

# Out-of-network payments for ESRD care: The National Renal Alliance case

—James B. Riley, Jr. • Daniel Soldato

The National Renal Alliance (NRA), and several of the dialysis facilities that it owns and manages in Georgia, filed a lawsuit Feb. 15 in the United States District Court against Blue Cross and Blue Shield (BCBS) of Georgia, the largest health insurer in that state.

In its complaint, NRA accused BCBS of violating both federal and state laws and sought damages for BCBS's 88% reduction of its "usual, customary, and reasonable" reimbursement rates for dialysis treatments that had been performed out of network under several health plans.

NRA claimed that BCBS's reduction of reimbursement rates was substantially injuring both providers of dialysis services and patients with end-stage renal disease.

National Renal Alliance claimed that Blue Cross Blue Shield had breached its contractual duties to cover NRA's costs of treatments to certain ESRD patients.

The complaint stated that providers, such as NRA, were being hurt due to the unique reimbursement system for ESRD treatments under the Medicare program, which made providers rely on commercial insurance reimbursement to sustain their business. ESRD patients often select out-of-network providers because they are closer to their homes, easing the burden of travel to and from numerous treatments, and are staffed by doctors who have treated them continuously for ESRD. The complaint stated that ESRD patients were being injured because they were restricted from selecting out-of-network facilities at which to receive dialysis treatment, and BCBS's reduction in the reimbursement rate for out-of-network dialysis treatments posed a significant challenge to the dialysis industry and its patients.

Reimbursement for ESRD treatments is unique because it is the only disease for which Medicare is the primary payer (subject to the Medicare secondary payment regulations)

even when private health insurance is available to the patient. According to NRA's complaint, federal law required that private health insurers provide the same coverage for ESRD patients as they do for other insured persons without taking into account the ESRD patients' eligibility for Medicare benefits. NRA claimed that BCBS was violating this federal anti-discrimination law, 42 U.S.C. § 1395y(b)(1)(C), by specifically targeting their reimbursement rate reduction for ESRD treatments provided by out-of-network under PPO and POS plans. NRA also claimed that BCBS was violating Georgia's PPO Statute, designed to prohibit arrangements that "[h]ave an adverse effect on the availability or quality of services." Finally, NRA claimed that BCBS had breached its contractual duties to cover NRA's costs of treatments to certain ESRD patients.

## Legal history

In a past case, BCBS of Texas Inc. had successfully singled out ESRD patients for a reduction of commercial insurance coverage based on the fact that ESRD patients were covered by Medicare, despite the anti-discrimination provisions of the Medicare Secondary Payer Statute (MSP). In *BCBS of Texas Inc. v. Shalala*, 995 F.2d 70 (5th Cir. 1993), the court decided that the MSP Statute's anti-discrimination provision did not prevent BCBS of Texas from ceasing commercial insurance coverage for certain ESRD patients under a group health plan. This was due to a provision in the Consolidated Omnibus Budget Reconciliation Act (COBRA) that specifically stated that bridge health care coverage under COBRA could be stopped for a group health plan beneficiary, such as an ESRD patient, once that individual became eligible for Medicare. In the BCBS of Texas case, the commercial insurance company relied on specific statutory language allowing a reduction in coverage, which Congress had specifically authorized under COBRA. NRA has provided no possible statutory justification for this violation in its complaint as was provided in BCBS of Texas.

The complaint stated the PPO statute prohibits health plans from altering the amount of reimbursement as BCBS had done so as to have an adverse effect on the availability and quality of services (see O.C.G.A. § 33-30-23(b)(5)).

While no cases based on similar claims have been decided in the state of Georgia, the stated intent of the PPO statute is "to encourage health care cost containment while preserving



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quality of care by allowing health care insurers to enter into preferred provider arrangements” (see O.C.G.A. § 33-30-21). NRA’s complaint implied that BCBS had violated both of those principles of the statute and stated that those patients living in rural areas of Georgia would be forced to travel great distances in order to obtain dialysis treatments. NRA would no longer be able to serve this population in dialysis facilities close to their homes, which was previously the focus of its business.

NRA also claimed that BCBS had breached its contractual obligations to NRA as an assignee of some of the ESRD patients’ right to payments and as a third-party beneficiary of payments BCBS owed to some ESRD patients. NRA stated that it was an assignee of BCBS payments because many ESRD patients not covered under the Employee Retirement Income Security Act of 1974 (ERISA) had signed assignment of benefits forms designating NRA as assignee. BCBS PPO contracts stated that it would provide coverage for out-of-network providers, such as NRA, so NRA claimed that the failure to fully cover the costs of services due to the reduction in reimbursement was a breach of contract. NRA also claimed, as a third-party beneficiary of BCBS’s PPO contracts, that payment of only 12% of the usual and customary charges for out-of-network charges by BCBS constituted a breach of contract that had resulted in damages for NRA.

BCBS filed a motion to dismiss NRA’s amended complaint on March 6. At press time, the court had not ruled on the motion, in which BCBS focused its arguments on NRA’s claim regarding BCBS’s alleged violation of the MSP. BCBS argued that the MSP was designed to protect the finances of Medicare and not providers. The MSP contains a private right of action that BCBS argued was designed to preserve the “fiscal integrity” of Medicare. BCBS stated that because NRA’s complaint did not allege that Medicare incurred any additional costs, the claim arising under the MSP should be dismissed. In regard to NRA’s other claims,

BCBS stated that the claim arising under ERISA should be dismissed because NRA failed to exhaust its administrative remedies and because NRA failed to plead the requisite facts. BCBS also argued that the state law claims should be dismissed, *inter alia*, because they are preempted under ERISA.

NRA’s lawsuit against BCBS is not the first filed by dialysis suppliers in response to what the suppliers deem improper rate reductions for dialysis services. On April 24, 1990, the United States Court of Appeals for the District of Columbia Circuit decided that the case brought by the National Kidney Patients Association against the United States Department of Health and Human Services, and BCBS of Florida was moot because of an intervening change in

of National Kidney Patients Association because it concluded that National Kidney Patients Association was likely to succeed on its claims, including a claim that the modification of charges was arbitrary and capricious. It is worth noting, however, that the issues in the Sullivan case and in the complaint filed by NRA are distinguishable because of the fact that the Sullivan case involved Medicare reimbursement while the NRA complaint involves reimbursement by a commercial insurance company.

### Conclusion

The lawsuit filed by NRA against BCBS is significant for the ESRD community because there is increasing pressure on commercial insurance companies to pay for ESRD services. More commer-

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the applicable law. National Kidney Patients Ass’n v. Sullivan, 902 F.2d 51 (D.C. Cir. 1990) was filed by National Kidney Patients Association following the reduction of reimbursement rates for home dialysis suppliers by BCBS of Florida, a Medicare carrier responsible for establishing the rate of charges for Medicare services. BCBS of Florida had been given a directive from the Health Care Financing Administration (HCFA), the predecessor to the Centers for Medicare & Medicaid Services, to modify charges that were unreasonable. Pursuant to the directive, it reduced the home dialysis supplier charge, which it deemed unreasonable based on several factors, including a comparison to the charges for dialysis treatments in a clinic. The district court in the case issued a preliminary injunction in favor

of commercial insurance companies may choose to act similarly to BCBS in order to reduce reimbursement rates in a manner that is adverse to both ESRD service providers and ESRD patients. That could differentiate between the benefits the commercial insurer provides between individuals having ESRD and others enrolled in the plan, on the basis of the existence of ESRD. This will continue to be a significant issue due to provisions in the proposed Children’s Health and Medicare Protection (CHAMP) Act (HR 3162). It will put more pressure on commercial insurance companies by extending the coordination period during which commercial insurance is the primary payer for ESRD services, from 30 to 42 months, for those individuals who receive health insurance coverage through a large group health plan. **N**