Balance Billing and Physician Reimbursement in an Age of Austerity

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I. Introduction

A. Introduction and Plan of Article

This Article challenges a basic premise of American health law by suggesting that patients, even those who contract with insurance companies or Medicare to pay for their care, may be levied the balance of their bills that remain unpaid to their provider. Although a long-standing proscription in federal law, state law, and provider-insurer contracts forbidding balance billing exists, this Article argues for the revival of the practice in certain circumstances. In short, this Article argues that just as out-of-network patients are required to pay the balance of their healthcare bills and as a byproduct receive superior access *vis-à-vis* patients who dutifully go to contracted physicians, so too in-network patients may be charged the balance of their healthcare bills and in turn may receive superior access *vis-à-vis* similar in-network patients who do not choose to pay the balance of their bills.† In order to understand the policy choice

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† In this instance, what I mean by "superior access" for patients who seek access by out-of-network physicians is that they find a physician they like, trust, or otherwise can treat their condition, whereas an in-network physician may not meet the patient's standard(s) for likeability, trustworthiness, or competence. Some health policy commentators have concluded that the extant Medicare balance billing ban has not led to inferior access for seniors, or for that matter a
outlined in full in Section IV, Section II of the Article provides a brief précis of the American law of balance billing, both of private, commercial insurers and public programs, particularly Medicare and Medicaid. Section III briefly discusses the state law of balance billing and also more fully explicates the economic and financial reasons a doctor would want to engage in a balance billing program. Sections II and III will outline the systemic reasons physicians and patients might want to engage a system in which they remain tethered to insurance companies, yet at the same time be “trued up” to the healthcare provider’s full charges. Section IV argues for a healthcare world that could be much more fully contractarian in nature than the world we live in today. The healthcare system imagined in Section IV is one in which both the patient and the physician get exactly the benefits for which they pay. In the patient’s case, the payment would elicit meaningful access to physicians and prompt responses by those physicians when the patient needs assistance. For physicians, the system imagined in Section IV is more hospitable, allowing physicians to treat fewer patients in more meaningful ways because the overall reimbursement is better. It is a system in which the physician may practice his craft more deliberately because he is marginally less concerned about his profit margins. That is, he will have fewer money worries that plague most physicians in their day-to-day practices because he is receiving more revenue from those patients who choose to pay their entire bills in exchange for better service. Section V of the Article provides a brief conclusion.

B. Austerity’s Effects on a Healthcare System

Austerity. The mere mention of the word evokes trepidation in its hearers. It is onomatopoeia, for it sounds as severe as it actually is. It is the tonic called for by creditor nations to fix the wounds caused by profligate spending and reckless indebtedness piled up by debtor nations. As it is a program that affects every sector of sharp decline in physician income. See Robin McKnight, Medicare Balance Billing Restrictions: Impacts on Physicians and Beneficiaries, 26 J. HEALTH ECON. 340 (2007) (concluding Medicare restrictions on balance billing created a 9% benefit and no loss of access). See also Susan Jenks, Limits On Balance Billing Won’t Hurt Most Physicians, MEDICAL WORLD NEWS (Mar. 26, 1990) (describing the March 1990 report of the Physician Payment Reform Commission to Congress). The report urged Congress to keep the relatively new, at the time, ban on balance billing in place, because the detrimental effect on Medicare reimbursement for physicians was minimal. Id. 2 See Josh Sanburn, What Is The Definition of Austerity?, TIME NEWSFEED BLOG (Dec. 20, 2010), http://newsfeed.time.com/2010/12/20/what-is-the-definition-of-austerity/ (naming “Austerity” 2010’s most searched for word in Merriam-Webster Dictionary). See also Greek Pols Approve Harsh Austerity After Riots, CBS NEWS (Feb. 12, 2012, 6:58 PM), http://www.cbsnews.com/8301-202_162-57376249/greek-pols-approve-harsh-austerity-after-riots/ (tying Greek government austerity measures to its massive indebtedness).
a nation's economy, healthcare providers and services deeply feel the desperate cuts occasioned by austerity measures.

Greece is probably the best known state laboring under the heavy oars of austerity. Practically every part of Greece’s economy that was once greased by easy government money has learned hard and fast to do without a spigot of Euros flowing from the central Athens government. But the healthcare sector of the economy may have been hit the hardest, as the players within it—doctors, hospitals, and patients—have been forced to confront a new reality that what was once relatively simple to procure or deliver is not now so facile. Greek citizens once had open access to healthcare, as Greece provides its citizens a universal care system. However, since austerity measures have been imposed, public hospital admissions have dramatically increased, while private hospital admissions have dramatically decreased, and devastating infections have skyrocketed, as Greeks must now cope with the “new normal” that their supply of healthcare has tightened. Greeks now face more difficulty accessing a general practice physician, which is regrettable, as those doctor visits used to cost less than $10 per visit. Previously, drugs were purchased and processed in a normal supply chain, as in other Western countries. Now, big pharmaceutical manufacturers, like the American giant, Roche, are refusing to deliver drugs, including chemotherapy agents, to Greek state-run hospitals, as invoices have piled up and remain unpaid well past their normal due dates. The Greek health care system is teetering on the edge of collapse: citizens


The report said that in preparation for the new cuts the government was reviewing public spending programs, focusing on savings in social transfers, defense and the restructuring of central and local administration. There would be job cuts in the public sector according to a redundancy and recruitment rule of 1 entry for 5 exits.

Id.


6 Id.

7 Jeanne Whalen, Roche Keeps Drugs From Strapped Greek Hospitals, WALL ST. J., Sep. 17, 2011, available at http://online.wsj.com/article/SB10001424053111904491704576574791877220786.html Roche CEO, Severin Schwan claimed, of hospitals in Portugal and Italy, "[t]here are hospitals who haven't paid their bills in three or four years . . . . There comes a point where the business is
are not receiving necessary care, insurance that was once plentiful has now been rationed, doctors are forced to make do with vastly curtailed pay, and hospitals lack the materials to care for those suffering in their overflowing corridors.  

Italy has not fared much better than Greece. Burdened by the same debt contagion as Greece, the Italian government has been forced to slash spending in all areas of its central budget, including line items for healthcare. Access to physician services will be particularly hard hit in Italy’s austerity budget, as finding replacements for retiring physicians will be very difficult in the coming years. The Italian Senate has proposed that Italians pay a modest co-payment to see physician specialists as part of their state-run and state-subsidized insurance. A ten percent Euro co-payment, while somewhat controversial in Italy, is relatively modest, when compared to the twenty percent copayment American seniors pay when they see a Medicare-contracted physician. 

Essentially, Italians and Greeks are in the beginning stages of suffering under rationing by extreme scarcity. These southern Europeans are quickly coming to the point where it will be hard to get the healthcare that they need—whether physician

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8 See Clarissa Ward, Austerity Brings Greece’s Healthcare System to its Knees, CBS NEWS (Jun. 14, 2012 8:12 PM), http://www.cbsnews.com/8301-18563_162-57453670/austerity-brings-greeceshealth care-system-to-its-knees/. Greek citizens will lose their state funded health insurance if they become unemployed for more than a year or if they owe the government money. Id. Consequently, an increase in the uninsured is forcing those patients to make alternative arrangements to receive care at free clinics. Id. For those that still have insurance the outlook is not much better. Physician's pay has been cut by one-third, emergency rooms are overflowing, and urgent healthcare is often delayed because Greek hospitals do not have the resources to provide the necessary treatment. See Liz Alderman, Amid Cutbacks, Greek Doctors Offer Message to Poor: You Are Not Alone, N.Y. TIMES, Oct. 24, 2012, available at http://www.nytimes.com/2012/10/25/world/europe/greek-unemployed-cut-off-from-medical-treatment.html. Austerity packages signed by the government now force Greek citizens to pay all out-of-pocket costs of their healthcare treatment after government benefits expire. Id.


10 Id.


12 See id. (discussing the "tickets" or copayments now required of Italians to see physician specialists); see also, CENTERS FOR MEDICARE AND MEDICAID SERVICES, MEDICAID & YOU, 34 (2014), available at http://www.medicare.gov/Pubs/pdf/10050.pdf, (explaining after meeting annual deductible Part B beneficiaries typically pay 20% copayment).
services or drugs or other services—at any price.\textsuperscript{13}

Spain, one of the so-called “PIIGS” countries affected by crushing debt and a concomitant austerity program, is faced with many of the same problems in its healthcare sector as Italy and Greece.\textsuperscript{14} Drug companies and other vendors have not been paid in months, and sometimes years. Health facilities are on the verge of closure and physicians face the real possibility of losing their jobs. Spain’s public healthcare system, once considered the envy of Europe, now lies in tatters.\textsuperscript{15}

\section*{C. Austerity’s Impact in America}

Unlike the PIIGS, America’s “debt bomb” has yet to explode. However, policymakers have proposed austerity measures for the nation’s budget including its publicly financed healthcare sector. In a recent essay in the \textit{New England Journal of Medicine}, health policy analyst Jonathan Oberlander outlines the austerity measures contemplated or already codified by Congress.\textsuperscript{16} On top of the billions in savings to Medicare occasioned by the Patient Protection and Affordable Care Act, Oberlander reports that the House and the President have discussed cutting between $350-$400 billion in additional expenditures from Medicare.\textsuperscript{17} Among other measures, Congress has also considered changing the mechanism by which federal Medicaid dollars are appropriated to the states.\textsuperscript{18}

\begin{itemize}
  \item \textsuperscript{13} See supra text note 5 and accompanying text.
  \item \textsuperscript{14} The "PIIGS" are: Portugal, Ireland, Italy, Greece, and Spain. See \textit{The PIIGS That Won’t Fly}, \textit{The Economist} (May 18, 2010), available at http://www.economist.com/node/15838029.
\end{itemize}
If legislators follow through and make Medicare bear the brunt of federal budgetary cuts, they could find themselves on the wrong end of a revolt, which could result in service delivery interruptions to seniors. Historically, seniors and the advocacy groups to which they belong have valued their Medicare benefits as highly as any other benefit provided by the federal government.19 Seniors were especially keen to protect their Medicare benefits in the 2012 national elections.20 Eventually, if Congress dramatically decreases their benefits, seniors might not riot with pitchforks and machetes, but they just might galvanize at the polls and throw out those who stood in the way of their receiving certain Medicare benefits. Fear, real or imagined, over the fate of Medicare belies a deeper and more unsettling fear by American policymakers that America could, however unlikely, go the way of its Southern European allies.21 Though it seems impossible that America could suffer through the same types of riots and pillaging experienced in Greece during 2011 and early 2012, such thoughts are not out of the question should the American economic situation continue to deteriorate.22 Thus, these policymakers argue that rigorous steps should be taken now before unwieldy debt and the full-blown currency debasement make reforms more severe than they already are.23

D. Physician Struggles in the Fee-for-Service System

Notwithstanding the prospect of crisis, American physicians are already under

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Throughout Washington's budget debate over the last year, AARP members and Americans 50-plus urged AARP to prevent cuts in Social Security and Medicare benefits. People recognize that these programs need to be strengthened and are tired of politicians in Washington proposing cuts to Social Security and Medicare to close Washington's budget gap. Those are benefits earned and paid for through long years of work.

Id.


22 Id.

siege. Beset by mountains of indecipherable regulations, molehills of liability concerns, the constant headache of limited fee-for-service reimbursement, and pressure to shift to the “new” iteration of the health maintenance organization, the Accountable Care Organization, doctors are more professionally vulnerable than ever. Doctors are so disenchanted with the profession that there has been some speculation that a mass exodus could occur, especially in light of passage of the Affordable Care Act. This comes at a time when the recent health care reform legislation has highlighted America’s significant shortages of primary care providers and the even more significant reasons why the nation needs a robust corps of those frontline physicians. Unfortunately,

24 See generally, M. Renee Zerehi, Solutions to the Challenges Facing Primary Care Medicine, AMERICAN COLLEGE OF PHYSICIANS (2009). Cf. Jason Shafrin, What are Accountable Care Organizations?, HEALTHCARE ECONOMIST (Jan. 26, 2010), http://healthcare-economist.com/2010/01/26/what-are-accountable-care-organizations/ (denying that ACOs are squarely like HMOs, but at the same time claiming that physicians will see ACOs as HMOs). The Accountable Care Organization (ACO) was codified in the Affordable Care Act as a mechanism to align physician and hospital incentives who are working on behalf of patients. See 42 U.S.C.A. §1395jjjj (2010). See Benjamin P. Geisler, How an ACO will affect physicians and Medicare patients, KEVINMD.COM, http://www.kevinmd.com/blog/2011/04/aco-affect-physicians-medicare-patients.html (discussing how ACOs might affect physicians’ practices).

25 See Andrea Santiago, The Medicus Firm Physician Survey: Health Reform May Lead to Significant Reduction in Physician Workforce, THE MEDICUS FIRM (Jan. 2010), http://www.themedicusfirm.com/physician-survey-2010-article; see also, Paul H. Keckley, Sheryl Coughlin, & Elizabeth L. Stanley, Deloitte 2013 Survey of U.S. Physicians, Physician Perspectives About Health Care Reform and the Future of the Medical Profession, DELoitTE CENTER FOR HEALTH SOLUTIONS (2013), http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us_chns_2013SurveyofUSPhysicians_031813.pdf. “Six in 10 physicians say that it is likely that many physicians will retire earlier than planned in the next one to three years.” Id. It is important to note that the dire predictions foreseen by Medicus and other groups have yet to come to pass, however, the structural problems inducing doctors to think of quitting the profession still remain. In addition to the innovation of the Accountable Care Organization, Congress placed other novelities within the Affordable Care Act with the intent keeping frontline physicians within the delivery system. See, e.g., Patient Protection and Affordable Care Act, Pub. L. 111-148, §§5501, 124 Stat. 119 (2010). These measures include increasing Medicare reimbursement by 10% between January 1, 2011 and January 1, 2016 and increasing Medicare reimbursement for general surgeons working in Health Professional Shortage Areas by 10% during the same time period. Id. See also Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, §1202(a), Stat. 1029 (2010). The Act leveled Medicaid reimbursements for primary care codes to Medicare amounts for two years from January 1, 2013 to December 31, 2014.

26 Concerns over the size of the primary care workforce have been perennial. See, e.g., Paul G. Barnett & John E. Middling, Public Policy and the Supply of Primary Care Physicians, 262 J. AM. MED. ASSOC. 2864 (1989); Gordon Moore & Jonathan Showstack, Primary Care Medicine in Crisis: Toward Reconstruction and Renewal, 138 ANNALS OF INTERNAL MED. 244 (2003). See Thomas Bodenheimer, Kevin Grumbach, & Robert Berenson, A Lifeline for Primary Care, 360 NEW ENG. J.
those who do complete medical school are choosing sub-specialties instead of primary care at a record, and alarming, rate. Those who do choose primary care (family medicine, general internal medicine, pediatrics, and obstetrics-gynecology) must do so with their eyes open. These physicians must realize that their work is a piecemeal, volume-based business in which they are “moving meat” through a system that no longer cares to compensate their work at a rate that is level with their production costs.

It is this piecemeal nature of physicians’ work that lies at the heart of their problems. A doctor who must account for his time with arbitrary billing codes is never free to practice medicine according to his own personal predilections. Each patient in the waiting room, in effect, represents a bill to the insurance company, which does not necessarily reflect the costs borne by the doctor to complete the treatment. Despite the physician’s ostensible freedom, in many ways he is no more than a hard-working independent contractor of the payor, whether private or public.

But it is too facile to conclude that all doctors’ woes can be laid at the feet of non-ideal reimbursement. In truth, doctors are being pulled in a thousand different directions. They must meet patients’ expectations, master new technologies and pharmaceuticals arriving to market at a dizzying rate, and keep their animosity toward their ‘real’ employers, the insurance companies, somewhat in check.
loyalties belie the actual problem in the delivery of health care: a steady, yet inexorable loss of professional autonomy in the face of forces beyond their control.33

In short, doctors have many different masters. But at bottom, their lack of autonomy reflects the reality of the predominant payment structure: the piper, whether in the form of government or private, third party payers, calls the tune for doctors’ day-to-day practices.34 Third party reimbursement defines the scope, types, and amount of medicine that is dispensed to and practiced upon patients by directing such services as the tests, examinations, and procedures the doctor can order for a patient and the amount the doctor will receive for those ministrations, and indirectly controlling such factors as the number and type of employees the doctor has in his office.

Doctors argue that payers have pinned them in their match of professional wrestling because of the payers’ overwhelming strength in the medical marketplace.35 This accession of control to the payers is notable because one of the touchstones of the medical persona is judicious detachment from the mundane cares fretted over by most entrepreneurs.36 The doctor should not have to worry about meeting payrolls and salary ladders. The doctor should not have to worry about inconsequential things like unemployment insurance and hiring billing clerks from the local trade school. Rather, the vaunted picture of the doctor is one of cool and dispassionate equipoise. The

33 National Survey of Physicians, Part III: Doctors Opinions about their Profession, KAISER FAMILY FOUNDATION 1, 3 (2002), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/highlights-and-chart-pack-2.pdf (examining physicians’ views of their profession). “Among the almost half of doctors who would not recommend the profession today, administrative hassles and loss of autonomy are cited as the main reasons for dissatisfaction . . . .” Id.

34 See id. at 4-5 (citing physicians’ strong disaffection for managed care).


The doctor was all of those things. And perhaps for many patients, their doctors still sit high on those lofty perches. However, many, and perhaps most doctors in the American system, now see medicine in the steely, straight lines of business. The payers have compelled such a change. Now, medicine is about turning over patients, shuttling between examination rooms and keeping employees scurrying about the doctor's office. It is ironic that the change in the doctor's practice orientation has been made mainly because of the way the doctor is paid. A doctor would not need a bevy of coding clerks and other administrative personnel if he did not have to allow the insurance company to tell him how his bills to them must be presented. Other doctors are allured by the Patient Centered Medical Home, which consolidates many of the patient's medical service needs in one location. These doctors are leaving traditional, payer driven, fee-for-service medicine, in search of things past, where certainty of payment, like in the managed care era, is high—though total remuneration, as compared to pure fee-for-service, is questionable at this point.

37 See Jack Coulehan, Suffering, Hope, and Healing, in HANDBOOK OF PAIN AND PALLIATIVE CARE: BIOBEHAVIORAL APPROACHES FOR THE LIFE COURSE 717, 725 (Rhonda J. Moore, ed., 2012) (quoting preeminent physician William Osler that "a calm equanimity is the desirable attitude" for physicians).

38 See Sandeep Jauhar, A Doctor by Choice, a Businessman by Necessity, N.Y. TIMES, July 7, 2009, at D5 (reflecting on shift to profit generating requirements in medical profession); Pamela Hartzband & Jerome Groopman, Money and the Changing Culture of Medicine, 360 NEW ENG. J. MED. 101, 101-02 (2009) (articulating time and money pressures facing today's physicians).

39 See KAISER FAMILY FOUNDATION supra note 33 at 4-5.


41 Susan Dorr Goold & Mack Lipkin, Jr., The Doctor-Patient Relationship: Challenges, Opportunities, and Strategies, 14 J. GEN. INTERNAL MED. S26, S30 (1999) (noting physician duty to scrutinize payment incentives to avoid undue influence to individual treatment decisions).

42 See generally, Hammond, supra note 30 at 348 (noting ability of cash only doctors to streamline staff after doctors discontinue contracting with insurers).


Providers should consider ACOs as more than a short-term business opportunity. The shift from volume-driven to value-driven payment is inevitable, and getting limited shared savings while embarking on the needed
Even within the traditional fee-for-service system, doctors are beginning to cry out in resistance to poor reimbursement. Payers, especially government payers, have kept up neither with general inflation or the many other factors necessary to run a busy medical practice. Payers seem willing to let primary care physicians, at least, shoulder the burden of increasing costs. Further, physicians can foresee draconian cuts to their already meager payments and have begun flexing their market muscles, warning policymakers not to balance budgets on their backs. All of this presages a time in the

investments to build the infrastructure and relationships for improving delivery is better than getting no rewards under the fee-for-service system. It may be better to spend now in order to save later and avoid the consequences of the inevitable ratcheting down of fee-for-service rates.

Id. at 2086. See also CENTER FOR MEDICARE & MEDICAID INNOVATIONS: BUNDLED PAYMENTS FOR CARE IMPROVEMENT (2013), http://innovations.cms.gov/initiatives/bundled-payments/index.html (last visited Jan. 21, 2014) (providing descriptions of different models of bundled payments); Robert Wood Johnson Foundation, Patient Centered Medical Homes, HEALTH AFFAIRS, Sep. 14, 2010, available at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=25 (last visited Jan. 21, 2014). The article explains that patient centered medical homes (PCMHs) are heavily dependent on primary care physicians to take the lead in organizing a patient's medical care. Id. It also posits that structural changes to physician reimbursement have not yet been made to allow PCMHs to be widely adopted. Id.


45 See AMERICAN MEDICAL ASSOCIATION: ACCESS TO PHYSICIANS IN JEOPARDY AS RATES FALL FURTHER BEHIND COST INCREASES (2012), available at http://www.ama-assn.org/ama1/pub/upload/mm/399/nac-gap-chart.pdf. The American Medical Association argues that, once adjusted for inflation, physicians' fees in the Medicare program in 2020 will be one-half of what they were in 2001. Id.

not-too-distant future when doctors may consider leaving the practice of medicine for happier work environments, unburdened by picayune bureaucratic tasks, unnecessary overhead, and a “mother may I” approach to getting paid.\(^\text{47}\)


Establishing overall physician expenditure targets may, if it is enforced, control total expenditures but it does not provide any incentives to the individual physician to reduce their use of services; in fact, it may have the opposite effect, to cause physicians to increase their use of services if the conversion factor is reduced. The SGR formula also does not provide any incentives for improving quality or clinical appropriateness of physician services.

Limits on both balance billing and Medicare fee increases (conversion update) are causing a significant shift of primary physician to the non-Medicare market. If the gap between Medicare and private fees for primary care physicians becomes too large, the elderly may find that increase their access to PCPs they will have to join a Medicare managed care plan, where restrictions do not exist on what the plan can pay physicians.

\textit{Id.}

\(^{47}\)\textit{See} AMERICAN COLLEGE OF PHYSICIANS: ACP AND ABIM SURVEY FINDS GENERAL INTERNISTS LEAVE PRACTICE SOONER, LESS SATISFIED WITH CAREER THAN SUBSPECIALISTS, May 7, 2010, \textit{available at} http://www.acponline.org/pressroom/int_survey.htm (finding that 17%
E. The Balanced-Billing Solution

It does not have to be this way. Physicians are not inexorably locked-in to a system that provides them poor reimbursement and other intolerable working conditions. Doctors can claim at least a modicum of their professional identities, which insurance companies have captured, and at the same time, primary care doctors can continue to service their insurance patients. At least as it pertains to insurance-subsidized patients, the prospect of balance billing for the full amount of the doctor’s charge is a valuable, yet overlooked way of infusing much needed cash and professional pride back into the doctor’s practice. Currently, balance billing lies on the scrap heap of American health regulation. Congress has prohibited its use in the Medicare and

of board certified general internists leave their practice within a decade of certification); Gardiner Harris, More Doctors Giving Up Private Practice, N.Y. TIMES, Mar. 26, 2010, at B1; Val Willingham, Half of primary-care doctors in survey would leave medicine, CNN HEALTH (Nov. 17, 2008), available at http://articles.cnn.com/2008-11-17/health/primary.care.doctors.study_1_primary-care-medicare-patients-medicaid-patients?s=PM:HEALTH. The article draws from a survey of primary care physicians by the Physicians’ Foundation that concluded that almost one-half of primary care physicians surveyed said that they would leave the practice of medicine in three years’ time if they had an opportunity to do so. Id. Some physicians, however, are choosing to remain in medicine while giving up their private practices and becoming employed by hospitals, health systems, or insurers. Id.

Medicaid programs, rationalizing that requiring patients to pay more than the modest copayments and monthly premiums already required of them violates the social contract ends of government payment programs. Further, and more importantly, before the advent of modern reimbursement algorithms, the doctor was basically left to his own devices in fashioning his charges. Thus, bills for the balances of a physician’s charge, even after the government paid its rather modest amount, might have quickly impoverished the same cohort of low to middle-income Americans that Medicare and Medicaid were intended to serve in the first place.

Heretofore, balance billing has been considered only in the light of how it burdens patients and concomitantly, how it benefits physicians. This dichotomous

http://www.workforce.com/articles/the-last-word-drilling-down(providing opposing viewpoints on whether to encourage or prohibit balance billing).


In its 'customary, prevailing, and reasonable' (CPR) version, Medicare’s payment for a service was an amount equal to the least of the three charges: (1) the actual, submitted charge, (2) the physician’s customary charge (that is, median of the charges submitted by the physician for the same service in the preceding year), and (3) the prevailing charge, which was the seventy-fifth percentile of the distribution of the customary charges of all physicians in the area for the same service.

Id. CPR charges were not able to staunch the steep growth in physician reimbursement. Id. at 83. Hence, Congress employed a new method in the 1970s, called the Medicare Economic Index (MEI), to reign in growing charges. Id. at 82. But charges continued to rise, eventually leading to the RBRVS and the Physician Fee Schedule. Id. at 87-88. Paul Feldstein asserts that, with the advent of the MEI, the gap between private market fees and Medicare fees continued to diverge. See FELDSTEIN, supra note 46 at 126. Feldstein has also argued that the ability to balance bill Medicare beneficiaries would keep physicians from substituting their time into patients with private insurance that pay better than Medicare. Further, for conscientious physicians who carefully listen to their patients, balance billing remains unavailable to them to be remunerated for their time or attention. See id. at 135-36.

See FELDSTEIN, supra note 46 at 86 (describing "maximum allowable . . . charge[s]," limiting doctors from balance billing more than 15% of the prevailing charge).

thinking calls for a paradigm shift into one that considers benefits to both patients and physicians. Indeed, such a new paradigm can be created when considering balance billing in light of the physician’s routine, daily practice.

Though the framers of the Affordable Care Act sought to provide baseline, low-level access to healthcare through the individual mandate, they have ignored some of the deeper structural issues endemic in modern medicine. For instance, when a patient is sick and makes an appointment with her physician, she is lucky to be seen on the same day as her call. Further, regardless of whether the appointment is scheduled at the last minute or has been settled for weeks, it is quite common for the patient to wait anywhere from several minutes to several hours in the doctor’s office before the doctor sees her. Though some waiting is understandable, extended waiting, even past an agreed-upon appointment time, causes nothing but anger, frustration, and resentment toward the doctor. At the same time, many doctors who feel guilty about missing appointments altogether are not as disturbed by their excessive tardiness, but rather chalk up their lack of punctuality to a reimbursement system that requires them to see more patients than can be reasonably seen in a day.

It would be too much to say that something must give. Doctors can continue to go along to get along. They can busily shuffle patients in and out of their examination rooms, never to fully catch-up. Patients can continue to slowly simmer in their anger toward their physicians, wondering why their doctors do not respect their time. However, if something does not give in the near future, America’s health care system as

53 See 26 U.S.C. § 5000A (2013) (explaining the individual mandate provision, requiring all Americans to procure health insurance or pay a penalty).
54 See American Academy of Family Physicians, Fixing Health Care: What Women Want (March 20-24, 2008), 6, http://www.yumpu.com/en/document/view/8275902/fixing-health-care-what-women-want-american-academy-of-. The results of a survey conducted by the AAFP in which 31% of women could secure a same day primary care appointment, 32% of women could get an appointment in one to two days, and 36% of women had to wait three or more days for an appointment.
56 See Cohen, supra note 55.
57 See Alderman, supra note 55. “Emergencies can throw a well planned day into chaos, and doctors who accept insurance may feel forced to overbook their schedules to assure they can bill for every minute of the day.” Id.
we know it is in line for a potential serious blow. No one can prognosticate with certainty that physicians, especially primary care physicians, will maintain their practices in the face of regulatory burdens, insufficient reimbursement, and the specter of severe funding cuts from the government.\textsuperscript{58} If something is done as a good faith measure to mollify these physicians, particularly primary care physicians, such a gesture just might be the marginal incentive necessary for doctors to remain in the system and for more to enter it.

In short, something \textit{can} give. Patients and doctors can forge a better way in which patients are expeditiously treated and doctors gain a modicum of satisfaction, knowing that they are paid in full for their services. Patients and physicians can contract so that patients who pay the balance of the physician’s bill receive a higher priority in the physician’s queue and are treated faster than patients who do not pay the balance bill.\textsuperscript{59}

This proposal is startling, if not shocking, to most health policy experts. A foundational premise of contemporary health policy in America is that all patients are created equal.\textsuperscript{60} Moreover, all patients deserve, by virtue of their presence in America,


\textsuperscript{59} See discussion infra, Part. IV.B (describing this Article’s plan to allow physicians to re-prioritize patients who agree to balance bill). See also, Sid Kircheimer, \textit{The Doctor Will See You But Not Your Insurance}, (Aug. 6, 2013), http://www.aarp.org/health/health-insurance/info-08-2013/direct-primary-care.html. Kircheimer stated:

\begin{quote}
Patients pay a monthly membership fee – typically $50 to $80. In exchange, they get a more generous allocation of appointments, sometimes for the same day or the day after they called. Appointments usually last longer than the average seven minutes per insurance-based visit. Doctors are often accessible via phone, email or Internet chat and some even make house calls.
\end{quote}

\textit{Id.}

\textsuperscript{60} See, e.g., DAVISON M. DOUGLAS & NEAL DEVINS, \textit{REDEFINING EQUALITY} at 3 (Oxford University Press 1998). The notion of equality is central to American life. Enshrined in two of the nation's central documents - the \textit{Declaration of Independence} ("We hold these truths to be self-evident, that all men are created equal") or the U.S. Constitution ("No state shall ... deny to any person within its jurisdiction the equal protection of the laws") - equality is one of the basic foundations of our national life. \textit{See also}, L.R. POLE, \textit{THE PURSUIT OF EQUALITY IN AMERICAN HISTORY}, 1 (University of California Press, 2d. ed., 1993).
meaningful access to health care goods and services. No patient, claim the theorists of equality, should be advantaged in the procurement of health care services, overtly or insidiously, merely because he has more money than his fellow man. Indeed, Congress recognized that there was a fundamental discrepancy between millions of Americans: while most had access to some form of health insurance, many millions more had no means to access health care services because they did not have the insurance that would make that access practical. Thus Congress sought to bridge the yawning gap between the ‘haves’ and ‘have nots’ by requiring everyone to procure health insurance, and providing generous subsidies for those citizens who cannot procure insurance on their own. Our national problem is that primary care doctors are leaving their practices in droves, driven out by their low pay, relative to that of specialists, long hours and mountains of paperwork. Some of them go to work in emergency rooms or hospitals, others become specialists, and many simply abandon the practice of medicine.

Not only were the people of Britain’s North American colonies the first subjects of any of Europe’s colonial empires to gain their independence from the Old World, but they were the first of any nation to base their national existence on an abstract moral principle. The principle that all men are created equal was inseparably woven into the moral foundation on which the Continental Congress justified the colonies’ rebellion against the crown and the existence of the United States as an independent nation.


See, e.g., EZEKIEL J. EMANUEL, HEALTHCARE GUARANTEED: A SECURE, SIMPLE SOLUTION FOR AMERICA, 1 (Public Affairs, 1st ed. 2008). Emanuel’s plan “guarantees all Americans health coverage-and by all we mean 100 percent of them.” Id.

156 Cong Rec. S11826-02 (2009) WL 4001834 (debating the need for extensive health care reform to address the “46 million ... uninsured in the country”).

Patient Protection and Affordable Care Act, §1501 (2010) (describing a “Requirement to Maintain Minimum Essential Coverage”); Id. at § 1402 (demonstrating “Reduced Cost-Sharing for Individuals Enrolling in Qualified Health Plans”).

II. The Law and Policy of Balance Billing

A. Prohibitions Against Balance Billing in Medicare

1. Reining-In Charge-Based Reimbursement

The story of Medicare is one in which the legislators who crafted the program and the bureaucrats who administered it were not originally concerned with outflows from its coffers ruining the program. Only after the passage of a significant amount of time, in the case of Medicare six years after the program signed up its first beneficiary, did the administrators of the program begin to worry about costs associated with reimbursing physicians for their professional services. The first few years of the Medicare program's existence saw the program, its contracted physicians, and its beneficiaries, swept up on a fast moving wave of economic growth. Like its cousin program, Social Security, Medicare is constructed on the premise of "pay as you go" or "pay go." The program depends on a robust corps of taxpaying workers to fund its ongoing operations, particularly for Medicare Part A ("Part A"), which funds inpatient benefits. In the first several years of the program's existence, a generous surplus of taxpayers supported the relatively modest number of beneficiaries. Gradually, as the

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66 See AMERICAN MEDICAL ASSOCIATION, SAVING MEDICARE FOR THE LONG TERM: DEALING WITH THE TRUST FUND MYTH, available at http://www.ama-assn.org/ama1/pub/upload/mm/363/savingmedicare.pdf. (last visited Jan. 21, 2013). In 1965, the year the Medicare Act was passed, there were 5.5 taxpaying workers for every beneficiary, now there are 3.9 workers for every beneficiary, and by 2020, the ratio will decline to 2.2 workers per beneficiary. Id.

67 See MAYES, supra note 50 (discussing Medicare Economic Index (MEI) as a regulator of a physician's CPR fees).

68 See NORMAN FRUMKIN, TRACKING AMERICA'S ECONOMY 305 (M.E. Sharpe Inc. 4th ed. 2004). "Relatively low interest rates were associated with high economic growth in the 1960s, lower real interest rates in the 1970s were associated with lower economic growth in the 1960s..." Id.

69 See American Medical Association, supra note 66 at 1. The analogy made by the AMA to the "pay go" model was to a chain letter. Id. The 'pay-as-you-go' financing of Part A is similar to a chain letter in that it promises future benefits to those who fund services for current participants. Id. Likewise, the number of workers contributing payroll taxes to finance the Part A trust fund is declining and there is a continual need for a growing number of new contributors to fund the growing number of new beneficiaries. Chain letters, however, eventually collapse from an insufficient influx of new contributors. Id.


71 See William G. Dauster, Protecting Social Security and Medicare, 33 HARV. J. ON LEGIS. 461, 482 (1996). In the first twenty years of operation, surpluses averaged $1.5 billion per year. Id. In 1989, the Medicare Part A fund surplus amounted to $17 billion. Id.
“Greatest Generation” and the Baby Boomers started retiring and claiming their Medicare benefits, and as the American manufacturing base began to erode, Medicare’s actuaries began to project negative balances in the program’s capital accounts.\textsuperscript{72} Simply, the program slipped off the path of robust fiscal growth and fell into a quagmire and may soon find itself with more beneficiaries than supporting taxpayers can handle.\textsuperscript{73} If Part A and its elusive trust fund were to run out of money, as has been long threatened, the hospital insurance benefits of millions of senior Americans would be imperiled, and the nation itself would suffer a \textit{bona fide} crisis.\textsuperscript{74}

\textsuperscript{72} \textit{BD. OF TRS. OF THE FED. HOSP. INS. AND FED. SUPPLEMENTARY MED. INS. TRUST FUNDS, THE 2008 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS} 59-61 (2008), available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2008.pdf. \textit{See also} U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-11-126R, \textit{MEDICARE: PRIVATE SECTOR INITIATIVES TO BUNDLE HOSPITAL AND PHYSICIAN PAYMENTS FOR AN EPISODE OF CARE} 1 (2011), available at http://www.gao.gov/new.items/d11126r.pdf. The Office warned “we and other federal fiscal experts—including the Congressional Budget Office (CBO) and the Medicare Trustees—have noted the rise in Medicare spending and expressed concern that the program is unsustainable in its present form.” \textit{Id.} The name of the Part B program is not to be confused with a Medicare supplement policy, which pays for the costs that the Parts A and B programs do not cover. This is how the Centers for Medicare and Medicaid Services describes a Medicare supplement policy:

A Medicare supplement (Medigap) insurance, sold by private companies, can help pay some of the health care costs that Original Medicare doesn’t cover, like copayments, coinsurance, and deductibles.

Some Medigap policies also offer coverage for services that Original Medicare doesn’t cover, like medical care when you travel outside the U.S. If you have Original Medicare and you buy a Medigap policy, Medicare will pay its share of the Medicare-approved amount for covered health care costs. Then your Medigap policy pays its share.

A Medigap policy is different from a Medicare Advantage Plan. Those plans are ways to get Medicare benefits, while a Medigap policy only supplements your Original Medicare benefits.


\textsuperscript{73} \textit{See} \textit{BD. OF TRS. OF THE FED. HOSP. INS. AND FED. SUPPLEMENTARY MED. INS. TRUST FUNDS, supra} note 72 at 60. The relatively small number of persons born after the 1970s that will make up the labor force as the baby boom generation becomes eligible to receive Medicare benefits is insufficient to finance the rapid increase in Medicare expenditures resulting from such increased eligibility. \textit{Id.}

\textsuperscript{74} \textit{See} \textit{BD. OF TRS. OF THE FED. HOSP. INS. AND FED. SUPPLEMENTARY MED. INS. TRUST FUNDS, supra} note 72. Presumably, if the Part A trust fund were ever to be extinguished, then CMS
Medicare Part B ("Part B"), formally called Supplemental Medical Insurance, is not dependent on the "pay-go" model. In a sense, Part B can never run a deficit that threatens its existence. Whatever expenditures from Part B are not covered by beneficiaries' monthly premiums are covered by general funds appropriated by Congress and held in custody by the Department of Treasury. If the Centers for Medicare and Medicaid Services ("CMS") were ever to overrun its allotted funds, the Department of the Treasury would simply sell Treasury securities to cover any shortfalls. Even though Part B's budgetary problems have a simple solution, policymakers are not unconcerned with the rate of Part B spending. On the contrary, untrammeled growth in Part B spending has been a cause for concern since the first decade of the program's existence. The expansion of Part B spending threatens to crowd out other programs for which Congress might appropriate funding. Simply, its growth cannot indefinitely continue.

In an attempt to control Part B spending, the government has placed limits on

would simply have to "ration" the payment for some of its bills over others until it could return once again to a footing of solvency. Id. See also TRUSTEES: MEDICARE FUND WILL RUN OUT IN 2026, CBS NEWS (May 31, 2013), http://www.cbsnews.com/news/trustees-medicare-fund-will-run-out-in-2026/ (last visited Jan. 21, 2014). Ten thousand baby boomers are reaching retirement age and will qualify for Medicare benefits. Id. Depletion of the trust reserves will trigger reductions in benefits. Id.

See How is Medicare Funded?, supra note 70. Part B is supported by Congress and by premiums paid by enrollees. Id.

See Dauster, supra note 71, at 482. "[T]he SMI Fund is as actuarially sound as the United States government. Consequently, few debate its solvency." Id.

See How is Medicare funded?, supra note 70 (noting the Part B "trust fund" consists of enrollee premiums and budget appropriations).


See SUE A. BLEVINS, MEDICARE'S MID-LIFE CRISIS 56 (2001). Part B spending increased from $1.27 billion to $2.18 billion between 1967 and 1972, and increased to more than $90 billion in the year 2000. Id. As early as July 1967, President Johnson expressed concern with the cost of Medicare. Id. at 60.

See RICHARD W. JOHNSON & CORINA MOMMAERTS, WILL HEALTH CARE COSTS BANKRUPT AGING Boomers? vi (2010), available at http://www.urban.org/uploadedpdf/412026_health_care_costs.pdf. "As many analysts have observed, steady cost growth threatens to bankrupt Medicare and strain the federal budget, potentially crowding out other government priorities." Id.
reimbursement. In the first several years of the program’s existence, Part B contracted physicians were reimbursed according to their “reasonable” charges. For the most part, physicians could set their own prices. These physicians could set their fees at whatever level they desired, as long as their own idiosyncratic fee schedule did not exceed 75% of the average fees in their particular community. This charge-based reimbursement made the program’s payment agents and central administration nothing more than a collection point for physicians’ bills and information about prevailing charges within the disparate communities of America. This era of largesse began to come to an end in the 1980s. In order to trim the sails of “out-of-control” physicians, Congress moved away from a dispersed, multi-price system to a system in which prices were centrally set and administered. In 1989, Congress created the Resource Based

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83 A. Bruce Steinwald, U.S. Gov’t Accountability Office, GAO-06-1008T, Medicare Physician Payments: Trends in Service Utilization, Spending, and Fees Prompt Consideration of Alternative Payment Approaches 3 n.7 (2006), available at http://www.gao.gov/new.items/d061008t.pdf. “Medicare paid physicians on the basis of ‘reasonable charge,’ defined as the lowest of the physician’s actual charge, the customary charge (the amount the physician usually charged for the service), or the prevailing charge (based on comparable physicians’ customary charges).” Id.
84 See Mayes, supra note 50 at 82.
85 Id. (noting prevailing charge is seventy-fifth percent of physicians’ charges in community for same service).
86 See Sylvia A. Law & Barry Ensminger, Negotiating Physicians’ Fees: Individual Patients or Society? (A Case Study in Federalism), 61 N.Y.U. L. Rev. 1, 12 (1986). Congress gave Blue Cross Blue Shield the responsibility of paying doctors and required such payment be based on doctors’ reasonable charges. Id. Thus, the CMS played only a passive role in the day-to-day processing of claims. Id. See also Theodore R. Marmor, The Politics of Medicare 63 (2nd ed. 2000) (offering reason why the government allowed “reasonable charges” system). “[C]ongressional sympathy with the doctors’ distaste for government control, and a fear that doctors would elect not to treat Medicare patients under more restrictive fee schedules, made ‘reasonable charges’ appear a sensible standard of payment.” Id.

Hospitals, physicians and other providers had even less incentive to hold the line on costs, since larger total insurance reimbursements implied larger total payments to providers. The end result was that costs soared out of control. Eventually employers, Medicare, and Medicaid were all forced to make changes to reduce expenditures. In Medicare and Medicaid, the freedom of doctors and hospitals to charge what they wanted was replaced by controlled administrative prices under the prospective payment “Resource Based Relative Value System” (RBRVS) . . . and “Diagnostically Related Group” (DRG).
Relative Value Scale (RBRVS), that itself generated the Medicare Physician Fee Schedule for the first time in 1992. For the first time in Medicare’s twenty-six years of existence, CMS had a way to centrally set prices so it would better be able to plan for physician expenses. However, even a master price list, generated entirely within the control of CMS, could not adequately tamp down costs. In 1997 Congress created the Sustainable Growth Rate, which has been roundly panned in all quarters as an abject failure.

Not only are physicians’ prices now centrally fixed, no longer can a contracted physician easily charge patients for the balance of their outstanding bills. For over twenty years, Congress has upheld the overarching policy goal of Medicare that seniors should receive medical care without posing an inordinate burden on their financial well-being. Thus, the dictate is clear: physicians contracted to the Medicare program may

90 See Joe Eaton, Little-Known AMA Group Has Big Influence On Medicare Payments, KAISER HEALTH NEWS, (Dec. 3, 2013, 3:50 PM), http://www.kaiserhealthnews.org/stories/2010/october/27/ama-center-public-integrity.aspx (explaining that the CMS has overwhelmingly rubber-stamped RUC recommendations). An AMA physicians’ guide states “from the AMA’s perspective, the RUC provides a vital opportunity for the medical profession to continue to shape its own payment environment.” Id. Since Congress created the RBRVS, the “AMA has been involved in the reimbursement system,” serving as a contract liaison “between practicing physicians and the Harvard researchers who initially ranked physician services.” Id. According to an AMA handbook, this role “ensured medical societies were ‘involved in important aspects of the development of the relative values for their specialties.’” Id.
91 See Chris Jacobs, Medicare’s Sustainable Growth Rate: Principles for Reform, THE HERITAGE FOUNDATION, (Dec. 3, 2013, 3:55 PM), http://www.heritage.org/research/reports/2013/07/medicares-sustainable-growth-rate-principles-for-reform. The Sustainable Growth Rate was enacted by Congress as part of the Balanced Budget Act of 1997. Balanced Budget Act of 1997, 42 U.S.C. § 1395w-4(d)(3) (1997). The SGR acts as a “governor” on inflation in the Physician Fee Schedule by tying growth in fee schedule to growth of the gross domestic product. See id. The Sustainable Growth Rate can also “ratchet down” fees on the fee schedule. See id. However, Congress has consistently stayed the application of the SGR. Even though Congress may stay the cuts, they accumulate. See Jim Hahn, CONG. RESEARCH SERV., MEDICARE PHYSICIAN PAYMENT UPDATES AND THE SUSTAINABLE GROWTH RATES (SGR) SYSTEM (2010). Thus, if SGR were ever to be implemented, the cuts occasioned by it would be draconian. See id.
93 See Omnibus Budget Reconciliation Act of 1989, 42 U.S.C. § 1395w-4(g)(2) (1991) (enacting the balance billing prohibition in 1991). A prominent health economist has attributed the desire to balance bill, to the rational economic impulse, present in the first several years of the Medicare program’s existence, to price discriminate, or charge different patients different prices, based on
not charge their patients the balance on their bills.94

2. The Participating/Non-Participating Physician Conundrum

The statutory proscription against balance billing does not tell the entire story of Medicare’s stance toward the practice. Physicians can require patients to pay the balance of their bills. Indeed, physicians can demand payment of their entire bills up front, but only if the physician enters into a Faustian bargain with the government in exchange for completely forswearing direct payment of Medicare reimbursement for a period of one year, physician’s may charge patients up to 115% of the Physician Fee Schedule price for each good or service provided.95 This fifteen percent difference between the fee schedule for “participating” and “non-participating” physicians is referred to as the “limiting charge.”96

The government wields its bargaining power with physicians even in situations that are only tangentially related to the program.97 Medicare partially sidelines physicians for one year, denying them the benefit of a steady stream of revenue provided by claims that are promptly paid by Medicare’s payment agent.98 If a patient wants to see a particular doctor who does not accept assigned claims, the patient must front the entire
bill and then subsequently seek reimbursement from Medicare. This is akin to a patient seeking treatment from an out-of-network doctor, paying the doctor's entire bill, and then seeking partial reimbursement from the insurance company, which is typically less than the insurance company would pay an in-network doctor. The non-participating physician has less opportunity to reap a steady stream of senior patients—a stream that would positively inure to the overall revenues of the physician's business. Although Medicare does not force non-participating physicians to completely refuse assignment—the non-participating physician may accept assignment on a case-by-case basis—this flexibility is limited by the amount that the non-participating doctor can charge.

Even physicians who do not accept assigned claims, are limited by the government in the amount they may charge—in this case, 115% of the price set by the Medicare Physician Fee Schedule. This is the tradeoff that the physician accepts in order to be tangentially affiliated with the Medicare program. The doctor cannot charge his own fee schedule price for the good or service, unless the doctor's idiosyncratic price just happens to coincide with the limiting charge, which reflects the doctor's estimation of her value for the item. At the same time, the doctor can charge a significantly higher percentage of the Physician Fee Schedule for the item by opting out of

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100 See Id. See also In-Network vs. Out-of-Network Care, FAIR HEALTH CONSUMER LOOK UP, http://www.fairhealthconsumer.org/reimbursementscenarios/installment_two.aspx (last visited Jan. 21, 2014).
101 See Sandra J. Carnahan, Law, Medicine, and Wealth: Does Concierge Medicine Promote Health Care Choice, Or Is It a Barrier to Access?, 17 STAN. L. & POL'Y REV. 121, 141 (2006). A non-participating provider can choose on a case-by-case basis whether or not to take assignment of a patient’s claim. Id. A claim is paid on an “assignment-related basis” if it is reasonable and the physician agrees not to charge for services denied by Medicare Part B. 42 U.S.C. §§1395u(h)(1)-(2); §§1395u(b)(3)(B)(ii). A “participating physician” is a physician who at the time of providing services is enrolled with Medicare. Id. at §1395u(h)(1). See FELDSTEIN, supra note 46 at 266-68 (discussing economics of physician taking assignment). Feldstein argues that “[t]he closer Medicare-approved fees were to fees in the private sector, the higher the assignment rate.” Id.; but see Carol Stevens, Is there any reason not to paripate in Medicare?, 69 MED. ECON. 44 (Jul. 6, 1992) (arguing against non-participating Medicare physicians for economic reasons).
102 Carnahan, supra note 99 at 141 (discussing limitations on charging patients when physicians do not accept assigned claims). “No person may bill or collect an actual charge for the service in excess of the limiting charge described in paragraph (2) for such service.” 42 U.S.C.A. §§1395w-4(g)(1)(A)(i). See 42 U.S.C.A. §§1395w-4(g)(2)(C) (defining “limiting charge . . . [as] 115% of the recognized payment under this part for nonparticipating physicians . . . ”)
103 See Carnahan, supra note 99 at 141 (noting physicians may only charge up to 115% of Medicare allowable rates).
This is one way that Congress tries to corral costs, even for physicians who do not accept assignment. By tying these doctors' reimbursements to the Physician Fee Schedule, albeit at a higher rate than most doctors, Congress has not swung the pendulum all the way back to charge-based reimbursement. Congress wants to retain a modicum of control over the physicians who treat Medicare beneficiaries by not allowing those physicians to inordinately drain its fisc. By placing a hard cap on non-participating physicians' charges, Congress runs the risk of marginalizing, and therefore pricing out physicians who strongly resent not being able to charge their own prices to their patients. Nevertheless, it is a risk that Congress was willing to take, given the social insurance and even moral claims engendered by the Medicare program. There has been a movement within the past several years to allow Medicare-contracted physicians to go beyond the limited reimbursement available through the balance billing of unassigned claims.

B. Medicare Private Contracts—Small Change, Yet Dramatic Effect on Physician Access

The year 1997 saw a minor concession to the concept of private contracting—a small step that would allow physicians to recover the full extent of their personal charges. In that year's Balanced Budget Act, Congress allowed Medicare-enrolled physicians to enter into private contracts with patients with two very large caveats. One is an "all in" type of provision. First, any physician who chooses to enter into a private contract with a patient must forego all Medicare reimbursement for a two year period. Second, the patient with whom the private contract is made cannot use Medicare

104 Id. "Physicians wishing to set their own fee schedules for Medicare patients must opt out of the Medicare program entirely and enter into private contracts with their Medicare patients . . . [and] may set their own fee services, unencumbered by Medicare billing limitations." Id.
105 See id. at 140-41.
106 See id.
107 See THOMAS E. GETZEN, HEALTH ECONOMICS AND FINANCING 139 (John Wiley & Sons, Inc. 4th ed. 2010). Getzen claimed that physicians who do not take Medicare at all may want to substitute into "obstetrics, sports medicine, or another specialty in which they treat few elderly clients". Id.
108 See ROBERT DALLEK, LYNDON B. JOHNSON: PORTRAIT OF A PRESIDENT, 344 (Oxford University Press 2004) (claiming "Medicare is a triumph of rightness").
110 See id.
111 Id. at § 1395a(b)(3)(B)(ii).
her Medicare benefits to pay the compensation to the privately contracted physician. In other words, no claim for Medicare reimbursement can be made for a privately contracted service.

Medicare’s extant version of private contracting is an “all or nothing” endeavor and is draconian for physicians and particularly for patients. Physicians must forego all connections with the Medicare program for a significant amount of time. Patients who do not avail themselves of a private contract would be deprived of a physician who may be competent, and moreover, who they may generally like. It seems incongruous for Congress to force physicians and patients into a genuine Hobson’s Choice, particularly at a time when primary care physician affiliation with the Medicare program is waning.

In 1997, Senator John Kyl put forth a bill whose purpose was to allow Medicare-contracted physicians and beneficiaries to make private, side contracts concerning the payment for patients’ care. Furthermore and equally important, it would have allowed physicians to remain enrolled in Medicare, notwithstanding the side-contract with one or more patients. It was the hope of Senator Kyl and other sponsors of the bill that an allowance, though not a mandate, for side contracts would keep physicians in the Medicare program. Nothing in the bill would have prevented contracting physicians from reprioritizing their patients within the physicians’ treatment queues according to the physicians’ and patients’ mutual benefit.

Senator Kyl’s bill never made it to President Clinton’s desk. Seniors’ interest

112 Id. at §§ 1395a(b)(1)(A); (b)(2)(B)(ii).
113 Id.
114 See Moffit, supra note 28 at 5-6 (discussing these and other criticisms of the extant Medicare private contracting allowance). See United Seniors Ass’n v. Shalala, 182 F.3d 965, 966-67 (D.C. Cir.1999) (discussing prominent litigation about §4507); see William Buczko Ph.D., Provider Opt-Out Under Medicare Private Contracting, 26 Health Care Fin. Rev. 43, 1 (Winter 2004-2005). Buczko discusses an empirical look into private contracting, concluding that relatively few Medicare-affiliated physicians have taken advantage of the private contracting option. Id.
115 See Buczko, supra note 114 at 1. In serving as a substitute for the Balanced Budget Act’s section 4507, Kyl’s bill omitted the provision in which physicians would have to foreswear Medicare reimbursement for two years. Id.
117 See id.
118 Medicare Beneficiaries Freedom to Contract Act of 1997: Hearing on S. 1194 Before the S. Comm. on Finance, 105th Cong. (1997). Senator Kyl’s bill was the subject of a hearing before the Senate Finance Committee, but it did not progress past that hearing. Id.
groups, including the AARP, effectively killed the bill.\textsuperscript{119} Notwithstanding this opposition, it is doubtful that Kyl's bill would have had severe deleterious effects on physician access for poor to middle-income seniors.\textsuperscript{120} Some physicians who already served a primarily wealthy population likely would have been able to fill their schedules with patients willing to privately contract with them.\textsuperscript{121} However, apart from those areas of the country with significant concentrations of wealth, the chances of wealthy seniors squeezing out more modest-means seniors seemed remote.\textsuperscript{122}

This criticism of the potential crowd out of poorer patients holds weight not only for Kyl's failed bill, but also for contemporary bills that have revived the concept of private contracting.\textsuperscript{123} It is possible, though not probable, that doctors would fill up their schedules with patients willing to enter into private contracts with them.\textsuperscript{124} Further, it is seems yet more likely that many doctors would choose to treat some willing private contract patients, as well as other "regular" Medicare patients.\textsuperscript{125} Physicians could be satisfied seeing fewer patients and earning the same amount of fees from fewer patients, represented by the difference between private contracting patients and "regular" Medicare patients.\textsuperscript{126}

\begin{thebibliography}{99}
\bibitem{120} See Marilyn Moon, Freedom to Pay or Freedom to Choose? Private Contracting and Medicare Beneficiaries, 10 HEALTH MATRIX: JOURNAL OF LAW-MEDICINE 21, 30-31 (2000).
\bibitem{121} See id. at 29. In having the freedom to charge high-income patients more for services, many physicians have argued that they would subsequently have more resources to treat low-income patients. \textit{Id}.
\bibitem{122} See id. "[D]octor's in midtown Manhattan with well-heeled patients are not likely to also treat low-income patients from elsewhere in New York City." \textit{Id}.
\bibitem{123} See Medicare Patient Empowerment Act of 2013, H.R. 1310, 113th Cong. § 2(b) (2013). Section 2(b) of this legislation, which was introduced in the House by Rep. Tom Price (R-GA) on March 21, 2013 and referred to the Subcommittee on Health the following day, would amend § 1802 of the Social Security Act and provides that "nothing in this title shall prohibit a Medicare beneficiary from entering into a contract with an eligible professional for any item or service covered under this title." \textit{Id}.
\bibitem{124} See Moon, supra note 120, at 31. A number of studies highlight the role affordability plays in preventing individuals from receiving proper care, and with prices driven up as a result of private contracting, the number of physicians willing to treat Medicare patients instead of their privately contracted (and higher paying) patients, conceivably, could be substantially reduced. \textit{Id}. Additionally, physicians may be inclined to cut time spent with patients who provide lower payment levels. \textit{Id} at 32.
\bibitem{125} See id. at 29 (explaining leverage benefit of contracting while claiming many physicians could not afford total Medicare avoidance).
\bibitem{126} See id. at 29-30.
\end{thebibliography}
Though the full complement of Medicare physicians could suffer some losses with the advent of private contracting, it represents a beneficial alternative to those physicians contemplating leaving the Medicare program altogether.\(^{127}\) Considering the full array of problems faced by the Medicare program, including more senior patients with more chronic diseases than originally anticipated, it behooves the government to do whatever is possible to woo physicians to stay within the program to care for this cohort of patients.\(^{128}\)

**C. Contemporary Private Contracting Initiatives**

Several Congressmen, including Representative Tom Price of Georgia, have proposed a system in which Medicare-contracted doctors can make one-off contracts with beneficiaries while allowing the doctors to remain enrolled as a Medicare participating supplier.\(^{129}\) The bills introduced to formalize these incipient contracts would not have placed any limits on the remuneration from the patient to the doctor.\(^{130}\) The beneficiary would be able to use her Medicare benefits up to the limit of assigned

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\(^{127}\) See id. at 30 (arguing private contracting could give Medicare beneficiaries access to physicians currently refusing Medicare participation).


\(^{130}\) See H.R. 1310, 113th Cong. (1ST Sess. 2013). Specifically, in subsection (b)(2) of the act:

Payment made under this title for any item or service provided under the contract shall not render the eligible professional a participating or non-participating physician or supplier . . . requirements of this title that may otherwise apply to a participating or non-participating physician or supplier would not apply with respect to any items or services furnished under the contract.

*Id.*
claims to finance her private contract with her doctor.131 Further, the bill would allow beneficiaries to use their Medicare benefits to pay physicians who themselves are not contracted with the Medicare program.132

Medicare private contracts have also met with some approbation in the United States Senate.133 In 2013, Senator Lisa Murkowski of Alaska reintroduced the “Medicare Patient Empowerment Act,” which is the mirror to Representative Price’s 2013 bill.134 As in Price’s bill, Senator Murkowski’s bill, if passed, would allow Medicare beneficiaries to use their Medicare benefits towards the assigned claim amount.135 Doctors could charge patients their full list price, and patients would be responsible for the spread between the assigned amount and the full charge.136 Further, as is reflected in the House bill, the Senate bill’s express purposes are to: (a) maintain access to physicians for the Medicare senior population, and (b) funnel more service-based compensation to Medicare-contracted physicians who might otherwise drop out of the program altogether.137

Unsurprisingly, predecessors of both bills received the endorsement of the American Medical Association, which has thrown the full weight of its lobbying and public policy apparatuses behind it.138 This should not come as a shock because the AMA has robustly supported many measures that would bring more compensation to its members in the past.139 Further, the Association has criticized other entrenched policy

131 See H.R. 1310 § 3(C)(ii).
132 See H.R. 1310 § 2(b)(1).
136 See id.
137 See id.
initiatives, like the Sustainable Growth Rate, which have historically threatened to tamp down compensation from the Medicare program to physicians.\textsuperscript{140}

The AMA's clear endorsement of the private contracting bills and the concomitant criticism of reimbursement-reducing measures, like SGR, reflect a constituency that is focused on maximizing revenue and sacrificially serving its senior base.\textsuperscript{141} The AMA's support bespeaks the cold, yet realistic fact that doctors are, at bottom, agents of their own economic well-being.\textsuperscript{142} These bills represent, at best, a marginal improvement over current Medicare reimbursement as projected across the broad scope of physicians' reimbursement lines.\textsuperscript{143} Not every Medicare beneficiary will want to enter into private contracts with his physician.\textsuperscript{144} According to one recent survey, most Medicare beneficiaries are quite content with the access and quality of

strressed that payment models "[m]ust be accessible for physicians in all practice sizes and settings, and must include physicians in all specialties." Charles Fiegl, Medicare pay: Insurers preview a post- SGR world, AMERICAN MEDICAL NEWS, (Feb. 4, 2013) http://www.amednews.com/article/20130204/government/130209969/4/.

\textsuperscript{140} See Fiegl supra note 139. Specifically, Fiegl states:

Medicare's physician payment system continues to be panned universally by lawmakers, health economists, physicians, hospitals and insurers who would prefer a more stable, innovative system. But cost issues and a variety of other factors have stymied meaningful pay reform for the government-run entitlement program. For lawmakers, it was easier to pass the $25 billion stopgap measure at the last minute than to approve a package 10 times as costly — one that repeals the SGR and moves the Medicare pay system to one that rewards quality and efficiency.

\textit{Id.} See also Understanding the Sustainable Growth Rate (SGR) A.K.A. the Doc Fix, POLICY AND MEDICINE, (Mar. 18, 2013), http://www.policymed.com/2013/03/understanding-the-sustainable-growth-rate-sgr-aka-the-doc-fix.html (demonstrating the AMA president's desire for different reimbursement system for Medicare-contracted physicians).

\textsuperscript{141} See John Carroll, How Doctors Are Paid Now, And Why It Has to Change, MANAGED CARE (Dec. 2007), http://www.managedcaremag.com/archives/0712/0712.docpay.html (discussing the built-in payment bias in Medicare).

\textsuperscript{142} See id.

\textsuperscript{143} See supra note 120 and accompanying text. Private contracting, on a service-by-service basis, allows physicians to charge more for services that are inadequately compensated for by Medicare. See Moon, \textit{supra} note 120 at 29. However, since price discrimination proves difficult to accomplish in a competitive market, potential patients can find suppliers offering the same service for a lower price. See Moon, \textit{supra} note 120 at 29.

\textsuperscript{144} See Moon, \textit{supra} note 120, at 31. If a physician raises charges for a procedure than Medicare reimbursement, some beneficiaries may be unable to afford the higher rate, thereby choosing not to enter into private contracts with their physicians. See Moon, \textit{supra} note 120, at 31.
healthcare provided by Medicare. However, there are some beneficiaries who are dissatisfied enough to redirect their resources towards entering special contracts with their physicians for special access to those physicians. If a similar bill is ever enacted, the marginal benefit, however small, could be enough to incentivize some physicians, particularly primary care providers, to remain at their posts and affiliated with the Medicare program.

A physician, even a primary care physician, enters into a private contract with a Medicare beneficiary only if such a contract benefits the physician. Physicians know that there is a practical limit above which Medicare will not pay for a good or service. With that in mind, physicians have an aversion to providing goods or services to Medicare beneficiaries at the prices listed in the Medicare Physician Fee Schedule. Medicare can be outbid for the item because the private contracting physician wants to maximize his reimbursement. That coupled with the freely bargained-for contract price between the patient and the physician, means that the physician will be more amenable to reciprocate the contract consideration by prioritizing the patient in the physician’s queue. Because the patient has agreed to the physician’s peculiar payment terms, the benefit conferred by the physician is that the patient gets the best of the doctor’s time and attention, all while making access convenient for the patient.

If ever sanctioned by Congress, the Medicare private agreement would be the paradigmatic example of a contractarian relationship. Truly, the res of the transaction, the healthcare good or service, would be bargained-for at arms' length on terms that are mutually satisfying for both parties. Importantly, the more sophisticated the patient

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145 See Bankers Life and Casualty Company and the Center for a Secure Retirement, Retirement Healthcare for Middle-Income Americans, 4 (Jan. 2012), available at http://www.centerforasecureretirement.com/media/166389/retirement-healthcare-report.pdf. The publication notes that 81% of surveyed seniors were "extremely" or "very" satisfied with the access to and quality of the healthcare that they received as Medicare beneficiaries, while only 2% of beneficiaries surveyed were "not too" or "not at all" satisfied with the access or quality of health care funded through Medicare. Id.

146 Id. Some patients will enter in private contracts with their physicians when certain expert physicians do not take Medicare patients. Thomas Greeson & Heather L. Gunas, Section 4507 and the Importance of Private Contracts, 10 Health Matrix 35, 44 (Winter, 2000).


148 KANT PATEL & MARK RUSHEFSKY, HEALTH CARE POLITICS AND POLICY IN AMERICA 128-29 (3d ed. 2006) (supporting proposition that Medicare beneficiaries can negotiate with their physicians at arms-length).
counterparty, the more he or she can request or demand from the physician.\(^\text{149}\) However, the innovative Medicare private contract does not have the key sticking point besetting physicians who might currently choose to enter into a private contract with a Medicare beneficiary. Under Congressman the proposed bills, (and unlike the current version of Medicare private contracting), physicians who want to make private contracts with their patients could remain in the Medicare program.\(^\text{150}\) Thus, physicians who choose to sign private contracts with patients for certain goods and services would, in essence, be signing new payer contracts, like the several that most physicians already have.\(^\text{151}\) The private contract counterparty would represent, like the physician’s extant commercial and government payer contracts, a party with spoken and unspoken requests, demands, and needs—a party whose needs would have to be satisfied in order to have an ongoing and indefinite relationship. But the key difference would be the benefit flowing from the patient to the physician.\(^\text{152}\) Because the patient pays the full price—legitimately determined before the service is rendered by both patient and physician—the physician can feel satisfied.\(^\text{153}\) The physician can believe that he is being fairly and completely compensated for the services provided to these patients, even if that work is only a small fraction of the overall work that he does for his full roster of patients.\(^\text{154}\)

D. Medicaid

Like Medicare, the Medicaid prohibition against balance billing is comprehensive, though it does not have the restrictive exceptions found in Medicare reimbursement law. Instead, Medicaid’s restriction is both comprehensive and sleek: balance billing is prohibited, period.\(^\text{155}\) If a doctor decides to become a Medicaid

\(^\text{149}\) Id. at 308. Large employers will be able to use their large employee pool in order to directly negotiate with health care providers for more appealing rates. Id.

\(^\text{150}\) See Marilou M. King, The Tortuous History of the Kyl Amendment, 10 HEALTH MATRIX 51, 52 (Winter, 2000). King describes how physicians must opt out of Medicare for two years in order to contract privately with Medicare beneficiaries. Id.

\(^\text{151}\) Ronen Avraham, Private Regulation, 34 HARV. J.L. & PUB. POL’Y 543, 594 (2011). Examples of payer contracts include ‘healthcare maintenance organizations’ (HMO’s), ‘preferred payer organizations’ (PPO’s), and Medicare. Id. at 552-53.

\(^\text{152}\) See Moon, supra note 120, at 29 (discussing nature of private contracting payment scheme for physicians).

\(^\text{153}\) See Moon, supra note 120, at 29-32. “[P]rivate contracting would aid physicians, allowing them to determine what to charge which patients . . . allowing physicians to key in on specific payments that they believe are too low and establish higher charges for those services.” Id. at 29.

\(^\text{154}\) See Moon, supra note 120, at 29-33 (discussing potential benefits of private contracting for physicians and Medicare beneficiaries).

contractor, then he must take assignment of Medicaid claims and, consequently whatever paltry reimbursement his state's Medicaid program offers. Since Medicaid reimbursement is generally low, one must wonder why a physician would become a Medicaid participating physician when Medicaid physicians are typically reimbursed about 30% below that of Medicare-contracted physicians.

Why, then, do doctors treat Medicaid patients at all? If a doctor looks at each of his Medicaid patients as an isolated transaction, then it makes no sense to treat them. From a financial standpoint, Medicaid patients adversely affect a contracted physician's net profit because each transaction is a loss to the physician. Some doctors start losing money on patients very quickly into the appointment session. However,

156 See Omnibus Budget Reconciliation Act of 1989 § 6203(a). "The Medicaid program is jointly funded by the federal government and states. The federal government pays states for a specified percentage of program expenditures, called the Federal Medical Assistance Percentage (FMAP)."


158 See Nathan Kaufman, A Coming Physician Shortage for Medicare and Medicaid Patients, HOSPITALS & HEALTH NETWORKS July 25, 2012, http://www.hhnmag.com/hhnmag/HHNDailyDisplay.dhtml?id=1290001114 (explaining physicians are limiting or refusing to see Medicaid patients because of "threat to physician income").

159 See Kevin Sack, As Medicaid Payments Shrink, Patients Are Abandoned, N.Y. TIMES, March 16, 2010, at A1. Sack recounts the story of Dr. Saeed J. Sahouri, a doctor in Michigan who previously accepted Medicaid:

Dr. Sahouri said that his reimbursements from Medicaid were so low - often no more than $25 per office visit - that he was losing money every time a patient walked in his exam room. The final insult, he said, came when Michigan cut those payments by 8 percent last year to help close a gaping budget shortfall. 'My office manager was telling me to do this for a long time, and I resisted,' Dr. Sahouri said. 'but after a while you realize that we're really losing money on seeing these patients, not even breaking even. We were starting to lose more and more money, month after month.'


Robert Maro Jr., a Cherry Hill, N.J. internist, said he has not accepted new Medicaid patients for 15 years because of low pay. He notes the state
doctors with high volume Medicaid practices may be able to break even or even eke out a small profit because they have refined their systems and processes to such a sophisticated level they are able to shuttle patients through their exam at a much faster rate than that called for by the appointment parameters. In other words, physicians who make it with these patients risk becoming the new “Medicaid mills” aka—“focused factories” in which patients are seen on a quick basis, yet no real connection is made between doctor and patient during the office visit.

Maro said he treats Medicaid patients in the hospital and in nursing homes, but he would lose money treating them in the office where his administrative costs are higher.

He said he would start seeing new Medicaid patients only if he knew the pay hike under the health law would continue beyond 2014. Otherwise, he worries he would take on new patients only to see rates fall back to the old levels in 2015, and then he would be required legally and ethically to keep treating them.

“That would be a nightmare,” he said.


One commentator recounted the practice habits of a very hard-working family physician who saw an almost unimaginable number of Medicaid patients in a year’s time and made a very good living doing it:

With hard work, it is possible to make an extraordinary living even from Medicare and Medicaid reimbursements. I know a family practice physician who works incredibly hard, seeing patients 6 1/2 days a week for 10-12 hours a day, and averaging close to 40 patients a day! He lives in a poor community with many Medicaid patients, but is patient volume (due in part to his efficiency, seeing a patient every 15 minutes) makes up the difference since overhead is relatively fixed. By having over 12,000 appointments a year, this doctor is able to take home roughly half a million per year, likely in the top 1% of all family practice doctors nationwide. While this cannot be expected of all doctors, it is possible to make money while serving the poor on Medicaid!

Very few practices (or providers) operate this efficiently and in such a focused manner. Many doctors inevitably have an array of payers and thus any single day may bring the doctor a bevy of patients with different payment sources. Further, doctors may not be able to march their patients through their exam rooms with the ruthless efficiency required for the doctor to profit from a Medicaid-only practice. The doctor may not be very skilled or the patient’s illness(es) may merit closer attention than a perfunctory exam. The patient’s condition, the physician’s conscience and conscientiousness, as well as the demands of modern medicine may prompt the doctor to linger just a little longer than he otherwise would if making a profit was the overriding goal on his mind.

E. Private Commercial Insurance

Private commercial insurance, like Medicare, attacks balance billing with a dual-pronged stick. First, most contracts between insurers and physicians prohibit balance billing of the insurer’s beneficiaries. This is the well-known prohibition against “in-network” balance billing. The exceptions to this general principle are that the

is likely not running a Medicaid mill, a practice, like that physician’s, that sees only Medicaid patients in a very regimented manner, has two conditions ripe for having a Medicaid mill. The two conditions are: first, the absence of a state-imposed limit on the number of doctor visits allowed by Medicaid beneficiaries; second, providers willing to conspire with the Medicaid beneficiary to defraud the payer. See id.


166 See Steven M. Harris, Balance-billing a no-no in most cases, AMERICAN MEDICAL NEWS (Sept. 3, 2007), www.amednews.com/article/2007/0903/business/309039998/5/. Harris concludes that the prohibition against in-network balance billing is ubiquitous in private payer contracts:

Payer contracts often include a provision prohibiting doctors from billing a plan’s members for covered services in excess of applicable co-payments. The contract of a prominent payer, for example, generally states that “the provider agrees to accept the payer’s network rate as payment in full for covered services and shall not balance-bill the payer’s subscribers.” If an in-network physician bills a covered patient in violation of such a provision, the physician could risk termination of the contract and financial penalties.
beneficiary must always meet his co-payment obligations and his annual deductible. Nevertheless, there are two obvious rationales for the in-network prohibition. First, insurers want to give their insureds some certainty in making purchasing decisions for their healthcare. Though insureds might not be able to completely plan and budget for all of their healthcare needs, they know that they will not be subject to the vicissitudes of a healthcare provider's list prices, and the provider's whims—in ordering tests, procedures, office visits, or days in the hospital. Second, to the extent that it is possible, insurers want to check the prices they pay to contracted providers. As with Medicare and Medicaid, the provider's inability to balance bill his patient represents an artificial control on his "real" prices. So, the prohibition on in-network balance billing represents a check on dramatic price inflation, to the extent that insureds do not have to pay the full list price, while still allowing for incremental inflation.

Just as Medicare's legal prohibition is reified in its provider contracts, so too are private insurance's prohibitions. Forty-nine of the fifty states and the District of Columbia prohibit balance billing for in-network insureds of at least some managed care health care coverage products. These codified prohibitions are a sizeable concession to the insurance industry because they provide an outer frame for insurers' contracted prices paid to providers. While providers invariably have their list of charged prices

Id. Indeed, it is not so much the insureds who experience negative consequences because the health care provider orders tests, procedures, and days in the hospital beyond that which is absolutely necessary to care for the patient’s health. The patient, in fact, might desire this extra attention from his health care provider because he does not bear the full marginal cost burden these extra interventions represent. Paul Feldstein, a health economist observes:

The expression 'the insurance will cover it' is indicative of the lack of incentives facing patients and their providers. The public has also had little incentive to compare prices among different providers, as the costs they would incur searching for less-expensive providers would exceed any savings on their already low copayments.

167 See Marchitelli, supra note 52 (explaining how balance billing prohibitions control costs).

(hospitals, as an example, list these full prices on their “chargemaster” spreadsheets), the “real” prices that are billed to and paid by insurance companies are also inevitably scheduled in the contract between the provider and the insurer or they are represented in the payer contract as a certain percentage of the provider’s gross charges. Statutory prohibitions on balance billing provide an outer frame in the sense that they reinforce and protect the concept of the contracted price. Once the code for the test, service, or procedure has been billed to the insurer, and subsequently, the contracted price has been paid for the code, then the transaction is finished. Everyone, from the doctor, to the patient, to the insurer, can be sure and there is no trailing financial liability for any party.

III. Balance Billing State Laws and Economic Considerations

A. Balance Billing Laws

Because the statutory and contractual prohibitions against balance billing are so stark, the case law about balance billing is less than compelling. There is a sense in examining the case law that many violations of balance billing prohibitions are binary in nature; one either violates the statutory, regulatory, or contractual provision, or one does not. Providers who violate a prohibition against balance billing are penalized, through contract or statute, and that is the end of the controversy. There is not a seminal case that successfully takes on balance billing prohibitions and makes a foundational challenge to their existence on any pertinent ground, whether contractual or constitutional. From the payer’s perspective, balance billing provisions are indicative...
of the payer's dominant market power over the provider. However, that power is not so
great as to be considered unconscionable, representative of undue influence, or
otherwise making the contract between payer and physician unenforceable on traditional
contract-policing grounds.

The existing case law falls into two basic categories. The first set of cases show
providers who are penalized for demanding the balance of the patient's bill when there
is a clear statutory or regulatory prohibition against the practice. In the second set of
cases, aggressive providers balance bill in the "gaps." That is, the provider is allowed to
balance bill, yet a court retrospectively views the balance bill as inappropriate.

The best and most recent example of the second type of balance billing
occurred in the California Supreme Court case Prospect Medical Group, Inc. v. Northridge
Emergency Medical Group. At the time, California did not proscribe balance billing in
emergency situations. Members of the Northridge Emergency Group along with
members of its co-respondent, provided professional services to beneficiaries of
Prospect Medical Group, an Independent Practice Association that itself was contracted
with an HMO, although Prospect did not have a contract with Northridge. As is
customary, the HMO, through Prospect, paid the groups an out-of-network benefit that
it thought was "reasonable," though the benefit was less than the group's list price.
Consequently, the group balance billed the patient up to the group's full price. The
California Supreme Court settled on a compromise, in which the physician group was
required to seek reimbursement wholly from the HMO, and the HMO was required to
pay the group a reasonable price for its services.

This case generated attention because the California Supreme Court enforced a
ban on balance billing in a situation that was formerly not subject to a ban. There are

177 See id. (reviewing various statutes and cases where balance billing is prohibited).
1202427316466&Prospect_Medical_Grp_Inc_v_Northridge_Emergency_Medical_Grp.
180 Id.
181 Id.
182 Id.
183 Id. at 93.
184 See id. at 92-93. See also Jeffrey Gold, Danielle Drayer, & Cara Zucker, Reimbursement for
Emergency and Non-Emergency Services Provided by Out-of-Network Physicians: The Issue of Balance Billing, 8
good reasons that the Court enforced the ban, namely the emergent situation in which
the patient found himself, when he was not able to make a reasoned decision about
whether he should seek treatment from an in-network on out-of-network provider. 185

Prospect had equally compelling reasons for being free of restrictions on billing,
namely that there was no extant balance billing prohibition at the time the services were
rendered. 186 This reason is a basic, even jurisprudential reason that cuts in favor of the
physicians' position – they should be able to do anything, including balance billing their
non-contracted emergency patients, when there is not a specific and verifiable
prohibition against the practice. As it stands now, the California Supreme Court’s ruling
smacks something of an ex post facto law. The Affordable Care Act seeks to remedy the
conundrum of out-of-network balance billing in emergency situations by prescribing
reimbursement limits for providers. 187 The ACA now allows patients to enjoy the same
cost-sharing and co-insurance obligations they would have with out-of-network
providers that they do with in-network providers. 188

B. Balance Billing and Physician Economics

Apart from the special problems occasioned by emergencies, the problem
remains in the private market that all the parties have not been made whole by the
contracted transaction protected at law. 189 The doctor has a “real” price that he thinks
his time, labor, and skill are worth for any particular good or service he provides in his
office. 190 There is a great deal of dissonance between being “made whole” by patients
who pay for their medical services with cash and patients who have impersonal
insurance companies liquidate their responsibilities to the doctor. 191 This dissonance is
heightened by two factors. One is the irony that a significant number of patients who
do make the doctor whole by paying with cash might not otherwise have access to
health insurance. 192 Thus, their payments to the doctor do not represent a payment of

186 Id. at 94.
187 See Plans Develop Strategies to Address Out of Network Billing, 17 No.2 Employer’s Guide to Self-
Insuring Health Benefits News 2 (Nov. 2009) (discussing out of network billing practices
generally).
188 See Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010) (remaining
provisions found scattered beyond § 18001).
189 See Prospect Med. Grp., 198 P.3d at 94.
190 See id. at 88-89.
191 See Hammond, supra note 30 at 335-39 (discussing certain hassles physicians experience in
insurance-based system).
192 See id. at 339. "[T]he polarizing antipodes of the individual mandate and Americans’
luxury, made out of the largesse of their surplus, but rather as a frank admission that they have no other way to access the physician for their sore throat, broken wrist, or stomach pain.

One could also argue the doctor's real price is not his full cash price, as listed in his personal chargemaster, but rather the prices paid by the insurance company. This is particularly true when one or two insurers dominate the doctor's roster of payers. If, for example, the physician lives in a state in which a Blue Shield plan pervades, the price set by the Blue Shield plan is transformed over time to be the doctor's de facto real price. This transformation merely represents the economic reality that the pervasive insurance plan exercises extensive market power over the affected physician. This market power that changes the physician's behavior (his billing practices), the way that he thinks about his medical practice, and his overall satisfaction in the medical field.

Though the passage of time may transform physicians' conception of their real price because of the pervasive specter of a powerful payer, it should not be presumed that physicians are automatically satisfied with the payments made by insurers with the balance of market power over them. Physicians who are better organized or who bring more patients to the payer than their peers, namely, physicians who themselves have market power vis-à-vis their payers, demand better compensation.

Therefore, reviving balance billing in the private commercial market would, on the one hand, be a clear homage to a bona fide market transaction. The patient would

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193 See id. at 317.
194 Michael McWilliams et al., Changes in Health Care Spending and Quality for Medicare Beneficiaries Associated With a Commercial ACO Contract, 310 JAMA 8 (2013); see also Carroll, supra note 141.
195 Carroll, supra note 141.
196 Carroll, supra note 141.
197 See Carroll, supra note 141. Carroll states:

The need for health plans to balance the demand for a large provider network against the need to offer employers competitive premiums has shoved what some see as a built-in payment bias in Medicare into overdrive. Primary care doctors operating in regions where physician shingles are a common sight are earning less—often much less—than specialists. And specialists are finding greater strength in numbers. This is driving physicians of all stripes to organize into larger groups that can exercise greater bargaining clout.

Id.

198 See, Jack Hoadley et al., Unexpected Charges: What States Are Doing About Balance Billing,
receive medical services, and in turn, the physician would receive the significant satisfaction that comes with being paid the entire wage for his particular service. And yet, on the other hand, it would be giving physicians more than they bargained for with their payers. As described earlier in this Article, physicians' true masters, who indeed are their contractual payment counterparties, are the insurance companies. Payers and physicians make deals "fair and square" for the physician to receive significant discounts off of the physician's stated fees plus any copayment and deductible due from the patient.

C. Balance Billing and Insurer-Physician-Patient Relationships

That a physician would be allowed to receive, under this Article's plan, more than the payer-physician contracted price for a service could be a divergent signal to payers. First, as in the Medicare context, it should signal to payers that they are not paying physicians enough. That a physician would dare to go outside the stated contract price and risk alienating patients who do not have the wherewithal to participate in a balance billing plan, in order to be made whole, bespeaks a very dissatisfied physician indeed. However, the balance billing plan could also emit a sharper signal to the payer. A physician willing to participate in balance billing might be one, ironically enough, who could withstand a slight "haircut" in the payer's contracted prices. The payer would likely see the physician's ability to receive the full "true-up" compensation from some patients as that which can fill-in-the-gap from diminished funding from the contracted prices.

Insurers and legislators have different concerns about insured's that choose to


200 Id.

201 See Law & Ensminger, supra note 84.


204 See id.
seek treatment from providers who do not contract with the insurer.\textsuperscript{205} Generally speaking, providers who provide “out-of-network” treatment charge patients the full amount of their real price(s).\textsuperscript{206} The provider has no contractual privity with an out-of-network patient as he does with an in-network patient and therefore he has no reason not to charge the patient his “real” price.\textsuperscript{207} Insurers do make a concession to their insureds by agreeing to pay a significantly smaller percentage of the doctor’s real price for out of network goods or services than they would for in-network services.\textsuperscript{208}

\textsuperscript{205} See Raeburn, \textit{supra} note 202.

\textsuperscript{206} Id.

\textsuperscript{207} See Gold, \textit{supra} note 184 at paras. 2-4 (asserting there is no incentive for physicians to charge less than full price to out-of-network patients).


With most plans, coinsurance is higher for out-of-network care. Coinsurance is the part of the covered service you pay for (e.g. the plan pays 80\% of the covered amount and you pay 20\% coinsurance).

\textit{Id.}

Out-of-network rates are higher

An out-of-network doctor sets the rate to charge you. It is usually higher than the amount your Aetna plan ‘recognizes’ or ‘allows.’

An out-of-network doctor can bill you for anything over the dollar amount that Aetna recognizes or allows. This is called “balance billing.” A network doctor has agreed not to do that.

Deductibles are separate, higher

What you pay when you are balance billed does not count toward your deductible. And it is not part of any cap your plan has on how much you have to pay for covered services.

Many plans have a separate out-of-network deductible. This is higher than your in-network deductible. (Sometimes, you have no deductible at all for care in the network.) You must meet the out-of-network deductible before your plan pays any benefits . . .

How we determine what to pay for out-of-network care

The plan you or your employer pick determines how much you pay for care out of the network. The exact amount depends on the:

Method you plan uses to set the recognized or allowed amount

Percent of the allowed amount to be paid by the plan (like 80\% or 60\%)
However, insurers make up for the concession by chastening their beneficiaries and requiring them to pay providers whatever the insurer does not.\textsuperscript{209}

There are strong contractarian reasons for insurers to cover a much smaller amount of their beneficiaries' bills when those beneficiaries seek care from non-contracted providers.\textsuperscript{210} The reduced amount of payment squarely vindicates the patient's prerogative to choose whomever and wherever she desires to receive treatment. If, for example, a patient with a rare form of cancer lives in El Paso and can be treated there, yet the nearest expert on her particular type of cancer is in Dallas, it might be worth it to the patient to make the several hundred mile trek and pay the several thousand dollars it would take to be seen by the expert, even if the expert is out of network.

That same reasoning counsels the patient to receive all of her oncological care in El Paso. For example, by paying only 70\% of the Dallas physician's rate and allowing the Dallas physician to balance bill up to his list charge for his professional services (and any drugs or tests administered to the patient), the El Paso cancer patient now has a powerful incentive to stay home.\textsuperscript{211} She must decide whether to spend a portion of her family's assets for services that push against the margin of the "best" for her condition, or to settle for merely competent services for her condition in El Paso.

The allowance for providers to balance bill out-of-network patients is the insurer's very powerful channeling mechanism to keep their beneficiaries in line and network.\textsuperscript{212} And thus, Lon Fuller's conception of contract remedies as a channeling mechanism is vindicated, even in the modern insurance contract.\textsuperscript{213} It would seem that by seeking medical care from out-of-network providers, patients who have the means to be balance billed are engaging in a form of queue jumping.\textsuperscript{214} Those who have the

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To find the method and percent, check your plan documents. Or call Member Services at the toll-free number on your ID card.

\textsuperscript{209} E.g., id.; see Marchitelli, supra note 52 at para. 23 (explaining that private health insurance coverage is mostly a contractual issue).

\textsuperscript{210} See Marchitelli, supra note 52 at paras. 25-26.

\textsuperscript{211} Raebum, supra note 204. Even though the treatment benefits out-of-network could be significantly better in the long run, the up front costs are not affordable for most families. Id.

\textsuperscript{212} See Lon L. Fuller, Consideration and Form, 41 COLUM. L. REV. 799 (1941).

\textsuperscript{213} Id.

means to go to an out-of-network provider can use those means to get the treatment they desire instead of the “normal” or “standard” treatment from their regular, in-network providers. The patient who pays for out-of-network treatment tangibly states that she would prefer a different, special, or more cutting-edge treatment from someone or somewhere else. While the patient may be sorted in whatever idiosyncratic queue the out-of-network provider conceives, she experiences at least a modicum of comfort knowing she is receiving the diagnosis, second opinion, test, or treatment that might benefit her. She is, in a very real way, paying for bona fide access to healthcare not available to everyone else.

No one should begrudge the patient who has a hard to diagnose or hard to treat condition from leaving the doctors and hospitals in her local area and going to the Mayo Clinic or Cleveland Clinic or some other quaternary, nationally-known facility to receive diagnosis, testing, or treatment for her condition. These facilities and their affiliated physicians exist to provide the patient answers and healing when other doctors and hospitals have exhausted their abilities. That many patients are out-of-network vis-à-vis these quaternary facilities does not change the good that they do or the esteem in which many Americans hold them.

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215 See Fuller, supra note 212.
216 See id.
217 See id.
218 See Epstein, supra note 214 (explaining how these other facilities help patients whose options have been exhausted).
The fact that not every sick patient can take advantage of the Mayo Clinic, the Cleveland Clinic, or the Texas Heart Institute bespeaks fundamental economic and sociological realities: scarcity is endemic to all goods and services, including high level healthcare, as there are not enough quaternary centers to go around. No one argues the expert level quaternary centers should be abolished in the name of equality of opportunity to be treated or opportunity of outcome or that all Americans should be expressly tethered to the care available in their own home areas. Further, no one argues that the quaternary centers should, somehow, have an "all comers" policy and abolish the out-of-network restrictions in their payer contracts and in their home states' laws. Rather than express resentment at the person who can receive care at a nationally known medical center, most people would wish the person well and hope that she can indeed be healed from the disease that ails her.

The phenomenon of quaternary care comes into sharper relief when viewed through the economic lens of margins. By jumping the queue of the patients waiting for standard treatments, the patient who vaults into treatment at a quaternary center is pushing on the possibility of a margin of incrementally better physicians, treatments, or procedures over the services available at home. The home physicians, drugs, and facilities are presumably capable of treating the patient. However, the physicians, drugs, and facilities in the quaternary centers are thought to be, and may actually be more capable of treating the patient thus helping her achieve her goal of health.

At this point, one might draw the sharp distinction between a person seeking care at the Mayo Clinic for an exotic disease or a common disease for which a cure is

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220 See, e.g., Mayo Clinic, U.S. NEWS & WORLD REPORT, http://health.usnews.com/best-hospitals/area/mn/mayo-clinic-661MAYO/for-professionals (last visited Jan. 21, 2014). Although "the first and largest integrated, not-for-profit group practice in the world," the more than 500,000 patients treated by Mayo Clinic each year must travel from across the country and the globe to Mayo's main sites in Minnesota, Florida, and Arizona, or to one of its community-based providers in southern Minnesota, western Wisconsin or northeast Iowa. Id. See also THE LEADERSHIP CONFERENCE EDUCATION FUND, THE ROAD TO HEALTH CARE PARITY: TRANSPORTATION POLICY AND ACCESS TO HEALTH CARE (2011), available at http://civilrightsdocs.info/pdf/docs/transportation/The-Road-to-Health-Care-Parity.pdf (discussing the lack of affordable transportation to medical facilities' contribution to health disparity).

221 See Feldstein, supra note 46, at 39. Under traditional consumer demand theory, consumers will use a service until their marginal cost (price paid for the last unit purchased) equals their marginal benefit (additional value received from last unit purchased). Id. When marginal benefit equals marginal cost, consumers are said to be maximizing their utility. Id.

222 See id.

223 See id.
elusive and the patient with a run-of-the-mill condition who seeks to jump the queue in his family doctor’s office. On the one hand are patients who are literally fighting for their lives, and thus should face no criticism about their quest for wellness. On the other hand are patients who are merely inconvenienced by long lines and frustrating waiting times in their primary doctor’s offices. Some might say that there is really no comparison at all—that it is acceptable both morally and financially to “pull out all the stops” to save one’s life or prevent a crippling or disfiguring disease. Contrarily, some might argue that it is not acceptable, neither morally nor financially, to gain an advantage over one’s fellows when both the well-off (those able to be balance billed) and those not so well-off (those not able to be balance billed) are felled by the same maladies—everyday illnesses that beset most everyone at one time or another.

Healthcare goods and services, whether primary, secondary, tertiary, or quaternary, like any other consumer good or service, are items exchangeable in a market. All actors in the healthcare market rationally act to maximize what is most important to them. For example, if a person is dissatisfied with her internist, she is free to “fire” that doctor and move on to another. It has been argued that health care should be immune from market pressures since everyone at some point in time will need to avail themselves of the goods and services in the healthcare market. In other

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224 See, e.g., Epstein, supra note 214 at ¶7 (discussing pro-queue jumping for relatively rare conditions like organ failure requiring a transplant).
225 See, e.g., Pasquale, supra note 214 at 40-42 (discussing anti-queue jumping for care, including routine care, provided by retainer physicians).
227 See FELDSTEIN, supra note 46, at 20. “In making choices, the consumer is assumed to be rational, that is, he or she attempts to evaluate the expected benefits and costs of their choices.” FELDSTEIN, supra note 46, at 20. Indeed, the balance billing/private contracting model proffered in this Article seems to be a quintessential form of consumer-directed healthcare (hereinafter “CDHC”). FELDSTEIN, supra note 46, at 20. “The supply side similarly assumes that the firm, the supplier of goods and services, has an objective, namely, to maximize their profits, subject to a budget constraint . . . .” FELDSTEIN, supra note 46, at 20.
229 See Kenneth Jost, Health-Care Economics Too Hard for Some on High Court, JOST ON JUSTICE, LAW & JUSTICE BLOG (Apr. 2, 2012), http://jostonjustice.blogspot.com/2012/04/health-care-economics-too-hard-for-some.html. Indeed, commentators on the Supreme Court arguments of the Affordable Care Act cases have noted the practical certainty that everyone in America, regardless of their insurance status, gets sick and avails him or herself of the healthcare market. Id. Jost states, speaking of an Affordable Care Act case:

At the Supreme Court, all four of the conservative justices who participated in
words, because all of us, whether rich or poor, are frail and prone to age, breakdowns, and disease, we therefore should have equal access to the treatments, facilities, and drugs that will make us well.\textsuperscript{230} Indeed, one of the main themes permeating the Affordable Care Act is that every American has access to health insurance so that they can access their own healthcare needs.\textsuperscript{231}

Nevertheless, people will always invest in what they want, if they want it badly enough. Some people choose to pay not even a marginal amount over insurance, but rather all of a healthcare good or service in cash, thereby bypassing queues in standard healthcare settings.\textsuperscript{232} Some people choose to “up the ante” by paying cash for concierge or retainer physicians, who can provide (relatively speaking) luxurious amenities to their patients on top of basic healthcare services.\textsuperscript{233} Physicians and other

the questioning - Clarence Thomas was silent, as is his custom - either ignored or distorted these economic realities. Justice Anthony M. Kennedy asked whether the government could "create commerce" in order to regulate it, missing the point that everyone is always either an actual or a potential participant in the health care market.


\textsuperscript{232} See Pasquale, \textit{supra} note 214, at 39. “Retainer care arrangements allow patients to pay a retainer directly to a physician’s office in order to obtain special access to care.” Pasquale, \textit{supra} note 214, at 39. Thus, in these retainer care markets, patients can “queue jump,” which is the ability to see one’s doctor more quickly and for a longer period of time. Pasquale, \textit{supra} note 214, at 41.

\textsuperscript{233} See generally Pasquale, \textit{supra} note 214 (discussing the balance billing implications of providing retainer or concierge care to Medicare patients under existing law); Carnahan, \textit{supra} note 101 at 140-144. Though drilling down on all the fraud and abuse implications of reversing a balance billing ban is beyond the scope of this Article, both Pasquale and Carnahan have done a nice job of summarizing the fraud and abuse implications of retainer care programs, particularly how the (federal) fraud and abuse laws are implicated when balance billing (allegedly). See Pasquale, \textit{supra} note 214; Carnahan, \textit{supra} note 103 at 140-46. Nonetheless, one point about fraud and abuse is appropriate at this point: for the admittedly aspirational plan in this Article to work, the Department of Health and Human Services’ Office of Inspector General and the Department of Justice would have to see the plan (with a regulatory safe harbor or other communication from OIG) as not violating of the federal Anti-Kickback Statute, which prohibits, in part the
healthcare providers themselves expend enormous sums in capital, time, and skill in providing healthcare services, and expect market rates of return on their investments.\textsuperscript{234}

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None of these patients should be condemned or criticized for their choices. All of these patients have simply opted out of a system in which all players are corralled to have similar resources and make similar decisions about their care.\textsuperscript{235} Instead, these patients have chosen to direct their own care according to their own ends. If, however, the American system were not a badly functioning market, then there would be little hope of entrance or egress from the market, as we have now.\textsuperscript{236} Currently, Americans do not live in a universal coverage system in which they are required to purchase their healthcare from the federal government, nor has anyone seriously suggested that our healthcare system will soon move to that type of delivery model.\textsuperscript{237} Indeed, private capital is free to organize new hospitals and other types of facilities while doctors are free to choose their own specialty, subject to competitive pressures, chosen geographic location, and payer mix.\textsuperscript{238} The government does not make doctors practice in a certain manner or certain place, or for particular patients.\textsuperscript{239}
\end{quote}

solicitation or receipt or the offer or payment of “remuneration” in exchange for a referral a good or service reimbursed by a federal health care program. 42 U.S.C. §1320a-7b(b). Theoretically, the Anti-Kickback Statute could be implicated in that the offer, payment, or receipt of the balance of a patient’s bill could be construed as remuneration in exchange for a referral reimbursed by a federal health care program.

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\textsuperscript{\textsuperscript{234}See} Kaufman, \textit{supra} note 158 (discussing coming shortage of physicians who will accept Medicare and Medicaid patients); \textsuperscript{see} Kavilanz, \textit{supra} note 58 (discussing doctors fed up with the costs of their practice); \textsuperscript{see also} Robert M. Portman and Kate Romanow, \textit{Concierge Medicine: Legal Issues, Ethical Dilemmas, and Policy Changes}, J. HEALTH & LIFE SCI. L., 1 (2008). Concierge Medicine emerged from physician frustration due to decreased physician reimbursement, increased practice costs, and greater administrative burdens imposed by Medicare and private insurers. \textit{Id.} at 3.
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\textsuperscript{\textsuperscript{235}See} supra note 233 (discussing concierge medicine); Portman, \textit{supra} note 234 at 33. Patients that belong to a concierge practice will receive more preventative and primary care services and therefore will likely have less need for other healthcare services. \textit{See} Portman, \textit{supra} note 234 at 33.
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\textsuperscript{\textsuperscript{236}See} Oberlander, \textit{supra} note 16 (discussing Health Care Policy in a time of austerity); KAISER FAMILY FOUNDATION, \textit{supra} note 33 (discussing doctor dissatisfaction with the profession).
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\textsuperscript{\textsuperscript{237}See} What is Universal Health Coverage?, WORLD HEALTH ORGANIZATION, http://www.who.int/features/qa/universal_health_coverage/en/index.html (last visited Jan. 21, 2014). “The goal of universal health coverage is to ensure that all people obtain the health services they need without suffering financial hardship when paying for them.” \textit{Id.}
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\textsuperscript{\textsuperscript{238}See} supra notes 27-29 (discussing doctors choosing their specialty).
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\textsuperscript{\textsuperscript{239}See} Kristi L. Tonn, \textit{Concierge Medicine: Tension Between Physician Autonomy and the Ethical Obligation to Provide Indigent Care}, Health Law Perspectives Health Law & Policy Institute; University of Houston Law Center, December 2010 at 1. “[F]ree choice is an important cornerstone in our society, and this is holds true in our health care system.” \textit{Id.} at 4. The American Medical
IV. The Plan - Its Criticisms and Potential Benefits

A. Plan

The plan posited by this Article is ambitious since the law in most states and the federal Medicare and Medicaid programs would have to be changed in order to accommodate its implementation. Currently, state and federal law prohibits balance billing for “in-network” patients—those who are subscribers to an insurance plan with which their doctor also has a payer contract. In brief, the plan calls for relaxing state and federal proscriptions of in-network balance billing for patients who enter into a private side contract with their physicians. In turn, if agreed to by the patient and physician, the physician could prioritize balance billed patients in his treatment queue in a way that is beneficial to the patient. Instead of having to languish in waiting and treatment rooms, the patient with a balance billing contract with his physician could jump to the front of the line and be seen immediately by the physician.

Evaluators of the plan could point to two particularly cogent criticisms. They could argue that allowing some patients, particularly in-network patients, to pay a marginal amount, which, when added to his insurance reimbursement, makes the physician completely whole, defeats one of health insurance’s main social roles—that of a cost containment mechanism. Health insurance, especially conceived in America as the main payment mechanism for physician professional services, serves as a governor on the prices that physicians can charge in the healthcare marketplace.

Critics may also claim that patients who pay more for physician services get better treatment from their doctors, and those who do not or cannot pay the doctor’s real price get the doctor’s “second best”. This is a real concern. However, the answer for this concern is that any doctor will have a line and will order that line according to

Association (AMA) endorses a physician’s right to choose his or her type of practice. Id.

See supra note 48 (discussing health maintenance organization balance billing prohibitions in state law).

See Alderman, supra note 55 (discussing the average wait time for an appointment in a doctor’s office); see Epstein, supra note 214 (discussing queue jumping); see also Pasquale, supra note 214 (addressing queue jumping).

See Harris, supra note 166 (discussing prohibition against in-network balance billing); see also KAISER FAMILY FOUNDATION, supra note 168 (discussing bans on balance billing).

his own idiosyncratic criteria. That criteria could be patient acuity, the time the appointment was made, physician preference about types of illnesses to treat or types of services to perform during a workday, or payment source. Or the physician could have more than one of these listed reasons, or none of the listed reasons. Inevitably, regardless of this Article’s plan, one patient will be first in the doctor’s line and another patient will be last in the doctor’s line. One patient will be treated by the doctor when the doctor is at his freshest, and another patient will be treated by the doctor when he is most drained.

Another concern is that a doctor who participates in this plan might make enough revenue from his balance billed patients that he would want to downsize his practice, presumably eliminating patients who are not willing to be balance billed. If this happened, however, it would merely be an acceleration of a nascent trend that is beginning outside the context of balance billing. It would not be much different from a “cash only” physician who loses a considerable amount of his total patient panel once he decides to forego insurance.244

Up to this point, doctors and insurers have been suspicious of each other. Doctors believe insurers try to exact draconian concessions from their real list prices. On the other hand, insurers offer doctors an almost-Faustian bargain—in exchange for the possibility of a swath of patients with the insurer, that insurer insists it must demand a steep discount off of the physician’s list prices.245 This argument, however, fails to acknowledge that cost containment is not the only goal of participants in the healthcare treatment enterprise. Doctors are not only concerned with the flow of patients offered by a strong payer, they are also interested in receiving what they think their services are truly worth.246 Reimbursement from the insurer, plus the patient’s co-payment and any deductible, along with any balance billed amounts, gets the physician to his true worth.

B. Limitations

There are distinct limitations to this plan. First, it does not make any sense for

244 See Kircheimer, supra note 59 (discussing patient membership fees and their benefits).
doctors to prioritize a "full freight" patient when another patient has a *bona fide* emergency. The doctor's professional obligation to render emergency aid and his duty of faithful treatment of patients (e.g., the principle of non-desertion) should always trump a doctor's contractual duty to re-prioritize the balance billed patient in his treatment queue. In fact, the prudent doctor who adheres to the Article's plan would be wise to affirmatively represent in the balance billing contract that the doctor can freely and without penalty treat all emergent patients without being in breach of the contract. For example, if a patient has a heart attack or lapses into asthmatic distress while waiting to see the doctor, it is absurd to think that doctor would make that patient wait while the doctor treated the balanced billed patient. When grave risk of death or injury would result from the doctor's queue reprioritization, then the doctor must accede to his instincts and treat those emergent patients.

Doctors who participate in a balance billing program should recognize the potential changes to their practice made by participation in the program. Although the thesis of this Article is that the opportunity to be balance billed should be available to any patient, it is likely true that only a wealthy cohort of a doctor's patients would participate in a balance billing program. Wealth, in this context, of course is a relative term. The participating patient might not be wealthy in the sense that his bank accounts are overflowing; he might just choose to allot whatever disposable income he might have toward a balance billing program.

247 See, e.g., Ricks v. Budge, 64 P.2d 208 (Utah 1937); see also BARRY R. FURROW, ET. AL., THE LAW OF HEALTHCARE ORGANIZATION AND FINANCE 213-17 (7th ed. 2013) (explaining the common law duty to treat).

248 As a related matter, Section 4507 of the Balanced Budget Act of 1997, Medicare's private contracting provision, requires that a private contract not be entered into between the physician and the patient when the patient is experiencing a medical emergency. See 42 U.S.C.§1395a(b)(2)(A)(iii) (2009); see also supra notes 111, 112 and accompanying text.

249 See Emily R. Zoellner, *Medical Repatriation: Examining the Legal and Ethical Implications of an Emerging Practice*, 32 WASH. U. J.L. & POL'Y 515, 517 (2010) (stating hospitals are required to "treat patients suffering from emergent healthcare needs.")

It is unknown at this time whether this cohort would also be the sickest of the doctor's patients. If so, then any reprioritization of those very sick balance billed patients likely would cause more delay for the cohort of patients who choose not to participate in the program. The doctor could possibly give the non-balance billed patients short shrift, thinking that he has to rush through the rest of his workday because he gave careful attention to a group of patients earlier in the day who pay the doctor's full price.

It is equally possible the patients who participate in a doctor's balance billing program might be, all things considered, relatively healthy. They might be relatively stable chronically diseased patients, who can be rapidly diagnosed, treated, and counseled. If this is the case, and the doctor's non-balance billed patients are sicker and more acute than participating patients, then an intangible element that contributes to the doctor's overall career satisfaction could be affected. If a doctor perceives that he is overwhelmed with sick patients, though sick patients that he chose to see in the latter part of his day, he might have a negative outlook toward his practice.

As a matter of prudence and rough economic justice, it makes little sense for the preferential treatment option to apply to hospital-based treatment. Generally speaking, one day of inpatient hospital care costs many times that of an ambulatory office visit. It is one thing for a patient to pay $30, $40, even a $100 or more to "true up" the doctor to his idiosyncratic list price for an office visit. It is quite another thing for the same patient to pay thousands of dollars to true up the hospital to its list price. The admitted hospital patient does not, as a matter of course, have the time pressures of the office patient. The admitted patient is "stuck" in the hospital for a length of time, whether for a day or two or week or two, or more. Unless the patient suffers an


253 See Pasquale, supra note, 214 at 51-52 (discussing financial differences between retainer and non-retainer physicians).

254 See Pasquale, supra note, 214, at 44-45.

255 See Pasquale, supra note 214, at 44-47.


257 See id. (recounting anecdotes of patients who were stuck with extraordinarily large bills to pay, even after their insurance benefits were exhausted).

258 CENTERS FOR DISEASE CONTROL AND PREVENTION, HOSPITAL UTILIZATION, (updated May
emergency complication while an inpatient, there is no particular reason to give the patient any priority over other patients. The only thing gained by an inpatient that pays for the privilege of being treated before others is the satisfaction of being treated first. After treatment, he then has to wait twiddling his thumbs until his doctor next performs his rounds.

C. Justification

There are three main reasons for loosening the broad proscriptions against balance billing. First, physicians of all stripes, whether primary care or specialists, have attenuated relationships between themselves, as economic agents who, under current law and contractual provisions, cannot sell their services for compensation that they think is attainable on the open market, and their patients, because the payer interposes itself between the physician and the patient. Since the insurer became the doctor's real contractual counterparty, the doctor-patient relationship has suffered, because managed care, with all of its rules, barriers, and gates restricting access, has risen between the patient and the physician.

It is important to note that, although the ability to balance bill will likely affect primary care physicians more than specialists, because specialists are already able to receive more for their contracted services than primary care doctors, the ability to balance bill should not be foreclosed to specialists. Like primary care doctors, specialists have a list price from which they are required to give automatic discounts. And like primary care doctors, specialists would be made whole if they were able to both charge and receive their full list price. All a specialist needs is a patient willing to pay a marginal amount in addition to his copayment and deductible in order to unlock a superior level of access to the physician.

Second, the ability to balance bill likely will aid, though in a marginal way, primary care staffing and access levels. Primary care physician income has declined over the past several years, even though the Resource Based Relative Value Scale was

30, 2013), available at http://www.cdc.gov/nchs/fastats/hospital.htm (providing statistics showing average length of stay for inpatient care in 2010 was 4.8 days).

259 Pasquale, supra note 214, at 91-92.


261 Pasquale, supra note 214, at 44.

262 Pasquale, supra note 214, at 49-50.
established to normalize, in part, primary care and specialist physician reimbursement.\textsuperscript{263} Primary care physicians' reimbursement has suffered under private programs and government payer programs like Medicare and Medicaid.\textsuperscript{264} If the plan in this Article works as intended, the ability to balance bill will prevent a marginal number of physicians from leaving medicine as a career, or alternatively, from foregoing public or even all third party payer programs.\textsuperscript{265}

Third, doctors' queues, in no small part due to insurance as the predominant method of payment for healthcare services, have gotten unmanageably long, especially in primary care.\textsuperscript{266} It is not uncommon for patients to wait thirty minutes, an hour, even two hours or more, to be seen by the doctor after arriving at his office.\textsuperscript{267} The patient becomes ensnared in the doctor's insurance trap. The doctor must see more and more patients, most all of whose care is financed by insurance, in order to keep up with the overhead occasioned by the third party payment system.\textsuperscript{268} Many doctors have a whole coterie of filing clerks, billing clerks, and other administrative staff, who manage the patient and paperwork flow brought about by third party payment systems.\textsuperscript{269}

**D. Economics**

Until now, balance billing has received little attention from health law scholars.\textsuperscript{270} Perhaps the reason is that it has been virtually invisible as a health

\textsuperscript{263} See supra notes 88-89 and accompanying text (discussing establishment of Resource Based Relative Value Scale).

\textsuperscript{264} See Marchitelli, supra note 52, at, § 15 (discussing shift from physicians and other medical providers toward government and private health insurers).

\textsuperscript{265} See Marchitelli, supra note 52 at, §15-44 (providing applicability and validity of balance billing within private and public insurer context).


\textsuperscript{267} See id. at 166. See also Braddock & Snyder, supra note 40, at 1058.


\textsuperscript{269} See Hammond, supra note 30, at 346.

reimbursement phenomenon for the past several years. Further, balance billing labors under the federal and state laws' heavy predisposition that it is burdensome, and even immoral, to require insurance beneficiaries to pay an amount on top of their co-payments, co-insurance, or deductibles. Rather, legislators and policymakers depend on the principle that insurance beneficiaries should be able to somewhat plan for the financial consequences of their care, rather than have open-ended commitments that could seriously damage their financial futures, if not bankrupt them. However, from a basic, conceptual viewpoint, balance billing forces health policy observers to recognize that the insurer interposes itself as a third party and interferes in what was once a true bilateral contract between the patient and the physician. Though it is true that the insurer-doctor relationship vindicates contractarian ideals since payer contracts are entered into freely, with terms fully disclosed and able to be negotiated, it is also true that the insurer-doctor contract attenuates the doctor-patient relationship. The payer interposes itself between the patient and the physician and makes treatment less about a caring and fulfilling experience for the patient and more about living up to the picayune strictures of the doctor's insurance contract. The contractarian ideal, no matter the res of the contract, is based on mutuality, namely mutual assent on the contract's terms. From a health perspective, the contractarian ideal bespeaks a mutuality principle that is deeper than that of a contract for painting services or widgets. Before insurance fundamentally changed from true reimbursement of a doctor's charges to a commodity packaged according to the patient's acuity and the doctor's time demands, both doctors and patients could feel or intuit they each received a fair deal from the patient's


Marchitelli, supra note 52 at § 4.

See Marchitelli, supra note 52 at § 4.

See e.g. supra note 229-231 and accompanying text (discussing policy goals behind the Affordable Care Act).

Marchitelli, supra note 52, at § 4.

See Marchitelli, supra note 52, at § 13


See id. at 551

payment. The doctor absorbed the patient’s pain and physical complaint, and in turn, the patient gladly paid the doctor for his expertise, attention, and time. It was a relationship based on mutual trust and the goal, both short-term and long-term, of the patient’s well-being. The physician also had an understanding that, as he developed more and deeper relationships with patients in his community, he would earn a comfortable living ministering to the physical needs of his patients.

When doctors’ revenue streams are highly dependent on third party payers, the payer becomes the dominant party in the payer-doctor-patient relationship. The doctor must see an ever increasing number of patients in a day in order to satisfy his cash flow and overhead demands. Ironically enough, when the doctor slows down and forswears third party payment, he typically sees fewer patients in a day, yet his career satisfaction and income levels seem to be positively affected. Two provisional hypotheses are at work for the doctors who realize more income from weaning themselves from third party forms of payment. First, their overhead is dramatically lower than the insurance-receiving doctors. Second, these “cash-only” doctors are able to actualize their accounts receivable quicker than physicians who take insurance.

279 Id. at 20-21 (pointing out changes in the way patients and doctors relate to each other).
280 Id. at 20 (highlighting decrease in doctors’ professional authority and voluntary choice due to restrictions by insurance and hospitals).
281 Id. at 19 (discussing rise of doctors to professionals from whom patients sought advice).
282 Id. at 21.
283 Id. at 25 (highlighting threat that bureaucratic organizations make on the medical profession).
284 See Shannon Brownlee, Why Your Doctor Has No Time To See You, NEWSWEEK (Apr. 16, 2012, 12:00 AM), http://www.thedailybeast.com/newsweek/2012/04/15/why-your-doctor-has-no-time-to-see-you.html. “While specialists could often combat falling fees by doing more procedures, primary-care doctors get paid by the office visit, so all they could do was cram more appointments into a day and increase their panel size—the number of patients in their practices.” Id.
285 See Kircheimer, supra note 59. Kircheimer noted that “without insurance mandates, doctors treat patients at they deem fit. The membership model provides a steady income, allowing doctors to see fewer patients each day—and therefore freeing the doctors to spend more time with each.” See Kircheimer, supra note 59.
286 See Kircheimer, supra note 59.
287 See Kircheimer, supra note 59. Hopefully, this should go without saying. A doctor who receives payment in full at the point and time of service is compensated “better” or “more completely” than a doctor who has to wait, however short or long the time may be, to be reimbursed at a percentage of his set rate. Kircheimer states:

‘Most estimates show that a medical practice spends 30 percent or more of its time and money just trying to collect payments from insurance companies,’ says Ryan Neuhofel, D.O. who operates a pay-as-you-go family medicine practice in Lawrence, Kan., consisting of himself and a nurse. (Both answer
Doctors who cannot or will not forego all forms of third-party payment instead revert to a phenomenon that is as old as supply and demand. They lower their contracted prices for private payers in order to attract more patients. Yet, in acceding to the market power of the private insurers, physicians give up the ability to control their own destinies. They would rather take the chance of receiving marginally superior reimbursement to that of having a balanced life. Doctors who lower their contracted prices with private payers do so in order to make up for the shortfalls in reimbursement they suffer with regard to public programs. Yet, if a doctor were allowed to balance bill his public program patients, he might not perceive the need to take on an overload of private payer patients.

It is important to realize that, as a marginal fix to doctors’ fundamental problems of compensation and overall career satisfaction, balance billing helps solve one-half of the problems immediately identified above. By definition, a physician’s engagement in balance billing presupposes his robust participation in third-party payer programs. He would not be able to rid himself of the identified structural problem of onerous overhead costs, including billing clerks, file clerks, and insurance liaisons. Further, although a physician would be motivated to give his balance billed patients the “full” treatment of a complete office visit (i.e., one that did not run too short because the doctor had to hurry to his next appointment), those patients might comprise a relatively small cohort of his overall patient pool.

Nevertheless, physicians are rational actors in the healthcare marketplace. If left to their own devices, physicians would balance bill to the maximum extent possible in order to round out their revenues. Further, they would balance bill if they had a

the phone.) ‘And when we’re talking notes about patient visits or care, it’s mostly about checking off boxes to satisfy insurance requirements.’

See Kircheimer, supra note 59.


Id.

See supra Part III.B.C.

See supra Part I.E (outlining balanced billing).

See supra note 41 and accompanying text (noting the ability of cash only doctors to streamline their practices).

See J.R. Perry, Balance Billing and Medical Unrest, 26 CAN. FAM. PHYSICIAN 1468 (NOV. 1980) (opining on the evils of all out balance billing).
willing counterparty to the balance billing contract or to feel the inchoate satisfaction that comes with having a patient pay the full price for the service rendered by the doctor.²⁹⁴ However, given the “revenue maximization” consideration, it is by no means certain that a physician would push a large swath of his patients into balance billing contracts. In other words, “the maximum extent possible” might very well mean a relatively small overall cohort of the doctor’s total patient pool. If pushed, patients might feel threatened and might rebel against the physician to look for another who does not push a balance-billing agenda. So, the physician would have to be delicate and non-threatening, else he alienate the broad swath of patients that makes the biggest part of his patient population.

V. Conclusion

A major lesson of austerity economics is that often-generous healthcare benefits can be sacrificed to staunch heavy financial bleeding. Though Americans do not have a single-payer system like those in Greece and other southern European nations, our government programs are fraught with the prospect of austerity, in the form of the Sustainable Growth Rate and other innovations to traditional fee-for-service payments.

As a counterweight to the severity of austerity, Congress has considered bringing back balance billing, in the form of private contracts. Though a form of private contracting is currently set in law, it is a form, that at least in the Medicare context, exacts a heavy price from both the physicians and patients who choose to use it – the privately contracting physician (or anyone else) must not bill Medicare for professional services for two years. Nevertheless, broadly speaking, private contracting is a most promising prospect of vindicating the contractarian ideals of the marketplace. Private contracting, along with more ‘routine’ balance billing in both private and public programs, if coupled with a queue-shifting mechanism favoring patients willing to be balance billed, would allow patients and doctors to make arms-length contracts on terms suitable for both parties. Further, a revival of balance billing might be the spark, the marginal catalyst, which would keep physicians in the system as practicing caregivers, rather than dropping out, fed up with the time, trouble, and relatively low reimbursement of the current system.

²⁹⁴ Perry, supra note 293 at 1469.