

To Waive or Not to Waive, That is the Question

by Darren M. Gelber

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.¹

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.”²

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.”³ A person who recklessly commits healthcare claims fraud is guilty of a third-degree crime, and faces the same enhanced fine.⁴

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 insured patients’ co-payment amounts, even if based on the patients’ financial hardship, may be in violation of N.Y. Penal Law.”⁵
- That same office has written even more clearly that “if a health care

provider, as a general business 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.”⁶

- The United States Department of Health and Senior Services has published the following advisory: “[A]nyone who routinely waives copayments or deductibles can be criminally prosecuted under 42 U.S.C. 1320a-7b(b), and excluded from participating in Medicare and the State health care programs under the anti-kickback statute. 42 U.S.C. 1320a-7(b)(7).”⁷

Even the American Medical Association has warned its members that “[r]outine forgiveness or waiver of copayments may constitute fraud under state and federal law.”⁸ 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).⁹ 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.¹⁰

While there may not be a New Jersey case on point, insurers typically rely on *Feiler v. New Jersey Dental Ass’n*¹¹ to argue that the waiver of coinsurance, 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.¹² 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.¹³ *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*,¹⁴ the Chancery Division specifically held that a waiver of copayments or coinsurance 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.¹⁵ 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 recklessness, or with knowledge of illegality” when submitting the contested claims.¹⁶

In finding that medical providers did not act fraudulently in waiving co-insurance, the court emphasized that New Jersey 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 simply 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 obligation of Health Net subscribers to pay co-insurance....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 ruling 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 violated even when there is a failure to disclose 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 violate the statutory provisions of the IFPA.

In addition, New Jersey’s administrative 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 declined to pass legislation clarifying the lawfulness of waiving coinsurance.²³ On the other hand, a different regulatory 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 disclosed 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 undisclosed waiver of patient responsibility and a claim submitted to an insurance carrier exposes the provider to prosecution 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 appropriately advised about the risks of waiving 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 suggestion 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

1. N.J.S.A. 2C:21-4.2.
2. N.J.S.A. 2C:21-4.6.
3. N.J.S.A. 2C:21-4.3a.
4. N.J.S.A. 2C:21-4.3b.
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 responsibility. 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/physician-resources/medical-ethics/code-medical-ethics/opinion612.page).
9. N.J.S.A. 17:33A-1, *et seq.*
10. See *Aetna Health Care, Inc. v. Carabasi*, 2006 WL 66460 (App. Div. Jan. 13, 2006), *certif. denied*, 186 N.J. 366 (2006) (remanding fraud-based case for further fact-finding on pivotal issue of whether practitioner disclosed 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 violation in case in which surgery center did not disclose waiver of coinsurance, 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. 1983), *aff’d* 199 N.J. Super. 363 (1985) (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), *aff’d*, 199 N.J. Super. 363 (1985).

12. *Id.*
13. *Id.* at 447.
14. *Garcia v. Health Net of New Jersey*, 2007 N.J. Super. Unpub. LEXIS 2995 (Ch. Div., Nov. 20, 2007), *aff'd*, 2009 N.J. Super. Unpub. LEXIS 2858 (App. Div. 2009), *certif. den.*, 201 N.J. 442 (2010).
15. *Garcia*, 2007 N.J. Super. Unpub. LEXIS 2995 at *40.
16. *Id.* at *37.
17. *Id.*
18. *Id.* at *40.
19. *Id.*
20. *Garcia v. Health Net of New Jersey*, 2009 N.J. Super. Unpub. LEXIS 2858 (App. Div. 2009), *certif. den.*, 201 N.J. 442 (2010).
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_I1.HTM (S1743) and www.njleg.state.nj.us/2010/Bills/A3000/2511_I1.HTM (A2511)).
24. See N.J.A.C. 13:30-8.12.
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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