The Discount Dilemma

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Practice Points

- Discounts to direct and immediate payers (patients) may run afoul of local and national statutes.
- Routine waiving of co-pays and deductibles can be problematic.
- Consistency of administration, objectivity in policies, and documentation of individual eligibility are essential in private practices.

Health care reform has triggered considerable discussion both in print and online about the administrative problems it has created for private practitioners, including decreased cash flow, increased paperwork and business expenses, and an increasing number of high-deductible insurance exchanges with the infamous 90-day "grace periods." Extending discounts to patients who pay at the time of service or out of pocket may mitigate damage caused by all 3 of these issues; however, caution is necessary, as discounts often can run afoul of federal and state laws, including anti-kickback statutes,[1] the anti-inducement provision of the Health Insurance Portability and Accountability Act,[2] the Medicare exclusion provision,[3] and state insurance antidiscrimination provisions.[4]

Avoid Kickback Penalties From Patient Discounts

From a legal standpoint, any discount is technically a kickback of sorts because you are returning part of your fee to the patient, and many laws designed to thwart true kickbacks can apply to patient discounts. Take the relatively straightforward case of time-of-service discounts for cosmetic procedures and other services not normally covered by insurance. You would think that these transactions are strictly between you and your patients, but if these discounts appear to be marketing incentives to attract patients, you may face a penalty.[5]

Patient discounts also may impact third-party payers. Many provider agreements contain "most favored nation" clauses, which require you to automatically give that payer the lowest price you offer to anyone else, regardless of what would be paid otherwise. In other words, the payer could demand the same discount you offer any individual patient. A time-of-service discount is, of course, exactly that: it is offered only when payment is made immediately. Third parties never pay at the time of service and would not be entitled to it, but they may try to invoke their agreement.

If you want to extend discounts for covered services, you must be sure that the discounted fee you charge the patient also is reflected on the claim submitted to the insurer. Billing the insurer more than you charged the patient invites a charge of fraud.[6] It is important to avoid discounting so regularly that the discounted fee becomes your usual and customary rate in the eyes of the insurer.

Waiving Costs and Kickbacks

Waiving coinsurance and deductibles can be trouble too, particularly with Medicare and Medicaid. You might intend it as a good deed, but the Centers for Medicare & Medicaid Services (CMS) will see it as an inducement or kickback, especially if you do it

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routinely, and similar to private carriers, they will consider the discounted fee your new customary fee. The CMS has no problem with an occasional waiver, especially "after determining in good faith that the individual is in financial need," according to the Office of Inspector General,[7] but thorough documentation is necessary in such cases.

Waiving co-pays for privately insured patients can be equally problematic. Nearly all insurers impose a contractual duty on providers to make a reasonable effort to collect applicable co-pays and/or deductibles. They view the routine waiver of patient payments as a breach of contract, and litigation may occur against providers who flout this requirement.[8] As with the CMS, accommodating patients with individually documented financial limitations is acceptable, but if there is a pattern of routine waivers and a paucity of documentation, you will have difficulty defending it.

Antidiscrimination Laws

In addition to kickback laws, some states also have antidiscrimination laws that forbid lower charges to any subset of insurance payers or to direct payers.[4] Some states make specific exceptions for legitimate discounts, such as individual cases of financial hardship, or if you pass along your lower billing and collection expenditures to patients who pay immediately, but other states do not.

Determining Discount Amounts

The discount amount depends on the physician's situation and deserves careful consideration. If the amount or percentage that you choose to offer as a discount is completely out of proportion with the administrative costs of submitting paperwork as well as the hassles associated with waiting for third-party payments, you could be accused of running a discount policy that is in effect a de facto increase to insurance carriers, which also could result in charges of fraud.[2]

In cases of legitimate financial hardship, the most effective and least problematic strategy may be to offer a sliding scale. Many large clinics and community agencies as well as all hospitals have written policies for this system, often based on federal poverty guidelines. To avoid any potential issues, contact your local social service agencies and welfare clinics, learn the community standard in your area, and formulate a written policy with guidelines for determining a patient's indigence.

Final Thoughts

Consistency of administration, objectivity in policies, and documentation of individual eligibility will ensure that the discounts you offer patients are in line with legal and payer regulations. Before you establish a discount policy, be sure to check your state's applicable laws, and as always, run everything by your attorney.

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