

The “War” Between Out-of-Network Providers and Insurers Spreads Into COVID-19 Territory

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ERISA litigators know that a war has been raging between “out-of-network” medical providers, on one hand, and the entities that insure and administer group health plans, on the other (collectively, “Insurers”). For years, out-of-network providers have been suing plans and Insurers claiming they were “underpaid” for their medical services, often to the tune of millions of dollars. Hundreds of these cases have cropped up around the country in recent years. COVID-19 has now opened up a new front in this war, and the first skirmishes have already started.

On April 10, 2020, Columbus Specialty Hospital (“Columbus”) filed a complaint in New Jersey state court seeking \$36 million from various New Jersey insurance companies (the “Defendant-Insurers”) for payment of treatment it provided during the “COVID-19 crisis.” See *Columbus Specialty Hosp. v. Amerigroup Corp., et al.*, No. ESX-L-002635-20 (N.J. Sup. Ct. April 10, 2020). According to Columbus, it provides “long term acute care” to “immunocompromised seniors”—the “prime targets for COVID-19 infection.” Columbus claims the Defendant-Insurers grossly underpaid it “for the live-saving treatment” it provided to those “vulnerable patients.”

Columbus’s lawsuit is similar in some ways to the out-of-network provider cases that have cropped up around the country—but it adds a few new twists.

The Common Elements

Columbus’s lawsuit shares common features with the out-of-network provider lawsuits that came before it. Like the providers in those cases, Columbus does not directly sue for benefits under the terms of the health plans at issue. Instead, it asserts various

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contractual and quasi-contractual claims, alleging (among other things) that the Defendant-Insurers promised to pay Columbus its “usual and customary rates” for the services in question. This is a common tactic by out-of-network providers because their “usual” rates are much higher than the rates called for in the plan documents. In another relatively common move, Columbus asserts claims under state “prompt pay” statutes, which regulate the length of time in which an Insurer must pay providers for submitted claims.

The New Elements

While Columbus’s lawsuit shares a common structure with other out-of-network provider cases, it introduces new elements and could set new trends in this area of litigation.

First, Columbus tries to bolster its claims by highlighting the emotional aspects of the “national and state emergency” related to COVID-19. According to Columbus, the Defendant-Insurers’ failure to pay does not simply affect its bottom line; it means members of the “greatest generation” are not receiving “the live-saving care” they deserve. Columbus also accuses the Defendant-Insurers of putting health care workers at risk by preventing Columbus from purchasing personal protection equipment. By tying its claims to the COVID-19 crisis, Columbus is hoping to tilt the scales of equities in its favor—a potentially effective move, especially for claims tried before a jury. Expect other medical providers to follow suit and tie their claims to the COVID-19 crisis.

Second, Columbus’s lawsuit indicates that out-of-network providers may be shifting tactics for how they attempt to bind Insurers to “contractual” promises to pay the providers’ rates. As mentioned above, these out-of-network provider lawsuits often turn on whether the Insurer and provider formed a “contract” through communications about reimbursement rates. Traditionally, providers have alleged that such a contract or promise arose from phone calls with an Insurer’s billing department, during which the Insurer allegedly confirmed a patient’s coverage and reimbursement rates. Here, by contrast, Columbus claims it actually faxed formal contracts to the Defendant-Insurers, which they accepted by their conduct. This tactic is plainly an attempt to avoid the contractual formation and ERISA preemption defenses that defendants usually assert in these cases. Expect other out-of-network providers to employ similar tactics in their efforts to bind Insurers to commitments outside the four corners of the relevant health plan document.

Third, Columbus’s lawsuit illustrates the astonishing size of provider bills for COVID-19 treatments and the limited time that Insurers have to process those claims. Columbus alleges, for example, that it billed \$8.9 million for one patient for services related to COVID-19. While that sum is just an allegation, it is nonetheless a staggering number. And Columbus invokes New Jersey’s “prompt pay” statutes to insist that the Defendants-Insurers should have processed its multi-million dollar bills at breakneck speeds.

This combination of large bills and pressure to pay those bills quickly puts enormous pressure on Insurers’ billing departments. This flurry of large bills also opens the door to fraud and abuse by unscrupulous providers. Insurers will have to find a way to manage

this risk, while still ensuring that proper bills are paid in a timely fashion. But inevitably, Insurers will discover overpayment after the fact, which may trigger recoupment actions by Insurers and the group health plans, which they administer.

Should you seek additional information about these types of claims, feel free to contact us.