Hardship Discounts on Copayments and Deductibles

One of the most significant inducement violations in healthcare is the routine waiving of copayments and deductibles. It is such a serious violation that federal advisory opinions have been written on the subject. Often, providers believe that simply the proclamation of hardship is enough, and high copayments or deductibles constitute a hardship on the patient. This is absolutely not so! In the context of Medicare and Medicaid patients, the routine waiving of deductibles and copayments is prohibited in the absence of the patient demonstrating financial hardship, and the physician verifying that stated hardship. The Office of Inspector General clarified this in a Fraud Alert on the topic when they stated that “Routine waiver of deductibles and copayments by charge-based providers, practitioners or suppliers is unlawful because it results in (1) false claims, (2) violations of the anti-kickback statute, and (3) excessive utilization of items and services paid for by Medicare.” In certain cases, a provider, practitioner or supplier who routinely waives Medicare copayments or deductibles also could be held liable under the Medicare and Medicaid anti-kickback statute. 42 U.S.C. 1320a-7b(b). The statute makes it illegal to offer, pay, solicit or receive anything of value as an inducement to generate business payable by Medicare or Medicaid. When providers, practitioners or suppliers forgive financial obligations for reasons other than genuine financial hardship of the particular patient, they may be unlawfully inducing that patient to purchase items or services from them.

A provider who routinely waives copayments or deductibles is also misstating the actual charge. For example, if a physician claims that the charge for a service is $100, but routinely waives the copayment, where the coinsurance percentage is 20%, the actual charge is $80. The carrier should be paying 80 percent of $80 (or $64), rather than 80 percent of $100 (or $80). As a result of the provider’s misrepresentation, the carrier is paying $16 more than it should for this service. Such waivers of co-payments and deductibles by an “out-of-network” provider may be viewed as a potential kickback, insurance fraud or grounds for disciplinary action against the physician who waives the co-payments, co-insurance or deductible. In fact, the provider’s waiver of co-payments or deductibles may also affect the provider’s rights to collect insurance from the payer, based on certain State law related to acceptance of assignment. In Texas, for example, the Attorney General has made it clear that “the payment of benefits under an assignment does not relieve the covered person of contractual responsibility for the payment of deductibles and copayments. A physician or other health care provider may not waive copayments or deductibles by acceptance of an assignment.”[Emphasis added.] This means that when the physician accepts assignment from the patient, he is not relieved from seeking payment from the patient of the applicable co-payments and deductibles. Although the Opinion does not impose a mandatory obligation on the collection of co-payments and deductibles, it does suggest that telling the prospective patient that these will be waived may be interpreted as an “inducement” for the patient.

Under the legislation creating the Health Insurance Portability and Accountability Act (HIPAA,) it is considered mail fraud to have a scheme intended to “defraud any health care benefit program” which is a crime under federal law. This interpretation was corroborated in an OIG Advisory Opinion in 1997 with the finding that the proposed non-collection of co-payments from patients with employer-sponsored Medicare complementary coverage by an ASC would constitute grounds for sanctions under section 231 (h) of HIPAA (42 USC §1320a-7(a)(5) or under Section 1128B (b) (relating to payment of kickbacks) under the Social Security Act (42 USC §§ 1320a-7(b)(b) and 1320a-7(b)(7)).

There is no dispute that physicians who participate in managed care plans must comply with the terms of the provider agreement. Waivers or discounts of copayments or deductibles by in-network providers should be made only on the basis of demonstrated patient financial need. Providers should review the terms of the signed contract to look for
language that explains the stipulations allowed for hardship waivers. Many contracts have provisions for such hardship, but you must ensure that such a specification exists before setting your policy.

Where a physician is not a participating provider and engages in routine waiver of copayments or deductibles but accepts assignment of benefits for direct payment from the payer, both the patient (who made the assignment) and the physician (who accepts the assignment) are expected to follow the terms of the policy. These out of network providers should contact provider relations to confirm the policy for waiver of copayments or deductible in light of demonstrated and verified financial hardship. The carrier may require that the practice bill differently or send documentation for the record.

Medicare prohibits the routine waiver of copayments and coinsurance to Medicare beneficiaries. Medicare views discounts and coinsurance waivers as inducement to patients to choose a particular provider, especially if the discounts are offered at or before the time of service. The only way to offer discounts to Medicare beneficiaries without incurring increased risk is to meet the following criteria:

- The waiver is not offered as part of any advertisement or solicitation;
- Waivers are not routinely offered to patients;
- The waiver occurs after determining in good faith that the individual is in financial need;
- The waiver occurs after reasonable collection efforts have failed.

The most important exception to the prohibition against waiving copayments and deductibles is that providers may forgive the copayment in consideration of a particular patient's financial hardship. This hardship exception, however, must not be used routinely; it should be used occasionally to address the special financial needs of a particular patient. Except in such special cases, a good faith effort to collect deductibles and copayments must be made. Otherwise, claims submitted to Medicare may violate the statutes discussed above and other provisions of the law.