

Understanding Your Rights

under Out-of-Network ERISA Plans and Health Care Sharing Ministries

TAHFA & South Texas HFMA Fall Symposium

San Antonio, Texas

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GOALS

- Provide a Working Understanding of:
 - OON ERISA Plans
 - Health Care Sharing Ministries
- Provide recommendations on dealing with these Plans to maximize reimbursement
- Discussion focused solely on Texas providers



OUT-OF NETWORK ERISA PLANS

ERISA Plans

An **ERISA Plan** is typically an employer sponsored, self-funded, health plan that is governed by the Employee Retirement Income Security Act (“ERISA”).

- ERISA is a Federal Statute that preempts all State Laws that attempt to regulate ERISA Plans.
- A Hospital’s Rights relative to an ERISA Plan come from either:
 - A Contract or a Contracted Network; or
 - An Assignment of Benefits executed by the Patient (Plan Beneficiary).

Out-of-Network ERISA Plans

An **Out-of-Network (“OON”) ERISA Plan** is one that meets the requirements of an ERISA Plan, and where the Provider:

- Does not have a contract with the Plan; and
- Does not have a contract with a Network that includes the OON ERISA Plan as an Affiliate or Designated Plan under the Network.

Assignment of Benefits

An **Assignment of Benefits (“AOB”)** is a contractual assignment of rights from the Patient to the Provider that:

- Is usually contained in the Consent for Admission;
- Conveys the rights held by the Patient at the time of the signing of the AOB; and
- Is typically enforceable under Texas law.

Billing Rights

Does a provider have the right to directly bill an OON ERISA Plan?

- Yes, but only if the provider has a valid AOB that contains the appropriate assignment language.
 - A provider's rights arise only from the Assignment of Benefits.
 - If there is no Assignment of Benefits, the provider has no legal right to force any action from the OON ERISA Plan, including:
 - Reimbursement at the appropriate amount;
 - Appeals; or
 - Litigation.

Payment

Does a Provider have the right to receive Payment directly from an OON ERISA Plan?

- Yes, but only if the Provider has a valid AOB that contains the appropriate assignment language.
 - A provider's rights arise only from an Assignment of Benefits.
 - If there is no Assignment of the right to receive payment, the provider has no legal right to force the OON ERISA Plan to send the payment directly to the Provider.

Reimbursement

Does the Provider have the Right to Dictate the Amount of the OON ERISA Reimbursement?

- No, because under the AOB, the Provider is entitled to the same benefits as the Patient that signed the AOB.
- Each OON ERISA Plan will specify the benefits – including the amount to be paid to health care providers – that each Patient is entitled to as a Beneficiary under the Plan.
 - This amount is typically specified as a percentage of Medicare reimbursement, usual and customary, or some other specifically enumerated payment structure.
 - The payment structure can be tailored to inpatient versus outpatient services, or other rational distinctions in services.
 - The Provider is only entitled to force the Plan to pay the Amount Specified in the OON ERISA Plan documents, not total charges.

Reimbursement

Can a provider bill the patient for the remaining balance after the OON ERISA payment?

- Yes, unless the provider agrees not to bill the patient for the remaining balance in order to obtain the OON ERISA Payment.
- **Remember:** There is no agreement to make the payment a “payment in full” or requiring a contractual adjustment.
 - A Provider can agree not to pursue the remaining balance through a single case agreement or other documented agreement, and such an agreement will be enforceable against the Provider under Texas law.
 - Most OON ERISA Plans will make some effort to make their payment a “payment in full” even though there are not entitled to such an outcome, through coverage card language, EOB language, restricted endorsements on payments and single case agreements.

Appeals

Does the Provider have the Right to Appeal an Unpaid or Underpaid Claim by an OON ERISA Plan?

- Yes, if these rights are assigned under the AOB, the Provider has the right to appeal to the extent the Plan provides appeal rights.
- Each OON ERISA Plan will specify the appeals procedure required to challenge a denied or underpaid claim for benefits.
 - The **appeal process must be followed strictly** to ensure compliance with the Plan.
 - If the Provider does not exhaust the appeal remedies in the Plan, the failure to exhaust will most likely preclude any further appeal or litigation of the claim.

Best Outcome

What is the best outcome with an OON ERISA Plan?

- The OON ERISA Plan pays the full amount of reimbursement specified in the relevant Plan documents; *and*
- The Provider is free to pursue the remaining balance (with no contractual adjustment) from the patient, because:
 - ERISA does not prohibit balance billing; and
 - Texas law does not prohibit balance billing for out-of-network ERISA plans, although any relevant notice and dispute resolution requirements must be followed.

Impediments

What are some of the impediments to achieving the Best Outcome?

- Anti-Assignment Clauses
- Assignment Revocation Clauses
- Tricky “Paid in Full” Efforts:
 - Member Card Language
 - Check Endorsements
 - EOB Language
- Single Case Agreements

Recommendations

Recommendation #1 – Update your AOB

- **The AOB is the Key** to success with OON ERISA Plans.
- Make sure it is comprehensive, including an Assignment of:
 - The Right to Payment;
 - The Right to Pursue and Appeal Claims with Specific ERISA language; and
 - The Rights of an Authorized Representative.
- AOB language that is even 6 month or a year old should be reviewed and updated.

Recommendations

Recommendation #2 – Obtain Plan Documents

- All Rights are controlled by the OON ERISA Plan Documents.
- Do not make decisions without them.
- ERISA provides the Right to Obtain the relevant plan documents, with a daily penalty for failure to timely provide the Plan documents if properly requested.

Recommendations

Recommendation #3 – Make Good Decisions

- Really understand your rights as they relate to OON ERISA Plans.
- Understand the value of the OON ERISA Plan and the potential for recovery from the patient.
- Make the best decision for the specific plan and the specific patient on each account. Sometimes hard and fast rules can diminish recoveries.



HEALTH CARE SHARING MINISTRIES

Health Care Sharing Ministries

What is a Health Care Sharing Ministry (also known as a Health Share Plan)?

- The fact is that:
 - A Health Care Sharing Ministry is neither insurance nor an ERISA Plan;
 - A member does not have the same rights as with an insurance or ERISA plan; and
 - A Provider does not have the same rights as with an insurance or ERISA plan.
- Health Care Sharing Ministries are not governed by either federal statutes or the Texas Department of Insurance.
- A Health Care Sharing Ministry is typically a non-profit sharing organization, based around religious beliefs, that pays for a member's medical expenses on a discretionary basis out of "shared funds."
- However, Health Care Sharing Ministries can qualify as sufficient coverage to avoid ACA Penalties.

Health Care Sharing Ministries

What does it take to Qualify as a Health Care Sharing Ministry in Texas?

- Texas Insurance Code 1681.001– 1681.003 addresses Health Care Sharing Ministries.
- In order to qualify in Texas, the Health Care Sharing Ministry must meet the following requirements:
 - limit its participants to individuals of a similar faith;
 - acts as a facilitator among participants who have medical bills and matches those participants with other participants with the present ability to assist those with medical bills in accordance with criteria established by the health care sharing ministry;
 - provides for the medical bills of a participant through contributions from one participant to another;

Health Care Sharing Ministries

What does it take to Qualify as a Health Care Sharing Ministry in Texas?

- In order to qualify in Texas, the Health Care Sharing Ministry must meet the following requirements (continued):
 - provides amounts that participants may contribute with no assumption of risk or promise to pay among the participants and no assumption of risk or promise to pay by the health care sharing ministry to the participants;
 - provides a written monthly statement to all participants that lists the total dollar amount of qualified needs submitted to the health care sharing ministry, as well as the amount actually published or assigned to participants for their contribution;
 - discloses administrative fees and costs to participants;

Health Care Sharing Ministries

What does it take to Qualify as a Health Care Sharing Ministry in Texas?

- In order to qualify in Texas, the Health Care Sharing Ministry must meet the following requirements (continued):
 - provides that any card issued to a participant for the purpose of presentation to a health care provider clearly indicates that the participant is part of a health care sharing ministry that is not engaging in the business of insurance;
 - provides a written disclaimer on or accompanying all applications and guideline materials distributed by or on behalf of the ministry that complies with Section 1681.002; and
 - does not operate a discount health care program as defined by Section 7001.001.

Health Care Sharing Ministries

What is the Effect of Qualifying as a Health Care Sharing Ministry in Texas?

- If the nine (9) requirements Texas Insurance Code section 1681.001 are met, then the Health Care Sharing Ministry “is not considered to be engaging in the business of insurance.”
 - This means that the Texas Insurance Code will not apply to a qualifying Health Care Sharing Ministry.
 - Compliance with this provision essentially removes the Health Care Sharing Ministry from state regulation.

Health Care Sharing Ministries

How do Health Care Sharing Ministries work?

- Individuals or Families typically pay a “Sharing Amount” each month.
- Individuals or Families effectively receive:
 - Discounts on healthcare through either contracts or negotiated single case agreements;
 - Limited out-of-pocket liability; and
 - Predictable Monthly Payments.
- “Sharing Amounts” and “Deductibles” are typically much lower than premiums and deductibles under traditional health plans.
- Since not governed by the ACA, Health Care Sharing Ministries can have:
 - Religious or Moral limitations on the type of treatment covered under the plan;
 - Individual factors that eliminate coverage (i.e. smoking, obesity, etc); and
 - Lifetime limits on coverage.

Health Care Sharing Ministries

The largest Ministries and Plans currently available are:

- Liberty Healthshare
- Christian Medi-Share
- Samaritan Ministries
- Altrua Healthshare
- There are many smaller Health Share entities across the country, each with individual missions, conditions and requirements.
- Nationwide Utilization of Ministries and Plans is currently estimated at more than 1 million Americans, up from an estimated 160,000 Americans in 2014.

Billing Rights

Does a Provider have the right to directly Bill a Health Care Sharing Ministry?

- Yes, if the Provider has either:
 - a contract with the Health Share Plan providing the right to bill; or
 - a valid AOB that contains the appropriate assignment language.
- However, as is addressed above, there is no true commitment to pay for the submitted claim.

Payment

Does a Provider have the right to receive Payment directly from a Health Care Sharing Ministry?

- Yes, if the Provider has either:
 - a contract with the Health Share Plan providing the right to receive payment directly from the Health Share Plan; or
 - a valid AOB that contains the appropriate assignment language.

Reimbursement

Does a Provider have the right to force a certain level of Reimbursement from a Health Care Sharing Ministry?

- No, unless the Provider has a contract with the Health Care Sharing Ministry that requires payments different from those in the Health Care Sharing Ministry Plan documents.
- Otherwise, a Health Share Plan will pay, at its discretion, the amount contained in its Health Share Plan documents, if there is a match between the claim and a participant with an ability to pay.
- The Health Care Sharing Ministry “Plan” documents will often specify the benefits – including the amount to be paid to health care providers – that each member is entitled to under the Plan.
 - This amount is typically specified as a percentage of Medicare reimbursement.
 - However, unlike other true coverages, there is no real commitment to pay and discretionary language that allows denials in situations not present for other plans, such as:
 - Inappropriate or immoral conduct of the Member; or
 - Other reasons related to the religious or moral code relevant to the Health Care Sharing Ministry.

Reimbursement

Can a Provider bill the patient for the remaining balance after the Health Share Plan payment?

- Yes, unless the Provider enters into an agreement not to bill the patient for the remaining balance in order to obtain the Health Share Plan.
 - Without such an Agreement, there is no obligation to accept the payment as “payment in full” or requiring a contractual adjustment.
 - A Provider can agree not to pursue the remaining balance and such an agreement will be enforceable against the Provider.
- Most Health Care Sharing Ministries will attempt to require their payment to be the “payment in full” either through a single case agreement, language in the EOB, or a restricted endorsement on the payment.

Appeals

Does the Provider have the Right to Appeal an Unpaid or Underpaid Claim by a Health Care Sharing Ministry?

- Yes, if:
 - The Plan contains the rights of appeal for Members; and
 - Those rights are assigned under the AOB.
- Each Health Care Sharing Ministry will specify the appeals procedure required to challenge a denied or underpaid claim for benefits.
 - A substantial number of the Plans will have very limited or no appeal rights because of the discretionary nature of the Plan.
 - These Plans often have discretionary language that make Appeals difficult.
 - If there are appeal procedures and the provider does not exhaust the appeal remedies in the Plan, the failure to exhaust will most likely preclude any litigation of the claim.

Best Outcome

What is the best outcome with a Health Care Sharing Ministry?

- The Health Share Plan pays the full amount of reimbursement specified in the relevant Plan documents; and
- The provider is free to pursue the remaining balance (with no contractual adjustment) from the patient.

Impediments

What are some of the impediments to the Best Outcome?

- Lack of Regulatory Scheme – Cannot apply:
 - Texas Department of Insurance Statutes and Regulations; or
 - Federal ERISA Guidelines.
- Discretionary Payment Provisions:
 - Often a Vague or Non-Existing Obligation to Pay in the Plan;
 - Limited by Religious and Moral Parameters of the Health Share Plan; and
 - Can impose limitations that are prohibited by ACA.
- Obtaining Plan Documents because of lack of regulatory framework and penalties.

Impediments

More Impediments?

- Anti-Assignment Clauses
- Assignment Revocation Clauses
- Paid in Full Provisions
 - Check Endorsements
 - Member Card Language
 - Explanation of Benefits Language
- Single Case Agreements

Recommendations

Recommendation #1 – Remember that You are Not Dealing with Insurance

- Make sure you have the processes in place to identify a Health Care Sharing Ministry
- Consider tracking patients with Health Care Sharing Ministries separately with their own workflow, or treat as uninsured.
- Manage expectations for reimbursement. Consider:
 - The payment available from the Health Care Sharing Ministry;
 - Any other opportunities for reimbursement (other coverages, hospital lien recoveries, etc); and
 - The financial situation of the patient.
- Follow the route that results in the best financial outcome for your provider, even if it is out of the normal course of dealings with insurance payers.

Recommendations

Recommendation #2 – Play the Game

- Most Health Care Sharing Ministries want to operate like an insurance company without being regulated by an insurance company.
- If you play the game and treat them like an insurance company with the demands and expectations of an insurance company, the Ministry will often:
 - Process claims like a regular insurance company;
 - Provide reimbursement according to its “Plan” documents; and
 - Even negotiate higher reimbursement in some instances.
- The sticking point is usually related remaining patient responsibility after the payment or a moral or religious reason for non-payment.

Recommendations

Recommendation #3 – Update your AOB

- The AOB is also critical to success with Health Care Sharing Ministries.
- Make sure your AOB is comprehensive, including an Assignment of:
 - The Right to Payment;
 - The Right to Pursue and Appeal Claims with Specific ERISA language; and
 - The Rights of an Authorized Representative.
- While the nature of Health Care Sharing Ministries makes any appeal or enforcement effort difficult, there will be no rights without either a contract or a comprehensive, signed AOB.

Recommendations

Recommendation #4 – Obtain Relevant Ministry “Plan” Documents

- Much like an ERISA Plan, Health Care Sharing Ministries are controlled by their “Plan” documents.
- Ask for these documents as early in the process as possible.
- If possible, do not make decisions without them.

Recommendations

Recommendation #5 – Avoid Frustration and Make Good Decisions

- Really understand your rights as they relate to the Health Care Sharing Ministry.
- Understand the value of the Health Share Plan and the potential for recovery from the Patient.
- Make the best decisions related to the Ministry and the specific Patient on each account.



THANK YOU!
QUESTIONS?

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