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View From McDermott: A New Type of ERISA-Based Hold-Up—The Rise of Out-of-Network Provider Suits Against Self-Funded Health Care Plans

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Over the past decade, there has been a significant increase in the number of physicians who have dropped out of Preferred Provider Organization ("PPO") and Health Maintenance Organization ("HMO") networks and attempted to negotiate their own financial reimbursement with insurance companies and self-funded health care plans related to medical treatment provided to participants whose plan are governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA")[1].

These moves have led to a corresponding increase in the number of health care benefit suits brought by out-of-network physicians and treatment centers seeking to gain through litigation that which they could not get through direct negotiations with insurers and plan administrators—higher reimbursement amounts for health care treatment from ERISA-governed medical plans.

Many of these suits first centered on the transparency provided by insurance companies and ERISA plans in determining the Usual, Customary and Reasonable benefit rate ("UCR") for which out-of-network physicians would be reimbursed. The physicians argued that the insurance companies and plan administrators were hiding the true basis for how they would determine the objective reimbursement rates for the physician's out-of-network services, while the insurance companies and plans argued that the physicians unreasonably inflated their treatment fees in an effort to receive increased out-of-network reimbursement.

From these larger theoretical fights, individual physicians and treatment centers have entered the fray—with the individual physicians or groups looking to recover for allegedly undervalued UCR determinations on a participant-by-participant basis.

These relatively new out-of-network provider suits are now filling the federal district courts and ERISA plan administrative claim dockets with cookie-cutter lawsuits seeking to re-write the rules by which out-of-network treatment is reimbursed. This article will address the background of this growing ERISA issue, ana-

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[1] *See* 29 U.S.C. § 1001, *et seq.*

lyze current trends in provider-driven litigation and contemplate how ERISA plan fiduciaries and administrators may be able to address these issues to limit liability and avoid litigation.

In-Network Versus Out-of-Network Treatment

Participants and beneficiaries in ERISA-governed health care plans are often faced with the difficult question of whether to use an in-network or out-of-network physician for a particular medical treatment. More often, many medical specialists are moving away from being in-network for ERISA-governed health care plans and insurance policies in an attempt to be free of lower reimbursement amounts and have more freedom to price their services as they wish. Thus, an initial question is presented—what is the difference between in-network and out-of-network services for a participant or beneficiary?

In-network providers are physicians, treatment providers and medical facilities that have negotiated with an insurance company or ERISA plan to provide treatment to plan participants and beneficiaries at a pre-negotiated rate. When a participant or beneficiary seeks medical treatment from an in-network provider, the participant or beneficiary will likely will pay a lower out-of-pocket price—through co-insurance payments and any cost-sharing—than they would if they received treatment out-of-network. Most networks typically provide participants and beneficiaries with a ''menu'' of physicians from which to select to receive this lower out-of-pocket cost treatment. For the providers, they receive a steady stream of patients to perform their services in exchange for receiving a set reimbursement amount for the services they provide.

It follows that out-of-network providers are physicians, treatment providers and medical facilities that have not negotiated a service ''rate'' with an insurance company or ERISA plan. In the out-of-network world, the patient agrees to pay whatever rate the provider sets for the treatment, and then the patient—or the provider if an assignment of benefits is executed—will seek reimbursement from the insurance company or ERISA plan, if the plan so provides for an assignment under its governing document.

Unlike in-network providers, out-of-network providers are not restricted by a fee schedule and may charge a patient any amount they so choose. Some health care plans, like HMOs, do not provide any reimbursement for services received from out-of-network providers, unless the HMO does not have an adequate provider to perform the individual's necessary medical procedure. In that instance, a patient must cover the full cost of their treatment, or negotiate some payment plan with the provider.

For other health plans, like PPOs and Point of Service (''POS'') plans, the ERISA plan will provide a reimbursement amount, which may not be the same amount as the provider's billed amount, and typically will require the participant to incur greater co-insurance payments and may also be subject to increased deductibles and out-of-pocket benefit maximums.

If reimbursement of out-of-network services is provided at all, the benefit payable will be based on a non-contracted amount, which is typically the Maximum Allowable Amount (''MAA'') or the UCR rate established by the benefit plan's governing documents. These amounts are usually far less than the provider's billed amount. An out-of-network provider can charge the difference to the patient from what the provider is paid by the benefit plan and its billed amount.

The plans and insurance companies look to various available resources, including Medicare rates, independently published rates and group tables, to determine the reasonable and customary reimbursement for a particular medical treatment in a certain geographical area or region.

The determination of the MAA or UCR is at issue in a number of out-of-network provider legal disputes, and this fight has morphed over the years from a theoretical conflict across plans and insurance companies to a fight in the trenches on medical treatment provided by a single out-of-network provider on a patient-by-patient basis.

Early Fights on What Was a Usual, Customary and Reasonable Reimbursement Rate

In the realm of out-of-network reimbursement, there exists a real conflict between the insurance industry and the out-of-network providers. Providers allege that insurance companies and plan administrators have an incentive to under-report the costs of treatment within any geographical area so that the percentage of reimbursement provided for in the policy or plan will be smaller than that expected or charged by the provider. Insurers and plans allege that out-of-network providers have an incentive to over-charge patients for their services so that they will receive a greater amount for the allowed UCR reimbursement rate under these plans. It is this conflict out of which several large lawsuits were filed in the late 2000s [2].

Some of these lawsuits involved Ingenix, which was a wholly-owned subsidiary of United Healthcare and which controlled the only two national UCR databases—Medical Data Resource (''MDR'') and Prevailing Healthcare Charge System (''PHCS'')[3]. In these lawsuits, Ingenix was alleged to have reported artificially low UCR rates, leaving patients to pay a larger share of their out-of-network health care treatment bills. This alleged lack of transparency in UCR calculations led to the lawsuits as well as an investigation by the New York Attorney General.

Ultimately, settlements of these matters resulted in the creation of new databases or standards by which to determine UCR or MAA, including use of Medicare-approved rates by insurers and plan administrators.

New Focus of Litigation on Individual Providers versus Individual Self-Funded Plans

One of the intended results of these UCR settlements was for out-of-network UCR reimbursement to become more transparent. However, disagreements between out-of-network providers and insurers remain. Many insurers and ERISA plans chose alternative means of making their UCR determinations more transparent.

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[2] *See AMA v. Wellpoint/Anthem Blue Cross,* Case No. 2:09-ml-2074 (C.D. Cal.); *AMA v. Aetna Health Inc.,* Case No. 2:07-CV-3541 (D.N.J.); *AMA v. Cigna Health Corp.,* Case No. 09-CV-578 (D.N.J.).

[3] See http://www.fairhealthconsumer.org.

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For example, some insurers and plan administrators tie UCR decisions to a percentage of Medicare-approved rates that generally result in lower UCR reimbursement rates, much to the out-of-network providers' disdain. Also, some insurers and plans create their own databases of provider rates and base UCR decisions from their own data, usually set forth in the plan's governing documents. These alternative bases for determining UCR reimbursement have also resulted in substantial litigation.

Unlike the large class action cases discussed above, much of the new litigation involves legal challenges by individual providers or treatment centers against individual insurance companies or ERISA plans.

One of the largest ongoing disputes is between Aetna and Bay Area Surgical Management, Inc. (''BASM''), based in Northern California. BASM is a group of surgical centers in Northern California that generally work out-of-network in providing ambulatory surgery services[4]. In 2012, Aetna filed a lawsuit in California state court against BASM and its affiliates alleging that the defendants, all out-of-network with Aetna, recruit physicians to invest in their surgical centers and require them to refer Aetna-insured patients to the centers[5]. Aetna contends that BASM and its affiliates overbilled Aetna for routine medical procedures and then paid kickbacks to the participating physicians. The surgical centers allegedly did not charge patients co-payments or deductibles, which were required under the patients' individual policies or plans. Cigna and United Healthcare are fighting similar lawsuits against BASM in California, which contain similar allegations[6].

Not to be outdone, earlier this year, BASM filed its own lawsuit in the U.S. District Court for the Northern District of California against Aetna and over a hundred separate employers who sponsor self-funded employer health care plans, alleging ERISA breach of fiduciary duty violations.[7] In that suit, BASM alleged that Aetna and the ERISA plan administrators breached their fiduciary duties to their participants and beneficiaries by failing to reimburse BASM using reasonable UCR rates. BASM's suit has created a firestorm of legal activity on UCR-related issues in Northern California.

The impact that the insurance industry's focus on a single out-of-network provider (or even group of providers) will have on UCR reimbursement nationwide is unclear. If Aetna and the other insurers are successful in these lawsuits, it could serve as a ''shot over the bow'' to other providers to steer their provider charges towards the geographical mean or to encourage them to join ''in-network'' where their charges are known. However, if the provider is successful in proving that Aetna's (and others) UCR reimbursement scheme is improper, it could result in a mass of litigation by providers seeking increased out-of-network charges, which could serve to increase health care costs for all employees and individuals across the board to pay due to the increased benefit costs and legal fees resulting from such a result.

Increase in UCR-Related Suits Against Individual Self-Funded Plans Akin to Shake Downs

Aside from the BASM-type litigation, there has also been a surge of cases in pockets of the country filed by individual out-of-network providers and facilities against single self-funded health care plans and their employer-sponsors.

It is becoming increasingly popular for out-of-network providers to require their patients to sign assignments of their benefit claims against the patients' self-funded insurance plans so that the provider may seek reimbursement for the medical services directly from the ERISA plans without patient involvement (or interference). In these cases, the out-of-network provider will provide the service and then submit an administrative benefit claim to the ERISA plan administrator, seeking increased benefits under the plan due to a deficient UCR reimbursement rate for the service provided.

The bases for the claims run across a broad spectrum, but typically involve a complaint alleging that the plan administrator utilized an improper UCR database or used an improper reduction percentage off of the Medicare reimbursement rate for the debated medical treatment. If the ERISA plan administrator denies the claims administratively, the providers then assert standing to sue on the patient's behalf in federal court.

While many of these individual out-of-network provider suits are one-off attempts to get greater reimbursement for a specific medical treatment of a specific individual participant, some out-of-network providers have utilized the courts as a pseudo-negotiation forum for their claims.

In New Jersey, one orthopedic surgical facility—Professional Orthopedic Associates—has filed over 50 individual lawsuits in the U.S. District Court for the District of New Jersey since 2010, challenging the reimbursement rate they received for providing out-of-network services for individual patients[8].

In almost every case, these providers seek to recover the full amount of their billed charges—typically for back or other orthopedic surgeries—that generally run over $150,000 per claim. The lawsuits generally allege that the ERISA plan's and its administrator's decision to pay a percentage of the Medicare UCR rate for the surgery as an out-of-network reimbursement is unreasonable, and that a larger reimbursement should be provided. In almost every case, the lawsuit is settled before the Court decides the case's merits.

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[4] *See* http://www.basurgical.com.

[5] *Aetna Life Insurance Co. v. Bay Area Surgical Mgmt. LLC,* Case No. 1:12-CV-217943, pending in Santa Clara County Superior Court, California.

[6] *See Connecticut General Life Insurance Co. v. Bay Area Surgical Management LLC,* Case No. 5:13-CV-156, pending in U.S. District Court for the Northern District of California; *Bay Area Surgical Mgmt. LLC v. United Healthcare Ins. Co.,* Case No. 12-CV-1421, filed in U.S. District Court for the Northern District of California.

[7] *Bay Area Surgical Group Inc. v. Aetna Life,* Case No. 13-CV-5430, pending in U.S. District Court for the Northern District of California.

[8] For example, see *Cohen, M.D., F.A.C.S. v. Blue Cross Blue Shield of Alabama,* Case No. 3:12-CV-4381 (D.N.J.); *Professional Orthopedic Assocs., P.A. v. Horizon Blue Cross Blue Shield of N.J.,* Case No. 2:14-CV-4731 (D.N.J.); Torpey, M.D., *F.A.C.S. v. Blue Cross and Blue Shield of Fl.,* Case No. 3:11-CV-4069 (D.N.J.); and *Johnson, M.D., F.A.C.S. v. Blue Cross Blue Shield of Oklahoma,* Case No. 3:13-CV-2875 (D.N.J.). These cases are representative of the over 50 cases that have been filed by these providers' counsel in the past few years.

Considering that the defense of an ERISA lawsuit like these can cost upwards of $100,000 or more depending on how complicated the claims and the case's duration, the employers sued are typically faced with the difficult business decision of paying defense costs and fees that could be as large as the total amount of benefits sought by the provider—and far greater than the amount these providers would have received had they been in-network for the services.

Alternatives for Employers to Limit Liabilities

With the increase in these individual out-of-network provider suits, employers are faced with the prospect of increased benefit liabilities through greater out-of-network provider reimbursements and/or increased administrative costs to pay attorneys to defend their plans in court. Since employers are not likely to eliminate out-of-network coverage for their employees where it exists (as such a move would only harm their workers economically), they will likely be seeking alternatives to either having the plan limit benefit costs or reduce the possibility that they can be named by an out-of-network provider in such a suit.

The first line of defense for employers is to state specifically in their self-funded health care plans what the reimbursement amount will be for out-of-network providers. By stating a specific percentage or amount that will be paid on out-of-network claims, which is not tied to UCR or MAA reimbursement determinations, the out-of-network providers will not be able to challenge what is allegedly an undefined reimbursement system. Moreover, the employer will be able to have a better grasp on what their plan's out-of-network costs will be through plan drafting.

Another alternative for employers is to amend their ERISA health care plans to include an anti-assignment clause for benefits and benefit claims. If an employer fears having its plan sued repeatedly by out-of-network providers, the addition of an anti-assignment clause may bar an out-of-network provider from having standing to sue the plan in federal court. For example, in one of the suits brought by the New Jersey orthopedic surgical providers referenced above, the ERISA plan at issue contained an express anti-assignment clause: ''The right of a Covered Person to receive benefit payments under this coverage is personal to the Covered Person and is not assignable in whole or in part to any person, Hospital, or other entity nor may benefit of this coverage be transferred, either before or after Covered Services are rendered ....''[9] In that case, the court found that the out-of-network provider did not have standing as a participant or beneficiary to bring a benefit denial claim under ERISA Section 502(a)(1)(B) because that anti-assignment clause was enforceable[10]. Also, these plan provisions should have specific language that direct payments to an in-network provider would not constitute a waiver of the anti-assignment provision. Some courts have held that direct payments to in-network providers can constitute a waiver of the anti-assignment protection when trying to enforce that provision against an out-of-network provider. By providing specific language in the plan to protect against such a waiver, it is likely that the court will enforce the plan's terms as written and the anti-assignment provision will be given effect.

Another alternative, short of a total bar on assignments of benefits, would be for the employer to limit under the ERISA plan's terms what entities may be considered ''authorized representatives'' to bring an administrative benefit claim. ERISA permits only participants, beneficiaries or their authorized representatives to submit benefit claims and, ultimately, file suit under ERISA[11]. By limiting a participant's or beneficiary's right to name an out-of-network provider as an authorized representative under the plan's terms, the employer may be able to block the provider from bringing suit against the plan on the participant's or beneficiary's behalf [12]. At the very least, employers may want to consider amending their definition of ''beneficiary'' to exclude specifically out-of-network providers, as some courts have found that out-of-network providers that receive direct payments from ERISA plans constitute ''beneficiaries'' for purposes of ERISA standing in litigation.

In sum, the move of out-of-network provider litigation from the class action realm to individual suits against single ERISA plans and employers makes every employer that sponsors a self-funded health care plan vulnerable to increased administrative and legal costs. Unless some of these suits reach a resolution on their merits, both sides of the dispute will be left with difficult questions as to how to proceed: for employers and plan administrators, the decision to settle unsupported claims or pay substantial legal fees trying to defeat them; and for out-of-network providers, should they continue to remain outside the provider network and be forced to ''negotiate'' a reimbursement rate in a plan's administrative claims process or in court or should they accept in-network rates and the corresponding increase in patients. For either side, some legal resolution of these issues will be necessary soon or the costs associated will only work to increase health care costs for all involved—something neither side nor the employees and patients they serve would like.

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[9] *See Cohen v. Independent Blue Cross,* 820 F.Supp.2d 594, 604 (D.N.J. 2011).

[10] *Id.* at 607. However, *see also Pennsylvania Chiropractic Assn. v. Blue Cross Blue Shield Assn.,* 2014 WL 1276585, *12 (N.D. Ill. Mar. 28, 2014) (holding that in-network providers that are assigned benefits through an ERISA plan qualify as beneficiaries and have standing under ERISA Section 502(a)(1)(B), and anti-assignment clauses do not apply).

[11] 29 C.F.R. § 2560.503-1(g)(1).

[12] *See Hahnemann University Hosp. v. All Shore, Inc.,*514 F.3d 300, 308 n. 5 (3d Cir. 2008) (''[I]f there is a valid assignment'' of benefits to a health care provider, the provider ''becomes the only claimant because the original claimant gives up her claim by the assignment.'' (citing *Principal Mutual Life Ins. Co. v. Charter Barclay Hosp., Inc.,* 81 F.3d 53, 55-56 (7th Cir. 1996))).

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