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RECENT TRENDS IN ERISA

Out of network self-funded employer ERISA plans are paying Medicare based fee schedules for patients not on Medicare

Within the last year or two, self-funded employer ERISA health plans who opted not to pay a premium and purchase health insurance for their employees from insurers who contract with health care providers; opted not to contract directly with healthcare providers for contractually agreed upon discounts, and opted not to participate in PPO networks who contract with healthcare providers for discounts, have unilaterally elected to limit allowable benefit levels in their plan documents to Medicare based fee schedules plus a certain percentage.

In short, the ERISA health plans are limiting benefit levels for their employees and dependent beneficiaries to levels slightly above Medicare. The result is that on many occasions, if not a vast majority of accounts, providers are getting paid at levels ranging from 7% to 30% of billed charges for patients not eligible for Medicare. Typically, accompanying the check from the ERISA Plan's third part administrator is an EOB setting forth miniscule patient liability, along with language alleging payment by assignment constitutes a full accord and satisfaction according to the plan document, therefore, the provider cannot balance bill the patient. The EOB also typically states that if the provider does not agree with the benefit determination, the provider has 180 days to appeal to the employer self-funded ERISA Plan.

DON'T BE FOOLED!! DON'T APPEAL!! BALANCE BILL THE PATIENT.

Providers can balance bill patients who have non-contracted, out of network self-funded Employer ERISA plans. ERISA self-funded employer plans are not the Federal Government of the United States of America and therefore, they cannot impose a Medicare based fee schedule on a provider. Moreover, these non-Medicare patients were not the intended beneficiaries of Medicare legislation and accordingly, they do not and cannot receive the benefits promulgated under that governmental program. Moreover, typically, the assignment language in these plans cannot satisfy the elements of an Accord and Satisfaction under the Restatement of Contracts, nor is it clear how or when a provider would become aware that by pursuing payment by assignment it foregoes its right to bill for the remainder. One can certainly question the

enforceability of the language in the plan's assignment provision that requires a provider to accept the rules of a plan when it is unclear how a provider would have a copy of the plan document prior to or concurrent with the patient receiving treatment.

Another trend is becoming more and more frequent. After balance billing a patient with an out of network ERISA plan that pays Medicare based rates, hospitals are receiving letters from either a so called "patient advocacy" entity or a law firm paid by the ERISA plan to "scare off' the provider from balance billing. These letters are merely "aggressive posturing" by these out of network ERISA plans to "scare off' providers, despite appellate courts across the country giving the green light to balance bill patients without In- Network/ Contracted Insurance Plans, based upon the patient's contract with the hospital that is signed upon admission in which the patient agrees to pay for any and all amounts not covered by his or her insurance.

Providers will be seeing more and more of this aggressive posturing by self-funded ERISA plans paying Medicare based fee schedules for non-Medicare eligible employees and their dependent beneficiaries. For more information, please feel free to contact the undersigned at chilton@cjhiltonlaw.com.

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