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Federal "Balance Billing" Legislation: Constitutional Implications

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Washington, DC 20004
June 19, 2019

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Executive Summary

Members of Congress have recently focused on the practice known as "balance billing" in the healthcare industry. Balance billing is the process by which a healthcare provider bills a patient for charges that the patient's health insurance plan refuses to cover—*i.e.*, when a provider seeks to recoup an unpaid balance for services rendered. This practice generally arises in two circumstances: (1) when a patient receives emergency care from an out-of-network healthcare provider, or (2) when a patient receives scheduled care from an out-of-network healthcare provider at an in-network facility. By comparison, balance billing does not occur when a patient receives care entirely in-network. In those cases, the patient's health insurance plan simply reimburses the healthcare provider based on a contracted rate reached through arms-length bargaining between the plan and the provider, and there is no balance left to recover. Prompted by concerns that balance billing is unfair to patients, as the bills may exceed what patients are accustomed to paying for in-network care, members of Congress have advanced various legislative proposals to curb the practice. Among other things, those proposals aim to ban balance billing altogether, force hospital-based physicians to join the networks their hospitals have otherwise joined, and impose ceilings on the compensation that healthcare providers may recover from health insurance plans for out-of-network services. Under some proposals, providers who perform out-of-network services may be limited to recovering only the median rate for a comparable in-network service.

Those efforts not only oversimplify a complex issue and deviate from bedrock principles of freedom to contract; they also raise constitutional concerns. While most healthcare providers have managed to secure reasonable rates from most health insurance plans—and thus are in-network with respect to those plans—that is primarily because the threat of declining to join the network (while charging market rates and collecting unpaid fees through balance billing) has given them the negotiating leverage to achieve those rates. After all, plans that cannot attract providers into their networks are unlikely to attract consumers. And when healthcare providers have declined to contract with particular plans, that is typically because those plans were unwilling to agree to reasonable rates. Thus, some providers have elected to remain out-of-network with respect to certain networks—and utilize balance billing when appropriate—because that offers the best chance of sustaining their practices and continuing to provide quality care at reasonable rates.

It is therefore no understatement to say that federal proposals to eliminate balance billing pose a significant threat to all healthcare providers and their ability to

secure sufficient compensation for their services. All providers would lose the modest negotiating leverage they have with health insurance plans, and they may have to decide between one of two untenable alternatives: accept unreasonable rates dictated by health insurance plans if they elect to go in-network (or are forced to go in-network), or stay out-of-network and abide by federal price caps that may themselves be linked to those very same in-network rates—in fact, a *single* in-network rate (the median rate) that does not reflect variations across geographies, specialties, or practice locations. Moreover, because health insurance plans would gain all negotiating power in a regulatory environment where balance billing is unlawful, in-network rates would become increasingly divorced from market realities as time passes. Indeed, even if in-network providers are receiving reasonable compensation today under preexisting network agreements, health insurance plans would have no incentive to offer fair market rates once those agreements expire, leading to systematic under-compensation for in-network providers in the future. If a federal rate-setting scheme is tied to in-network rates, then it too would suffer from these same creeping effects. In the long run, then, the net result of a ban on balance billing would be to render healthcare practices economically non-viable—for in-network and out-of-network providers alike.

All of this raises two distinct constitutional concerns. First, a federal ban on balance billing raises problems under the Takings Clause of the Fifth Amendment. The Supreme Court has recognized that government price regulations may effect a "regulatory taking" based on a consideration of the three "*Penn Central* factors," derived from the Supreme Court case of the same name: (1) the economic impact of the regulation on the claimant, (2) the extent to which the regulation has interfered with distinct investment-backed expectations, and (3) the character of the governmental action. All three of those factors would cut in favor of a takings claim if Congress were to pass some forms of balance-billing legislation. Both in-network and out-of-network providers would suffer a severe economic impact, and the legislation would plainly defy investment-backed expectations because healthcare providers had no reason to suspect that the federal government would regulate their business with unprecedented price caps or force them to join particular health insurance networks in order to continue practicing at their preferred hospitals. Indeed, the notion that healthcare providers would not be free to charge reasonable rates for their services in the absence of a contract with a health insurance plan is entirely novel and runs counter to bedrock freedom-of-contract principles. Further, most balance-billing legislation would ultimately concentrate the cost of providing cheaper healthcare (especially emergency care that hospitals are required to provide as a matter of federal law) on healthcare providers when that burden could be distributed much more evenly. Congress' impulse to shield patients from unanticipated healthcare costs is

understandable, but the Takings Clause is designed to guard against forcing some people alone to bear burdens that should be borne by the public as a whole.

Balance-billing legislation raises particularly acute concerns in the context of emergency services. Because federal law imposes duties on healthcare providers to provide care in cases of medical emergency without regard to the patient's insurance status or ability to pay, healthcare providers are akin to public utilities or common carriers in providing those services. And a long line of cases makes clear that, when regulating the rates of public utilities or common carriers that have no choice but to provide services to the public, the government cannot impose unreasonable or confiscatory rates. Forcing healthcare providers to furnish emergency services at government-dictated rates—even to those who can pay fair market value—raises all the same takings concerns that courts have expressed when dealing with unfair or confiscatory rate-setting in the context of public utilities and common carriers. If anything, the concerns are more pronounced in the context of healthcare providers, who are not free to redirect capital investments into unregulated industries; physicians would be unable to escape either the emergency-services mandate or the price regulations. Accordingly, healthcare providers would have particularly forceful takings claims if balance-billing legislation were to preclude them from recovering sufficient compensation for the emergency services that they are obligated to provide.

Balance-billing legislation would also raise First Amendment problems because it would interfere with healthcare providers' ability to associate together, refuse to associate with health insurance plans, and insist on higher reimbursement rates. Such legislation would be the functional equivalent of a ban on private-sector labor strikes. Just as anti-strike legislation neuters associational activity by stripping employees of the one device that allows them to negotiate with employers on an equal footing, banning balance billing or prohibiting providers from staying out-of-network would do the same to providers, as they have historically relied upon their ability to stay out-of-network to secure reasonable compensation. It is doubtful that Congress could impose an outright ban on private-sector labor strikes without raising serious First Amendment concerns: If employees cannot strike, then their First Amendment right to associate for the purpose of bringing their interests to bear on management is essentially meaningless. The same principles would preclude Congress from choosing sides between providers and health plans and stripping the former of their ability to remain out-of-network unless the latter agrees to mutually-acceptable terms. In both contexts, the right to withhold services in the absence of agreed-upon terms has a constitutional dimension that cannot be cast aside simply because strikes or balance billing are perceived to inconvenience third parties.

In short, federal balance-billing legislation raises multiple constitutional concerns. If Congress proceeds with legislation, it should at least include safeguards that would ameliorate those concerns—namely, by ensuring that out-of-network healthcare providers will have some leverage to insist on receiving adequate payments for their services. Such a system should include at least two components. First, if an out-of-network healthcare provider treats a member of a health insurance plan in an emergency situation or at an in-network facility, the provider should receive an "interim direct payment" ("IDR") to ensure that the provider obtains some compensation immediately. The IDR would be equal to either the payment rate that prevailed under the most recent contract between the plan and provider or, in the absence of any prior contracting history, the prevailing rate for similarly-situated commercial health plans and providers in the geographic area. Second, if either party disputes the IDR amount, the parties should resolve it in a binding "baseball style" arbitration proceeding, where both parties submit their best offers and a neutral arbitrator selects the most reasonable one. Although this system would not address all constitutional objections to balance-billing legislation, it would at least alleviate concerns that out-of-network healthcare providers—including those providing life-saving emergency care—would lose all leverage to insist on receiving reasonable, market-based compensation for their services.

Analysis

I. OVERVIEW OF THE ISSUES.

Balance billing is nothing new. In the healthcare industry, the practice goes back decades. *See, e.g.*, Marilyn Moon, *Freedom to Pay or Freedom to Choose? Private Contracting and Medicare Beneficiaries*, 10 Health Matrix 21, 22 (2000) (discussing balance billing in the 1960s). But most patients have little or no firsthand experience with it. In the ordinary course, a patient with private health insurance receives healthcare from an in-network provider—*i.e.*, a provider who has already negotiated a payment rate with a health insurance plan through arms-length bargaining. In this in-network setting, the mechanics of the billing process are familiar and straightforward for a patient. The health insurance plan pays the negotiated rate to the provider for the services rendered, with the patient typically contributing some cost-sharing amount, such as co-insurance or a co-payment. *See, e.g.*, Wen S. Shen, Cong. Res. Serv., *Balance Billing: Current Legal Landscape and Proposed Federal Solutions* 1 (Apr. 15, 2019) ("Shen"). Because the contracts between providers and plans establish the maximum rate for the relevant services, there is no remaining

balance for providers to recover—and thus no reason to balance bill—after the providers have been reimbursed at the contracted rate.

The majority of healthcare providers in the United States belong to a network. But providers that elect to go in-network have managed to negotiate reasonable rates with health insurance plans in large part *because* they retain the option to balance bill. If a plan refuses to agree to reasonable terms, the providers have an exit option: They can simply walk away from contract negotiations, stay out-of-network, charge market-based rates to members of the plan that refused to come to terms, and balance bill if the plan does not pay for the out-of-network care. *Cf.* Shen 1-2. The credible threat of staying out-of-network and engaging in balance billing thus provides much-needed negotiating leverage for providers. After all, a health plan that cannot entice providers to participate is unlikely to generate much business from consumers, who choose their plans in substantial part based on the access that the plan gives to a provider network. At the same time, the providers' need to retain this modest negotiating leverage is acute. Even under the status quo, hospital-based physicians treat all patients at their facilities regardless of the patients' ability to pay, and their practices incur the cost of providing that care without knowing how much they will be able to collect in the end, including through balance billing.

To make the threat of "exit" credible, some healthcare providers have refused to agree to terms with some plans. In those instances, the providers have consciously elected to stay out-of-network (and charge market rates and balance bill when appropriate). There is nothing sinister about that choice. For most providers who must resort to balance billing, it is out of financial necessity. Operating a healthcare practice is exceedingly expensive. If providers meekly accept only what health insurance plans are willing to pay, no matter how unreasonable those rates may be, their practices may become economically unsustainable. For some providers, the ability to balance bill thus can spell the difference between maintaining a healthcare practice and shutting it down.

As all of this underscores, the practice of balance billing is nuanced. Indeed, it serves two critically important purposes that help preserve an equilibrium in the healthcare industry: (1) providing at least some leverage for providers to secure reasonable, market-based rates from health insurance plans, and (2) serving as a financial backstop for providers when plans are unwilling to agree to reasonable rates. While no provider's first-choice option is to engage in balance billing—just the opposite—eliminating the option altogether would profoundly distort the healthcare market.

Today, balance billing is mostly limited to two narrow settings. The first involves emergency care. In an emergency, the nearest healthcare provider who can treat a patient may be one outside the patient's insurance network. By operation of federal law—*viz.*, the Emergency Medical Treatment & Labor Act ("EMTALA")—every hospital with an emergency department that participates in Medicare (which is to say, virtually every hospital with an emergency department) *must* treat and stabilize *every* patient who seeks emergency care, regardless of the patient's insurance status or ability to pay. *See* 42 U.S.C. §1395dd. To date, Congress has never provided funding to help fulfill this sweeping mandate. The day-to-day results of this unfunded mandate are predictable. Insurers often refuse to pay the full cost of emergency out-of-network care, leaving providers with little choice but to bill the patient for the outstanding balance. *See, e.g.*, *NFIB v. Sebelius*, 567 U.S. 519, 547 (2012) (opinion of Roberts, C.J.) (EMTALA "require[s] hospitals to provide a certain degree of care to individuals without regard to their ability to pay," and "hospitals end up receiving compensation for only a portion of the services they provide").

The second setting in which balance billing arises involves scheduled care at in-network facilities. Historically, there has been no legal obligation for hospital-based physicians to enter into network agreements with the health insurance plans that their hospitals have otherwise joined (or with any health insurance plan, for that matter). As noted, some physicians decline to join a particular network because the rates the plan is willing to offer are insufficient to sustain their practices. Accordingly, in certain circumstances, a patient may receive treatment from an out-of-network physician at an otherwise-in-network facility. As in the emergency-services context, health insurance plans often refuse to pay the full cost of this out-of-network care, which leaves the provider to turn to balance billing.

Until recently, Congress had never sought to ban balance billing in the context of private health insurance, which is primarily regulated at the state level. *See also* Namrata K. Uberoi, Cong. Res. Serv., *Balance Billing in Private Health Insurance Plans* 2 (July 23, 2015). But within the past several months, members of Congress have introduced various bills (or drafts of bills) designed to curb this practice. *See, e.g.*, S.___, 116th Cong. (2019) (TAM19864) (Discussion Draft); H.R.___, 116th Cong. (2019) (720823|10) (Discussion Draft); S. 1531, 116th Cong. (2019); S. 3592, 115th Cong. (2018); S. 3541, 115th Cong. (2018). While those bills differ in their particulars, most have some common components. These have included provisions that would ban balance billing altogether; compel out-of-network physicians to join the networks their hospitals have joined if those physicians wish to continue practicing at their preferred hospitals (*i.e.*, "network matching"); and cap the amount of money that a healthcare

provider may recover for an out-of-network service at the median rate for a comparable service within the patient's health insurance network (*i.e.*, "benchmark rates"). These proposals may be well intentioned, but they raise significant constitutional concerns.

II. BALANCE-BILLING LEGISLATION RAISES CONCERNS UNDER THE TAKINGS CLAUSE OF THE FIFTH AMENDMENT.

The first problem with congressional efforts to address balance billing is that they raise problems under the Takings Clause of the Fifth Amendment. The Takings Clause provides: "[N]or shall private property be taken for public use, without just compensation." U.S. Const. amend. V, cl. 4. As that text makes clear, the Takings Clause "requires the payment of compensation whenever the government acquires private property for a public purpose." *Murr v. Wisconsin*, 137 S. Ct. 1933, 1942 (2017). And under well-established Supreme Court precedent, the government may effect a taking either through a direct appropriation of property, or through regulation of property that "goes too far." *Pa. Coal Co. v. Mahon*, 260 U.S. 393, 415 (1922); *see also Tahoe-Sierra Pres. Council, Inc. v. Tahoe Reg'l Planning Agency*, 535 U.S. 302, 321-32 (2002). Balance-billing legislation undoubtedly affects protected property interests and implicates multiple strands of takings jurisprudence, as it threatens to both systematically devalue medical licenses and commandeer physical healthcare resources without providing just compensation. *See, e.g.*, *Sierra Med. Servs. All. v. Kent*, 883 F.3d 1216, 1224-25 (9th Cir. 2018) (noting that healthcare providers may have property interests "in their ambulances, equipment, wages, supplies, insurance, goodwill, and ambulatory-service and employment contracts"); *Sabow v. United States*, 93 F.3d 1445, 1456 (9th Cir. 1996) (noting that a "medical license" is a "protected property interest").

Some balance-billing proposals presents far-reaching problems under the regulatory-takings doctrine. That doctrine recognizes that government regulation "can be so burdensome as to become a taking." *Murr*, 137 S. Ct. at 1942. In most cases, the Supreme Court applies a three-pronged test to determine whether regulatory activity is tantamount to a taking: (1) "[t]he economic impact of the regulation on the claimant," (2) "the extent to which the regulation has interfered with distinct investment-backed expectations," and (3) "the character of the governmental action." *Penn Cent. Transp. Co. v. New York*, 438 U.S. 104, 124 (1978). While any one of these so-called "*Penn Central* factors" could suffice to support a taking, *see, e.g.*, *Ruckelshaus v. Monsanto Co.*, 467 U.S. 986, 1005 (1984), the Court typically balances all three factors, *see, e.g.*, *Palazzolo v. Rhode Island*, 533 U.S. 606, 634 (2001) (O'Connor, J., concurring). Balance-billing legislation implicates all three.

First, the restrictions on balance billing have a significant economic impact, one of the "[p]rimary" factors in the analysis. *Lingle v. Chevron U.S.A. Inc.*, 544 U.S. 528, 538-39 (2005). As explained, balance billing serves two critical functions: (1) providing at least some leverage for all healthcare providers to negotiate reasonable rates with health plans, and (2) providing a mechanism for out-of-network healthcare providers to receive reasonable compensation if health plans refuse to come to terms. Most balance-billing legislation strikes at the core of this economic dynamic. To take the latter function first, in circumstances where a patient receives care from an out-of-network provider, some current legislative proposals would allow the patient to pay only what his co-payment or co-insurance would have been had he received in-network care, and his health insurance plan may not have to pay anything more than what it would pay to the median in-network provider—no matter that the median in-network rate fails to account for variations across geographies, specialties, or practice locations. Perhaps even worse, some proposals would bar hospital-based physicians from staying out of the networks their hospitals have otherwise joined, and the physicians' failure to comply would prevent them from practicing at those hospitals altogether—and thus would result in a loss of *all* business for those physicians at those hospitals. But the entire point of staying out-of-network for many providers is that in-network rates are unreasonably low. Ultimately, then, some forms of balance-billing legislation run the risk of precluding providers who are currently out-of-network from receiving fair value for their services—even from patients who are willing and able to pay. *But see Kirby Forest Indus., Inc. v. United States*, 467 U.S. 1, 10 (1984) (a taking requires payment of "fair market value of the property"). That is antithetical to market-economy and freedom-of-contract principles that have long prevailed in this country.

The economic impact is far worse, moreover, because the effects of balance-billing legislation will become increasingly severe over time. Simply put, a ban on balance billing would fundamentally distort the market for healthcare services. After all, if healthcare providers are stripped of their negotiating leverage by being deprived of their exit option, then they will become systematically under-compensated over time. When current network agreements expire, healthcare plans will understand that they can do no worse in negotiations than getting the services of providers for some baseline rate dictated by historical averages. That regulatory price will then become a practical ceiling of what plans will offer in negotiations, which in turn will tend to freeze payment rates at their historical averages. Thus, although balance-billing legislation will pose an immediate threat to some providers who are currently out-of-network the day it is passed, such legislation is almost certain to result in systematic under-compensation for *all* healthcare providers as time goes on, including providers that are currently in-network and not directly targeted by the legislation.

The "financial burden" of all of this will be "considerable" for healthcare providers, to say the least. *E. Enters. v. Apfel*, 524 U.S. 498, 529 (1998) (plurality op.).

Turning to the second *Penn Central* factor, healthcare providers would bear the brunt of that burden despite "distinct investment-backed expectations" to the contrary. 438 U.S. at 124. Healthcare providers have invested in their medical licenses and practices on the understanding that they could recover market-based compensation for their services, both through staying out-of-network and balance billing itself and through the impact that the possibility of staying out-of-network has on in-network rates. Indeed, outside of unique contexts like public-utility and common-carrier regulation, the notion that the federal government would engage in sweeping rate-setting and intrusion into private contracting is practically unheard of. Even in those contexts, moreover, rate regulation is subject to the constitutional backstop that the government cannot impose "unreasonable" or "confiscatory" rates. *See, e.g.*, *Duquesne Light Co. v. Barasch*, 488 U.S. 299, 310 (1989). So not only did healthcare providers not expect to be treated like public utilities or common carriers when entering the healthcare market; they certainly did not expect to receive *less* constitutional protection than entities that knowingly entered into a rate-regulated industry. By enshrining into federal law a system that would both cap rates and exert continuous downward pressure on provider compensation, balance-billing legislation promises to accomplish just that unanticipated result.

The third and final *Penn Central* factor—"the character of the government action"—likewise raises takings concerns. 438 U.S. at 124. In fact, the character of the congressional action here runs directly contrary to the fundamental purpose of the Takings Clause, which is "to bar Government from forcing some people alone to bear public burdens which, in all fairness and justice, should be borne by the public as a whole." *Armstrong v. United States*, 364 U.S. 40, 49 (1960). The basic objective of balance-billing legislation is to relieve patients of the burden of paying unanticipated costs for out-of-network medical care. But rather than spread across the public the burdens that would result from a system in which patients are not obligated to pay the full cost of the services they obtain, some balance-billing legislation seeks to force *providers* to bear the full brunt of those costs. Congress' desire to help people avoid unanticipated healthcare costs is understandable, but Congress cannot achieve that goal by commandeering private-sector healthcare providers and prohibiting them from recovering the cost of furnishing care. There are plainly much fairer and more equitable ways to apportion the burden of providing such care—most obviously, Congress could allocate funding from the general tax base to cover those costs. In sum,

balance-billing legislation raises serious Takings Clause issues under the *Penn Central* framework.

Balance-billing legislation also raises distinct Takings Clause concerns in the context of emergency services. As a result of EMTALA, hospitals effectively have a statutory duty to serve members of the public—including patients who have insurance that is not accepted by those hospitals—and failure to do so may result in monetary penalties and other liability. *See* 42 U.S.C. §1395dd(d). In other words, in the emergency-services context, healthcare providers are treated as the equivalent of public utilities or common carriers. That raises concerns even now, as EMTALA essentially operates as a largely unfunded mandate, owing to the fact that many patients are simply unable to pay for the emergency services they receive. *See The Care of the Uninsured in America* 66 (Nancy J. Johnson & Lane P. Johnson eds., 2010) ("more than half (55%) of the emergency care in the United States is uncompensated"). But the lurking takings concerns with EMTALA would become even more acute were Congress to prohibit balance billing.

An analogy helps illustrate the point. If Congress tomorrow decided to impose an obligation on contractors across the nation to provide certain "emergency" repairs for apartments and houses without regard to the occupants' ability to pay, the contractors would raise legitimate takings concerns that a burden that should be shouldered by society as a whole (ensuring a minimum level of maintenance for the human need of shelter) was being imposed on a few (contractors). The one thing that might prevent such a mandate from running afoul of the Takings Clause would be the ability of the contractors to pass some of the cost of the mandate on to customers who could afford to pay. If Congress then restricted that ability—say, through a law dictating that contractors charge those who can pay no more than the historical average for their services—the takings problem with the emergency-repairs mandate would be exacerbated. The only mechanism for redistributing the costs of providing the mandatory services to a broader segment of the population would be restricted.

Some balance billing legislation would exacerbate the constitutional concerns with the burdens imposed by EMTALA in much the same way. EMTALA operates like the hypothetical mandate to provide emergency repairs, "forcing some people alone"—namely, healthcare providers—"to bear public burdens which, in all fairness and justice, should be borne by the public as a whole." *Armstrong*, 364 U.S. at 49. Indeed, as one observer noted, "[i]t would be no different if the government required that on cold nights, every Ritz Carlton, Hilton, and Marriott must open their rooms to the homeless, yet provided [insufficient] compensation either for the invasion of space or for the consumption of staff time, towels, and toiletries." E.H. Morreim, *EMTALA:*

Medicare's Unconstitutional Condition on Hospitals, 43 Hastings Const. L.Q. 61, 69 (2015). Many balance-billing proposals then exacerbate that constitutional difficulty by artificially capping what providers can charge those who can afford emergency services. By restricting the one available mechanism for sharing the burdens of the EMTALA mandate, those balance-billing proposals run directly contrary to the thrust of the Takings Clause.

That direct threat to Takings Clause values could be enough to condemn the proposals, but such proposals also raise related concerns under cases prohibiting confiscatory rate-setting and physical takings. If Congress is to regulate the rates that healthcare providers can recover for providing *mandated* emergency services under EMTALA, then just as with public utilities and common carriers that have obligations to serve the public, Congress cannot force healthcare providers to accept "unreasonable" or "confiscatory" rates in exchange for those services. *Duquesne Light Co.*, 488 U.S. at 310; *see also id.* at 308 ("If the rate does not afford sufficient compensation, the State has taken the use of utility property without paying just compensation and so violated the Fifth and Fourteenth Amendments."); *Verizon Commc'ns, Inc. v. FCC*, 535 U.S. 467, 523 (2002). Compounding the problem, balance-billing legislation implicates the *physical*-takings doctrine in the emergency-services context too, for EMTALA's mandate to screen and stabilize patients requires hospitals to devote physical space and medical supplies to patients.

If anything, the takings concerns are even more pronounced in the context of healthcare providers for two related reasons. First, unlike most public utilities and common carriers, healthcare providers cannot redirect capital investments into unregulated industries to try to offset the costs of the emergency-services mandate. Second, the notion that physicians would be simultaneously mandated to provide services to those who could not pay and precluded from passing on the costs to those who can pay is entirely unanticipated. Unlike investors in utilities who understand that they will have comparable obligations forced upon them, and generally insist on countervailing benefits like a publicly-conferred monopoly, physicians entered the market after years of training with the understanding that obligations to provide services to the indigent were accompanied by an ability to negotiate prices with those able to pay for the services. Eliminating that mechanism for distributing the costs of the mandate essentially converts providers into utilities contrary to their reasonable investment-backed expectations. *See E. Enters.*, 524 U.S. at 526-27 (plurality op.) ("the extent to which [a] regulation interferes with investment-backed expectations" is of "particular significance" to takings analysis).

In sum, if balance billing were eliminated, healthcare providers would be left with no way to avoid EMTALA's mandate, yet no way to comply with that mandate without imperiling their "financial integrity." *Verizon Commc'ns*, 535 U.S. at 524. Simply put, Congress cannot command healthcare providers to provide emergency services, but then deprive them of the means to recover "sufficient compensation" for the services that they are obligated to provide. *Duquesne Light Co.*, 488 U.S. at 308; *see also Horne v. Dep't of Agric.*, 135 S. Ct. 2419, 2427 (2015) ("people … do not expect their property, real or personal, to be actually occupied or taken away"). To the extent balance-billing legislation would accomplish that result, it raises serious problems under the Fifth Amendment for in-network and out-of-network providers alike.

III. BALANCE-BILLING LEGISLATION RAISES FIRST AMENDMENT CONCERNS.

Balance-billing legislation raises First Amendment concerns as well. The First Amendment provides that "Congress shall make no law … abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the government for a redress of grievances." U.S. Const. amend I. The Supreme Court has interpreted the First Amendment to include a right of people to associate to advance positions of common interest. *See, e.g.*, *Smith v. Ark. State Highway Emp., Local 1315*, 441 U.S. 463, 464 (1979) (per curiam) ("The First Amendment protects the right of an individual to speak freely, to advocate ideas, to associate with others, and to petition his government for redress of grievances. And it protects the right of associations to engage in advocacy on behalf of their members."). And that right must be meaningful. "The First Amendment would … be a hollow promise if it left government free to destroy or erode its guarantees by indirect restraints so long as no law is passed that prohibits free speech, press, petition, or assembly as such." *United Mine Workers of Am., Dist. 12 v. Ill. State Bar Ass'n*, 389 U.S. 217, 222 (1967); *Minn. State Bd. for Cmty. Colleges v. Knight*, 465 U.S. 271, 308-09 (1984) (Stevens, J., dissenting) (the "First Amendment was intended to secure something more than an exercise in futility—it guarantees a *meaningful* opportunity to express one's views").

The constitutional right to associate includes the right to band together for economic, as well as political, advantage. *See, e.g.*, *Roberts v. U.S. Jaycees*, 468 U.S. 609, 622 (1984) ("[W]e have long understood as implicit in the right to engage in activities protected by the First Amendment a corresponding right to associate with others in pursuit of a wide variety of political, social, economic, educational, religious, and cultural ends."). Put differently, freedom-of-contract principles, with the necessary corollary of the freedom not to contract on terms that are unacceptable, are

reflected in the First Amendment as well as the Fifth. *See id.* at 623 ("Freedom of association … plainly presupposes a freedom not to associate.").

These principles have been best developed in the context of the right of labor unions to refuse to work on unacceptable terms, which is to say a right to strike. As the Supreme Court recognized almost a century ago, an employee can "put[] himself on an equality with his employer" only by acting in "concert with his fellow[]" through a labor strike. *Charles Wolff Packing Co. v. Court of Indus. Relations of Kan.*, 262 U.S. 522, 540 (1923). In *Wolff Packing*, the Court struck down a state law that prohibited labor strikes and created an intolerable imbalance of power between employers and employees. *Id.* at 540, 544; *see also* James Gray Pope, *Contract, Race, and Freedom of Labor in the Constitutional Law of "Involuntary Servitude,"* 119 Yale L.J. 1474, 1544 (2010) ("Today, *Wolff Packing* remains available as authority for the proposition that there is a constitutional right to strike, and one that flows from concerns about the balance of power in dealings between workers and employers."). And the Supreme Court has described the right enshrined in §7 of the National Labor Relations Act, which encompasses the right to strike, as a "fundamental right." *NLRB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1, 33 (1937). "[T]he right to strike is, historically and practically, an important means of effectuating th[e] purpose" of "bring[ing] the workers' interests to bear on management," and "[a] union that never strikes, or which can make no credible threat to strike, may wither away in ineffectiveness." *United Fed'n of Postal Clerks v. Blount*, 325 F. Supp. 879, 885 (D.D.C.) (Wright, J., concurring), *aff'd*, 404 U.S. 802 (1971).

By the same token, a law banning balance billing or outright prohibiting providers from staying out-of-network would raise serious First Amendment concerns. In-network providers have managed to secure market compensation until now largely *because* they have always retained the option of joining together and refusing to accept the rates that they are being offered. That threat has played a critical role in forcing most health plans to enter into reasonable network agreements. A federal prohibition on balance billing would amount to a *de facto* ban on this associational activity, as it would render the decision to go out-of-network meaningless, and in the process strip healthcare providers of their only leverage in negotiating with health insurance plans for reasonable rates. And a federal "network matching" requirement would effectively amount to a *de jure* ban on this associational activity, as it would prevent hospital-based physicians from staying out-of-network if they wish to continue practicing at their hospitals—which is no choice at all for many physicians. There are serious questions as to whether Congress could neuter associational activity to such a degree. *Cf. Williams v. Rhodes*, 393 U.S. 23, 31 (1968) ("The right to form a party for the

advancement of political goals means little if a party can be kept off the election ballot and thus denied an equal opportunity to win votes.").

IV. AT A MINIMUM, CONGRESS SHOULD MITIGATE THE CONSTITUTIONAL PROBLEMS IF IT PROCEEDS WITH BALANCE-BILLING LEGISLATION.

As for foregoing makes clear, Congress must tread carefully in crafting any balance-billing legislation. If Congress nevertheless proceeds with such legislation, however, it should at least take care to mitigate the constitutional concerns detailed above. Congress can do so through (at least) two steps, both of which would help ensure that healthcare providers would maintain at least some leverage vis-à-vis health insurance plans.

First, any legislation should ensure that out-of-network providers who treat patients during an emergency or at an in-network facility receive at least some form of payment as soon as possible after providing the service. Under this "interim direct payment" ("IDR") system, providers would receive one of two dollar amounts. If the provider is currently out-of-network due to a termination of an existing network agreement or the failure to renew an existing network agreement, the IDR would simply be equal to the rate that prevailed in the prior network agreement. If, on the other hand, the provider and the plan have no prior contracting history, then the IDR would be equal to the market rate within the relevant geographic area for similarly situated commercial health plans and providers. Such an IDR system has several benefits. Most important from a constitutional perspective, it would allow the provider to receive compensation that gets reasonably close to approximating market value—exactly what the Takings Clause is designed to accomplish.

That said, IDRs are no silver bullet. After all, some providers may have terminated or declined to renew a network agreement precisely because the rates they were receiving were economically unsustainable. And as already explained, even "market" rates will become artificially depressed over time if healthcare providers lack the threat of holding out and engaging in balance billing. Accordingly, in any balance-billing legislation, Congress should also provide a "baseball style" arbitration process as a financial backstop. In "baseball style" arbitration, each party—both the provider and the plan—submit their best financial offers, and a neutral arbitrator selects whichever one she considers the most reasonable. Such an arbitration procedure would thus allow providers to present evidence regarding the true value of their services and the financial consequences of receiving anything less.

These two features in combination would alleviate concerns that out-of-network healthcare providers—including those providing life-saving emergency care—would lose all ability to receive reasonable, market-based compensation for their services.

Conclusion

Congressional efforts to ban balance billing raise numerous constitutional concerns. Such legislation threatens to take property from healthcare providers without just compensation, in violation of the Takings Clause of the Fifth Amendment. In addition, such legislation threatens to infringe on providers' associational activity, in violation of the First Amendment. Moreover, absent features such as both minimum-guaranteed payments and the possibility of baseball-style arbitration, the constitutional problems are almost certain to worsen over time, and the effects will be felt by in-network and out-of-network providers alike.