LEGAL IMPLICATIONS

of Offering Discounts on Patients' Copayments and Deductibles

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In 2012, Aetna Life Insurance Company filed a lawsuit against a group of San Francisco Bay Area surgery centers that was based, to a large extent, on the group's practice of not charging copayments for its out-of-network patients insured by Aetna. Four years later, a jury awarded Aetna some $37.4 million dollars in damages, demonstrating that violations of private payor contracts can be just as costly for providers as violating the federal and state laws governing discounts on patients' cost-sharing amounts.

It has been over four years since the *Aetna* decision and we still receive questions from health care providers and suppliers around the country as to whether (and if so, how) they can offset the out-of-pocket cost-sharing amounts (e.g., copayment and deductibles) that patients have to pay for health services and items. Such offsets may be proposed in the form of discounts, rebates, prompt-pay or cash-pay incentives, or coupons (collectively, "discounts") that reduce the service's or item's total cost or that directly reduce just the patient's cost-sharing portion. Proposals of this type might be focused on all payor types, including Medicare or Medicaid, or just on private pay (allegedly to avoid the regulations tied to the federal programs). In either scenario, providers need to be careful when considering such discounts.

There are a myriad of legal issues that must be carefully navigated when it comes to offering discounts. For one, a provider's practices must conform to the laws of the states where its services are offered. In some states, for example, it is illegal for a provider to engage in the practice of regularly waiving, rebating, or paying for all or a portion of a patient's health insurance deductible. For another, private payor contracts often require providers to collect patients' cost-sharing amounts in full. As in the Aetna case, an unauthorized discount could give rise to claims from the insurance carrier for breach of contract, tortious interference, and possibly insurance fraud, particularly if there is no showing of the patient's financial need or the provider's unsuccessful collection efforts.

Of course, we must also consider the applicable federal laws. If the services may be paid for under a federal health care program (e.g., Medicare or Medicaid), then the provider's practices must comply with the federal anti-kickback statute and civil monetary penalties law. The anti-kickback statute makes it a criminal offense to knowingly and willfully offer or give anything of value in order to induce or reward the purchase of any service for which payment may be made by a federal health care program. Similarly, the civil monetary penalties law makes it unlawful to offer or give anything of value to a patient if it is likely to influence his or her decision to choose a particular provider for a service that will ultimately be paid for by Medicare or Medicaid. For both laws, discounts are *something of value*. The penalties for violating either law can be quite harsh; however, because of their breadth, both laws have exceptions and "safe harbors" to protect certain billing or financial practices that might otherwise be illegal.

There is no exception or safe harbor that allows providers to offer a routine reduction or waiver of patients' out-of-pocket costs without regard to the individual patient's financial need. A provider might be able to utilize the "discount" safe harbor, which has several documentation and disclosure requirements and, most importantly, requires that any cost reductions given to the patient must be extended to the federal health care programs. The U.S. Department of Health & Human Services generally considers discount arrangements in which a federal program gets less than, or none of, its share of the savings recognized by the discount to be "seriously abusive," because such arrangements likely result in the program being overcharged.

Simply stated, any copayment coupons, rebates, or discounts, including prompt-pay and/or cash-pay discounts, that are applied just to the patient's cost-sharing amount and not to the total cost of the health service will not fit within the discounts safe harbor.

Reductions and waivers of patient cost-sharing amounts that are based on legitimate financial need are treated differently. Even then, however, the decision to reduce or waive a copay or deductible must be made on a case-by-case basis and cannot be done routinely. For such financial need waivers, providers should develop written criteria for determining and documenting patients' financial need, and should apply such criteria consistently.

All told, there is no bulletproof way for a provider to lower patients' out-of-pocket costs on services that are payable under a federal health care program, unless the provider: (a) passes a proportionate discount onto the federal payor, or (b) makes an individualized determination of each patient's financial need for the waiver or reduction. Although a discount that does not satisfy either of those two conditions is not illegal, *per se*, it would not qualify for protection under a safe harbor and, therefore, poses risk under the anti-kickback statute and civil monetary penalties law. Unauthorized or otherwise improper discounts might also lead to breach of contract claims and other civil actions from private payors, such as Aetna. Providers would be wise to consult qualified legal counsel before offering discounts for health services, regardless of whether such services involve the federal programs.