A burgeoning problem is developing for out-of-network healthcare providers that systematically fail to collect deductibles and coinsurance from patients. Insurance companies often seek to deny insurance coverage to subscribers in light of such collection failures, and also seek to recover past payments for services rendered by healthcare providers. In some instances, particularly where the healthcare providers failed to disclose the waiver of collecting deductibles and coinsurance, the insurers have attempted to cast that conduct as fraudulent and have invited state criminal and civil investigations.

Background

In order to understand the problem, a brief discussion of the contracts between healthcare providers and insurance companies is appropriate. Generally speaking, under in-network contracts with insurance carriers, the provider agrees to accept a negotiated sum as payment-in-full for services rendered to the carrier’s patients (also referred to as subscribers). Participating provider names are published in carrier directories, and subscribers who see one of the in-network providers do so without any financial obligation beyond a small, fixed co-payment.

For subscribers who choose not to use the in-network providers, most insurance plans and policies also provide benefits for services rendered by healthcare providers who have not contracted with the insurer to accept negotiated rates for services. Deemed out-of-network, these providers have made no agreements with the carrier regarding their fees, and are free to set their own schedule of fees for services rendered. Carriers universally limit reimbursement for out-of-network providers, and hold subscribers responsible for payment of a pre-determined percentage of the allowed amount, which varies according to subscribers’ plans.

The Problem Presented in a Practical Day-to-Day Scenario

In order to attract patients, out-of-network providers sometimes offer to waive any and all coinsurance, deductibles and other patient payment for out-of-network services, and instead agree to accept as payment-in-full the carrier’s portion of the allowed amount. In other words, an out-of-network provider might bill a carrier $500 for services rendered to a patient, and the carrier, under the terms of its out-of-network coverage, might be obligated to pay 80 percent of the allowed amount. If the allowed amount of the $500 claim was $300, the carrier would pay 80 percent of the $300, or $240, and the patient would be responsible for $60. However, in this example, the out-of-network provider agrees to waive the patient of responsibility for payment of the $60, and agrees to accept the carrier’s $240 payment as payment-in-full.

The issue is sometimes raised whether this practice constitutes insurance fraud. In the example cited above, the insurance carrier may argue that by waiving patient responsibility, the provider should actually be billing for $440 (the original $500 claim, less the waiver of $60 from the patient), and the carrier should be entitled to calculate its own responsibility accordingly.

Providers who do waive patient responsibility thrust themselves into murky waters in terms of potential criminal liability, as discussed below.

What Would New Jersey Do If Presented with a Failure to Collect Scenario?

New Jersey criminalizes false and misleading billing in seeking payment for the rendering of healthcare services:

“Health care claims fraud” means making, or causing to be made, a false, fictitious, fraudulent, or misleading statement of material fact in, or omitting a material fact from, or causing a material fact to be omitted from, any record, bill, claim or other document, in writing, electronically or in any other form, that a person attempts to submit, submits, causes to be submitted, or attempts to cause to be submitted for payment or reimbursement for health care services.

The more generic offense of insurance fraud occurs when a
provider (or anyone else) “knowingly makes, or causes to be made, a false, fictitious, fraudulent, or misleading statement of material fact in, or omits a material fact from, or causes a material fact to be omitted from, any record, bill, claim or other document, in writing, electronically, orally or in any other form, that a person attempts to submit, submits, causes to be submitted, or attempts to cause to be submitted as part of, in support of or opposition to or in connection with...a claim for payment.”

A practitioner who knowingly commits healthcare claims fraud is guilty of a second-degree crime, punishable by up to 10 years in prison, and subject to a fine of “up to five times the pecuniary benefit obtained or sought to be obtained.” A person who recklessly commits healthcare claims fraud is guilty of a third-degree crime, and faces the same enhanced fine.

Admittedly, there is no known reported case in New Jersey of a provider being prosecuted criminally for waiving patient responsibility and not disclosing the waiver on a claim for payment to an insurance carrier. However, given the sums of money involved industry wide, providers and their counsel would be well advised to broach the risk with their healthcare provider clients to ensure a sound approach to billing practices. Such proactive discussions are particularly appropriate in light of some important state and federal authorities that have announced their positions on the issue in favor of a finding of fraud.

- The New York State Department of Insurance has issued an opinion that “a chiropractic group that, as a general practice, waives otherwise required co-insurance requirements, that provider may be guilty of insurance fraud. For example, if a health care provider indicates that the charge for a procedure is $100 and the insurer anticipates that the provider will collect a 20% co-payment amount, the insurer will reimburse the insured $80. If, however, the provider waives the co-payment, that provider’s actual charge becomes $80, which then obligates the insurer, assuming payment at 80% of the usual charge, to reimburse the insured only $64.”

Even the American Medical Association has warned its members that “routine forgiveness or waiver of copayments may constitute fraud under state and federal law.” As such, a criminal prosecution based on a provider’s systemic waiver of patient responsibility, and a failure to disclose that waiver to an insurance carrier, is a clear potential fraud, and attorneys advising healthcare providers should be guided accordingly.

What if the Provider Discloses Waiving of Coinsurance and Deductibles to the Insurer?

A closer question is presented when the healthcare provider actually discloses the waiver to the carrier at the time the claim is presented. For this proposition, it is useful to analyze some decisions under the Insurance Fraud Prevention Act (IFPA). The plain language of the IFPA, particularly N.J.S.A. 17:33A-4, is quite similar to the related criminal statutes, and reveals the legislative mandate that a violation of this provision be limited to knowing misrepresentations or omissions.

Importantly, research has not uncovered a single case sustaining, or even involving, an allegation of fraud or deception against a facility or practitioner that expressly disclosed to the insurer its waiver of co-insurance. To the contrary, consideration of the sparse law on the issue confirms that disclosure to the insured defeats any fraud-based complaints resting upon the failure to collect patient responsibility.

While there may not be a New Jersey case on point, insurers typically rely on Feiler v. New Jersey Dental Ass’n to argue that the waiver of co-insurance, without disclosure of the waiver, constitutes fraud. In Feiler, a dentist faced allegations of unfair competition and common-law fraud after submitting claims to insurance carriers without first informing the carrier that he was waiving collection of co-insurance. The remedy posited by the court, for what the court determined to be improper conduct by the dentist, was a requirement that the dentist either: 1) submit to the insurer a statement indicating the fee the provider actually intends to collect for the procedure; or 2) “type, print or stamp on the fact of the statement, or on a label affixed thereto, in legible characters at least ten points in height” a statement indicating the provider will waive copayments. Feiler thus stands for the proposition that a disclosed waiver of patient responsibility can defeat a claim of fraud by an insurer.

In Garcia v. Health Net of New of New Jersey, the Chancery Division specifically held that a waiver of copayments or co-insurance by an out-of-network provider did not constitute fraud under the IFPA, because the insurer could not demonstrate the provider knowingly violated the law or
acted with reckless disregard of the law.\(^{16}\)
The court determined that the “knowing”
requirement under the IFPA requires some
proof of scienter, namely evidence by
which a “reasonable factfinder could
conclude that doctors...acted with reckless-
ness, or with knowledge of illegality”
when submitting the contested claims.\(^{16}\)

In finding that medical providers did
not act fraudulently in waiving co-insur-
ance, the court emphasized that New Jer-
sy law does not “expressly prohibit the
practice of waiving co-insurance in the
context of ambulatory surgical centers.”\(^{17}\)
The Garcia court explained that because a
waiver of coinsurance did not violate
New Jersey law, providers who submitted
claims for reimbursement and routinely
waived copayments could not be charged
with “knowledge” of any illegality sim-
ply because they waived copayments.\(^{18}\)

The court concluded:

I find no authority to establish that the
doctors or the Center acted unlawfully
in routinely failing to enforce the obli-
gation of Health Net subscribers to pay
copayments....No fraud is perpetrated
by the failure of the Center to pursue
these patients. No violation of the law
occurred.\(^{19}\)

The Appellate Division affirmed the rul-
ing in Garcia, confirming that even in
instances where an ambulatory surgery
center fails to disclose that it intends to
waive patient financial responsibility, no
violation of the Insurance Fraud Protection
Act occurs.\(^{20}\) If, as the Appellate Division
found in Garcia, the IFPA may not be vi-o-
lated even when there is a failure to dis-
close the waiver of patient responsibility,\(^{21}\)
it then unalterably follows as a matter of
logic that proper disclosure of potential
waiver of patient responsibility cannot vi-o-
late the statutory provisions of the IFPA.

In addition, New Jersey’s administra-
tive regulations do not prohibit the
practice of waiving coinsurance in the
context of ambulatory surgery centers.\(^{22}\)

Despite recent and growing attention to
the issue, the New Jersey Legislature has
decided to pass legislation clarifying the
lawfulness of waiving coinsurance.\(^{23}\)

On the other hand, a different regula-

tory chapter, governing dentists, expressly
imposes a requirement that dentists
must disclose to the insurer that they
intend not to collect coinsurance.\(^{24}\)

It is worth adding that the lack of a
New Jersey statute prohibiting such dis-
closed waivers, taken together with the
express banning of the practice in other
states such as Nevada,\(^{25}\) Georgia,\(^{26}\) and
South Dakota,\(^{27}\) suggests New Jersey
does not believe such conduct is illegal.

**Conclusion**

From these cases and statutes, we can
distill some common themes. First,
along the spectrum of legality, an undis-
closed waiver of patient responsibility
and a claim submitted to an insurance
carrier exposes the provider to prosecu-
tion for violation of the state’s health-
care claims fraud and insurance fraud
statutes. As such, counsel should make
efforts to ensure their clients are appro-
riately advised about the risks of wai-
ing copayments and deductibles. Next,
although there are no criminal cases in
New Jersey analyzing the issue, a review
of civil cases seems to strongly support a
conclusion that a disclosed waiver of
patient responsibility defeats any sugges-
tion of wrongdoing under New Jersey
law, criminal or civil. Ultimately, the
question of whether to waive or not to
waive is answered by a simple yes or no
question: “Will you disclose?”

**Endnotes**

5. See www.dfs.ny.gov/insurance/ogco
2000/rg012141.htm.
6. See www.dfs.ny.gov/insurance/ogco
2008/rg080404.htm.
7. See https://oig.hhs.gov/fraud/docs/
alertsandbulletins/121994.html. This
advisory from federal authorities is
cited as further evidence of potential
generalized criminality arising from
routine waivers of patient responsi-
bility. The reader is cautioned that
the issues described in this article are
presented in the context of private
insurance carriers under New Jersey
law, as an entirely separate set of
statutes and regulations affect
Medicare and Medicaid programs.

8. See AMA Opinion 6.12 (available at
www.ama-assn.org/ama/pub/physi-
cian-resources/medical-ethics/code-
medical-ethics/opinion612.page).
10. See Aetna Health Care, Inc. v. Carabasi,
2006), certif. denied, 186 N.J. 366
(2006) (remanding fraud-based case
for further fact-finding on pivotal
issue of whether practitioner dis-
closed to insurance company its
waiver of coinsurance); Garcia v.
Health Net of New Jersey, 2007 N.J.
Super. Unpub. LEXIS 2995 (Ch. Div.,
Nov. 20, 2007) (finding no IFPA viola-
tion in case in which surgery center
did not disclose waiver of coinsur-
ance, but also did not misrepresent
on billing forms that it did collect
coinsurance)(appeal pending), aff’d
2009 N.J. Super. Unpub. LEXIS 2858
(App. Div. 2009), certif. den., 201 N.J.
442 (2010); Feiler v. New Jersey Dental
Ass’n, 191 N.J. Super. 426 (Ch. Div.
(holding dentist who waived patient
responsibility without disclosure
engaged in unfair competition and
requiring as remedy future disclosure
to insurance companies of intent to
waive co-payments); see also N.J.A.C.
13:30-81, et seq. (codifying disclosure
requirement for waiver of patient
copayments in dental industry).
11. 191 N.J. Super. 426 (Ch. Div. 1983),
12. *Id.*
13. *Id.* at 447.
16. *Id.* at *37.
17. *Id.*
18. *Id.* at *40.
19. *Id.*
21. *Id.* at *12 to *13 (affirming trial court’s opinion).
22. See N.J.A.C. 8:43A (regulating ambulatory surgery centers).
23. See proposed legislation denoted as S-1743 and A-2511 (introduced March 11, 2010, to establish that “a waiver, rebate or payment of an insured’s deductible, copayment, or coinsurance by a health care practitioner, owed by a covered person pursuant to the terms of an insurance policy between that person and an insurance company, shall be considered a form of insurance fraud.”) (available at www.njleg.state.nj.us/2010/Bills/S2000/1743_11.HTM ($1743) and www.njleg.state.nj.us/2010/Bills/A3000/2511_11.HTM (A2511)).
25. N.R.S.449.195 (“A medical facility shall not waive a deductible or copayment if: 1. The medical facility is not a preferred provider of health care; and 2. The waiver would reduce the financial effect of a preferred provider’s incentive or disincentive to its insureds.”).
26. Ga. Code Ann., 43-1-19.1 (“it shall not be considered a misleading, fraudulent, or deceptive act for a provider to waive occasionally such a deductible or copayment required to be made under the patient’s health insurance contract, policy, or plan if the waiver is authorized by the insurer or if the waiver is based on an evaluation of the individual patient and is not a regular business practice of the person providing the health care services.”).
27. S.D.C.L. 58-17-57 (“A person who provides health care commits abuse of health insurance, if, as a regular business practice, he knowingly accepts from any third-party payor, as payment in full for services rendered, the amount the third-party payor covers, or submits a fee to a third-party payor which is higher than the fee he has agreed to accept from the insured with the understanding of waiving the required deductible or co-payment, if the effect of either business practice is to eliminate the need for payment by the insured of any required deductible or co-payment applicable in the insured’s health benefit plan.”).

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