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Health Insurers Allege Fraud and Kickbacks Against Out-of-Network ASC Providers Who Forgive Patients' Financial Responsibility

From the article:

Health insurers have long challenged the efforts of out-of-network providers to increase patient volume by waiving or forgiving the patient's coinsurance, deductible or other financial obligation. Until recently, we have seen that health insurers were mostly content to limit their challenge to not paying the providers' billed charges, or claiming subsequent overpayments. Litigation on the issue was rare. However, in a significant shot across the bow in the ongoing struggle between health insurers and out-of-network providers over payment, Aetna has sued seven California surgery centers for an alleged "fraudulent billing scheme" that it claims to be "illegally striking at the very financial core of" Aetna's managed care network. Regardless of whether Aetna ultimately prevails, the case promises to have significant repercussions for the out-of-network provider community.

The lawsuit, Aetna Life Insurance Co. v. Bay Area Surgical Management LLC, case no. 112CV217943, filed on Feb. 2, 2012 in Santa Clara County Superior Court, alleges that the surgery centers illegally induced its physician investors, who are in-network with Aetna, to refer their patients to the surgery centers with promises that the patients would not have any financial responsibility to the surgery centers for their out-of-network coinsurance and deductibles. Aetna claims that the surgery centers then turned around and submitted charges for reimbursement that were "artificially inflated," because "they are much greater than the amount the facility expects to be paid …, which is reflected by the fact that the facility does not collect those charges from the member." Aetna alleges that this type of billing scheme drives up the cost of health insurance coverage, because by not having any "skin in the game," patients have no incentive to become better educated about the true costs of their healthcare.

From the health insurers' perspective, when a provider routinely waives the patient's financial obligation for receiving out-of-network coverage, the provider's bill reflecting a percentage of the provider's "reasonable and customary" charge is a phantom number. For example, in one example listed in Aetna's complaint, a patient who received a bunion repair was responsible for a 20 percent coinsurance portion pursuant to the terms of the patient's benefit plan. Instead of charging Aetna a reasonable and customary charge minus the patient's 20 percent coinsurance, the surgery center waived the coinsurance and submitted its full billed charge to Aetna — in the amount of $66,100 — with the expectation that Aetna would pay 80 percent of that total amount.