Written By Ron E. Peck

THE TOWER OF BABEL – TALKING HEADS TALKING PAST EACH OTHER

As the 2020 Presidential Election draws closer, the topic of healthcare continues to dominate the airwaves. Be it media or debate, this is one of the (if not the) issues about which everyone is talking; but pay close attention and you'll notice they aren't all speaking the same language.

ACCESS VS. CARE VS. INSURANCE

One word everyone can agree upon is "affordability." The issue, however, is that depending upon whom you ask, what it is that ought to be "affordable" differs. Some people throw the term "access" around, while others seek affordable "care," whilst still others focus (candidly) on affordable insurance.

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Interestingly, for many, the term they use (access versus healthcare) matters little, as – once their position is better defined – a shrewd listener will note that the goal is ultimately the same; make insurance cheaper. They seem to believe that insurance is healthcare, and cheaper insurance is thereby cheaper healthcare. Further, they believe that the only "cost" of healthcare, incurred by an insured person is their premium, co-pay, coinsurance, and deductible.

This, then, is one misconception that continues to dominate political, regulatory, and economic discourse; that by attacking the cost of insurance for the general populace (i.e. premiums/contributions, co-pays, coinsurance, and deductibles), you somehow fix the problem of limited access and/or the high cost of healthcare.

HEALTH INSURANCE IS NOT HEALTHCARE

I've written in the past, and continue to argue today, that health insurance is not healthcare. Health insurance is one means by which the risk of payment for healthcare is shifted from the consumer of healthcare to a third-party payer. Changing who pays for healthcare doesn't (on its own) address how much the healthcare costs. For instance, before you argue that Congress should establish a funding mechanism to support the "cost of caring" for those with significant medical needs, ask first what it means to pay for care. Are you referring to the cost of insurance, or the cost of the "actual" health care for which insurance pays?

Some might argue, however, that when a "new" payer is designated, (be it insurance, a self-funded plan, or the government), if they are large enough and possess enough clout, they can strongarm the provider into accepting lower prices for care – thereby reducing the actual cost of care. Thus, while making insurance more affordable doesn't in and of itself reduce the cost of care, by providing more lives (and this negotiation power) to the payer, those payers in turn are provided with more "power" to force providers into accepting lower prices. Indeed, a single-payer would hold all the cards, and thus name their own price.

In a vacuum it makes sense, and if we were purchasing potatoes or tires it may work (in a truly free-market environment), however, in healthcare some features apply that are unique to this industry.

A NON-MARKET MARKET

In any other market, a vendor of goods or services can set any price for those goods or services. Supply, demand, and competition will then force the vendor to increase or reduce their price or fail. This allows the "free market" to naturally set prices at a level both the seller and buyer can live with.

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In healthcare, however, providers leverage things like technology, reputation, rankings, and sponsorships to compete for "customers" (a/k/a patients), rather than the price. Providers compete for these other things; if and when price is a matter over which there is competition between vendors (providers), it's a competition to see who can charge the most.

Indeed, one of the big pushbacks against transparent pricing in healthcare is that some providers will see that other providers "get away" with charging higher prices for the same services … and will increase their rates to match. Imagine if that same argument applied to every other industry; that the cost of bananas couldn't be transparent, because grocers will compete to raise prices faster than the competition. Welcome to a world where the consumer has no skin in the game, and no price-based incentive to pick the lower cost options exists.

In healthcare, where patients don't know, or (they think) pay the price of healthcare (at the time the care is consumed), and the consumer doesn't appreciate the impact of higher healthcare prices on insurance costs, providers are able to freely raise prices without the negative repercussions vendors in other industries would immediately suffer.

Additionally, even if patients know the price, if they (at least in their mind) don't think they are the ones paying the price, then higher prices will – at best – not dissuade them from consuming care, and – at worst – will steer them away from reasonably priced care to higher cost providers, thanks to an (inaccurate) assumption that higher price equates to higher quality.

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In healthcare, however, rarely can we say there is truly a meeting of the minds. It is rare indeed to see a provider (the vendor) and patient (the consumer) agree upon a price prior to the provision of services.

Yet, despite this, Quantum Meruit – applicable to other commercial exchanges – has no place in healthcare, and rather, the provider is allowed to balance bill the patient whatever amount it wants – usually the amount that exists between the provider's "charge master" price, and what it already received from the applicable carrier or benefit plan.

QUANTUM MERUIT

At the same time, contract law states that a customer who agrees to pay a certain price for a service or product has entered into a contract with the vendor. This preemptive agreement between the customer and vendor, regarding what will be paid, and what will be received by the customer, is titled a "meeting of the minds."

If the customer later fails to pay the amount to which they'd previously agreed, this would be deemed a breach of contract. Even if objectively, one could argue the agreed upon price is excessive, assuming the customer had the requisite capacity to enter into such a deal, the contract is binding.

If, however, someone receives a good or service but there was no meeting of the minds (agreement about what would be provided, and a specific price for said goods or services), the customer will be forced to pay an objectively reasonable price – determined by an objective third party, using objective pricing parameters – and NOT whatever price the vendor chooses to collect.

This concept, called Quantum Meruit, ensures vendors are adequately compensated based upon objectively reasonable parameters, and customers are not unjustly enriched (don't "get something for nothing") but also aren't forced to pay a price they never agreed to (and which is excessive by all reasonable, objective measurements).

Note that the only prohibition on this billing practice is the prior existence of a contract between a payer and the provider, by whose terms the provider agrees to accept the payer's payment as payment in full. This agreement, many argue, is the greatest value a network offers.

Given that the law protects a provider's right to charge whatever they wish – with no limits based in reasonableness, meeting of the minds, or Quantum Meruit – and limited only by pre-negotiated contracts, payers generally negotiate from a weak position.

As such, simply ensuring everyone has insurance will not drastically reduce the cost of healthcare itself. Further, people – whether they are insured or not – will pay the cost when healthcare is too expensive. Be it balance bills for the uninsured, or rising premiums and deductibles for the insured – the money needs to come from somewhere.

Compounding the issue further is that fact that Americans generally suffer from a lack of long-term vision. We are, as a society, driven by a need for instant gratification. People use credit cards to buy things now, that they can't afford later. People purchase homes and take out mortgages now, that they can't afford later. Likewise, people obtain healthcare now that they can't afford later.

Make no mistake; even those with insurance pay the cost later, in the form of higher premiums, co-pays, deductibles, and co-insurance. Therein lies the rub – people are quick to target out of pocket expenses at the time care is received, and the cost of insurance in general, but they do so without asking why insurance is expensive or addressing that root cause.

Until people understand that – with or without insurance – patients will ultimately be responsible for the actual cost of care, then the issue will not be resolved. In other words, focusing on the rising out of pocket expenses, such as premiums, co-pays, and deductibles – without also focusing on why these expenses are increasing – addresses a symptom without diagnosing the disease.

WHAT DOES THIS MEAN FOR US?

Many candidates and their supporters are proponents of the so-called "Medicare for All" plan, yet even many who support those candidates are beginning to hesitate, worrying that under Medicare payment rates (forced down providers' throats by a single payer monopoly), some hospitals struggling to stay open might close. Here, then, we see the opposite issue – ushered in when a monopoly is in place. A single payer with too much power can force opposition into accepting unduly low, unfair rates.

Is there a happy medium? Some have argued that a so-called "public option" may be one such "middle ground," but this idea cannot live in harmony with private benefits for long … resulting in the demise of private plans, and eventual monopoly that is a single payer, and which (as already discussed) most agree needs to be avoided.

Consider as "Exhibit A" the State of Washington. Washington is set to become the first state to enter the private health insurance market with a so-called "public option," at rates supporters say will be 10% cheaper than comparable private insurance. Almost as if the lawmakers read my article above (before I even wrote it), they claim these savings will be achieved thanks to a cap on rates paid to providers.

Without going into too much detail regarding the pricing model (spoiler alert – it's a percentage of Medicare), if this public option is indeed available to all residents, and if they can "force" providers to accept these payments as payment in full (thereby preventing balance billing), why would anyone sign up for a private plan? If, then, all private plan members are steered by sheer common sense to this public option, private plans will cease to exist and – in this way – a single payer emerges from the exchange.

It was this threat that caused a public option to be removed from the proposed PPACA legislation, but now it's back, at the State level as well as in proposals presented by Democratic candidates for the Presidency.

In the end, unless private plans and providers can achieve a meeting of the minds … and make healthcare affordable long term … this may be the future sooner than we think. ■

Ron E. Peck has been a member of The Phia Group's team since 2006. As an ERISA attorney with The Phia Group, Ron has been an innovative force in the drafting of improved benefit plan provisions, handled complex subrogation and third party recovery disputes, healthcare direct contracting and spearheaded efforts to combat the steadily increasing costs of healthcare. Attorney Peck obtained his Juris Doctorate from Rutgers University School of Law and earned his Bachelor of Science degree in Policy Analysis and Management from Cornell University. Attorney Peck now serves as The Phia Group's Executive Vice President and General Counsel, and is also a dedicated member of SIIA's Government Relations Committee.