Increasingly, providers rely on participation in preferred provider plans to maintain patient volume. However, as providers have become more dependent on participating provider status, managed care plans have begun to limit provider participation in their networks to maintain cost efficiency. When a provider is out-of-network, the result for plan members who receive services from the provider is that they owe higher copayments, deductibles and other patient cost sharing amounts. Consequently, some out-of-network providers have begun to encourage patients to continue receiving services despite the provider's out-of-network status by waiving or reducing the increased portion of the copayment, coinsurance, or deductible amount attributable to the out-of-network services. Notably, this reduction or waiver is being given without regard to the patient's financial ability to pay in an attempt to create parity for the member so that the cost to the plan member is the same as if he or she had gone to an in-network provider (the "Practice"). But, providers who engage in this Practice risk being charged with violating state and federal laws and sued by managed care organizations ("MCOs").

**Federal Law Implications**

**Federal Civil Monetary Penalties.**

The Practice may run afoul of federal law to the extent that any persons receiving the benefit of the Practice are Medicare or Medicaid program beneficiaries. Under section 1128(A)(a)(5) of the Social Security Act (the "SSA"), a person who offers or transfers to a Medicare or Medicaid beneficiary any remuneration that the person knows or should know is likely to influence the beneficiary's selection of a particular provider of Medicare or Medicaid payable items or services may be liable for civil money penalties ("CMPs"). The SSA defines "remuneration" to include waivers of copayments and deductible amounts (or any part thereof) and transfers of items or services for free or for other than fair market value. The "should know" standard is met if a provider acts with deliberate ignorance or reckless disregard. Significantly, no proof of specific intent is required.

The Office of Inspector General's ("OIG") rationale for restricting inducements to beneficiaries was threefold. First, the provision of items or services for free or other than fair market value can corrupt the decision-making process. Second, there is potential harm to competing providers and suppliers because the use of giveaways creates an uneven playing field, disadvantaging smaller and less well-capitalized providers or suppliers. Third, these practices could negatively affect the quality of care given to beneficiaries. 1

The OIG has stated that the "inducement" element is met by any offer of valuable (i.e., not inexpensive) goods and services as part of a marketing or promotional activity, regardless of whether the marketing or promotional activity is active or passive. For...
example, even if a provider does not directly advertise or promote the availability of the 
copayment or deductible waiver to beneficiaries, there may be indirect marketing or 
promotional efforts or informal channels of information dissemination, such as “word of 
mouth” promotion by practitioners. In addition, the OIG considers the provision of free 
goods or services to existing customers who have an ongoing relationship with a 
provider likely to influence those customers’ future purchases.

Inexpensive gifts (other than cash or cash equivalents) or services are permissible if the 
value is not more than $10 individually and $50 in the aggregate annually per patient. 
Providers may offer more valuable or expensive items or services if the action falls 
within one of five statutory exceptions: (1) non-routine, unadvertised waivers of cost-
sharing amounts based on individualized determinations of financial need; (2) properly 
disclosed copayment differentials in health plans; (3) incentives to promote the delivery 
of certain preventive care services; (4) any practice permitted under an Anti-Kickback 
Statute safe harbor; and (5) waivers of hospital outpatient copayments in excess of the 
minimum copayment amount under the Medicare hospital outpatient fee schedule. 2

If an exception does not apply and the value of the cost-share reduction given to a 
Medicare or Medicaid beneficiary exceeds $10, a provider is at risk for the imposition of 
CMPs.

Anti-Kickback Statute.

As with the CMPs, the Anti-Kickback Statute would be implicated to the extent that a 
waiver or reduction of copayment or deductible amounts is offered or given to a 
Medicare or Medicaid beneficiary to induce referrals. Because the waiver is intended to 
remove a financial impediment or disincentive for a patient who may choose the 
provider for treatment, the Practice may be viewed as an offer to “pay” remuneration in 
order to solicit a patient to come to the provider for services over another facility.

There are only two safe harbors which could be applicable to this situation: the 
Discount Safe Harbor and the Waiver of Beneficiary Coinsurance and Deductible 
Amounts Safe Harbor. However, as discussed below, the Practice is unlikely to satisfy 
the criteria for federal safe harbor protection because it is ordinarily designed so that 
(1) the reductions or waivers of copayments or deductibles apply only to patients in 
whose MCO the provider does not participate; and (2) the reduction or waiver is done 
routinely without regard to financial need.

Under the Discount Safe Harbor, the term “discount” means a reduction in the amount 
a buyer is charged for an item or service based on an arms-length transaction. 3 Among 
others, the term expressly does not include: (a) a reduction in price applicable to one 
payor but not to Medicare, Medicaid or other federal healthcare programs; and (b) a 
routine reduction or waiver of any coinsurance or deductible amount owed by a 
Medicare or Medicaid beneficiary. 4 Therefore, the reduction of a member’s out-of-
network copayment, deductible or coinsurance amount would not qualify as a discount 
eligible for safe harbor protection.

While a waiver of beneficiary coinsurance or deductible amounts safe harbor also exists, 
it is limited in application and it is unlikely that a provider can satisfy the standards in 
this scenario. In the absence of safe harbor protection, if the requisite intent exists, the 
provider could be subject to criminal penalties.

State Law Implications

Deceptive Trade Practices.

A provider may also risk an enforcement action or lawsuit under a state deceptive trade
practices act if the waiver or reduction of copayments and deductibles is actively communicated or disclosed to the public or members of MCOs. These statutes prohibit false, misleading or deceptive advertising. If the terms of the member's benefit plan require payment of the full cost-sharing amount, but the provider misleads the patient into believing that he or she is not obligated to pay more for out-of-network services, a violation may occur.

**Insurance Claim Fraud.**

State insurance fraud statutes generally provide that a person commits an offense if, with intent to defraud or deceive an insurer, the person presents to an insurer in support of a claim for payment a statement that the person knows contains false or misleading information concerning a matter that is material to the claim, and the matter affects a person's right to a payment or the amount of payment to which a person is entitled. The provider's failure to disclose to the MCO that the provider has reduced, or intends to reduce or waive, the MCO member's patient responsibility portion could be construed as submitting false or misleading information to an insurer.

**Common Law Fraud.**

A provider could also be subject to a common law fraud claim brought by the MCO. The elements of common law fraud are a material misrepresentation, which the party knows or should know to be false, made with the intent that it be relied and acted upon, and which is relied upon by another to that party's detriment. As with a statutory insurance fraud claim, nondisclosure to the MCO of the Practice is typically the problematic element.

**Case Law.**

The seminal case in this area dates back to 1991. In *Kennedy v. Connecticut General Life Insurance Co.*, Connecticut General Life Insurance Company ("CIGNA") demanded proof by a chiropractor ("Kennedy") that he complied with CIGNA policy by collecting a co-payment from a beneficiary. After confirming its suspicions that the provider had not collected the co-payment, but had agreed to accept whatever the insurer would pay as full compensation, CIGNA refused to pay Kennedy for the claim. Kennedy filed suit as assignee of the claim against the insurer. The district court held in favor of CIGNA because CIGNA's policy provided that no payment would be made for charges that the beneficiary was not legally required to pay. By promising that he would look solely to CIGNA for payment, the court determined that Kennedy had relieved the beneficiary of any legal obligation to pay.

In affirming the decision, the Seventh Circuit explained that when "a provider routinely waives co-payments, a fee stated as 80% of the charge is a phantom number. Instead of charging $100, collecting $20 from the patient and $80 from the insurer, the provider may announce a fee of $125, waive the co-payment, and collect $100 from the insurer." Although this case was limited to application of Illinois law, it sheds some light on how other courts might construe the Practice. The court in *Kennedy* recognized the insurer's right to require beneficiaries to pay cost-sharing obligations such as copayments, and ruled against a healthcare provider who waived such payments.

**Regulatory Agency Interpretation.**

Some state regulatory agencies have taken a proactive stance on this issue. For example, the Texas Department of Insurance ("TDI") sent a letter to the Texas Medical and Hospital Associations addressing inquiries TDI had received relating to "providers that have not contracted with the managed care plan [who] are waiving any applicable patient financial responsibility in order to attract patients to the non-contracted provider or facility." TDI outlined some of the Texas statutes a provider may violate by waiving a
patient's cost-sharing amounts and stated that the waiver of patient responsibility amounts may create "several problematic issues for a healthcare provider."  

Following the TDI letter, the Texas Department of State Health Services issued a letter in 2005 to all hospital administrators warning that any licensed hospitals found to be waiving any applicable copayments or deductibles—if the hospital has accepted assignment of benefits—may be subject to denial, suspension or revocation of a hospital's license or the imposition administrative penalties. The agency indicated that a hospital which has not contracted with a managed care plan that waives any applicable patient financial responsibility to attract patients to the non-contracted facility has permitted the commission of an illegal act. Since then, in Texas, a number of providers have been subject to investigation and enforcement action for engaging in the Practice.

Conclusion.

Reductions or waivers of copayment or deductible amounts for an out-of-network patient of an MCO's plan, without regard to financial need, raises a number of concerns under state and federal laws. While it may seem like a quick fix, providers should carefully evaluate the potential risks before adopting such a practice.

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1 See, e.g., OIG Advisory Opinion Nos. 02-14 (affirming the limitations established in the August 2002 Special Advisory Bulletin), 06-01.
2 42 U.S.C. § 1320a-7a(i)(6).
3 42 C.F.R. § 1001.952(h)(5).
4 See also 64 Fed. Reg. 63527 (1999).
5 924 F.2d 698 (7th Cir. 1991).
6 Id. at 699.
7 Letter from Jose Montemayor, Commissioner of Insurance, Texas Department of Insurance, to Louis J. Goodman, Ph.D., CAE, Executive Vice President/CEO, Texas Medical Association and Richard Bettis, CAE, President/CEO, Texas Hospital Association (Dec. 9, 2004).