

# What to Do When You Receive an Out-of-Network Shakedown Letter

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**PRACTICES** Employee Benefits and Executive Compensation

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Your daily routine is interrupted when the mailroom clerk drops a thick certified mail envelope on your desk. Inside that envelope is a dense, rambling and threatening 20-page demand letter from an attorney. The letter appears to be challenging the denial of a benefits claim under your company's group health plan. The amount claimed to be owed by the plan is wildly inflated compared to the value of the medical services and supplies that were actually or allegedly provided.

The demand letter contains a document signed by the health plan participant that purports to assign to an out-of-network medical provider the participant's benefits and legal rights, and also to appoint the out-of-network provider as the participant's "authorized representative" and "assignee" under the Employee Retirement Income Security Act (ERISA) and the plan.

The demand letter says that your "usual and customary rates" for paying out-of-network claims are invalid. With a generous sprinkling of boldface, underlines and ALL CAPS, the barely coherent demand letter purports to back up its spurious claims with a hodgepodge of sources, such as newspaper articles, lawsuits in faraway places and a 2008 investigation by the New York attorney general.

Situations like this have become all too common under employer-sponsored group health plans. A physician-owned, out-of-network health care service provider — such as an ambulatory surgery center or a sleep center — sends a demand letter to the plan administrator. The letter asserts an appeal of a denied benefits claim by one of the plan's participants; requests copies of a lengthy list of plan-related documents; and alleges that the plan administrator, the plan sponsor, the plan's third-party claims administrator, the insurance carrier and/or the plan itself have violated ERISA and other federal or state laws relating to plan administration or the participant's benefits claim.

Often, there is evidence that the out-of-network provider has waived some or all of the participant's portion of the charges otherwise payable for the health care services received, such as a waiver or reduction of the participant's required cost-sharing amount under the terms of the plan for deductibles, co-pays and co-insurance pertaining to the covered services.

What should you do when you receive this kind of shakedown letter? And more importantly, what should you be doing to avoid getting a letter like this in the first place?

Excerpted from *HR Magazine*. To read the full article, click [here](#).