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

Issued: September 19, 2001

Posted: September 26, 2001

[name and address of requestor redacted]

Re: OIG Advisory Opinion No. 01-15

Dear [name redacted]:

We are writing in response to your request for an advisory opinion regarding the proposal to subsidize the Medicare+Choice premiums and copayments of your members who are eligible for both Medicare and certain limited Medicaid benefits (the "Proposed Arrangement"). Specifically, you have inquired whether the Proposed 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 ("CMP") 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) or under the CMP provision for violations of the prohibition against inducements to beneficiaries at section 1128A(a)(5) of the Act.

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 relevant facts and agreements among the parties.

In issuing this opinion, we have relied solely on the facts and information presented to us. We have not undertaken an independent investigation of such information. This opinion is limited to the facts presented. If material facts have not been disclosed or have been misrepresented, this opinion is without force and effect.

Based on the facts certified in your request for an advisory opinion and supplemental submissions, we conclude that the Proposed 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") would not impose administrative sanctions on Plan A, Plan B, or Plan C (the "Requestors"), 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 Proposed Arrangement, nor would the OIG impose CMPs on the Requestors in connection with the Proposed Arrangement for violations of the prohibition against inducements to beneficiaries under section 1128A(a)(5) of the Act.

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

I. FACTUAL BACKGROUND

A. The Requestors

The Requestors are managed care organizations ("MCOs") that arrange and provide prepaid comprehensive medical care to their enrollees. They are also non-profit corporations exempt from Federal income tax pursuant to § 501(c)(3) of the Internal Revenue Code. The Requestors share a management structure for limited centralized functions and have separate management structures for operations. A group of individuals constitutes the Boards of Directors of all of the Requestors.

The Requestors are group model MCOs and deliver their health care services through affiliated medical groups that contract with the Requestors under bilaterally exclusive contracts referred to as Medical Service Agreements ("MSAs"). The affiliated medical groups provide virtually no medical services other than those provided pursuant to the MSAs. The MSAs provide that the Requestors' payments to each medical group be negotiated annually and the basic contractual payment be the product of an agreed upon capitation rate and the number of health plan members enrolled in a given month. These payments do not include the MCOs' copayments for medical services.

The Requestors offer pre-payment health care plans to individuals and to employer groups for the benefit of their employees and retirees. In addition, each of the Requestors contracts with the Centers for Medicare and Medicaid Services ("CMS") to offer a Medicare+Choice ("M+C") product.[1] The Requestors are responsible directly or indirectly for providing all care to enrollees of its M+C plans.

Until recently, most M+C plans have been offered to Medicare beneficiaries as zero premium plans (i.e., there was no monthly premium imposed on enrollees in addition to

---

[1]Two of the Requestors also have Medicare cost contracts pursuant to §1876 of the Act, although these contracts have not been open to new enrollees for several years and will expire by force of statute in 2004.

their part B premium). Reflecting a trend within the M+C industry, the Requestors have begun to charge premiums on all of their M+C plans. As of January 1, 2001, the Requestors' M+C premiums ranged from $10 to $115 per month, depending on the patient's county of residence and level of benefits.

The Requestors cover approximately 650,000 M+C members. Of these, approximately 36,000 members (or 5.5%) are entitled to some level of Medicaid benefits as well (hereafter, "dually eligible beneficiaries"). These dually eligible beneficiaries fall into two categories: (1) those Medicare beneficiaries who qualify for full Medicaid benefits; and (2) those Medicare beneficiaries for whom Medicaid provides assistance only with some or all of the beneficiaries' cost-sharing obligations of Medicare coverage. For dually eligible beneficiaries, CMS pays M+C plans a higher capitation rate to compensate them for the generally higher level of health care utilization that these beneficiaries generate, as compared to other Medicare beneficiaries.

B. The Proposed Arrangement

The Requestors believe that dually eligible beneficiaries, who tend to be poorer than other Medicare beneficiaries, are less likely to be able to afford the M+C plan's copayments and recently instituted premiums and, therefore, are more likely to disenroll from M+C rather than pay the premiums and copayments. The Requestors also believe that disenrollment would impact negatively on the continuity and quality of the dually eligible beneficiaries' access to medical care.

M+C regulations permit a M+C plan to contract with a state Medicaid agency for the latter to pay all or part of the M+C plan premiums and copayments on behalf of dually eligible beneficiaries.[2] The Requestors are taking steps to enter into such contracts with state Medicaid agencies. However, to the extent that this effort is unsuccessful, the Requestors would seek to pay the M+C plan's premiums and copayments on behalf of the dually eligible beneficiaries.

The Requestors annually allocate a portion of their revenue to serve as funds for Direct Community Benefits Investment ("DCBI"). Where a state Medicaid agency does not subsidize the Requestors' M+C plan premiums and copayments for dually eligible beneficiaries, the Requestors propose to subsidize the premiums and copayments out of their DCBI funds. Where a state Medicaid agency partially subsidizes the Requestors' M+C plan premiums and copayments for dually eligible beneficiaries, the Requestors propose to subsidize the balance of the premiums and copayments out of their DCBI

---

[2] See 42 C.F.R. § 422.106.

funds. These subsidies would be available to all current dually eligible beneficiaries enrolled in the Requestors' M+C plans for whom a state Medicaid agency does not subsidize the M+C plan premiums and copayments in full and, at the Requestors' option, to all future enrollees identically situated.

In lieu of making any independent determination of dually eligible beneficiaries' financial need, the Requestors will rely on the state Medicaid agencies' determinations of the beneficiaries' Medicaid status, which the Requestors will check monthly. The Requestors will not advertise the existence of the premium and copayment subsidy, nor promote it in any marketing material. The Requestors will obtain CMS's prior written approval regarding the content and wording of the Requestors' letters to dually eligible beneficiaries enrolled with the Requestors informing them of the premium and copayment subsidy's availability, as well as the terms, conditions, and eligibility requirements. If required or requested by a state Medicaid agency or CMS, the Requestors will memorialize the premium and copayment subsidy in contracts or letters of agreement with the applicable state Medicaid agencies.

II. LEGAL ANALYSIS

A. Law

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 a Federal health care program. 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, directly or indirectly, overtly or covertly, in cash or in kind.

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 CMPs 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.

The Proposed Arrangement also may violate section 1128A(a)(5) of the Act, which prohibits a person from offering or transferring remuneration to a Medicare or Medicaid beneficiary that such person knows or should know is likely to influence the beneficiary to order or receive items or services from a particular provider, practitioner, or supplier for which payment may be made by Medicare or Medicaid. For purposes of section 1128A(a)(5), "remuneration" includes the waiver of coinsurance and deductible amounts (or any part thereof) and transfers of items or services for free or for other than fair market value. See section 1128A(i)(6) of the Act. Where a party commits an act described in section 1128A(a)(5) of the Act, the OIG may initiate administrative proceedings to impose CMPs on such party. However, the statute also contains an exception for certain waivers of coinsurance and deductible amounts that are not advertised nor routine, and that are made on the basis of individualized determinations of financial need. Id.

B. Analysis

The Requestors propose to protect dually eligible beneficiaries in their M+C plans from increased cost-sharing obligations. This practice could implicate the anti-kickback statute and the prohibition against improper inducements to beneficiaries, because it provides a financial benefit that could induce the dually eligible beneficiaries to self-refer to the Requestors' M+C plans.

In reviewing the Proposed Arrangement, we make the following observations. First, as a general matter, the payment by a provider of a beneficiary's copayments and insurance premiums, whether primary or supplemental, implicates both the anti-kickback statute and the prohibition against inducements to beneficiaries. The fact that the beneficiary is already a patient is irrelevant because the payment may influence the patient's future choice of providers. Moreover, as we have previously noted, the payment of insurance premiums by a provider or supplier who is paid on a fee-for-service basis significantly increases the incentive for overutilization and other abuse. See, e.g., Notice of Proposed Rulemaking for CMP Safe Harbor to Protect Payment of Medicare Supplemental Insurance and Medigap Premiums for ESRD Beneficiaries, 65 Fed. Reg. 25,460 (2000).

Second, in this case involving group model MCOs, however, the insurer and provider are essentially one and the same. Each MCO essentially pays itself the beneficiary's plan premiums and copayments. While we recognize that the payments will be made out of DCBI funds that have been allocated for the public benefit, for our purposes, we consider the payment to be functionally indistinguishable from a waiver of premiums and

copayments by the provider. In both cases, the payments are for services that the MCO itself provides, and the MCO is simply forgoing money that it might otherwise collect from the enrollee. By contrast, when a provider pays a patient's premium for an indemnity type of insurance policy, it typically makes the premium payment to a third party insurer in order to tap into the third party's source of reimbursement for future services by the provider.

Third, it is longstanding policy that a provider is free to waive a Medicare beneficiary's cost sharing obligations based on an individualized determination of financial need. In this case, the Requestors would rely on the applicable Medicaid agencies' determinations of Medicaid eligibility of existing Medicare beneficiaries and would reconfirm these determinations on a monthly basis. For purposes of the anti-kickback statute and the CMP for improper inducements to beneficiaries, the monthly determinations of Medicaid eligibility by state Medicaid agencies would serve as a reasonable and reliable substitute for individualized determinations of financial need. Under these circumstances, the OIG would not impose administrative sanctions for the Requestors' proposed subsidy program for M+C plan premiums and copayments.

III. CONCLUSION

Based on the facts certified in your request for an advisory opinion and supplemental submissions, we conclude that the Proposed 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 would not impose administrative sanctions on Plan A, Plan B, or Plan C 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 Proposed Arrangement, nor would the OIG impose CMPs on the Requestors in connection with the Proposed Arrangement for violations of the prohibition against inducements to beneficiaries under section 1128A(a)(5) of the Act. This opinion is limited to the Proposed Arrangement and, therefore, we express no opinion about any ancillary agreements or arrangements disclosed or referenced in your request letter or supplemental submissions.

IV. LIMITATIONS

The limitations applicable to this opinion include the following:

- This advisory opinion is issued only to Plan A, Plan B, and Plan C, which are the requestors 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 of this opinion.

- This advisory opinion is applicable only to the statutory provisions specifically noted above. No opinion is expressed or implied herein 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 Proposed 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, even those which 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 Plan A, Plan B, or Plan C with respect to any action that is part of the Proposed 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 Proposed 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 Plan A, Plan B, or Plan C 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,

D. McCarty Thornton
Chief Counsel to the Inspector General