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Waiving Co-Pays and Deductibles
Part One

By Stuart J. Vogelsmeier

Most health care providers have compassion for the sick, injured, and those with chronic conditions. Providers, as a general rule, look for ways to make the lives of patients better. Often, providers consider whether a patient should get some type of discount or assistance with co-payment, deductibles and co-insurance amounts (collectively, I will refer to these payments as "co-pays"). This article is the first of a two part series on waiver of co-pays. Providers have long considered provided free care or reduced rates to patients such as financially disadvantaged patients to professional colleagues and their families. These articles will address Federal and state laws, as well as managed care contracts. Part One will address waiver of co-pays in the commercial insurance and managed care realm, while Part Two will address Federal and state laws.

For the purposes of this article, I will use a simple example that can be applied to a variety of settings, from inpatient hospital settings to individual provider settings. Provider provides a service to patient, and provider's "allowable charge" for that service is $100. The provider has a contract with the patient's health insurance plan which states that the provider will collect the applicable co-payment for that patient. Through the authorization process, provider's office staff determines that this patient's co-pay is $20. In this example, the patient is the parent of a good friend of the provider's child. The provider does not know that patient's financial status, but assumes 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 co-pay". The provider sends the insurance plan a bill for the "allowable charge" of $100, and expects that the insurance company will pay the remaining balance of $80.

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 co-pays, and prohibits the provider from waiving co-pays. The theory behind this type of clause is that if patients have some level of financial responsibility for their own care, the patients will be better consumers of their own health care. Waiver of the co-pay 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.

Let's change the example just a bit. Let's assume in this case that 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 percent of out-of-network charges. If the provider again waives the 20 percent, 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, I will assume that the insurance plan's policy is to pay for 80 percent 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 percent, the insurance plan could argue that the actual "charge" was only $80, and then pay the provider $64 (80 percent of $80). Even worse, if the entire co-pay is waived, the insurance plan may take the position that the plan's responsibility is 80 percent of the "patient's entire responsibility", and if the patient is billed $0, then the insurance plan's responsibility is $0 (80 percent of $0 is $0).

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, Aetna filed a lawsuit in California in early 2012 alleging that seven out-of network provider routinely waived co-pays for Aetna patients, and that this practice amounted to insurance fraud under California law.

Although I will provide additional information in Part Two of this series, the general rule of thumb that providers should consider is to waive co-pays only on a case-by-case basis and based on the financial need of a particular patient.

Stay tuned . . .

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