DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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HOSPITAL DISCOUNTS OFFERED TO PATIENTS WHO CANNOT AFFORD TO PAY THEIR HOSPITAL BILLS

This document addresses the views of the Office of Inspector General ("OIG") on the following topics: (1) discounts provided by hospitals for uninsured patients who cannot afford to pay their hospital bills and (2) reductions or waivers of Medicare cost-sharing amounts by hospitals for patients experiencing financial hardship. For the following reasons, the OIG believes that hospitals have the ability to provide relief to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing amounts. The OIG fully supports hospitals' efforts in this area.

Discounts for Uninsured Patients Who Cannot Afford to Pay Their Hospital Bills

No OIG authority prohibits or restricts hospitals from offering discounts to uninsured patients who are unable to pay their hospital bills. It has been suggested that two laws enforced by the OIG may prevent hospitals from offering discounted prices to uninsured patients. We disagree and address each law in turn.

- **The Federal Anti-Kickback Statute.**[1] The Federal anti-kickback statute prohibits a hospital from giving or receiving anything of value in exchange for referrals of business payable by a Federal health care program, such as Medicare or Medicaid. The Federal anti-kickback statute does not prohibit discounts to uninsured patients who are unable to pay their hospital bills. However, the discounts may not be linked in any manner to the generation of business payable by a Federal health care program. Discounts offered to underinsured patients potentially raise a more significant concern under the anti-kickback statute, and hospitals should exercise care to ensure that such discounts are not tied directly or indirectly to the furnishing of items or services payable by a Federal health care program. As discussed below, the statute and regulations offer means to reduce or waive coinsurance and deductible amounts to provide assistance to underinsured patients with reasonably verified financial need.

- **Section 1128(b)(6)(A) of the Social Security Act.**[2] This law permits – but does not require – the OIG to exclude from participation in the Federal health care

[1] 42 U.S.C. § 1320a-7b(b).

[2] 42 U.S.C. § 1320a-7(b)(6)(A).

programs any provider or supplier that submits bills or requests for payment to Medicare or Medicaid for amounts that are substantially more than the provider's or supplier's usual charges. The statute contains an exception for any situation in which the Secretary finds "good cause" for the substantial difference. The statute is intended to protect the Medicare and Medicaid programs – and taxpayers – from providers and suppliers that routinely charge the programs substantially more than their other customers.

The OIG has never excluded or attempted to exclude any provider or supplier for offering discounts to uninsured or underinsured patients. However, to provide additional assurance to the industry, the OIG recently proposed regulations that would define key terms in the statute.[3] Among other things, the proposed regulations would make clear that free or substantially reduced charges to uninsured persons would not affect the calculation of a provider's or supplier's "usual" charges, as the term "usual charges" is used in the exclusion provision. The OIG is currently reviewing the public comments to the proposed regulations. <u>Until such time as a final regulation is promulgated or the OIG indicates its intention not to promulgate a final rule, it will continue to be the OIG's enforcement policy that, when calculating their "usual charges" for purposes of section 1128(b)(6)(A), individuals and entities do not need to consider free or substantially reduced charges to (i) uninsured patients or (ii) underinsured patients who are self-paying patients for the items or services furnished</u>.

As noted in the preamble to the proposed regulations, the exclusion provision does <u>not</u> require a hospital to charge everyone the same price; nor does it require a hospital to offer Medicare or Medicaid its "best price." However, hospitals cannot routinely charge Medicare or Medicaid substantially more than they usually charge others.

In addition to the two laws discussed above, it has been suggested that hospitals are reluctant to give discounts to uninsured patients because the OIG requires hospitals to engage in vigorous collection efforts against uninsured patients. This misperception may be based on some limited OIG audits of specific hospitals' compliance with Medicare's bad debt rules. The bad debt rules and regulations, including the scope of required collection efforts, are established by the Centers for Medicare & Medicaid Services ("CMS"). No OIG rule or regulation requires a hospital to engage in any particular collection practices.

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[3] 68 Fed. Reg. 53939 (Sept. 15, 2003).

Reductions or Waivers of Cost-Sharing Amounts for Medicare Beneficiaries Experiencing Financial Hardship

The fraud and abuse laws clearly permit the waiver of all or a portion of a Medicare cost-sharing amount for a financially needy beneficiary.[4] Importantly, under the fraud and abuse laws, the "financial need" criterion is not limited to "indigence," but can include any reasonable measures of financial hardship.

Like many private insurance plans, the Medicare program includes a cost-sharing requirement. Cost-sharing is an important control on overutilization of items and services. If beneficiaries are required to pay for a portion of their care, they will be better health care consumers, selecting items or services because they are medically needed.

The routine waiver of Medicare coinsurance and deductibles can violate the Federal anti-kickback statute (discussed above) if one purpose of the waiver is to generate business payable by a Federal health care program.[5] In addition, a separate statutory provision prohibits offering inducements – including cost-sharing waivers – to a Medicare or Medicaid beneficiary that the offeror knows or should know are likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier.[6] (This prohibition against inducements offered to Medicare and Medicaid beneficiaries does not apply to uninsured patients.)

However, there are two important exceptions to the general prohibition against waiving Medicare coinsurance and deductibles applicable to hospitals, one for financial hardship situations and one for inpatient hospital services.

First, providers, practitioners, and suppliers may forgive a Medicare coinsurance or deductible amount in consideration of a particular patient's financial hardship. Specifically, under the fraud and abuse laws, Medicare cost-sharing amounts may be waived so long as:

- the waiver is not offered as part of any advertisement or solicitation;

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[4]Hospitals still need to ensure that they comply with all relevant Medicare program rules.

[5]In certain circumstances, the routine waiver of coinsurance and deductible amounts can implicate the False Claims Act, 31 U.S.C. § 3729. See Special Fraud Alert: Routine Waiver of Copayments or Deductibles Under Medicare Part B, 59 Fed. Reg. 65372, 65374 (Dec. 19, 1994), available on the OIG webpage at http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html.

[6]42 U.S.C. § 1320a-7a(a)(5). The statute includes several other exceptions. One exception permits the waiver of cost-sharing amounts for certain preventive care services without any requirement to determine financial need. 42 U.S.C. § 1320a-7a(i)(6)(D); 42 C.F.R. § 1003.101; see also 65 Fed. Reg. 24400, 24409 (April 26, 2000).

- the party offering the waiver does not routinely waive coinsurance or deductible amounts; and
- the party waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need or reasonable collection efforts have failed.[7]

The OIG recognizes that what constitutes a good faith determination of "financial need" may vary depending on the individual patient's circumstances and that hospitals should have flexibility to take into account relevant variables. These factors may include, for example:

- the local cost of living;
- a patient's income, assets, and expenses;
- a patient's family size; and
- the scope and extent of a patient's medical bills.

Hospitals should use a reasonable set of financial need guidelines that are based on objective criteria and appropriate for the applicable locality. The guidelines should be applied uniformly in all cases. While hospitals have flexibility in making the determination of financial need, we do not believe it is appropriate to apply inflated income guidelines that result in waivers for beneficiaries who are not in genuine financial need. Hospitals should consider that the financial status of a patient may change over time and should recheck a patient's eligibility at reasonable intervals sufficient to ensure that the patient remains in financial need. For example, a patient who obtains outpatient hospital services several times a week would not need to be rechecked every visit. Hospitals should take reasonable measures to document their determinations of Medicare beneficiaries' financial need. We are aware that in some situations patients may be reluctant or unable to provide documentation of their financial status. In those cases, hospitals may be able to use other reasonable methods for determining financial need, including, for example, documented patient interviews or questionnaires.

Second, another exception to the general prohibition against Medicare cost-sharing waivers is contained in an OIG "safe harbor" regulation related to inpatient hospital services.[8] Compliance with a safe harbor regulation is voluntary, and failure to comply does not necessarily mean an arrangement is illegal. However, a hospital that complies fully with a safe harbor is assured that it will not be prosecuted under the Federal anti-kickback statute.[9]

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[7]42 U.S.C. § 1320a-7a(i)(6)(A); Special Fraud Alert, supra note 5.

[8]42 C.F.R. § 1001.952(k).

[9]Furthermore, 42 U.S.C. § 1320a-7a(i)(6)(B) provides that any waiver that fits in a safe harbor to the anti-kickback statute is similarly protected under the beneficiary inducements statute (discussed above).

The safe harbor for waivers of coinsurance and deductibles provides that a hospital may waive coinsurance and deductible amounts for inpatient hospital services for which Medicare pays under the prospective payment system if the hospital meets three conditions:

- the hospital cannot claim the waived amount as bad debt or otherwise shift the burden to the Medicare or Medicaid programs, other payers, or individuals;

- the waiver must be made without regard to the reason for admission, length of stay, or diagnostic related group; and

- the waiver may not be part of a price reduction agreement between the hospital and a third-party payer (other than a Medicare SELECT plan).

While the OIG is not concerned about bona fide cost-sharing waivers for beneficiaries with genuine financial need, we have a long-standing concern about providers and suppliers that use "insurance only billing" and similar schemes to entice Federal health care program beneficiaries to obtain items or services that may be medically unnecessary, overpriced, or of poor quality.

OIG Advisory Opinion Process

The OIG has an advisory opinion process that is available to hospitals or others that want assurance that they will not run afoul of the fraud and abuse laws.[10] OIG advisory opinions are written opinions that are legally binding on the OIG, the Department of Health and Human Services, and the party that requests the opinion. To obtain an opinion, the requesting party must submit a detailed, written description of its existing or proposed business arrangement. The length of time that it takes for the OIG to issue an opinion varies based upon a number of factors, including the complexity of the arrangement, the completeness of the submission, and how promptly the requestor responds to requests for additional information. Further information about the process, including frequently asked questions, can be found on the OIG webpage at http://oig.hhs.gov/fraud/advisoryopinions.html.

[10]Section 1128D(b) of the Social Security Act; 42 C.F.R. part 1008.

Conclusion

Hospitals have the ability to provide discounts to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing obligations. Nothing in the OIG rules or regulations prohibits such discounts, and the OIG fully supports the hospital industry's efforts to lower health care costs for those unable to afford care. While every case must be evaluated on its own merits, it is important to note that the OIG has never brought a case based on a hospital's bona fide discounting of its bill for an uninsured or underinsured patient of limited means.

Guidance about the anti-kickback statute and other fraud and abuse authorities is available on the OIG's webpage at http://oig.hhs.gov/. This guidance includes the Special Fraud Alert on Routine Waivers of Copayments and Deductibles under Medicare Part B; safe harbor regulations (and the "preamble" discussions that include explanatory information), the compliance program guidance for hospitals, and OIG advisory opinions.

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