Payments to physicians from health insurance and managed care companies have continued to spiral downward, even as plan-related protocols and payment policies become more vexatious. In response, many frustrated physicians have contemplated opting out of plan participation altogether, instead seeking payment as "out-of-network" service providers. Out-of-network physicians are even finding that in some cases subscriber agreements provide more attractive reimbursement than do in-plan arrangements, especially when the out-of-network payment is calculated as a percentage of charges. The problem, of course, is that patients seeking out of network services are frequently required to pay a larger share of their physician's bill when they so opt. Because of the economic incentives for seeking in-network care, physicians are naturally concerned that remaining out-of-network will translate into a lighter patient load.

Some out-of-network physicians have attempted to even the playing field, enhance patient choice, and encourage out-of-network use, by waiving all or part of their patients' share of the bill. Others refrain from doing so, because they are concerned that waiving co-insurance may be "illegal." In Maryland, at least, this is not necessarily the case. If done carefully, out-of-network physicians may legally waive out-of-network patient co-pays and co-insurance, thus presenting themselves as attractive clinical service alternatives to in-network providers.

At the outset, it is important to note that it is generally not permissible to waive Medicare and Medicaid patients' co-insurance obligations; such waivers may violate federal and state anti-kickback statutes, and could subject physicians to criminal and other sanctions. In contrast, and unlike several other states, no Maryland statute expressly prohibits the waiver of commercially insured patients' co-insurance obligations. In addition, since out-of-network physicians do not have a contractual relationship with the commercial insurer, waiving co-insurance obligations for that insurer's beneficiaries will not constitute a breach of contract.

Physicians should be aware, however, that a basis does exist upon which co-payment waivers could be challenged under Maryland law, and craft their waiver approaches in a way to avoid this potential legal barrier. Specifically, Maryland law provides that it is a "fraudulent insurance act" for a person "to present or cause to be presented to an insurer documentation with knowledge that the documentation...contains false or misleading information about a matter material to the claim."

Certain approaches to waiving co-payments could lead to false claims allegations. For example, in the federal setting, the government has made clear its position that if a physician submits a claim stating that he "customarily charges" $500 for a particular procedure, but typically does not intend to collect the $100 co-insurance from the patient, the physician's "true" charge for the procedure is $400, not $500. Under the government's theory, advising an insurance company in the situation described above that one's "customary charge" is $500 would be akin to submitting an inflated or "false" claim. Not only could the insurance company assert that it was obliged to pay its share of only the $400 "charge," but, of even more concern, the
claim could be viewed as "fraudulent." The strongest false claims arguments under this theory would arise when either a) an individual patient's co-pay was waived at the outset of the treatment, obviating any argument that the charge included the co-pay amount or b) co-pays are routinely waived for all out-of-network patients.

Along with the false claims theory, in each situation described above, an insurer could also assert that the claim falsely represented that its subscriber was actually "at risk" to pay the physician's bill. If the patient's risk was removed, it could be argued, so too was the insurer's indemnity obligation.

While the "fraudulent claim" theory described above has not yet been tested in Maryland courts, similar theories have had some success in other jurisdictions. These cases are instructive in suggesting how to avoid the potential risk that waivers of patient co-insurance could be challenged under the "false claims" argument. At the outset, all correspondence between the physician and his/her patients and between the physician and carrier, should be clear and truthful. For example, if a physician utilizes a "patient financial responsibility" form, that form should clearly and accurately describe the co-insurance waiver policy. The form should also advise the patient to carefully review his own insurance policy to determine whether or not such a waiver would affect his carrier's payment obligation.

We also recommend that while the potential for obtaining a co-insurance waiver may properly be communicated to a patient early on in the clinical process, the actual waiver decision ought not be finally made until the patient's insurance payment is received. This will make clear that the charge has not been altered, and will assure that the patient in fact remains "at risk" for payment until the carrier steps in.

Physicians should also make sure that each claim submitted to an insurance company is clear and truthful. Actual charges should be listed as actual charges. The claim might also include language advising the insurance company that, as an out-of-network provider, the physician retains the discretion to determine the amounts chargeable to patients upon receipt of the insurer's payment.

Finally, it should be recognized that while the state of the law in Maryland currently permits the waiver of patient co-payments by out-of-network providers if properly undertaken, insurance companies and administrative and legislative policy makers are likely to keep a close eye on the impact of these strategies on insurance costs. To the extent the widespread implementation of co-payment waiver policies begins to impact on these strategies on insurance costs, future legislative or administrative action may be taken to prevent their long-term effectiveness.

For more information, please contact the professional(s) listed below, or your regular Crowell & Moring contact.