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Out-of-Network ERISA Claims: Identifying Provisions Subject to Provider Challenge

Anti-Assignment Clauses, Leveraging Ambiguities in Fee Forgiveness Provisions, Bad Faith, and Other Factors

WEDNESDAY, JANUARY 27, 2021

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OUT-OF-NETWORK ERISA CLAIMS

OUT OF NETWORK CLAIMS – A CONSULTANT'S PERSPECTIVE

- The Network Centric Market is Universal
- Historic Data Point: By 1990 only 5% of plans had no utilization review & 38% of plans were network plans.
- Different Network Models:
  - HMO
  - HMO with POS *(Point of Service)*
  - Exclusive Provider Organization "EPO", least common
  - Preferred Provider Organization "PPO" with Out of Network "OON"
  - Medicare

Common OON Plan Provisions

- Different, possibly mutual exclusive deductibles
- Different co-pays
- Different Premiums/Contributions
- Reimbursed based on:
  - percentile of “usual and prevailing”, “reasonable and customary”
  - percentile typically not disclosed
  - SPD’s seldom commit to an independent database
  - percentage of Medicare, most commonly more than Medicare
  - in network
  - percentage of in network – commonly less
  - claim negotiation “wrapped networks”
- Any approach leaves a “balance billing” situation for the participant/patient. “Surprise billing” is possible, but not limited to OON.

"Fee Forgiveness"

- Common for OON providers to waive some or all of co-pay and deductible
- Providers should disclose to payers
- Significant push back from payers
- Clear and unambiguous, Summary Plan Description, plan language is the starting point:
  - *"For charges that the covered individual is not obligated to pay or for which you are not billed or would not have been billed except that you were covered under the coinsurance plan".* ***Neither clear nor unambiguous.***
- State regulatory involvement

“Anti-assignment language” another challenge

- As always, the starting point is the Summary Plan Description, plan document:
- Does it have clear and unambiguous language?
- Complicating factors:
  1. ERISA and Department of Labor Regulations allow appointing a “representative”
  2. Distinction between assigning rights and authorizing direct payment.
  3. The system relies on providers billing electronically.

COMMON THEMES IN OON LITIGATION

- BALANCE BILLING
- ANTI-ASSIGNMENT CLAUSES
- “FEE-FORGIVING”
- ERISA PREEMPTION AND ANTI-DELEGATION LAWS
- PASS-THROUGH BILLING

BALANCE BILLING

- PATIENT RESPONSIBLE FOR AMOUNT INSURANCE DOESN'T PAY
- OFTEN OON PROVIDERS FAIL TO TELL PATIENTS THEY ARE OON AND FAIL TO PROVIDE ESTIMATE OF CHARGES
- RECENT FEDERAL LEGISLATION
- INCREASING AND VARYING STATE STATUTES

ASSIGNMENTS

- REQUIRED TO ESTABLISH DERIVATIVE STANDING UNDER ERISA
- MAY NOT BE REQUIRED FOR MANY STATE LAW CLAIMS
- MANY PLANS CONTAIN ANTI-ASSIGNMENT CLAUSES
  - CAN BE ENFORCED
  - BUT THERE ARE EXCEPTIONS
    - LACHES
    - ESTOPPEL
    - WAIVER

FEE-FORGIVING

- TAKES MANY FORMS
- HONORING “IN-NETWORK” RATES
- DISCOUNTING OR WAIVING COPAYS, COINSURANCE, OR DEDUCTIBLES
  - SOME PROVIDERS COLLECT OR SEND BILLS AS A MATTER OF PRACTICE, OR
  - TO SHOW SOME EFFORT TO COLLECT

PREEMPTION ISSUES

- ERISA PREEMPTION
  - ERISA PREEMPTS CLAIMS THAT RELATE TO ERISA PLANS
  - ERISA DOES NOT PREEMPT CLAIMS ARISING OUT OF A DUTY THAT EXISTS INDEPENDENT OF ERISA
- ANTI-DISCRETIONARY CLAUSES
  - < 20 STATES HAVE ENACTED LAWS OR REGULATIONS THAT INVALIDATE CLAUSES
  - *Hancock v. Metro. Life Ins. Co*., 590 F. 3d 1141 (10th Cir. 2009) (Utah's ban on discretionary clauses preempted).
  - *Standard Ins. Co. v. Morrison*, 584 F.3d 837 (9th Cir. 2009) (Montana's anti-discretionary clause not preempted).

RECENT CASES

RECENT CASES

- *Am. Orthopedic & Sports Med. v. Indep. Blue Cross Blue Shield*, 890 F.3d 445, 448 (3d Cir. 2018)
- *Conn. Gen. Life Ins. Co. v. Humble Surgical Hosp., L.L.C.*, 878 F.3d 478, 481 (5th Cir. 2017)
- *N. Cypress Med. Ctr. Operating Co., Ltd. v. Cigna Healthcare*, 952 F.3d 708 (5th Cir. 2020)
- *Wit v. United Behavioral Health*, Case No. 14-cv-02346 (N.D. Cal. 2020)

OON CLAIMS INFLUENCE NETWORK NEGOTIATIONS?

- CHANGES IN REIMBURSEMENT MODELS, NETWORK STRUCTURES → SOME PROVIDERS CHOOSE TO STAY OON

- ALLEGATIONS IN CASES THAT PAYORS DENY OON CLAIMS TO FORCE PROVIDERS IN NETWORK

- VARIETY CLAIMS ASSERTED BASED ON THOSE ALLEGATIONS, VARYING RESULTS

- *SEE, E.G.*, *Productive MD, LLC v. Aetna Health & Aetna Life Ins. Co.*, 969 F. Supp. 2d 901, 906 (M.D. Tenn. 2013)

OTHER TRENDS

- OON PROVIDERS FILE IN STATE COURT, ASSERTING ONLY STATE LAW CLAIMS AND DISCLAIM ANY RELIANCE ON ERISA OR OTHER FEDERAL STATUTES
  - Some courts permit such claims to go forward.
  - Many courts hold that the mere payment of claims and verification of benefits does not form a contract and is not a basis for fraud claim (in the absence of a “misrepresentation” regarding payment for services)

SURPRISE BILLING LAWS

- No Surprises Act
  - Becomes effective 2022
  - Protects consumers from surprise bills for: 1) emergency services delivered by out-of-network providers, including emergency air transport, or by out-of-network facilities; and 2) nonemergency services provided by out-of-network providers in network facilities and for which patients do not consent.
  - Consumers' costs will be limited to cost-sharing amounts that apply to in-network services
- 17 states enacted some form of surprise billing laws
- Texas – SB 1264
  - Applies to certain providers (emergency services, OON providers practicing at in-network facilities, OON diagnostic providers)
  - applies to the 16% of individuals with state-regulated health insurance (not self-funded plans, FEP, Medicare)

CURRENT ISSUES 🔥🔥🔥

- PASS-THROUGH BILLING
  - OON PROVIDERS (OFTEN LABS) SUBMITTING CLAIMS THROUGH IN-NETWORK PROVIDERS
- MENTAL HEALTH PARITY CLAIMS (WILDERNESS THERAPY)
- COVID 19
  - TREATMENTS
    - *See Columbus Specialty Hosp. v. Amerigroup Corp., et al.*, No. ESX-L-002635-20 (N.J. Sup. Ct. April 10, 2020)
  - TESTING

BRINGING OUT-OF-NETWORK CLAIMS: KEY CONSIDERATIONS FOR PLAINTIFFS

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Presented January 27, 2021

BASICS OF OUT-OF-NETWORK REIMBURSEMENT

- By definition, no contract governs reimbursement amounts for out-of-network providers.
- Claim payments largely dictated by benefit plan terms.
  - Federal laws may also impact payment rates – Affordable Care Act requires insurers to reimburse out-of-network emergency medical providers at least the greatest of (1) the negotiated in-network rate, (2) the "usual, customary, and reasonable" amount, or (3) the Medicare rate. 45 C.F.R. § 147.38(b)(3)(A)-(C); 29 C.F.R. § 2590.715-2719A(b)(3)(i)(A)-(C).
  - State laws (if not preempted) also may require certain minimum levels of payment (i.e., for out-of-network emergency services).

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STATE LAW CLAIMS PROVIDERS MAY PURSUE

- 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
  - If ERISA Plan is involved, parties will likely argue ERISA preemption

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BALANCE BILLING

- Out-of-network providers typically can "balance bill" patients
  - Most prefer to seek additional payment from insurer/benefit plan if there is a good argument that an underpayment occurred
  - Must ensure compliance with "surprise bills" laws (if not preempted by ERISA)
    - Versions of surprise bills laws exist in many states (at least NY, NJ, CA, CO, CT, FL, GA, NC, OR, TX, MD)
    - Late December 2020, Congress included federal surprise bills law in the omnibus spending bill – slated to take effect for 2022 Plan years

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REFUSAL TO PAY OUT-OF-NETWORK PROVIDERS DIRECTLY

- 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

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CLAIMS UNDER ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) – KEY QUESTIONS

502(a): Persons Empowered to Bring a Civil Action.—A civil action may be brought—

(1) by a participant or beneficiary—

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

IS THE BENEFIT PLAN GOVERNED BY ERISA?

- Claim under ERISA § 502(a)(1)(B) is the appropriate way to seek additional benefits from a Plan governed by ERISA
  - If try to pursue a state law cause of action seeking additional payment from an ERISA Plan, claim will be preempted by ERISA
- ERISA covers most health plans, but there are exemptions under ERISA § 4(b), including:
  - Governmental plan
  - Church plan
  - Plan to comply with workers' compensation laws
  - Plan maintained outside U.S. primarily for nonresident aliens
- If not dealing with an ERISA Plan, Plaintiff can pursue state law causes of action (like breach of contract)

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WHO SHOULD THE PLAINTIFF SUE?

- Old majority view: § 502(a)(1)(B) claim may be brought only against the Plan and/or the Plan fiduciary responsible for making benefit determinations (*e.g.*, Plan Administrator), and no other defendant is proper. The culpable party in a § 502(a)(1)(B) claim is the Plan (because only benefits may be awarded).
- Courts have recently been more expansive in many jurisdictions, holding that an insurer or employer is also a proper defendant if liable for payment of benefits. *See, e.g., Cyr v. Reliance Standard Life Ins. Co.*, 642 F.3d 1202 (9th Cir. 2011).

DOES THE PROVIDER HAVE STANDING AS AN ASSIGNEE?

- "Participants" and "beneficiaries" have standing under statute.
  - "Participant" = covered employee or former employee
  - "Beneficiary" = covered spouse or dependent
- Party with standing (*e.g.*, participant) can "assign" standing to third party (*e.g.*, medical provider) *if* plan allows assignments.
  - Assignment language in Plan is key; courts universally honor unambiguous anti-assignment language in Plans.
    - Recent developments: Some 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.
  - If Plan has anti-assignment language, providers can consider whether to argue waiver by Plan.

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MAY THE PROVIDER PROCEED AS AN AUTHORIZED REPRESENTATIVE OF THE PATIENT?

- Medical provider should be allowed to function as authorized personal representative of patient if patient has granted that authority.
- 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).

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WERE ADMINISTRATIVE REMEDIES EXHAUSTED?

- A Plaintiff may not sue seeking benefits without first exhausting the administrative remedies provided for in ERISA, implementing regulations, and Plan documents.
  - Key regulations: 29 C.F.R. § 2560.503-1 & 45 C.F.R. §147.136
  - If Plan Administrator fails to make decisions as required, Plaintiff can argue administrative remedies "deemed exhausted."
- "Futility" exception (failure to exhaust is excused where it would be futile to comply with the Plan's administrative procedures).
- For medical benefits, must exhaust administrative remedies for all relevant dates of service.

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WILL CLAIM HOLD UP TO DEFERENTIAL STANDARD OF REVIEW?

- If the Plan grants discretion to the Plan Administrator, any interpretation/decision by the Plan Administrator is given deference by the court; may be overturned only if "arbitrary and capricious." *Firestone v. Bruch*, 489 U.S. 101 (1989).
  - Sometimes referred to as "abuse of discretion."
- Standard for what is arbitrary and capricious varies among Circuits. Most Circuits hold decision must be "reasonable."

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WILL CLAIM HOLD UP TO DEFERENTIAL STANDARD OF REVIEW? (continued)

- A "conflict of interest" by the Plan Administrator is considered in determining whether its decision is arbitrary and capricious.
- Prior "inconsistent treatment" by Plan Administrator with respect to other claimants may be considered in determining whether decision is arbitrary and capricious.
- Courts have differed on the effect on the arbitrary and capricious standard of review if the Plan Administrator has failed to comply with ERISA's claims procedures:
  - Some courts revert to *de novo* review.
  - Some courts reduce deference.
  - Some courts ignore the failure if insignificant.

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HOW STRONG IS THE ADMINISTRATIVE RECORD?

- Court is limited to review of the "administrative record" where the standard of review is arbitrary and capricious.
- The administrative record is generally all information that was before the Plan Administrator when it made its decision(s).
  - If administrative record demonstrates that the Plan Administrator failed to comply with ERISA's claims procedures, Plaintiff can argue for less deference.

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HOW STRONG IS THE ADMINISTRATIVE RECORD? (continued)

- General Rule: Introduction of arguments and/or evidence outside the administrative record not permitted – Plaintiff can't make arguments not raised during administrative appeals; Plan can't change reasons for decision at litigation stage.
  - Extrinsic evidence may be admitted to show conflict of interest, inconsistent treatment, or other procedural irregularities.
  - Some courts have let in new arguments or evidence if injustice would otherwise result.
  - Some courts have distinguished between new evidence (not permitted) and new arguments (permitted).
  - Some courts have let in new evidence/arguments from participants and not from Plans/fiduciaries.
  - If court allows new arguments/new evidence, may require remand to Plan Administrator to consider in first instance.

HOW STRONG IS PLAN LANGUAGE RELIED UPON?

- Plaintiffs should ensure that they have all applicable Plan documents and amendments.
  - Can utilize ERISA § 104(b)(2) requests for Plan documents – must be directed to Plan Administrator, who must respond within 30 days.
- Plaintiffs must carefully consider Plan benefit limitations and exclusions.
- Consider: Are applicable Plan provisions lawful (under Affordable Care Act, Medicare Secondary Payer Act, etc.)?

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IS A UCR PROVISION AT ISSUE?

- Most Plans do not state specific amounts they will pay; include some sort of Usual, Customary, and/or Reasonable ("UCR") language.
  - Often vague; grant considerable discretion to Plan Administrator.
  - Does the UCR definition focus on "charges" or "payments"?
    - *Holland v. Trinity Health Care Corp.*, 791 N.W.2d 724 (Mich. Ct. App. 2010) – "usual and customary *charges*" refers to amounts *charged*.
    - *Corsini v. United HealthCare Servs., Inc.*, 145 F. Supp. 2d 184 (D.R.I. 2001) – term "charges" not reasonably interpreted to mean amount billed; amount charged does not reflect amount paid.
  - Some courts have held it is not appropriate to consider Medicare and Medicaid payment rates. *E.g.*, *Baker Med. Servs. v. Aetna Health Mgmt.*, 31 So. 3d 842, 845-46 (Fla. App. Dist. 2010); *Prospect Med. Grp. v. Northridge Emergency Med. Grp.*, 39 Cal. Rptr. 3d 456, 466 (Cal Ct. App. 2006), *rev'd on other grounds*, 198 P.3d 86 (Cal. 2009).

IS A UCR PROVISION AT ISSUE? (continued)

- Does the UCR definition specify how it will be applied, or what specific data will be relied upon?
- Has the Plan been transparent and provided data/ methodology used to calculate UCR in response to requests?
  - ERISA includes right to "full and fair review."
  - Plans must provide all information "considered, submitted, generated, or relied on in making benefit determinations" – this can include UCR data.
    - *Spectrum Health, Inc. v. Good Samaritan Emp'rs Ass'n, Inc. Trust Fund*, No. 1:08-CV-182, 2008 WL 5216025, at *2-4, *7-10 (W.D. Mich. Dec. 11, 2008)
    - *Bio-Medical Applications of Ky., Inc. v. Coal Exclusive Co., LLC*, 782 F. Supp. 2d 438, 442-48 (E.D. Ky. 2011)

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IS A UCR PROVISION AT ISSUE? (continued)

- Courts sometimes impose a reasonableness standard in determining appropriate UCR for out-of-network services.
  - Example: "[E]vidence of [insurer's] in-network rates, as well as evidence of industry custom, is pertinent but certainly not determinative. In assessing a reasonable reimbursement rate, the trial court may take into account all of these factors, as well as others that may be pertinent, such as whether the rate for in-network providers is appropriate for out-of-network providers, given the difference in the volume of [the insurer's] enrollees treated. Moreover, the trial court may consider factors that increase the provider's costs, such as [insurer's] repeated automatic disallowance of claims previously authorized, apparently onerous and costly appeal and approval procedures, and delays in payment." *River Park Hosp. v. BlueCross BlueShield of Tenn., Inc.*, 173 S.W.3d 43, 60 (Tenn. Ct. App. 2002).

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IS CLAIM WITHIN THE LIMITATIONS PERIOD?

- No limitations period in ERISA for § 502(a)(1)(B) actions.
- Limitations period is that for the most similar cause of action in the relevant state (usually for breach of contract).
- Plans can add enforceable contractual limitations periods (courts enforce so long as reasonable).
- When does the claim for benefits "accrue" in order to trigger the start of the limitations period?
  - Many Circuits hold that "clear repudiation" triggers accrual; some say this means a formal claim and denial.
  - In the absence of Plan language, claims may not accrue until administrative appeals process is completed.
  - Supreme Court held in *Heimeshoff v. Hartford Life & Accident Ins. Co.* (2013) that Plans can specify that claims will accrue before the administrative appeals process is completed.

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IS REMEDY SUFFICIENT?

- Remedy under § 502(a)(1)(B) is limited to benefits under the Plan, and the Plan terms control.
- No punitive damages, extra-contractual damages, etc.
- Possibility of recovering attorneys' fees and costs if prevail (under ERISA § 502(g)(1), awarded in court's discretion).

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