

RETHINKING THE EMERGENCY-ROOM SURPRISE BILLING
CRISIS: WHY ARE PATIENTS LIABLE FOR EMERGENCY CARE
THEY DO NOT SEEK?

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ABSTRACT

Emergency patients who receive unrequested and unconsented care can be held liable for the entire cost of their medical bills under the common law doctrine of restitution. This Note analyzes the problem faced by these unlucky emergency patients in the American healthcare system billed for exorbitant sums. Rosenwald argues the statutory fixes recently enacted in some states are an important starting point, but they are ultimately insufficient. Reform is needed to better effectuate our sense of fairness and increase transparency within the healthcare market. Rosenwald encourages legislatures and the judiciary to reexamine the scope of the emergency exception in the restitution doctrine to reflect the numerous uncertainties inherent in emergency healthcare.

* J.D. (2020), Washington University in St. Louis. I am grateful to the editors of this volume for their hard work and helpful suggestions, all while adjusting to these disorienting times. Any mistakes, of course, are mine alone. I dedicate this note to Megan, whose everlasting love, wisdom, wit, and determination have made this note, and much else, possible.

INTRODUCTION

Imagine you experience a freak accident. One of your hobbies, perhaps bike riding, suddenly goes awry. Your arm is mangled beyond recognition and you are rushed to a hospital hoping it can be saved. Though you get some pain medication in the ambulance, at the hospital you desperately need more. As the medical team takes stock of your injuries, they give you additional doses for your pain and begin to consider next steps.

The medical team assesses that your injuries are beyond their skillset, and they need to transfer you to the specialty trauma center a hundred miles away. As the morphine kicks in, you hear them discussing the use of a medical helicopter to get you there. Perhaps aware of the scientific literature critical of the cost-benefit proposition of medical helicopter transports,¹ you manage to inquire, despite your pain and the effects of the medication, regarding the cost of such an arrangement. Maybe you want to engage in a discussion about its pros and cons, as you would whenever you consider the benefits of a service before agreeing to pay for it. Unfortunately, the pain medication puts you over oblivion's edge before you receive an answer.

Imagine you wake up a few days later recovering from surgery at the trauma center. Though they were unable to save your arm, you are grateful that they saved your life, and you are excited to return home to continue the healing process. Your recovery progresses reassuringly well for a few months. And then a bill comes. It turns out that you were in fact transported by helicopter, and your insurance refuses to pay because the air ambulance service isn't in their network. By law, you are liable for every last penny. The bill exceeds \$56,000.

For people like Naveed Kahn, this startling series of events is far from imaginary. In November 2017, Dr. Kahn experienced an A.T.V. accident, the outcome of which was a series of events much like that described above.² As such experiences make plain, the technological marvel of modern emergency medicine—the lifesaving drugs and procedures administered by impeccably trained professionals—comes with a cost: bills

1. See Greg M. Borst et al., *When Birds Can't Fly: An Analysis of Interfacility Ground Transport Using Advanced Life Support when Helicopter Emergency Medical Service is Unavailable*, 77 J. TRAUMA & ACUTE CARE SURGERY 331, 335 (2014).

2. See Alison Kodjak, *Taken for a Ride: After ATV Crash, Doctor Gets \$56,603 Bill for Air Ambulance Trip*, KAISER HEALTH NEWS (Sept. 26, 2018), <https://khn.org/news/taken-for-a-ride-after-atv-crash-doctor-gets-56603-bill-for-air-ambulance-trip/> [<https://perma.cc/K6VK-MEW9>].

that can ensnare patients in a financial abyss just as they are escaping from the medical precipice. While the problem of runaway patient-care costs seemingly knows no bounds in American health care,³ it is particularly pernicious in the context of emergencies like Dr. Khan's, where a patient is physically unable to participate in medical decision-making.⁴ In such situations, of course, a patient is physically unable to form a contract for his care.⁵ How, then, can he be liable for it?

This fundamental question underscores how financial liability for emergency care is uniquely situated within the broader set of issues regarding health care billing. In addressing this topic in particular, this note highlights the unique legal rationale under which patients can be held liable for the cost of care that they did not request, and to which they did not consent. It is not contract law, but the separate common-law doctrine of restitution that forms the legal underpinning for patient liability for emergency care. Moreover, atop this foundation, a thicket of often well-meaning but frequently ineffectual or detrimental legislation amplifies the concrete implications of this theoretical problem for countless Americans. This note argues that, while statutory fixes like those enacted recently in some states are important starting points for controlling this crisis, they are ultimately insufficient because they fail to remedy the underlying incoherence of using an old-fashioned legal rationale—developed generations before modern health-care regulation—to make a minority of spectacularly unlucky patients liable for thousands of dollars of care that

3. See LIZ HAMEL ET AL., THE BURDEN OF MEDICAL DEBT: RESULTS FROM THE KAISER FAMILY FOUNDATION/NEW YORK TIMES MEDICAL BILLS SURVEY 26 (Henry J. Kaiser Family Foundation 2016) <https://www.kff.org/wp-content/uploads/2016/01/8806-the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey.pdf> [https://perma.cc/QZK7-GFN5] (“[P]roblems related to unaffordable medical bills and medical debt are prevalent . . . [including among people] who have higher incomes, who are insured, or who are otherwise in good health . . .”).

4. Except where specified otherwise, this note uses the term *emergency* to refer to an unforeseen situation causing a patient to become unable to participate in decision-making due to diminished decisional or communicative capacity; it thus excludes some situations that would usually be considered medical emergencies but that do not interrupt a patient's ability to make and communicate decisions (e.g., chest pain). See generally James Li et al., *The “Prudent Layperson” Definition of an Emergency Medical Condition*, 20 AM. J. EMERGENCY MED. 10 (2002).

5. Mark A. Hall, *The Legal and Historical Foundations of Patients as Medical Consumers*, 96 GEO. L.J. 583, 595 (2008). This note does not address situations of post-rescue ratification, in which an individual's subsequent promise to compensate a provider of lifesaving care creates a contract despite the arguable absence of consideration. See Ross A. Albert, Comment, *Restitutionary Recovery for Rescuers of Human Life*, 74 CALIF. L. REV. 85, 94-95 (1986) (citing *Webb v. McGowin*, 168 So. 196 (Ala. Ct. App. 1935)).

they did not seek.

To reach this conclusion, this note proceeds as follows. Following this introduction, Part I provides background on the law of restitution and its emergency exception. Part II addresses the practical issues that arise from the theoretical background discussed in Part I, exploring how modern insurance and regulatory frameworks associated with emergency medical care can result in problematic liability for recipients of emergency care, and highlighting potential solutions. Part III then analyzes these potential solutions, identifies their successes and deficiencies, and recommends features that would improve future legislation.

I. RESTITUTION AS A BASIS FOR HEALTH CARE BILLING

A. Overview of Restitution

I. Common Law Origins

Recent legal scholarship regarding the root causes of exorbitant patient liability in the American health care system has begun to recognize the relevance of underlying common-law doctrines, despite the amalgamation of mounds of federal and state regulation on top of the common law in recent decades. An early wave of this scholarship focused on tort law,⁶ while a more recent wave focuses on contract law.⁷ The focus on tort law is unsurprising because common sources of patient dissatisfaction, such as malpractice, are chiefly handled through the tort system.⁸ As to the billing side of patient concerns, contract law is of great relevance because health care, like other consumer services, is usually delivered in circumstances where “patients can turn down unnecessary care or seek lower priced care,” consistent with the free-market ideal that “patients [should] shoulder more

6. See, e.g., George L. Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 YALE L.J. 1521 (1987); Note, “Common Sense” Legislation: *The Birth of Neoclassical Tort Reform*, 109 HARV. L. REV. 1765 (1996).

7. Two recent examples are Wendy Netter Epstein, *Price Transparency and Incomplete Contracts in Health Care*, 67 EMORY L.J. 1 (2017), which provides a robust assessment of the contract law implications of—and solutions to—the dearth of price transparency in many health care transactions, and Daryl M. Berke, Note, *Drive-by-Doctoring: Contractual Issues and Regulatory Solutions to Increase Patient Protection from Surprise Medical Bills*, 42 AM. J.L. & MED. 170 (2016), which addresses the problem of physicians billing patients for care beyond what was contracted for.

8. See RESTATEMENT (SECOND) OF TORTS § 323 (AM. LAW INST. 1965).

of the economic burden of their health-care decisions . . . in hopes that [this] will prompt patients to act more like traditional consumers.”⁹

Because of the emergency patient’s physical inability to engage in a bargain regarding her care, traditional contract principles are generally inapplicable in this context.¹⁰ These instances instead fall under the common-law doctrine of restitution,¹¹ which, although often given the appellation “quasi-contract,”¹² is a body of law entirely distinct from contract law.¹³ The law of restitution is known for its opacity,¹⁴ which, in addition to the rarity of true cases of nonbargained emergency care,¹⁵ may contribute to its being overlooked as a factor in health care billing. To help cut through the confusion, a convenient place to begin an explanation of restitution is by delineating what it is not.

Though also frequently described as “quasi-contract” or “unjust enrichment,”¹⁶ these terms can be misleading because restitutionary liability requires neither a prior agreement nor fault on the part of the liable party.¹⁷

9. Epstein, *supra* note 7, at 3-4.

10. *Id.* at 52.

11. Hall, *supra* note 5.

12. See Epstein, *supra* note 7, at 52.

13. RESTATEMENT (THIRD) OF RESTITUTION AND UNJUST ENRICHMENT § 1 cmt. d (AM. LAW INST. 2011).

14. For example, a federal court recently found the doctrine so opaque as to render it “understandable” that a “[p]laintiff . . . conflate[d] several equitable doctrines,” none of which amounted to the plaintiff’s intended restitution claim. Judge Rotenberg Educ. Ctr., Inc. v. Blass, 882 F. Supp. 2d 371, 377 (E.D.N.Y. 2012). See also Andrew Kull, *Rationalizing Restitution*, 83 CALIF. L. REV. 1191, 1195 n.15 (citing *United States v. Consol. Edison Co.*, 580 F.2d 1122 (2d Cir. 1978), as an example of a case where a “distinguished panel” of circuit judges misapplied principles of restitution, displaying insufficient “comfort[] with the basic propositions of the Restatement of Restitution”).

15. See NAT’L CTR. FOR HEALTH STAT., CTRS. FOR DISEASE CONTROL & PREVENTION, NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY: 2015 EMERGENCY DEPARTMENT SUMMARY TABLES TABLE 5, https://www.cdc.gov/nchs/data/nhamcs/web_tables/2015_ed_web_tables.pdf [<https://perma.cc/9AG7-X3VB>] (reporting that only eight percent of patients are categorized in either of the two most severe triage categories at time of arrival to emergency department).

16. See RESTATEMENT (THIRD) OF RESTITUTION AND UNJUST ENRICHMENT § 1 cmt. c (AM. LAW INST. 2011) (“[M]ost of the law of restitution might more helpfully be called the law of unjust or unjustified enrichment . . . while the name ‘restitution’ invites misunderstanding, it remains the word most commonly employed[.]”); Chaim Saiman, *Restating Restitution: A Case of Contemporary Common Law Conceptualism*, 52 VILL. L. REV. 487, 507 (2007) (identifying at least six names for the doctrine).

17. RESTATEMENT (THIRD) OF RESTITUTION AND UNJUST ENRICHMENT § 1 cmt. d (AM. LAW INST. 2011) (“Restitution is the law of nonconsensual and nonbargained benefits in the same way that torts is the law of nonconsensual and nonlicensed harms. Both subjects deal with the consequences of transactions in which the parties have not specified for themselves what the consequences of their interaction should be.”).

Rather, restitution exists alongside—and separate from—tort and contract as an “independent basis of liability.”¹⁸ In particular, it is the basis upon which “a person who is unjustly enriched at the expense of another is subject to liability.”¹⁹ The gist of restitution’s function also can be clarified by contrast with the other common-law bases of liability: contract law creates individualized duties to perform or forbear as agreed; tort law creates common duties to forbear from certain injurious acts; restitution law creates common duties to perform certain compensatory acts.²⁰

Recognized as its own legal discipline in the United States in the late nineteenth century,²¹ restitution’s legal history stretches to seventeenth-century England,²² and its philosophical history to Ancient Rome.²³ A robust historical record provides insights into the underpinnings of this body of law,²⁴ which has been bolstered by recent efforts to reinvigorate the scholarship in this field.²⁵

Perhaps the most recognizable pillar on which restitution is based is a sense of moral justice: Restitution serves to vindicate the common perception that “‘natural justice’ dictate[s]” that one should “repay what [one] did not deserve to receive.”²⁶ Despite this origin, the field has consciously moved towards more determinate rules rather than those based on abstract philosophical maxims.²⁷ The doctrine’s applicability is generally

18. *Id.* § 1 cmt. a; *see also* Richard A. Epstein, *The Ubiquity of the Benefit Principle*, 67 S. CAL. L. REV. 1369, 1371 (1994).

19. RESTATEMENT (THIRD) OF RESTITUTION AND UNJUST ENRICHMENT § 1 (AM. LAW INST. 2011).

20. *See* Saul Levmore, *Explaining Restitution*, 71 VA. L. REV. 65, 67 (1985).

21. Louis E. Wolcher, *Intent to Charge for Unsolicited Benefits Conferred in an Emergency: A Case Study in the Meaning of “Unjust” in the Restatement (Third) of Restitution & Unjust Enrichment*, 68 WASH. & LEE L. REV. 911, 914 (2011) (identifying the critical point as the publication of WILLIAM A. KEENER, TREATISE ON THE LAW OF QUASI-CONTRACTS (1893)).

22. Daniel Friedmann, *Restitution for Wrongs: The Measure of Recovery*, 79 TEX. L. REV. 1879, 1879 & nn.2-3 (2001).

23. Christopher T. Wonnell, *Replacing the Unitary Principle of Unjust Enrichment*, 45 EMORY L.J. 153, 156 (1996).

24. *See generally* Andrew Kull, *James Barr Ames and the Early Modern History of Unjust Enrichment*, 25 OXFORD J. LEGAL STUD. 297 (2005).

25. *See* Saiman, *supra* note 16, at 494 (describing the RESTATEMENT (THIRD) OF RESTITUTION AND UNJUST ENRICHMENT as “operat[ing] . . . against . . . the assumption that restitution is little more than accumulated bits of discretion garbed as doctrine”).

26. *Federal Deposit Ins. Corp. v. Bank One, Waukesha*, 881 F.2d 390, 392 (7th Cir. 1989) (citing *Moses v. Macferlan* (1760) 97 Eng. Rep. 676, 2 Burr. 1005 (Lord Mansfield, C.J.)).

27. *See* RESTATEMENT (THIRD) OF RESTITUTION AND UNJUST ENRICHMENT § 1 cmt. b (AM. LAW INST. 2011) (asserting that the rules it lays out are “both predictable and objectively determined, because

limited to redressing the wrongful accrual of “benefits that yield a measurable increase in the recipient’s wealth,”²⁸ meaning that courts ought not impose restitutionary liability that would “leave the recipient worse off (apart from the costs of litigation) than if the transaction giving rise to the liability had not occurred.”²⁹

2. *Recent Contributions of Law and Economics*

Though not as canonical as the fairness rationale, recent decades have also seen the development of another pillar for the general principles of restitution—the field of law and economics. An influential article by Professor Saul Levmore describes restitution as the vehicle by which courts address “the question of whether to create bargains where the parties have not done so,”³⁰ aiming to strike a balance between society’s baseline preference for private bargains and the recognition that these are at times impracticable.³¹ Levmore asserts that “the bulk of everyday nonbargained benefit [i.e., restitution] cases . . . are neatly explained” by two theories: wealth dependency and market encouragement.³²

The wealth-dependency theory begins by distinguishing between two types of transactions: those relating to personal consumption, where individuals’ choices differ depending on their wealth and tastes;³³ and business transactions, where actors evidence a universal desire for anything that “can be turned into money.”³⁴ Levmore argues that restitution is appropriate only in the latter case (e.g., a mistaken bank transfer), because courts can easily assess the value to both parties. Conversely, when a benefit’s value is taste-based, as in the case of mistaken home improvements, restitution is not appropriate even if a market value can be ascertained, because the market value does not account for the recipient’s desire—or lack thereof—for the nonbargained benefit.³⁵

Complementing the wealth-dependency theory, the market-

the justification in question is not moral but legal”).

28. *Id.* § 1 cmt. d.

29. *Id.* § 50(3).

30. Levmore, *supra* note 20, at 67.

31. *Id.* at 69.

32. *Id.* at 123.

33. *Id.* at 75.

34. *Id.* at 76.

35. *Id.* at 76-78.

encouragement theory posits that restitution operates to support competition by preventing intermeddlers from interfering with established contracts.³⁶ This desire to ward off anticompetitive attempts to foist a bargain on one who does not desire it explains why restitution is often denied even in financial contexts where the wealth-dependency theory would predict the opposite outcome.³⁷

B. The Emergency Exception

Notably, despite the broad coherence of restitution as a body of law,³⁸ it is only because of an exception to restitution's general principles that liability exists against recipients of nonbargained emergency medical care.³⁹ Restitution's broad principles are laid out in Section 2 of the *Restatement (Third) of Restitution and Unjust Enrichment*, which declares that "liability in restitution may not subject an innocent recipient to a forced exchange."⁴⁰ Conversely, Section 20 states that any provider of "services required for the protection of another's life or health is entitled to restitution from the other as necessary to prevent unjust enrichment, if the circumstances justify the decision to intervene without request."⁴¹ This exception, which is universally adopted,⁴² is all the more remarkable because it only exists if the

36. *Id.* at 79-81.

37. *Id.* at 81. Though newer and more in keeping with the Restatement's shift toward clear rules, Levmore's theories are sometimes critiqued as incomplete. For example, Bailey Kulin, *The Morality of Evolutionarily Self-Interested Rescues*, 40 ARIZ. ST. L.J. 453, 456-57 (2006), posits that the evolutionary psychology of altruism can contribute to a comprehensive explanation as to why some voluntarily conferred benefits do not require compensation under restitution doctrine.

38. See Michael Traynor, *The Restatement (Third) of Restitution and Unjust Enrichment: Some Introductory Suggestions*, 68 WASH. & LEE L. REV. 899, 899 (2011) (describing the RESTATEMENT (THIRD) OF RESTITUTION AND UNJUST ENRICHMENT as having "brought order to the law of restitution and unjust enrichment").

39. Wolcher, *supra* note 21, at 926 ("Courts granting restitution in such [emergency] cases do so as an exception to the usual rule.").

40. RESTATEMENT (THIRD) OF RESTITUTION AND UNJUST ENRICHMENT § 2(4) (AM. LAW INST. 2011). This section also notes that "liability in restitution for an unrequested benefit voluntarily conferred" is possible in circumstances where the "intervention in the absence of contract" was "justif[ied]." *Id.* § 2(3). Health care is notable as one of very few situations in which justification is presumed. *Id.*; see also *id.* §§ 20, 30. Aside from this handful of situations, a finding of justification is usually confined to cases where a certain *benefit* was unrequested but accompanied an intentional *transaction*. See *Knope v. Green Tree Servicing, LLC*, 161 A.3d 696, 701 n.3 (Me. 2017); *Swanberg v. Swanberg*, 2016 WL 2908333 (Mich. Ct. App. 2016).

41. *Id.* § 20(1).

42. Albert, *supra* note 5, at 98-99.

intervenor expects to be remunerated for her efforts, as in the case of professional health care providers.⁴³

Though not always referred to in its modern terminology, doctrines resembling the emergency exception have long been applied by courts ordering recovery for professional emergency medical care. A well-known early example of this phenomenon is *Cotnam v. Wisdom*,⁴⁴ an action brought by a physician who had rendered care to the unconscious victim of a streetcar accident.⁴⁵ This decision, handed down by the Supreme Court of Arkansas in 1907, found decisively for the physician against the injured man's estate, holding that a "person utterly bereft of all sense and reason by the sudden stroke of an accident or disease, may be held liable, in assumpsit, for necessities furnished to him in good faith while in that unfortunate and helpless condition."⁴⁶ The court accepted the defendant's contention that no contract was created but rejected his contention that the law could not create an obligation to pay in the absence of a prearranged contract, maintaining that, although it was "somewhat awkward," this obligation in fact existed "in the region between contracts on the one hand, and torts on the other"⁴⁷ In support of the existence of such an obligation, the court analogized to the more well-established obligation of guardians to reimburse those who provide care to their children.⁴⁸

The court further held that liability could not be reduced by virtue of the treatment having been unsuccessful, because success "lies with the forces of nature . . . [and] the surgeon is not responsible therefor."⁴⁹ The court also held that any financial difficulties caused by the judgment are inadmissible as evidence because "[t]he inquiry was as to the value of the professional services" and one's wealth "could shed no legitimate light upon this issue."⁵⁰

43. *Id.* at 87, 88 n.19.

44. 104 S.W. 164, 165 (Ark. 1907) (cited in RESTATEMENT (THIRD) OF RESTITUTION AND UNJUST ENRICHMENT § 20 Reporter's Note b) (AM. LAW INST. 2011)).

45. *Id.* at 165.

46. *Id.* (quoting *Sceva v. True*, 53 N.H. 627 (1873)).

47. *Id.* at 166 (quoting *Sceva*, 53 N.H. 627 (1873)).

48. *Id.* (citing *Lewis v. Lewis*, 87 S.W. 134 (Ark. 1905)). This idea, known as the *doctrine of necessities* arose in the common law to guard against paternal "economic abandonment" at a time when families were usually wholly dependent on the father's financial support. See Karol Williams, Note, *The Doctrine of Necessaries: Contemporary Application as a Support Remedy*, 19 STETSON L. REV. 661, 661 (1990).

49. *Cotnam*, 104 S.W. at 166.

50. *Id.* (quoting *Morrissett v. Wood*, 26 So. 307 (Ala. 1899)).

While the longstanding acceptance of the rules established in *Cotnam* and propounded in Restatement § 20 means that these cases are rarely litigated today,⁵¹ one recent case cited with approval in the Restatement⁵² is the Connecticut Supreme Court's 2004 decision in *Yale Diagnostic Radiology v. Estate of Fountain*.⁵³ In *Fountain*, a physician sued the estate of a minor for an unpaid bill of \$17,694⁵⁴ for care rendered after the minor was transported to the physician's hospital for treatment of a gunshot wound to the head.⁵⁵ The physician initiated the proceeding against the minor's estate after the minor's mother, who was statutorily responsible for the minor's medical bills, obtained a bankruptcy judgment discharging her debt to the physician.⁵⁶ The court found in favor of the physician.⁵⁷

As in *Cotnam*, the court analogized to guardian liability cases.⁵⁸ After noting that restitutionary liability is distinct from contractual liability (despite the name "quasi contract"),⁵⁹ the court declared a rule that whenever a minor receives necessary medical care, a contract exists with the provider.⁶⁰ The court further explained that such a contract is implied in law based on "no other test than what, under a given set of circumstances, is just or unjust, equitable or inequitable, conscionable or unconscionable."⁶¹

Two commonalities between *Cotnam* and *Fountain* stand out and are worth briefly mentioning here. First, they both analogize to the duty of parents to pay certain debts if their children are unable to satisfy them.⁶² In

51. See David J. Marchitelli, *Propriety and Use of Balance Billing in Health Care Context*, 69 A.L.R.6th 317 (2011) (stating that balance billing, a phenomenon described *infra* Part II.A, which is responsible for much of the billing discussed here, is generally presumptively unrestricted, unless "by law [or] contract").

52. RESTATEMENT (THIRD) OF RESTITUTION AND UNJUST ENRICHMENT § 20 Reporter's Note b (AM. LAW INST. 2011).

53. 838 A.2d 179 (Conn. 2004).

54. For context, it is worth noting that this fee merely represents services performed by the plaintiff, who was but one of "a variety of medical services providers" who treated the minor. *Id.* at 181.

55. *Id.* at 180-81. The court's opinion refers to this treatment as having been "lifesaving" and does not otherwise address the circumstances of the minor's death. *Id.* at 181.

56. *Id.*

57. *Id.* at 186.

58. *Id.* at 182-83.

59. *Id.* at 183-84 (quoting *Bershtein, Bershtein & Bershtein, P.C. v. Nemeth*, 603 A.2d 389 (Conn. 1992)).

60. *Id.* at 184.

61. *Id.* (quoting *Bershtein*, 603 A.2d 389).

62. See *supra* text accompanying notes 48 and 58. This doctrine began as a requirement that husbands pay necessary expenses of their wives and children, but most states that retain it in modern

each case, no one other than the patient had such a duty to pay. The reliance on the “doctrine of necessities”—a doctrine of third-party liability for others’ contracts—is thus somewhat peculiar in this context. This is especially so because that doctrine can only be employed as a result of individuals’ intentional choices, such as the choice to engage in a familial relationship. Moreover, it is expressly limited by ability to pay. These courts therefore seem to have taken part of the rationale for the doctrine of necessities—that doctors deserve to recover money for their potentially lifesaving efforts—and transformed it into the whole rationale for restitutionary recovery for nonbargained emergency care.

Further, there is a marked tension between the judicial deference to the plaintiffs’ asserted losses in *Cotnam* and *Fountain* (neither case placed any meaningful limit on the damages requested by the emergency care providers) and the Restatement’s insistence that restitutionary awards be tied to the gain that accrues to the recipient.⁶³ Not only is this the reverse of the way restitution traditionally measures damages, but it too simplistically assumes that the value of unsuccessful lifesaving care is sufficiently unquantifiable as to necessitate looking to the plaintiff’s costs to arrive at a damages figure. Other areas of the law demonstrate that courts can take a more active role adjudicating the dollar value of esoteric goods like continued life. For example, courts commonly undertake to value the life of a victim in wrongful death actions.⁶⁴ Because only five states permit inclusion of the value of life itself in the damages calculus, these awards

times formulate it gender-neutrally and with a focus on paying for necessary goods and services rendered to a couple’s children. See Jill Elaine Hasday, *The Canon of Family Law*, 57 STAN. L. REV. 825, 846-48 (2004).

63. Compare *Cotnam v. Wisdom*, 104 S.W. 164, 166 (Ark. 1907) (basing the measure of damages entirely on the “value of the professional services,” to the exclusion of any consideration of the financial status of the recipient, or even the outcome of the services) and *Fountain*, 838 A.2d at 184-86 (affirming award of damages without explaining why the amount was reasonable) with RESTATEMENT (THIRD) OF RESTITUTION AND UNJUST ENRICHMENT § 50(2) (AM. LAW INST. 2011) (“Unjust enrichment from unrequested benefits is measured by the standard that yields the smallest liability . . . [which] is normally the lesser of market value and a price the recipient has expressed a willingness to pay.”). But see *id.* § 20 cmt. c (suggesting that “market value” can be used as a measure of damages when doing so is an easy way to solve the “classroom paradox” presented by the fact that “medical treatment . . . [is] difficult to value”). For a discussion of the market distortions that make market *price* a particularly poor indicator of the value of medical services in the United States, see *infra* Section II.A.

64. Eric A. Posner & Cass R. Sunstein, *Dollars and Death*, 72 U. CHI. L. REV. 537, 543-44 (2005). Wrongful-death statutes became popular in the mid-to-late nineteenth century; Arkansas’s predates the *Cotnam* decision by twenty-two years. James E. Goldie, Comment, *The Arkansas Wrongful Death Statute*, 35 ARK. L. REV. 294, 295 (1981) (finding that Arkansas enacted its first such statute in 1883).

vary widely based on factors that can be analyzed without the moral murkiness of valuing life per se, such as the decedent's income, family status, and pain and suffering prior to death.⁶⁵ These sorts of factors could inform a proper recipient-focused damages analysis in a restitution case if courts were inclined to use them.

II. PATIENTS' FINANCIAL LIABILITY FOR NONBARGAINED EMERGENCY MEDICAL CARE

A. Background on the U.S. Health Care System and Balance Billing

The cases described in Part I make clear that the common law leaves emergency patients vulnerable to enormous financial liability for nonbargained emergency care. While restitution nowadays generally operates in the background, the confounding behemoth of twenty-first century American health care perpetuates this liability daily. The health care system in the United States is an outlier in many ignominious respects, including being the world's most expensive per capita.⁶⁶ It is also an outlier in its lack of universal health-insurance coverage,⁶⁷ and its implementation instead of a variety of piecemeal payment modalities throughout the health care market: some privately funded, others publicly, and others a mix of the two.⁶⁸ Thus, "the American healthcare system stands out not only for its cost and inequities but also for its extraordinary complexity."⁶⁹

Medical emergencies exacerbate these inherent costs, inequities, and complexities, especially as related to the payment for such care.⁷⁰ Though emergencies account for only a small fraction of health care spending,⁷¹ they are ripe for study because they present issues that generally do not arise

65. Posner & Sunstein, *supra* note 64, at 543-44.

66. KAREN DAVIS ET AL., MIRROR MIRROR ON THE WALL: HOW THE PERFORMANCE OF THE U.S. HEALTHCARE SYSTEM COMPARES INTERNATIONALLY 7 (The Commonwealth Fund 2014).

67. *Id.* at 8.

68. Paul Starr, *Law and the Fog of Healthcare: Complexity and Uncertainty in the Struggle Over Health Policy*, 6 ST. LOUIS U. J. HEALTH L. & POL'Y 213, 214 (2013).

69. *Id.* at 213.

70. See Erin C. Fuse Brown, *Consumer Financial Protection in Health Care*, 95 WASH. U. L. REV. 127, 130-31 (2017) ("The United States is the only economically developed country where a slip and fall and a trip to the emergency room could spell financial ruin . . . insurance coverage does not ensure financial protection for patients.").

71. Epstein, *supra* note 7, at 45; see also U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, NAT'L CTR. FOR HEALTH STATISTICS, *supra* note 15.

elsewhere in the system.⁷² In addition to the important ethical questions such cases raise regarding what care should be provided (and how that decision should be made),⁷³ an emergency patient's inability to form a contract for the provided services raises difficult questions about how the system should operate in the absence of express agreements.⁷⁴ When a patient receives such nonbargained emergency medical care, the law of restitution, overlaid by a variety of statutory law, nonetheless imposes an obligation to pay in accordance with the relevant regulatory scheme.⁷⁵

In recent years, the news media have been replete with stories that highlight the unfortunate outcomes of this state of affairs: the emergency physician whose patients are furious because they would have preferred less care rather than more medical bills;⁷⁶ the forty-four-year-old triathlete and teacher who was temporarily incapacitated by a heart attack and got billed \$108,951.31 because the hospital to which he happened to be transported did not take his insurance;⁷⁷ the Texas man who received a bill for \$7,924 after he was beaten unconscious on the sidewalk, even though the ambulance had serendipitously transported him to a hospital *within* his insurance network.⁷⁸ Reporting stories about massive hospital bills for care that patients did not choose has even become a regular feature of today's health care journalism.⁷⁹ Yet, few of these cases ever see litigation because

72. Epstein, *supra* note 7, at 45.

73. See Richard S. Saver, *Critical Care Research and Informed Consent*, 75 N.C. L. REV. 205, 230-31 (1996). Cost is not considered part of the calculus relating to what care should be provided. *Id.* While this paradigm is beyond the scope of this note, serious concerns regarding financial liability, along the lines of those raised in this note, might reasonably lead ethicists to reconsider whether price is truly irrelevant in this regard. See generally Joan H. Krause, *Reconceptualizing Informed Consent in an Era of Health Care Cost Containment*, 85 IOWA L. REV. 261 (1999).

74. Epstein, *supra* note 7, at 10 n.43.

75. George A. Nation, *Taking Advantage of Patients in an Emergency: Addressing Exorbitant and Unexpected Ambulance Bills*, 62 VILL. L. REV. 747, 759 (2017).

76. Farzon A. Nahvi, Opinion, *Don't Leave Healthcare to a Free Market*, N.Y. TIMES (July 10, 2017), <https://www.nytimes.com/2017/07/10/opinion/health-insurance-free-market.html> [https://perma.cc/2P3G-L4YF].

77. Chad Terhune, *A Jolt to the Jugular! You're Insured but Still Owe \$109k for your Heart Attack*, KAISER HEALTH NEWS (Aug. 27, 2018), <https://khn.org/news/a-jolt-to-the-jugular-youre-insured-but-still-owe-109k-for-your-heart-attack/> [https://perma.cc/G7AP-K6GU].

78. Sarah Kliff, *He Went to an In-Network Emergency Room. He Still Ended up with a \$7,924 bill*, VOX (May 23, 2018, 6:00 AM), <https://www.vox.com/2018/5/23/17353284/emergency-room-doctor-out-of-network> [https://perma.cc/R9R6-RJ7A].

79. Nisarg A. Patel, *Journalism Shouldn't Be a Safeguard Against Unreasonably High Health Care Bills*, SLATE (Oct. 18, 2018, 9:00 AM), <https://slate.com/technology/2018/10/surprise-billing-health-care-journalism.html> [https://perma.cc/6HF5-HCGK] (identifying at least three national news

the validity of the underlying liability is so well established under restitution doctrine.⁸⁰

Statistics bear out the prevalence of stories like those above. Roughly half of all debt sent to collections arises from medical care,⁸¹ impacting one in every five U.S. credit reports.⁸² While it is intuitive that individuals without medical insurance are most susceptible, the problem does not stop there.⁸³ Private insurance pays less than half of the average emergency department bill.⁸⁴ And, despite the relative paucity of it in the overall health care market, emergency care leads to more than half of patient-reported inability to pay.⁸⁵ Often, hospitals hold the patients liable for the remaining balance after their insurance pays whatever it is willing to, a practice known as *balance billing*, which can have ruinous financial consequences for patients.⁸⁶

Two burgeoning developments exacerbate the balance-billing problem. The first is a recent reversal of the trend toward decreasing numbers of uninsured Americans—after the uninsured rate dropped nearly by half from 2014 to 2016, much of that improvement was wiped out between 2016 and 2018.⁸⁷ At the end of 2018, 13.7% of Americans lacked any health insurance.⁸⁸ Secondly, emergency physicians (who often bill separately from the hospitals in which they practice) increasingly refrain from joining any insurance networks at all,⁸⁹ perhaps because emergency physicians need not build practices on the basis of repeat patients, and thus have less

organizations that regularly perform such reporting and opining that journalism “has turned into America’s best defense against surprise health care costs”).

80. See Marchitelli, *supra* note 51.

81. CONSUMER FIN. PROT. BUREAU, CONSUMER CREDIT REPORTS: A STUDY OF MEDICAL AND NON-MEDICAL COLLECTIONS 4 (2014).

82. *Id.* at 5.

83. HAMEL ET AL., *supra* note 3, at 1.

84. Jonathan Yun et al., *Per Visit Emergency Department Expenditures by Insurance Type, 1996-2015*, 37 HEALTH AFFAIRS 1109, 1111 (2018).

85. HAMEL ET AL., *supra* note 3, at 4.

86. Zack Cooper & Fiona Scott Morton, *Out-of-Network Emergency Physician Bills—An Unwelcome Surprise*, 375 NEW ENG. J. MED. 1915, 1917 (2016).

87. Dan Witters, *U.S. Uninsured Rate Rises to Four-Year High*, GALLUP (Jan. 23, 2019), https://news.gallup.com/poll/246134/uninsured-rate-rises-four-year-high.aspx?utm_source=alert&utm_medium=email&utm_content=morelink&utm_campaign=syndication [https://perma.cc/B548-V79V].

88. *Id.*

89. Cooper & Scott Morton, *supra* note 86, at 1916.

incentive than other physicians to keep their charges at reasonable levels.⁹⁰ A report from the New York State Department of Financial Services describes this bluntly, finding that “a relatively small but significant number” of physicians “take advantage” of patients’ inability to comparison shop or choose in-network care in an emergency.⁹¹

All told, medical bills are the leading cause of bankruptcy in the United States, including among individuals who would be considered “middle class” or even well-off by many standards.⁹² Nearly one out of every seven households with an annual income above \$100,000 faces problems satisfying its medical debts.⁹³ Hospitals face a converse problem: of every dollar they bill directly to patients, they collect only thirty-three cents.⁹⁴ Viewing this phenomenon from another lens, an economic study recently found that individuals with low incomes only value their government insurance at twenty to forty percent of its cost to the government.⁹⁵ In short, a variety of metrics indicate that there is a large gulf between what hospitals like to say their care is worth and what people are actually able and willing to pay for it.

In addition to its well documented costliness, emergency care is notable for the way in which small variations can have outsized effects on clinical outcomes and financial costs. In an emergency, the presence or absence of a simple intervention such as the application of a tourniquet to an injured limb before arrival at the hospital can dramatically alter the likelihood of complications of stunning financial (not to mention physical) cost, such as amputation.⁹⁶ Simple interventions such as providing appropriate education to patients at risk for future incidence of heart failure can often cost far less

90. Zack Cooper et al., *Surprise! Out-of-Network Billing for Emergency Care in the United States* 3 (Nat’l Bureau of Econ. Research, Working Paper No. 23623, 2018), <https://www.nber.org/papers/w23623.pdf> [<https://perma.cc/6TGP-HP27>].

91. BENJAMIN LAWSKY, AN UNWELCOME SURPRISE: HOW NEW YORKERS ARE GETTING STUCK WITH UNEXPECTED MEDICAL BILLS FROM OUT-OF-NETWORK PROVIDERS 3 (N.Y. State Dept. of Financial Services, 2012), http://www.statecoverage.org/files/NY-Unexpected_Medical_Bills-march_7_2012.pdf [<https://perma.cc/DB4A-XNLV>].

92. Epstein, *supra* note 7, at 36.

93. HAMEL ET AL., *supra* note 3, at 2.

94. Epstein, *supra* note 7, at 37.

95. Amy Finkelstein et al., *The Value of Medicaid: Interpreting Results from the Oregon Health Insurance Experiment* 33 (Nat’l Bureau of Econ. Research, Working Paper No. 21308, 2015).

96. Alison A. Smith et al., *Prehospital Tourniquet Use in Penetrating Extremity Trauma: Decreased Blood Transfusions and Limb Complications*, 86 J. TRAUMA & ACUTE CARE SURGERY 43, 46–47 (2018).

than the future emergency care that such clinical forethought can help prevent.⁹⁷

B. Relevant Federal-Law Framework

Many of the problems related to the present system of patient liability for emergency care arise alongside a thicket of federal legislation. The Emergency Medical Treatment and Active Labor Act⁹⁸ (EMTALA) mandates that any hospital emergency department that participates in Medicare must provide assessment and stabilization for any patient who presents to its emergency department.⁹⁹ Hospitals are subject to a \$50,000 penalty for each violation,¹⁰⁰ in addition to being liable to any patients harmed by a hospital's failure to treat in compliance with EMTALA.¹⁰¹ This statute aimed to remedy what Congress viewed as a shortcoming in state tort law, whereby no liability existed for failing to provide emergency care.¹⁰² Congress intended to ensure that "each patient, regardless of perceived ability or inability to pay, is treated in a uniform manner in accordance with the existing procedures."¹⁰³ Yet, despite this intent to cabin a hospital's use of pre-treatment knowledge of a patient's financial status, EMTALA establishes no independent duty to avoid making such inquiries.¹⁰⁴

An early 2000s Pennsylvania case, *Temple University Hospital v. Healthcare Management Alternatives, Inc.*,¹⁰⁵ sits at the intersection of EMTALA, insurance, and emergency care. The suit arose after Temple declined to extend a contract with HMA whereby Temple provided care to enrollees of HMA's managed-care program; when HMA patients continued to seek emergency care at Temple following the contract's expiration, Temple remained legally bound to treat them in accordance with EMTALA.

97. Vishwaratn Asthana et al., *Heart Failure Education in the Emergency Department Markedly Reduces Readmissions in Un- and Under-Insured Patients*, 36 AM. J. EMERGENCY MED. 2166, 2169-70 (2018).

98. 42 U.S.C. § 1395dd (2018).

99. *Id.* §§ (a)-(b).

100. *Id.* § (d)(1).

101. *Id.* § (d)(2).

102. *Williams v. United States*, 242 F.3d 169, 177 (4th Cir. 2001).

103. *Phillips v. Hillcrest Med. Ctr.*, 244 F.3d 790, 797 (10th Cir. 2001).

104. *Amato v. UPMC*, 371 F. Supp. 2d. 752, 758 (E.D. Pa. 2005) (holding that such inquiries are only prohibited if they would also run afoul of EMTALA's prohibition on delaying care).

105. 832 A.2d 501 (Pa. Super. Ct. 2003), *appeal denied*, 847 A.2d 1288 (Pa. 2004).

Temple then sought payment from HMA at the previously contracted rates.¹⁰⁶ HMA paid only a portion of these bills,¹⁰⁷ alleging that the full charges were “commercially unreasonable.”¹⁰⁸

The court recognized the lack of choice that is inherent when patients seek emergency care.¹⁰⁹ The court quickly dispensed of HMA’s claim that no unjust enrichment occurred at all, and moved onto the thornier question of whether the trial court correctly measured HMA’s liability.¹¹⁰ It held that the trial court had fixed liability too high by basing it solely on Temple’s published price list, which the trial court deemed “unreasonable” but not unconscionable.¹¹¹ The court held that this approach “ignore[d] the equities in this case, as well as the realities of the current state of the health care industry,” and therefore fixed liability lower than Temple’s published price list would have indicated.¹¹²

The *Temple* case is fairly typical of courts’ comfort with hospitals’ requests to hold defendants liable for emergency care. It indicates that this is true even where everyone agrees that no contract existed, and even where courts are not entirely comfortable with health care providers’ desired reimbursement rates. Yet, this picture would be quite different if the insurer were the federal government itself. Federal law provides strong balance-billing protections for enrollees of both Medicare¹¹³ and Medicaid.¹¹⁴ In addition to indicating the desirability of such a setup (given that the federal government uniquely acts as both insurer and insurance rule-maker), these

106. *Id.* at 505. On a prior appeal in the same case, the court had determined that no implied contract existed between the parties after the expiration of the contract they had explicitly negotiated. *Id.*

107. *Id.*

108. *Id.* at 506.

109. *Id.* at 507.

110. *Id.* at 507-08.

111. *Id.* at 508.

112. *Id.* Of course, this sort of pro-debtor ruling that liability is less than the care-provider asserts will be of little comfort to those who lack the resources necessary to pursue litigation in the first place—a category that likely includes most American households facing crushing medical debt.

113. 42 U.S.C.A. § 1395w-4(g)(1)(A) (2018). Because this provision was amended as part of the Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), it may be affected by ongoing litigation that seeks to hold the entire ACA unconstitutional. *See Texas v. United States*, 352 F. Supp. 3d 665 (N.D. Tex. 2018) (holding entire ACA unconstitutional), *aff’d in part and vacated in part*, 945 F.3d 355 (5th Cir. 2019), *cert. granted sub nom. California v. Texas*, 140 S. Ct. 1262 (Mar. 2, 2020) (Nos. 19-840, 19-1019). The case was argued at the Supreme Court in November 2020. *Session Beginning November 2, 2020*, SUP. CT. U.S. (Aug. 19, 2020), https://www.supremecourt.gov/oral_arguments/calendars/MonthlyArgumentCalNovember2020.html [<https://perma.cc/73RW-72AV>].

114. 42 C.F.R. § 447.15.

provisions exemplify a straightforward form of liability minimization quite unlike the convoluted protections for private-insurance customers described in the following section. For example, in contrast to those more complex schemes, the Medicaid balance billing prohibition provides simply that physicians who accept Medicaid must accept it as “payment in full,” subject only to the patient’s prior commitment with the Medicaid program for payment of a deductible or copay.

A further complexity is introduced at the federal level by the Employee Retirement Income Security Act of 1974, better known as ERISA.¹¹⁵ Under ERISA, states are expressly preempted from directly regulating “employee benefit plans.”¹¹⁶ Moreover, the preemptive effect of this provision is interpreted broadly to preempt even state legislation whose effect on such plans would be rather attenuated.¹¹⁷ This requires states to be careful about how their legislation is framed in this arena.¹¹⁸

C. Attempted Legislative Solutions

The problems posed by costs of emergency care have recently garnered political attention.¹¹⁹ Economic analysis makes a strong case for the need for legislative intervention by showing that, in the current environment, emergency physicians “need not set their prices in response to market forces . . . [which] exposes patients to significant financial risk, and reduces social welfare.”¹²⁰

Several states have passed legislation protecting patients from at least some subset of balance billing. Nevertheless, these laws frequently fail to sufficiently ameliorate exposure to financial risk.¹²¹ A common approach is typified by Louisiana, where health care providers are prohibited from balance billing enrollees of an insurance plan with which the provider has an agreement, except to the extent of the patient’s prearranged copayment

115. See Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. § 1001).

116. 29 § U.S.C. 1144(a) (2018).

117. Fuse Brown, *supra* note 70, at 184.

118. *Id.* at 184-85.

119. *Id.* at 147-49.

120. Cooper et al., *supra* note 90, at 2.

121. Fuse Brown, *supra* note 70, at 147-48. For a comprehensive review of legislative proposals to curtail balance billing both within and beyond the emergency context, see Merlow M. Dunham, Comment, *Avoiding Sticker Shock: Legislative Approaches to Protect Consumers from Surprise Medical Bills*, 11 ST. LOUIS U. J. HEALTH L. & POL’Y 179 (2017).

or deductible.¹²² An analogous provision of the federal Affordable Care Act prohibits insurers from leaving their enrollees liable for out-of-network emergency care costs except to the extent they would be liable for the same care in-network.¹²³ By their terms, such protections are only availing to patients who both have insurance and are lucky enough to seek care from a provider who contracts with their insurance plan (also known as being “in network”). Moreover, even in situations where they are applicable, these protections are often countermanded by high deductibles and other market complexities that undermine the goal of this legislation.¹²⁴

Recently, some states have begun to go further towards liability protection for recipients of nonbargained emergency care. In Massachusetts, an insurer whose enrollee receives emergency care at an out-of-network hospital is responsible for paying “at the same level and in the same manner” as if the patient had received the care in-network.¹²⁵ Since enacting its new law on the subject¹²⁶ in 2015, New York’s approach has been described as providing the most robust financial protections for recipients of such emergency care.¹²⁷ Many of its provisions, such as price-disclosure requirements,¹²⁸ do not have particular salience in the emergency context. New York’s signature provision for recipients of emergency care is similar to that found in Massachusetts, in that it protects insured patients from paying bills greater than their in-network “copay, coinsurance, or deductible” regardless of whether the emergency providers were in network.¹²⁹

New York goes beyond the Massachusetts legislation through increased regulation of the insurer-provider dynamic related to settlement of out-of-network emergency bills. Rather than mandating a specific level of payment, as Massachusetts does, New York allows an insurer to pay “an amount it deems reasonable for the emergency services rendered by the non-participating physician,” and creates a framework for physician-insurer

122. LA. STAT. ANN. § 22:1874(A) (Westlaw, through 2018 Third Extraordinary Session).

123. 42 U.S.C.A. § 300gg-19a(b) (2018). Like the provisions discussed above, this provision is in limbo as a result of the ongoing *Texas* litigation.

124. See Fuse Brown, *supra* note 70, at 141-42.

125. MASS. GEN. LAWS ANN. ch. 176I, § 3(b) (West, Westlaw through ch. 276 of 2018 2d annual sess.).

126. N.Y. COMP. CODES R. & REGS. tit. 23, § 400.5 (2018).

127. Dunham, *supra* note 121, at 197.

128. N.Y. COMP. CODES R. & REGS. tit. 23, § 400.5(f) (2018).

129. *Id.* § 400.5(a)(1).

negotiations on this front along prescribed timelines.¹³⁰ A state-run arbitration process exists to resolve such negotiations if the parties are unable to do so on their own.¹³¹

A variety of federal proposals have arisen recently as well. In October 2018, Senators Maggie Hassan and Jeanne Shaheen introduced the No More Surprise Medical Bills Act of 2018.¹³² Like the state enactments discussed above, this bill would prohibit providers from charging out-of-network emergency patients more than those patients would have paid for the same services in-network.¹³³ It would additionally set up a binding dispute resolution mechanism akin to the one that exists in New York.¹³⁴ No action was taken on the bill prior to the end of the legislative session.¹³⁵

Lastly, nongovernmental organizations have proposed other legislative solutions as well. In 2015, the National Association of Insurance Commissioners proposed the Health Benefit Plan Network Access and Adequacy Model Act. While many of its provisions mirror those that exist in the New York and Massachusetts laws, it is notable for also proposing an affirmative duty for hospitals to notify patients that they may not be liable for the full extent of a balance bill.¹³⁶

III. ANALYSIS AND RECOMMENDATIONS

While it may seem surprising to combine Part I's analysis of old-fashioned common law with Part II's discussion of modern regulatory and insurance frameworks, this approach helps to elucidate the full picture of the modern emergency billing crisis, beginning with its root causes. One upshot of this discussion is that, at least in the context of nonbargained emergency care, many critiques of health care billing often in some measure miss the forest for the trees. Certainly, the complex frameworks under which hospital rates are established and billed contribute to the scourge of

130. *Id.*

131. *Id.* § 400.5(a)(2).

132. S. 3592, 115th Cong. (2d Sess., Oct. 11, 2018).

133. *Id.* § (2)(c)(2).

134. *Id.* § (4).

135. S. 3592—*No More Surprise Medical Bills Act of 2018*, U.S. CONGRESS, <https://www.congress.gov/bill/115th-congress/senate-bill/3592> [<https://perma.cc/NK6B-AJQ7>].

136. HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY MODEL ACT § 7(D) (Nat'l Ass'n Ins. Comm'rs 2015), <https://www.naic.org/store/free/MDL-74.pdf> [<https://perma.cc/9D4X-H9M3>].

emergency balance billing.¹³⁷ Yet, tinkering with these will often amount to little more than moderate changes at the margins, when what is really needed is the sort of fundamental rethinking that entails a reevaluation of the underlying, deceptively impactful, common-law rules.

The success with which hospitals bill emergency patients for exorbitant sums largely arises from health care providers running roughshod over courts' belief that restitution doctrine leaves them little room to question the bills that such providers issue to emergency patients.¹³⁸ Before I discuss practical legislative solutions to this conundrum, it is worth noting that courts may actually be mistaken in this belief. The emergency exception is generally justified on a public-interest theory wherein society benefits from the provision of emergency health services in a way that is categorially different from other sorts of nonbargained benefits.¹³⁹ Like many common-law rules, this undoubtedly made sense in a time long before the modern welfare state and health care regulation more broadly. Now, however, EMTALA prescribes hefty penalties for hospitals who refuse unpaying patients; probably due to some combination of this law and evolving public perceptions of health care as a public service rather than purely for-profit enterprise, hospitals like Temple comply despite substantial uncertainty that they will actually be paid for emergency services rendered.¹⁴⁰

Moreover, this judicial approach relies on assumptions that are questionable at best. These include that the services are easy enough to value or represent significant opportunity costs for the physicians providing them, thereby justifying the imposition of liability on unsuspecting patients where it would otherwise seem impractical or inequitable.¹⁴¹ By focusing on the plaintiff's costs rather than the defendant's benefits, and by failing to consider the success or failure of the medical treatment in these cases,¹⁴² restitution's response to emergencies is an outlier from the rest of the doctrine.¹⁴³

The pitfalls of this approach go all the way back to the early cases of

137. See Fuse Brown, *supra* note 70, at 130.

138. See, e.g., *Yale Diagnostic Radiology v. Estate of Fountain*, 838 A.2d 179, 184 (Conn. 2004).

139. Albert, *supra* note 5, at 100.

140. See *Temple Univ. Hosp. v. Healthcare Mgmt. Alternatives*, 832 A.2d 501 (Pa. Super. Ct. 2003).

141. Albert, *supra* note 5, at 100-01.

142. Wonnell, *supra* note 23, at 171 ("Physicians are one of the only rescue groups who are awarded recovery for their unsolicited services even when those efforts are unsuccessful.")

143. See Kull, *supra* note 14, at 1201, 1201 n.27 (1995) ("[T]he ordinary measure of recovery is . . . defendant's gain.")

restitutionary liability for emergency care like *Cotnam v. Wisdom*.¹⁴⁴ While *Cotnam* may seem far removed from modern health care billing in both time and simplicity, the legal principles it (and its sister cases in jurisdictions throughout the United States) announced should not go overlooked as essential components underlying the present morass. This is especially true with respect to the measure of liability. In 1907, it may have been a straightforward matter to take a physician's word as to the value of his services; in 2019, such a judicial approach leaves patients at the mercy of complex corporations that face a variety of inflationary incentives.¹⁴⁵

Whatever the merits of a more active judicial role in these cases, it is no doubt unlikely that such a sea change would occur anytime soon (or that patients would even bring the necessary lawsuits in the first place). The problem must therefore be addressed legislatively. In doing so, however, state legislators can learn from the pitfalls of their judicial colleagues' overreliance on old assumptions about liability in emergencies. In other words, states should go beyond the examples of New York and Massachusetts, which continue to endorse an overbroad role for insurers by tying a patient's balance billing immunity to her insurance coverage. Instead, a true solution to the emergency balance billing crisis must lie in a reexamination of the scope of the emergency exception in restitution doctrine. Given all the uncertainties of emergency health care—whether one will need it at all, whether it will be effective, whether it will be at an in-network facility, whether the treating physicians will strive for cost-effectiveness—states should simply recognize that in the small subset of cases of true nonbargained emergency care,¹⁴⁶ patient financial liability under the doctrine of restitution no longer represents the reliably beneficial societal trade-off it once did.

This solution may sound radical, but given the relatively minor share that emergencies constitute in most hospitals' revenue streams, it will have a much stronger positive impact on a few unlucky individuals than a negative impact on hospital balance sheets. Balance billing in the emergency context is therefore just the kind of problem ripe for a radical rethinking: the burden of subsidizing this significant benefit for a few can be spread widely throughout the health care system. Such an approach

144. 104 S.W. 164 (Ark. 1907).

145. See Cooper & Scott Morton, *supra* note 86.

146. See Epstein, *supra* note 7, at 45.

would have several advantages over current policy. In addition to vindicating the animating principles of restitution—including fairness, efficiency, and damages calculated based on gain rather than loss—such a solution would also ensure that the federal regulatory framework around emergency medical care functions as it is intended. In particular, while the statutory text of EMTALA does not address matters of patient liability, its purpose of equalizing treatment across the socioeconomic spectrum is plainly not accomplished in the modern reality where any medical emergency can quickly become a game of financial roulette.¹⁴⁷ This solution would also obviate the preemption problems posed by ERISA, because it operates directly on the patient-provider relationship; it would not change the functioning of insurance, only carve out a small subset of health care for which insurance would become unnecessary.

Finally, it is worth noting that though this note makes recommendations with the goal of easing the burden faced by recipients of emergency medical care, these recommendations would not be entirely adverse to providers of that care. Hospitals face significant challenges in collecting on bills they send directly to patients (as opposed to those sent to their insurers).¹⁴⁸ The increased predictability of reimbursement would likely offset some of the potential revenue loss entailed.

Even under the reasonable assumption that this proposal would result in net costs to most hospitals that operate emergency rooms, it is preferable to the current situation. Hospitals already argue that low reimbursement rates for emergency care justify price increases for non-emergency care.¹⁴⁹ By eliminating hospitals' ability to have their cake and eat it too—by issuing massive bills to emergency patients while telling non-emergency patients they need to subsidize the non-payment of these bills—states can take another step towards making the healthcare market a more transparent one. It is quite likely that hospitals would increase prices for the large majority of care that, at least nominally, does result from a bargaining process. Patients would at least be able to evaluate these prices knowing that the hospital will not later be able to bill them heavily for the very care that hospitals seek to subsidize with higher prices elsewhere.

147. See Fuse Brown, *supra* note 70, at 130-31.

148. Epstein, *supra* note 7, at 37.

149. See *id.*

CONCLUSION

The American health care system is a complex animal. Its myriad intricacies can be evaluated from a variety of viewpoints. While none is likely to lead to a complete solution to any issue, each has its own unique way of helping to chart a way forward. Going back to first principles, while certainly counterintuitive in a system so heavy with recent and voluminous legislation, can help us see that these hidden rules have in some cases come to be out of step with the goals and principles that first gave rise to them centuries ago.

While many solutions in health care will need to be novel, in the context of patient liability for emergency medical bills, the true problem is that in modern times the old rules no longer effectuate our sense of fairness as they once did. Now that we have laws like EMTALA and complex billing schemes where hospitals overcharge in one area to subsidize non-payment in another area, we no longer need to worry about the doctor who might not get paid for helping an emergency patient, but about the doctor, like Naveed Khan, who may see his savings wiped out because of a freak accident. In this narrow subset of health care—true emergencies—looking backward can help show us the way forward.