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Health Plans, Providers, and Payment Challenges

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I. Introduction and Overview of Topics

Managed care relationships among providers and payers can present a variety of operational and payment challenges. This paper provides an overview of a variety of those challenges and points out laws and regulations applicable to those challenges, as well as common sense advice on how to manage and resolve them.

First, the paper considers trends and common issues with out-of-network reimbursement, including the different regulatory regimes that apply to different types of out-of-network claims, and patient management with the increase in narrow network benefit designs. Next, it looks at some current issues created by the expansion of the 340B discount drug program. Finally, it offers practical tips and strategies for payment disputes, including by examining some issues unique to the Medicare Advantage program.

II. Out-of-Network Reimbursement Trends and Problems

A. Different Rules for Different Claims

In general, reimbursement rates and the rules governing those rates can be impacted by, among others, the following factors: (i) the network status of the provider; (ii) the type of health plan making the reimbursement; and (iii) the type of claim for service submitted for reimbursement. With respect to the first factor, an "in-network" provider is a hospital, physician, or other provider that has contracted with a managed care payer to accept discounted fees in exchange for being identified to patients as an "in-network" provider. Typically, the managed care contract requires the provider to accept a discounted payment, together with the patient's copay and deductible, as payment in full for services rendered. In contrast, an "out-of-network" provider is one that has not contracted to participate in a network and has not agreed to accept discounted payments.

The latter two above-referenced factors (health plan type and type of claim) are discussed more fully below. Specifically, this section of the paper discusses the different out-of-network reimbursement rules and trends that are dependent on (i) whether the health plan making the reimbursements is self-funded or insured, and (ii) whether the claim being submitted for reimbursement is for emergent or non-emergent care. In addition, case illustrations are provided at the end of this section to highlight the often-complex issues raised in out-of-network reimbursement litigation.

1. Self-Funded Plans

A self-funded plan is one for which the employer assumes the risk and responsibility of paying for its employees' claims for healthcare services. As many employers lack the expertise or experience necessary to assume all administrative responsibilities for the plan, employers frequently hire third-party administrators to manage the employee health benefit plan. Unlike traditional health insurance, which is governed by various state and federal laws and regulations,

self-funded plans are predominantly governed under the federal Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq*.

In payment disputes over claims between an out-of-network provider and a self-funded plan, the plan or plan administrator remains liable for the underpaid out-of-network claims. (The administrator will sometimes take the position that only the health plan itself has financial responsibility for any underpayment.) Under ERISA, a participant or beneficiary can sue 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."[1] The Fifth Circuit has held that "beneficiary" includes providers to whom ERISA plan participants assign their benefits under ERISA.[2]

In determining whether a participant or beneficiary (or provider as assignee) is entitled to plan benefits, the inquiry typically focuses on what the relevant plan documents provide with respect to the plan's or plan administrator's payment obligations for out-of-network providers, as well as additional sources of law that may apply. Some providers have elected, however, not to proceed as assignee of the member's benefits under an ERISA plan but rather to pursue direct claims against the plan under Texas common law theories.[3]

ERISA plans have differing provisions for out-of-network reimbursement. While some plans may specify Medicare-based methodologies, others may provide that the plan or plan administrator will pay the "usual and customary" (UCR) level of reimbursement, which many in the industry consider to be a charge-based methodology. Other sources of law or contract may apply, for example, to specific types of health plans or types of service, such as Affordable Care Act obligations that apply to emergency services, as discussed below.

2. Insured Plans and State Regulations Impacting Level of Reimbursement for Emergency Claims

For insured plans (as opposed to self-funded plans), a licensed health insurer bears the claims funding risk. These types of plans may be subject to ERISA; however, regardless of whether ERISA applies, Texas law provides that in circumstances requiring emergency care or when a preferred provider is not reasonably available to an insured, the insurer must "pay the claim, at a minimum, at the usual and customary charge for the service . . . ."[4] Under Texas insurance law, the payment to out-of-network providers must be calculated pursuant to a methodology that, if based on a UCR payment basis, is based on generally accepted industry standards and practices for determining the customary billed charge for a service and that fairly and accurately reflects market rates, including geographic differences in costs.[5]

In a January 2017 report on usual and customary rates, the Texas Department of Insurance (TDI) expressly recognized that when a patient is experiencing a medical emergency

[1] 29 U.S.C. § 1132(a)(1)(B).
[2] *Hermann Hosp. v. MEBA Med. & Benefits Plan*, 845 F.2d 1286, 1289 (5th Cir. 1998).
[3] *E.g., Rogers v. CIGNA Healthcare of Texas, Inc.*, 227 F. Supp. 2d 652 (W.D. Tex. 2001).
[4] 28 Tex. Admin. Code § 3.3708(b)(1).
[5] *See id*. § 3.3708(c)(1).

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