

How Much Flexibility Do I Have in Billing the Patient?

Weighing the risks of waiving insurance copays

By Stuart J. Vogelsmeier, J.D., Lashly & Baer, P.C.

Often, providers consider whether a patient should get some type of discount or assistance with copayment, deductibles and co-insurance amounts (collectively, I will refer to these payments as “copays”). Providers have long provided free care or reduced rates to patients such as financially disadvantaged individuals or professional colleagues and their families. This article will examine the waiver of copays in the commercial insurance and managed-care realm, as well as under federal and state laws. It will also discuss whether billing as an out-of-network provider really gives the provider unlimited flexibility in terms of billing to patients.

Example

For the purposes of this article, I will use a simple example that can be applied to a variety of settings. The provider provides a service to the patient, and the provider’s charge for that service is \$100. The provider’s office staff determines that this patient’s copay is \$20. Also, the patient is the parent of a good friend of the provider. The provider does not know the patient’s financial status, but assumes that in this day and age that any patient would gladly keep the \$20 in his or her pocket, so the provider tells his office staff to “waive the copay.” The provider sends the payor a bill for the charge of \$100, and expects that the payor will pay the remaining balance of \$80. Is there risk in this provider’s decision?

Medicare/Medicaid

Let’s assume, for the sake of this example, that the patient’s sole coverage is Medicare, and the waiver of copay is provided. The U.S. Office of Inspector General gave guidance on the issue of waiver of copays for Medicare patients in a 1994 Special Fraud Alert, and that guidance is still sound in 2013. Routine waiver of copays by providers may be unlawful because it results in 1) false claims, 2) violation of the Anti-Kickback statute, and 3) excessive utilization of services paid for by Medicare. The OIG believes that a routine waiver of copays is a misstatement of the provider’s actual charge. In our example above, if the provider waives the copay, the OIG believes that the provider’s actual charge is \$80, not \$100. Medicare should be paying 80% of \$80 (or \$64), rather than 80% of \$100 (or \$80). As a result, Medicare is paying \$16 more than it should.

Some providers may think that by waiving the copay, they are helping the Medicare patient. The OIG disagrees. Government studies have shown that if patients have some level of financial responsibility for their own care, the patients will be better consumers of their own health care, and will choose their services

because they need them, rather than simply because they are free. Ultimately, the OIG believes that if copays are waived, Medicare will pay for services that are not needed, and there will be less Medicare funds available to pay for truly necessary services.

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Following are signs the OIG believes highlight potential unlawful activity:

- Advertisements which state “Medicare Accepted as Payment in Full” or “No Out-Of-Pocket Expense”
- Collection of copays only when the patient has Medicare supplemental insurance
- Charges to Medicare patients which are higher than those made to other persons for similar services (the higher charges offset the waiver of copays)
- Routine use of “financial hardship” forms, where there is no real determination of a patient’s financial condition

The OIG has stated, however, that copays may be forgiven in specific instances of financial hardship. This hardship exception must truly be an exception which addresses a specific patient’s financial circumstances. A good-faith effort to evaluate each patient and to collect copays must be shown. The general rule of thumb that providers should consider is to waive copays for Medicare/Medicaid (and other government payors) only on a case-by-case basis and based on the financial need of a particular patient.

Managed Care/Commercial Payors

If the provider in the above example has a contract with the payor, this provider has probably violated the terms of the provider’s contract with that insurance plan. Most managed-care contracts have a provision which requires the collection of applicable copays, and prohibits the provider from waiving copays. The theory behind this type of contractual clause is similar to the government’s theory: if patients have some level

of financial responsibility for their own care, they will be better consumers of their own health care. Waiver of the copay in the example set out above could subject this provider to termination of the provider's contract, and perhaps a claim by the insurance plan that the provider's bill was fraudulent.

One thought may be to avoid going "in network." Let's change the example just a bit and assume the patient has health insurance coverage with a provider who is not contracted by the patient's plan. In other words, the provider is out of network. The provider knows, from experience, that this patient's insurance pays for 80% of out-of-network charges. If the provider again waives the 20%, is that a problem? Intuitively, a provider may think, "I'm not under contract with this plan, and I can do whatever I want." Sometimes intuitions, and the best intentions to help a patient who is a friend, can still subject providers to risk.

In the out-of-network example, we will assume that the insurance plan's policy is to pay for 80% of the charge by an out-of-network provider. If the out-of-network provider sends the insurance plan a bill with a charge of \$100, yet does not bill the patient the remaining 20%, the insurance plan could argue that the actual charge was only \$80, and then pay the provider \$64 (80% of \$80). Even worse, if the entire copay is waived, the insurance plan may take the position that the plan's responsibility is 80% of the patient's entire responsibility, and if the patient is billed \$0, then the insurance plan's responsibility is \$0 (80% of \$0 is \$0).

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Only a few states have actually passed laws that prohibit the waiver of copays by out-of-network providers. However, this has not stopped some payors from challenging the practice of waiving copays in court. In the out-of-network example above, not only does the provider risk lower payment or non-payment by the insurance plan, the provider may run the risk of a fraud lawsuit. For instance, over 20 years ago, CIGNA filed suit against an Illinois chiropractor who agreed with a patient to accept as full compensation "whatever the insurer would pay." In that case, the U.S. Court of Appeals for the 7th Circuit held that a provider who waives copays may forfeit the right to payment from the health plan. More recently, Aetna filed a lawsuit in California in early 2012 alleging that seven out-of-network providers routinely waived copays for Aetna patients, and that this practice amounted to insurance fraud under California law. This case is currently pending in California Superior Court.

Aetna has filed similar lawsuits which are currently pending in New Jersey, New York and Texas.

We are aware that some providers have attempted to waive copays for out-of-network patients by notifying the payor of the practice directly on the bill to the payor. The providers have been prepared to argue that by clearly stating their waiver on the bill, the payor cannot argue fraud. In other instances, we are aware that some providers actually bill the patients for the copay, but make no effort to actually collect the copay. We are also aware, anecdotally, that payors are aware of these practices, and have argued against them.

In terms of out-of-network providers, the law is very unsettled, and a number of lawsuits are pending. Additionally, some state legislatures are examining these issues more closely. Providers who seek to provide relief for patients should do so carefully, and in consultation with counsel.

Professional Courtesy

What about professional courtesy, which is the practice of providing care to other providers and their families at a reduced charge? At this point, there are no exceptions under Medicare/Medicaid and most managed-care contracts which allow physicians to waive copays of other providers and their families. Waiving the physician's entire fee is probably much safer than waiving or discounting copays. A waiver of charges should never, however, be provided as a way to induce referrals, especially referrals of Medicare/Medicaid patients.

Conclusion

Physicians should proceed very carefully prior to entering into a decision to waive or reduce the copay. Contrary to some popular thinking, going out-of-network does not provide unlimited options. ◀



Stuart Vogelsmeier

Stuart Vogelsmeier is a partner with the St. Louis law firm of Lashly & Baer, P.C. Mr. Vogelsmeier regularly counsels health-care providers on issues such as Stark Law and Anti-Kickback Law compliance, corporate structure, employment agreements, joint ventures, adding ancillary services to practices and asset protection. He can be contacted at (314) 436-8349 or at sjvogels@lashlybaer.com. The firm's website is www.lashlybaer.com.

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