

Court Finds ERISA Requires Disclosure of “Reasonable and Customary” Methodology

November 1, 2018

A federal district court in Michigan, in *Zack v. McLaren Health Advantage, Inc.*, recently considered whether the claims regulations under ERISA require an employer-sponsored group health plan to disclose its methodology for determining the “reasonable and customary” amount related to a benefit claim for services rendered to a plan participant by an out-of-network medical service provider, regardless of whether the participant requested such information. **Summary of the Case** The claimant, Zack, who was a participant in the group health plan sponsored by her husband’s employer, obtained medical services from an out-of-network provider and filed a benefits claim under the plan. The plan stated that out-of-network benefits would be paid at 60 percent of a “reasonable and customary amount”, but did not define what that term meant or how it would be calculated. In practice, the “reasonable and customary amount” under the plan (“**R&C Amount**”) was determined by calculating an *average* derived from various fees charged by the plan’s in-network providers for the same kind of procedure (the “**Methodology**”). The plan sponsor was the plan’s claims and appeal decision maker in this case and determined that Zack’s claim would be paid at 60 percent of the R&C Amount as calculated based on the Methodology; however, the plan sponsor did not disclose the Methodology in its claim determination notice to Zack. Zack then challenged the plan sponsor’s calculation of the R&C Amount on appeal under the plan. The plan sponsor upheld its original decision on the claim but did not directly address Zack’s challenge regarding the R&C Amount or disclose the Methodology in its appeal determination notice sent to Zack. Thereafter, Zack filed suit against the plan sponsor. The court noted that Zack never requested a description of the Methodology from the plan sponsor but, even so, held that where a plan participant specifically challenges the calculation of the R&C Amount for reimbursement, ERISA requires disclosure of the methodology applied as part of the plan sponsor benefit and appeal denial in order to provide a “full and fair review” of the claim as mandated by ERISA. The court further found that because the plan failed to provide a definition of the R&C Amount, and also offered no explanation of the meaning of this term during the benefit or appeal process, the plan sponsor’s denial of the benefit claim on appeal based on its undisclosed interpretation was “arbitrary and capricious” under ERISA’s standards. The court remanded the benefits claim back to the plan sponsor, ordering that the plain meaning of the term “reasonable and customary amount” (*i.e.*, the prevailing market rate generally charged for the service in the relevant geographic area) be used by the plan sponsor in performing a full and fair review of Zack’s claim. **Practice Tips for Group Health Plan Sponsors** *Zack* is controlling only in the jurisdiction of the federal district court in Michigan that issued the opinion. However, this case highlights several general tips that group health plan sponsors should consider:

- Plan documents and summary plan descriptions should be carefully reviewed and revised as needed to ensure that key terms, such as “reasonable and customary amount”, “allowable amount”, and similar terms that determine the basis for benefit payments are clearly and accurately defined (including, as appropriate, references to any applicable methodologies).
- The plan sponsor should confirm that any third-party claims administrator is processing claims in a reasonable manner and using methodologies that are consistent with the terms of

the official plan document and summary plan description (including definitions of key terms).

- The plan sponsor should confirm that the plan's decision maker is issuing claim determination notifications that contain the information required by ERISA's claims review and appeal regulations (including, as appropriate, any methodologies, internal guidelines, or similar criteria that were relied upon by the decision maker in making the claim or appeal determination).

Zack v. McLaren Health Advantage, Inc., No. 17-11253 (E.D. Mich. Sept. 20, 2018).