

WAIVING COPAYS AND DEDUCTIBLES

Providers sometimes waive patients' cost-sharing amounts (e.g., copays or deductibles) as an accommodation to the patient, professional courtesy, employee benefit, and/or a marketing ploy; however, doing so may violate fraud and abuse laws and/or payor contracts. From a payor's perspective, waiving cost-sharing amounts creates two problems. First, payors often contract with providers to pay based in part on the provider's usual charges. The Office of Inspector General ("OIG") has argued that a provider who routinely waives copays is misrepresenting its actual charges. Second, and more importantly, payors require copays to discourage overutilization and reduce costs. Waiving copays and deductibles removes the disincentive for utilization, thereby potentially increasing payor costs. Accordingly, federal and state laws as well as payor contracts generally prohibit waiving cost-sharing absent genuine financial hardship.

Federal Programs. Waiving copays and deductibles for government program beneficiaries implicates at least the following laws:

1. Monetary Penalties Law. The federal Civil Monetary Penalties Law ("CMPL") prohibits offering or transferring remuneration to federal program beneficiaries if the provider knows or should know that the remuneration is likely to influence the beneficiary to order or receive items or services payable by federal or state healthcare programs (e.g., Medicare) from a particular provider. (42 USC 1320a-7a(a)(5)). Violations may result in penalties of \$10,000 per item or service provided, treble damages, repayment of amounts paid, and exclusion from federal programs. (Id.; 42 CFR 1003.102). The CMPL specifically defines "remuneration" to include waivers of copays and deductibles. (42 USC 1320a-7a(i)).

2. Anti-Kickback Statute. The federal Anti-Kickback Statute ("AKS") prohibits knowingly and willfully offering, paying, soliciting or receiving remuneration to any person to induce such person to order or receive any items or service for which payment may be made under a federal healthcare program unless the arrangement fits within a regulatory safe harbor. (42 USC 1390a-7b(b)). The AKS is violated if "one purpose" of the remuneration is to induce federal program business. (*United States v. Greber*, 760 F.2d 68 (3rd Cir. 1985)). Violations may result in a five year prison term, \$25,000 criminal penalty, \$50,000 administrative penalty, treble damages, and exclusion from Medicare and Medicaid. (Id.; 42 CFR 1003.102). The Affordable Care Act also made an AKS violation an automatic violation of the False Claims Act, which may result in additional penalties of \$5,500 to \$11,000 per claim submitted, and repayment of amounts improperly received. (42 USC 1320a-7a(a)(7); 42 CFR 1003.102). The Office of Inspector General ("OIG") has interpreted the Anti-Kickback Statute to apply to waiving patient cost-sharing amounts if "one purpose" of the waiver is to induce or reward federal program business, a difficult standard to defend against. (OIG, *Special Fraud Alert: Routine Waivers of Copayments or*

Deductibles under Medicare Part B (May 1991)). The OIG has specifically warned against the following practices:

- Advertisements which state, “Medicare Accepted as Payment in Full”, “Insurance Accepted as Payment in Full,” or “No Out-of-Pocket Expenses.”
- Advertisements which promise that “discounts” will be given to Medicare beneficiaries.
- Routine use of “financial hardship” forms which state that the beneficiary is unable to pay the coinsurance/deductible (i.e., there is no good faith attempt to determine the beneficiary’s actual financial condition).
- Collection of copayments and deductibles only where the beneficiary has Medicare supplemental insurance (“Medigap”) coverage (i.e., the items or services are “free” to the beneficiary).
- Charges to Medicare beneficiaries which are higher than those made to other persons for similar services and items (the higher charges offset the waiver of coinsurance.)
- Failure to collect copayments or deductibles for a specific group of Medicare patients for reasons unrelated to indigency (e.g., a supplier waives coinsurance or deductible for all patients from a particular hospital in order to get referrals).
- “Insurance programs” which cover copayments or deductibles only for items or services provided by the entity offering the insurance. The “insurance premium” paid by the beneficiary is insignificant and can be as low as \$1 a month or even \$1 a year. These premiums are not based upon actuarial risks, but instead are a sham used to disguise the routine waiver of copayments and deductibles.

(Id.).

3. Exception: Financial Hardship. The OIG has confirmed that it will not enforce the CMPL and AKS against providers who waive copays or deductibles due to genuine financial hardship. The CMPL specifically excludes from the definition of “remuneration” the waiver of copays and deductibles if all of the following conditions are satisfied:

- (i) the waiver is not offered as part of any advertisement or solicitation;
- (ii) the person does not routinely waive coinsurance or deductible

amounts; and (iii) the person (I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need; or (II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts.

(42 USC 1320a-7a(i)). The AKS also contains an exception for cost-sharing waivers for inpatient hospital services if certain conditions are satisfied (*see* 42 USC 1001.925(k)); however, even if this exception does not apply, the OIG has stated:

The Federal anti-kickback statute does not prohibit discounts to uninsured patients who are unable to pay their hospital bills. However, the discounts may not be linked in any manner to the generation of business payable by a Federal health care program. Discounts offered to underinsured patients potentially raise a more significant concern under the anti-kickback statute, and hospitals should exercise care to ensure that such discounts are not tied directly or indirectly to the furnishing of items or services payable by a Federal health care program.

(OIG, *Hospital Discounts Offered to Patients Who Cannot Afford to Pay Their Hospital Bills* (Feb. 2004)). The OIG offered some direction for hospitals (and other providers) in determining and documenting financial need:

The OIG recognizes that what constitutes a good faith determination of "financial need" may vary depending on the individual patient's circumstances and that hospitals should have flexibility to take into account relevant variables. These factors may include, for example: (i) the local cost of living; (ii) a patient's income, assets, and expenses; (iii) a patient's family size; and (iv) the scope and extent of a patient's medical bills. Hospitals should use a reasonable set of financial need guidelines that are based on objective criteria and appropriate for the applicable locality. The guidelines should be applied uniformly in all cases. While hospitals have flexibility in making the determination of financial need, we do not believe it is appropriate to apply inflated income guidelines that result in waivers for beneficiaries who are not in genuine financial need. Hospitals should consider that the financial status of a patient may change over time and should recheck a patient's eligibility at reasonable intervals sufficient to ensure that the patient

remains in financial need. For example, a patient who obtains outpatient hospital services several times a week would not need to be rechecked every visit. Hospitals should take reasonable measures to document their determinations of Medicare beneficiaries' financial need.

(Id.; see also OIG, *Questions On Charges For The Uninsured* (Feb. 17, 2004)).

Other Laws. In addition to the foregoing, waiving cost-sharing amounts may violate other laws. For example, waiving copays and deductibles for referring physicians would usually establish a financial relationship that would trigger the federal Stark law unless the arrangement were structured to fit within a regulatory safe harbor, such as the “professional courtesy” exception. (See 42 USC 1395nn; 42 CFR 411.357(s)). Although States may also have their anti-kickback statutes or laws prohibiting the waiver of copays or deductibles. For example, Idaho law states:

It is unlawful for a service provider to engage in a regular practice of waiving, rebating, giving, paying, or offering to waive, rebate, give or pay all or part of a claimant’s deductible or claim for casualty, disability insurance, worker’s compensation insurance, health insurance or property insurance.

(IC 41-348). Other states may have similar statutes that apply to government programs and/or private pay programs.

Private Payors. In addition to relevant laws, private payor contracts generally require that the provider collect copays and deductibles. Failure to do so without the payor’s express approval would violate the contract terms and could result in claims for breach of contract or repayment. Most payors likely would not complain if the provider could establish that it waived the cost-sharing amount due to financial need, but to be safe, the provider may want to confirm same with the payor.

Next Steps. Healthcare providers should review and, if necessary, update their policies and practices and train their staff concerning waiver of copays and deductibles to ensure compliance. As appropriate, providers may want to work with their significant private payors to confirm the situations in which the provider would be allowed to forego collecting cost-sharing amounts, such as documented financial hardship. Addressing the issue upfront may avoid costly repayments or adverse claims in the future.