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NON-NETWORK EMPLOYER HEALTH PLANS – THE STRUGGLE CONTINUES

With employee health plan costs continuing to rise at an alarming rate, medium-sized employers are increasingly rejecting traditional insurance models built around a network of preferred providers and turning to a non-network model wherein the plan appoints a pricing consultant as a "Designated Decision Maker" ("DDM") with discretionary and ultimate decision-making authority for determining the extent of covered benefits under the plan and resolving any appeals related to denied benefits. In several states, we are seeing aggressive marketing for this alternative coverage by pricing consultants such as ELAP Services, Group Pension Administrators ("GPA") and Benefit Administrative Services ("BAS").

Under the non-network model, the plan document is revised to provide for payment of only "allowable claim limits" as determined exclusively by the DDM under the plan's review and audit program. The allowable claim limit for hospital services is typically based upon: (i) a percentage of the hospital's departmental cost ratio as reported to CMS on the hospital's most recent Medicare Cost Report; (ii) a percentage of the Medicare allowed amount; or (iii) a percentage of another "industry standard" resource. Because there is no contractual agreement defining the relationship between the plan and the hospital, the hospital's billed charges are irrelevant to the plan's payment for covered services (unless, of course, they are less than the DDM determined allowable claim limits).

Beneficiaries of non-network plans are carefully instructed to pay only the plan-determined out-of-pocket amounts to the hospital and to notify the DDM immediately upon receipt of a balance bill or any collection notice from a hospital. In which event, the DDM asks the beneficiary to authorize a lawyer retained by the DDM to represent his or her interests with regard to any balance billing issues related to the hospital services.

In response to the receipt of a balance bill, the DDM typically notifies the hospital that payment has been made in accordance with a determination of the plan's allowable claim limits. The hospital is instructed to pursue any appeal of this determination through the plan's review and audit procedure. However, unfortunately, by doing so, the question shifts from what the hospital charges are for covered services rendered to the beneficiary to what the plan benefits are for such services. Therefore, by accepting assignment of the beneficiary's plan benefits, the hospital is entitled to recover only that which the beneficiary is entitled to under the plan document (i.e., the DDM determined allowable claim limits).

There has been a plethora of litigation filed against non-network employee health plans and/or their pricing consultants over the years. The majority of cases filed have been resolved without a court determination. Therefore, we don't know the terms of the resolution. However, our review of available case law has culminated in the following broad observations.

First, the financial responsibility agreement signed by the patient before treatment is often the only contract governing payment for the hospital services received. Therefore, it is imperative that the terms of this agreement be clear, specific and understandable to the patient. Courts will consider whether the patient had an opportunity to request additional information, reject or negotiate the terms of the agreement before signing it. A court may be less inclined to uphold the terms of such an agreement if it was signed by an anxious patient while awaiting treatment for an acute medical episode than by a patient who pre-registered for a planned admission. Additionally, if the agreement requires the payment of "charge master," "standard" or "usual and customary" rates, additional information concerning such rates should be made available to the patient, upon request.

In the event it finds the terms of a patient financial responsibility agreement to be unenforceable, a court will likely conclude that the hospital is entitled to be paid the reasonable value of the services rendered to the patient. This will be a hotly contested issue. However, one court that addressed this issue determined that a hospital was entitled to payment for services rendered to a non-network beneficiary in the same amount that the hospital would have accepted had the same services been rendered to a self-paying patient, eligible for the hospital's prompt payment discount.

Most of these non-network plans are self-insured and/or governed by the Employee Retirement Income Act of 1974 ("ERISA"). Therefore, as discussed above, a hospital that accepts an assignment of benefits and pursues additional payment through the plan's internal appeal procedures may be limited to recovery of the plan-determined allowable amount, assuming the plan or its DDM followed the plan's

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guidelines for making such a determination. Therefore, it is not generally advisable for the hospital to pursue such an appeal.

Finally, two hospitals have recently filed complaints alleging untested theories against a plan and/or its DDM. In one of the complaints, the hospital is pursing recovery based upon the terms set forth in the patient financial responsibility form and, among other things, alleges that the DDM violated applicable state trade practices law by misrepresenting the appropriateness of the hospital's billed charges and the hospital's right to be paid such charges. The hospital filing the other referenced complaint did exhaust the plan's audit and appeal procedures, and its complaint alleges, among other things, that the plan's benefit determination exposes the patient to out-of-pocket expenses that violate limitations set forth in both the plan document and the Affordable Care Act. We will continue to monitor these cases and applicable regulations and provide additional guidance as they evolve.

PRACTICAL TAKEAWAYS

To effectively manage potential payment disputes arising from services rendered to beneficiaries of non-network plans and pricing consultants, we recommend the following.

- Train hospital registrars and other front line personnel to flag patients covered by a non-network plan;
- Verify that the terms of the patient responsibility agreement are adequate and preserve the hospital's right to balance bill a beneficiary of a non-network plan;
- Develop a strategy to clearly communicate the hospital's payment expectations to the patient before services are rendered, whenever possible;
- Clearly communicate the hospital's payment expectations directly to each non-network plan as soon as possible;
- Decline to accept assignment of the beneficiary's right to appeal a non-network plan's benefit determination;
- If the hospital decides to accept a reduced payment from a non-network plan to avoid the cost of litigation, notify the plan and the DDE (if applicable) that the hospital reserves the right to collect billed charges for other admissions and/or other plan beneficiaries; and
- If a non-network plan significantly underpays a large claim on the basis that the charges exceed the plan's allowable claim limits, consult legal counsel from a health lawyer experienced in the resolution and litigation of commercial payment disputes.

If you have any questions or would like additional information about this topic, please contact:

- Angela M. Smith at (317) 977-1448 or asmith@hallrender.com;
- Thomas M. Donohoe at (303) 801-3534 or tdonohoe@hallrender.com;
- Amy L. Mackin at (919) 447-4963 or amackin@hallrender.com; or
- Your regular Hall Render attorney.

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