Payment for Out-of-Network Services: The Provider's Perspective

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This article identifies the relevant issues, and reports on the current state of the law, in connection with payment to health care providers for services rendered to members of commercial health insurance plans on an "out-of-network" (OON) basis.[1] Specifically, it addresses the key factors for a provider to consider if it believes a plan has not properly adjudicated and paid a reimbursement claim for OON services.[2] These factors involve not only the provider's interactions with the plan, but also how the provider obligates the patient for the cost of the care, as well as bills and seeks to collect cost-sharing payments from the patient.

Managed Care Networks: An Overview

Network contracting by commercial plans and providers follows a pattern. The providers maintain a database of their retail (or "full-billed") charges for the health care goods and services that they provide. The plans, in turn, enter into contractual relationships with certain providers under which "participating" or "network" providers agree both: (1) to accept network rates that are less than the providers' full-billed charges as payment in full from the plans; and (2) not to bill the members of the plans for the difference between the network rates and the providers' full-billed charges, which is known as "balance billing." Providers agree to join plans' networks, and accept these lower payments, in exchange for benefiting from a greater volume of patients from those plans. Services rendered by participating providers are referred to as "in-network services."

Many plans also give their members the option to obtain services from providers that do not participate in the plans' networks. These services are commonly referred to as "OON services." Plans typically charge their members higher premiums for the right to access covered OON services and higher cost-sharing amounts for those services than the member would have to pay to access the same care from a network provider. These increased out-of-pocket cost-sharing obligations, and the potential for balance billing by the provider, serve as disincentives for the patient to seek services from OON providers, which costs the plan more money than if the members stay in network. There are three types of patient cost shares: (1) a copay, which is a fixed dollar amount a plan member must pay a provider each time the member receives treatment; (2) a deductible, which is a fixed dollar amount a member must pay to providers generally in a given coverage year before the member's insurance benefits kick in; and (3) coinsurance, which is a percentage of the amount the insurer pays (i.e., either the rate agreed to by the provider for in-network services *or* the "allowable amount" set by the plan's contract of insurance with the member for OON services) that the member must contribute to his or her own care.

In theory, market forces should ensure that the allowable amounts plans agree to pay providers for OON services do not dip below a certain threshold. In practice, however, that is not necessarily the case. Consider, for example, a large employer that seeks to attract high-quality employees. To compete for the best workers, the employer wants to offer access to a relatively broad range of OON providers at a manageable out-of-pocket cost to the employee. To do that, the employer needs to ensure that the allowable amount set by its benefits plan (i.e., the amount—minus the patient's OON cost-share obligation—that the plan will actually pay the OON provider) is high enough so that the balance bill the provider may ultimately send to the patient (i.e., for the difference between the allowable amount the insurer pays the provider and the provider's full-billed charges) is not too high. If a plan sets the allowable amounts too low, and employee members find themselves saddled with extremely high balance bills from OON providers, one would expect the employees to complain and the employer to be pressured into raising the allowable amounts at issue, if for no other reason than to be able to continue to recruit and retain a desirable workforce.

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Many factors, however, can complicate the economics of OON benefit levels. *First*, employer health insurance plans—and, more precisely, the third-party administrators that administer those plans—can make it difficult for OON providers to obtain insurance payment. The plans do so in various ways, including by not honoring the member's assignment of benefits to the OON provider (and sending the payment to the patient rather than the provider), requiring additional prior authorization for OON services, delaying payment, and/or routinely demanding supporting medical record documentation from the provider before paying a claim in the ordinary course of business. *Second*, many providers are unable to collect the full balance billed amount from a significant number of their patients. *Third*, for that reason, and others, some providers choose not to balance bill their OON patients at all or, at least, not to send such patient accounts to collection agencies even if the patient fails to make the payments owed after receiving multiple invoices. *Fourth*, plans frequently work with repricing entities (like MultiPlan) to strike deals for the plans with OON providers for payment at an agreed-upon rate, conditioned on the provider agreeing not to balance bill the patients covered by these repricing arrangements.

All of these factors dilute the cause/effect relationship between an employer plan reducing its allowable amount for OON services and employees—who might otherwise object to the reduction—feeling a resulting financial burden. Consequently, the providers who render the services are paid less, but with little leverage to advocate for the plan to reset the allowable amount, other than the drastic step of refusing to provide elective services to the employee members of the plan in the future.

Provider Interaction with the Patient

A number of legal disputes between OON providers and commercial plans regarding payment for services have played out in the courts over the years.[3] Decisions in these cases have clarified what steps a provider should take with respect to securing the right to collect the patient's insurance benefits, as well as obligating and billing the patient for the cost of the care, to create the strongest case for payment by the health plan. These steps include: (1) securing a valid assignment of benefits from the patient; (2) having the patient take financial responsibility for the full cost of care; and (3) making a good faith effort to bill and collect the patient's cost-share obligations at the OON level set by his or her benefits plan.

Assignment of Benefits

Initially, to ensure proper payment from the plan, an OON provider needs to obtain a valid written assignment of the patient's health insurance benefits from the patient. This document should not only make the patient's applicable health coverage benefits directly payable to the provider, but should also convey to the provider the patient's right to bring any legal cause of action or right to recovery related to those benefits. Further, the assignment should specifically encompass entitlement to the benefits under any plan subject to the federal Employee Retirement and Income Security Act (ERISA). In general, ERISA governs self-funded employer health insurance plans, such as those offered by large companies, administered by insurers acting as third-party administrators (like Cigna, Aetna, and United Healthcare). Fully-insured benefits plans, which are both administered *and* underwritten by insurers, by contrast, are generally subject to state regulation.

The ideal assignment should state that the OON provider may serve as the patient's "Authorized Representative" for any claim, right, or cause of action in connection with the benefits—rather than merely "assigning" to the provider ownership of a claim—and thus give the provider standing to assert the right and sue on its own behalf.

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Patient Financial Responsibility

In addition to obtaining an appropriate assignment of benefits from the patient, an OON provider should also get in writing the patient's promise to pay the provider's full-billed charges for the care to be rendered.[6] Consistent with that statement of patient financial responsibility, the provider is in effect billing the patient's insurance plan only as a courtesy; the patient remains liable to pay any amount of the full-billed charges—whether characterized as a patient cost share, a balance bill, or otherwise—not covered by the plan. Case law suggests that this financial commitment by the patient is key to compelling the plan, if necessary, to remit to the OON provider the allowable amount set by the applicable benefits coverage, minus the patient cost share.[7]

Patient Billing

Many courts and jurisdictions have addressed the relationship between how an OON provider bills a patient for services and the corresponding obligation of the patient's plan to pay the full allowable amount (again, minus the patient cost share) directly to the provider. The case law is clear that the best way to ensure the right to the foregoing payment by the plan is for the provider to make a good faith, timely, and well-documented effort to collect the full OON-level cost-share amount from the patient.[8] Beyond that best practice, however, there are various other factors to consider.

Initially, especially some years ago, many OON providers sought to discount the cost share they would charge to the patient, such as by reducing it to the lower level the patient would pay for in-network services, in an effort to remove some of the built-in disincentive for patients to seek care from a non-participating provider. Likewise, these providers frequently offered to accept less from the patient as payment in full of the cost share if the patient agreed to make payment earlier—i.e., a so-called prompt pay discount.

There are several problems with this strategy of routinely discounting OON patients' cost-share responsibilities.[9] *First*, if the commercial plan at issue is a Medicare Advantage plan or a Medicaid managed care organization, such a routine reduction in the cost share will likely violate the federal law prohibiting offering inducements to federal health care program beneficiaries.[10] A newer federal law, moreover, also deems any such discounts in connection with addiction treatment services (i.e., a recovery home, clinical treatment facility, or clinical laboratory), even when offered to members of purely commercial health insurance plans, to constitute an illegal kickback.[11] *Second*, various states have passed laws specifically prohibiting providers from discounting patient cost shares.[12] *Third*, to the extent a provider is in a state that does not prohibit such discounts and is not subject to any other applicable statutory or regulatory bar to offering them, the courts have still found that failure to provide notice to the plans of the discount constitutes potential fraud and, most important, may absolve the plan of the obligation to pay the provider the full allowable amount set by the member's benefits.[13]

To avoid possible liability for fraud, an OON provider that is otherwise able to and wishes to discount the cost share for OON patients must therefore at the least stamp every claim it submits to the plan so as to provide clear and explicit notice that the patient has not been billed for the full, OON-level cost share. Sending periodic

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general notices of the discounts to the plans is also advisable. One large national administrator/insurer in particular has challenged charging OON patients less than required by their benefits plans, which it dubs "fee-forgiving," and it is hard to imagine given current trends in the industry that any plan will routinely pay providers at the full benefits level upon receiving claims informing them that the patient has not been held to his or her expected cost-share burden for accessing OON care.

Another issue related to patient cost shares for OON providers, separate and apart from offering discounts on cost sharing, is the degree to which the providers in fact collect the out-of-pocket payments from the patients. Plans have taken the position in some cases that they will not pay an OON provider until it demonstrates, through showing a credit card receipt or cancelled check, that it has actually collected the full OON cost share from the patient. Generally, however, courts have found that an OON provider must demonstrate that it has made *a good faith effort* to collect, or at least has not waived the patient obligation to pay, the cost-share payment as a prerequisite to the provider compelling the plan to make payment on assignment.[14] Accordingly, providers are well served to legally obligate the patient to incur the cost-share debt and to invoice the patient at least three times.

Finally, plans have also argued that OON providers must successfully balance bill patients before those providers can seek to compel payment on assignment by the plans. We are not aware of any court that has imposed a duty on an OON provider to balance bill a patient, much less show actual collection of that full balance bill amount, as a prerequisite to the plan being required to meet its obligation to pay validly assigned benefits to the provider.

Provider Interaction with the Plan/Administrator

Once an OON provider has laid the groundwork discussed above for getting paid by the plan, rendered the health care service, and timely submitted a clean reimbursement claim, what can and should it do if the plan denies or underpays the claim? The best practical course may well turn on: (1) the amount of payment at stake; (2) whether this is an isolated denial/underpayment or part of an ongoing pattern by the same entity; (3) the importance of the plan (or third-party administrator) at issue to the provider's overall payor mix, including whether the provider wishes to, and has a realistic chance of, joining the plan's network at acceptable rates; and/or (4) whether the provider wants to, or believes it can successfully, balance bill the patient. If the foregoing factors dictate further action by the provider, there are numerous and interrelated issues to consider. Some of the key ones are discussed below.

Claim Denials

If the plan denied payment altogether, what was its basis for doing so? There is by definition no services agreement between the parties in this OON context, so the basis for the plan's refusal to pay cannot be a violation of contract terms. Most likely, the plan has taken the position that the claim—or perhaps the supporting documentation for the claim, if the plan requested and was furnished with that documentation—fails to comply with the plan's payment policies and procedures, or possibly that the plan did not cover the patient on the date of service.

While lack of coverage would seem to be an unassailable denial rationale, the extent to which a plan can deny an OON claim based on its own policies and procedures is open to some debate. OON providers often argue that they have not signed up to follow the plan's rules for payment; the plans counter that to the contrary, if the provider chooses to accept one of the plan's members as a patient, the provider has thereby accepted the fact that it will only get paid if it does indeed abide by those rules. As is often the case, the reality is likely somewhere in between.

On the one hand, there can be little doubt that certain basic plan requirements—like that the provider must have been adequately qualified to provide treatment, the care must have been medically necessary, and the provider must have obtained any mandatory prior authorization for certain elective services—will withstand any legal challenge by the provider. On the other hand, recent case law makes clear that a plan cannot count on the courts to enforce third-party administrator rules, especially against an OON provider that has not specifically agreed to follow them, that contravene accepted treatment standards and perhaps even applicable law (such as whether someone with a particular license can render a particular service).[15]

In the case of a dispute between an OON provider and plan . . . there will of course be no general network agreement and thus no such agreement to arbitrate. To put itself in the strongest possible legal situation, the OON provider should nonetheless still avail itself of any available internal appeals.

Underpayments

If the plan does make payment, the question remains whether the amount it paid was correct. As noted above, the plan's obligation pursuant to the assignment of benefits executed by the patient is to pay the OON provider the allowable amount set by the patient's health benefits plan minus the OON-level cost-share payments owed to the provider by the patient. There is no way definitively to know the correct allowable amount without reviewing the member's policy, which is typically not available to the provider. Plans use various metrics to set these benefit levels, however, including based on: (1) the "usual and customary" payment made to providers of the same type for the same service in the same relevant geographic area; (2) a common reference figure, like, for example, 120% of what the Medicare fee-for-service program would have paid for the service; or (3) some other objective standard, such as a percentage of the provider's billed charges.

As discussed above, moreover, the allowable amount for the OON service may in certain cases be subject to adjustment based on a contract other than a network agreement. One common such arrangement is a single case agreement entered into by the provider and the plan, in which the parties agree to a specific payment unique to the one member and episode of care at issue. Another arrangement of this type is when there are two related contracts between the OON provider, the plan, and a repricing entity like MultiPlan. In those cases, both the OON provider and the plan will have entered into separate contracts with the repricing entity. Pursuant to its contract, the OON provider agrees to accept rates set by its agreement as payment in full from those plans that likewise choose to contract with the repricing entity, and choose to pay specific claims under its terms, and the provider further agrees not to balance bill the patient. The plans that choose to contract with the repricing entity, in turn, agree to pay the agreed-upon rates to the "participating providers," usually within a timeframe set by the contract, and to implement some mechanism by which the OON providers can identify members of eligible plans. That mechanism could be including the repricing entity's logo on the relevant plans' members' health insurance cards and/or agreeing to be included on a formal listing of plans contracted with the entity that is incorporated into the contracts between the entity and the OON providers.

Other Applicable Law

Various other laws may apply to reimbursement disputes between OON providers and plans. At least with respect to claims for members of fully insured plans, which are clearly subject to state regulation, for example, state law will likely set a prompt pay period by which remittance must be made on clean claims and plans must pay a mandated rate of interest if they fail to make timely payment. Similarly, state statutory and regulatory schemes often limit the amount of time after paying a claim that a plan can change its mind and demand a refund, on the ground that it has come to believe that it made a mistake in paying the claim.[16] A disputed claim might also involve a situation in which the patient was referred to the OON provider for an elective service by a network provider, which could implicate state law regarding notice to which the patient is entitled of the added financial burden he or she will likely face by getting care outside of the plan's network.[17] The referring provider's network contract, moreover, may well include its own terms limiting that provider's right to make referrals to OON entities. Finally, a growing number of states have passed so-called surprise billing laws, which restrict to various degrees the amount an OON provider can charge a patient in certain situations—such as cases in which the OON provider is a physician treating the patient in a facility that is in-network with the patient's plan.[18]

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Bringing an Action to Compel Payment

Commercial network contracts usually spell out a staged process for alternative resolution of reimbursement disputes. Initially, upon receiving what the network provider believes to be an improper denial or underpayment, it is typically contractually bound to follow the internal appeals process adopted by the third-party administrator that administers the plan, probably pursuant to a state law requirement that the administrator offer such a process. Most likely, this will involve one or two stages of consideration by reviewers retained by the plan. If the network provider is not satisfied with the outcome of that appeals process, the provider must then give formal notice of its desire to further contest the decision and meet with the administrator to seek a negotiated resolution. If that effort is likewise unsuccessful, the provider may then notice a binding arbitration. More often than not, the network contract will dictate the use of a particular arbitration service, such as the American Arbitration Association, the American Health Law Association's Dispute Resolution Service, or JAMS, for this purpose.

In the case of a dispute between an OON provider and plan, by contrast, there will of course be no general network agreement and thus no such agreement to arbitrate. To put itself in the strongest possible legal situation, the OON provider should nonetheless still avail itself of any available internal appeals. If not, the administrator may prevail in any subsequent court

proceeding based upon an assertion that the provider failed to exhaust its available administrative remedies.[19] If, and when, the internal appeals taken by the OON provider prove unsuccessful, its remaining option is to bring suit. The defendant in that action will most likely be the administrator, as opposed to the individual plan. To be sure, if the patient is a member of a self-funded plan, the plan itself is technically also a real party in interest, and the administrator may well argue that the payment is owed by the plan alone. Then again, it was the administrator that made the decision to deny or underpay the claim at issue, and the damage to the provider caused by that action is in fact the very same amount the plan should have paid.[20]

The many potential litigation issues and strategies that may arise in a suit by an OON provider to compel payment by a third-party payor are outside of the scope of this article. In concluding this analysis, however, we note one more key defensive tactic (in addition to the provider's failure to exhaust administrative remedies) a plan may assert and identify some of the causes of action a provider may plead in this kind of case.

The key defense is for the plan to invoke complete preemption or conflict preemption under the federal ERISA statute. Under the former doctrine, certain causes of action, no matter how they are pled, are necessarily federal in nature and thus removable to federal court.[21] Relevant to this discussion, the U.S. Supreme Court has found that if a health plan member could have brought his or her claim against a plan under ERISA Section 502(a)(1)(B), and where there is no other legal independent duty that is implicated by the plan's action, then the member's cause of action is completely preempted by ERISA.[22] If so, no matter how the member (or the provider acting as the member's assignee) has framed the complaint, the plan can overcome any effort by the plaintiff to remand the case to state court and force it to be tried in federal court instead. A plan can also assert conflict preemption, if it can demonstrate that a state law claim asserted by the member "relates to" an ERISA plan under the express preemption language in ERISA Section 514(a). A state law claim relates to an ERISA plan whenever it has "a connection with or reference to such a plan."[23] Unlike complete preemption, conflict preemption does not allow the defendant plan to move a case brought in state court to federal court. A successful assertion of conflict preemption, however, does deprive the plaintiff of the opportunity to assert a violation of state law and, as a practical matter, requires the plaintiff instead to make the often difficult case that the plan's denial of benefits was arbitrary and capricious.[24]

The causes of action an OON provider may seek to prove include ERISA violations and various state law theories. With respect to federal law, the OON provider could allege that the third-party administrator/plan violated ERISA Sections 502 & 503, codified at 29 U.S.C. Sections 1132 & 1133. State law theories may include unjust enrichment, quantum meruit, breach of an implied-in-fact contract, breach of contract, and violations of potentially applicable prompt payment, consumer protection, deceptive trade practices, and insurance claim processing laws. A breach of contract claim, finally, could stem from an authorization or could be based on the contract of insurance between the member and the plan.

Conclusion

Payment for health care services is complex, and especially so when the services are rendered on an OON basis. For various reasons, however, almost all providers will end up rendering elective care to at least some, and maybe many, members of plans in which the providers do not participate. The provider will be OON with the plan perhaps because the plan chooses not to contract with the provider on any terms (and there is no state law compelling that the plan contract with "any willing provider") or because the plan and provider cannot come to agreement on mutually acceptable network rates. The members of the plan may likewise seek out the OON provider for any number of reasons, including its reputation as a provider of high-quality care.

In any event, navigating the revenue cycle of OON services takes planning, foresight, and follow up. To increase its chances of being paid the right amount by the plan, the provider should ensure that the patient properly assigns his or her benefits and takes financial responsibility for the treatment. The provider should likewise ensure that it bills the patient properly, noting among other things that the patient, while not a member of a network plan, may still be a member of a plan that participates in a repricing arrangement in which the provider is also active. Once the OON provider has ensured that it rendered, documented, coded, and billed the service properly, it must be prepared to address any improper denials and underpayments. In the OON context, the latter also requires understanding what the proper payment likely should have been. Finally, the provider is well served to promptly challenge any payments with which it does not agree through the appeals process offered by the plan's administrator. At best, this may lead to a reversal and payment of the claim. At the least, it preserves the provider's right to mount a later legal challenge—in court—to compel payment of any remaining amounts the plan may owe.

1 At least some of the same issues examined here also arise when providers seek payment from OON Medicare Advantage and Medicaid managed care organization plans, as opposed to purely commercial plans. Issues unique to OON payment by such privatized federal health care program plans, however, are generally beyond the scope of this article.

2 As discussed at various times in this article, the provider's primary interaction is actually with the third-party administrator that administers the health insurance plan, as opposed to with the plan itself. Because the interests and actions of those administrators and the plans they serve are typically aligned with respect to the issues under consideration here, we refer to the "plan" for simplicity's sake in some cases in which the entity actually undertaking the relevant conduct is in fact the administrator, acting on the plan's behalf.

3 *See, e.g., Conn. Gen. Life Ins. Co. v. Humble Surgical Hosp., LLC*, No. 4:13-cv-3291 (S.D. Tex. June 1, 2016), *rev'd in part, vacated in part, and remanded*, 878 F.3d 478 (5th Cir. 2017), *cert. denied*, 138 S.Ct. 2000 (May 14, 2018); *Aetna v. Bay Area Surgical Mgmt., LLC*, Case No. 1-12-cv-217943 (Santa Clara Super. Ct.); *Bay Area Surgical Management LLC v. Aetna Life Ins. Co.*, No. 15-cv-01416 (N.D. Cal. 2015); *Arapahoe Surgery Ctr., LLC v. Cigna Healthcare, Inc.* 171 F. Supp. 3d 1092 (D. Col. 2016); *Conn. Gen. Life Ins. Co. v. Advanced Surgery Ctr. of Bethesda LLC*, 201 U.S. Dist. LEXIS 91689 (D. Md. July 15, 2015).

4 *See, e.g., Am. Orthopedic & Sports Med. v. Independence Blue Cross Blue Shield*, 890 F.3d 445, 453 (3d Cir. 2018) (finding anti-assignment cause in ERISA plan enforceable); *McCulloch Orthopaedic Surgical Servs., PLLC v. Aetna Inc.*, 857 F.3d 141, 147 (2d Cir. 2017) (same); *Physicians Multispecialty Grp. v. Health Care Plan of Horton Homes, Inc.*, 371 F.3d 1291, 1295-96 (11th Cir. 2004) (same); *LeTourneau Lifelike Orthotics & Prosthetics, Inc. v. Wal-Mart Stores*, 298 F.3d 348, 352 (5th Cir. 2002) (same); *City of Hope Nat'l Med. Ctr. v. HealthPlus, Inc.*, 156 F.3d 223, 228-29 (1st Cir. 1998) (same); *St. Francis Reg'l Med. Ctr. v. Blue Cross & Blue Shield of Kan., Inc.*, 49 F.3d 1460, 1465 (10th Cir. 1995) (same); *Davidowitz v. Delta Dental Plan of Cal, Inc.*, 946 F.2d 1476, 1479-81(9th Cir. 1991) (same).

5 *See Am. Orthopedic*, 890 F.3d at 455 (rejecting the insurer's "contention that the presence here of a valid anti-assignment clause renders futile any remand for [the provider] to perfect its power of attorney" on behalf of the patient).

6 *See Trustmark Life Ins. Co. v. University of Chicago Hosps.*, 207 F.3d 876, 884 (7th Cir. 2000) (finding in favor of a provider that waived copayment amounts but still held the member "ultimately responsible for any outstanding balance not covered by insurance," in a dispute with the plan over its payment for the services at issue).

7 *See, e.g., HCA Health Servs. of Ga., Inc. v. Emplrs. Health Ins. Co.*, 240 F.3d 982 (11th Cir. 2001); *Mitchell v. Blue Cross Blue Shield of N.D.* 953 F.3d 529 (8th Cir. 2020); *Arapahoe Surgery Ctr. LLC v. Cigna Healthcare, Inc.*, 171 F. Supp. 3d 1092 (D. Colo. 2016).

8 *See e.g., Garcia v. Health Net of N.J., Inc.*, 2009 N.J. Super. Unpub. LEXIS 2858, at *10 (N.J. Super. Ct. App. Div. Nov. 17, 2009) (affirming a decision by a trial court on summary judgment in favor of a provider that did not collect cost-share amounts from plan members, noting that at the time the facility submitted its claims to the plan, the facility "did not know whether it would enforce the subscriber's agreement to pay co-insurance"); *Kennedy v. Conn. Gen. Life Ins. Co.*, 924 F.2d 698, 702 (7th Cir. 1991) (holding that provider must collect co-payments "or at least leave the patient legally responsible for them" in order to collect money from an insurer who requires patients to make cost-share payments); *see also Am. Fed'n of State v. Bristol-Myers Squibb Co.*, 948 F. Supp. 2d 338, 350 (S.D.N.Y. 2013) (citing *Kennedy* for the proposition that health insurers may create contracts that relieve them of the duty to pay providers who routinely waive co-pays); *Ctr. for Restorative Breast Surgery, LLC v. Blue Cross Blue Shield of La.,* 2016 U.S. Dist. LEXIS 143531, *28-29 (E.D. La. 2016); *Aetna Life Ins. Co. v. Huntingdon Valley Surgery Ctr.,* 703 Fed. Appx. 126, 132-33 (3d Cir. 2017) (non-binding).

9 This kind of problematic routine discount is legally distinct from the more generally accepted practice of providers offering selective and objectively measured financial assistance to a limited number of patients who demonstrate a legitimate need (e.g., by showing income and assets below some threshold, such as 150% of the federal poverty level).

10 42 U.S.C. § 1320a-7a(a)(5).

11 *See Eliminating Kickbacks in Recovery Act of 2018* (part of the *Substance Use-Disorder Prevention that Promotes Opioid and Treatment for Patients and Communities Act, a/k/a The Support Act*).

12 *See, e.g.*, Idaho Code § 41-348; Colo. Rev. Stat. § 18-13-119; Fla. Stat. Ann. 817.234(7); Tex. Ins. Code Ann. § 1204.055(b).

13 *See, e.g., Conn. Gen. Life Ins. Co. v. True View Surgery Ctr. One, LP*, 128 F. Supp. 3d 501 (D. Conn. 2015); *North Cypress Med. Ctr. Operating Co., Ltd. v. Aetna Life Ins. Co*., 898 F.3d 461 (5th Cir. 2018); *Aetna Life Ins. Co. v. Huntingdon Valley Surgery Ctr*., 703 Fed. Appx. 126 (3d Cir. 2017) (non-binding).

14 *See, e.g., Ctr. for Restorative Breast Surgery, LLC v. Blue Cross Blue Shield of La.,* 2016 U.S. Dist. LEXIS 143531, *22 (E.D. La. 2016); *Conn. Gen. Life Ins. Co. v. Elite Ctr. For Minimally Invasive Surgery LLC,* 2017 U.S. Dist. LEXIS 21026, *16 (S.D. Tex. 2017).

15 *See, e.g., Wit v. United Behavioral Health*, 2020 U.S. Dist. LEXIS 205435, at *79 (N.D. Ca. Nov. 3, 2020) (ordering that United reprocess "using proper criteria" claims for reimbursement for behavioral health services, including residential care for substance use disorder, that United had improperly denied by applying its own, internal guidelines that were inconsistent with the terms of the members' benefits plans).

16 *See, e.g.*, Ariz. Rev. Stat. § 20-3102(I) ("Except in cases of fraud, a health care insurer or contracted or noncontracted health care provider shall not adjust or request adjustment of the payment or denial of a claim more than one year after the health care insurer has paid or denied that claim.").

17 *See, e.g.*, Md. Code, Ins. § 14-205.3(d)(3) ("If a physician who is a nonpreferred provider [i.e., OON provider] seeks an assignment of benefits from an insured, the physician shall provide the following information to the insured, prior to performing a health care service: . . . (3) a statement informing the insured that the physician may charge the insured the balance bill for covered services").

18 *See Hoadley, J. et al. (Feb. 5, 2021), State Balance-Billing Protections,* The Commonwealth Fund (https://www.commonwealthfund.org/sites/default/files/2021-03/Hoadley_state_balance_billing_protections_table_02052021.pdf). At the federal level, Congress enacted the No Surprises Act in 2020, which prohibits balance billing without prior notice in certain situations, such as when patients receive services from OON providers in emergencies or when no in-network provider is available. The No Surprises Act goes into effect on January 1, 2022.

19 *See N. Cypress Med. Ctr. Operating Co. v. Cigna Healthcare*, 952 F. 3d 708 (5th Cir. 2020). One recognized exception to the exhaustion requirement is if the plaintiff provider can demonstrate that taking the appeals would have been futile or useless. *Rogers v. UnitedHealth Grp. Inc.*, 144 F. Supp. 3d 792 (D.S.C. 2015). Courts consider whether a plaintiff has demonstrated the requisite futility to overcome a failure to exhaust defense on a case-by-case basis. *Wilson v. UnitedHealthcare Ins. Co.,* No. 2:17-cv-03059-DCN; 2020 U.S. Dist. LEXIS 159054 (D.S.C. Sept. 1, 2020); *Shepherd v. Cmty. First Bank,* Civil Action No. 8:15-cv-04337-MGL; 2019 U.S. Dist. LEXIS 52475 (D.S.C. Feb. 24, 2017).

20 In the unlikely situation that the administrator instructed a self-funded plan to pay the claim at the amount sought by the OON provider and the plan refused to do so, the same defense by the administrator would have merit—i.e., the provider would be able to seek relief in court only from the plan itself.

21 *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 64-65 (1987).

22 *Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004).

23 *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983).

24 *Metropolitan Life Ins. Co. v. Glenn*, 559 U.S. 554, 105 (2008) (affirming an earlier ruling that if a plan document grants a plan administrator discretionary authority to interpret the terms of the plan, the administrator's decisions are entitled to an abuse of discretion standard of review).