PREKER, UNDERSTANDING ORGANIZATIONAL REFORMS: THE CORPORATIZATION OF PUBLIC HOSPITALS 14–16 (Sept. 2000), https://documents1.worldbank.org/curated/pt/905371468780563628/pdf/288770Harding11Organizational1whole.pdf [https://perma.cc/ALT2-YBPV].

191. Curtis J. Milhaupt & Mariana Pargendler, *Governance Challenges of Listed State-Owned Enterprises Around the World: National Experiences and a Framework for Reform*, 50 CORNELL INT'L L.J. 473, 487 (2017).

192. Kevin R. Kosar, *Federal Government Corporations: An Overview*, CONG. RSCH. SERV. 7 (June 8, 2011), https://sgp.fas.org/crs/misc/RL30365.pdf [https://perma.cc/LD8G-JX8M].

193. The Federal Railroad Administration describes Amtrak as a "for-profit corporation" created by Congress and incorporated in Washington, D.C. *Amtrak*, U.S. DEP'T OF TRANSP. FED. R.R. ADMIN., https://railroads.dot.gov/passenger-rail/amtrak/amtrak [https://perma.cc/MM67-QBQF]. In 2015, the Supreme Court had to weigh in on Amtrak's status as a public or private entity:

> [F]or purposes of Amtrak's status as a federal actor or instrumentality under the Constitution, the practical reality of federal control and supervision prevails over Congress' disclaimer of Amtrak's governmental status. . . . The political branches created Amtrak, control its Board, define its mission, specify many of its day-to-day operations, have imposed substantial transparency and accountability mechanisms, and, for all practical purposes, set and supervise its annual budget. Accordingly, the Court holds that Amtrak is a governmental entity, not a private one . . . .

Dep't of Transp. v. Ass'n of Am. R.Rs., 575 U.S. 43, 54–55 (2015) (citations omitted).

enterprises like the Federal National Mortgage Association (Fannie Mae) and the Federal Home Loan Mortgage Corporation (Freddie Mac).[194] Unlike a special district, a government corporation can be "[a] self-funding, self-perpetuating, profit-making corporation [that] enjoys a degree of potential, and perpetual, independence undreamed of in most agencies."[195] Some of these entities feature characteristics particularly useful for the conception of healthcare districts, such as the ability to distribute dividends and a mixed ownership structure split between a preferred-stock-holding government and common-stock-holding private investors.[196] While the latter opens up a world of possibilities with respect to organizing private healthcare providers in healthcare district, it simultaneously raises questions over who and what guides the district's decision-making.

The distribution of interests and rights presents healthcare districts with a distinct principal-agent problem, or perhaps stated more accurately, a principal-agent-principal problem.[197] When those principals have different interests, or "heterogenous preferences," they must reckon with coordination costs in the form of agents' difficulty with determining the right goals.[198] Confronted with such agency costs, organizations generally look to legal constraints on agents and corresponding enforcement mechanisms.[199] This Note will next explore the bounds of a healthcare district's director's role in light of their principals' heterogenous preferences, asking whether directors can simultaneously act in the best interests of both individuals and providers.

2. Fiduciary Duties of Directors and Stakeholder Health Maximization

The election of a public official often involves what political scientists call a "mandate," or the set of policy priorities that form a candidate's platform and which the candidate is expected to implement upon election.[200] Elected officials are often judged by how they deliver on the promises they

194. Milhaupt & Pargendler, *supra* note 191, at 490.

195. A. Michael Froomkin, *Reinventing the Government Corporation*, 1995 U. ILL. L. REV. 543, 560.

196. *Senior Preferred Stock Purchase Agreements*, FED. HOUS. FIN. AGENCY, https://www.fhfa.gov/Conservatorship/Pages/Senior-Preferred-Stock-Purchase-Agreements.aspx [https://perma.cc/9JAK-TTJ2].

197. Armour et al., *supra* note 183.

198. *Id.*; *see also* Yueh-Ping (Alex) Yang, *Government Ownership of Banks: A Curse or a Blessing for the United States?*, 10 WM. & MARY BUS. L. REV. 667, 681 (2019) (citations omitted) ("Government corporations are incorporated by Congress through special charter laws to pursue certain governmental objectives. While they are in corporate form, and some of them are even publicly traded companies, their operation often implicates other social or policy goals that are beyond commercial purposes; this complicates the corporate governance of government corporations.").

199. *Id.*

200. Gregg B. Johnson & Brian F. Crisp, *Mandates, Powers, and Policies*, 47 AM. J. POL. SCI. 128, 128 (2003).

made to voters on the campaign trail. Should they fail, they may lose reelection or even a recall election.

The elected representatives of corporations are guided by the ubiquitous and often legally enforced commitment to "shareholder wealth maximization" or "shareholder primacy."[201] Delivering value to shareholders is the utmost concern, and a failure to adhere to this principle could result in liability for breach of fiduciary duty.[202] The representatives of nonprofit corporations, on the other hand, are guided by the organization's mission.[203] Directors are generally motivated, at least in large part, by an interest in maintaining tax-exempt status and adhering to the nonprofit's stated mission in its articles of incorporation and IRS filings.[204]

The goals of a for-profit corporation and a nonprofit organization are not difficult to discern. But what if an entity comprises both? How should a board of directors square the push and pull of seemingly competing goals?

Healthcare today is dominated by entities that, on paper, appear to be either for-profit or nonprofit, but the rapid growth of nonprofit hospitals has blurred the line between them. The lack of an explicit profit motive does not stop nonprofit hospitals from generating enormous revenue exceeding their costs—but instead of distributing the funds to shareholders, they must instead reinvest the funds.[205] ACOs particularly struggle with the conflicts of differing business models because their provider networks may consist of a mixture of for-profit and nonprofit entities.[206] The Healthcure System proposed here is no different.

In an era of skyrocketing healthcare costs, health law experts have begun to reevaluate organizational forms in healthcare to better accommodate missions beyond shareholder wealth maximization. The public benefit corporation is a form available in some states, and it allows corporations to augment shareholder wealth maximization and express an additional mission.[207] The form essentially provides "cover" to directors in

201. Bernard S. Sharfman, *Shareholder Wealth Maximization and Its Implementation Under Corporate Law*, 66 FLA. L. REV. 389, 393 (2014).

202. *Id*. at 397.

203. Melanie Lockwood Herman, *The Top 10 Legal Risks Facing Nonprofit Boards*, VENABLE LLP (Feb. 2011), https://www.venable.com/insights/publications/2011/02/the-top-10-legal-risks-facing-nonprofit-boards [https://perma.cc/7GQ9-FUWA].

204. *Id*.

205. Derek Jenkins & Vivian Ho, *Nonprofit Hospitals: Profits and Cash Reserves Grow, Charity Care Does Not*, HEALTH AFFS. (June 2023), https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.01542 [https://perma.cc/CP65-A3Q7].

206. Terry L. Corbett, *Healthcare Corporate Structure and the ACA: A Need for Mission Primacy Through a New Organizational Paradigm?*, 12 IND. HEALTH L. REV. 103, 167 (2015).

207. Terry L. Corbett, *The Case for a Health Care Benefit Corporation*, 47 CAP. U. L. REV. 183,

the event that shareholders bring a lawsuit alleging a breach of fiduciary duty for taking actions not in the interest of shareholder wealth maximization.[208] If the directors can point to a stated mission of the public benefit corporation as the motivating factor behind a challenged action, they will be shielded from liability.[209]

A full exploration of alternative corporate forms reaches far beyond the scope of this Note, but to the extent that some bear on healthcare, it will be useful to acknowledge prior efforts to develop novel forms. Dayna B. Matthew argued for a "fiduciary medicine model" that imposes new fiduciary duties on health care organizations, such as considerations of larger systemic duties and an expansion of fiduciary law to modern health care delivery systems.[210] Terry Corbett articulated a new legal form for ACOs based on the benefit corporation form. This form, the health care benefit corporation ("HCBC"), promotes accountability through legally enforceable mission primacy that can supersede the pursuit of profits.[211]

Accountability measures may even be found in antitrust. Rather than combat consolidation outright, the Healthcure System brings providers together and seeks downward price pressures elsewhere. This would seem to throw antitrust enforcement mechanisms out the window, such as blocking mergers or forcing divestitures in closely competing entities, but antitrust principles may serve some use when considering the role of the board of directors.[212] Accordingly, "conduct remedies" that pertain to the behavior of consolidated entities can protect against price increases in the absence of traditional structural remedies.[213] For instance, states may direct healthcare districts to set an overall expenditure growth target that can be tied to the region's economy and enforced by the state attorney general's office as part of its antitrust enforcement.

Ultimately, though, the Healthcure System offers its own theory on which to base director fiduciary duties: what this Note calls "stakeholder health maximization." Intentionally analogous to shareholder wealth maximization, stakeholder health maximization would be the paramount aim

282, 231 (2019).

208. *See id*. at 222.

209. *Id*.

210. *Id*. at 305.

211. Corbett, *supra* note 207, at 312 ("[T]hose who use the corporate form of organization to provide such health care must be held to legally-enforceable fiduciary duties to do so in furtherance of an explicitly-stated social mission that necessarily trumps any unlimited right by the enterprise to 'profit' beyond certain specified constraints.").

212. David M. Cutler & Fiona Scott Morton, *Hospitals, Market Share, and Consolidation*, 310 JAMA 1964, 1969 (2013).

213. *Id*.

of healthcare district directors and is intended to orient their decision-making toward the constant improvement of health outcomes. Every decision, at its core, must be grounded in an effort to positively impact the health of the community. Cost savings, for instance, can be justified under stakeholder health maximization because the reduction of costs allows for improved allocation of scare resources: additional funds mean more people can get more care and better care. Conversely, efforts by providers to extract higher incentive payments without a justification based on health outcomes result in waste that would otherwise fund care.

With stakeholder health maximization as its guide, a healthcare district's board of directors can navigate the distinct interests of its stakeholders with a potentially reduced risk of conflict. It is a path forward for balancing the three pillars of cost, quality, and access, even when stakeholders might push to prioritize one pillar over the rest. That is, as long as boards remain answerable to their constituents.

Director fealty to the public is as much an open question in elections of Congress as it is in the proposed healthcare district. There is no easy answer. The Supreme Court has made it clear that there is no path for constraining the rights of business entities such as for-profit healthcare providers to engage in political speech.[214] Ultimately, representative governance requires trust in the democratic process, and while the Healthcure System certainly relies on that trust, it is bolstered by protections such as stakeholder health maximization and an incentive payment model to help ensure that patient and provider interests are aligned.[215]

V. QUALITY: ALIGNING THE INCENTIVES OF PROVIDERS AND PATIENTS TO DRIVE COST-EFFECTIVE, VALUE-BASED CARE

For the purposes of this Note, quality refers to both the scope of benefits available to individuals as well as the health outcomes of those benefits. Up to this point, this Note has explored the tax-based revenue stream and novel governance model of healthcare districts, but it has yet to describe how these features translate to cost savings and outcomes improvements. The third and final piece of the Healthcure System directly addresses the misaligned incentives of the traditional fee-for-service provider reimbursement model by replacing it with a three-part outcomes-based incentive structure.

A century's worth of refinement of the managed care model and the recent piloting of ACOs have led to a moment in which the healthcare system

214. *See* Citizens United v. FEC, 558 U.S. 310, 350–51 (2010).

215. *See* Brinkerhoff & Bossert, *supra* note 157, at 689 (explaining how local accountability institutions such as municipal health councils reduced corruption in other countries).

can finally capitalize on the cost-efficiencies of vertical integration. Doing so will require the full participation of providers in the risk and reward to counteract the adverse selection and moral hazard problems that plague the system today.[216] The Healthcure System's approach to healthcare payment reform draws on an integrated model that has been successfully implemented in California for over seventy-five years by the nonprofit health system Kaiser Permanente ("KP").[217]

KP is made up of three separate entities linked together by exclusive contract to share financial incentives, coordinate care, and manage the health of a population. These entities—the not-for-profit Kaiser Foundation Hospitals ("KFH"), the for-profit medical groups (made up of physicians), and the not-for-profit Kaiser Foundation Health Plan (the insurance company)—share board members and leadership to seamlessly coordinate the allocation of capital between them.[218] The KP model explicitly rejects fee-for-service and its unnecessary incentive on increasing quantity of services over quality, instead using a capitated model of payment. The capitation system consists of the health plan making monthly payments of a set dollar amount calculated per enrollee, regardless of whether they seek services.[219]

If this arrangement sounds familiar, it is because the KP model is one of the earliest in a long lineage of managed care models that counts ACOs and the Enthoven-inspired Health Security proposal of the 1990s as siblings.[220] This Note proposes a further refinement on the model, adding the layers of electoral accountability and novel governance as previously discussed, as well as a dividend payment scheme that emphasizes the shared responsibility of health within a particular region.

Under the Healthcure System's stakeholder health maximization model, payments to providers consist of capitated payments as well as back-

216. *See supra* Section II.A.

217. JESSE PINES, JEFF SELEVAN, FRANK MCSTAY, MEAGHAN GEORGE & MARK MCCLELLAN, KAISER PERMANENTE—CALIFORNIA: A MODEL FOR INTEGRATED CARE FOR THE ILL AND INJURED 3 (2015), https://www.brookings.edu/wp-content/uploads/2016/07/KaiserFormatted_150504RH-with-image.pdf [https://perma.cc/XE56-GLNG].

218. *Integrated Care Stories Overview*, KAISER PERMANENTE INST. HEALTH POL'Y, https://www.kpihp.org/integrated-care-stories-overview [https://perma.cc/3UNQ-XY6P].

219. ERIC HAMMELMAN, NARDA IPAKCHI, JENNIFER SNOW & BOB ATLAS, REFORMING PHYSICIAN PAYMENTS: LESSONS FROM CALIFORNIA 1 (Sept. 2009), https://digirepo.nlm.nih.gov/master/borndig/101530869/ReformingPhysicianPaymentsLessonsFromCA.pdf [https://perma.cc/P3VX-2S4X].

220. Suzanne F. Delbanco, *The Payment Reform Landscape: Capitation with Quality*, HEALTH AFFS. BLOG (June 6, 2014), https://www.healthaffairs.org/do/10.1377/hblog20140606.039442/full [https://perma.cc/2MRF-HZB8]; John Hubner, *The Abandoned Father of Healthcare Reform*, N.Y. TIMES MAG. (July 18, 1993), https://www.nytimes.com/1993/07/18/magazine/the-abandoned-father-of-healthcare-reform.html [https://web.archive.org/web/20221217033907/https://www.nytimes.com/1993/07/18/magazine/the-abandoned-father-of-healthcare-reform.html].

end payments based on outcomes and cost savings. The capitated payments provide hospitals a lump sum per event, and the provider then bears the cost of all services rendered during the patient's event. But incentives to keep costs as low as possible can only serve a partial role in delivering an aligned-incentives payment structure. On their own, capitated payments can incentivize "bare minimum" treatment that would fulfill a district's essential health benefits guarantee but disincentivize a great deal of innovative, risky, or even preventive treatments. Furthermore, there will surely be instances when an individual's course of treatment exceeds the capitated payment a provider receives. While this is a risk the system is designed to handle, the system should equally incentivize providers to go above and beyond with their treatment and reward them when successful. Accordingly, the Healthcure System includes back-end payments in two forms: (1) event-based outcomes incentive payments and (2) regional dividends based on the overall population's health benchmarks. Event-based incentives offer payments based on each service provided to a patient. Suppose a doctor's treatments for a patient exceed the capitated payment for a particular illness, but they successfully treat the illness. The event-based outcomes incentive makes the treatment a financially sustainable one. The incentive payments may be calculated using similar formulas to those employed by the Medicare Quality Payment Program Merit Based Incentive Payments System.[221] But even worthwhile treatments may not always be successful, and there are strong policy reasons for encouraging best practices on a macro scale. Regional dividends reward providers for positive health trends across a community. Such dividends can encourage providers to collaborate and promote wellness beyond their particular practice. Moreover, the state or federal government may make additional adjustment payments in certain cases, such as rural healthcare districts, low-income districts, or catastrophic regional events such as natural disasters.

The result is a multi-payer, universal access healthcare system that ensures providers' basic costs are covered, with downward price pressure to keep those costs as low as possible, while rewarding positive health outcomes and best practices with incentive payments from healthcare districts.

221. *MACRA*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs [https://perma.cc/Q4TQ-2HD2].

VI. PRACTICAL CONCERNS OF IMPLEMENTING HEALTHCARE DISTRICTS

The Healthcure System model proposed in this Note is nothing short of a radical rethinking of the overall structure of the healthcare system. To implement it on a state or even national scale would likely mean a reform package even larger than the ACA. As such, there are a number of practical barriers that would need to be overcome for a successful transition to take place.

This Note provides a general overview of the basic structure of the Healthcure System and a broad survey of the economic, legal, and policy considerations it implicates. Additional study will yield a better understanding of its practical applications, particularly through empirical modeling of its operation in various regions. Another topic for exploration is the refinement of formulas with which to draw healthcare districts, calculate healthcare tax rates, set incentive and dividend payment rates, and determine the startup funding necessary for regions to transition into healthcare districts.

The Healthcure System involves a litany of issues of state law, further increasing the challenge of consistent deployment across the United States. One can look to the resistance of states to participate in the Medicaid expansion of the ACA as a preview of the challenge ahead.[222] Even financial support from the federal government may not be enough to convince some states to adopt the plan, especially if it is seen as a comparable expansion of coverage through a public program. A related objection is the Healthcure System's reliance on community rating instead of an actuarial fairness approach that attempts to price healthcare based on use.

Another topic ripe for exploration is the role of Medicare and Medicaid in the model proposed here. The MSSP's ACO program served as a jumping-off point for the Healthcure System, but the scope of this Note does not include how it might incorporate or augment Medicare or Medicaid. Further study could evaluate whether there are additional efficiencies to be found by merging the public insurance programs with the Healthcure System.

Perhaps the single most significant objection to the Healthcure System is the general resistance to a substantial disruption to the healthcare system. Voters were so concerned that the ACA would make them change their health insurance that President Obama made the promise, "If you like your

222. *See* Selena Simmons-Duffin, *12 Holdout States Haven't Expanded Medicaid, Leaving 2 Million People in Limbo*, NPR (July 1, 2021, 5:00 AM), https://www.npr.org/sections/health-shots/2021/07/01/1011502538/12-holdout-states-havent-expanded-medicaid-leaving-2-million-people-in-limbo [https://perma.cc/NT2B-9KF4].

health care plan, you'll be able to keep your health care plan" a central part of his pitch.[223] This Note's proposal upends healthcare by design. It is an effort to stave off unsustainable increases in healthcare costs by correcting market failures that are endemic to the status quo. A possible approach to easing the transition might be a gradual implementation of healthcare districts over a period of years, offering incentives to individuals who join early before all are eventually enrolled. Of course, this presents its own host of problems, namely a selective participation problem in which the risk pool may be concentrated with higher-risk individuals. A sound implementation plan would stave off such concerns by making every effort to allow individuals to keep their doctors, thereby reducing an otherwise significant barrier to enrollment.

CONCLUSION

This Note calls its proposed model the Healthcure System because it represents a fundamental fix to some of the most pervasive economic failings of healthcare in the United States. The Healthcure System aims to create downward pressures on cost by introducing three accountability measures: (1) accountability through price-elastic demand; (2) accountability to a population of voters; and (3) accountability through the aligned interests of stakeholders in an incentive payment structure. It does so by setting forth a novel organizational form that uniquely caters to the interest of patients and providers, and guides healthcare district directors to govern in the name of stakeholder health maximization. Although it would represent a monumental reform with an undoubtedly difficult challenge of federal and state lawmaking, the Healthcure System's regional approach to universal healthcare access and reduced costs could finally deliver broad access, low cost, and high-quality healthcare to an ailing and priced-out America.

223. *Obama: 'If You Like Your Health Care Plan, You'll Be Able to Keep Your Health Care Plan,'* POLITIFACT, https://www.politifact.com/obama-like-health-care-keep [https://perma.cc/AN8M-K9U9].