

MEDICINE AS A PUBLIC CALLING

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The debate over how to tame private medical spending tends to pit advocates of government-provided insurance—a single-payer scheme—against those who would prefer to harness market forces to hold down costs. When it is mentioned at all, the possibility of regulating the medical industry as a public utility is brusquely dismissed as anathema to the American regulatory tradition. This dismissiveness, however, rests on a failure to appreciate just how deeply the public utility model shaped health law in the twentieth century—and how it continues to shape health law today. Closer economic regulation of the medical industry may or may not be prudent, but it is by no means incompatible with our governing institutions and political culture. Indeed, the durability of such regulation suggests that the modern embrace of market-based approaches in the medical industry may be more ephemeral than it seems.

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INTRODUCTION

The debate over how to tame private medical spending tends to pit advocates of government-provided insurance—a single-payer scheme—against those who would prefer to harness market forces to hold down costs. When it is mentioned at all, the possibility of regulating the medical industry as a public utility is usually dismissed as a political nonstarter.¹ However common it may be in other countries, treating the health-care sector as a public utility is thought to be anathema to American political traditions that valorize patient choice and physician independence, treat hospitals as charities, and are suspicious of state interference in economic affairs.²

Missing from this conventional account is the pivotal role that public utility regulation has played in the development of the modern regulatory state. Missing, too, is an appreciation of how extensively such regulation has shaped health law—both for good and ill. Growing out of an ancient common law practice of imposing special obligations on innkeepers and common carriers, public utility regulation evolved during the Gilded Age and the Progressive Era into a comprehensive challenge to the principles of *laissez-faire*.³ Such regulation was originally justified—and insulated from constitutional attack—by a developing body of law governing those private businesses that were affected with a public interest. Such businesses could not make unfettered use of their private property; instead, the law imposed

1. See, e.g., Uwe E. Reinhardt, *The Many Different Prices Paid to Providers and the Flawed Theory of Cost Shifting: Is It Time for a More Rational All-Payer System?*, 30 HEALTH AFF. 2125, 2130 (2011) (observing that talk of rate-setting may appear “highly controversial and revolutionary”); Elisabeth Rosenthal, *Health Care’s Road to Ruin*, N.Y. TIMES, Dec. 21, 2013, at SR1, <http://www.nytimes.com/2013/12/22/Sunday-review/health-cares-road-to-ruin.html> (stating that regulating medicine as a public utility “is not politically acceptable here”); cf. Ryan Bubb & Richard H. Pildes, *How Behavioral Economics Trims Its Sails and Why*, 127 HARV. L. REV. 1593, 1596–97 (2014) (noting the widespread assumption “that the chastened, post-New Deal political era in which we live makes unlikely sufficient political support for interventions that are not choice-preserving”).

2. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 24–29 (1982) (charting how physicians established their professional authority with the public and used that authority in the twentieth century as “the ground for resistance to government”).

3. See BARBARA H. FRIED, *THE PROGRESSIVE ASSAULT ON LAISSEZ FAIRE* 161 (1998) (“To the contemporary eye, wont to view the field as the province of bureaucrats and technically-minded economists, the progressive romance with public utilities . . . rate regulation may be hard to fathom. . . . [But] it reflected the philosophical and political significance of public utilities in [limiting] government control of business.”); William J. Novak, *The Public Utility Idea and the Origins of Modern Business Regulation*, in *THE CORPORATION AND AMERICAN DEMOCRACY* (Naomi Lamoreaux & William J. Novak, eds., forthcoming 2015) (“Quite simply, public utility took over turn-of-the-century statute books, commission reports, and court records. And it dominated the period’s legal output: legislative, administrative, as well as judicial.”).

“an affirmative obligation . . . to be reasonable in dealing with the public.”⁴ In an influential 1911 treatise, Bruce Wyman divided that affirmative obligation into four distinct duties: “that all must be served, adequate facilities must be provided, reasonable rates must be charged, and no discriminations must be made.”⁵

Businesses affected with a public interest were variously described as public callings, public service corporations, and public utilities. They included not only natural monopolies like railroads, ferries, telegraph lines, electric plants, and water works, but also banks, insurance companies, housing interests, stockyards, and mines.⁶ Any industry that served an important human need and had the market power to exploit consumers could plausibly be characterized as a public utility. As J. Willard Hurst explained, “[t]he public utility concept rests on recognition that some economic power is wielded at key points of intersection of human relations” and that the law must constrain the behavior of those “new forms of organized power, characterized by great aggregations of capital and great capacity to affect life.”⁷

Prior to the Second World War, medicine was typically missing from even the most capacious lists of industries affected with a public interest. Yet that says more about the rudimentary state of medicine than it does about the acceptability of regulating health care as a utility. The private hospital industry was still in its infancy well into the Progressive Era, and hospitals were only slowly shedding their traditional role as charity wards for the dying sick. By today’s standards, they remained technologically unsophisticated and relatively cheap. For their part, physicians were independent professionals who sold personal services, not industrialists who put private property to public use. The absence of proven therapies for most illnesses kept medical expenditures in check, as did the competitive, even cutthroat, market for physicians that prevailed in the early decades of the twentieth century.⁸

As Bruce Wyman observed, however, any given industry might fall in and out of the legal category of public callings.⁹ And in the decades following the Second World War, the meteoric growth of the medical industry prompted the enactment of federal and state laws that bore the hallmarks of public utility regulation. Collectively, these laws regulated market entry, imposed service obligations, prohibited certain forms of price discrimination,

4. *Wolff Packing Co. v. Indus. Court*, 262 U.S. 522, 536 (1923).

5. 1 BRUCE WYMAN, *THE SPECIAL LAW GOVERNING PUBLIC SERVICE CORPORATIONS AND ALL OTHERS ENGAGED IN PUBLIC EMPLOYMENT*, at xi (1911).

6. See *Stafford v. Wallace*, 258 U.S. 495, 516 (1922) (stockyards); *Block v. Hirsh*, 256 U.S. 135, 156 (1921) (housing interests); *German Alliance Ins. Co. v. Lewis*, 233 U.S. 389, 413–14 (1914) (insurance companies); *Noble State Bank v. Haskell*, 219 U.S. 104, 113 (1911) (banks); *Strickley v. Highland Boy Gold Mining Co.*, 200 U.S. 527, 531 (1906) (mines).

7. James Willard Hurst, *Problems of Legitimacy in the Contemporary Legal Order*, 24 OKLA. L. REV. 224, 226 (1971).

8. See *infra* Section II.C.

9. 1 WYMAN, *supra* note 5, at x (“What branches of industry will eventually be of such public importance as to be included in the category . . . it would be rash to predict.”).

and even fixed prices.¹⁰ In the last decades of the twentieth century, some of this economic regulation gave way in the face of the resurgent belief that market forces, not state control, ought to guide the distribution of health-care services.¹¹ But a durable strain of the law has always treated modern medicine as a public calling—even today.

The fit is natural. Public utility regulation aims to address the sorts of problems in market ordering—supply imbalances, access restrictions, and abusive and discriminatory pricing—that have long afflicted the medical industry. Now that the Affordable Care Act (ACA) has eased public concerns about the uninsured, the serious economic challenges facing those with insurance are likely to become more salient. Should the ACA fail to remedy a number of disturbing practices in the medical marketplace, policymakers may find public utility regulation increasingly attractive. Indeed, nascent interest in such regulation suggests that we may already be heading in that direction.

The possibility of regulating medicine as a public utility has not passed altogether unnoticed;¹² indeed, talk of such regulation was common in the 1960s and 1970s.¹³ For at least three reasons, however, few recall how deeply the public utility model once influenced medical regulation, and fewer still appreciate how it continues to shape such regulation today.

First, the idea of public utility regulation seems stale.¹⁴ In part, this is a legacy of the modern law-and-economics movement, which has subjected public utility regulation to withering criticism.¹⁵ Deregulation of the airline and trucking industries reinforced the idea that the public utility model, outside a few narrow enclaves, ought to be abandoned.¹⁶ As Barbara Fried explains, modern economists can find “no justification for expanding the lessons of public utility regulation beyond public utilities and other formal

10. See *infra* Section III.A.

11. See *infra* Part III.

12. See, e.g., Roger Colton et al., *Lessons for the Health Care Industry from America's Experience with Public Utilities*, 18 J. PUB. HEALTH POL'Y 389 (1997); A.J.G. Priest, *Possible Adaptation of Public Utility Concepts in the Health Care Field*, 35 LAW & CONTEMP. PROBS. 839 (1970). As some commentators have noted, the ACA in some respects regulates health insurance—but not the health-care industry as a whole—as a public utility. See, e.g., Richard A. Epstein & Paula M. Stannard, *Constitutional Ratemaking and the Affordable Care Act: A New Source of Vulnerability*, 38 AM. J.L. & MED. 243, 262–63 (2012).

13. See Roger G. Noll, *The Consequences of Public Utility Regulation of Hospitals*, in CONTROLS ON HEALTH CARE 25 (1975) (“[Since the mid-1960s], serious demands have been made . . . to subject the industry to ‘public utility’ regulation.”).

14. See Novak, *supra* note 3 (“[F]or all intents and purposes, today, [the public utility idea] has almost disappeared—erased from all but the most specialized historical memory. What was once at the forefront of law, economics, and public policy discussion has been relegated to the backbench—the dustbin—of American history.”).

15. See Harold Demsetz, *Why Regulate Utilities?*, 11 J.L. & ECON. 55 (1968); Sam Peltzman, *Toward a More General Theory of Regulation*, 19 J.L. & ECON. 211 (1976); Richard A. Posner, *Natural Monopoly and Its Regulation*, 21 STAN. L. REV. 548 (1969); George J. Stigler, *The Theory of Economic Regulation*, 2 BELL J. ECON. & MGMT. SCI. 3 (1971).

16. See STEPHEN BREYER, REGULATION AND ITS REFORM 197–239 (1982).

or natural monopolies.”¹⁷ The ascendance of economics as a discipline—and its particular influence in health policy—may have obscured the influence of the public utility model on health law.¹⁸

Second, the law of public callings is often thought to do little more than impose a duty on certain businesses to serve all paying customers. In medicine, the Emergency Medical Treatment and Labor Act (EMTALA) resonates with that service duty, as do several antidiscrimination laws with particular significance for health care, mainly Title VI and the Americans with Disabilities Act. But the law of public callings has traditionally involved much more, including the regulation of market entry and the prices charged for services. This sort of extensive economic regulation was a conspicuous feature of health law in the middle decades of the twentieth century. Yet a narrow conception of the duties owed by businesses affected with a public interest misses the link between such regulation and the law of public callings.

Third, questions about insurance coverage have properly consumed the political and academic discourse around health care. Public debate has thus centered on how, if at all, the state should redistribute resources to guarantee insurance to those who might otherwise go without. The sustained focus on the uninsured has drawn attention away from a persistent, ongoing practice of using state power to curb unfair and oppressive practices in the medical marketplace.

This Article aims to recover that neglected tradition of public utility regulation. My claim is not that medicine was once treated as a pure public utility; it was not. My claim, instead, is that laws bearing the characteristic features of public utility regulation became prominent in the decades following the Second World War. Many of those laws remain on the books today. If the American state embraced a public utility model for medicine in the recent past, such an approach would seem to be compatible with our governing institutions and political culture. And the durability of the tradition—the fact that it stretches back more than a century—suggests that the current embrace of market-based approaches in health care may be more ephemeral than it seems. Indeed, as I explain, the pendulum may already be swinging back toward public utility regulation.

Whether treating medicine more like a public utility would count as an improvement is genuinely hard to say. Any effort to closely regulate a large, complex, and rapidly changing industry would be fraught with difficulties. Economic regulation might well create more problems than it would solve. But, absent concrete evidence of the ineffectiveness of such regulation, I see no reason to dismiss it out of hand. Most other countries treat health care as a public utility—albeit as a publicly funded, not privately financed, utility.

17. FRIED, *supra* note 3, at 201.

18. See JACOB S. HACKER, *THE ROAD TO NOWHERE* 156 (1997) (“In the health policy community, the most influential ideas have been associated with economists. For nearly two decades, the neoclassical critique . . . has enjoyed a privileged position within health policy circles.”).

They typically spend far less for care that, along many dimensions, appears superior to ours.¹⁹ And it is not obvious that health-care markets—which suffer from well-understood failings associated with market concentration, informational asymmetries, and moral hazard—would outperform a rate-setting body that, say, used Medicare’s payment system as a model.²⁰

So I do mean to give the pendulum a gentle push. Commentators seem defensive, almost embarrassed, to raise the possibility of regulating medicine as a utility. Maybe they fear being tarred as insensitive to the risks of economic regulation, unsophisticated about the market, and ignorant of the American regulatory tradition. They need not be so defensive. Public utility regulation is every bit as much a part of that tradition as *laissez-faire*. And if the market-oriented approaches that are ascendant today prove unsatisfactory, public utility regulation is an option worth exploring. It may not be the answer, but the debate between market-oriented and regulatory approaches should unapologetically examine the virtues and vices of both.

A word about the boundaries of the project. Public utility regulation entails government restrictions on a private business’s use of its property. But the state can also adjust business conduct through the use of its purchasing power, and the line between (mandatory) direct regulation and (voluntary) spending conditions is not always sharp. Medicare, for example, fixes the rate that providers can bill the federal government for providing services to beneficiaries. Because few providers can afford not to participate in Medicare, the program’s rate schedules resemble public utility regulation for the beneficiary population. Yet the economic conditions associated with public insurance programs like Medicare and Medicaid are typically limited to that population. (A few important exceptions are discussed below.²¹) My concern here is with the economic regulation of the relationships between privately insured patients and the institutions and individuals that care for them.

I. HEALTH CARE: WHERE DO WE GO FROM HERE?

The ACA marks a watershed in its extension of health coverage to tens of millions of the uninsured. By no means, however, has it remedied other flaws in the private health-care system. After the ACA, attention is likely to

19. See NAT’L RESEARCH COUNCIL & INST. OF MED. OF THE NAT’L ACADS., U.S. HEALTH IN INTERNATIONAL PERSPECTIVE: SHORTER LIVES, POORER HEALTH 1 (Steven H. Woolf & Laudan Aron eds., 2013), <http://www.iom.edu/Reports/2013/US-Health-in-International-Prospective-Shorter-Lives-Poorer-Health.aspx> (“Americans live shorter lives and experience more injuries and illnesses than people in other high-income countries.”); ORG. FOR ECON. CO-OPERATION AND DEV., HEALTH AT A GLANCE 2013, at 154 (2013), <http://www.oecd.org/health/health-systems/health-at-a-glance.htm> (reporting that per capita health-care spending in the United States is “two-and-a-half times the average of all OECD countries” and “around twice as much” as France and Germany).

20. See JOSEPH WHITE, *COMPETING SOLUTIONS* 278 (1995) (“Within the international standard, costs are controlled by setting fees, making budgets, and imposing controls on investment, not by competition.”).

21. See *infra* Section III.B (discussing Hill-Burton, the charitable tax exemption, and EMTALA).

shift to the challenges that even the insured will face in a market plagued by a number of well-understood failings. Should these challenges prove acute, they could feed the perception that private hospitals, physicians, and other providers wield inordinate power in the market—power that federal and state governments may come under pressure to curtail.

A. Supply

Because those with insurance use more medical services than those without,²² the existing medical infrastructure could buckle under the weight of increased demand associated with the ACA's insurance expansion. Policy-makers' greatest immediate concern is a coming "doc shortage," especially a shortage of primary-care physicians, who were in short supply even before the ACA's enactment.²³ Recent estimates suggest that the nation will need at least 40,000 new primary care physicians over the next decade to meet rising demand.²⁴ Especially severe shortages are expected in rural areas and inner cities.²⁵

The nation's shrinking capacity to provide universal primary care has given rise to acute access concerns. Close observers of physician supply note that "[i]t can be debated whether the current primary care practitioner-to-population ratio is adequate, but two things are unquestioned: Adult patients are having difficulty gaining timely access to primary care, and a serious shortage of primary care practitioners is inevitable in the near future."²⁶ Especially in rural and poor urban areas, frustration could mount over the inadequate supply and inappropriate distribution of primary-care practitioners.

B. Access

In an effort to keep their premiums low, most health plans restrict, to some extent, the providers they accept into their coverage networks. Price competition has spurred insurers on the new exchanges to constrain their

22. See Thomas C. Buchmueller et al., *The Effect of Health Insurance on Medical Care Utilization and Implications for Insurance Expansion: A Review of the Literature*, 62 *MED. CARE RES. & REV.* 3, 20 (2005).

23. See, e.g., Adam N. Hofer et al., *Expansion of Coverage Under the Patient Protection and Affordable Care Act and Primary Care Utilization*, 89 *MILBANK Q.* 69, 84 (2011); Elbert S. Huang & Kenneth Finegold, *Seven Million Americans Live in Areas Where Demand for Primary Care May Exceed Supply by More than 10 Percent*, 32 *HEALTH AFF.* 614, 614 (2013).

24. Thomas S. Bodenheimer & Mark D. Smith, *Primary Care: Proposed Solutions to the Physician Shortage Without Training More Physicians*, 32 *HEALTH AFF.* 1881, 1881 (2013). But see *INST. OF MED. OF THE NAT'L ACADS., GRADUATE MEDICAL EDUCATION THAT MEETS THE NATION'S HEALTH NEEDS 7–8* (2014), <http://www.iom.edu/Reports/2014/Graduate-Medical-Education-That-Meets-the-Nations-Health-Needs.aspx> (concluding that fears of a physician shortage may be overblown).

25. See Thomas Bodenheimer & Hoangmai H. Pham, *Primary Care: Current Problems and Proposed Solutions*, 29 *HEALTH AFF.* 799, 802 (2010).

26. *Id.* at 801.

provider networks more assertively than in the past.²⁷ A McKinsey report optimistically suggests that “[t]his trend is consistent with what we see in most well-functioning consumer markets ranging from cell phone plans to automobiles—a variety of choices comprising different value propositions at different price points.”²⁸

Not everyone views the trend with such equanimity. In many transactions, as Margaret Radin emphasizes, “[t]here is an irreducibly nonmarket or nonmonetized aspect of human interaction going on between seller and recipient, even though a sale is taking place at the same time.”²⁹ Many people find it hard to square the caregiving relationship at the heart of medicine with the notion that prestigious hospitals and popular physicians might refuse their insurance. The effect even has a name—“doc shock”—and narrow networks have triggered fears that only the wealthy, who can afford to purchase gold-plated plans, will have access to the finest medical care, while everyone else will have to make do with second- and third-rate providers.³⁰ The concerns are often misplaced—more expensive hospitals typically don’t provide higher-quality care³¹—and many people are comfortable with the trade-offs that come with purchasing cheaper health plans. But many others resent the implication that access to high-quality health care turns on who pays more.

C. Discriminatory Prices

Over the past two years, a number of widely circulated articles have exposed enormous and hard-to-justify price variations in the health-care system.³² Story after story has highlighted what health-policy experts have long understood: that the uninsured pay higher prices for medical services than the insured; that prices for medical services vary dramatically from

27. See David H. Howard, *Adverse Effects of Prohibiting Narrow Provider Networks*, 371 *NEW ENG. J. MED.* 591, 591 (2014) (“[A]bout 40% of plan networks were classified as ‘ultranarrow’ or ‘narrow,’ meaning that they contracted with less than 30% or 70%, respectively, of the hospitals in the plan rating area.”).

28. MCKINSEY CTR. FOR U.S. HEALTH SYS. REFORM, *HOSPITAL NETWORKS: CONFIGURATIONS ON THE EXCHANGES AND THEIR IMPACT ON PREMIUMS 1* (2013), www.mckinsey.com/~/media/mckinsey/dotcom/client_service/Healthcare%20Systems%20and%20Services/PDFs/Hospital_Networks_Configurations_on_the_Exchanges_and_Their_Impact_on_Premiums.ashx.

29. MARGARET JANE RADIN, *CONTESTED COMMODITIES* 107 (1996).

30. See Lori Gottlieb, Op-Ed., *Daring to Complain About Obamacare*, *N.Y. TIMES*, Nov. 11, 2013, at A25, http://www.nytimes.com/2013/11/11/opinion/daring-to-complain-about-obamacare.html?_r=2& (describing people’s frustration at being “mandated to buy expensive exchange or private policies without access to their current doctors”).

31. See Chapin White et al., *Understanding Differences Between High- and Low-Price Hospitals: Implications for Efforts to Rein in Costs*, 33 *HEALTH AFF.* 324, 329 (2014).

32. For two of the most prominent exposés, see Steven Brill, Special Report, *Bitter Pill: How Outrageous Pricing and Egregious Profits Are Destroying Our Health Care*, *TIME*, Mar. 4, 2013, at 16; Elisabeth Rosenthal, *As Hospital Prices Soar, a Stitch Tops \$500*, *N.Y. TIMES*, Dec. 3, 2013, at A1, <http://www.nytimes.com/2013/12/03/health/as-hospital-costs-soar-single-stitch-tops-500.html>.

hospital to hospital, even in the same geographic region; and that the prices charged bear no apparent relationship to underlying costs. Responding to interest in the issue, Medicare—for the first time—released data in 2013 documenting extraordinary variations in the costs that hospitals claimed they incurred for treating a range of conditions.³³ Encouraged by the positive response, Medicare followed up in 2014 with the public release of comprehensive billing data for each of its 880,000 participating physicians.³⁴

Because discriminatory pricing is most apparent in the prices that hospitals charge the uninsured, concerns about variable prices may become less urgent as the ranks of the uninsured dwindle. The ACA, however, leaves intact a different source of “unfair” price variation: variations in prices for exchange plans that can’t be explained with reference to variable demand for medical services. The premiums for exchange plans in Wisconsin are substantially higher—in some areas, almost twice as high—as premiums in neighboring Minnesota.³⁵ And while a standard “silver” plan for a family of four in Nashville, Tennessee cost \$6,708 in 2014, the same plan in Jackson, Mississippi—one state over—ran \$14,592.³⁶ Because silver plans are designed to cover only 70 percent of a family’s average health-care expenses, the average Jackson family will also spend an additional \$6,253 out of pocket, more than twice as much as an average Nashville family.³⁷ These disparities, which appear to be driven primarily by differences in provider market power, have already begun to stoke claims of unfairness arising from the happenstance of geography.³⁸

D. Costs

All of these concerns—with supply, access, and discriminatory pricing—are likely to pale in comparison to the frustration that could attend the continued escalation of prices for medical care. In rejecting a single-payer model for paying for medical services, the ACA pinned frontline responsibility for controlling private medical spending on private health plans. The exchanges are a key feature of this strategy. By facilitating cost-conscious

33. *Medicare Provider Utilization and Payment Data*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/index.html> (last visited Feb. 24, 2015).

34. See Jonathan Blum, *Next Steps in Medicare Data Transparency*, CMS BLOG (Apr. 2, 2014), [http://blog.cms.gov/?s=next\\$steps+in+data+transparency](http://blog.cms.gov/?s=next$steps+in+data+transparency).

35. Christopher Snowbeck & MaryJo Webster, *On Health Exchanges, Rates Swing at Border: Western Wisconsin Rates Almost Twice Those in Twin Cities*, ST. PAUL PIONEER PRESS, NOV. 3, 2013, at A1, http://www.twincities.com/politics/ci_24437197/health-exchanges-rates-swing-at-border (examining unpublished data from the Kaiser Family Foundation).

36. See ASSISTANT SEC’Y FOR PLANNING & EVALUATION OFFICE OF HEALTH POLICY, U.S. DEP’T OF HEALTH & HUMAN SERVS., ASPE ISSUE BRIEF 10 (2013), http://www.whitehouse.gov/sites/default/files/docs/marketplace_premiums_ib_final.pdf.

37. *Id.*

38. See, e.g., Jordan Rau, *In Southwest Georgia, the Affordable Care Act Is Having Trouble Living up to Its Name*, KAISER HEALTH NEWS (Feb. 3, 2014), <http://kaiserhealthnews.org/news/Georgia-insurance-costs-obamacare>.

shopping in the individual and small-group markets, the exchanges sharpen insurers' incentives to negotiate low prices with providers.

Although managed care organizations have been at the center of health policy for the past quarter-century,³⁹ their track record is not encouraging. The rise of managed care in the 1990s appeared to reduce cost growth for a brief period, but medical inflation resumed its inexorable rate of increase by the early 2000s.⁴⁰ Cost growth in the private market has generally outpaced cost growth in Medicare, and that divergence has accelerated over the past decade.⁴¹

Managed care organizations face a number of challenges when it comes to restraining medical spending. Direct oversight of provider behavior is devilishly hard.⁴² Financial incentives are blunt tools to encourage hospitals and physicians to provide low-cost, high-quality care.⁴³ And public resistance to cost-management techniques can be fierce.⁴⁴

Of greatest significance, dominant providers' market power can enable abusive pricing practices and impede insurers' efforts to drive down costs.⁴⁵ In markets where managed care organizations cannot credibly threaten to exclude high-cost providers from their coverage networks—if, for example, exclusion of a prominent local hospital would make a plan unmarketable—the providers can name their price. And concentration in the health-care sector is pervasive. Deploying a widely used economic metric, David Cutler and Fiona Scott Morton recently showed that roughly half of all hospital markets are highly concentrated and another third are moderately concentrated.⁴⁶ The extent of concentration has increased sharply since the 1980s, and the trend is accelerating.⁴⁷ More and more hospitals are transforming themselves into integrated medical systems with close links to physician

39. See Alain Enthoven & Richard Kronick, *A Consumer-Choice Health Plan for the 1990s*, 320 *NEW ENG. J. MED.* 29 (1989) (laying out the principles of managed competition).

40. See *National Health Expenditure Tables*, *CTRS. FOR MEDICARE & MEDICAID SERVS.* tbl.13, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/tables.pdf> (last modified May 5, 2014).

41. See Cristina Boccuti & Marilyn Moon, *Comparing Medicare and Private Insurers: Growth Rates in Spending over Three Decades*, *HEALTH AFF.*, Mar.–Apr. 2003, at 230, 232–33; *Per Enrollee Growth in Medicare Spending and Private Health Insurance Premiums (for Common Benefits), 1970-2012*, HENRY J. KAISER FAMILY FOUND. (Mar. 6, 2014), <http://kff.org/health-costs/slide/per-enrollee-growth-in-medicare-spending-and-private-health-insurance-premiums-for-common-benefits-1970-2012/>.

42. See James C. Robinson, *The End of Managed Care*, 285 *JAMA* 2622, 2627 (2001).

43. See Einer Elhauge, *Why We Should Care About Health Care Fragmentation and how to Fix It*, in *THE FRAGMENTATION OF U.S. HEALTH CARE* 1, 7–10 (Einer R. Elhauge ed., 2010).

44. See Robinson, *supra* note 42, at 2623.

45. See Gerard F. Anderson et al., *It's the Prices, Stupid: Why the United States Is So Different from Other Countries*, *HEALTH AFF.*, May–June 2003, at 89; David M. Cutler & Fiona Scott Morton, *Hospitals, Market Share, and Consolidation*, 310 *JAMA* 1964, 1969 (2013).

46. See Cutler & Morton, *supra* note 45, at 1966.

47. See *id.*; Julie Creswell & Reed Abelson, *New Laws and Rising Costs Create a Surge of Supersizing Hospitals*, *N.Y. TIMES*, Aug. 13, 2013, at B1, <http://www.nytimes.com/2013/08/13/business/bigger-hospitals-may-lead-to-bigger-bills-for-patients.html>.

practices.⁴⁸ In one of the more startling changes over the past decade, hospitals have purchased physician practices at a furious rate.⁴⁹ By 2011, for the first time, hospitals owned half of all physician practices.⁵⁰

The ACA may be partly responsible. One of the notorious failings of the American health-care system is its fragmentation—the inability of disparate physicians, hospitals, and other providers to coordinate the care they offer to patients, especially the chronically ill.⁵¹ To address this challenge, the ACA uses Medicare reform to spur the development of integrated medical systems.⁵² Most prominently, the ACA encourages the creation of accountable care organizations (ACOs), which can share in any savings they generate for Medicare if they hit certain quality targets and reduce spending for a target population.⁵³

Laudable as that effort is, it is at loggerheads with the ACA's attempt to use managed care to reduce medical inflation. As Katherine Baicker and Helen Levy note, attempts to defragment the health-care sector to improve care coordination can contribute to anticompetitive consolidation.⁵⁴ Recent empirical work confirms the point.⁵⁵ Although the antitrust agencies have issued policies that aim to discourage such consolidation,⁵⁶ few observers expect antitrust enforcement to much diminish provider concentration.⁵⁷

48. See Lawton Robert Burns & Ralph W. Muller, *Hospital-Physician Collaboration: Landscape of Economic Integration and Impact on Clinical Integration*, 86 MILBANK Q. 375 (2008).

49. See Manoj Jain, *Hospitals Buy Private Practices, and a Medical Tradition Fades*, WASH. POST, Mar. 13, 2012, at E1, http://www.washingtonpost.com/national/health-science/doctors-in-private-practices-are-now-joining-hospital-staffs/2012/02/14/gIQAEFz07R_story.html.

50. See Cutler & Morton, *supra* note 45, at 1966 (“From 2004 to 2011, hospital ownership of physician practices increased from 24% of practices to 49%.”).

51. See generally THE FRAGMENTATION OF U.S. HEALTH CARE, *supra* note 43.

52. See Nicholas Bagley, *Bedside Bureaucrats: Why Medicare Reform Hasn't Worked*, 101 GEO. L.J. 519, 569 (2013).

53. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3022, 124 Stat. 119, 395 (2010). For a more comprehensive list of the ACA's various efforts to promote greater coordination, see Katherine Baicker & Helen Levy, *Coordination Versus Competition in Health Care Reform*, 369 NEW ENG. J. MED. 789, 790 (2013).

54. Baicker & Levy, *supra* note 53, at 789.

55. See, e.g., MARTIN GAYNOR & ROBERT TOWN, ROBERT WOOD JOHNSON FOUNDATION, THE SYNTHESIS PROJECT, POLICY BRIEF No. 9, THE IMPACT OF HOSPITAL CONSOLIDATION-UPDATE (2012), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261; Laurence C. Baker et al., *Vertical Integration: Hospital Ownership of Physician Practices Is Associated with Higher Prices and Spending*, 33 HEALTH AFF. 756 (2014); Austin B. Frakt et al., *Plan-Provider Integration, Premiums, and Quality in the Medicare Advantage Market*, 48 HEALTH SERVICES RES. 1996 (2013).

56. See Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Problem, 76 Fed. Reg. 67,026 (Oct. 28, 2011).

57. See Clark C. Havighurst & Barak D. Richman, *The Provider Monopoly Problem in Health Care*, 89 OR. L. REV. 847, 868–76 (2011) (discussing the failure of antitrust enforcement to prevent consolidation in the health-care sector and raising concerns about ACOs).

As a result, dominant hospital systems in some markets may come to resemble the natural monopolies that have traditionally been regulated as public utilities. Should those systems exploit their market power, rising insurance premiums would cut into wages and could raise the cost of exchange plans to unaffordable levels. Tax credits for exchange plans will provide only partial relief. Through 2018, the tax credits will rise to cover any increase in exchange premiums.⁵⁸ After that, however, the credits will grow only at the rate of inflation, shifting the costs of growing premiums to individuals and families.⁵⁹

The meteoric growth of high-deductible health plans could exacerbate cost concerns. In 2006, just one out of ten employees received employer-sponsored coverage with a deductible that exceeded \$1,000 per year. That's for individual coverage; deductibles for family coverage are higher.⁶⁰ By 2013—just seven years later—almost four in ten exceeded \$1,000 per year.⁶¹ At small firms today, one in three employees has a deductible in excess of \$2,000 per year.⁶² Many exchange plans will have similarly high deductibles.⁶³ Caps on out-of-pocket expenses—set at \$6,350 for individuals and \$12,700 for families—will somewhat limit financial exposure,⁶⁴ but many people are already experiencing sticker shock at the medical bills that insurance doesn't cover.⁶⁵

The proliferation of high-deductible plans means that millions of insured families and individuals could, when they encounter health problems, find themselves in a precarious financial situation.⁶⁶ Although the ACA will allow many families to avoid bankruptcy, it by no means fully protects them against the financial shocks associated with health care.

58. See I.R.C. § 36B(b)(3)(A)(ii) (2012).

59. See *id.*; see also JOHN E. McDONOUGH, *INSIDE NATIONAL HEALTH REFORM* 300–01 (2011) (noting that premiums could increase as much as 10 percent per year).

60. HENRY J. KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUCATIONAL TRUST, *EMPLOYER HEALTH BENEFITS: 2013 ANNUAL SURVEY* 110 (2013), <https://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20132.pdf>.

61. *Id.*

62. See *id.* at 111.

63. See Leslie Scism & Timothy W. Martin, *Deductibles Fuel New Worries of Health-Law Sticker Shock*, *WALL ST. J.*, Dec. 9, 2013, at A1, <http://www.wsj.com/articles/SB10001424052702303330204579246211560398876>.

64. See Robert Pear, *A Limit on Consumer Costs Is Delayed in Health Care Law*, *N.Y. TIMES*, Aug. 13, 2013, at A1, <http://www.nytimes.com/2013/08/13/us/a-limit-on-consumer-costs-is-delayed-in-health-care-law.html?pagewanted=all&r=0>.

65. See Peter Frost, *Obamacare Deductibles May Cause Sticker Shock*, *CHI. TRIB.*, Oct. 13, 2013, at 1.1, http://articles.chicagotribune.com/2013-10-13/business/ct-biz-1013-obamacare-deductibles-20131013_1_health-care-overhaul-health-insurance-health-coverage.

66. See McDONOUGH, *supra* note 59, at 300 (“The Massachusetts experience with a similar structure shows that most consumers choose lower-premium options, leaving them vulnerable to high cost sharing in the event of a serious illness.”).

* * *

The problems sketched out here—supply shortages, access restrictions, and capricious, exorbitant prices—are specific manifestations of deep problems in the health-care market. Prices for health care are rarely discussed openly, and comparison shopping is almost unheard of.⁶⁷ Informational asymmetries make consumers unusually dependent on third parties—mainly physicians—in making health-care decisions.⁶⁸ Scientific evidence about the medical benefits of conventional therapies is often so sparse that it's hard to make good cost-quality tradeoffs.⁶⁹ Physicians and hospitals can stimulate demand for their own services and often have financial incentives to do so.⁷⁰ And the prevalence of insurance enables excessive consumption because patients are shielded from the full costs of care.⁷¹

Nonetheless, persistent problems with supply, access, and prices could stoke dissatisfaction with a market-based approach to organizing the private health-care sector. It's impossible to predict the depth of such dissatisfaction; indeed, the ACA could provoke systemic changes that mitigate much of it. If not, however, pressure will build for a government response.

What might such a response look like? Some critics on the right hope to jettison the ACA and its effort to achieve near-universal coverage in favor of a purer embrace of the market.⁷² As they see it, a slew of well-intentioned but poorly designed state interventions have exacerbated the health-care market's failings. For them, the ACA is the apotheosis of this sort of needless government meddling, its nominal embrace of managed competition belied by regulatory restrictions that will impede the very competition the ACA was supposed to enable. Only by ditching the ACA—and sweeping other needless laws off the books—can the promise of the market be realized.

Strictly as a matter of practical politics, however, the ACA's abandonment looks increasingly unlikely. Millions of people have already signed up for exchange plans; millions more are now enrolled in Medicaid. Returning to a pre-ACA status quo in which they would lose that coverage, and insurers would lose their business, is close to a political nonstarter.⁷³ To be sure,

67. See Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 653–59 (2008).

68. Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 965–66 (1963).

69. See OFFICE OF TECH. ASSESSMENT, U.S. CONG., IDENTIFYING HEALTH TECHNOLOGIES THAT WORK: SEARCHING FOR EVIDENCE 21 (1994) (estimating that at least 80 percent of widely used medical interventions lack rigorous research documenting their efficacy).

70. See HENRY J. AARON, SERIOUS AND UNSTABLE CONDITION: FINANCING AMERICA'S HEALTH CARE 13–17 (1991).

71. See *id.* at 10–13.

72. See, e.g., Richard A. Epstein & David A. Hyman, *Fixing Obamacare: The Virtues of Choice, Competition, and Deregulation*, 68 N.Y.U. ANN. SURV. AM. L. 493 (2013).

73. See Henry J. Aaron, *Here to Stay—Beyond the Rough Launch of the ACA*, 370 NEW ENG. J. MED. 2257, 2258 (2014) (“Although some opponents continue to call for repeal of the ACA, the law is here to stay.”). *But see* David A. Super, *The Modernization of American Public*

the ACA could be adjusted in a more market-friendly direction by relaxing certain regulations that limit the range of plans that can legally be sold.⁷⁴ But the ACA's core is likely to remain intact, and modest changes are unlikely to resolve the market failings that might spur interest in alternatives to managed competition.

From the political left, the leading reform alternative is the adoption of a single-payer scheme—Medicare for All. But moving to single payer is, if anything, even less likely than the abandonment of the ACA. Many of those with employer-sponsored coverage—almost 150 million people—would resist surrendering it in favor of a government-run plan.⁷⁵ And insurers, including the exchange insurers, would lobby fiercely against any move that would put them out of business.⁷⁶

Public utility regulation offers a less disruptive alternative, one that retains the basic architecture of the private financing system while asserting state control over the medical industry's perceived excesses.⁷⁷ That such regulation would obviate the need for socialized insurance is no coincidence: public utility regulation has long been understood to preserve a role for the private while attending to the needs of the public.⁷⁸ As Wyman explained, “[t]his principle of State control does not lead one to socialism; indeed, it saves one from socialism if truly understood.”⁷⁹ Here, Wyman was echoing Henry Carter Adams's claim a generation earlier that economic regulation “stands opposed to anarchy on the one hand, which is individualism gone to seed; and to socialism on the other, which, both historically and logically, is a revolt against the superficial claims and pernicious consequences of *laissez-faire*.”⁸⁰

Law: Health Care Reform and Popular Constitutionalism, 66 *STAN. L. REV.* 873, 897–901 (2014) (arguing that the ACA is more vulnerable than its supporters appreciate).

74. See Joseph R. Antos, *Health Care Reform After the ACA*, 370 *NEW ENG. J. MED.* 2259, 2261 (2014).

75. See HACKER, *supra* note 18, at 148 (“Support for the [Clinton health-care] proposal waned . . . because of a general fear among Americans that the proposal would make them worse off.”); *Health Insurance Coverage of the Total Population*, HENRY J. KAISER FAMILY FOUND. (2013), <http://kff.org/other/state-indicator/total-population/>.

76. Cf. HACKER, *supra* note 18, at 177 (“[I]t is extremely unlikely that [a single-payer] plan would have garnered strong enough support to overcome the frenetic opposition it would have provoked.”); McDONOUGH, *supra* note 59, at 47 (“Single-payer advocates, passionately as they believed in their cause, were unable to convince even sympathetic lawmakers that there was a way to get a Medicare for All bill to the president’s desk.”).

77. Cf. M. Gregg Bloche, *The Emergent Logic of Health Law*, 82 *S. CAL. L. REV.* 389, 397 (2009) (“[Health-care reformers] should look for potential evolutionary pathways that launch from present-day institutional arrangements and incentives.”).

78. See FRIED, *supra* note 3, at 164 (“Indeed, progressive commentators routinely suggested, regulation might be the best friend capitalism had, given that public regulation of private property was the only remaining viable alternative to outright public ownership.”).

79. 1 WYMAN, *supra* note 5, at viii.

80. HENRY CARTER ADAMS, *Relation of the State to Industrial Action*, in *TWO ESSAYS BY HENRY CARTER ADAMS* 57, 125 (Joseph Dorfman ed., 1969).

II. THE AMERICAN TRADITION OF PUBLIC UTILITY REGULATION

The modern reluctance to entertain the possibility of regulating medicine as a public utility doesn't arise from clear evidence that it can't work. International experience suggests that it can.⁸¹ The reluctance seems to stem, instead, from the persistent sense that, in the United States, public utility regulation is adopted rarely and only as a last resort. Apart from occasional and regrettable excesses, typified by the regulation of the airline and trucking industries, public utility regulation, the story goes, has properly been confined to the regulation of natural monopolies. Because medicine—a fragmented industry comprising hospitals, physicians, and a dizzying array of other providers—is not a true natural monopoly, treating it as a public utility is out of step with historical practice and presumptively inappropriate. Maybe other countries treat medicine as a utility, but it's not how we do things here.

But in fact we do. The dominant account reflects a certain historical blindness about the pivotal role that public utility regulation has played in the American state. In the decades following the Civil War, the economic regulation of public callings became both common and intrusive. By the Progressive Era, such regulation covered an extraordinary array of industries—not just natural monopolies. What linked those industries together, and what made state intervention both necessary and consistent with the Fourteenth Amendment, was the perception that they wielded undue market power over goods or services upon which the public had grown dependent.

The dominant account also overlooks how extensively public utility regulation has shaped health law. As medicine became technologically more sophisticated and acquired substantial market power in the decades after the Second World War, policymakers began drawing on the public utility model in earnest. And no wonder. Public utility regulation was developed precisely to address the concerns with supply, access, discrimination, and unfair pricing that had begun to plague the modern medical industry.

A. *The Rise of Public Utility Regulation*

During the Gilded Age, the rapid advance of railroads, the rise of industrial production, and improvements in international trade fueled explosive growth.⁸² These developments also stirred resentment, at first from farmers who, subject to the fluctuations of the international markets and the caprice of the railroad magnates, felt caught in a vise.⁸³ In the 1870s, agrarian interests in the Midwest pressed for the adoption of what became known as the

81. See WHITE, *supra* note 20, at 7 (noting that other industrialized nations control medicine “through systems of regulation” that include “fee schedules or budgeting—usually both” and “limits [on] capital investment for the largest part of hospital care”).

82. See ROBERT H. WIEBE, *THE SEARCH FOR ORDER 1877–1920*, at 46 (1967).

83. See RICHARD HOFSTADTER, *THE AGE OF REFORM 51–52* (1955).

Granger laws, which fixed prices for the railroads and grain warehouses that farmers depended on to market their goods.

But were the new laws constitutional? The ratification of the Fourteenth Amendment, together with the growing prominence of laissez-faire ideas in economic and legal thought, had raised anew the question of how far, and under what circumstances, the states could intrude on the rights to private property and liberty of contract.⁸⁴ Even the most committed adherents to laissez-faire recognized that the Due Process Clause posed no general impediment to the regulation, through the police power, of public health, safety, and morals.⁸⁵ Less clear was whether the Due Process Clause constrained states' ability to oversee the fairness of private business transactions. As Ernst Freund explained in 1914, economic interests "obviously do not affect the public welfare as urgently as safety, morals and order. With regard to many conceivable phases of industrial regulation, the legitimacy of the police power is seriously disputed."⁸⁶

The Granger laws came before the Supreme Court in 1877. In *Munn v. Illinois* and its companion cases, the Court seemed to accept the principle that the states lacked plenary power to regulate the affairs of purely private businesses.⁸⁷ But the Court rejected the claim that all private businesses had a constitutional right to conduct their business relations as they saw fit. The Court reasoned that some businesses were "affected with a public interest" and, as such, were the appropriate targets of economic regulation.⁸⁸

As refashioned by the Supreme Court, the concept of businesses "affected with a public interest" had a source in two bodies of law. The first was the common law, which from time immemorial had imposed special duties on certain callings—most notably, innkeepers and common carriers.⁸⁹ (Interestingly, ancient English common law appears to have treated the practice of medicine as a public calling.⁹⁰) Those duties included, among other things, accepting all comers on a nondiscriminatory basis and offering reasonable rates.⁹¹

84. See, e.g., Thomas M. Cooley, *Limits to State Control of Private Business*, 1 PRINCETON REV. 233 (1878) (considering the question).

85. See FRIED, *supra* note 3, at 20.

86. Ernst Freund, *Police Power*, in 2 CYCLOPEDIA OF AMERICAN GOVERNMENT 706, 707–08 (Andrew C. McLaughlin & Albert Bushnell Hart eds., 1914).

87. See 94 U.S. 113, 126 (1877).

88. *Munn*, 94 U.S. at 126.

89. See, e.g., JOSEPH HENRY BEALE, JR., THE LAW OF INNKEEPERS AND HOTELS, INCLUDING OTHER PUBLIC HOUSES, THEATRES, SLEEPING CARS (1906).

90. 1 WYMAN, *supra* note 5, at 7 ("From other cases it is plain that the curing of man or beast was considered a public calling.").

91. *Id.* at 16 ("To compel the proprietors of those businesses which had been regarded as peculiarly affected with a public interest to serve all that applied at reasonable rates was immemorial practice and therefore was indisputably due process of law.").

Corporate charters provided the second source for the idea that some businesses owed special duties to the public. Before the Civil War, corporations by and large were individually chartered under state law.⁹² Those business-specific charters often included detailed conditions on the businesses receiving them.⁹³ Although the gradual shift to general charters of incorporation eventually did away with charter conditions,⁹⁴ the idea persisted that the state could properly oversee the conduct of private corporations carrying out public business.

Munn's apparent endorsement of the principle that the Constitution prohibited the economic regulation of a purely private business has led many to read it as a step on the road to *Lochner*.⁹⁵ As William Novak has recently shown, however, the opposite is closer to the truth: *Munn* inaugurated an era of muscular economic regulation of private businesses deemed to be affected with a public interest.⁹⁶ The public utility idea was expansive, not restrictive, and the agrarian populists who succeeded the Grange agitated, with some success, for legislation aimed at the "money power."⁹⁷ In particular, the regulation of railroads and grain elevators became ubiquitous, first at the state level⁹⁸ and then at the federal level with the 1887 enactment of the Interstate Commerce Act.⁹⁹

More generally, the populists' distrust of private power found expression in the common law. By 1900, the industries that the courts deemed to be "affected with a public interest" included banking, insurance, railroads, telephone, telegraph, electric power, natural gas, water, urban transportation, heating, interurban electric, motor bus and truck, airways, radio, pipe lines, warehouses, stockyards, ice plants, milk, fuel, and meatpacking.¹⁰⁰

Even as the populist movement sputtered out in the mid-1890s, a new generation of progressive reformers came to the fore. Centered in the cities, supported by the rising middle class, and optimistic about expert governance, the progressives shared an intense distrust of private power with the

92. See JAMES WILLARD HURST, *THE LEGITIMACY OF THE BUSINESS CORPORATION IN THE LAW OF THE UNITED STATES 1780–1970*, at 13–18 (1970).

93. See ERNST FREUND, *THE POLICE POWER: PUBLIC POLICY AND CONSTITUTIONAL RIGHTS* 19 (1904) ("[T]he state may grant the required permit or license upon such conditions as it pleases."); Cooley, *supra* note 84, at 233 ("Wherever the business is a privilege, and the taking out of a license is required, the state may impose conditions upon the privilege.").

94. See Novak, *supra* note 3.

95. See *id.* (collecting sources).

96. *Id.*

97. See generally GEORGE H. MILLER, *RAILROADS AND THE GRANGER LAWS* (1971).

98. See Novak, *supra* note 3.

99. Interstate Commerce Act of 1887, ch. 104, 24 Stat. 379.

100. See, e.g., FREUND, *supra* note 93, at 381 (cataloging such industries); 1 WYMAN, *supra* note 5, at xi (describing characteristics of such industries); Charles K. Burdick, *The Origin of the Peculiar Duties of Public Service Companies*, 11 COLUM. L. REV. 514, 515 (1911) (same).

populists.¹⁰¹ Yet, as historian Robert Wiebe explains, “[w]here their predecessors would have destroyed many of urban-industrial America’s outstanding characteristics, the new reformers wanted to adapt an existing order to their own ends.”¹⁰²

In the early decades of the twentieth century, the progressives called for the creation of regulatory bodies that could better control public utilities.¹⁰³ “The human interests and legal rights protected remain the same,” John Dickinson explained, “but the old legal procedure has been superseded by direct governmental action on the plea of prevention, or greater speed and effectiveness of the remedy.”¹⁰⁴ Starting with Wisconsin and New York in 1907, the states moved almost without exception to establish public service commissions.¹⁰⁵ The new commissions oversaw a vast range of industries, including

steam railroads, electric and street railways, interurban or suburban railways, elevated railroads or subways, automobile railroads, steamboats and other water craft, express lines and messenger lines, signalling facilities, bridges and ferries connected with railroads, pipe lines for the transportation of oil or water, sleeping, parlor and drawing-room cars, terminals, union depots, docks, wharves, storage elevators, fast freight lines, stage lines, messenger companies, telegraph and telephone companies, facilities for the manufacture and sale of gas or electricity, heat, light, water, power, hot or cold air or steam, and irrigation and sewage facilities.¹⁰⁶

By 1916, Frank Goodnow, one of the fathers of American administrative law, could note the significance of the “change of ideas” when it came to the regulation of public utilities:

Not only is no constitutional question any more raised as to the power of the competent organ of our government to take the necessary regulatory measures but public opinion justifies regulation of so drastic a character that it would hardly have been deemed possible even a quarter of a century ago.¹⁰⁷

101. See HOFSTADTER, *supra* note 83, at 313 (arguing that progressive regulation reflected “the purpose of eliminating that private power to tax which is the prerogative of monopoly”).

102. WIEBE, *supra* note 82, at 165.

103. See G. LLOYD WILSON ET AL., PUBLIC UTILITY REGULATION 15–20 (1938).

104. JOHN DICKINSON, ADMINISTRATIVE JUSTICE AND THE SUPREMACY OF LAW IN THE UNITED STATES 7 (Russell & Russell, Inc. 1959) (1927); see also WIEBE, *supra* note 82, at 166 (“The heart of progressivism was the ambition of the new middle class to fulfill its destiny through bureaucratic means.”).

105. FRIED, *supra* note 3, at 161.

106. I. Leo Sharfman, *Commission Regulation of Public Utilities: A Survey of Legislation*, 53 ANNALS AM. ACAD. POL. & SOC. SCI. 1, 8–9 (1914); see also G.H. ROBINSON, CASES AND AUTHORITIES ON PUBLIC UTILITIES 77–78 (2d ed. 1935) (offering a similarly expansive list).

107. FRANK JOHNSON GOODNOW, THE AMERICAN CONCEPTION OF LIBERTY AND GOVERNMENT 28–29 (1916); see also FELIX FRANKFURTER, THE PUBLIC AND ITS GOVERNMENT 31 (1930) (“Suffice it to say that through [modern government’s] regulation of those tremendous human and financial interests which we call public utilities, the government may in large measure determine the whole social-economic direction of the future.”); Dexter Merriam

B. *The Attributes of Public Callings*

What made a business a public calling? Or, to put it another way, when was it appropriate for the state to subject an industry to public utility regulation? Because constitutional objections to such regulation dropped away only when the business was deemed “affected with a public interest,” judicial doctrine played an unusually prominent role in shaping the policy debate.¹⁰⁸ The courts, however, were not very clear about the attributes of public callings.¹⁰⁹ As Felix Frankfurter and Henry Hart noted, “the futile efforts at dogmatic statement of doctrine cover a clash of opinion on a far reaching issue; namely, to what degree free competition is so complete a protection to the public interest as to render arbitrary any governmental departure from it.”¹¹⁰

Nonetheless, legislatures and courts had, by the early decades of the twentieth century, reached a workable consensus about which businesses were affected with a public interest.¹¹¹ That consensus was oriented around two basic considerations: first, that the business in question met an important human need; and second, that some feature of the relevant market presented the risk of oppression.¹¹² When these conditions were satisfied, it was both appropriate as a policy matter and fully constitutional to require

Keezer, *Some Questions Involved in the Application of the “Public Interest” Doctrine*, 25 MICH. L. REV. 596, 596 (1927) (“[A]pplication of the [affected with a public interest] doctrine has been steadily expanded, bringing within its scope an increasing range and diversity of enterprises. . . . [that] will continue to be enlarged.”).

108. See ROBINSON, *supra* note 106, at 5 (“[T]he legislature speaks and the court also speaks, and because the selection [of public businesses] is conceived of as a matter of ‘due process of law’ . . . the apparatus [for selecting] is a combination of legislature-court-state-and-federal elements.”).

109. See FREUND, *supra* note 93, at 382; FRIED, *supra* note 3, at 169 (“[T]he Court invoked a dizzying array of tests to determine whether a business was affected with a public interest . . .”).

110. Felix Frankfurter & Henry M. Hart, Jr., *Rate Regulation*, in 13 ENCYCLOPEDIA OF THE SOCIAL SCIENCES 104, 106 (Edwin R.A. Seligman & Alvin Johnson eds., 1934). Indeed, not everyone was convinced that the Fourteenth Amendment had anything to say about the constitutionality of the economic regulation of private business. See Edward A. Adler, *Business Jurisprudence*, 28 HARV. L. REV. 135, 158 (1915); Burdick, *supra* note 100, at 516.

111. BARRY CUSHMAN, *RETHINKING THE NEW DEAL COURT* 50 (1998) (“Marginal disagreements concerning the precise location of the boundary between public and private enterprise persisted. There was, however, a broad measure of agreement concerning where the division lay.”).

112. *Charles Wolff Packing Co. v. Court of Indus. Relations*, 262 U.S. 522, 538 (1923) (“In nearly all the businesses [that are affected with a public interest], the thing which gave the public interest was the indispensable nature of the service and the exorbitant charges and arbitrary control to which the public might be subjected without regulation.”); *Block v. Hirsh*, 256 U.S. 135, 156 (1921) (“The space in Washington is necessarily monopolized in comparatively few hands, and letting portions of it is as much a business as any other. Housing is a necessary of life. All the elements of a public interest justifying some degree of public control are present.”); REXFORD C. TUGWELL, *THE ECONOMIC BASIS OF PUBLIC INTEREST* 100 (1922) (“[Courts allow] regulation of the prices and standards of service of a business under the economic interest phase of the police power when: 1. The commodity or service is virtually a

the industry to satisfy the public need on a reasonable and nondiscriminatory basis.

1. Necessity

Throughout the Progressive Era, it was common ground that a business was “affected with a public interest” only if it controlled access to a necessity. As Wyman explained in 1911:

This extraordinary activity of the law in behalf of the individual is . . . confined to necessary services. The law has little concern with the monopolization of unessential things. It subjects a “scenic railway” at an amusement park to no exceptional liabilities. It leaves a circular railway built primarily to view the Niagara Gorge outside the pale of State aid. And it leaves skating rinks and theaters to deal as they please with their public, and exclude whomsoever they choose.¹¹³

Still, necessity was a broad concept. It was linked not to bare survival, but to ideas of dependence, expectation, and reliance. In 1926, the influential progressive economist John Maurice Clark explained that “[w]hat we think of as economic coercion acts mainly through the power to withhold access to goods or services, where the person from whom they are withheld needs access to these particular goods or services so much that he is, or feels, ‘dependent’ on them in some substantial degree.”¹¹⁴ Pushing the point even further, Rexford Tugwell—a future member of President Roosevelt’s brain trust—canvassed the case law in 1922 and concluded that “[p]erhaps . . . the most precise and complete definition would be one which would conceive a necessity as any good or service which contributes to a psychologically full life.”¹¹⁵

Something might be thought “necessary” not just for individuals, but for society more broadly. The Supreme Court captured the thought in *New State Ice Co. v. Liebmann*, when it rejected an effort to regulate the sale of ice because it was not “a paramount industry upon which the prosperity of the entire state in large measure depends.”¹¹⁶ Frankfurter similarly emphasized

necessity. 2. There is maintained a price or a standard of service resulting in harm to consumers.”).

113. 1 WYMAN, *supra* note 5, at 99 (footnotes omitted); *see also* *Tyson & Bro.-United Theatre Ticket Offices, Inc. v. Banton*, 273 U.S. 418, 440 (1927) (rejecting an effort to regulate the price of admission to the theater in part because “in importance it falls below . . . an interest in . . . food and shelter”); *Charles Wolff Packing Co.*, 262 U.S. at 537 (“It has never been supposed, since the adoption of the Constitution, that the business of the butcher, or the baker, the tailor, the wood chopper, the mining operator or the miner was clothed with such a public interest that the price of his product or his wages could be fixed by State regulation.”); *A.M. Holter Hardware Co. v. Boyle*, 263 F. 134, 137 (D. Mont. 1920) (invalidating price regulation that “ranges from the street corner vendor of popcorn and bananas to the merchant prince, from coal to diamonds, from the babe’s first swaddling band and cradle to the aged man’s shroud, his coffin, and his grave. Trifles, necessities, luxuries—all are within its scope”).

114. JOHN M. CLARK, *SOCIAL CONTROL OF BUSINESS* 115 (2d ed. 1939).

115. TUGWELL, *supra* note 112, at 103.

116. 285 U.S. 262, 277–78 (1932).

that “[o]ur whole social structure presupposes satisfactions for which we are dependent upon private economic enterprise.”¹¹⁷ Linking necessity to the economic and social development of the broader community helps explain why banking and insurance, among other industries, were thought to be affected with a public interest.¹¹⁸ As Freund explained, “banks and life insurance companies are the depositaries of a large proportion of the savings of the people, so that the management of each institution affects a considerable part of the public.”¹¹⁹

2. Power

A business was not “affected with a public interest” merely because the public was dependent on the goods or services that it controlled.¹²⁰ In Wyman’s telling, the law of public callings served to protect against a business’s exploitation of its monopoly power.¹²¹ In this, the law of public callings bore a kinship to antitrust law: the latter aimed to prevent monopoly, the former to control it. The idea that state power to regulate the economic affairs of private business turned on the presence of monopolistic conditions found expression in Supreme Court opinions throughout the period.¹²²

Yet a business need not be monopolistic in a strict sense. An extraordinary range of market features—the costs of shopping around, bargaining inequalities, informational disadvantage, rampant fraud, collusive pricing, emergency conditions, and more—could all frustrate competition and so give rise to “virtual” or “practical” monopolies that would warrant state intervention.¹²³ By no means was the regulation of public callings confined to

117. FRANKFURTER, *supra* note 107, at 81; *see also* 2 LEVERETT S. LYON & VICTOR ABRAMSON, *GOVERNMENT AND ECONOMIC LIFE: DEVELOPMENT AND CURRENT ISSUES OF AMERICAN PUBLIC POLICY* 622 (1940) (observing that an individual’s need for public utilities “is augmented by his indirect interest in living in a society where these services are readily available for general social and industrial use”); Gustavus H. Robinson, *The Public Utility Concept in American Law*, 41 HARV. L. REV. 277, 277 (1928) (noting that the concept of a public utility responded to “the sense, upon the part of contemporary society, of its dependence upon certain sorts of enterprises”).

118. *See* *German Alliance Ins. Co. v. Lewis*, 233 U.S. 389, 414–15 (1914) (insurance); *Noble State Bank v. Haskell*, 219 U.S. 104, 111–13 (1911) (banking).

119. FREUND, *supra* note 93, at 419.

120. *Charles Wolff Packing Co. v. Court of Indus. Relations*, 262 U.S. 522, 535–36 (1923); *see also* FREUND, *supra* note 93, at 388–89.

121. Bruce Wyman, *The Law of the Public Callings as a Solution of the Trust Problem*, 17 HARV. L. REV. 156 (1903).

122. *See, e.g., Charles Wolff Packing Co.*, 262 U.S. at 538; *German Alliance Ins. Co.*, 233 U.S. at 410; *Brass v. North Dakota ex rel. Stoeser*, 153 U.S. 391, 403 (1894).

123. *See* CLARK, *supra* note 114, at 151–61 (describing appropriate bases for economic regulation apart from monopoly, including informational asymmetries, dependence on another’s expertise, and providing a social minimum); 1 WYMAN, *supra* note 5, at §§ 50–80 (cataloging the varied justifications for imposing duties of fair treatment on businesses and distinguishing “natural monopolies” from “virtual monopolies”).

the natural monopolies that today are thought to be its proper targets.¹²⁴ The 1914 case *German Alliance Insurance Co. v. Lewis* illustrates the point. In upholding the constitutionality of a Kansas law fixing the rates for fire insurance, the Supreme Court reasoned that

the price of insurance is not fixed over the counters of the companies by what Adam Smith calls the higgling of the market, but formed in the councils of the underwriters, promulgated in schedules of practically controlling constancy which the applicant for insurance is powerless to oppose and which, therefore, has led to the assertion that the business of insurance is of monopolistic character and that “it is illusory to speak of a liberty of contract.”¹²⁵

Far from insisting on what a modern economist would call a monopoly, the Court approved Kansas’s effort to constrain market power arising from another source—here, seemingly insurers’ superior information about an opaque, complex financial product. *German Alliance* is not unusual. The case law, though littered with references to monopoly, was often inattentive to questions of market concentration.¹²⁶ All innkeepers, for example, were treated as affected with a public interest, however competitive the local market for inns.¹²⁷

The law of public callings was organized not around an orthodox economic understanding of monopoly, but instead around a contestable political idea of power. The key was the “consumer disadvantage”¹²⁸ or “widespread oppression”¹²⁹ that could arise in the market. As Justice Stone observed in 1927:

An examination of the decisions of this court in which price regulation has been upheld will disclose that the element common to all is the existence of a situation or a combination of circumstances materially restricting the

124. See BREYER, *supra* note 16, at 15–16. See generally N. GREGORY MANKIW, *ESSENTIALS OF ECONOMICS* 278 (6th ed. 2012) (“An industry is a natural monopoly when a single firm can supply a good or service to an entire market at a lower cost than could two or more firms.”).

125. 233 U.S. at 416–17.

126. See, e.g., *Brass*, 153 U.S. at 403 (“When . . . it is competent for the legislative power to control the business of elevating and storing grain . . . in cities of one size and in some circumstances, it follows that such power may be legally exerted over the same business when carried on in smaller cities and in other circumstances.”); *People ex rel. Durham Realty Corp. v. La Fetra*, 130 N.E. 601, 606–07 (N.Y. 1921) (“The power of regulation [of prices] . . . is not limited to public uses or to property where the right to demand and receive service exists or to monopolies or to emergencies.”); see also TUGWELL, *supra* note 112, at 66 (“Monopoly is almost never established as a fact in these cases, though often inferred. That it is inferred, not directly established, lends color to the theory that consumer disadvantage is in and by itself sufficient to establish public interest.”).

127. Joseph William Singer, *No Right to Exclude: Public Accommodations and Private Property*, 90 Nw. U. L. REV. 1283, 1319–20 (1996) (“[N]o lawyer, judge, or treatise writer ever suggested that innkeepers in cities like Boston should be exempt from the duty to serve the public.”).

128. TUGWELL, *supra* note 112, at 92.

129. *La Fetra*, 130 N.E. at 609.

regulative force of competition, so that buyers or sellers are placed at such a disadvantage in the bargaining struggle that serious economic consequences result to a very large number of members of the community.¹³⁰

In the Progressive Era, the prevailing consensus was that the private market was shot through with such consumer disadvantage.¹³¹ Public utility regulation thus became the dominant governance strategy for managing important industries that neither the market nor antitrust law could adequately discipline.¹³²

C. Medicine's Absence

Yet medicine was absent from even the most capacious lists of industries affected with a public interest. Why? If insurers and banks were regulated as public callings, why not hospitals and doctors? The answer is straightforward: prior to the Second World War, the medical industry lacked the sort of market power over essentials that called for state intervention.

The decades from 1870 through 1910 marked a period of enormous change for medicine.¹³³ At the close of the Civil War, hospitals in the United States little resembled modern hospitals:

These institutions were primarily the last resort for the sick. Their standards of care did not approach those for the simplest custodial care today. Hospital cleanliness was unknown, nursing was unskilled, equipment did not include even the clinical thermometer. The pills and potions of visiting staff physicians provided therapy. Major surgery was performed only in dire emergencies and was confined largely to fractures and amputations. . . . "Patients dreaded the hospital and surgeons distrusted themselves, so much so that the hospital system itself was in danger of passing out of society."¹³⁴

130. *Tyson & Bro.-United Theatre Ticket Offices, Inc. v. Banton*, 273 U.S. 418, 451–52 (1927) (Stone, J., dissenting).

131. FRIED, *supra* note 3, at 25 ("The view that monopolies were becoming the rule rather than a limited exception to an otherwise competitive market . . . was widely shared among centrist and even conservative economists and political theorists.").

132. *See id.* at 112 ("By the early twentieth century, all but the strongest probusiness forces agreed that it was appropriate for the government to intervene in any business that was in the position to administer prices."); Walton H. Hamilton, *Affection with Public Interest*, 39 *YALE L.J.* 1089, 1107 (1930) ("The system of control may be set down as three presumptions, which are to be taken in order: . . . price is to be left to free enterprise; the antitrust laws are to be used, if need be, . . . to keep enterprise free; and, if free enterprise cannot be made to . . . work, resort is to be had to formal price-fixing.").

133. *See* 1 *COMM'N ON FIN. OF HOSP. CARE, FACTORS AFFECTING THE COSTS OF HOSPITAL CARE* 8 (John H. Hayes ed., 1954) ("[T]he general hospital, which had been essentially an institution for custodial care, began at the turn of this century to evolve into an institution in which the physician renders medical care.").

134. *Id.* at 9 (quoting HOWARD W. HAGGARD, *MYSTERY, MAGIC, AND MEDICINE* 167 (1933)).

Over the next forty years, medicine started to come into its own as a science. Medical schools became more rigorous and selective.¹³⁵ Doctors turned to hospital practice to enhance their public prestige and improve their private practices. Hospitals became slightly safer and began to proliferate. Although large public hospitals, often in urban centers, remained at the core of this growing hospital industry, the number of private, charitable hospitals—often called “voluntary hospitals”—surged.¹³⁶ By 1909, 4,359 hospitals dotted the country, nearly the number in existence today.¹³⁷

Endowed by private philanthropists and supported by the state, the voluntary hospitals were regulated not as private businesses but as charities.¹³⁸ Consistent with hospitals’ charitable missions, most patients were still housed in large, institutional wards; physicians typically didn’t charge for their hospital-based practices; and many charitable hospitals still served a large percentage of indigent patients.¹³⁹

As voluntary hospitals rose to prominence, however, the ancient association between hospital care and charity started to show strain. Financial pressures pushed voluntary hospitals to avidly seek out paying customers, particularly the well-off, to whom they provided private rooms and nicer amenities.¹⁴⁰ “From refuges mainly for the homeless poor and insane,” Paul Starr explains, “[hospitals] evolved into doctors’ workshops for all types and classes of patients. From charities, dependent on voluntary gifts, they developed into market institutions, financed increasingly out of payments from patients.”¹⁴¹

The law was slow to respond to hospitals’ evolution from charitable entities to market actors. The sheer number of cases in which municipalities challenged the tax-exempt status of voluntary hospitals—because they demanded payment from all their patients, segregated paying patients from nonpaying patients, or ran for-profit ventures alongside the nonprofit hospital—suggests that many were not run along especially charitable lines.¹⁴² Some courts did recognize the inherently public nature of private charities.¹⁴³ But the economic regulation of public callings arose to curb the excesses of profit-making businesses that, by dint of their practical monopoly

135. STARR, *supra* note 2, at 116–23.

136. *Id.* at 150–54.

137. Compare 1 COMM’N ON FIN. OF HOSP. CARE, *supra* note 133, at 10, with AM. HOSP. ASS’N, HOSPITAL STATISTICS 3 (2012 ed.) (identifying 4,995 nonfederal U.S. hospitals in 2010).

138. See RESTATEMENT (SECOND) OF TRUSTS § 368 (1959) (“Charitable purposes include . . . the promotion of health.”); Jill R. Horwitz, *Does Nonprofit Ownership Matter?*, 24 YALE J. ON REG. 139, 148–50 (2007) (discussing history of charitable exemption).

139. See 1 COMM’N ON FIN. OF HOSP. CARE, *supra* note 133, at 12–13.

140. See STARR, *supra* note 2, at 147–54.

141. *Id.* at 146.

142. See JOHN A. LAPP & DOROTHY KETCHAM, HOSPITAL LAW 5 (1926) (reporting that “[h]undreds of cases have been decided” on whether a hospital “is a charitable institution”).

143. See, e.g., *In re Application for Judgment Against Certain Lots*, 8 N.W. 595, 596 (Minn. 1881) (“The word ‘public’ has two proper meanings. A thing may be said to be public when owned by the public, and also when its uses are public. The [private hospital] falls

on important human needs, could exploit consumers. Charities fell in a different conceptual category: as one court put it in 1917, “the establishment of charitable hospitals is in no sense a recognized business.”¹⁴⁴ For charities, the absence of a profit motive was thought to discourage the sorts of unfairness that could characterize private dealings.¹⁴⁵ There was no need for a law of public callings to smooth the edges of market competition when charitable hospitals stood outside that competition.

The charitable status of the voluntary hospitals thus distinguished them from the private, for-profit businesses that were regulated as public utilities. That distinction came under pressure not only because the voluntary hospitals began to behave more like market actors,¹⁴⁶ but also because, in the early twentieth century, an increasing number of proprietary hospitals—private, for-profit hospitals, usually established by physicians as stand-alone surgical centers—started to crop up.¹⁴⁷ Although the law of charities had no application to these for-profit businesses, they undeniably served an important public function, much like railroads and banks. Were they properly classified as affected with a public interest?

That question went largely unanswered. The sharp practices of private hospitals were simply not a salient issue.¹⁴⁸ For most of the period, a hospital stay was relatively cheap. In 1910, the average cost of a day in the hospital was just \$2, or less than \$50 today in inflation-adjusted dollars.¹⁴⁹ Concern

within this description of an institution of purely public charity. That patients who are able to pay are charged for hospital services according to their ability, and that the county pays for such services rendered to those who are a legal county charge, are facts of no importance upon the question as to the character of the institution as one of purely public charity; for the fact still remains, that, notwithstanding all receipts from such sources, the hospital is established, maintained, and conducted without profit or a view to profit, and that, on the whole, it is operated at a loss, which is necessarily made up by private contributions.”).

144. *Lawrence v. Nissen*, 91 S.E. 1036, 1038 (N.C. 1917); *see also* *Van Campen v. Olean Gen. Hosp.*, 210 A.D. 204, 207 (N.Y. App. Div. 1924) (“That [voluntary hospitals] are engaged in charitable work for the benefit of the public and thereby affected with a public interest, does not make them public corporations.”)

145. *See* *Trs. of Acad. of Protestant Episcopal Church v. Taylor*, 25 A. 55, 57 (Pa. 1892) (“A private hospital, built and conducted as a business enterprise, stands upon widely different ground [from a charity]. There is no trust involved, no charitable use impressed, upon such an establishment.”).

146. *See* ROSEMARY STEVENS, *IN SICKNESS AND IN WEALTH: AMERICAN HOSPITALS IN THE TWENTIETH CENTURY* 122–23 (1989).

147. *See* STARR, *supra* note 2, at 219–20.

148. *See* STEVENS, *supra* note 146, at 129 (“State legislatures . . . had little interest in extending their authority over what appeared to be a successful mix of charitable, proprietary, and local-government general hospitals . . .”). A comprehensive 1926 treatise on hospital law covers a wide range of topics, but makes no mention of the kind of economic regulation that was regularly directed at public callings. *See* LAPP & KETCHAM, *supra* note 142, at 205–13. Nonetheless, in a brief section in his treatise, Wyman averred that private hospitals were affected with the public interest: their activities, he explained, were “public in character.” 1 WYMAN, *supra* note 5, at 60.

149. 1 COMM’N ON FIN. OF HOSP. CARE, *supra* note 133, at 13.

with hospital charges first emerged in the 1920s,¹⁵⁰ when just 3.5 percent of gross national product went toward health care.¹⁵¹ (That figure stands at 17.2 percent today.¹⁵²) Yet even in 1930, Walton Hamilton, a prominent supporter of state control of private enterprise, could still write that “there is little evidence that the price of bread, of clothing, of *medical service*, or of the talkies needs to become a matter of legislative concern.”¹⁵³ In part because hospitalization wasn’t that expensive, hospital insurance was nonexistent for most of the period, emerging only in the 1930s.

The modesty of hospital charges reflected the limits of medical science.¹⁵⁴ Antiseptic surgery was not widely used until the end of the nineteenth century; penicillin, not until the Second World War. The ineffectiveness of medicine in the face of most disease meant that “for most Americans, illness, injury, and early death were more to be suffered than helped by a doctor, much less insured against.”¹⁵⁵ Only in the early decades of the twentieth century, according to the historian Rosemary Stevens, was medicine “beginning its long transition from a luxury to a necessity, from a privilege to a right.”¹⁵⁶ Progressive reformers who worried about health concentrated not on medical care but on public-health measures—occupational safety, improved sanitation, and control of contagious disease.¹⁵⁷

For their part, physicians were unable to exercise the kind of market power that might have made them the targets of economic regulation. If physician prices were too high, Americans could go without medical care of dubious efficacy. Many did. For most of the period, too, physicians operated in a fiercely competitive environment. The absence of licensing laws, compounded by the proliferation of thousands of medical schools willing to confer degrees on paying students, complicated the profession’s efforts to limit entry or consolidate its authority. As a result, physicians did not charge

150. See STARR, *supra* note 2, at 259.

151. Randall R. Bovbjerg et al., *U.S. Health Care Coverage and Costs: Historical Development and Choices for the 1990s*, 21 J.L. MED. & ETHICS 141, 142 (1993). Even by 1945, urban families spent just \$150 on average per year on medical care. JAMES T. PATTERSON, *GRAND EXPECTATIONS: THE UNITED STATES, 1945–1974*, at 11 (1996).

152. See Anne B. Martin et al., *National Health Spending in 2012: Rate of Health Spending Growth Remained Low for the Fourth Consecutive Year*, 33 HEALTH AFF. 67, 67 (2014).

153. Hamilton, *supra* note 132, at 1100 n.54 (emphasis added).

154. See Bovbjerg et al., *supra* note 151, at 141 (“Neither medicine nor health coverage was very advanced prior to the Great Depression. Accustomed to the medical miracles of the late 20th century, one tends to forget that 19th century doctors could do little for patients, and hospitals were mainly charity wards where the poor went to die.”).

155. *Id.*; see also PATTERSON *supra* note 151, at 318 (“[A]s late as the 1930s[, physicians] had been able to do little more than diagnose people and to console patients when they got sick . . .”).

156. ROSEMARY STEVENS, *AMERICAN MEDICINE AND THE PUBLIC INTEREST* 133 (1971); see also 1 COMM’N ON FIN. OF HOSP. CARE, *supra* note 133, at 13 (“[A]s hospital care became increasingly expensive [from 1910 to 1935] it became more and more essential for those in all economic groups.”).

157. See WENDY E. PARMET, *POPULATIONS, PUBLIC HEALTH, AND THE LAW* 38 (2009) (“[P]ublic health’s influence on American law was at its zenith during the Progressive era.”).

much for their services and the medical profession as a whole was not held in especially high esteem.¹⁵⁸ Far from wielding fearsome economic power, physicians were disciplined by the market.

Not until the late 1890s did physicians secure state licensing laws that restricted entry into the profession. Building on that foundation, physicians began a painstaking effort over the following decades to consolidate their status and power.¹⁵⁹ Although successful in the end, physicians had, by the eve of the Great Depression, only just begun to reap the benefits of their newfound power in the market. It was still the case that “physicians did not charge—or earn—large amounts. In 1929, for instance, the average net income for non-salaried physicians was some \$5,200,¹⁶⁰ or about \$71,000 in today’s dollars. (That figure stands at \$190,000 today.¹⁶¹) Physicians saw that income drop nearly in half over the next decade.¹⁶² In short, “in the era before health insurance, when patients themselves paid for almost all health care, the medical economy behaved much like the rest of the economy and was small relative to the whole.”¹⁶³

To contemporaries, the very idea that physicians were affected with a public interest might have seemed like a category error. The Progressive Era exhibited a deep faith in professionals, who were thought to operate outside the theater of business and to stand as a bulwark against the rapacity of private enterprise.¹⁶⁴ Much as the charitable orientation of the voluntary hospitals put them outside the category of private businesses affected with a public interest, so too did physicians’ professional orientation make them an awkward fit for the category of public callings.

Nonetheless, in 1911, Wyman mused about whether physicians might be affected with a public interest. He closely examined the famous 1901 case of *Hurley v. Eddingfield*, in which the Indiana Supreme Court held in a terse opinion that a physician had no duty to treat a former patient who was in dire need.¹⁶⁵ *Hurley*’s curt rejection of the claim that physicians might be likened to innkeepers or common carriers suggests that the analogy was far-fetched. Wyman thought otherwise:

158. See STARR, *supra* note 2, at 79–144.

159. *Id.* at 232.

160. Bovbjerg et al., *supra* note 151, at 142.

161. See U.S. Dep’t of Labor, *May 2012 National Occupational Employment and Wage Estimates*, BUREAU OF LABOR STATISTICS, http://www.bls.gov/oes/2012/may/oes_nat.htm#00-0000 (last modified Nov. 27, 2013). By way of comparison, lawyers earned on average about the same amount as physicians in 1929; today, lawyers earn roughly one-third less. Compare Lawrence R. Klein, U.S. Dep’t of Labor, *Professional Income: Lawyers and Dentists, 1929-48*, 70 MONTHLY LAB. REV. 396, 396 (1950), with U.S. Dep’t of Labor, *supra*.

162. See Bovbjerg et al., *supra* note 151, at 142.

163. *Id.*

164. See HOFSTADTER, *supra* note 83, at 148–64; see also STARR, *supra* note 2, at 140 (“In the Progressive period, reformers and muckrakers crusading against business interests held up professional authority as a model of public disinterestedness.”).

165. 59 N.E. 1058 (Ind. 1901).

When the need of the applicant is immediate the person from whom he asks service has the upper hand. This monopoly may only be temporary; but it is none the less real. . . . Here again this classification of the authorities cannot as yet be safely taken as a generalization In [*Hurley*,] a physician was held not liable for refusing service to a patient in a desperate condition [T]he need was urgent, and in the nature of things must always be. But perhaps in the community at present there are enough of such men always at hand to preclude the probability of injury by delay in the average case. Or perhaps the modern law balks at requiring personal service.¹⁶⁶

Today, the casebooks present *Hurley* as an exemplar of the ancient common law rule that physicians owe no duty to treat.¹⁶⁷ Yet even in 1911, when medicine was neither as effective nor as expensive as it is today, the *laissez-faire* assumptions that animated *Hurley* were contested.

III. PUBLIC UTILITY REGULATION IN THE MEDICAL INDUSTRY

As medicine grew more technologically sophisticated, costly, and indispensable in the postwar era, the business of medicine assumed the essential attribute of a public calling: it acquired the power to abuse its control over a necessity. It is no coincidence that courts began holding that hospitals were “affected with a public interest” in the 1940s and 1950s.¹⁶⁸ By then, the constitutionality of economic legislation no longer turned on the label: the Supreme Court had discarded the “affected with a public interest” standard in assessing constitutionality in the 1934 case of *Nebbia v. New York*.¹⁶⁹ The label nonetheless reflected growing concern that medicine had acquired market power that it lacked in an earlier era.¹⁷⁰

The concern is much more acute today. In Mark Hall and Carl Schneider’s words, “enduring features of therapeutic relationships give rise to monopolistic power that is ripe for exploitation.”¹⁷¹ To protect patients in this “desperate market,” Hall and Schneider call on courts to reinvigorate the common law tradition, cataloged in Wyman’s treatise, of imposing special

166. 1 WYMAN, *supra* note 5, at 86–87 (footnotes omitted).

167. See, e.g., MARK A. HALL ET AL., HEALTH CARE LAW AND ETHICS 104, 109 (8th ed. 2013).

168. See, e.g., *Nw. Hosp. v. Pub. Bldg. Serv. Emps.’ Union Local No. 113*, 294 N.W. 215, 217–18 (Minn. 1940). Similarly, a 1939 Michigan statute regulated labor relations “where the employer is operating a public utility, or hospital, or any other industry affected with a public interest.” *Local Union No. 876 v. State Labor Mediation Bd.*, 293 N.W. 809, 810 (Mich. 1940) (emphasis added) (quoting 1939 Mich. Pub. Acts 176, § 13).

169. 291 U.S. 502, 536–37 (1934).

170. See *Tunkl v. Regents of Univ. of Cal.*, 383 P.2d 441, 444–46 (Cal. 1963) (offering a litany of reasons, including the “essential nature of the service” and “superior bargaining power,” for holding that a hospital contract was affected with a public interest); *Greisman v. Newcomb Hosp.*, 192 A.2d 817, 821–23 (N.J. 1963) (analogizing hospitals to innkeepers and common carriers in holding that they were “affected with a public interest”).

171. Hall & Schneider, *supra* note 67, at 667.

duties on public callings.¹⁷² But in focusing on judicial doctrine, Hall and Schneider may have downplayed the significance of a host of laws enacted in the postwar era that aimed to address the very problems they identify. This Part surveys prominent examples of these laws, organizing its discussion around the four duties of businesses affected with a public interest: to provide enough facilities to meet the public need, to serve all paying customers, to charge them nondiscriminatory rates, and to offer a fair price.¹⁷³ To a much greater extent than is commonly appreciated, health law bears the distinctive mark of the law of public callings.

To be clear, the claim is not that the entire business of medicine was once treated as a pure public utility. The economic regulation of physician practices, for example, has been and remains uncommon. Instead, such regulation has typically been directed at hospitals, which are responsible for the largest share of the nation's medical spending, as well as at insurers, which finance most medical care. Even there, public utility regulation has been incomplete, subjecting hospitals and insurers at varying times to more and less stringent duties to fairly serve the public. Especially since the 1980s, much (but by no means all) such regulation has given way to a renewed faith in the market.¹⁷⁴

The claim instead is that seemingly disparate state and federal laws can be collectively understood to reflect a coherent effort, characteristic of the public utility tradition, to curb the economic power of the medical industry by inhibiting the free use of its private property. In this, the laws stand as a rejection of the premise that the market will adequately meet the public need for accessible, fairly priced health care. They also belie the conventional assumption that treating medicine as a utility would break decisively with the American regulatory tradition.

A. Supply

The years after the Second World War marked an inflection point for health care.¹⁷⁵ Medical advances, vividly on display among troops in combat,

172. *Id.* at 666–67, 684 (citing 1 WYMAN, *supra* note 5).

173. Wyman, *supra* note 121, at 156 (“[I]n public businesses one must serve all that apply without exclusive conditions, provide adequate facilities to meet all the demands of the consumer, exact only reasonable charges for the services that are rendered, and between customers under similar circumstances make no discriminations.”); *see also* FREUND, *supra* note 93, at 382 (“Turning to the special control exercised over [businesses affected with a public interest], we find that it assumes one or more of the following forms: the regulation of charges; the requirement of equal service; requirements in the interest of public convenience; and requirements and restraints in the interest of financial security.”); WILSON ET AL., *supra* note 103, at vii (“The obligation to render adequate service at reasonable and nondiscriminatory rates has long been recognized as a duty of public utility enterprises.”).

174. *See* Rand E. Rosenblatt, *The Four Ages of Health Law*, 14 HEALTH MATRIX 155, 156 (2004) (“The market competition model developed in the early 1970s, began affecting policy very quickly, and became the dominant paradigm in the 1980s and 1990s.”).

175. *See* PATTERSON, *supra* note 151, at 67 (“Faith in medicine and in the goodness of physicians rose dramatically among the middle classes who could afford them.”).

contributed to a felt need to assure that returning soldiers and the civilians who had contributed to the war effort had access to needed care.¹⁷⁶ Yet hospital construction had stalled during the Depression, leaving the nation's hospital system in tatters, even as private hospital admissions more than doubled from 1935 to the end of the war.¹⁷⁷

Building new hospitals could have been left to the private market. Because of the rapid spread of hospital insurance—virtually nonexistent in 1930, but covering more than 77 million people by 1951—hospitals were on sounder financial footing than ever before.¹⁷⁸ Nevertheless, as the war came to a close, the mismatch between medical need and hospital supply led to a bipartisan call for hospital planning.¹⁷⁹ The push for planning reflected the view that the proper distribution of hospitals, with their newfound public importance, could not be left to the hurly burly of the market.¹⁸⁰

Planning was first embraced as a national goal in 1946 with Congress's enactment of the Hospital Survey and Construction Act, more commonly known as Hill-Burton.¹⁸¹ Building on state-level experiments with hospital planning started in the 1920s,¹⁸² Hill-Burton used the promise of federal money to encourage state planning agencies to survey the need for hospital construction and develop plans to meet that need.¹⁸³ The federal money was not insubstantial. Although the Act initially authorized just \$75 million for hospital construction, the federal government would eventually spend \$4.4 billion over three decades to build and upgrade medical facilities, amounting to roughly 8 percent of the total costs of hospital construction nationwide.¹⁸⁴

With federal money on the line, every state in the country save Nevada had, by 1948, submitted plans detailing their hospital needs.¹⁸⁵ These plans were meant not only to channel public subsidies, but also to guide development more generally.¹⁸⁶ “For the first time,” the Surgeon General declared,

176. See DAVID M. KENNEDY, *FREEDOM FROM FEAR: THE AMERICAN PEOPLE IN DEPRESSION AND WAR, 1929–1945*, at 716 (1999).

177. See STARR, *supra* note 2, at 176–77; STEVENS, *supra* note 146, at 204.

178. See SYLVIA A. LAW, *BLUE CROSS: WHAT WENT WRONG?* 6, 11 (1974).

179. See STEVENS, *supra* note 146, at 213–16.

180. Cf. Charles A. Reich, *The Law of the Planned Society*, 75 *YALE L.J.* 1227, 1230–32 (1966) (linking the rise of planning to the regulation of public service corporations).

181. Hospital Survey and Construction Act, Pub. L. No. 79-725, § 2, tit. VI, 60 Stat. 1040, 1041–49 (1946) (codified at 42 U.S.C. § 291 (2012)). For a general discussion, see STEVENS, *supra* note 146, at 216–24.

182. See Sallyanne Payton & Rhoda M. Powsner, *Regulation Through the Looking Glass: Hospitals, Blue Cross, and Certificate-of-Need*, 79 *MICH. L. REV.* 203, 233 (1980).

183. See Hospital Survey and Construction Act, § 601(a) (assisting state planning agencies to devise plans for “furnishing adequate hospital, clinic, and similar services to all their people”).

184. See H.R. REP. NO. 93-1382, at 24, 26 (1974).

185. STEVENS, *supra* note 146, at 221.

186. See INST. OF MED., *HEALTH PLANNING IN THE UNITED STATES: ISSUES IN GUIDELINE DEVELOPMENT* 10–11 (1980), http://www.nap.edu/openbook.php?record_id=9937&page=R1 (defining planning and distinguishing it from overt regulation).

“a national policy is established whereby hospitals and health centers are to be planned, located and operated in relation to the over-all health needs of the people.”¹⁸⁷ As Stevens notes:

On paper, at least, these plans were impressive. . . . [T]he United States had a nationally defined, regionally organized network for hospital provision—a grid of lines of coordination across the country. The hospital plans, taken together, looked like plans for the national distribution of electricity. . . . Hospitals were regarded as a national resource which should be organized rationally as a national system.¹⁸⁸

During the 1960s, Hill-Burton was repeatedly amended to expand the role of state planning agencies and subsidize a wider array of construction.¹⁸⁹ As Hill-Burton changed focus, so too did health planning. Planning agencies were asked to assess (among other things) the need for community mental health facilities,¹⁹⁰ nursing homes,¹⁹¹ rehabilitation facilities,¹⁹² and neighborhood health centers.¹⁹³ In 1965, Congress allocated \$600 million to regional medical programs that would coordinate treatments for heart disease, cancer, and stroke.¹⁹⁴ And in 1966, Congress overhauled the health-planning apparatus and appropriated almost \$200 million for “comprehensive health planning” at the state level over the next eight years.¹⁹⁵ By the mid-1960s, health planning had entrenched itself as the preferred tool for channeling public subsidies toward areas of perceived need.

Yet planning in the Hill-Burton era lacked regulatory bite. Planning agencies could call for the construction of needed facilities and direct federal and state money toward desired projects, but they couldn’t compel private

187. *Parran Sees Gains for Public Health: Annual Report Hails Hospital Building Plan, Psychiatry Aid and World Organizing*, N.Y. TIMES, Feb. 14, 1947, at 14.

188. STEVENS, *supra* note 146, at 221.

189. See U.S. DEP’T OF HEALTH, EDUC., AND WELFARE, HILL-BURTON PROGRAM PROGRESS REPORT, July 1, 1947 - June 30, 1971, at 27 (1972) (“[T]he focus [of Hill-Burton] has shifted from the prime objective of providing general hospitals in rural areas, then to constructing sorely needed long-term care facilities for the growing numbers of chronically ill and aged, still later to the modernization of obsolete inpatient care facilities primarily in urban areas, and most recently to increased emphasis on . . . outpatient facilities.”).

190. See Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, Pub. L. No. 88-164, §§ 134–35, 77 Stat. 282, 287–88 (codified as amended at 42 U.S.C.A. § 291 (2014) (West, Westlaw through P.L. 113-296 (excluding P.L. 113-235, 113-287, and 113-291))).

191. See Hospital and Medical Facilities Amendments of 1964, Pub. L. No. 88-443, § 3, 78 Stat. 447, 447–62 (codified as amended at 42 U.S.C.A. § 291 (2014) (West, Westlaw through P.L. 113-296 (excluding P.L. 113-235, 113-287, and 113-291))).

192. See Vocational Rehabilitation Amendments of 1968, Pub. L. No. 90-391, § 8, 82 Stat. 297, 300–01 (codified at 29 U.S.C. § 35 (1970)), *repealed by* Rehabilitation Act of 1973, Pub. L. No. 93-112, § 500(a), 87 Stat. 355, 390.

193. See Medical Facilities Construction and Modernization Amendments of 1970, Pub. L. No. 91-296, §§ 110–11, 84 Stat. 336, 339–40 (codified as amended at 42 U.S.C.A. § 291 (2014) (West, Westlaw through P.L. 113-296 (excluding P.L. 113-235, 113-287, and 113-291))).

194. See H.R. REP. No. 93-1382, at 15 (1974).

195. See *id.* at 9.

hospitals or physician practices to do anything. “At best,” the Institute of Medicine reported in 1980, “health planning was viewed as inconsequential, and often it was irrelevant to the development of health care delivery, utilization of services or health care expenditures.”¹⁹⁶ Perhaps for that reason, “[h]ospitals, physicians, and others who had feared and opposed the planning movement as the enemy of professional and institutional autonomy now saw it as a lesser evil than the growing threat of direct public regulation.”¹⁹⁷

Around the same time, skyrocketing medical spending made it harder to defend Hill-Burton. Roemer’s Law—the theory, articulated by Milton Roemer, that a built bed is a filled bed¹⁹⁸—came into vogue, suggesting that facility construction was itself contributing to medical spending.¹⁹⁹ The 1965 enactment of Medicare, which lavishly reimbursed hospitals and other institutional providers for their capital expenses, exacerbated the problem. Health planners began to see that assuring access to reasonably priced health care required more than public subsidies and community meetings. Increasingly, planners sought to prevent heedless, duplicative facility construction.

Their primary technique for doing so—certificate-of-need (CON) legislation—reprise the Progressive Era innovation of demanding that public utilities secure “certificates of convenience and necessity” before constructing new facilities.²⁰⁰ The idea behind CON is simple: prior to undertaking certain capital-intensive projects or purchasing expensive new equipment, hospitals or other medical facilities must secure a permit from a state planning agency. If the proposed investment is judged unnecessary to satisfy a local need for medical services, the permit is denied.

In 1966, a run of large premium increases for Blue Cross plans prompted New York to enact the nation’s first CON law for the medical sector.²⁰¹ Over the next six years, twenty states followed suit.²⁰² In 1972,²⁰³ and then more forcefully in 1974,²⁰⁴ Congress enacted legislation to push for

196. INST. OF MED., *supra* note 186, at 15 (quoting Herbert E. Klarman, *Health Planning: Progress, Prospects, and Issues*, 56 MILBANK MEMORIAL FUND Q. 78, 79 (1978)).

197. *Id.* at 14–15.

198. See Milton I. Roemer, *Bed Supply and Hospital Utilization: A Natural Experiment*, J. AM. HOSP. ASS’N, Nov. 1, 1961, at 36.

199. See INST. OF MED., *supra* note 186, at 7–8 (linking health planning, and limitations on supply, to Roemer’s law).

200. See WILSON ET AL., *supra* note 103, at 33 (“The public utility acts of practically all states provide that no person or corporation shall undertake and engage in the supplying of at least certain types of public utility service without first having obtained from the public service commission a certificate of public convenience and necessity.”); Ford P. Hall, *Certificates of Convenience and Necessity*, 28 MICH. L. REV. 107, 107–08 (1929).

201. See James B. Simpson, *Full Circle: The Return of Certificate of Need Regulation of Health Facilities to State Control*, 19 IND. L. REV. 1025, 1036 (1986).

202. *Id.*

203. See Social Security Amendments of 1972, Pub. L. No. 92-603, § 221, 86 Stat. 1329, 1386 (codified as amended at 42 U.S.C.A. §1320a-1 (2014) (West, Westlaw through P.L. 113-296 (excluding P.L. 113-235, 113-287, and 113-291))).

204. See National Health Planning and Resources Development Act of 1974.

CON's nationwide adoption. CON quickly became ubiquitous.²⁰⁵ According to the Institute of Medicine, “[t]he certificate-of-need programs constitute the closest the United States comes to nationwide control of the supply of health services and the spread of expensive new technology.”²⁰⁶

Anticipating that CON would form a key part of a reinvigorated health-planning apparatus, Congress’s 1974 legislation combined the various responsibilities that Congress had previously assigned to disparate planning agencies and handed them to a set of regional “health systems agencies.”²⁰⁷ Subject to oversight from statewide and national coordinating councils, these revamped agencies—there were usually three or four in each state—would distribute Hill-Burton funds, undertake comprehensive health planning, and coordinate regional medical programs.²⁰⁸ By discouraging wasteful but remunerative medical investments, CON could spur investments in health-care resources that might otherwise be in scarce supply.

In the 1980s, enthusiasm for CON began to wane. As studies demonstrated that CON did little or nothing to control medical inflation, questions arose about its wisdom and necessity.²⁰⁹ Concern mounted that dominant hospitals were exploiting CON to erect barriers to entry and squelch competition.²¹⁰ In addition, the 1983 reform of Medicare’s hospital-payment scheme and the steady proliferation of managed care organizations introduced new incentives for cost-containment into the health-care system, arguably diminishing the need for state oversight of capital expenditures. After Congress repealed its pro-CON legislation, a number of states ended their programs.²¹¹ Even so, CON was hardly abandoned. To this day, CON remains in place in roughly two-thirds of the states.²¹²

* * *

As Wyman and others emphasized during the Progressive Era, public service corporations owe a duty to the public to provide adequate facilities

205. See Simpson, *supra* note 201, at 1055.

206. INST. OF MED., *supra* note 186, at 19.

207. See H.R. REP. NO. 93-1382, at 30–33 (1974).

208. National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1975).

209. See, e.g., Christopher J. Conover & Frank A. Sloan, *Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?*, 23 J. HEALTH POL. POL’Y & L. 455, 456 (1998) (“[A] substantial amount of empirical evidence accumulated by the early 1980s indicat[ed] that CON regulations were ineffective in cost containment.”).

210. See generally Payton & Powsner, *supra* note 182 (so arguing).

211. See Health Planning, Pub. L. No. 99-660, § 701, 100 Stat. 3743, 3799 (1986).

212. See Jill R. Horwitz & Daniel Polsky, *Cross Border Effects of State Health Technology Regulation*, 1 AM. J. HEALTH ECON. 101, 107 fig.1 (2015).

to meet the public need.²¹³ In medicine, that duty found aspirational expression in Hill-Burton before gaining a regulatory foothold through CON.²¹⁴

B. Service

Under the common law, “[a] private hospital owes the public no duty to accept any patient not desired by it, and it is not necessary to assign any reason for its refusal to accept a patient for hospital service.”²¹⁵ The same is said to hold true for physicians.²¹⁶ Contrary to this accepted common law wisdom, however, hospitals and physicians are in fact legally obliged to serve many of those who seek their services. Because traits like race, religion, and disability supply the most common reasons for refusing service, the story of how the duty to serve became stitched into health law is in part a story about the development of the civil rights laws. But only in part. The service obligation doesn’t just prohibit specific types of especially harmful discrimination. It is instead an affirmative duty to serve to the extent of the business’s ability. In medicine, this broader access norm—one that prohibits discrimination on almost any ground save ability to pay—has found expression through the special duties imposed on charitable hospitals and, more recently, through EMTALA.

1. Civil Rights

Under the common law, private charitable hospitals were required to accept, within the limits of their capacities, members of the public on whose behalf the hospital had been established.²¹⁷ Often that was the public at large: cases from the late nineteenth and early twentieth centuries regularly spoke of hospitals that do “not discriminate as to race, sex or religion, but receiv[e] equally all who apply.”²¹⁸ Yet the common law declined to extend a full-fledged service obligation. Hospitals established on behalf of a particular religion or race, for example, could restrict access to members of those groups.²¹⁹ And hospital trustees were empowered to select which members

213. Wyman, *supra* note 5, at xi.

214. See STARR, *supra* note 2, at 376 (“In the United States, where planning has never been widely approved as a role for government, health planning was a limited exception.”).

215. 41 C.J.S., *Hospitals*, § 8, at 345 (1944) (citing Birmingham Baptist Hosp. v. Crews, 157 So. 224, 225 (Ala. 1934)).

216. SARA ROSENBAUM ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 17–19 (2d ed. 2012).

217. See RESTATEMENT (SECOND) OF TRUSTS §§ 372, 374 (1959).

218. Philadelphia v. Pa. Hosp., 8 Pa. C. 72, 74 (1890); see also Hot Springs Sch. Dist. v. Sisters of Mercy of Female Acad. of Little Rock, Ark., 106 S.W. 954, 954 (Ark. 1907); Sisters of the Third Order of St. Francis v. Bd. of Review, 83 N.E. 272, 273 (Ill. 1907); Lutheran Hosp. Ass’n v. Baker, 167 N.W. 148, 149 (S.D. 1918); St. Joseph’s Hosp. Ass’n v. Ashland Cnty., 72 N.W. 43, 43 (Wis. 1897).

219. See LAPP & KETCHAM, *supra* note 142, at 213.

of the public they would serve. As the Massachusetts Supreme Court explained in 1876, “no person has individually a right to demand admission to [a charitable hospital’s] benefits.”²²⁰

That attitude slowly began to change after the Second World War. Building on the public orientation of charitable hospitals, Hill-Burton required hospitals that received federal subsidies to make their facilities available on a nondiscriminatory basis (albeit with a pre-Civil Rights Era allowance for separate-but-equal facilities).²²¹ Hill-Burton was just the beginning. Two decades later, with the connection to health care “prominent in the minds of its authors,”²²² Title VI of the Civil Rights Act of 1964 prohibited discrimination in any programs receiving federal financial assistance.²²³ The enactment of Medicare and Medicaid the following year made Title VI a powerful tool to induce hospitals to offer medical services to the public on a nondiscriminatory basis.²²⁴

Still, Title VI marked only a partial advance. Bowing to political pressure, the Johnson administration declined to characterize Medicare payments to physicians as federal financial assistance.²²⁵ And Title II of the Act, which prohibited discrimination on the basis of race, religion, or sex in “public accommodations,” pointedly did not extend to hospitals and physicians’ offices.²²⁶ Under federal law and most state laws, physicians thus remained free to discriminate.²²⁷

A quarter century later, the Americans with Disabilities Act of 1990 (ADA) marked a transformative step in bringing the service obligation to medicine.²²⁸ Like the Civil Rights Act, the ADA prohibited discrimination in

220. *McDonald v. Mass. Gen. Hosp.*, 120 Mass. 432, 435 (1876).

221. Hill-Burton also required those hospitals to provide “a reasonable volume of hospital services to persons unable to pay therefor,” Hospital Survey and Construction Act, Pub. L. No. 79-725, § 622(f), 60 Stat. 1040, 1043 (1946) (codified at 42 U.S.C. § 291e (2012)), but this was understood to be aspirational. As James Blumstein explains, Hill-Burton “was not designed as a program to pay for indigent care. Rather, it was a program designed to develop facilities to which access would be available to all on a nondiscriminatory basis.” James F. Blumstein, *Court Action, Agency Reaction: The Hill-Burton Act as a Case Study*, 69 *IOWA L. REV.* 1227, 1229 (1984). To put it slightly differently, Hill-Burton was not social-welfare legislation. It reflected the sort of economic regulation to which public callings had long been subjected.

222. Sara Rosenbaum & Joel Teitelbaum, *Civil Rights Enforcement in the Modern Health-care System: Reinvigorating the Role of the Federal Government in the Aftermath of Alexander v. Sandoval*, 3 *YALE J. HEALTH POL’Y L. & ETHICS* 215, 220 (2003).

223. Civil Rights Act of 1964, Pub. L. No. 88-352, tit. VI, 78 Stat. 241, 252–53 (current version at 42 U.S.C. §§ 2000d to 2000d-4 (2012)).

224. See DAVID BARTON SMITH, *HEALTH CARE DIVIDED* 115–21 (1999).

225. See Joel Teitelbaum & Sara Rosenbaum, *Medical Care as a Public Accommodation: Moving the Discussion to Race*, 29 *AM. J.L. & MED.* 381, 382 & n.8 (2003).

226. Civil Rights Act of 1964 tit. II.

227. Teitelbaum & Rosenbaum, *supra* note 225, at 386 & n.28 (noting that the twenty states with public accommodations laws didn’t cover hospitals or physicians’ offices).

228. See Americans with Disabilities Act of 1990, Pub. L. No. 101-336, §§ 101–07, 104 Stat. 327, 330–36 (codified as amended at 42 U.S.C. §§ 12111–17 (2006)).

public accommodations. Unlike the Civil Rights Act however, the ADA included hospitals and physicians' offices within the scope of its protections.²²⁹ By 1990, this extension of public-accommodations law to medicine was so uncontroversial as to pass almost unnoticed.²³⁰

2. Revenue Rulings

Although the civil rights laws made inroads on the classical view that property owners have an absolute right to exclude, they aimed primarily to eradicate institutional discrimination against disfavored groups. As such, the civil rights laws overlap with, but are distinct from, the service obligation. In some respects, the service obligation is narrower: businesses not typically thought to be "affected with a public interest"—barber shops and grocery stores, for example—are still subject to the civil rights laws. In other respects, the service obligation is broader: where it applies, it not only prohibits discrete types of discrimination but also imposes an affirmative duty to serve.

As early as 1956, that broader duty began to be imposed in the health-care sector through the vehicle of federal tax law.²³¹ In a significant revenue ruling, the IRS determined that voluntary hospitals, which accounted for two-thirds of all hospital admissions in the country,²³² would be considered charitable (and thus tax-exempt) only if they were "formed for the purpose of furnishing hospital facilities to *all persons* in the community at the lowest possible cost."²³³ The revenue ruling thus reflected a legal recognition that charitable hospitals could not exclude patients at will.

The service obligation assumed greater prominence in a 1969 revenue ruling updating the IRS's rules on nonprofit hospitals.²³⁴ Two features of the 1969 ruling are noteworthy. First, the ruling obligated charitable hospitals to treat Medicare and Medicaid beneficiaries.²³⁵ The duty to serve those patients thus increased the pressure on nonprofit hospitals to accept federal funding—funding that would, in turn, expose them to the strictures of Title VI of the Civil Rights Act. Second, the revenue ruling required nonprofit

229. 42 U.S.C. § 12181 (2012) (defining "public accommodations," for purposes of the ADA, to include "professional office[s] of a health care provider" and "hospital[s]").

230. Teitelbaum & Rosenbaum, *supra* note 225, at 389.

231. For a discussion of the revenue rulings, see Horwitz, *supra* note 138, at 151–52.

232. See F.H. Arestad & Mary A. McGovern, *Hospital Service in the United States*, 152 JAMA 143, 144 tbl.C (1953).

233. Rev. Rul. 56-185, 1956-1 C.B. 202 (emphasis added).

234. Rev. Rul. 69-545, 1969-2 C.B. 117.

235. See *id.* (requiring treatment "for all those persons in the community able to pay the cost thereof either directly or through third party reimbursement"); E. Ky. Welfare Rights Org. v. Simon, 506 F.2d 1278, 1289 (D.C. Cir. 1974) ("[H]ospitals seeking to qualify as charities pursuant to Revenue Ruling 69-545 must accept Medicare and Medicaid patients . . .").

hospitals to operate “an emergency room open to all persons.”²³⁶ The connection here to the law of public callings is unmistakable.²³⁷ Having built a hospital and opened it to the public, the law imposed a duty to offer a needed public service (a blunt form of health planning) and to serve all in need of that service.²³⁸

3. EMTALA

In the mid-1980s, highly publicized incidents of “patient dumping”—the practice of refusing emergency medical services to those who can’t afford care²³⁹—prompted Congress to enact the Emergency Medical Treatment and Active Labor Act (EMTALA).²⁴⁰ As a condition of participating in Medicare, EMTALA requires hospitals with emergency rooms, as well as their on-call physicians, to treat any person who either has an emergency medical condition or is in advanced labor.²⁴¹ Because Medicare participation is a financial necessity for nearly all hospitals, and because the treatment duty extends to the general public, not just Medicare beneficiaries, EMTALA imposes what is in effect a limited service obligation on all hospitals.

EMTALA mirrors a number of state court decisions holding that, under the common law, emergency rooms must accept for treatment anyone who presents with an emergency condition.²⁴² Some of those decisions were premised on the conclusion that hospitals were affected with a public interest.²⁴³ Still others invoked the reliance interests that were arguably implicated when emergency rooms held themselves out as open to the public²⁴⁴—a move that features prominently in cases involving public callings.²⁴⁵

In the years after its enactment, EMTALA has come in for serious academic criticism. EMTALA may encourage hospitals to shut their emergency

236. 1969-2 C.B.

237. See Mark A. Hall, *The Unlikely Case in Favor of Patient Dumping*, 28 JURIMETRICS J. 389, 390 (1988) (“Largely due to the conception of hospitals as businesses affected with the public interest, for decades these institutions have been subject to numerous sources of law that impose more scrutiny on their criteria for patient selection.” (footnotes omitted)).

238. In 1983, the IRS somewhat softened the obligation to operate an emergency room, but only when a state planning agency found that opening another emergency room would be “unnecessary and duplicative.” Rev. Rul. 83-157, 1983-2 C.B. 94.

239. See David A. Hyman, *Patient Dumping and EMTALA: Past Imperfect/Future Shock*, 8 HEALTH MATRIX 29, 32–33 (1998).

240. See Consolidated Omnibus Reconciliation Act of 1985, Pub. L. No. 99-272, tit. IX, § 9121, 100 Stat. 82, 164–67 (1986) (codified as amended at 42 U.S.C. § 1395dd (2012)).

241. See 42 U.S.C. § 1395dd(d)(1) (2012).

242. See Hall, *supra* note 237, at 392 (“Since the *Manlove* decision in 1961, no court has refused to require at least stabilizing care in a serious emergency, and several decisions have gone much further.”).

243. See, e.g., *Thompson v. Sun City Cmty. Hosp., Inc.*, 688 P.2d 605 (Ariz. 1984) (en banc); *Payton v. Weaver*, 182 Cal. Rptr. 225 (Ct. App. 1982).

244. See, e.g., *Wilmington Gen. Hosp. v. Manlove*, 174 A.2d 135, 140 (Del. 1961).

245. See Singer, *supra* note 127, at 1308.

rooms.²⁴⁶ Hospitals may cope with EMTALA's unfunded obligation by inflating prices for paying patients, many of whom cannot pay more for their care.²⁴⁷ And EMTALA papers over the problem of the uninsured.²⁴⁸ As David Hyman reports, however, "[t]he statute is wildly popular across the entirety of the political spectrum, and among such disparate interest groups as physicians, advocates for the poor, professors of law and public health, and consumer groups."²⁴⁹ EMTALA owes its popularity to the deeply felt and widely shared belief that private hospitals violate a public trust when they refuse medical care to those in need.

* * *

The service obligation in medicine is by no means fully developed. The civil rights laws protect only against discrimination on certain protected grounds; the rules for charitable organizations demand treatment only of Medicare and Medicaid beneficiaries; and EMTALA applies only to emergency services. As the authors of a leading casebook speculate, "[p]erhaps this body of law is not more developed because doctors and hospitals rarely turn away patients who can pay."²⁵⁰ Nevertheless, taken as a whole, the network of laws regulating access to medical services reflects the impulse that private actors serving important needs owe a legal duty to serve the public.

C. *Nondiscriminatory Rates*

As an adjunct to the service obligation, the law has traditionally required public service corporations to charge the same rates for the same services. Otherwise, the service obligation would be of little value: private businesses could either gouge those in desperate need or hike their prices for those whom they preferred not to serve.

In contrast to health planning and the service obligation, prohibitions on price discrimination have not taken hold when it comes to the direct regulation of hospitals and other providers. By and large, providers retain wide freedom to charge different patients different prices.²⁵¹ Yet few people pay directly for medical services. In the private market, most get insurance either through their employers or, less commonly, on the individual market.

246. RICHARD A. EPSTEIN, *MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE?* 95–98 (1997).

247. Robert A. Carolina & M. Gregg Bloche, *Paying for Undercompensated Hospital Care: The Regressive Profile of a "Hidden Tax"*, 2 *HEALTH MATRIX* 141 (1992).

248. See Hall, *supra* note 237, at 394–95.

249. Hyman, *supra* note 239, at 29.

250. HALL ET AL., *supra* note 167, at 117.

251. State restrictions on "balance billing"—the practice of charging patients more than what Medicare or Medicaid pays for their services—are a limited exception. See, e.g., *Mass. Med. Soc'y v. Dukakis*, 815 F.2d 790 (1st Cir. 1987) (upholding such a restriction).

Because the insured are insulated from the full price of their care, discriminatory pricing at the hospital or in a physician's office is often not an urgent concern.

The pricing practices of insurers are more worrisome. An insurer that charges actuarially fair rates will charge the old and unhealthy more for insurance than the young and healthy. Whether "experience rating" amounts to price discrimination in the classical sense is contestable: even if the terms and benefits package of two health plans are identical, the plan sold to the sicker person is, as an actuarial matter, quite different from the plan sold to the healthier person.²⁵² Many people nonetheless view experience rating as unfair discrimination on the basis of health.

Experience rating was not a feature of the health-insurance market when it first arose in the 1930s. The voluntary hospitals, confronted with a funding crisis arising from the confluence of rising medical costs and the Depression, moved to establish Blue Cross organizations to serve as their financing arms.²⁵³ Aligning themselves with the community orientation of the voluntary hospitals, these early Blue Cross organizations charged a single, uniform "community rate."²⁵⁴

That didn't last long, however. When Blue Cross proved the success of the business model, private insurers quickly entered the market. That put Blue Cross plans in an unenviable spot. Because healthier people were attracted to the new, experience-rated plans, Blue Cross organizations had to hike their premiums to cover the larger medical costs of their relatively unhealthy enrollees. Doing so, however, only drove more healthy people away. By the mid-1950s, Blue Cross plans relented to market pressure and, like the private insurers, began to charge sicker enrollees more for their coverage.²⁵⁵

The desire to guard against "unfair" price discrimination in the insurance market has prompted a number of legislative interventions. In the early 1990s, the harshness of experience rating—especially for small businesses, which could find insurance out of reach if a single employee contracted a high-cost illness—provoked forty-five states to limit insurers' ability to discriminate on the basis of health status in the small-group market.²⁵⁶ A handful of those states, including New York, mandated pure or nearly pure community rating in both the individual and small-group markets.²⁵⁷

252. See BREYER, *supra* note 16, at 17 ("'Price discrimination' means, charging, say, different customers two or more different prices for the identical product.").

253. LAW, *supra* note 178, at 6–7.

254. See *id.* at 11–12.

255. See Herman M. Somers & Anne R. Somers, *Private Health Insurance, Part Two: Problems, Pressures and Prospects*, 46 CALIF. L. REV. 508, 514 (1958).

256. See Thomas Buchmueller & John DiNardo, *Did Community Rating Induce an Adverse Selection Death Spiral? Evidence from New York, Pennsylvania, and Connecticut*, 92 AM. ECON. REV. 280, 280 (2002).

257. See OFFICE OF HEALTH POLICY, U.S. DEP'T OF HEALTH & HUMAN SERVS., *THE REGULATION OF THE INDIVIDUAL HEALTH INSURANCE MARKET* 24–26 (2008), aspe.hhs.gov/health/reports/08/reginsure/report.pdf (identifying seven states that mandate some form of community rating in the individual market and eleven states that do so in the small-group market).

The federal government soon got into the reform game. In the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Congress prohibited employers from crafting eligibility rules or raising a worker's premiums based on health status.²⁵⁸ HIPAA thus served as an employer-specific prohibition on price discrimination. The enactment of the Genetic Information Nondiscrimination Act of 2008 went a small step further in barring employers and insurers from using genetic information to deny coverage or increase premiums.²⁵⁹ And the ACA went much further by prohibiting all insurers in the small-group and individual markets—not only those on the exchanges—from experience rating.²⁶⁰ Insurance premiums can still vary based on geography, family status, tobacco use, and age.²⁶¹ Otherwise, insurers must offer the same rate to all comers. In this the ACA represents a partial extension of the public utility model into medicine.²⁶² The ACA, however, draws the line at insurers, eschewing public utility regulation when it comes to physicians, hospitals, and other providers.

D. Fair Rates

As with other aspects of the public utility model, rate regulation became prominent in the medical industry in the second half of the twentieth century. The earliest price controls came through the oversight of Blue Cross plans. A handful of state insurance commissioners—seven in 1974—had the authority to review the rates that Blue Cross plans charged to assure they were not “excessive, inadequate, or unfairly discriminatory.”²⁶³ Eleven more required rates to be “fair and reasonable.”²⁶⁴ Most exercised the authority gingerly, but a few, including Pennsylvania, pushed hard to curb Blue Cross premiums.²⁶⁵

These early efforts to control medical spending were not terribly effective. As medical inflation continued to escalate, attention shifted to direct oversight of hospital rates. Starting with New York in 1969, eight states, concentrated in the Northeast, moved over the next decade to impose price

258. See Pub. L. No. 104-191, § 702, 110 Stat. 1936, 1945 (codified at 29 U.S.C. § 1182 (2012)).

259. See Pub. L. No. 110-233, 122 Stat. 881 (codified in scattered sections of 26, 29, and 42 U.S.C.).

260. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2701, 124 Stat. 119, 155–56 (2010) (codified at 42 U.S.C. § 300gg (2012)).

261. *Id.*

262. See Sara Rosenbaum, A “Broader Regulatory Scheme” — *The Constitutionality of Health Care Reform*, 363 NEW ENG. J. MED. 1881, 1881–82 (2010) (“The [ACA] fundamentally transforms health insurance from a product designed to preserve profitability in the face of rampant adverse selection to a regulated industry whose long-term strength and stability are essential to the public interest and that, in its restructured form, will therefore take on certain characteristics of a public utility.”).

263. LAW, *supra* note 178, at 13.

264. *Id.* (internal quotation marks omitted).

265. See *id.* at 17, 112–13.

controls on hospitals.²⁶⁶ At least nineteen more monitored hospital prices.²⁶⁷ Four states—New York, New Jersey, Massachusetts, and Maryland—took an especially comprehensive approach to rate regulation. They fixed not only the rates that private insurers and Medicaid would pay for hospital services, but also secured federal waivers requiring Medicare to pay hospitals at the state-regulated rates. In the 1970s, this “all-payer rate-setting” dominated the debate over how to restrain hospital prices.²⁶⁸

“In no state was the ‘public utility’ model of rate regulation more conspicuous than in the Empire State”²⁶⁹ Enacted in large part to cut crippling large Medicaid expenditures, New York’s price control laws initially targeted the rates that hospitals could charge Blue Cross and Medicaid. As Sylvia Law explained in 1974:

The theory of the New York cost control plan is that, in the absence of competitive market influence, an incentive-penalty mechanism is needed to keep hospital prices down. The incentive is the amount of money the hospital can plan on and retain if its annual costs total less than its budget projection. Similarly, the amount by which a hospital’s costs exceed its projected budget becomes a financial penalty which the hospital must absorb.²⁷⁰

Over the next decade, New York gradually expanded the scope of its price controls until they covered all payers, including Medicare.²⁷¹

New Jersey tackled rate regulation somewhat differently. Rather than capping overall hospital budgets, New Jersey demanded that hospitals change how they billed for care. No longer could they bill per service or per day; instead, hospitals in New Jersey would bill per case. Under this new diagnosis-related group (DRG) system, hospitals would charge a fixed sum for treating a patient with a particular condition (say, acute pneumonia), giving the hospital an incentive to treat conservatively.²⁷² New Jersey’s experiment with per-case pricing served as the foundation for Medicare’s shift to DRGs in 1983.²⁷³ But where Medicare used DRGs to pin responsibility for controlling costs on hospitals, New Jersey remained committed to a public

266. See Frank A. Sloan, *Rate Regulation as a Strategy for Hospital Cost Control: Evidence from the Last Decade*, 61 MILBANK MEMORIAL FUND Q. 195, 197–98 (1983).

267. See *id.* at 198 tbl.1.

268. Gerard F. Anderson, *All-Payer Ratesetting: Down but Not Out*, HEALTH CARE FINANCING REVIEW, 1991 Supp., at 35, 35 (“All-payer ratesetting for hospitals was at the center of the policy paradigm for controlling health care costs during the 1970s.”).

269. Robert B. Hackey, Commentary, *Regulatory Regimes and State Cost Containment Programs*, 18 J. HEALTH POL. POL’Y & L. 491, 495 (1993).

270. Law, *supra* note 178, at 105.

271. See Anderson, *supra* note 268, at 35–36.

272. See RICK MAYES & ROBERT A. BERENSON, *MEDICARE PROSPECTIVE PAYMENT AND THE SHAPING OF U.S. HEALTH CARE* 24–27 (2006) (describing New Jersey’s adoption of DRGs).

273. *Id.*

utility model of rate regulation.²⁷⁴ It is no accident, as Bruce Vladeck notes, “that the statute creating the New Jersey DRG system is in fact literally an amendment to the state’s health planning law.”²⁷⁵

Experience in New York and New Jersey convinced many observers in the 1970s that price controls were inevitable.²⁷⁶ In an effort to fend off federal oversight, the American Hospital Association established an Advisory Panel on Public Utility Regulation and in 1972 accepted the panel’s endorsement of model legislation that would establish independent rate-regulation commissions at the state level.²⁷⁷ Three years later, Congress authorized grants for states to explore rate regulation.²⁷⁸ And in 1977, President Carter, as a cornerstone of his effort to tackle inflation, proposed federal legislation that would—as he explained in a message to Congress—“restrain increases in the reimbursements which hospitals receive from all sources: Medicare, Medicaid, Blue Cross, commercial insurers, and individuals.”²⁷⁹ Under pressure from the hospital industry, Carter’s bill was narrowly defeated in 1979.²⁸⁰

The defeat of the bill was a harbinger of a diminished appetite in the 1980s for all-payer rate-setting. Starting with Wisconsin in 1986, nearly every state moved to dismantle its rate-setting apparatus.²⁸¹ Today, only two states—Maryland and West Virginia—still impose price controls on hospitals, and Maryland’s ability to sustain its system depends on a statutory waiver requiring Medicare to pay Maryland hospitals based on state-negotiated rates (and, not incidentally, allows Maryland providers to reap an additional \$500 million every year in Medicare payments).²⁸²

274. See Bruce C. Vladeck, *Diagnosis Related Group-Based Hospital Payment: The Real Issues*, 62 BULL. N.Y. ACAD. MED. 46, 46–48 (1986).

275. *Id.* at 53–54.

276. See Lawrence D. Brown, *Political Evolution of Federal Health Care Regulation*, HEALTH AFF., Winter 1992, at 17, 25 (“Hospital association heads believed, and persuaded their constituents, that federal rate regulation was on its way and that they might claim exemption for their homegrown systems when that unhappy day arrived.”).

277. See AM. HOSP. ASS’N, GUIDELINES FOR REVIEW AND APPROVAL OF RATES FOR HEALTH CARE INSTITUTIONS AND SERVICES BY A STATE COMMISSION (1972) (accepted by the Board of Trustees on Feb. 9, 1972).

278. See National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, § 3, 88 Stat. 2225, 2227–59 (1975) (codified as amended at 42 U.S.C.A. 1320a-1 (2014) (West, Westlaw through P.L. 113-296 (excluding P.L. 113-235, 113-287, and 113-291))).

279. President Jimmy Carter, Health Care Legislation Message to the Congress (Apr. 25, 1977), <http://www.presidency.ucsb.edu/ws/?pid=7401> (discussing the Hospital Cost Containment Act of 1977, H.R. 6575, 95th Cong. (1st Sess. 1977)).

280. Steven V. Roberts, *House Unit Defeats a Proposal to Curb Hospital Cost Rises: Major Setback to President*, N.Y. TIMES, July 19, 1978, at A1.

281. See John E. McDonough, *Tracking the Demise of State Hospital Rate Setting*, HEALTH AFF., Jan.–Feb. 1997, at 142, 143–44.

282. Mark Pauly & Robert Town, *Maryland Exceptionalism? All-Payers Regulation and Health Care System Efficiency*, 37 J. HEALTH POL. POL’Y & L. 697, 699 (2012).

Significantly, however, all-payer rate-setting was not discarded because it had been proven ineffective. To the contrary, numerous studies showed that rate-setting reduced per-capita and per-discharge prices, although the evidence was mixed as to whether price controls reduced overall medical expenditures.²⁸³ Instead, as John McDonough argues, managed care killed price controls.²⁸⁴ Managed care organizations were expected to negotiate forcefully with providers over prices. Because rate regulation would interfere in those market negotiations, the waxing of managed care led to the waning of rate regulation.

More generally, the surging interest in managed care in the 1980s reflected a renewed faith in the market and a growing distrust of government solutions to complex social problems. That distrust extended to rate-setting schemes, which were so complex that they fostered suspicion that powerful hospitals manipulated them to their own advantage.²⁸⁵ In this newly skeptical environment, supporters of all-payer rate-setting became “defensive about acknowledging the parallels to [public] utility regulations.”²⁸⁶ Policymakers became so disenchanted with rate-setting by the early 1990s that all-payer rate-setting virtually vanished from the public conversation.²⁸⁷ As McDonough explains, “[t]he public utility model for hospitals, popular with many rate-setting pioneers, is a direct casualty in this transition.”²⁸⁸

* * *

In sum, public utility regulation has formed a strong undercurrent of medical regulation in the modern era, particularly from 1945 to 1980. The supply of medical resources has been overseen; public access has been guaranteed; price discrimination has been curbed; and rates have been regulated. Because the public utility model is now out of fashion, the extent to which it has shaped the regulation of medicine has been obscured. For similar reasons, the policy debate today has distanced itself from the possibility of treating medicine as a public utility.

IV. THE RISE OF PUBLIC UTILITY REGULATION?

Growing faith in the market in the late 1970s and 1980s, a distrust of the cartelization that could arise from single-industry regulation, the political power of organized medicine, and the rise of managed care all contributed to renewed skepticism about the wisdom of treating the medical industry as

283. See KAREN DAVIS ET AL., HEALTH CARE COST CONTAINMENT 100–03 (1990) (reviewing studies); Anderson, *supra* note 268 (same).

284. See McDonough, *supra* note 281, at 142.

285. *Id.* at 144.

286. Vladeck, *supra* note 274, at 48.

287. Anderson, *supra* note 268, at 35 (“[By the 1990s,] the discussion of all-payer ratesetting in national policy circles was almost non-existent . . .”).

288. McDonough, *supra* note 281, at 148.

a public utility. For medicine, approaches that attempt to leverage market forces—not restrain them—have been dominant for three decades.²⁸⁹

The tide may be turning, however. The turn is hard to see in part because, in today's political climate, the adoption of the public utility model at the federal level seems quite unlikely. But the recent relentless focus on federal law, stoked by the long debate over the ACA and its tumultuous implementation, may have distracted from the possibilities of state intervention. Even after the ACA's reshaping of the insurance markets, states retain the authority to regulate hospitals, physicians, and other providers. Not all states will embrace public utility regulation. But might it play an increasingly important role in some?

Without question, political views about the propriety and wisdom of economic regulation will matter. But public utility regulation may also be more attractive in those states with more dysfunctional health-care markets. Exorbitant insurance prices, for example, are an urgent concern in large parts of Connecticut, Colorado, and Wisconsin.²⁹⁰ Similarly, access concerns are expected to be more acute in sprawling rural states—including New Mexico, Idaho, and Nevada—than in smaller states with large urban and suburban populations.²⁹¹

Heterogeneity of preferences and circumstances among the states partly explains why they have historically taken the lead in adapting public utility regulation to medicine. Health planning and CON legislation, although supported by the federal government, were both state-level efforts. State public accommodations laws and emergency-care obligations antedated the Civil Rights Act of 1964 and EMTALA. A number of states moved ahead with community rating in the insurance markets prior to the enactment of the ACA. And New York, New Jersey, and Massachusetts were trailblazers for hospital rate setting.

A new generation of public utility regulation need not mimic these older interventions. The states might, for example, reform their CON laws to more closely superintend provider consolidation, the construction of expensive facilities, or the acquisition of novel technologies. They might enact legislation forcing insurers to accept any willing providers into their networks. Or they might establish commissions to monitor provider prices and perhaps even fix rates.²⁹² Designing institutions that could competently oversee the sprawling medical marketplace and successfully resist pressure from

289. See HACKER, *supra* note 18, at 156 (“The importance of the neoclassical critique to the prevailing intellectual framework of the health policy community helps explain the level of acceptance that has greeted the managed-competition approach.”).

290. See Jordan Rau, *The 10 Most Expensive Insurance Markets in the U.S.*, KAISER HEALTH NEWS (Feb. 3, 2014), <http://kaiserhealthnews.org/news/most-expensive-insurance-markets-obamacare/>.

291. See Bodenheimer & Pham, *supra* note 25, at 802.

292. For an extended, pre-ACA discussion of how cost controls and entry restrictions in use in other countries could be adapted for the United States, see WHITE, *supra* note 20, at 271–82.

the medical industry would be no easy feat.²⁹³ But states confronted with rank unfairness in their health-care markets may come to feel that they have no real alternative.

Whatever the precise contours of state intervention, public utility regulation today would have one advantage over earlier efforts. Instead of focusing on hospitals and neglecting physicians and alternative care settings, economic regulation could target the large medical systems that are coming to dominate the health-care landscape. Not only would that enable economic oversight of services offered outside the hospital. Better still, the states could press those medical systems to adopt pricing models—including fixed budgets or bundled payments—that would encourage care coordination and undermine the pernicious incentives of the fee-for-service system. It's happened before: in the 1970s, New Jersey's rate regulators developed the hospital payment system that Medicare still uses.

Even now, it is possible to discern a renewed interest in public utility regulation, especially, but not exclusively, at the state level. The adoption of pricey technology of dubious medical value—including, in particular, proton-beam accelerators with price tags of \$100 million or more²⁹⁴—has spurred interest in new CON legislation.²⁹⁵ And the impending physician shortage has rekindled interest in health planning, specifically in efforts to address perceived inadequacies in the practitioner workforce.²⁹⁶ For now, workforce planning efforts are largely confined to financial inducements. The ACA, for example, appropriated \$11 billion over five years to support community health centers and the National Health Service Corps, both of which aim to make medical care more readily available in under-resourced areas.²⁹⁷

Access concerns prompted by the exclusion of large hospital systems from insurer networks have also provoked a response from state policymakers. Mississippi, Pennsylvania, South Dakota, and New Hampshire have all

293. Cf. Rachel E. Barkow, *Insulating Agencies: Avoiding Capture Through Institutional Design*, 89 TEX. L. REV. 15 (2010) (examining the complexities of institutional design and agency capture).

294. See Jaimy Lee, *Proton-Beam Centers Sprout Despite Evidence Drought*, MODERN HEALTHCARE, Apr. 14, 2014, at 12, <http://www.modernhealthcare.com/article/20140412/MAGAZINE/304129979>; Amitabh Chandra et al., *Is This Time Different? The Slowdown in Healthcare Spending*, BROOKINGS PAPERS ON ECON. ACTIVITY, Fall 2013, at 261, 287 fig.8, http://www.brookings.edu/~media/Projects/BPEA/fall-2013/2013b_chandra_healthcare_spending.pdf.

295. See TRACY YEE ET AL., NAT'L INST. FOR HEALTH CARE REFORM, RESEARCH BRIEF NO. 4, HEALTH CARE CERTIFICATE-OF-NEED LAWS: POLICY OR POLITICS? 1 (2011) (“[T]here is renewed interest in certificate-of-need regulation as a way to improve health planning and help control spending growth.”); Michael D. Rosko & Ryan L. Mutter, *The Association of Hospital Cost-Inefficiency with Certificate-of-Need Regulation*, 71 MED. CARE RES. & REV. 280, 280 (2014) (“Results suggest that CON regulation may be an effective policy instrument in an era of a new medical arms race.”).

296. See John K. Iglehart, *A New Day Dawns for Workforce Redesign*, 32 HEALTH AFF. 1870 (2013).

297. See 42 U.S.C. § 254b-2(b) (2012).

given serious consideration to bills that would require insurers to accept any provider willing to accept their terms into their networks.²⁹⁸ In addition, some state insurance commissioners have indicated that they will more assertively oversee insurer networks to “make sure when people purchase health insurance, they have reasonable access to health-care providers,” as California’s commissioner put it.²⁹⁹ Earlier this year, New York adopted a law protecting patients from surprise bills if they get treatment from out-of-network providers when in-network providers are unavailable to treat them.³⁰⁰ And the Obama administration recently announced that it will cooperate with state insurance commissioners to craft stringent new rules to assure the adequacy of provider networks on the exchanges.³⁰¹

Nascent interest in regulating prices can perhaps be seen in the rapid proliferation of public databases, all but unknown just a decade ago, that collect information about the rates that private insurers pay for treatment. Frustrated at the secrecy shrouding charges that providers negotiate with insurers,³⁰² sixteen states have moved over the past decade to enact legislation establishing “all-payer claims databases.”³⁰³ The state laws vary along important dimensions—participation is voluntary in some and mandatory in others—but they all aim to give policymakers a sense of the prices that hospitals and other providers actually charge.³⁰⁴ In this, the new databases are reminiscent of state oversight schemes from the 1970s that allowed state officials to monitor hospital rates.

298. See Jay Hancock, ‘Narrow Networks’ Trigger Push-Back from State Officials, KAISER HEALTH NEWS (Nov. 25, 2013), <http://kaiserhealthnews.org/news/states-balk-at-narrow-networks>.

299. Anna Wilde Mathews & Christopher Weaver, *Insurers Face New Pressure Over Limited Doctor Choice*, WALL ST. J., Feb. 6, 2014, <http://www.wsj.com/articles/SB10001424052702304450904579365373011903340>; see also Howard, *supra* note 27, at 592 (“States are . . . stepping up enforcement of existing network-adequacy requirements and considering new restrictions on insurers’ networks.”).

300. Anemona Hartocollis, *State Curbs Medical Bills Containing Surprises*, N.Y. TIMES, Mar. 30, 2014, at A19, http://www.nytimes.com/2014/03/31/nyregion/new-york-curbs-medical-bills-containing-surprises.html?_r=0.

301. Robert Pear, *To Prevent Surprise Bills, New Health Law Rules Could Widen Insurer Networks*, N.Y. TIMES, July 20, 2014, at A12, <http://www.nytimes.com/2014/07/20/us/insurers-face-new-health-law-rules-to-widen-networks-and-prevent-surprise-bills.html>.

302. See White et al., *supra* note 31, at 324.

303. See PATRICK MILLER & ASHLEY PETERS, ALL-PAYER CLAIMS DATABASE COUNCIL, APCD LEGISLATION: REVIEW OF CURRENT PRACTICES AND CRITICAL ELEMENTS 1 (2013), https://apcdouncil.org/sites/apcdouncil.org/files/APCD%20Council%20Legislation_November%202013.pdf.

304. See DENISE LOVE ET AL., THE COMMONWEALTH FUND, ALL-PAYER CLAIMS DATABASES: STATE INITIATIVES TO IMPROVE HEALTH CARE TRANSPARENCY 2 (2010), http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2010/Sep/1439_Love_allpayer_claims_databases_ib_v2.pdf.

Most significantly, rate setting has assumed a new prominence in the policy debates. Leading health economists—including Joseph Newhouse,³⁰⁵ Stuart Altman,³⁰⁶ and David Cutler,³⁰⁷ among others³⁰⁸—have, with varying degrees of enthusiasm, raised the possibility of shifting to an all-payer approach to rate regulation. Its most avid proponent, Uwe Reinhardt, believes the health-care system is at

a clearly delineated crossroads. On one road, Americans would seek better control over national health spending through an all-payer system, such as the one operated by Maryland for the hospital sector. On the other road, Americans would seek better control of health care prices and national health spending through greater reliance on market forces for most of the health system. . . . The battle over US health policy in the coming decades is likely to be over which road to take.³⁰⁹

Interest in rate-setting is not confined to commentators. Maryland, for example, has recently announced it will strengthen its all-payer system in an effort to hold cost growth to roughly the rate of economic growth over the next five years.³¹⁰ Because the Maryland system has done much to limit costs per admission but little to reduce the number of admissions per patient,³¹¹

305. Joseph P. Newhouse, Analysis and Commentary, *Assessing Health Reform's Impact on Four Key Groups of Americans*, 29 HEALTH AFF. 1714, 1723 (2010) (“Despite all of the substantive and political problems of price setting, some sort of all-payer regulatory regime may be the only feasible alternative.”).

306. Financing Comprehensive Health Care Reform: Testimony Before the S. Comm. on Finance, 111th Cong. (2009) (written testimony of Stuart H. Altman), <http://www.finance.senate.gov/imo/media/doc/Stuart%20Altman.pdf> (“I would recommend that the federal government encourage more states to establish all-payer systems . . .”).

307. See Cutler & Morton, *supra* note 45, at 1969 (“A third approach, if there is no other way to obtain good care except through monopoly organizations, is for policy makers to regulate prices or total spending.”).

308. See, e.g., ANNA S. SOMMERS ET AL., NAT'L INST. FOR HEALTH CARE REFORM, POLICY ANALYSIS NO. 9, ADDRESSING HOSPITAL PRICING LEVERAGE THROUGH REGULATION: STATE RATE SETTING (2012), <http://www.nihcr.org/1tl92>; Robert Murray, *The Case for a Coordinated System of Provider Payments in the United States*, 37 J. HEALTH POL. POL'Y & L. 679 (2012); Joseph White, Cost Control and Health Care Reform: The Case for All-Payer Regulation (May 12, 2009) (unpublished manuscript), www.ourfuture.org/files/JWhiteAllPayerCostControl.pdf; Paul B. Ginsburg, *All-Payer Rate Setting: A Response to a 'Modest Proposal' from Uwe Reinhardt*, HEALTH AFF. BLOG (July 24, 2009), <http://healthaffairs.org/blog/2009/07/24/all-payer-rate-setting-a-response-to-a-modest-proposal-from-uwe-reinhardt/>; Jonathan Skinner et al., *The 125 Percent Solution: Fixing Variations in Health Care Prices*, HEALTH AFF. BLOG (Aug. 26, 2014), <http://healthaffairs.org/blog/2014/08/26/the-125-percent-solution-fixing-variations-in-health-care-prices/>.

309. Reinhardt, *supra* note 1, at 2129 (citing Robert Murray, *Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience*, 28 HEALTH AFF. 1395, 1399 (2009)).

310. See *Maryland All-Payer Model*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/> (last visited Mar. 4, 2015).

311. See Robert Murray, *Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience*, 28 HEALTH AFF. 1395, 1399 (2009) (“[A]lthough costs per admission were well controlled, the same cannot be said for hospital admissions and overall hospital volume.”).

the state's new plan will establish fixed budgets for hospital systems keyed to the overall patient population.³¹² Those fixed budgets will put pressure on the systems to reduce not only the costs of care, but also the amount of care they provide. In this, the Maryland plan resembles New York's first efforts at rate-setting in the 1970s.³¹³ As the federal government explained in announcing a partnership with the state, "the Maryland system may serve as a model for other states interested in developing all-payer payment systems."³¹⁴

The trend toward a greater acceptance of the public utility model is nowhere more apparent than in Massachusetts. Because the state addressed the insurance crisis in 2006—four years before the ACA was enacted—it has had longer to attend to other weaknesses in the private health-care system. In a series of enactments culminating in the 2012 adoption of the most ambitious cost-control legislation in the country, Massachusetts has edged much closer than is commonly appreciated toward treating medicine as a public utility.

For starters, the state has put health planning at the center of its new approach. The 2012 law establishes a "health planning council" to catalog "the location, distribution and nature of all health care resources in the commonwealth" and develop "recommendations for the appropriate supply and distribution" of those resources.³¹⁵ The goal of the health plan is "to rationally distribute health care resources across geographic regions of [the] state based on the needs of the population on a statewide basis, as well as, the needs of particular geographic areas of the state."³¹⁶

Massachusetts has also taken steps to more closely monitor provider charges. The state established an all-payer claims database in 2008³¹⁷ and in 2012 expanded the database to require a wider range of data from a broader set of providers about their organizational structure and finances.³¹⁸ In addition, the 2012 legislation created a new entity—the Health Policy Commission—and invested it with authority to oversee state spending targets.³¹⁹ Should the state fail to meet its target in a given year, the commission can review the business practices of any provider with excessive expenditures.³²⁰ Even more significantly, each provider in the state must inform the commission before making any meaningful changes in its operations or governance

312. See MD. DEP'T OF HEALTH AND MENTAL HYGIENE, MARYLAND'S ALL-PAYER MODEL: PROPOSAL TO THE CENTER FOR MEDICARE AND MEDICAID INNOVATION 12 (2013), <http://dhmh.maryland.gov/docs/Final%20Combined%20Waiver%20Package%20101113.pdf>.

313. See *supra* notes 268–271 and accompanying text.

314. *Maryland All-Payer Model*, *supra* note 310.

315. MASS. GEN. LAWS ch. 6A, § 16T(a)–(b) (2012).

316. *Id.* § 16(b).

317. See Act of Aug. 1, 2008, ch. 305, sec. 3, § 16K(a), 2008 Mass. Acts 1322, 1322–23 (2008) (repealed 2012).

318. See MASS. GEN. LAWS ch. 12C, §§ 9, 10(b) (2012).

319. See MASS. GEN. LAWS ch. 6D (2012).

320. See MASS. GEN. LAWS ch. 12, § 11N (2012).

structure.³²¹ If the commission concludes that a change will impair the state's ability to meet its spending target, it can undertake a "cost and market impact review" and, where necessary, refer the provider to the state attorney general for an investigation into potential antitrust violations.³²²

Recent experience suggests that the commission is no paper tiger. Last year, it rebuked Partners HealthCare, Massachusetts's largest hospital system, over its proposed acquisition of a hospital system and physician network.³²³ Believing that the acquisitions would increase the hospital system's market power, the commission referred Partners to the attorney general for possible action.³²⁴ In mid-May, the attorney general announced that she had entered into an agreement with Partners that would allow it to proceed with its acquisitions. In exchange, Partners agreed to rudimentary price controls: it promised (among other things) not to raise costs above the rate of inflation for the next six years.³²⁵

Massachusetts has thus made a considered effort to oversee supply, to reduce discriminatory pricing, and to control costs. In this, Massachusetts's efforts bear the imprint of public utility regulation. By no means has the state unequivocally endorsed the public utility model for regulating medicine: the new legislation is in many respects tentative, particularly when it comes to the enforcement of statewide spending targets. But Massachusetts may be a leading indicator of a broader trend.

CONCLUSION

In 1980, the Institute of Medicine published a report titled *Health Planning in the United States*.³²⁶ Prepared in the heat of a transformational presidential election by a committee of nationally renowned experts, the report's fervent embrace of health planning reflected the then-prevailing consensus that such planning was, and would continue to be, central to the development of the health-care market.

The only discordant note came from committee member Clark Havighurst, an early and avid proponent of the turn to market-oriented strategies in health care. Havighurst offered a separate statement that amounted to a dissent: "My own preference is for restoring competition to a dominant resource-allocation role. The committee acknowledges the existence of this

321. See MASS. GEN. LAWS ch. 6D, §13(a) (2012).

322. *Id.* § 13(a), (h).

323. See HEALTH POLICY COMM'N, REVIEW OF PARTNERS HEALTHCARE SYSTEM'S PROPOSED ACQUISITIONS OF SOUTH SHORE HOSPITAL AND HARBOR MEDICAL ASSOCIATES: FINAL REPORT (2014), <http://www.mass.gov/anf/docs/hpc/20140219-final-cmir-report-phs-ssh-hmc.pdf>.

324. See *id.* at 59.

325. See Martha Bebinger, *AG Inks Deal to Rein in Partners HealthCare, but Does It Go Far Enough?*, WBUR'S COMMONHEALTH (May 19, 2014), <http://commonhealth.wbur.org/2014/05/partners-south-shore-ag-deal>.

326. INST. OF MED., *supra* note 186.

point of view but minimizes its realism. Nevertheless, it is an idea whose time may well be coming . . . ”³²⁷

Havighurst proved prescient. Yet, thirty-four years after Havighurst penned his dissent, public utility is now the idea whose time may be coming (back). In so arguing, I do not mean to minimize how hard it would be to regulate medicine as a utility. Nor do I discount the risks of such an approach. But the familiar objections to public utility regulation—its susceptibility to domination by powerful interests, its inefficiency, the intrinsic difficulty supervising a complex market—may come to seem, in time, less like reasons to dismiss it than as challenges to be managed. If so, the urgent question won’t be whether to treat medicine as a utility. It will be how to assure that the agencies charged with overseeing the medical marketplace have the authority, expertise, and independence to do their jobs.

I could of course be wrong about all of this. Maybe the pendulum is not swinging back; maybe the ACA’s market-oriented approach will prove both workable and durable. Whatever happens, however, the public debate remains much too dismissive of a mode of regulation, deeply rooted in the American tradition, that has long been used to tame the unruly market for health care.

327. *Id.* at A3 (statement of Clark C. Havighurst).