I do not believe that the proposed answer to Question 28 is accurate. The answer now states:

While health plans aren’t allowed to charge a higher copayment or coinsurance for out-of-network services received in an emergency, [Insert state name] allows health care providers to bill consumers for the difference between the cost of emergency care received out-of-network and the amount the plan allows. For more information about [insert name of state]’s rules on balance billing, please contact [insert specific state contact information].

This is the language I would suggest:

While health plans aren’t allowed to charge a higher copayment or coinsurance for out-of-network services received in an emergency, you may encounter a health care provider who bills you for the difference between its charges for emergency care received out-of-network and the amount the plan allows. The amount you are obligated to pay is a matter for state courts to determine.

My objection is to the use of two terms in the proposed answer.

The proposed FAQ answer asserts that the state “allows” the practice of balance billing. I presume the drafter meant that the state allows this in the sense that regulators do nothing to stop it. However, I think the term “allow” connotes that there is some controlling legal authority supporting the lawfulness of collecting the difference between what the insurer paid and the provider’s charges. That is not the case.

Under the common law, a patient’s relationship with an emergency room doctor or other non-participating provider is one of “quasi-contract,” and in the absence of explicit price terms, compensation is set as “usual, customary and reasonable.” See Confold Pacific, Inc. v. Polaris Industries, Inc. 433 F.3d 952 (2006). If an insurer pays the UCR amount on the patient’s behalf, by my reckoning, the physician would not be able to collect any additional amount in court. There is no case law on point that I am aware of (i.e., emergency room doctor versus consumer), but there is plenty of case law saying that a provider is limited to the UCR amount—not “charges”—when there are no explicit contract terms.

We can say with some certainty that balance billing would not be “allowed” in Pennsylvania, Temple Univ. Hosp. v. Healthcare Management, 832 A.2d 501 (Pa. Super. Ct. 2003), or in Tennessee, River Park Hosp. v. Bluecross Blueshielde TN, 173 S.W.3d 43 (Tenn. Ct. App. 2002). In Illinois, providers can collect charges if they are equivalent to UCR: Victory Memorial Hospital v. Rice, 493 N.E.2d 117 (Ill.App. 1986). Balance billing probably would not be allowed in California, Corenbaum v. Lampkin, 156 Cal.Rptr.3d 347 (2013), or Texas, Haygood v. De Escabedo, 356 S.W.3d 390, 395 (Tex. 2011) (those cases are on tort damages for medical bills so not directly on point). There are some cases saying that hospitals can collect their chargemaster amounts if they are filed with the state—they can be then be incorporated by reference—but also
cases going the other way on that too: Doe v. HCA Health Services Of Tennessee, Inc., 46 S.W.3d 191 (Tenn. 2001). I’ve seen no such case law permitting a physician “chargemaster.”

I would not want state insurance departments saying anything that encourages consumers to pay exorbitant medical bills, especially those generated by physician staffing corporations that gain exclusive franchises from hospitals but then refuse to bargain in good faith with insurance plans.

I also object to the phrase “the cost of emergency care.” “Cost” is a term of art when referring to payments for providers—in the Medicare and Medicaid programs, it refers to the input costs of providing a service. In those programs, payments are supposed to be set at a bit above the cost incurred by an efficient provider. If it is possible for an in-network emergency room doctor to make a profit seeing a patient for, say, $200, then that would be a reference for the legitimate “cost,” not an arbitrary charge five times that amount. So I suggest changing “cost” to “charges.”

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