101 Tosca Drive
Stoughton, MA 02072 USA
(Phone) 781.297-2034
(FAX) 781.297-2039
(Web) www.csmisolutions.com

Billing Insurance for Athletic Training Services:
Waiver of Co-Payments and Other Patient Responsibilities

Disclaimer: In response to questions raised by athletic trainers on the legality of forgiving patient co-payments and deductibles when billing insurances for services, Computer Sports Medicine Inc. ("CSMi") contacted a law firm with experience in health care and insurance billing to provide this general overview of the potential issues involved. This document and the information contained in it is not intended to provide legal advice, and should not be used as a substitute for receiving competent legal advice specific to your particular situation from a licensed professional attorney. CSMi is providing this information and any desired assistance in finding legal counsel solely as a courtesy to our users.

Current Case Law on Waiving Fees

Below are a few examples of recent lawsuits brought by private insurance companies against providers for waiving patient co-payments:

- Conn. Gen. Life Ins. Co. v. Elite Center For Minimally Invasive Surgery LLC, 2017 BL 45450, S.D. Tex. No. 4:16-cv-571 - Cigna sued a network of ambulatory surgery centers for $8 Million under ERISA and various state laws as a result of the centers having waived patient cost-sharing amounts. In May 2018, the parties settled the suit out of court for an undisclosed amount. Although the settlement has not been made public, an article containing further information on the case can be found at https://setexasrecord.com/stories/511444983-cigna-connecticut-general-life-surgical-centers-reach-settlement-in-overpayment-suit.
- Aetna Life Ins. Co. v. Humble Surgical Hosp., LLC, 2016 BL 436734, S.D. Tex., No. 4:12-cv-01206 - In December 2016, Aetna was awarded over $51 Million in a suit it brought against a hospital involved in a fraudulent billing scheme that included routine waiver of patient cost-sharing amounts. The hospital was later forced to file for bankruptcy. An article with further information about the case can be found at https://www.healthcarefinancenews.com/news/humble-surgical-hospital-goes-bankrupt-after-scamming-aetna-51-million.

Below is an example of recent government enforcement actions against providers for waiving patient co-payments:

- United States ex rel. Abrahamsen v. Hudson Valley Hematology-Oncology Assocs. RLLP, S.D.N.Y., No. 7:14-cv-02653, settlement approved 10/19/16 – A New York-based hematology-oncology practice agreed to pay $5.3 Million to settle claims that it violated the federal Anti-Kickback Statue and federal False Claims Act due to routinely waiving co-payments for Medicare patients without a lawful basis for doing so. The government press release regarding the settlement can be found at https://www.justice.gov/usao-sdny/pr/manhattan-us-attorney-announces-531-million-civil-settlement-against-hematology.

Billing Insurance in General

Billing third party insurance companies and other payors – including private payors and federal and state funded programs, – for the provision of athletic training services involves a variety of issues. State laws that govern the practice of athletic training have implications for whether athletic training services may be billed to insurances. Further, state laws and the terms of the specific insurance policies may additionally affect the *manner* in which athletic training services may be billed. For example, in certain instances, athletic trainers may be allowed to enroll as individual providers in insurance plans and bill for services directly. In other instances, however, athletic training services may only be billed "incident to" the services of a physician or other medical professional, with the athletic trainer acting as a "physician extender." The laws and regulations involved vary from state to state, and athletic training programs should seek the advice of legal counsel in reviewing their state's athletic trainer practice act and other applicable laws and regulations, in addition to the insurance policies involved, before submitting any bills to third party insurances.

Waiver of Patient Financial Responsibilities

In addition to the general billing issues discussed above, additional laws and regulations are implicated with regard to billing (or failing to bill) patients or their guardians for insurance co-payments, deductibles, co-insurance amounts or any other financial responsibilities for which they may be responsible. For various reasons, a provider may choose to "waive," or forgo billing, these amounts. However, athletic trainers, like other providers, should be aware of potential legal issues and liabilities that can arise as a result of the waiver of co-payments and other patient financial responsibilities.

Below is a brief overview of some of these potential risks. While the risks involved in waiving co-payments and other patient charges may not be readily apparent, these waivers can result in significant financial penalties, and in some instances jail time, and thus full consideration should be given to this issue.

If a patient has private insurance:

- State Insurance Fraud Laws:
    - Most states prohibit the submission of claims to an insurer that contain "false" or "misleading" information.
    - In this context, when a provider submits a claim to an insurer, the provider is stating that it is charging "$X" for the service. Pursuant to the terms of the insurance policy, the insurer has agreed to pay a certain percentage of "$X", with the patient being left responsible for the remaining balance (whether in the form of co-payments, deductibles, etc.). By waiving a patient's balance, the waiver may be viewed as causing the initial submission to the insurer to be "false". Insurers have claimed that because the provider never intended to collect the percentage owed by the patient, "$X" was not the provider's "real" or "truthful" charge for the service.
    - State insurance fraud laws can be implicated for claims submitted both in-network and out-of-network, and private insurance companies regularly sue providers pursuant to these laws.
- Common Law Fraud
    - States also have prohibitions against general common law fraud. Common law fraud generally requires that: (i) a misrepresentation was made, (ii) the party which made the

misrepresentation knew or should have known that it was false, (iii) the misrepresentation was made with the intent that it be relied and acted upon, and (iv) the misrepresentation was actually relied upon by another party to that party's detriment.

  - Just as with state insurance fraud laws, waiving a patient's financial responsibility while submitting a claim to an insurer listing the "full" charge could constitute common law fraud. Insurers may seek damages for common law fraud in conjunction with claims brought pursuant to state insurance fraud laws.

- Tortious Interference
  - States prohibit "tortious interference", which is where a person or entity intentionally interferes with a contract between two other parties.
  - In the context of out-of-network claims, even though a provider does not have a contract with an insurer, the insurer is providing health care coverage to the patient pursuant to an insurance agreement between the patient (or the patient's employer) and the insurer. Although these insurance agreements may allow for out-of-network services, they are structured to incentivize patients to receive services from in-network providers, as in-network services result in lower out of pocket costs for patients.
  - When an out-of-network provider waives a patient's financial responsibility, insurers have argued that the provider is in essence trying to steer the patient away from in-network services, and thus "tortuously interfering" with the coverage agreement between the insurer and the patient.
- ERISA
  - The Employee Retirement Income Security Act ("ERISA") is a federal law that governs certain health insurance plans.
  - Insurers have asserted that ERISA authorizes them to deny coverage for services for which a provider has not enforced a patient's financial responsibility requirements (i.e., waived a patient's co-pay amount). Further, insurers have sought repayment from providers under ERISA, claiming that by waiving patients' financial responsibilities, the insurer was caused to "overpay" the provider.

If a patient has <u>federal or state-funded insurance</u>:

- Anti-Kickback Statute
  - The federal Anti-Kickback Statute prohibits providers from giving (or offering to give) anything of value to federal health care program patients to induce, or to reward, the patients to receive services from the provider. A waiver of patient co-payments could be viewed as a "reward" to patients which incentivizes them to choose or receive services from the provider, in violation of this law. <u>The federal Anti-Kickback Statute is a criminal law, and violations can result in jail terms in addition to financial penalties</u>. Many states also have analogous state anti-kickback prohibitions which mirror the federal Anti-Kickback Statute. The government regularly investigates and prosecutes alleged violations of the Anti-Kickback Statute.
- Civil Monetary Penalties Law
  - The Civil Money Penalties Law authorizes the federal government to impose fines, and also exclude providers from participating in federal health care programs in the future, if

a provider is found to have, among other things, "induced" patients to receive services from the provider. Just as with the federal Anti-Kickback Statute, this law is actively enforced.

- False Claims Act
    - The federal False Claims Act states that any person who knowingly submits "false claims" to the government will be liable for the government's damages, which may be trebled, or multiplied, up to 3 times to punish the provider for the wrongdoing. Just as discussed with regard to private insurers, if a provider submits a claim to a federal health care program for "$X" but waives the amount the provider is supposed to collect from the patient, this may be viewed as submission of a false claim to the government. All states also have their own state version of the False Claims Act.
    - The False Claims Act importantly allows for "whistleblowers," or private persons with knowledge of the fraud, to bring lawsuits in place of, or alongside, the government. Known as "*qui tam*" suits, whistleblowers are incentivized to bring these suits because they can share in a percentage of the damages recouped by the government. Whistleblowers are often employees or former employees of the provider itself.
    - Due in part to the government's ability to recoup treble damages, the False Claims Act is vigorously enforced. In 2017 alone, the federal government obtained over $3.7 Billion from judgments and settlements stemming from alleged violations of the False Claims Act.

Special Concerns:
Alternatives to Outright Waiver Utilized by Certain University Athletic Training Departments

Athletic training departments at certain universities have sought out alternatives to waiving co-payments or other patient financial responsibilities. Through various programs, schools have explored ways to bill a student's insurance while still holding the student harmless from any out of pocket costs. Below is a brief overview of two alternatives currently being explored by certain schools. Just as with outright waiver of patient financial responsibilities, these alternatives involve many potential complications and risks.

- Funding a secondary insurance plan for students, specifically with the intent that it capture any amounts not covered by a student's primary insurance:
    - In this scenario, a university will bill a student's primary insurance, and then submit a bill for any amounts not covered by the primary insurance (e.g., co-payments) to the secondary insurance, which the university paid for on behalf of the student.
    - However, secondary insurance will generally not cover services provided by the same entity (or a closely related affiliate) as the entity which pays for the insurance plan. Here, the university is paying for the insurance, and thus services provided by a university-employed athletic trainer would not be covered by the secondary insurance. Further, most secondary insurances specifically exclude coverage for athletes.
    - Additionally, even if a university were able to negotiate with an insurance specifically to allow the university to lawfully both fund the insurance coverage and act as a provider/bill the plan for services provided to athletes, the cost of secondary coverage may outweigh any potential financial benefit to the university.
- Using other university funds to pay co-payments and deductibles on behalf of students:
    - In this scenario, a university-employed athletic trainer would still "bill" a student for their co-pay/deductible, but the university would use a pool of funds to pay these bills on behalf of the student.
    - The source of the university funds used to cover the bills may vary. For example, in some instances, students may pay a specifically delineated "health fee" as part of their tuition. A university may then use this pool of "health fee funds" to pay the co-payments and deductibles for students seen at on-campus providers. In other instances, the funds may originate from other sources.
    - Funding student co-payments and deductibles in this manner is complicated for a number of reasons. First and foremost, some states may view the university itself as acting as an insurer – it is taking "premium payments" (here, the "health fee") from "plan enrollees" (here, the students) and creating a pool of funds which can then be used to pay providers for their services.
    - Further, a university may choose to track the amounts paid out on behalf of a student against the amount paid by that student by way of the health fee. Once a student's health fee amount has been exhausted, the university will no longer cover any bills on behalf of the student (or may choose to no longer bill insurance for services provided to such student). However, if the university doesn't track the payments, the university is taking on "risk" (as the term is used in the insurance industry) – the university is risking that the overall annual amount it receives in health fees from all students will be enough to cover the amount it pays out to providers. This may further cause a state regulator to view the university as a provider of insurance.

- Additionally, there may be complications with using the funds specifically to cover services provided to athletes, as opposed to applying the program to claims submitted on behalf of all students.
- Thus, depending on the structure of the program, a university may be required to register with the state department of insurance (or similar governing body) as an insurance provider. Certain universities may already be registered as such, depending on other programs already in place at the university. However, a university should engage counsel to ensure that it is not running afoul of state insurance regulations (which can carry hefty fines).
- *Assuming* that a university is operating lawfully within state insurance regulations (i.e., properly registered with the state department of insurance, if necessary),
    - For students with private insurance, this alternative of funding co-payments may be less risky than simply waiving co-payments. As detailed earlier in this document, private insurance companies are mainly concerned that a provider has submitted a "false" bill. By waiving a patient's co-payment, the bill a provider submitted to an insurance with the "full" amount could be considered "false", as the provider never intended to collect the patient's responsibility for the service. In this scenario, however, the provider always intends to be reimbursed for the full amount; it just happens that another branch of the university is paying the provider, on behalf of the student, for the student's financial responsibility. Nevertheless, an insurer may take the position that funding a student's co-payment in this manner is fundamentally the same as waiving the student's co-payment, and thus an insurer may still attempt to bring a claim for fraud.
    - For students with federal or state-funded insurance, such as Medicaid, the government may view this program as just another form of co-payment waiver. In contrast to insurance laws applicable to private insurance plans, fraud laws applicable to federally-funded plans are concerned, in part, about a provider improperly incentivizing/inducing federal beneficiaries to receive services from the provider. Here, improper patient inducement could arguably still be present. By using funds held by another arm of the university to essentially "pay itself" and relieve the student of any co-payments that the student would normally be responsible for, the student could arguably be seen as receiving the same financial benefit he/she would have received had the co-payment simply been waived.

* * *

Note: There are certain instances where co-payments and other patient responsibilities may lawfully be waived. These instances, however, can vary depending on the particular state, insurance plan and/or patient in question. Further, implementation of an alternative program to relieve university students of any out of pocket costs is a complex issue with many variables.

Before implementing a policy of waiving patient financial responsibilities or undertaking any alternative arrangement, athletic trainers and athletic training departments should consult with qualified legal counsel with experience in health care fraud and abuse issues for a proper analysis of their specific circumstances. Please contact CSMi if you would like assistance in finding legal counsel.