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A New Twist in the Ongoing Out-of-Network Provider Lawsuit Saga

The Northern District of California recently considered a case brought by a hospital against a self-funded health plan claiming the underpayment of out-of-network claims (Salinas Valley Memorial Healthcare System vs. Rocket Farms). The health plan did not have in-network hospitals (though it did have other in-network providers) and set the reimbursement rate for hospitals at 140% of the Medicare rates. The plaintiff (the "Hospital") alleged that when it called to certify coverage, it was told about the coinsurance rate, but it was not informed that benefits were capped at these rates. It claimed that the health plan should have paid the claims based on reasonable and customary amounts and that the plan should have reimbursed 100% of claims for those who reached their maximum out-of-pocket limit (MOOP). The Hospital alleged claims under ERISA Section 502(a), for violations of the Affordable Care Act's MOOP requirements, unfair advertising, and for intentional and negligent misrepresentation. The defendant moved to dismiss on the basis that the Hospital did not have standing to sue given that its assignment rights were limited to the payment of benefits and for failure to allege a viable claim for relief.

Although the Court dismissed the various claims alleging recovery under ERISA Section 502(a) due to standing issues, it did allow the plaintiff to amend the claim relating to enforcing ERISA's disclosure requirements in an action for payment of benefits. The claim relating to false advertising was also dismissed, but the claims relating to misrepresentation were not dismissed.

Perhaps the most interesting part of this case relates to the claim that the plan used an improper reference pricing model and violated the Affordable Care Act (ACA) rules regarding MOOPs. The Hospital cited the FAQs under ACA which provide that reference pricing cannot be used as a subterfuge for otherwise prohibited limitations and require that plans using this model ensure adequate access to quality providers. Specifically, a 2016 FAQ provides that a plan using a reference price without ensuring adequate access at that price will not be considered to have established a network for purposes of Section 2707(b) of the Public Health Service Act which relates to cost-sharing requirements and permissible MOOPs. The court found this argument somewhat convincing and declined to dismiss this claim.

Although this type of medical plan is rare (no in-network hospitals), this case is instructive for employers who use reference pricing. It is a good reminder that employers who use reference pricing should confirm that they fall within the guidance for establishing a network and confirm that their administrators are correctly explaining the plan terms to providers who call to determine coverage.