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ERISA and hospital charges **granting an inch, not a mile**

The Employee Retirement Income Security Act of 1974 is a confusing part of the complex web of statutes, regulations, and case law that regulate the healthcare industry. The statute is regularly a subject of U.S. Supreme Court opinions that analyze the "preemption clause," "saving clause," and "deemer clause" to determine whether ERISA preempts a state law addressing health care. Over time, the Supreme Court has replaced a test it earlier developed for interpreting whether a state law was preempted by ERISA (*Kentucky Association of Health Plans, Inc. v. Miller*) and observed that "[t]he unhelpful drafting of these antiphonal clauses ... occupies a substantial share of this Court's time" (*Rush Prudential HMO, Inc. v. Moran*).

Into this fertile ground for confusion now come certain claims review "services" that cite ERISA as an authority allowing an ERISA plan administrator to reduce a hospital's billed charges. The argument is that because the ERISA plan states that the plan administrator has a duty to pay no more than "the reasonable value of services," or some such similar language, these plan documents, augmented by the mystery and complexity of the ERISA statute, give the ERISA plan the ability to reject "unreasonable" charges.

AT A GLANCE

Some claims review "services" have cited ERISA as an authority allowing an ERISA plan administrator to reduce a hospital's billed charges based on "the reasonable value of services." However, nothing in ERISA allows a plan administrator to change the terms of a contract between a payer and a provider, or places any limitations on the structure or price of hospital charges.

ERISA Governs Only ERISA Plans, Not Hospital Charges

To begin with, ERISA does not place any limitations on the structure or price of hospital charges. ERISA governs only ERISA plans and their administrators; it does not reach further (*Wadsworth v. Whaland*). For example, ERISA imposes only general fiduciary duties on a plan administrator to, among other things, "discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries" and "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims" (29 U.S.C. §1104). Indeed, the reference to "the circumstances then prevailing" speaks not to a supervening power to create yet another class of government payers who pay less than the cost of services, but to a duty to work within current market conditions.

ERISA Has Special Leverage Over Neither Contract Terms ...

Most services are provided under a contract between the provider and a payer. Nothing in ERISA allows a plan administrator to change the terms of a contract between a payer (with whom the plan contracts) and a provider. The ERISA statute does require the plan administrator to discharge its duties "in accordance with the documents and instruments governing the plan" (29 U.S.C. §1104). One common argument is that the plan documents' requirement that the administrator pay only for the reasonable value of health services gives the plan, or its contracting insurer, the right to reject charges or lower charge prices. However, a plan document may not amend the terms of an independent contract. If a provider contract truly contained "unreasonable rates," the arguable breach would be that of the administrator's fiduciary duty to its plan to contract for rates that it believes to be reasonable. The ERISA statute gives it no remedy to rewrite the contract.

ERISA's inability to breach provider contract rates is also shown by the case law that excludes contract rate disputes from the federal court jurisdiction of ERISA because these disputes are governed by contract law and thus decided either in state court or in arbitration. A provider seeking payment under a contract with an insurer who in turn contracts with an ERISA plan has its remedy under the terms of the contract instead of the ERISA statute. In *Blue Cross of California v. Anesthesia Care Associates Medical Group, Inc.*, the issue was whether the dispute over Blue Cross' unilateral changes to the rates in the contract between Blue Cross and the medical group were preempted by ERISA because the right to payment was based on an assignment from the plan beneficiaries to the medical group. The court held that they were not. "The dispute here is not over the right to payment, which might be said to depend on the patients' assignments to the Providers, but the amount, or level, of payment, which depends on the terms of the provider agreements" (*Blue Cross of California v. Anesthesia Care Associates Medical Group, Inc.*). Thus ERISA does not give an ERISA plan administrator any special leverage in challenging the amount that it should pay for hospital services under a contract.[a]

... Nor Noncontracted Services

If the services were provided to a beneficiary of an ERISA plan where the hospital does not have a contract with an insurer or with the plan, then the analysis of the amount owed is no different than it would be in the case of noncontracted services provided to anyone else. The most common occurrence of noncontracted services is, of course, emergency services. The legal rate of payment for noncontracted medical services is the reasonable value of the services under the legal doctrine of quantum meruit, also known as an implied-in-law contract (see, e.g., *Bell v. Blue Cross of California*).

The custom and usage in the healthcare industry is that noncontracted emergency services are paid at the hospital's full charges. As with any business, a hospital can make a profit by selling a higher volume of services at a lower margin per unit or a smaller volume of services at a higher margin per unit. Payers that want a discount "purchase" that discount by agreeing to direct a volume of services to the hospital. Simply because lesser amounts for the same services are accepted from commercial insurers or government programs does not mean that amounts charged by a hospital are unreasonable (*Huntington Hospital v. Abrandt*). And no court has ruled that a hospital's billed charges to a commercial payer are unreasonable because they include the expense of treating patients funded by government health programs that do not pay the full cost of care.[b]

Although most payers still pay full charges for emergency services, it has become fashionable among some payers in recent years to claim that a hospital's full charges are not the reasonable value of emergency services because most payers, either government programs or payers with a contract, do not pay them. This is nothing less than a payer's demand for a discount from the hospital that the payer does not

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a. Note, however, that the provider who seeks payment as the assignee of a plan beneficiary where no contract of insurance determines the amount of payment procedurally must pursue payment under ERISA as if it were the beneficiary. See *Misic v. Building Serv. Employees Health & Welfare Trust*, 789 F.2d 1374 (9th Cir. 1986).

b. See, e.g., *Methodist Medical Center of Illinois v. Taylor*, 489 N.E.2d 351 (1986) [The Social Security Act did not proscribe the hospital from shifting portion of cost of treating Medicare patients to commercial patients].