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Health Plans must Explain Reasonable and Customary

As most plan sponsors know, demand letters and lawsuits from out-of-network providers have been on the rise the past few years. This rise in out-of-network provider demands and lawsuits is a product of the sharp rise in out-of-network provider billing rates, more providers moving out-of-network and employer sponsored health plans curtailing reimbursement rates. One of the ways that health plans have curtailed out-of-network reimbursement rates is through reasonable and customary reductions. Out-of-network providers have responded with creative theories as to why a health plan's reasonable and customary reductions violate ERISA, the ACA and any other acronyms that their legal counsel can include.

However, regardless of how a health plan applies reasonable and customary, a health plan is required to disclose the methodology under the ERISA claims procedure rules. A federal district court in Michigan recently sided with a participant (see *Zack v. McLaren Health, 2018 WL 4501488*) regarding the determination of the amount payable for an out-of-network surgery given the failure to explain how "reasonable and customary" was determined under the plan.

In determining the amount payable, the health plan limited the reimbursement to 60% of the average amount that would have been paid had the services been in-network. However, the plan documents provided that out-of-network claims would be paid at 60% of the "reasonable and customary" amount, and it did not provide a definition or explanation of that term. Further, the notices provided to the participant on the initial claim and appeal did not explain the methodology used to determine the "reasonable and customary" amount.

The court found that failing to disclose the methodology used to determine the amount payable for out-of-network claims was a violation of the ERISA claims procedures, even though the participant did not specifically request an explanation, because the use of the negotiated in-network amounts to determine the reasonable and customary amount was an internal criteria that was relied upon in making the decision. Further, although the use of the negotiated rates was not, on its face, arbitrary and capricious, denying benefits on the basis of an undisclosed interpretation of a key term was arbitrary and capricious. As a result, the court ordered the claim to be recalculated based on the ordinary meaning of the term – the prevailing market rates.

This case serves as an important reminder to review plan documents to ensure key terms that are used to determine benefits or exclusions are defined and/or explained in sufficient detail. Further, plan sponsors should confirm that their claims administrators are providing non-evasive and specific explanations in their notices of adverse benefit determinations and are disclosing the internal criteria and fee schedules where appropriate.