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The State of South Carolina
OFFICE OF THE ATTORNEY GENERAL

CHARLES MOLONY CONDON
ATTORNEY GENERAL

August 14, 1995

James Randall Davis, Esquire
Post Office Box 489
Lexington, South Carolina 29071-0489

Re: Informal Opinion

Dear Mr. Davis:

You have asked whether and under what circumstances a hospital can waive the co-payments and deductibles that otherwise would be due from patients covered by various health benefit plans. You set forth the following factual background:

> [h]istorically, third party payers responsible for paying health benefits on behalf of their enrollees have structured benefits in a manner that requires patients to bear some financial responsibility for the medical treatment received. This financial responsibility generally is in the form of deductibles and co-payments. For example, traditional insurance may not provide any financial coverage until after the payment has satisfied a $500 annual deductible payment for all services received. After the deductible is satisfied, the patient generally is responsible for a co-payment of say 20% of the charges. The purpose behind the co-payments and deductibles is to sensitize the patient to the costs of care that is being provided, give the patient an incentive to scrutinize bills for accuracy and discourage unnecessary and inappropriate utilization of medical services.
>
> Co-payments and deductibles have become even more important in an era of managed care. Many managed care

plans such as health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs") have entered into a number of contracts with providers such as hospitals and physicians. Pursuant to these contracts, the providers agree to significant discounts and other price and operational concessions in return for the managed care plan's selection of the provider as one of the "preferred providers."

Managed care plans generally require that patients selecting providers that have not entered into preferred provider contracts with the managed care plan pay substantially higher co-payments. For example, a managed care plan might require patients selecting in-network preferred providers to pay a co-payment of 10% of charges, while patients selecting non-preferred providers pay a co-payment equal to 30% to 40% of charges. The collection of co-payments and deductibles by all providers is crucial to maintaining the terms under which preferred providers agreed to contract with the managed care plans.

Providers that were not selected as a preferred provider sometimes seek to attract patients away from preferred providers by agreeing to waive the applicable co-payments. The practice of waiving co-payments makes patients indifferent between selection of in-network and out-of-network providers. Indeed, in some cases, patients might be economically better off by selecting an out-of-network provider who waives all of the co-payments rather than selecting an in-network provider who cannot waiver any portion of a lesser co-payment.

The waivers of co-payments and deductibles thus works to undercut the foundations of HMO and PPO networks. Hospitals and other providers that made significant price and other concessions in order to become preferred providers lose business to providers who did not make the necessary concessions to become preferred providers, but waive co-payment charges to patients. Waivers of co-payments thus undercut the very design of PPOs and HMOs. The waivers ignore the

> providers which offered substantial discounts in return for the right to be a "preferred provider".

LAW / ANALYSIS

I have not been able to locate any South Carolina case which addresses your specific question. I would note that there are decisions in other jurisdictions which speak to this general area. Thus, it would be helpful to discuss these at some length. One Court has recently described the purpose of co-payments as follows:

> [c]o-payments sensitize [patients] to the costs of health care, leading them not only to use less but also to seek out providers with lower fees ... which makes medical insurance less expensive and enables employees [and health care plan providers] to furnish broader coverage ... [I]f waiver of co-payments is allowed, [or if the patient does not have to make the payment herself] patients prefer the lower outlays but waivers annul the benefits of the co-payment system. The health insurer wants assurance that the patient has given enough thought to the need for [and price of] this medical care to be willing to pay. Patients who pay nothing have no reason to moderate their demands for medical service, and providers may inflate the bill .... Thus an insurer's efforts to force providers to honor their mandatory co-payment contracts increase the array of dental plans by making mandatory co-payment plans feasible, thereby giving consumers broader choice, reducing insurance costs, and enabling employers to furnish broader coverage.

Smilecare Dental Group v. Delta Dental Plan of California, 858 F.Supp. 1035 (1994).

Feiler v. N.J. Dental Assn., 191 N.J. Super. 426, 467 A.2d 276 (1983), affd., 199 N.J. Super. 363, 489 A.2d 1161 (1984) is a case which is particularly instructive. There, the New Jersey Dental Association brought suit, alleging that a dentist's billing practices to carriers and other third-party payers for dental services "untruthfully and deceptively [were presented] in such a way as to cause them to pay greater amounts than they otherwise would." 467 A.2d at 277.

Agreeing with the Dental Association, the lower court described the dentist's billing practices as follows:

> NJDA charges that Feiler's statements to carriers overstate his patient charges because he has already promised the patient that he will not collect the patient's portion of the charges. If, for instance, Fieler does a procedure for which he tells the insurance carrier he charges $100, then collects $80 from the carrier and, by prearrangement, forgives the patient's copayment, he has lied to the carrier. His charge is really $80 NJDA says, and the carrier should pay only $64. Moreover, if he does that as a rule, his usual and customary fee is $80 and not $100. In this way Feiler can promise free or almost free dentistry. To compete, another dentist would have to adopt the same means of billing.
>
> Feiler actually collects his "usual and customary" fee in only about 3% of the cases in his offices. 97% are discounted in one way or another and usually by the amount of the copayment prescribed by the insurance plan. But, he argues, this is not all prearranged. He says the patient's responsibility is for the gross fee he quotes. The copayment is forgiven an insured patient only upon receipt of the carrier's portion of the fee. An uninsured patient gains his substantial discount only by living up to a prearranged prompt payment plan.

(emphasis added) 467 A.2d at 281. Following extensive findings of fact, the Court reasoned that the following criteria should be applicable.

> [i]n order to say whether Feiler's billing methods constitute dishonest competition, one must decide whether they give him a competitive advantage over other practitioners, and whether that competitive advantage is one the law should bar. If his advantage is gained by improper means and other dentists can match it only by also employing improper means, it should be barred. In that connection, reference should be made to the elements of common law fraud. They are a false representation, by one who knows or believes in its falsity, the intention that others act thereon, reasonable reliance by others, and resulting damage .... In the absence of some special consideration, the absence of any one of the elements should bar a finding of dishonest competition based on fraudulent billing to achieve a competitive advantage. (emphasis added).

467 A.2d at 283. Based upon the relevant facts, the Court concluded:

> [t]he simple facts remain that Feiler does not tell the truth on his billing statements, that carriers largely rely on them and pay on the strength of them, that Feiler achieves a competitive advantage by offering what appears to be free or reduced price dentistry, and that the only way for honest practitioners to equalize is to adopt his unsavory approach. That is a choice the law should not demand of honest professionals.

467 A.2d at 286. (emphasis added).

On appeal, the Superior Court affirmed. The Court set forth the basic parameters of the lower court's holding as follows:

> [w]e concur with the trial judge's statement that "[t]here is nothing wrong, of course, with offering dental services at reduced prices." The reduction of costs to patients and consumers is a most desirable goal. Surely the charging of reduced fees by plaintiff would not in itself constitute unfair competition. Newspapers and air waves contain in abundance advertisements of those who proudly proclaim that their goods and services are less expensive than those of their competitors. However, the unfair competition in this case arises from the fact that plaintiff's competitors are unable to charge fees as low as plaintiff's unless they resort to plaintiff's practice of filing with insurance carriers misleading billing statements that do not comport with the underlying realities of the situation. They have the right to look to the courts in this regard. In conclusion we stress the fact that the injunction granted by the trial court does not prohibit plaintiff from waiving copayments from his patients, but merely requires that he apprise insurance carriers and third party payers of his actual intentions in this respect.

489 A.2d at 1163-1164. (emphasis added).

Other jurisdictions have analyzed this situation similarly. For example, in Tom v. Hawaii Dental Service, 606 F.Supp. 584 (D. Hawaii 1985), the Court upheld an insurance plan's refusal to reimburse a dentist where he waived co-payments based upon the fact

that "in reality he was overbilling the insurer by collecting his entire fee from it whereas [the insurance plan's] policy called for co-payment by the patient." 606 F.Supp. at 587. Likewise, the Court, in Reynolds v. California Dental Service, 246 Cal.Reptr. 331, 338 (Cal.App. 1 Dist. 1988), sustained the insurer's prohibition against waiver of co-payments, stating:

> [t]he ban against waiving the co-payment is simply the corollary of the rule that a dentist must report his true fee to [the insurer]; if a dentist intends to waive the co-payment, it is fraudulent for him to report to [the insurer] that his fee includes the co-payment.

And in Kennedy v. Connecticut General Life Ins. Co., 924 F.2d 698, 699 (7th Cir. 1991), the Court stated that "[w]hen a provider routinely waives co-payments, a fee stated as 80% of the charge is a phantom number." As is typically the case, observed the Court,

> ... co-payments sensitize employees to the costs of heath care, leading them not only to use less but also to seek out providers with lower fees. The combination of less use and lower charges (together with the 20% reduction in insured payments in the event care is furnished makes medical insurance less expensive and enables employers to furnish broader coverage ....

924 F.2d at 699.

As mentioned above, no South Carolina case appears to address or comment upon this issue. However, an earlier opinion of this Office concluded that the practice of "overbilling" by a dentist, where the dentist bills a carrier a full fee for procedures he performs and at the same time agrees with the patient to accept the carrier payment as payment in full, could be unlawful under South Carolina law. The Opinion specifically referenced S.C. Code Ann. § 39-9-30 which provides as follows:

> [a]ny agent, collector, physician or other person who shall cause to be presented to any insurance company licensed to do business in this State a false claim for payment, knowing the same to be false shall be guilty of a misdemeanor and upon conviction thereof, shall be fined or imprisoned in the discretion of the court.

In essence, the issue here is whether the billing practice of a hospital or medical provider is misleading as to the carrier. As stated in Reynolds v. California Dental Service, supra, a provider must "report his true fee" to the carrier. Moreover, as the New Jersey Appellate Court in Feiler put it, the injunction granted against the provider was not as to the waiver of co-payment, which the Court apparently did not deem unlawful, but to require that the provider "apprise insurance carriers and third party payers of his actual intentions in this respect." 489 A.2d at 1164. The Court strongly emphasized that "[t]here is nothing wrong with offering dental services at reduced prices." 489 A.2d at 1163. Consistently therewith, in the 1982 Opinion, referenced above, this Office deemed the unlawful activity to be not the waiver of co-payment, but the "overbilling"; in other words, it was telling the carrier that the usual and customary charge for a service was higher than was actually the case which violated the law. The lower Court in Feiler expressly noted that the factual basis for this conclusion was supported by the fact that the provider collected his "usual and customary" charge in only 3% of the cases, but that in 97% the usual and customary charge was discounted by the amount of co-payment.

Based upon the foregoing law, and our review of the relevant authorities, our 1982 Opinion is hereby reaffirmed today. We believe that it is indeed misleading and deceptive to "overbill" the carrier. Thus, it would be a violation of S. C. Code Ann. § 38-9-310, to tell the carrier that the usual and customary charge for a service is more than it truly is (thus "overbilling"), so that the provider is fully compensated, while at the same time he waives the co-payment to the patient.

Here, as we understand it, there is a dispute of fact as to what the provider tells the carrier and whether or not such information is actually misleading. Such a factual dispute is pivotal to the final resolution of this issue. Of course, this Office cannot and does not resolve factual disputes or make findings of fact. Op. Atty. Gen., December 12, 1983. In a particular case, if there is full and complete disclosure to the carrier that a co-payment, penalty or portion thereof is being waived, and the carrier is not being led to believe that the billed amount includes waiver of the co-payment, penalty or portion thereof with the result that the carrier is "overbilled", then a court would probably conclude that such does not violate South Carolina law. If, on the other hand, the provider is indeed "overbilling" the carrier, that is, using the billing practice to set his usual and customary charges so as to include the waived co-payment in order to "make up" for the waiver of the co-payment, penalty or portion thereof, while at the same time waiving the co-payment, penalty or portion thereof as to the patient, then a court could well conclude such conduct is unlawfully deceptive and misleading. In a nutshell, the critical factual issue is whether the provider, is, in reality, "overbilling the insurer by collecting his entire fee from it, whereas [the insurance plan's] policy called for co-payment by the patient." Tom v. Hawaii Dental Service, supra.

This Office can only set forth these general legal principles as representing what it believes the law in this area to be, and, leave the facts to be determined by a court of competent jurisdiction. In short, in an opinion, we cannot determine how a particular set of facts apply to the law in a particular instance.

This letter is an informal opinion only. It has been written by a designated Assistant Deputy Attorney General and represents the position of the undersigned attorney as to the specific questions asked. It has not, however, been personally scrutinized by the Attorney General nor officially published in the manner of a formal opinion.

With kind regards, I am

Very truly yours,

Robert D. Cook
Assistant Deputy Attorney General

RDC/an