Waiving Co-Pays and Deductibles
Part Two

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 copayment, deductibles and co-insurance amounts (collectively, I will refer to these payments as "co-pays"). This article is the second of a two part series on waiver of co-pays. Providers have long provided free care or reduced rates to patients such as financially disadvantaged patients to professional colleagues and their families. Part One addressed the waiver of co-pays in the commercial insurance and managed care realm, while Part Two will addresses Federal and state laws.

Similar to Part One, I will continue to use a simple example that can be applied to a variety of settings, from inpatient hospital settings to individual provider settings. The provider is a Medicare and Medicaid provider. The provider provides a service to patient, and provider's "charge" for that service is $100. Both Medicare and Medicaid require collection of a copayment from the patient. In our example, the 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, and is covered by Medicare. The provider does not know that 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 co-pay". The provider sends Medicare a bill for the "charge" of $100, and expects that Medicare will pay the remaining balance of $80.

The OIG gave guidance on the issue of waiver of co-pays for Medicare patients in a 1994 Special Fraud Alert, and that guidance is still sound in 2013. Routine waiver of co-pays by providers may be unlawful because its 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 co-pays is a misstatement of the provider's actual charge. In our example above, if the provider waives the co-pay, the OIG believes that the provider's actual charge is $80, not $100. Medicare should be paying 80 percent of $80 (or $64), rather than 80 percent of $100 (or $80). As a result, Medicare is paying $16 more than it should.

Some providers may think that by waiving the co-pay, 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 chose their services because they need them, rather than simply because they are free. Ultimately, the OIG believes, if co-pays are waived, that Medicare will pay for services that are not needed, and there will be less Medicare funds available to pay for truly necessary services.

What are some of the signs that the OIG believes highlight potential unlawful activity:

- Advertisements which state "Medicare Accepted as Payment in Full" or "No Out-Of-Pocket Expense";

- Collection of co-pays 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 co-pays);

- Routine use of "financial hardship" forms, where there is no real determination of a patient's financial condition.

The OIG has stated, however, that co-pays 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. Consistent with the advice set out in Part One, 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.

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