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Overcoming Out-of-Network Reimbursement Challenges: Assignment of Benefits, Improper Denials and Underpayments

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Overcoming Out-of-Network Reimbursement Challenges:

Assignment of Benefits, Improper Denials, and Underpayments

Presented by
David Greenberg & Alison Andersen
Arent Fox LLP

1/12/2022

Health Care Trends Driving Out-of-Network Reimbursement

- Provider Choice
- Narrow Networks
- Contract Terminations
- Growth of Managed Care in Federal and State Health Programs
    - (Medicare Advantage, Medicaid Managed Care, TRICARE)

Examples of Health Plans Operated, Administered, or Insured by Managed Care Industry

- Self-funded ERISA Plans
- Fully-insured ERISA Plans
- State and Local Governmental plans
- ACA Qualified Health Plans
- Insured Individual Policies (non-ACA)
- Medicare Advantage
- Medicaid Managed Care
- TRICARE
- Veterans Affairs (VA)
- FEHB Plans

Characteristics of Out-of-Network Claims

- No contract with insurer setting agreed-upon payment rates
- Claim payments are determined by health plan terms
- Payment may be percentage of the usual, customary, and reasonable rate (“UCR”) (e.g., 70% of UCR”) (Plans have varying definitions for UCR)
- Payment may be benchmarked based on the Medicare rate (e.g., 150% of Medicare)
- Claims may be governed by regulation (out-of-network claims for federal health care programs)
- Out-of-network providers usually can “balance bill” the insured for the difference between the amount charged and the amount the insurer pays

Improper Denials and Underpayments

- Determine why your claims are being denied or underpaid
- The type of payer dictates how you approach the underpayment dispute

Reasons for Denials or Underpayments

- Plan Coverage of Procedure Limitation or Exclusion
- Ambiguous Payment Methodologies (UCR reimbursement provisions)
- Limited Network Coverage
- Medical Coding
- Prior Authorization
- Application of Discount “Wrap” Network Agreements

Preparing to Challenge Payment Limitations or Denials: Proactive Steps

Obtain plan document or certificate of coverage

Review plan provider manuals and coverage guidelines

Contact the payer to determine additional information regarding bases for underpayment or denial, if unclear

Analyze and batch together claims to determine scope of issue

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Strategic and Procedural Considerations

Assignment of Benefits

Out-of-Network Claim Administrative Appeals Process

Prepare for Litigation

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Assignment of Benefits

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Assignment of Benefits

The Provider Perspective

- Obtain robust assignment for all health care benefits (regardless of plan)
- Beyond benefits, obtain rights to pursue recovery for fiduciary breach and file administrative claims and legal claims for benefits
- Rights to file litigation under federal and state law
- Designation as personal representative and/or power of attorney
- Rights to obtain medical documentation, plan documents, claims information
- Guarantee of patient to pay unpaid/underpaid claims

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Does the Provider Have Standing as an Assignee?

- "Participants" and "beneficiaries" have standing under ERISA
  - "Participant" = covered employee or former employee
  - "Beneficiary" = covered spouse or dependent
- Under ERISA, party with standing (*e.g.*, participant) can "assign" standing to third party (*e.g.*, medical provider) *if* plan allows assignments
- Other types of out-of-network payers may allow assignment of benefits and pursuit of appeals
- State common law regarding assignments, authorized representatives, and powers of attorney may apply
- Some payers insist upon use of their own specific forms

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Plan Anti-Assignment Clauses and Challenges

Assignment language in plan is key; courts pretty universally honor unambiguous anti-assignment language in plans

- *Am. Orthopedic & Sports Med. v. Indep. Blue Cross Blue Shield*, 890 F.3d 445, 453 (3d Cir. 2018) ("anti-assignment clauses in ERISA-governed health insurance plans as a general matter are enforceable")

Plan Waiver of Anti-Assignment Provision

- Very high bar for provider to establish – most waiver challenges fail
- Direct payments to provider and communications with provider *may* constitute waiver of ant-assignment provision depending on jurisdiction (e.g., *Encompass Off. Sols., Inc. v. Louisiana Health Serv. & Indem. Co.*, 919 F.3d 266, 281 (5th Cir. 2019))

Recent development: Plans including terms stating that assignment is contingent on medical provider waiving the right to appeal payment rates and/or the right to balance bill the patient

- Largely untested by courts

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Personal Representative / Power of Attorney

- Medical provider should be allowed to function as authorized personal representative of patient if patient has validly granted that authority, though case law is not clear
- Under ERISA regulations, plan claims procedures cannot preclude claimant's authorized representative from acting on behalf of claimant to pursue claims and appeals (29 C.F.R. § 2560.503-1(b)(4))
- Power-of-attorney designation may allow provider to prevail on motion to dismiss
  - *Somerset Orthopedic Assocs., P.A. v. Horizon Healthcare Servs., Inc.*, No. CV 19-8783, 2021 WL 3661326 (D.N.J. Aug. 18, 2021)

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Ignoring the Assignment – Paying the Patient

Some payers refuse to send payments for services directly to out-of-network medical providers; instead send payments to patients to then be turned over to their providers

- Often causes confusion for patients
- Often causes problems for providers who have to chase down their patients for payment
- Providers could require patients to pay more upfront; contractually obligate patients to turn over payments

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Administrative Appeals

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The Type of Payer Dictates the Administrative Appeal Process

Group and Individual Health Plans

42 C.F.R. § 147.136 / 29 C.F.R. § 2560.503-1

FEHB Plans

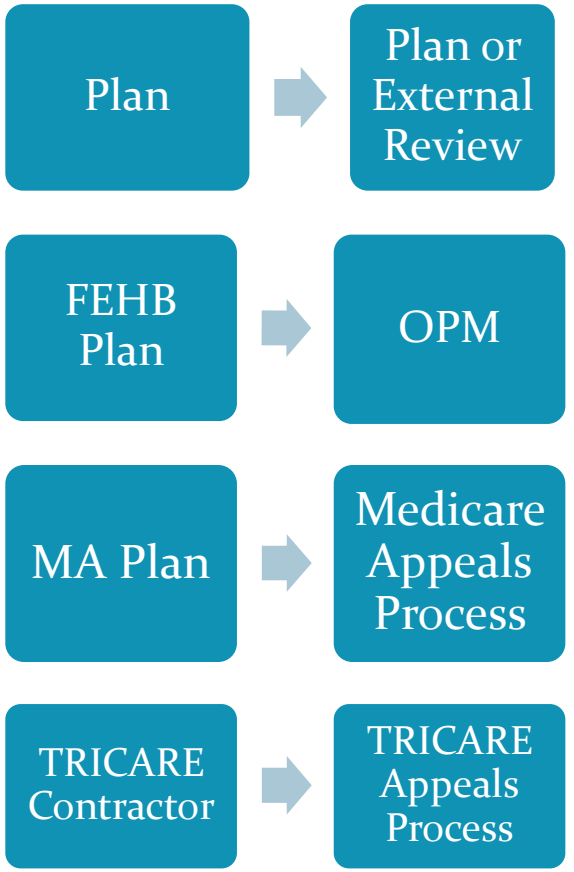
5 C.F.R. § 890.105

Medicare Advantage Out-of-Network Appeals

42 C.F.R. Part 422, Subpart M

TRICARE Managed Care Appeals

32 C.F.R. § 199.10



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Administrative Appeals – Requirements

- Timely filing of appeals – do not miss deadlines
  - Complete appeals process for all dates of service in dispute
- Create robust administrative record – parties may be stuck with it
  - Include all arguments and evidence relied upon during appeals process
- Follow applicable administrative processes – may include multiple levels of appeal
- Exhaust administrative appeals – may resolve issue and is often required prerequisite for litigation

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Administrative Appeals – Best Practices

- Include documentation of standing to appeal (assignment of benefits, authorization)
- Draft robust/accurate submissions challenging denial of coverage or payment, or underpayment, on legal grounds
- Challenge arbitrary and capricious claims payments and handling of appeals
- Gather and present data regarding UCR payment rates (if nature of dispute)
- Line up credible medical support for claims denied due to medical necessity
- Demand copies of plan documents and information
- Demand all documents (the “administrative file”) reviewed and considered as part of claim consideration and appeal process

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Litigation Perspectives

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Litigation Considerations

- Viability and strength of federal and/or state law-based claims
- Authority to bring claims on behalf of patient – proper assignment of benefits and/or authorization
- Availability of claims pursued in provider's own stead
- Amount in dispute
- Remedies available
- Strength of administrative record
- Proper defendants
- Standards of review (i.e., level of deference to decisions of fiduciaries interpreting benefit plans)
- Administrative exhaustion
- Statutes of limitation and timeframes

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Claims Providers May Pursue in Patient's Shoes

- Claims for Benefits/Amounts Due Under Plan/Policy Language
  - Consider: Do Plan terms violate any applicable laws (ACA, Medicare Secondary Payer Act, etc.)?
- Claims for Fiduciary Breach
- Claims for Equitable Relief
- Claims for Statutory Penalties
- Attorneys' Fees Under ERISA

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Claims Providers May Pursue In Own Stead

- Out-of-network providers may pursue claims against insurers/benefit plans for:
  - Breach of contract if a contract was formed between parties during communications, typically during the insurance verification process
  - Negligent misrepresentation, fraud, promissory estoppel, etc. if coverage, payment terms, etc. were misrepresented during insurance verification process
  - Federal and state laws may require minimum payment amounts, especially for emergency services (EMTALA, ACA, etc.)
- If ERISA plan is involved, parties will likely argue ERISA preemption
- If FEHB plan is involved, parties will likely argue FEHB preemption
- If underlying federal health plans, provider may not have cognizable legal claims against managed care company administrating plan

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Resolution/Settlement Considerations

- Payment terms, mechanics, and timing
- Lump sum payment versus reprocessing claims
- Mutual releases
- Precise terminology and definition of claims covered
- Potential for network or other relationship moving forward; do parties want agreement to be future-looking in any way?

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Out-of-Network Trends to Continue in 2022 and Beyond

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Surprise Billing Laws

State Law Frameworks

- Many states have had surprise bills laws in effect, some for years
- All with same goal in mind, but specifics and efficacy vary
  - Applicability: Emergency vs. non-emergency services; types of providers and patients covered
  - Applicability: Plans/payers covered (state laws typically exempt self-insured ERISA plans)
  - Requirements to provide cost estimates, consent requirements, etc.
  - Payment level expected, how described
  - Negotiation and/or IDR process

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Surprise Billing Laws

Federal No Surprises Act (effective 1/1/2022)

- Broadly applicable to emergency services and to non-emergency services at in-network hospitals and ambulatory surgical centers
- Broadly applicable to plans/policies (both group health plans and individual policies)
- Requires providers to provide good faith estimates to uninsured patients
- Expected payment level defined as “qualifying payment amount”
  - Plan’s historic median contracted rate for similar services in geographic area, adjusted by consumer price index; not to consider provider charges or Medicare/Medicaid payment rates
- Negotiation period and IDR provisions to include “baseball style” arbitration
- Uncertainty regarding interim final rules and final implementation

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COVID-19 Testing and Payment

Section 6001(a) of CARES Act, Public Law 116-136

> "(2) If the health plan or issuer does not have a negotiated rate with such provider [of the diagnostic testing], such plan or issuer shall reimburse the provider in an amount that equals the cash price for such service as listed by the provider on a public internet website, or such plan or issuer may negotiate a rate with such provider for less than such cash price."

- UHC refusing to pay for out-of-network Covid-19 laboratory tests
  - *Genesis Lab. Management, LLC v. United Health Group, Inc.,* No. 3:21-cv-12057-ZNQ-TJB (D.N.J.) (filed 6/2/21)
    - Complaint alleges violation of FFCRA and CARES Act, breach of implied contract, good faith and fair dealing, unjust enrichment, promissory estoppel, and state insurance laws
    - MTD: excessive charges for COVID testing, no private action under FFCRA and CARES Act, and ERISA preemption
    - Response: Charges consistent with Fair Health, implied right of action under FFCRA and CARES Act, claims do not relate to ERISA (rather a statutory obligation)
- Premera Blue Cross files suit against out-of-network laboratory
  - *Premera Blue Cross v. GS Labs LLC*, No. 2:21-cv-01399 (W.D. Wa.) (filed 10/14/2021)

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Behavioral Health Payment Disputes

- The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), incorporated as ERISA § 712, 29 U.S.C. § 1185a, prohibits ERISA-covered health plans from imposing treatment limitations on mental health and substance use disorder benefits ("mental health benefits") that are more restrictive than the treatment limitations they impose on medical and surgical (also called "medical/surgical") benefits.
- *Walsh v. United Behavioral Health,* No. 1:21-cv-04519 (E.D.N.Y.) (filed 8/11/2021)
  - Low payment levels for psychologists and licensed counselors vs. physicians for same mental health services, violating ERISA, plus concurrent review program to flag/halt therapy claims
  - $13 million in settlements to class, NY AG, and DOL
- Extensive class action activity representing plan participants vs. insurers

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Questions?

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