[*We redact certain identifying information and certain potentially privileged, confidential, or proprietary information associated with the individual or entity, unless otherwise approved by the requester*.]

Issued: August 17, 2001

Posted: August 24, 2001

[name and address redacted]

Re: OIG Advisory Opinion No. 01-13

Dear [name redacted]:

We are writing in response to your request for an advisory opinion regarding the "coordination of benefits" provisions of a provider agreement between [Requestor's name redacted] (the "Plan"), a health maintenance organization or "HMO", and the skilled nursing facilities in its provider network (the "Nursing Facilities"). In particular, you ask whether the method of coordinating insurance benefits in the Plan's commercial HMO plans with respect to the Nursing Facilities (the "Arrangement") would constitute grounds for the imposition of sanctions under the exclusion authority at section 1128(b)(7) of the Social Security Act (the "Act") or the civil monetary penalty provision at section 1128A(a)(7) of the Act, as those sections relate to the commission of acts described in section 1128B(b) of the Act.

The contractual provisions that are the subject of your advisory opinion request were also the subject of a prior opinion, OIG Advisory Opinion No. 98-5. In that opinion, we concluded that the Arrangement might violate the anti-kickback statute. While the Plan was a party to the contract at issue in OIG Advisory Opinion No. 98-5, the actual requestor of that opinion was one of the Nursing Facilities. In your advisory opinion request, you provided information about the particular regulatory and rate-setting scheme for HMOs in [name redacted] State and asked whether that information would affect our prior conclusion.

You have certified that all of the information provided in your request, including all supplementary letters, is true and correct, and constitutes a complete description of the facts and agreements among the parties regarding the Arrangement. In issuing this opinion, we have relied solely on the facts and information you presented to us. This opinion is limited to the facts presented. We have not undertaken any independent investigation of such information.

Based on the facts certified in your request for an advisory opinion and supplemental submissions, we conclude that the Arrangement could potentially generate prohibited remuneration under the anti-kickback statute, if the requisite intent to induce or reward referrals of Federal health care program business were present, but that the Office of Inspector General ("OIG") will not impose administrative sanctions on [Requestor's name redacted], under sections 1128(b)(7) or 1128A(a)(7) of the Act (as those sections relate to the commission of acts described in section 1128B(b) of the Act) in connection with the Arrangement.

We emphasize the limited nature of this opinion. While all advisory opinions are limited to their specific facts and must be read in conjunction with the express limitations therein, we particularly want to emphasize the following constraints:

- This opinion only addresses the anti-kickback statute. We express no opinion as to potential liability under the False Claims Act or as to the enforceability of the coordination of benefits provision under any other Federal law.

- This opinion only addresses a community-rated, state-regulated health maintenance organization. Other insurance products, such as employer-sponsored or experience-rated health plans, with the identical coordination of benefits provision raise separate issues not addressed here.

- This opinion only addresses Medicare's skilled nursing facility benefit and is specific to the benefit and reimbursement structure and methodology used by the Medicare program for such benefit. Other benefits, such as the hospital or physician services benefits, may raise other issues not addressed here.

This opinion may not be relied on by any persons other than the Plan, and is further qualified as set out in Part III below and in 42 C.F.R. Part 1008.

I. FACTUAL BACKGROUND

A. The Arrangement

The Plan is a [State name redacted], not-for-profit corporation licensed as an HMO. The Plan's primary business is a commercial HMO product, which covers approximately 350,000 HMO members in Western [State name redacted], of whom less than five percent have primary coverage under Medicare. In addition, the Plan and its affiliated companies offer other health care products, including a point-of-service plan, traditional

indemnity coverage, Medicare+Choice and Medicaid managed care plans, and administrative services for self-funded benefit programs; those products, in the aggregate, cover approximately 70,000 lives.

The Plan's advisory opinion request relates solely to the Plan's commercial HMO product. Commercial HMOs are subject to extensive regulation by the [name redacted] State Department of Insurance. In particular, commercial HMOs that market to the individual and small group markets must community rate the premiums they charge to purchasers of commercial insurance products. (*See* [State law citation redacted].) Regardless of the enrollee's age, sex, health risk, etc., each employer or subscriber pays the same insurance rate for the same benefit package subject to variations for coinsurance and policy riders. In addition, the Department of Insurance reviews and approves HMO premium rates, taking into account the level of profits that remain after the payment of claims and administrative expenses, including any offsetting recoveries from the coordination of benefits ("COB").

The Plan provides health services to commercial HMO enrollees through a contractual network of more than 4,700 providers in western [State name redacted], including sixty-three Nursing Facilities that provide multiple services, including short-term, sub-acute, and rehabilitative services. These sixty-three Nursing Facilities comprise over seventy percent of the skilled nursing facilities in the Plan's region of western [State name redacted]. Each of the Plan's participating provider agreements with the Nursing Facilities in the network is identical and carries the same terms and conditions, in particular, the same COB provision. Any skilled nursing facility provider can participate in the Plan's network provided it meets the Plan's quality standards and agrees to the fee schedule.

The COB provision in the Plan's participating provider agreements describes the coverage formula to be applied when a Plan's member has two or more forms of medical coverage and the Plan is the secondary payor (*i.e.*, Medicare or some other payor is primary and the Plan is secondary).[1] It has been in use by the Plan for at least ten years and is expressly permitted by [State name redacted] insurance department regulations. Specifically, the COB provision states:

> When [the Plan] is a secondary or later plan (not primary plan as defined in [citation redacted], it shall only pay when [the Plan's] allowed amount listed on Schedule B has not been paid to Participating Provider by the

[1]The Plan has certified that the COB provision complies with [citation redacted] of the Department of Insurance Regulations for [State name redacted].

> primary plan. If [the Plan's] allowed amount listed in Schedule B has been paid to Participating Provider by the primary plan, then Participating Provider shall hold the Member harmless from and against any and all charges including charges for copayments and deductibles. For purposes of this Agreement, primary plan may include hospital service corporations, indemnity corporations, commercial carriers, self-insured or self-funded plans and Medicare.

Thus, the Nursing Facilities agree to accept the amount listed in the fee schedule included in their provider agreements (the "Plan Fee Schedule"), as payment in full for services rendered. The Plan Fee Schedule's rates for Nursing Facility services apply across the board to all of the Plan's commercial HMO enrollees, the great majority of whom are not Medicare enrollees. The COB provision (i) releases the Plan from any obligation to pay benefits where the Nursing Facility has already received payment from the patient's primary insurer in an amount equal to or exceeding the Plan Fee Schedule amount and (ii) requires the Nursing Facility to hold the Plan's members harmless from any charges, including copayments, coinsurance amounts, and deductibles (collectively, "cost-sharing obligations" or "cost-sharing amounts").[2]

B. The Interaction of the COB Provision and Medicare Part A

Many Medicare beneficiaries have additional health insurance coverage that supplements their Medicare coverage, such as retiree health benefits. Generally, if supplemental coverage exists for Medicare beneficiaries, claims for Medicare covered health services for such beneficiaries are first submitted to Medicare (the "primary insurer") and the amounts not paid by Medicare are then submitted to the supplemental or "secondary"

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[2]A second provision of the contract expressly prohibits direct billing of the Plan's members: "Participating Provider hereby agrees that in no event . . . shall Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against [the Plan's] Members. . . ." These contractual *hold harmless* provisions restate a [State name redacted] regulatory requirement that protects "enrollees from billing by providers for services covered under the enrollee contract during the operation of the HMO or in the event of insolvency." [citation redacted].

insurer.[3] In the instant case, the number of Plan enrollees with primary coverage under Medicare (hereafter, the "Plan's Medicare enrollees") is less than five percent.[4]

The Medicare Part A reimbursement principles that apply to the Nursing Facilities require Medicare to pay the full amount of the facility's applicable per diem rate for the first 20 days of a beneficiary's stay. For days 21 through 100, the facility's payment from Medicare is reduced by a daily coinsurance amount equal to one-eighth of the hospital inpatient deductible.[5] *See* 42 U.S.C. § 1395e; 42 C.F.R. §409.85. Under the Act and implementing regulations, this coinsurance amount is a beneficiary's obligation. *See, e.g.*, 42 C.F.R. § 409.85; 42 C.F.R. § 409.61(b).

The COB provisions contained in the Nursing Facilities' provider agreements with the Plan, in conjunction with the Plan Fee Schedule, effectively result in a full or partial waiver of this Medicare coinsurance amount when Medicare is the primary payor and the applicable Medicare reimbursement is higher than the Plan Fee Schedule amount. The following hypothetical example is illustrative:

> For purposes of this example, the Nursing Facility's Medicare per diem rate is $300/day. The Medicare coinsurance is $95/day for days 21-100. The Plan Fee Schedule rate is $225/day.
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> One of the Plan's Medicare enrollees is admitted to the Nursing Facility for a 31 day stay. A Medicare coinsurance of $950 ($95 x 10 days) applies to the last 10 days. For those days, the Nursing Facility is entitled to Medicare reimbursement of $3,000 ($300 x 10 days). Medicare pays the Nursing Facility $2,050 ($3,000 - $950 coinsurance). The Nursing Facility bills the Plan for the $950 coinsurance.

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[3]In some situations not relevant here, employer plans are primary to Medicare under section 1862(b)(2) of the Act.

[4]The Plan applies the same utilization review procedures to its enrollees who have primary coverage under Medicare as it applies to other enrollees for whom the Plan pays in full. However, if the Plan's utilization review procedures conflict with a Medicare beneficiary's rights and benefits under Medicare, then Medicare's rules, regulations, and policies may preempt the Plan's utilization review policies.

[5]In some circumstances, the applicable coinsurance may be a lesser amount if a facility's actual charge is less than one-eighth of the hospital inpatient deductible. In such cases, the daily coinsurance is the amount of the actual charge per day. *See* 42 C.F.R. § 409.85.

> The Plan, applying its COB provisions, limits the Nursing Facility's reimbursement to $2,250 ($225 x 10 days). The Plan pays the Nursing Facility $200 ($2,250 - $2,050 Medicare payment). The Nursing Facility still has a balance owing of $750 for the Medicare coinsurance. Under its agreement with the Plan, the Nursing Facility is prohibited from billing the Plan's Medicare enrollee for the balance of the coinsurance.

In this example, the balance of the Medicare coinsurance owed to the Nursing Facility is effectively waived.[6]

II. LEGAL ANALYSIS

A. Introduction

The anti-kickback statute makes it a criminal offense knowingly and willfully to offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by Federal health care programs. *See* section 1128B(b) of the Act. Where remuneration is paid purposefully to induce or reward referrals of items or services payable by a Federal health care program, the anti-kickback statute is violated. By its terms, the statute ascribes criminal liability to parties on both sides of an impermissible "kickback" transaction. For purposes of the anti-kickback statute, "remuneration" includes the transfer of anything of value, in cash or in-kind, directly or indirectly, covertly or overtly.

The statute has been interpreted to cover any arrangement where *one* purpose of the remuneration was to obtain money for the referral of services or to induce further referrals. United States v. Kats, 871 F.2d 105 (9th Cir. 1989); United States v. Greber, 760 F.2d 68 (3d Cir.), cert. denied, 474 U.S. 988 (1985). Violation of the statute constitutes a felony punishable by a maximum fine of $25,000, imprisonment up to five years, or both. Conviction will also lead to automatic exclusion from Federal health care programs, including Medicare and Medicaid. Where a party commits an act described in section 1128B(b) of the Act, the OIG may initiate administrative proceedings to impose civil monetary penalties on such party under section 1128A(a)(7) of the Act. The OIG may also initiate administrative proceedings to exclude such party from the Federal health care programs under section 1128(b)(7) of the Act.

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[6]The state's *hold harmless* regulation ([citation redacted], discussed above) and the parties' agreement that the Nursing Facility will not collect cost-sharing amounts from beneficiaries in effect shift the Medicare coinsurance obligation from the Plan's Medicare enrollees to the Plan.

This opinion requires us to revisit OIG Advisory Opinion No. 98-5, in which we concluded that the COB provision in a participation agreement between the Plan and a Nursing Facility could, in certain circumstances, and depending on the intent of the parties, result in a violation of the anti-kickback statute. That conclusion remains correct; however, we have been provided additional facts that affect whether we would impose administrative sanctions. Here, we revisit the COB provision in the context of the specific regulatory scheme (namely, community rating) for the particular line of business at issue (a commercial HMO). For the reasons discussed below, we have concluded that the anti-kickback statute could be violated, depending on the intent of the parties; however, we will not impose sanctions on the Plan in connection with the Arrangement. Separately, we are also modifying OIG Advisory Opinion No. 98-5 to conform to our conclusions herein.

B. Concerns with COB Provisions

The OIG has a longstanding and well-known concern with arrangements under which health care providers routinely waive cost-sharing amounts that are required under Medicare, including agreements between insurers and providers that require providers to waive Medicare cost-sharing obligations as a condition of participation in an insurance company's network. Arrangements to waive Medicare cost-sharing obligations potentially implicate several criminal and civil statutes, including the Federal anti-kickback statute and the False Claims Act. The OIG has repeatedly articulated its concern about any arrangements that operate to waive Medicare cost-sharing amounts routinely.

Those concerns apply to situations in which COB provisions in commercial insurance products can operate, in effect, to waive Medicare cost-sharing obligations when the commercial policy is the secondary insurer and Medicare is primary. The obligation to pay the Medicare coinsurance is a requirement of the Social Security Act, and Federal law governing Federal programs generally overrides any contrary state law or private contractual provisions. If a plan has assumed a Medicare beneficiary's cost-sharing obligation, the plan should pay the cost-sharing amount.

This opinion applies to the anti-kickback statute. Not every instance of a secondary insurer's COB provision resulting in a waiver of some or all of a Medicare cost-sharing obligation is a violation of the anti-kickback law. Historically, COB provisions that are commonly found in insurance policies have *occasionally* resulted in the waiver of all or part of a Medicare cost-sharing obligation. These occasional waivers were not necessarily illegal, at least under a statute that requires intent or knowledge as an element of an offense, as does the anti-kickback statute.

Even so, we are concerned that some plans may knowingly manipulate these contractual COB provisions and the administration of these contracts to avoid their obligation to pay Medicare cost-sharing amounts for their own financial benefit and that of their customers. In particular, such plans could use the "savings" from the unpaid cost-sharing obligation to offer lower rates to customers with significant numbers of enrollees who also have primary coverage under Medicare (*e.g.*, retirees), thereby gaining a significant commercial advantage over competing plans that fulfilled their legal obligation to pay cost-sharing amounts.

C. The Requestor's COB Provision

That concern does not appear to be implicated in the circumstances here. *First*, the Arrangement appears more akin to the historical COB situation in which the provision results in an occasional forbearance of a Medicare cost-sharing obligation. The COB provision is longstanding and expressly approved by the State Department of Insurance. The rates in a Nursing Facility's Plan Fee Schedule apply across the board to all of the HMO's commercial enrollees, the great majority of whom are not Medicare enrollees. Significantly, even with respect to that subset of enrollees, the effect of the COB provision for any given Nursing Facility stay is unpredictable for the following reasons: (1) the Medicare coinsurance obligation only applies if the patient's skilled nursing stay exceeds twenty days; and (2) the amount of the Medicare payment waived under the COB provision depends on the amount of the applicable Medicare reimbursement (*i.e.*, the Resource Utilization Grouping rate, a/k/a the RUGs rate), which varies with the particular health status of the patient. In short, the effect of the COB provision on potential Medicare coinsurance obligations would appear to be unpredictable and relatively infrequent in the context of a commercial plan consisting primarily of non-Medicare enrollees.

Second, the potential financial advantage to the Plan is limited given the regulatory requirement of community rating for premiums and State oversight of rates. Under the State regulatory scheme, the premium charged by the Plan is the same for all purchasers who have the same benefit package. Accordingly, the Plan must charge identical premiums to an employer for the same benefit package, regardless of whether it has a sizable Medicare eligible population or not. Thus, the Plan has little incentive to manipulate the fee schedule to maximize waivers of coinsurance amounts, since it will not be in a position to offer lower premiums for the same benefit package to Medicare-heavy groups and populations. Moreover, coinsurance waivers should not result in substantially increased profits, given the substantial State involvement in the HMO's rate setting. The Department of Insurance reviews and approves HMO premium rates after taking into account the level of profits that remain after the payment of claims and administrative expenses, including any offsetting recoveries under COB provisions.

Third, another important inquiry is whether the Plan is in a position to influence the Nursing Facility placement of Medicare-eligible enrollees. Nursing facility placement decisions are typically influenced by the discharging hospital, the facility's geographic proximity to the patient, and availability of space. While a nursing facility's participation in the Plan's network is undoubtedly a threshold issue in the patient's selection of a nursing facility, where there is wide choice among facilities, the Plan's ability to influence referrals is attenuated. Given the wide and unrestricted participation in the Plan's nursing home network, and the relatively small number of enrollees with primary coverage under Medicare, the Plan's ability to influence placement of such individuals is minimal.

Fourth, the Arrangement should not have an adverse financial impact on the Medicare program. The Medicare program pays for Part A skilled nursing care based on a prospectively determined rate that is adjusted to reflect the severity of a beneficiary's condition. By contrast, Part B reimbursement is typically based on the lower of the provider's actual amount charged or a Centers for Medicare and Medicaid Services ("CMS")[7] fee schedule amount. The difference in reimbursement methodology is significant because under Part B, Medicare could benefit from any lower negotiated price through a lower actual charge. Under Part A, there is no comparable opportunity for the program to share in any discount. Therefore, this advisory opinion might have reached a different result if the underlying facts involved Part B reimbursement, rather than Part A reimbursement. Moreover, the risk of overutilization of Part A Nursing Facility services is low. The Plan applies the same utilization review procedures to its enrollees who have primary coverage under Medicare as it applies to other enrollees for whom the Plan pays in full.[8]

Fifth, we have reevaluated our concern regarding the potential for stinting on services. A Nursing Facility's inability to collect coinsurance would not increase the likelihood that the Nursing Facility will reduce services to the Plan's Medicare enrollees. After all, the Nursing Facility will receive the same reimbursement (or potentially more) from Medicare for these Plan enrollees as it will receive for the substantially larger number of enrollees for which the Plan is primary. In other words, under the Arrangement, the Nursing Facility will not receive less reimbursement for the Plan's Medicare enrollees;

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[7]CMS was formerly known as the Health Care Financing Administration ("HCFA").

[8]We note that utilization review is not necessarily an effective control against fraud and abuse. Standing alone, a utilization review program would not be a dispositive factor in a fraud and abuse analysis.

the Facility will simply not receive any greater reimbursement than it would for its non-Medicare residents. Since we assume the Nursing Facility has priced its services for the Plan's other enrollees to cover its costs plus some profit, there is no more incentive to withhold services from the Plan's Medicare enrollees than from any other enrollee.

D. Conclusion

Based on the facts certified in your request for an advisory opinion and supplemental submissions, we conclude that the Arrangement could potentially generate prohibited remuneration under the anti-kickback statute, if the requisite intent to induce or reward referrals of Federal health care program business were present, but that the OIG will not impose administrative sanctions on [Requestor's name redacted], under sections 1128(b)(7) or 1128A(a)(7) of the Act (as those sections relate to the commission of acts described in section 1128B(b) of the Act) in connection with the Arrangement.

We again emphasize the limited nature of this opinion. While all advisory opinions are limited to their specific facts and must be read in conjunction with the express limitations therein, we particularly want to emphasize the following constraints:

- This opinion only addresses the anti-kickback statute. We express no opinion as to potential liability under the False Claims Act or as to the enforceability of the COB provision under any other Federal law.

- This opinion only addresses a community-rated, state-regulated health maintenance organization. Other insurance products, such as employer-sponsored or experience-rated health plans, with the identical COB provision raise separate issues not addressed here.

- This opinion only addresses Medicare's skilled nursing facility benefit and is specific to the benefit and reimbursement structure and methodology used by the Medicare program for such benefit. Other benefits, such as the hospital or physician services benefits, may raise other issues not addressed here.

III. LIMITATIONS

The limitations applicable to this opinion include the following:

- This advisory opinion is issued only to [Requestor's name redacted], the requestor of this opinion.

- This advisory opinion has no application to, and cannot be relied upon by, any other individual or entity.

- This advisory opinion may not be introduced into evidence in any matter involving an entity or individual that is not a requestor to this opinion.

- This advisory opinion is applicable only to the statutory provisions specifically noted above. No opinion is herein expressed or implied with respect to the application of any other Federal, state, or local statute, rule, regulation, ordinance, or other law that may be applicable to the Arrangement.

- This advisory opinion will not bind or obligate any agency other than the U.S. Department of Health and Human Services.

- This advisory opinion is limited in scope to the specific Arrangement described in this letter and has no applicability to other arrangements or proposed arrangements, even those that appear similar in nature or scope. No opinion is expressed herein regarding the liability of any party under the False Claims Act or other legal authorities for any improper billing, claims submission, cost reporting, or related conduct.

- This opinion is also subject to any additional limitations set forth at 42 C.F.R. Part 1008.

The OIG will not proceed against the Requestor with respect to any action that is part of the Arrangement taken in good faith reliance upon this advisory opinion as long as all of the material facts have been fully, completely, and accurately presented, and the Arrangement in practice comports with the information provided. The OIG reserves the right to reconsider the questions and issues raised in this advisory opinion and, where the public interest requires, to rescind, modify or terminate this opinion. In the event that this advisory opinion is modified or terminated, the OIG will not proceed against the Requestor with respect to any action taken in good faith reliance upon this advisory opinion, where all of the relevant facts were fully, completely, and accurately presented and where such action was promptly discontinued upon notification of the modification or termination of this advisory opinion. An advisory opinion may be rescinded only if the relevant and material facts have not been fully, completely, and accurately disclosed to the OIG.

Sincerely,

/S/

D. McCarty Thornton
Chief Counsel to the Inspector General