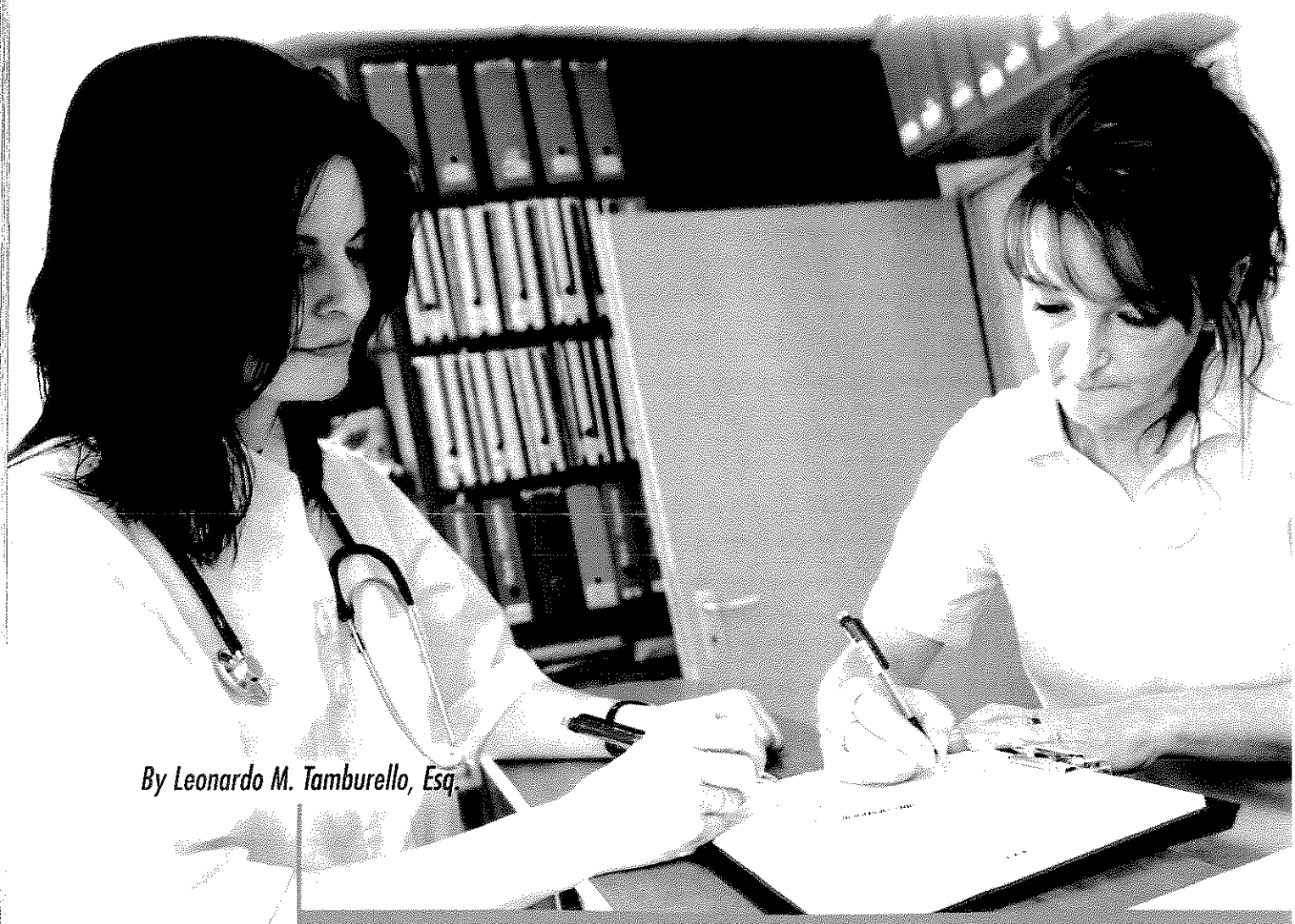

By Leonardo M. Tamburello, Esq.

DANGERS

ABOUND FOR OUT-OF-NETWORK PROVIDERS WHO ROUTINELY WAIVE COINSURANCE

Increasingly, New Jersey healthcare providers are accepting out-of-network insurance reimbursement as "payment in full" for services provided. From a patient perspective, relief from coinsurance responsibility has an obvious benefit. However, from the payer point of view, providers who do not collect coinsurance from patients threaten to undermine basic economic assumptions embedded in the health insurance business paradigms. The payer response has been to bring lawsuits against out-of-network providers who engage in such practices.

Thus far, a variety of courts have sided with payers in these disputes. A particularly virulent strain of similar litigation has recently appeared in New Jersey. Taking advantage of this state's powerful anti-insurance fraud statutes, payers have characterized such providers who routinely waive the collection of coinsurance amounts as perpetrators of insurance fraud. This has serious implications for all practitioners who see out-of-network patients.

THE OUT-OF-NETWORK MODEL

The prevailing payer-created model controls costs first by channeling members to in-network providers with whom the payer has negotiated a favorable rate. Copayments charged to members for obtaining treatment from non-participating, out-of-network providers act as financial disincentives to see such "non-preferred providers." Members who are successfully channeled to in-network services are also discouraged from "over" utilization through the use of deductibles that are set up on a per-visit and/or per-year basis as a secondary cost-containment barrier. Typically, for an out-of-network claim, the payer covers a percentage of the provider's "usual and customary" rate, and the member is responsible for the balance.

Courts outside New Jersey have generally agreed with arguments advanced by payers that out-of-network providers cannot routinely waive coinsurance. In 1991, a federal court observed that non-preferred providers who seek to increase their business by promising to waive coinsurance payments, although a boon to patients, "annul the benefits of the copayment system."[1] The "benefits" the court was referring to, of course, apply mostly to the payers who set up the system in the first place.

An illustrative case is one in which an out-of-network chiropractor waived coinsurance payments and started a lawsuit action against an insurance company that refused to pay anything based on his waiver of coinsurance. The court observed that, in light of the contradictory nature of the patient-payer and patient-provider contracts, the provider's promise to eliminate copayments was unenforceable if the provider wished to be paid anything from the insurance company for his services. These copayments are required, in the court's view, "to maintain incentives that hold down the cost of medical care."[2] Even though the provider never agreed to honor the terms of any participation agreement, he was compelled to capitulate to its terms.

From a legal perspective, it is astounding for the court to subjugate a non-participating provider to the payer's economic model with no regard for the fact that there is no contract between the two. The court was able to make this leap, it says, based "not on formal logic, but on the function of the two contracts" between the provider-patient and payer-patient.[3] In essence, the court acknowledged that, without the compulsory collection of coinsurance for strangers to the provider-patient relationship, the payer-created paradigm of incentives and "benefits" ceases to function when the disincentive to going out of network is removed.

Payers claim that providers who accept insurance company payments as "payment in full" must disclose this policy, not only to the patient but to the payer as well. Failing to do so can lead to overcharging insurance companies because a typical policy covers only 80 percent of an out-of-network provider's "usual, customary and reasonable" charge. If a provider's stated charge is $100 but he or she accepts an $80 insurance payment as full remuneration, the actual charge is only $80, for which payers argue they should have to pay only $64.

In *Feiler v. New Jersey Dental Association*, a New Jersey dentist's competitors sued after he made it known that he discounted services by not collecting copayments from patients.[4] A court found that the dentist made "untrue," but not necessarily fraudulent, statements to insurance companies regarding his usual and customary fee.[5] Also, according to payers and the courts, "[w]hen a provider routinely waives copayments, a fee stated at 80 percent of the charge is a phantom number."[6] For such providers, the full "customary remuneration" for such services is not the amount billed, but some lower percentage of the charge, leaving the insurer obligated to pay only a fraction of that lower amount.[7]

At the time that the *Feiler* case was decided in 1984, a provider who allegedly misstated charges to a payer was subject to a civil lawsuit in which damages were most likely limited to the amount in dispute. Payers therefore had to weigh the economic cost of a lawsuit in terms of their potential recovery multiplied by the probability of ultimate success. This calculation was altered in favor of the payers when the Legislature enacted the Insurance Fraud Prevention Act (IFPA).

THE INSURANCE FRAUD PREVENTION ACT

The IFPA statute is designed to interdict a broad range of fraudulent conduct and, up until recently, was most commonly used by insurance companies to combat fraud and abuse in the area of No-Fault Personal Injury Protection (PIP) benefits resulting from auto accidents.[8] From this arena, there is a well-developed body of law concerning the statute that can be directly applied to suits against practitioners for failing to collect coinsurance. Insurance companies have, with recent frequency, brought the IFPA to bear against providers who routinely do not collect coinsurance payments.[9]

A "person or practitioner" violates the IFPA if that person presents or "cause[s] to be presented" a claim for payment knowing that it contains "any false or misleading information" that is material to the claim.[10] The Act may also be violated by concealing, or knowingly failing to disclose, any information concerning the initial or continued right or entitlement to a benefit; presenting any knowingly false or misleading statement in an insurance application; or knowingly assisting, conspiring with, or urging any person or practitioner to violate any of the Act's provisions.[11]

Unlike other types of fraud that require the heightened proof of "clear and convincing" evidence, violations of the IFPA can be found upon a mere preponderance of the evidence, which is proof that the allegations were simply more likely than not.[12]

A successful IFPA prosecution is like an insurance company winning the lottery. An insurance company that prevails under the Act may recover compensatory damages, reasonable investigation costs and legal fees. Triple damages are mandatory against defendants who engage in a "pattern of violations" (defined as five or more violations involving the same victim or same or similar actions), as are civil penalties paid to the attorney general, along with investigative costs and counsel fees incurred by the state.[13] A violation of the IFPA may also lead to proceedings by a licensing body against one's professional license based upon acts of false promise, false pretense or professional misconduct.[14] Because of the extraordinary risk involved, providers who believe they may be subject to an IFPA claim, regardless of whether or not they believe that such a claim has merit, should immediately consult with experienced counsel regarding the situation.

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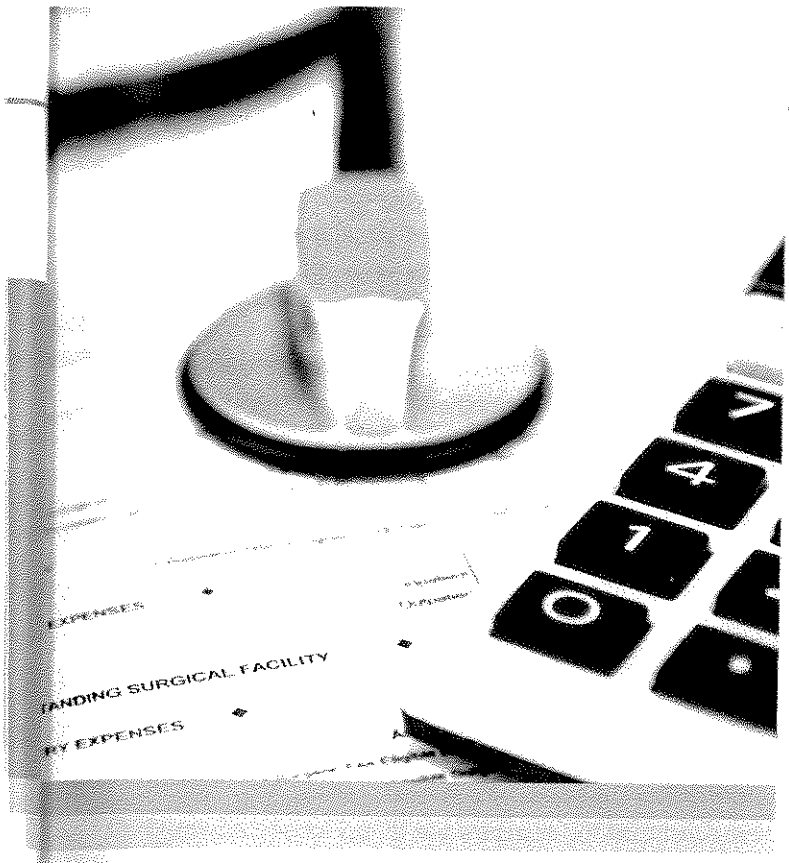
Providers may also be surprised to learn that most commercial general liability and "errors and omissions" policies specifically exclude any defense or indemnity coverage for fraud-based conduct.[15] Therefore, a provider may have to directly and/or personally absorb the costs of defense as well as that of any settlement or judgment in an IFPA case.

PREVENTIVE MEASURES MINIMIZE IFPA LITIGATION

Once suit is filed, the defense of an IFPA case must always take into account that protracted litigation brings with it the possibility that, because of the broad categories of damages available, any finding of liability will result in an award against the provider that is many times greater than the amount of the alleged fraud. Even the strongest defense to an IFPA claim can be frustrated and undermined by the sheer amount of financial and investigative resources available to institutional insurers.



In addition, discovery of the details regarding alleged insurance fraud is often thwarted by regulations that permit insurers to utilize, but not disclose, certain "special investigative unit" reports that are "confidential and privileged against disclosure."[16] Although a motion can be brought in an attempt to compel production of these materials, such a motion guarantees only additional defense costs, not results.

Because of the intense costs and extraordinary exposure involved in defending IFPA actions, whenever possible, proactive, preventative compliance measures that minimize IFPA exposure altogether are preferred. Practices that provide out-of-network services should establish an official, standardized procedure for the billing and attempted collection of coinsurance amounts from patients. Office staff or third-party billing services should be instructed in and be compelled to follow this procedure, even if ultimately no coinsurance amounts are collected. Although it cannot be known with certainty the precise nature or amount of effort required to achieve compliance, recent developments demonstrate that apathy or neglect in collection of coinsurance may lead to IFPA accusations and liability.

IFPA CASE STUDIES

In the past, providers who openly waived coinsurance, such as the dentist in the *Feiler* case, were exposed to a "mere" civil lawsuit. Today, practitioners must contend with the far more serious potential penalties under the IFPA. As the most powerful anti-fraud weapon in the insurance industry's arsenal, lately it has been deployed against individual practitioners and large institutions alike.

In 2006, Aetna Health sued an out-of-network provider, Carabasi Chiropractic Center, Inc., for, among other things, leaving blank the "amount paid" and "balance due" boxes on claims forms.[17] Aetna Health argued that this was tantamount to failing to disclose a coinsurance waiver, which resulted in overstatements of the total charges.[18] According to Aetna Health, this was done "to encourage over-utilization of services by insureds and to bill [Aetna Health] for amounts in excess of those actually charged to the patient."[19]

As a result of this and other supposed conduct, Aetna Health alleged violations of the IFPA, along with other legal theories of recovery including common law fraud, negligent misrepresentation, unjust enrichment and tortious interference.[20] Although the case was initially dismissed, the claims of insurance fraud, common law fraud and tortious interference were reinstated on appeal. Concerning the IFPA, the Appellate Division concluded that if Aetna Health actually relied upon the boxes left blank for "amount paid" and "balance due," then such conduct would be enough to sustain liability for insurance and common-law fraud.[21] This begs the question of whether, and to what extent, payers actually calculate their out-of-network reimbursement rates based upon invoices for services from providers.

Aetna Health also alleged that Carabasi, although an out-of-network provider, knew of contractual provisions between Aetna Health and its subscribers that required payment of a fixed percentage of the costs of services, with the balance being paid by the individual. Aetna Health, therefore, claimed that Carabasi's actions "tortiously interfered" with its subscriber contracts by "intentionally, in bad faith and without justification" waiving coinsurance payments "in order to access information, to encourage overutilization of services by the insureds and to bill for amounts in excess of those actually charged to the patients." Since payer contracts were designed to deter patients from receiving excessive treatment and using nonparticipating providers, Aetna Health claimed it was damaged as a result of this interference by Carabasi, which caused overutilization of services.[22]

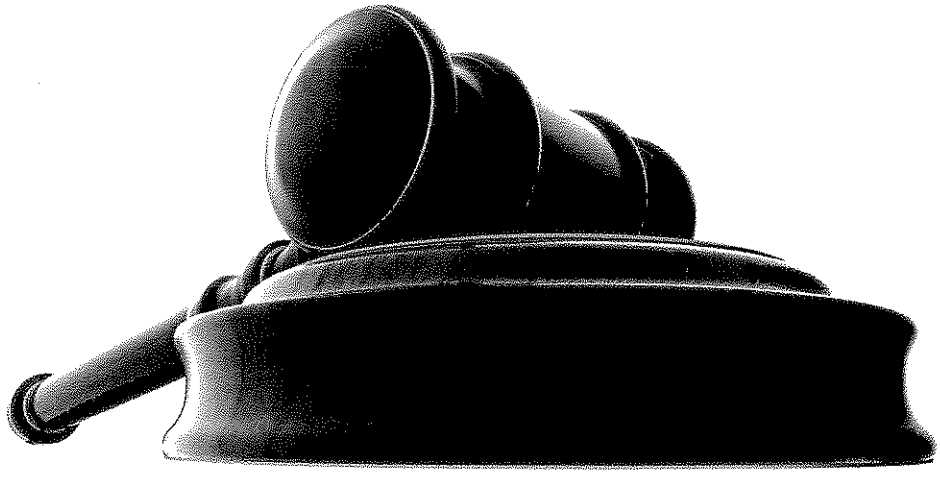
In another recent matter of *Garcia v. Health Net*, a Bergen County trial court judge held that it was *not* a violation of the IFPA or any other law for an ambulatory surgical center to not collect coinsurance from its out-of-network patients.[23] Although this decision has galvanized, and in some instances, emboldened, providers concerning waiver of coinsurance collection, it should not be given any authoritative weight. As an unpublished decision of a trial-level court, it has no binding precedential effect. Until an appellate tribunal speaks in a published decision, other courts considering this same issue may reach a different conclusion, regardless of this opinion.

The *Garcia* case notwithstanding, practitioners who do not collect coinsurance payments from out-of-network patients should understand the reality that such practices may be held to violate the IFPA. Indeed, *Garcia* may set a trap for unwary practitioners who mistakenly believe that this decision will shield them from such accusations or liability.

There is no panacea against increasingly common lawsuits alleging IFPA violations brought by insurance companies against providers who decide, as a matter of formal or de facto policy, not to collect coinsurance from out-of-network patients. To the contrary, as recently as May 2009, Horizon Blue Cross and Blue Shield of New Jersey (Horizon BCBSNJ) filed suit against Bayonne Medical Center, alleging that, among other things, it fraudulently induced Horizon subscribers to use the hospital "by waiving their liability for out-of-pocket costs and then presenting Horizon with phony, inflated bills."[24] Another similar suit has also recently been filed by Horizon BCBSNJ against Newton Memorial Hospital.[25]

There is an unanswered question in all of these cases: Under what circumstances is it permissible for a provider to "write off" or forgive balances? There are no New Jersey cases dealing with this issue. Providers who waive coinsurance on financial hardship grounds may be protected under a federal case in which an insured was denied a precertification request based on medical necessity grounds for specialized breast cancer treatment. The insured filed suit against her carrier and won an order to block the denial of benefits.[26] When the patient was admitted to the hospital, she signed an "Out-Patient Agreement and Authorization," which stated that she understood that she was financially responsible for the care, and that if her insurance failed to pay any amount due, she would be responsible for the balance.[27] Later, when the patient told the hospital she was unable to meet her copayment and deductible obligations, the hospital agreed to waive them.[28] As a result, the carrier sued the hospital for a refund of benefits the insurance company had paid, arguing that the hospital's waiver of copayments and deductibles voided the insurance coverage contract.[29]

In line with other cases, the Court of Appeals called



the routine practice of waiving copayments prior to services an "ongoing scheme of fraud by waiving the copayment but raising the fee." The court nevertheless sided with the patient in this case because the hospital had a legal right to seek the full balance not covered by insurance from the patient, but simply elected not to do so.[30]

While there may be significant differences between a general practice of not collecting coinsurance payments and an individualized finding of financial hardship resulting in a decision not to pursue payment in a particular case, it is not clear if these situations would be treated differently under the IFPA in the eyes of the insurance companies. Presumably, the latter are permissible to the extent they do not prejudice the insurer's incentives to keep members in-network and from overutilization of resources. If this is correct, then the rule could be that a provider may not incentivize patients by offering to waive coinsurance in advance, but a provider's "non-pursuit" of coinsurance is not per se unlawful.[31] This raises the issue of what effort must be made to collect coinsurance payments before "writing it off" becomes an impermissible waiver of coinsurance. Left open is the question of whether sending out one invoice or three is sufficient, or whether a collection suit must be instituted to meet this apparent "safe harbor."

LEGISLATION OUTSIDE NEW JERSEY

Although there is no New Jersey statute or regulation that explicitly prohibits an out-of-network provider from waiving or not collecting coinsurance payments,[32] making collection decisions based on this lack of regulation turns every invoice submitted to an insurance company into a game of Russian roulette. It would not, therefore, be surprising to see New Jersey join the cadre of other states that have outlawed this practice altogether.

In California, neither a health service plan nor a provider may "waive any right conferred upon the provider or any obligation imposed upon the plan relating to claims processing or payment."[33] Colorado makes the "regular business practice" of waiving copayments or deductibles an illegal abuse of health insurance. Such activity is considered a "regular business practice" if a provider waives more than 25 percent of copayments or deductibles during any calendar year or advertises its intent to do so.[34]

In Ohio, physicians are prohibited from waiving deductibles or copayments if the waiver is used to entice patients to receive services from the physician, unless the health benefit plan allows such a practice and waiver is done with the plan's full knowledge and consent.[35] In Connecticut, the waiver of a copayment or deductible may constitute as fraud under the state's Health Insurance Fraud Act.[36] Similarly in Florida, a non-hospital provider's "general business practice" of waiving copayments and deductibles "is a material omission and insurance fraud... if such provider has agreed with the patient or intends to waive deductibles or copayments, or does not for any other reason intend to collect the total amount of such charge."[37]

Out of step with these jurisdictions, New York takes an extremely passive approach to the issue of waiving deductibles or copayments. The state goes so far as to allow practitioners to advertise that they accept insurance as "payment in full" for services and to assert that such practices are not ipso facto barred by participation agreements with providers.[38] In fact, a New York physician who advertised that he accepted insurance reimbursement as "payment in full" was found to have forfeited the right to balance bill patients for the remainder, without any effect on the physician's entitlement to receive payment from the insurer.[39] Practices that span the Hudson River may, therefore, find that what is a matter of routine in New York creates exposure to claims under the IFPA in New Jersey.

Payer lawsuits alleging violations of the IFPA are being brought with increasing frequency. New Jersey providers who openly waive coinsurance collection for performance of out-of-network services create inviting targets for allegations of insurance fraud. Providers who do not have mechanisms in place to insure follow-up and at least attempt collection of coinsurance may face similar exposure if confronted by a particularly irascible payer. Defending such allegations is a challenging and expensive proposition that, if unsuccessful, can result in far-reaching consequences, well beyond the amount reflected in the allegedly fraudulent submission.

Leonardo M. Tamburello, JD, is a partner with Kalison, McBride, Jackson & Hetzel, P.C., in Warren, New Jersey, and a former Law Clerk to the Honorable Donald G. Collester, Jr., JAD. The majority of Mr. Tamburello's practice is devoted to representing healthcare providers in various types of litigation, including professional liability defense, claims disputes and arbitrations.

[1] *Kennedy v. Connecticut General Life Ins. Co.*, 924 F.2d 698, 699 (7th Cir. 1991).

[2] *Id.* at 702.

[3] *Ibid.*

[4] *Feiler v. New Jersey Dental Association*, 191 N.J. Super. 426, 436-37 (Ch. Div. 1983), *aff'd*, 199 N.J. Super. 363 (App. Div.), *certif. denied*, 99 N.J. 162 (1984).

[5] *Feiler*, 191 N.J. Super. at 43, 8-440.

[6] *Id.* at 699.

[7] *Id.* at 701.

[8] N.J.S.A. 17:33A-7. *See also, Material Damage Adjustment Corp. v. Open MRI of Fairview*, 352 N.J. Super. 216, 232 (Law Div. 2002).

[9] *E.g., Aetna Health, Inc. v. Carabasi Chiropractic Center, Inc.* Docket No. A-3 1 85-04TI (decided January 13, 2006); *Horizon Blue Cross and Blue Shield of New Jersey v. IJKG, LLC, et al*, Docket No. ESX-C-125-09 (filed May 13, 2009 in the Superior Court of New Jersey, Chancery Division, Essex County).

[10] N.J.S.A. 17:33A-4(a)(1).

[11] N.J.S.A. 17:33A-4(a)(3); -4(a)(4)(b); -4(a)(5)(b).

[12] *Liberty Mutual Ins. Co. v. Land*, 186 N.J. 163, 181 (2006). *See also Hille & Jackson*, Lowered Burden for Fraud Claims, 185 N.J.L.J. 78 (2006).

[13] N.J.S.A. 17:33A-3; N.J.S.A. 17:33A-7.

[14] N.J.S.A. 45:1-21(b) and -21(e).

[15] *Hampton Medical Group, P.A. v. Medical Inter-Insurance Exchange of New Jersey*, 366 N.J. Super. 165 (App. Div. 2004).

[16] N.J.A.C. 11:16-6.11.

[17] *Aetna Health, Inc. v. Carabasi Chiropractic Center, Inc.* Docket No. A-3 1 85-04TI (decided January 13, 2006), slip. op. at 8.

[18] *Id.* slip op. at 7.

[19] *Id.* slip op at 10.

[20] *Id.* slip op. at 3.

[21] *Id.* slip op. at 8.

[22] *Id.* slip op. at 10-11.

[23] *Garcia v. Health Net*, Docket No. C-37-06, Superior Court of New Jersey, Chancery Division, Bergen County, opinion dated Nov. 20, 2007 slip op. at 25-27.

[24] *Horizon*, Compliant at preamble (p. 2, ¶¶ 7 – 42).

[25] *Horizon Blue Cross and Blue Shield of New Jersey v. Newton Memorial Hospital*, Docket No. ESX-C-141-09, Superior Court of New Jersey, Chancery Division, Essex County.

[26] *Trustmark Life Ins. Co. v. University of Chicago Hospitals*, 207 F.3d 876, 879 (7th Cir. 2000).

[27] *Id.* at 884.

[28] *Id.* at 879.

[29] *Id.* at 884.

[30] *Ibid.*

[31] *See Garcia*, slip op. at 26.

[32] *Garcia*, slip op. at 25.

[33] *Cal. Admin Code* § 28 CCR 1300.71(p) (2008).

[34] *Colo. Rev. Stat. Ann.* §18-13-119 (2008).

[35] *Ohio Rev. Code* § 4731 .22(B)(28) and -(N) (2008).

[36] *Conn. Gen. Stat.* § 53-442 (2008).

[37] *Fla. Stat. Ann.* § 817.234(7)(a) (2008).

[38] *Desai v. Blue Shield of Northeastern New York, Inc.*, 178 A.D. 2d 894, 896 (3d Dept. 1991).

[39] *Cohen v. Fromovitz*, 1995 WL 478859 (N.Y. City Civ. Ct. 1995) at *1, *4.