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OIG APPROVES BENEFICIARY DISCOUNTS AND PREMIUM CREDITS FOR MEDIGAP PLAN USING PREFERRED HOSPITAL NETWORKS

The Department of Health and Human Services Office of Inspector General ("OIG") recently issued Advisory Opinion 16-11,[1] which provided a favorable opinion of a Medicare Supplemental Health Insurance plan's (the "Plan's") proposed arrangement (the "Arrangement") through which a preferred hospital network would offer Plan policyholders ("Policyholders") who elect to use a network hospital for inpatient stays a discount on Medicare deductibles for the inpatient stay. Additionally, the Plan would provide Policyholders utilizing network hospitals a $100.00 credit towards the Policyholder's next renewal premium. OIG concluded that because the Arrangement presented a sufficiently low risk of fraud and abuse, it would not warrant the imposition of administrative sanctions on the Plan under either the federal Civil Monetary Penalties Law ("CMP") or the federal Anti-Kickback Statute ("AKS").

PROPOSED ARRANGEMENT

The Plan is a licensed offeror of Medicare Supplemental Health Insurance ("Medigap") policies.[2] Under the Arrangement, the Plan would contract with a preferred hospital organization ("PHO") that maintains a national network of preferred hospitals (each a "Network Hospital"). When a Policyholder used a Network Hospital for an inpatient stay, the Network Hospital would provide a discount of up to 100 percent of the Medicare deductible that the Policyholder would otherwise incur as a result of the inpatient stay. Such discounts would apply only to the deductibles associated with Medicare Part A inpatient stays covered by the Plan and not to any other cost sharing amounts. The Plan would pay the PHO an administrative fee each time the Plan received a discount from a Network Hospital.

If the Policyholder was admitted to an out-of-network Hospital, the Plan would pay the full deductible amount for any inpatient Part A services incurred during the admission. The PHO network would be open to any accredited, Medicare-certified hospital that met the requirements of applicable state laws and that contractually agreed to discount Part A deductibles for Policyholders. The Plan certified that the Arrangement would have no impact on the liability of the Policyholder for payments for covered services, and the Policyholders' physicians and surgeons would receive no remuneration under the Arrangement for referring patients to a Network Hospital.

The Plan would return a portion of the savings generated by the Arrangement to those Policyholders who had an inpatient stay at a Network Hospital by offering those Policyholders a $100.00 credit towards their next renewal premium. The Plan intended to announce this premium credit to Policyholders through an initial notification letter and a program identification card and by sending information to Policyholders biannually regarding the participating Network Hospitals. The Plan also intended to send a written notice to Policyholders informing them that they would not incur additional costs under the Plan or otherwise be penalized if they received inpatient services at an out-of-network hospital.

DISCUSSION

The AKS makes it a criminal offense to knowingly and willfully offer or receive remuneration in an effort to induce or reward referrals of items or services reimbursable by federal health care programs. OIG has historically taken the position that waivers of Medicare cost-sharing amounts or relief from existing financial obligations are prohibited remuneration under the AKS. Because it involves the discounting of Medicare inpatient deductibles and offering premium credits to Policyholders, the Arrangement could be considered remuneration for selecting a Network Hospital and implicate the AKS.

Additionally, any person who offers remuneration to a Medicare or Medicaid beneficiary who the person knows (or should know) is likely to influence the beneficiary's selection of a provider for items or services that will be paid for by Medicare or Medicaid can be penalized under the CMP. Therefore, the proposed offering of premium credits to Policyholders who had an inpatient stay at a Network Hospital also implicates the CMP.

AKS Analysis

In its analysis of the Arrangement, OIG discusses two potentially applicable AKS safe harbors: (i) the safe harbor for waivers of beneficiary

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coinsurance and deductibles, which permits hospitals to waive Medicare Part A inpatient deductibles in certain circumstances;[3] and (ii) the safe harbor for reduced premium amounts offered by health plans, which allows plans to reduce an enrollee's obligation to pay cost-sharing or premium amounts in certain circumstances.[4] OIG noted that neither safe harbor would apply to the Arrangement. First, the safe harbor that allows for waiver of beneficiary coinsurance and deductibles specifically excludes such waivers when they are part of an agreement with an insurer, such as the Plan, except in certain circumstances not applicable to the Arrangement. Second, the safe harbor that allows for a reduced premium requires health plans to offer the same reduction to all enrollees - not just those who choose Network Hospitals, as would be the case under the Arrangement.

Because the Arrangement did not qualify for protection under an AKS safe harbor, OIG went on to analyze the various risk factors of the Arrangement. OIG determined that that the discounts offered to the Plan on inpatient deductibles and the premium credits offered to Policyholders presented a minimal risk of fraud and abuse under the AKS for the following reasons:

- Neither the discounts nor the premium credits would increase or affect per-service Medicare payments because Part A payments for inpatient services are generally fixed and unaffected by beneficiary cost-sharing.
- The discounts would be unlikely to increase utilization of services, because the discounts would be invisible to Policyholders and would only apply to the portion of a Policyholder's cost-sharing obligation that the Plan would otherwise cover. Further, OIG has traditionally held that waiving fees for inpatient services is not likely to significantly increase utilization.
- Because membership in the contracting PHO's preferred hospital network would be open to any accredited Medicare-certified hospital meeting the requirements of applicable state laws, competition among hospitals would not be unfairly affected.
- Providers' professional medical judgment would not be affected because physicians and surgeons would receive no remuneration.
- The Plan would clearly inform Policyholders that they may obtain inpatient services at any hospital without incurring additional out-of-pocket expenses for costs covered under the Plan.

CMP Analysis

Because the Plan's offering of a premium credit could induce Policyholders to obtain inpatient services (reimbursable under Medicare Part A) from a Network Hospital, the Arrangement also implicates the CMP. However, the CMP's definition of remuneration includes an exception which allows benefit plans to include differentials in coinsurance and deductible amounts as part of its benefit design, provided the differentials are properly disclosed and meet other requirements.[5] Under this exception, a benefit plan design under which enrollees pay different cost-sharing amounts depending on whether they use a network or non-network provider is permissible. OIG noted that although the premium credit in the Arrangement is not technically a differential in a coinsurance or deductible amount, it has substantially the same purpose and effect as a differential covered under the exception. Therefore, OIG concluded that the premium credit presented a sufficiently low risk of fraud and abuse under the CMP. Further, OIG observed that the Arrangement may actually lower costs for all Policyholders - even those who do not select Network Hospitals - because savings realized from the Arrangement would be reported to state insurance regulators who set rates.

PRACTICAL TAKEAWAYS

Health insurers, PHOs and providers participating in arrangements involving discounts and incentives to beneficiaries for utilizing in-network providers should carefully structure such arrangements in order to ensure that such discounts and incentives do not violate the AKS or CMP.

In order to minimize risk associated with such arrangements, stakeholders should:

- Structure arrangements to take advantage of an available AKS safe harbor or CMP exception, if possible;
- Ensure that discounts and beneficiary incentives do not increase per-service Medicare payments;
- Consider limiting discounts and waivers to fees for inpatient services only, as waiving fees for inpatient services is unlikely to result in increased utilization;
- Open provider participation in PHO networks to any willing hospital provider meeting Medicare certification and state law requirements;

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and

- Include safeguards to ensure that professional medical judgment remains unencumbered and that beneficiaries are permitted to select providers without regard to their network participation status.

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[1] For a copy of Advisory Opinion 16-11, click here.

[2] Sold by private companies, Medigap policies are designed to pay for certain health care costs that original Medicare doesn't cover, such as beneficiary copayments, coinsurance and deductibles.

[3] See 42 C.F.R. § 1001.952(k).

[4] See 42 C.F.R. § 1001.952(l).

[5] See Section 1128A(i)(6)(C) of the Social Security Act.

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