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Leading Health Law to Excellence through Education, Information, and Dialogue

Patient Co-payments and Speed Bumps

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Patient co-payments and deductibles are "speed bump" consumer controls used by insurers to curb individual over-utilization of plan resources. They are based on the theory that even a nominal out-of-pocket expense deters plan participants from over-utilization. Payor-provider contracts are the primary vehicle through which providers enforce co-payment and deductible terms.

Although payor-provider contracts usually require providers to collect the co-payment or deductible amount directly from the participant, there are few, if any, incentives for providers to reliably fulfill this duty. Paradoxically, providers who fail to collect co-payments or deductibles derogate their payor contract while gaining a competitive advantage over their colleagues who properly collect.

Payors have become increasingly aggressive in combating both in-network and out-of-network providers who neglect their responsibilities to collect co-payments and deductibles by bringing lawsuits alleging fraud and misrepresentation against the latter and actions for breach of contract against the former. Moreover, a growing number of states have enacted legislation prohibiting the regular waiver of co-payments or deductibles.

In addition to actions for breach of contract against network providers, payors have successfully argued that the failure of an in-network or out-of-network provider to collect co-payments or deductibles constitutes fraud and misrepresentation of the provider's usual, customary, and reasonable (UCR) charge for specific services.

Feiler v. New Jersey Dental Association[1] was one of the earliest cases to consider whether a provider who fails to collect co-payments and deductibles could be liable for fraud. The case began as a declaratory judgment action against Feiler's routine practice of waiving patient co-payments once he received reimbursement from the carrier, usually at 80% of his UCR charge. At trial there was evidence that Feiler collected his full UCR rate only 3% of the time and that the rest of his services were discounted in one form or another.[2]

The court viewed the case as essentially a contract dispute, saying:

> [d]ental insurers are entitled to write policies containing copayment provisions. Whether or not copayment encourages more conservative use of dental services or achieves some other lawful goal, the carriers are entitled to write a copayment provision and to enforce it. If is a socially undesirable provision, it is up to the government to bar its use. It is not up to dentists to tiptoe around it by overbilling.[3]

Summarizing the economic fraud the court said: "if [the dentist] tells the insurance carrier he charges $100 and then collects $80 from the carrier, and by prearrangement, forgives his patient's co-payment, he has lied to the carrier."[4] Under this reasoning, the dentist's actual UCR should have been submitted as $80 (based on the fact that he usually collected this amount from the insurance companies), for which 80% reimbursement would have been $64.

As a remedy, the court ordered that the dentist include a statement indicating whether he actually intends to collect co-payments on subsequent statements to carriers.[5] Presumably, if he stated that he intends to not collect co-payments, carriers would adjust the baseline UCR charge before applying their reimbursement rate.

Based on the record submitted and without any testimony, the Chancery Division concluded that:

> It is also clear that Feiler knows his statements of fees are false. They say he charges an amount which the evidence plainly shows he does not intend to collect. It is equally obvious that he in-

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> tends that the payers will rely on his representations, i.e., that they will make payments to him of amounts based on his stated fees.
>
> There can be no question but that a payer is injured by making payments based on agreed percentages of Feiler's false fee statements. The simple fact is that the payments are higher than they would otherwise be and that is injury enough.[6]

Although the court then held a plenary hearing on the remaining elements of common law fraud to determine whether there was actual deception and reasonable reliance on the billing statements, such proof would not be needed today to sustain a violation under New Jersey's Insurance Fraud Protection Act (IFPA),[7] which became law the same year as this decision. A person or practitioner violates the IFPA if he or she:

> [p]resents or causes to be presented any written or oral statement as part, or in support to, a claim for payment or other benefit pursuant to an insurance policy . . . knowing that the statement contains any false or misleading information concerning any fact or thing material to the claim.[8]

A payor bringing suit under the Act may seek compensatory damages, costs of investigation, costs of suit, and counsel fees.[9] Compensatory damages under the IFPA may include *all payments previously made to the provider.*[10] Treble damages are also available "if the court determines that the defendant has engaged in a pattern of violating the act."[11] A "pattern" is defined as "five or more related violations under [the Act.] Violations are related if they involve either the same victim or the same or similar actions on the part of the person or practitioner charged with violating [the Act.]"[12] Feiler's actions likely violated the IFPA and would also trigger its treble damages provisions.

Unlike common law fraud, which must be established by clear and convincing evidence, a violation of the IFPA may be sustained by a mere preponderance of the evidence.[13] In addition, such actions could be viewed by the Attorney General as false promise or false pretense[14] or professional misconduct[15] worthy of disciplinary proceedings and possible loss of professional license. In such proceedings, the collateral estoppel effect of the findings of fact during the civil litigation can be devastating and impossible to overcome.[16]

A cause of action may also exist by the payor against the provider for tortious interference with its contractual relationship with the patient occasioned by the provider's waiver of the co-payment or deductible.[17] The elements of a cause of action for tortious interference are: (1) plaintiff must have a reasonable expectation of economic advantage; (2) the interference and harm inflicted must be done intentionally and with "malice," not necessarily in the sense of ill will, but in the sense of conduct that is wrongful and without justification or excuse under all the circumstances; (3) the interference must have caused a lost prospective gain; and (4) the loss or injury caused damage. The damages available under this theory would be limited to compensatory damages (*i.e.*, the amount that the insurance company paid the provider) which are already available as under the IFPA.[18]

In *Aetna v. Carabasi*, the New Jersey Superior Court, Appellate Division, held that an out-of-network provider who routinely waives collection of co-payments or deductibles from patients may be liable for insurance fraud and intentional interference with economic advantage in New Jersey.[19] In that case, defendants were non-participating chiropractic providers who saw patients insured by plaintiff, and did not collect co-payments or deductibles but when billing Aetna would leave blank the area of the form for "Amount Paid" and "Balance Due."

Plaintiff claimed that this practice constituted insurance fraud, common-law fraud, negligent misrepresentation, unjust enrichment, and tortious interference with subscriber contracts.[20] After two days of oral argument, the Law Division dismissed the complaint for failure to state a claim[21] and other grounds. The Appellate Division reversed and reinstated the fraud and tortious interference claims, but affirmed the dismissal of the unjust enrichment claim.

Regarding the fraud allegations, the Appellate Division analyzed the threshold to be met for insurance fraud, common law fraud, and negligent misrepresentation. To survive a pretrial motion to dismiss its IFPA claim, Aetna must demonstrate that Carabasi "knowingly misrepresented or failed to disclose facts material to the claims submitted to Aetna for reimbursement."[22] For the claims of common law fraud to proceed, Aetna must establish facts "tending to show that Carabasi knowingly misrepresented a material fact with the intent to induce Aetna's reliance thereon and that Aetna did in fact rely upon Carabasi's misrepresentation and suffered damages as a consequence."[23] Finally, to go forward on its theory of negligent misrepresentation, Aetna was required to demonstrate only that "[a]n incorrect statement, negligently made and justifiably relied on [resulted in] economic loss or injury sustained as a consequence of that reliance."[24]

With respect to defendants' practice regarding co-payments and deductibles, plaintiff alleged that leaving the invoice spaces blank for "Amount Paid" and "Balance Due" was tantamount to a failure to disclose waiver of the co-payment or deductible from the patient that resulted in overstatements of the total charge for the services provided.[25]

The Law Division concluded that the blank spaces made no representation whatsoever to plaintiff (let alone a false one) regarding defendants' collection or waiver of co-payments. It then concluded that in light of plaintiff's failure to request additional information on these claims before paying them, it could not have relied on the blank spaces. The Appellate Division took specific exception with this finding, calling it "premature," and pointing out that if plaintiff's allegations are vindicated at trial, "[defendant] failed to disclose a fact material to his right to receive reimbursement and if done knowingly, could

certainly give rise to a claim of fraud under both the statute and common-law."[26] The rule of law that emerges from this is that a provider who leaves blank spaces on claims forms and does not collect a co-payment or deductible has failed to disclose a material fact, which, if relied upon, is actionable under the IFPA.

Plaintiff's tortious interference claim was based upon defendants' knowledge of its suscriber contracts that obligated it to pay only a fixed percentage of the cost of services with the balance paid by subscribers. In support of this theory, the complaint alleged that defendants waived the co-payments by members "in order to access insurance information, to encourage over utilization of services and to bill for amounts in excess of those actually charged to the patient."[27] Aetna also claimed damages from such interference, arguing that these provisions were designed to deter patients from and that defendants' conduct encouraged subscribers to: (1) use non-participating providers; (2) receive unnecessary or excessive treatment; and (3) over-utilize defendants' services in particular. The Appellate Division found these facts to "clearly set forth a claim for tortious interference." It reinstated this claim along with plaintiff's fraud theories, and remanded to the Law Division.[28]

Because defendant was an out-of-network provider, there were no grounds to argue that he misrepresented his contractual UCR charges. Nonetheless, plaintiff makes its functional equivalent by arguing that the non-disclosure of the co-payment waivers has "resulted in overstatements of the total charge for the services provided."[29] Plaintiff derived similar arguments from this point, *i.e.*, that defendants' conduct of failing to collect co-payments encourages patient over-utilization and destroys the disincentive for patients to seek treatment from out-of-network providers.

Although this decision can be fairly read to require that payors *affirmatively disclose* any non-payment of deductibles or co-payments to payors, it remains non-binding.[30] Moreover, the Appellate Division voiced skepticism at plaintiff's ability to carry its burden in demonstrating that it relied on defendants' bills in determining the amount of its payment in particular cases.[31]

Several federal courts have considered cases in which providers chronically failed to collect co-payments or deductibles from patients. For example, relying on *Feiler*, the U.S. District Court for the District of Hawaii granted an insurance company's motion for summary judgment in a breach of contract suit against a dentist who regularly waived the 30% co-payments he was supposed to be collecting from patients. In its opinion, the court characterized this activity as "a fraudulent and deceptive business practice" and "over-billing" by the dentist.[32]

Other decisions, like *Feiler*, conclude that in-network providers who submit claims to payors with no intention of collecting the co-payment from the patient inflate their UCR charges and breach the underlying provider agreement. As illustrated by *Carabasi*, this also applies to out-of-network providers who waive co-payments; such providers could also be subject to liability under the IFPA unless they inform the payors that there is no intention of collecting a co-payment. In those cases, the problem remains of determining their true UCR for the procedure in question and payors often argue, that as in *Feiler*, the doctor's true UCR is more in line with the actual payment from the insurance company, not the amount billed.

The Seventh Circuit, like the Chancery Division in *Feiler*, has held that where the provider-payor agreement requires collection of a co-payment, a provider's waiver of co-payments or deductibles constitutes a breach of the agreement that discharges the payor from paying the disputed bill.[33] This case arose when, following an audit, the payor discovered that Kennedy was not collecting co-payments in accordance with his provider agreement. Indeed, in his patient engagement letter, Kennedy explicitly stated that he would accept the carrier's payment as full compensation. When the carrier refused a particular claim citing Kennedy's breach of their underlying agreement and its failure to consent to the assignment of patient benefits as required by its policy, the provider sued to collect the bill. The payor removed the matter to federal court based on federal question jurisdiction arising under the assignability of the Employee Retirement Income Security Act (ERISA) benefits at issue.[34]

After a thorough analysis of the provider agreement and the physician-patient engagement letter, the appeals court agreed with the district court's finding that the physician-patient contract provision accepting the insurance payment as full satisfaction "is the principal device by which a provider of medical care waives co-payments." It therefore rejected the provider's argument that this provision should be treated as an assignment rather than a reduction in price.[35]

The court then viewed the overall co-payment structure and its economic basis on a functional level:

> We could not break the circle in favor of reimbursement without abrogating the co-payment requirement—a requirement that [the patient's employer] had every legal entitlement to create. So Kennedy must lose. If he wishes to receive payment under a plan that requires co-payments, then he must collect those co-payments—or at least leave the patient legally responsible for them. (What happens if a provider bills his patients for the 20% but never follows up is a question we need not answer.) Kennedy observes that the patient's rich aunt or best friend may pay the 20% and asks rhetorically: Why can't the doctor pay? The answer is contractual: *Because the plan and policy say that the physician must create a legal obligation in the employee or dependent. And there is a good reason for this contractual solution. Allowing the provider to "pay" the co-payment to himself is just another way to describe waiver of co-payments, with the baleful consequences we have mentioned.* Some welfare benefit plans have lower (or no) co-payments, perhaps

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because they doubt that the incentive effects of co-payments justify saddling with higher costs those employees unlucky enough to encounter medical difficulties. Co-payments mean more risk borne by participants. Whether full indemnity is preferable to a co-payment system is a question for the marketplace. The answer in this health plan is co-payments, and its terms will be enforced.[36]

Although *Kennedy* involved only a single patient as opposed to a mode of practice in *Feiler*, the facts are otherwise very similar. Moreover, the facts in *Kennedy* would likely be actionable if the IFPA applied, as evidenced by *Carabasi*. The insurer in this hypothetical would likely argue that because of Kennedy's agreement with his patient, the UCR rates that he then billed to the payor constituted a presentment of knowingly false or misleading information in support of a claim for payment, in violation of the IFPA.[37] Moreover, in New Jersey, if discovery then revealed five or more similar failures to collect co-payments or deductibles, treble damages would be available as well.[38]

Although *Kennedy* never decided the validity of the payor contract provision that prohibited the assignment of ERISA benefits, this issue arose in the Ninth Circuit. There, a group of California out-of-network dentists argued that ERISA required the assignability of benefit plan payments from Delta Dental, notwithstanding an express plan term prohibiting assignment.[39] Although Delta paid both participating and non-participating dentists the same percentage, it paid participating dentists directly and required them to collect the co-payment balance from the beneficiary. In contrast, Delta made beneficiaries pay non-participating dentists and then submit claims for reimbursement.[40]

To circumvent this system, non-participating dentists began asking patients for an assignment of Delta's benefits in exchange for waiving their co-payment. Delta's benefit plan expressly prohibited such assignments by beneficiaries, and Delta refused to mail indemnity checks to these dentists.[41] The dentists, arguing that ERISA mandated the assignability of these benefits, obtained a preliminary injunction against Delta's refusal to pay.[42]

On appeal, the Ninth Circuit adopted *Kennedy* regarding the enforceability of co-payment provisions and then went on to conclude that, although precedent holds ERISA's silence on this issue does not prohibit such assignments, such silence cannot be read as to mandate them. The court then reversed and upheld Delta's non-assignment clause, ERISA notwithstanding.[43]

The activities of the non-participating dentist in *Davidowitz* would probably not pass muster under the IFPA because, as was recognized in *Feiler*, a strong argument would exist that the out-of-network provider's true UCR charge is equal to the insurance company payment, not the bill that they submit.[44]

Five years later, Delta's policy of not recognizing co-payments from supplemental insurers as contractually valid and deeming participating dentists who accept them to be in breach of contract was before the Ninth Circuit when Similecare, a supplemental insurance company providing coverage for co-payments, sued Delta under § 2 of the Sherman Act alleging monopolization and attempt to monopolize.[45] After reaffirming its earlier decision in *Davidowitz*, which expanded on *Kennedy*, the court held that Delta's refusal to recognize payments by Smilecare was not prohibited by the Sherman Act because the two were not competitors. It then went on to equate supplemental insurance coverage to the "rich aunt" example postulated by the Seventh Circuit in *Kennedy*, (quoted *supra*), calling it "tantamount to a waiver of the co-payment" because it removes the economic disincentive from the patient's perspective.[46]

While the Ninth Circuit rests it decision on the Sherman Act and that portion of the opinion is not in question, its later comparison of supplemental insurance to the "rich aunt" example in *Kennedy* is inaccurate because it presumes that Smilecare, like the "rich aunt," provides its payment gratuitously. This assumption is almost certainly false, and Smilecare does not, as the court says, completely remove the economic disincentive from the equation as a rich aunt would, but only repackages it, perhaps by charging monthly premiums. The Ninth Circuit's *dicta* on this point is far from persuasive.

More importantly, if the co-payment is made via supplemental insurance, this legitimizes the amount that the provider charges for his services by demonstrating their intention to collect the full charge from a combination of primary and secondary insurance if the supplemental insurance reimburses at 100%. For example, a procedure is billed at $100 based on the provider's UCR rates to the primary insurance company which pays 80% ($80). The provider also submits the remaining 20% co-pay claim ($20) to the supplemental carrier. If the supplemental carrier[47] pays 100% ($20), he has collected 100% of his $100 charge. He has therefore properly charged the primary insurance company his UCR charge. If the supplemental insurance pays less than 100%, however, this becomes less clear. For example, at a 75% or 50% supplemental reimbursement rate, an argument can be advanced that the correct UCR charge should have been $95 or $90, respectively.

In the end, both *Davidowitz* and *Smilecare* clearly recognize that removing the disincentive imposed by the co-payment or deductible would undermine the co-payment paradigm upon which the coverage plans are based. Although the holdings are premised on Delta's contracts, the underlying policy (albeit somewhat flawed) is intended to preserve the economic paradigm of the co-payment plans as they have been established by the payors.

While New Jersey IFPA may be unique in its breadth and severity of penalties for waiver of co-payments or deductibles, it is nonetheless part of a growing trend among states. For example, California,[48] Colorado,[49] Illinois,[50] and Ohio[51] generally prohibit providers from waiving patient co-payments or deductibles without disclosure. In addition, Connecticut[52] and

Florida[53] have made such practices fraudulent *per se*.

In contrast to these approaches that look askance at co-payment and deductible waivers, New York regards a provider's obligation to collect co-payments or deductibles as a simple matter of contract law between the provider and the payor. This is illustrated by *Desai v. Blue Shield of Northeastern New York, Inc.*, where the plaintiff-dentist, after enrolling as a provider in the defendant's plan, then negotiated special rates with a local union that included a waiver of any portion of his fee not covered by insurance.[54] After a few months, the payor became concerned about the number of claims that the plaintiff had submitted. After learning that he was waiving co-payments for union members, it suspended payments to plaintiff for his services, reduced his fee profile to below the union rates, recalculated its past payments to plaintiff in accordance with the reduced fee profile, and then began recouping its "overpayments" by withholding 50% of all payments to plaintiff.[55]

The dentist sued seeking recovery of the withheld amounts and lost profits attendant to the fee schedule reduction. The trial focused on the dentist's participation agreement with the payor and whether the waiver of the co-payments was a breach of this agreement. Following a bench trial, the court found for plaintiff-dentist. On appeal, the Appellate Division held that that the provision in the agreement that allowed plaintiff to collect "not more than 20% of his usual fee from the patient" manifests "a clear range of possible charges under 20%, including zero or no charge." It consequently affirmed this part of the verdict.[56]

This New York provider was allowed to waive co-payments with impunity for *in-network patients* because of poorly written contract language that "allowed" him to collect "not more than 20%" of his regular fee as a co-payment. Based on this, there is every reason to believe that waiver of an out-of-network patient's co-payment would also be permitted.

In New York such contractual breaches are not equated with a UCR distortion, even though New York has its own Insurance Frauds Prevention Act.[57] This statute, however, lacks the penalties and broad application that are the hallmarks of the New Jersey IFPA. For example, it does not provide for a private right of action by payors and limits civil penalties at restitution plus $5,000.[58]

Also, it appears that, overall, New York has not taken as aggressive an approach towards insurance fraud when compared to New Jersey. In relevant part, the statute defines prohibited conduct in the healthcare context as follows:

> A fraudulent healthcare insurance act is committed by any person who, knowingly and with intent to defraud, presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by, an insurer or purported insurer or self-insurer, or any agent thereof, any written statement or other physical evidence as part of, or in support of, an application for the issuance of a health insurance policy, or a policy or contract or other authorization that provides or allows coverage for, membership or enrollment in, or other services of a public or private health plan, or a claim for payment, services or other benefit pursuant to such policy, contract or plan, which he knows to:
>
> (a) contain materially false information concerning any material fact thereto; or
>
> (b) conceal, for the purpose of misleading, information concerning any fact material thereto.[59]

Although New York's definition of "fraudulent healthcare insurance act" would appear to be aimed at the same conduct as New Jersey's, it has not been applied with nearly the same zeal.

Further evidence that in New York a provider's waiver of co-payments or deductibles for patients is simply a matter of contract law deserving of no particular scrutiny can be found in *Rotwein v. Sunharbor Manor Residential Healthcare Facility*.[60] There, a podiatrist brought an action against the healthcare facility where he was on staff (but not an employee), for retaliatory discharge in violation of the New York whistleblower law, breach of contract, and defamation. The whistleblower action was premised on allegations of illegal activity in the form of the facility's direction to plaintiff that he not seek reimbursement for deductibles or co-payments from residents' families. Plaintiff argued that this action violated federal law.[61]

On defendant's motion for summary judgment, plaintiff's whistleblower action was rejected as a matter of law for two reasons. First, even if the allegations were true, and the facility did, in fact, direct him not to seek payments from family members, the co-payment or deductible would be sought from the patient themselves. Even if seeking such payment would be a pointless exercise, the court found it not to be tantamount to a kickback. Second, illustrating the *laissez-faire* approach of New York, the court held that, even assuming that an actual violation of law occurred under these facts, there is no basis to conclude that such activity presents a "substantial and specific danger to the public health and safety," as required under the whistleblower law.[62]

For these reasons, the court dismissed this part of plaintiff's claim, holding that no violation of law actually occurred, and even if one were presumed on these facts, it was *de minimus*. If there were any additional statutory or regulatory requirements that the provider made a reasonable effort to collect the co-payments, the court would not have so nonchalantly dismissed plaintiff's claims when, in reality, the families are probably more able to make the co-payment or deductible payment than the residents themselves.

In another case that starkly illustrates New York's framing of this issue solely in terms of contract law, a physician sued various former patients and insurance companies for collection of past bills which were

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consolidated in a single action. In his advertisements, the doctor specifically stated that, for certain procedures, payment from no less than ten different insurance companies would be accepted as payment in full. Nonetheless, he sought to "balance bill" defendants and argued that it would be "illegal" and constitute "insurance fraud" to read his "Patient Acknowledgement Agreement" as limiting his rights to payment to the amount covered by their insurance carrier and excluding any co-payment or deductible.[63] The court first noted plaintiff's reliance on "a series of decisions in foreign jurisdictions that hold that a waiver of co-payments constitutes a fraudulent and deceptive practice." It then abruptly rebuked plaintiff, finding it "hard to understand" how plaintiff could advance such an argument in light of the dearth of New York authority to support his position and that "since plaintiff has unquestionably advertised his engagement in this very conduct . . . he should appreciate that there is no authority in New York forbidding such practice."[64]

New York regards this issue as strictly one of contract law. Where there is no specific contract, such as between an out-of-network provider and payor, the provider has no duty to collect or charge a co-payment or deductible. Indeed, where they hold themselves out as accepting the payor's reimbursement as "payment in full," they may be barred from doing so. Although this may be the most lenient approach taken by any state, New York is clearly in the minority. Without question, states are increasingly disdainful of practitioners who routinely waive co-payments and deductibles. Providers who engage in such practices may find themselves subject to civil suits, administrative hearings, and/or professional discipline.

Endnotes

1 467 A.2d 276 (N.J. Super. Ct. Ch. Div. 1983), *aff'd o.b.*, 489 A.2d 1611 (N.J. Super. Ct. App. Div. 1984).

2 *Id.* at 281.

3 *Id.* at 284.

4 *Id.* at 281.

5 *Id.* at 287.

6 *Id.* at 283-84.

7 N.J. Stat. Ann. § 17:33A-1 to -30 (West 1994 & Supp. 2006).

8 N.J. Stat. Ann. § 17:33A-4(a)(1) (West 1994 & Supp. 2006).

9 N.J. Stat. Ann. § 17:33A-7(a) (West 1994 & Supp. 2006).

10 *Material Damage Adjustment Corporation v. Open MRI of Fairview*, 799 A.2d 731, 741 (N.J. Super. Ct. Law Div. 2002).

11 N.J. Stat. Ann. § 17:33A-7(b) (West 1994 & Supp. 2006).

12 N.J. Stat. Ann. § 17:33A-3 (West 1994 & Supp. 2006).

13 *Liberty Mutual v. Land*, 892 A.2d 1240, 1250 (N.J. 2006).

14 N.J. Stat. Ann. § 45:1-21(b) (West 2004 & Supp. 2006).

15 N.J. Stat. Ann. § 45:1-21(e) (West 2004 & Supp. 2006).

16 *Zoneraich v. Overlook Hosp.*, 514 A.2d 53, 60, cert. denied, 526 A.2d 126 (N.J. 1986).

17 *Printing Mart-Morristown v. Sharp Elec. Corp.*, 563 A.2d 31, 37 (N.J. 1989).

18 N.J. Stat. Ann. 17:33A-7(a).

19 *Aetna Health, Inc. v. Carabasi Chiropractic Ctr., Inc.*, Docket No., A-3185-04T1 (N.J. Super. Ct. App. Div., Jan. 13, 2006).

20 *Id.* at 2. The complaint also alleged that defendants billed and received payment for services that were not actually performed, were not medically necessary, and/or were not sufficiently documented; and submitted bills and received payment for multiple charges for the same services, misrepresented the amounts actually changed, and received double-payment.

21 N.J. Ct. R. 4:6-2(e).

22 *Carabasi, supra*, at 6.

23 Id. (citing *Gennari v. Weichert Co. Realtors*, 691 A.2d 350, 367 (N.J. 1997)).

24 *Id.* (quotation omitted) (citing *H. Rosenblum, Inc. v. Adler*, 461 A.2d 138, 142-43 (N.J. 1983)).

25 *Id.* at 8.

26 *Id.* at 8-9.

27 *Id.* at 10. (quotation omitted).

28 *Id.* at 11.

29 *Id.* at 6.

30 N.J. Ct. R. 1:36-3.

31 *Id.* at 8.

32 *Tom v. Hawaii Dental Serv.*, 606 F. Supp. 584, 586-87 (D. Haw. 1985).

33 *Kennedy v. Connecticut Gen. Life Ins. Co.*, 924 F.2d 698, 699 (7th Cir. 1991). In slight contrast to New Jersey, where all payments to the provider (not just those in a particular dispute) may be subject to disgorgement. *See Open MRI of Fairview*, 799 A.2d at 741.

34 *Kennedy*, 924 F.2d 698.

35 *Id.* at 701.

36 *Id.* at 702 (emphasis added).

37 N.J. Stat. Ann. § 17:33A-4(a)(1) (West 1994 & Supp. 2006).

38 N.J. Stat. Ann. § 17:33A-3 (We 1994 & Supp. 2006).

39 *Davidowitz v. Delta Dental Plan of Cal., Inc.*, 946 F.2d 1476, 1477 (9th Cir. 1991).

40 *Id.*

41 *Id.*

42 *Id.* at 1477.

43 *Id.* at 1481.

44 *See also, Tom*, 606 F. Supp. at 587 (holding dentist who waived 30% co-payment was "over billing and "[h]is actual fee was only 70% of what he told [the payer] it was

45 *Smilecare v. Delta Dental Plan of Cal., Inc.*, 88 F.3d 780, 781-82 (9th Cir.), cert. denied, 519 U.S. 1028 (1996).

46 *Id.* at 783-84.

47 The opinion suggests that Smilecare reimbursed the entire payment. *See* 88 F.3d at 785 (speaking in terms of Smilecare custom who "might wish to obtain 100% coverage by purchasing supplemental coverage").

48 Cal. Admin Code § 28 CCR 1300.71(p) (West 2006) generally provides that a health service plan or the plan's capitated provider shall not require or allow a provider to waive any right conferred upon the provider or any obligation imposed upon the plan relating to claims processing or payment.

49 Colo. Rev. Stat. Ann. § 18-13 (West 2006) makes the "regular business practice" of waiving co-payments or deductibles an illegal abuse of health insurance. Such

activity is considered a "regular business practice" if a provider waives more than 25% of co-payments or deductibles during any calendar year, or advertises its intent to do so.

50 *Kennedy*, 924 F.2d at 699.

51 The Ohio State Medical Board prohibits physicians from waiving deductibles or co-payments if 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. Ohio Rev. Code § 4731.22(B)(28) and -(N) (West 2006).

52 Waiver of a patient's co-pay or deductible may qualify as fraud under Connecticut's Health Insurance Fraud Act. Conn. Gen. Stat. § 53-442 (West 2006).

53 A non-hospital provider's "general business practice" of waiving co-payments and deductibles "is a material omission and insurance fraud . . . if such provider has agreed with the patient or intends to waive deductibles or co-payments, or does not for any other reason intend to collect the total amount of such charge." Fla. Stat. Ann. § 817.234(7)(a) (West 2006).

54 577 N.Y.S.2d 932, 933 (N.Y. App. Div. 1991).

55 *Id.*

56 *Id.* at 934.

57 N.Y. Ins. Law §§ 401 - 409.

58 *Id.* at § 403(c).

59 N.Y. Penal Law § 176.05.

60 181 Misc. 2d 847, 851-52 (Sup. Ct. Nas. Co. 1999).

61 *Id.* at 851-52 (arguing that these actions violated 18 U.S.C. § 287 and 1001, 31 U.S.C. § 3729, 42 U.S.C. § 1320a-7a, 1320a-7b(b), and 1320a7(b)(7), which generally prohibit the making of false claims and statements and any form of illegal remuneration or "kickbacks").

62 *Id.* at 852.

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

64 *Id.* at *4.

Healthcare Liability and Litigation

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