Testimony of
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Good morning Mr. Chairman and Members of the Subcommittee. I am here today to discuss the Office of Inspector General's (OIG's) views on the discounts that hospitals offer to uninsured patients and to others who are unable to pay their hospital bills. We understand that there is widespread concern about hospitals' billing and collection practices as those practices affect patients who cannot afford to pay their hospital bills. I want to assure the Committee that OIG fully supports efforts that hospitals have made to help financially needy patients. We appreciate the opportunity to address this issue and to discuss OIG's legal authorities in this area.

Simply put, the fraud and abuse laws enforced by OIG allow hospitals and other health care providers and suppliers to offer discounts to patients who cannot afford to pay for their care. Indeed, our legal authorities have extremely limited application to discounts offered to uninsured patients. When the patient's health care is covered under a Federal health care program, such as Medicare or Medicaid, our legal authorities have greater application. But even then, the laws and regulations clearly enable hospitals and others to help patients who are experiencing financial hardship. OIG has long-standing and clear guidance on this point.

While today's presentation focuses on discounts that hospitals offer to uninsured and financially needy patients, the underlying principles apply equally to the rest of the Medicare- and Medicaid-serving health care industry. Before I discuss OIG's views, it is important to note that a thorough discussion of hospital discounts for patients with financial hardship also involves questions for the Centers for Medicare & Medicaid Services (CMS). CMS has programmatic responsibility for the Medicare program and has established the cost reporting and bad debt rules relevant to hospital discounting practices. A CMS witness is also testifying today and will address the CMS issues.

From OIG's perspective, discounts offered to uninsured patients are analyzed under two fraud and abuse laws: the Federal anti-kickback statute and the permissive exclusion

authority prohibiting providers and suppliers from charging Medicare or Medicaid substantially more than they usually charge other customers. Discounts offered to financially needy Medicare or Medicaid beneficiaries also must be analyzed under the civil monetary penalty (CMP) statute that prohibits offering inducements to Medicare and Medicaid beneficiaries.

Today, I will begin by describing the limited application of OIG's legal authorities to discounts offered to uninsured patients. Next, I will describe how a hospital may reduce or waive cost-sharing amounts for Medicare or Medicaid beneficiaries experiencing financial hardship. Finally, I will explain how hospitals and other health care providers and suppliers can obtain further guidance from OIG on these issues.

DISCOUNTS FOR UNINSURED PATIENTS

OIG authorities allow hospitals to offer discounts to uninsured patients. It has been suggested that two fraud and abuse laws -- the Federal anti-kickback statute and the exclusion authority prohibiting excessive charges to Medicare and Medicaid -- prevent hospitals from offering discounted prices to patients who do not have health care coverage. This view reflects a misunderstanding of the law.

The Federal Anti-Kickback Statute

The Federal anti-kickback statute is a criminal statute that prohibits the purposeful offer, payment, solicitation, or receipt of anything of value in exchange for, or to induce, business payable by any Federal health care program, including Medicare and Medicaid. Congress was concerned that improper financial incentives often lead to abuses, such as overutilization, increased program costs, corruption of medical-decision making, and unfair competition. Accordingly, Congress banned kickbacks in the Federal health care programs.

Giving something of value (such as a discount on hospital charges) to an uninsured patient does not implicate the Federal anti-kickback statute, unless the patient is in a

position to generate Federal health care program business. For example, a hospital asked OIG about the propriety of offering discounts to doctors who self-pay. Such discounts would implicate the statute if one purpose were to induce the doctors to refer Medicare or Medicaid business to the hospital. But those situations are not, in our view, typical of hospital policies for discounting to the uninsured. Rather, most need-based discounting policies are aimed at making health care more affordable for the millions of uninsured citizens who are not referral sources for the hospital. For discounts offered to these uninsured patients, the anti-kickback statute simply does not apply.

The Excessive Charges Exclusion Authority

By statute, OIG is authorized, but not required, to exclude from participation in the Federal health care programs any provider or supplier that charges Medicare or Medicaid substantially more than it usually charges other customers. This law is intended to protect the Medicare and Medicaid programs – and the taxpayers – from providers and suppliers that routinely charge the Medicare or Medicaid programs substantially more than they usually charge other customers.

Some providers have expressed concern that discounting to uninsured patients might skew their "usual charges" to other customers and possibly subject them to exclusion under this provision. Let me assure you that this is not the case. OIG has never excluded or even contemplated excluding any provider or supplier for offering discounts to uninsured patients or other patients who cannot afford their care.

OIG believes that the statute can be reasonably interpreted as allowing providers to exclude discounts to these patients when calculating their usual charges to other customers. To this end, when we proposed regulations in connection with this exclusion authority, we included a provision that would clarify that free or substantially reduced prices offered to uninsured patients do not need to be factored into a hospital's usual charges for purposes of the exclusion authority. Those proposed regulations are still under development.

To further assure the industry with respect to discounts to the uninsured, we issued guidance in February that, pending issuance of final regulations or a decision not to proceed with final regulations, we will continue our enforcement policy that, when calculating their "usual charges," providers and suppliers need not consider free or substantially reduced charges to uninsured patients.

In sum, no OIG authority or policy should deter hospitals and others from offering financial relief to uninsured patients.

WAIVERS OF COST-SHARING AMOUNTS FOR FINANCIALLY NEEDY MEDICARE AND MEDICAID BENEFICIARIES

A discount offered to a Medicare or Medicaid beneficiary generally takes the form of a waiver of all or a portion of the Medicare or Medicaid program copayment or deductible, that is, the portion of the bill that the beneficiary owes. Routine waivers of Medicare or Medicaid cost-sharing amounts are problematic under the fraud and abuse laws because they may be used impermissibly to induce Federal health care program business. For example, many fraud schemes use the promise of "free" or "no out-of-pocket cost" medical items or services to attract Medicare or Medicaid beneficiaries.

However, the law also clearly permits health care providers to waive Medicare and Medicaid cost-sharing amounts for financially needy beneficiaries. OIG has a long-standing and well-publicized position supporting such financial hardship waivers. For example, the ability to forgive Medicare cost-sharing amounts in consideration of a patient's financial hardship is discussed in a 1992 OIG special fraud alert on the waiver of copayments and deductibles. The alert is available on our web site, along with other guidance on this subject, at http://oig.hhs.gov/fraud/fraudalerts.html.

The Civil Money Penalty Prohibiting Beneficiary Inducements

While the Federal anti-kickback statute may be implicated in some cases, the primary legal authority in the area of waivers of Medicare and Medicaid cost-sharing amounts is

the CMP prohibiting inducements to beneficiaries. Enacted as part of HIPAA in 1996, the CMP prohibits offering a beneficiary anything of value, including waivers of cost-sharing amounts, that is likely to influence the beneficiary's selection of a provider, practitioner, or supplier of Medicare or Medicaid payable items or services. Beneficiary inducements are of particular concern because vulnerable beneficiaries may be enticed to obtain services that are medically unnecessary, overpriced, or of substandard quality.

While generally banning routine cost-sharing waivers, such "insurance only" billing and the like, the Congress recognized that some beneficiaries might not be able to afford their cost-sharing amounts. The statute thus includes an express exception for waivers on the basis of financial need. The exception has three requirements:

- the waivers may not be routine;
- the waivers may not be offered as part of any advertisement or solicitation; and
- the waivers may only be made after determining in good faith that the individual is in financial need or that reasonable collection efforts have failed.

This exception is available to hospitals and others that want to provide relief to Medicare and Medicaid beneficiaries who cannot afford their cost-sharing amounts.

We recognize that what constitutes a good faith determination of financial need may vary depending on individual patient circumstances. We believe that hospitals should have flexibility to consider relevant variables. For example, hospitals may consider:

- 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.

A hospital's financial need guidelines should be reasonable, based on objective criteria, appropriate for the hospital's locality, and applied uniformly to all patients. Hospitals should take reasonable measures to document the financial need determination. We are mindful that there may be situations when patients are reluctant or unable to provide documentation of their financial status. In such cases, hospitals may be able to use other reasonable, documented methods for determining financial need, including, for example, patient interviews or questionnaires.

As discussed in our 1992 special fraud alert and elsewhere, it is OIG's position that the principles articulated in this CMP exception apply equally to financial need-based cost-sharing waivers under the Federal anti-kickback statute. There also is a safe harbor under the Federal anti-kickback statute that protects certain cost-sharing waivers for inpatient hospital services (waivers protected under this safe harbor are also protected under the CMP). The safe harbor contains a number of conditions designed to prevent abusive waiver practices, but does not require a determination of financial need.

In sum, the fraud and abuse laws clearly allow hospitals to provide relief to Medicare and Medicaid beneficiaries who cannot afford their cost-sharing amounts.

OBTAINING OIG GUIDANCE

As evidenced by the number and range of fraud alerts, bulletins, and other guidance we have issued, OIG has a strong commitment to providing guidance to the health care provider community. As previously noted, in February we issued specific guidance on OIG's fraud and abuse authorities and their application to hospital discounting practices. This guidance, titled "Hospital Discounts Offered to Patients Who Cannot Afford to Pay Their Hospital Bills" ("Discounts Guidance"), is available on our website at www.oig.hhs.gov and is attached to this testimony.

In addition to these resources, OIG's advisory opinion process is available to hospitals or others that want to know how OIG views a particular discount arrangement. OIG advisory opinions are written legal opinions that are binding on 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 written description of its existing or proposed business arrangement. Further information about the process, including frequently asked questions, can be found on OIG's web site at:

http://oig.hhs.gov/fraud/advisoryopinions.html

In addition, our web site contains the Discount Guidance, the proposed regulations on the excessive charges exclusion authority, and a special advisory bulletin discussing the CMP statute, as well as special fraud alerts and bulletins, safe harbor regulations, compliance program guidances, and advisory opinions that relate to the issues I have discussed today.

CONCLUSION

In conclusion, I want to assure the Committee that OIG fully supports efforts to ensure that a patient's financial need is not a barrier to health care. Furthermore, OIG legal authorities permit hospitals and others to offer bona fide discounts to uninsured patients and to Medicare or Medicaid beneficiaries who cannot afford their health care bills.

Mr. Chairman and Members of the Committee, thank you for inviting OIG to testify today. I would be happy to answer any questions you may have.

Attachments

SUMMARY OF TESTIMONY

Lewis Morris, Chief Counsel, HHS Office of Inspector General

- The fraud and abuse laws enforced by OIG allow hospitals and other health care providers and suppliers to offer discounts to patients who cannot afford to pay for their care. OIG fully supports efforts by providers and suppliers to help financially needy patients.

- The principles underlying OIG's guidance on hospital discounts to uninsured patients and waivers of cost-sharing for financially needy Medicare or Medicaid beneficiaries apply equally to the rest of the Medicare- and Medicaid-serving health care industry.

- Giving a discount on hospital charges to an uninsured patient does not implicate the Federal anti-kickback statute, unless the patient is in a position to generate Federal health care program business. The anti-kickback statute simply does not apply to discounts offered to the vast majority of uninsured patients – who are not referral sources.

- It is OIG's enforcement policy that providers and suppliers do not need to consider free or substantially reduced charges to uninsured patients when calculating their "usual charges" for purposes of OIG's permissive exclusion authority against providers or suppliers that charge Medicare or Medicaid substantially more than they usually charge other customers.

- While routine waivers of Medicare or Medicaid cost-sharing amounts are problematic under the fraud and abuse laws, the laws clearly permit health care providers to waive Medicare and Medicaid cost-sharing amounts for financially needy beneficiaries, provided the waivers are not routine or advertised and are based on a good faith determination that the individual is in financial need or that reasonable collection efforts have failed. Financial need guidelines should be reasonable, based on objective criteria, appropriate for the hospital's locality, and applied uniformly to all patients. Providers should take reasonable measures to document financial need determinations.

- There is a safe harbor under the Federal anti-kickback statute that protects certain cost-sharing waivers for inpatient hospital services and does not require a determination of financial need.

- Further information on the application of OIG's fraud and abuse authorities is available at www.oig.hhs.gov. In addition, OIG's advisory opinion process is available to hospitals or others that want to know how OIG views a particular discount arrangement.

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. 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&)(6)(A), individuals and entities do not need to consider free or substantiallv reduced charges to (i) uninsured patients or (ii) underinsured patients who are self-paying patients for the items or services furnished.

As noted in the preamble to the proposed regulations, the exclusion provision does not 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.

[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 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.

February 2, 2004