Discounts for Uninsured and Underinsured Patients – "Cautious" Approval by CMS and the OIG

Mar 01 2004

Practice Area: Health Law

Providers are struggling with how to handle health care items and services that they furnish to individuals with limited means. This struggle has been fueled, at least in part, by concerns that the Medicare and Medicaid laws and regulations make it difficult, if not impossible, to effectively respond to requests of uninsured and underinsured individuals for discounted services.

In response to a request from the American Hospital Association ("AHA:), the Centers for Medicare and Medicaid Services ("CMS") and the Office of the Inspector General ("OIG") recently issued guidance addressing a provider's ability to offer discounts to uninsured and underinsured patients. Although CMS and the OIG both express their support of efforts to lower health care costs for those unable to afford health care, their guidance confirms that there are limitations on providers' ability to offer discounts. Bottom line – discounts to uninsured patients and discounts/waivers to underinsured patients should be acceptable if based on verified financial need, but waivers or discounts when the patient may be able to pay, do need to be examined closely.

Background
In December 2003, the AHA requested that the Department of Health and Human Services provide guidance regarding discounts for uninsured and underinsured patients. The AHA intended for this request to help clarify providers' concern and confusion about how the Medicare and Medicaid laws and regulations affect their ability to offer discounts to uninsured and underinsured individuals.

In response, Secretary Thompson stated that hospitals may provide discounts to uninsured and underinsured patients who cannot afford their hospital bills and stated that the Department's policy does not require that uninsured individuals pay "full price" for their health care services. He also directed the OIG and CMS to provide summaries of the Department's policy for providers, and, the OIG's and CMS' guidance is summarized below.

OIG Guidance
While the OIG states that it believes that providers have the ability to offer 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 does see limits on a provider's ability to do so.

In its analysis of the anti-kickback statute, the OIG explains that this statute does not prohibit discounts to uninsured and underinsured patients who are unable to pay their hospital bill, as long as discounts are not linked to the generation of business payable by the Medicare or Medicaid programs. The OIG cautions that discounts offered to underinsured patients raise a more significant concern under the anti-kickback statute and warned that hospitals should exercise great 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.

Whether a discount implicates the anti-kickback statute is a fact specific analysis that should be conducted on a case-by-case basis. However, if a discount is offered consistent with a provider's charity care policy, it likely will pass scrutiny because the provider should be able to demonstrate that it did not intend to induce the generation of business payable by the Medicare or Medicaid programs. Because intent is a crucial element of the anti-kickback statute, we recommend that providers document their analyses of a patient's financial need.

The OIG specifically addresses reductions or waivers of cost-sharing amounts for Medicare beneficiaries experiencing financial hardship. Both the federal anti-kickback statute and the prohibition against beneficiary inducement prohibit waivers of Medicare and Medicaid copayments and deductibles, unless the offeror does not intend for such waivers to induce further business from a federal health care program or influence the beneficiary's selection of a particular provider, practitioner or supplier.

The OIG provides two exceptions to the general prohibition – one for financial hardship and another for inpatient hospital services. The exception for financial hardship requires that the waiver is (1) not part of any advertisement or solicitation, (2) not routine, and (3) based on an individualized assessment of financial need. The exception for inpatient hospital services generally requires that (1) the hospital not claim the waived amount as bad debt, (2) the waiver be made without regard to reason for admission, length of stay or DRG, and (3) the waiver not be part of a price reduction agreement with a third-party payer (there is a separate safe harbor for third party payor arrangements).

The OIG also addresses its authority to exclude a provider from participation in the Medicare and Medicaid programs if the provider's charges to Medicare or Medicaid are substantially more than the provider's usual charge. Although the OIG could interpret this law to incorporate discounts to uninsured or underinsured patients, the OIG stated that it has never excluded or attempted to exclude any provider for offering such discounts. Instead, the OIG's current enforcement policy is that, when calculating their "usual charge," providers need not consider free or substantially reduced charges to uninsured patients or underinsured patients who are self-paying patients for the items or services furnished. The OIG explained in its proposed regulations that free or substantially reduced charges to uninsured patients would not affect the calculation of a provider's "usual charges" for purposes of this law.

CMS Guidance

In response to Secretary Thompson's directive, CMS issued a "Q&A" that addresses charges for the uninsured. CMS' overall message is that it does not prohibit a hospital from waiving collection of charges to any patient, as long as it is consistent with the hospital's indigency policy. CMS explained that a hospital does not need to obtain CMS' permission before offering discounts and addressed concerns regarding its uniform charge rule, lesser of costs or charges ("LCC") principle (which is largely no longer applicable), and bad debt policy.

With respect to its uniform charge rule, CMS emphasized that this rule is only a cost-reporting requirement and does not mandate that providers charge everyone the same amount for the items and services they provide. The uniform charge rule in fact assumes that charges are different, since its purpose is to gross up all charges to the same uniform level for cost reporting purposes.

With respect to its bad debt policy, CMS stressed that this rule defines what criteria a hospital must satisfy in order to claim Medicare bad debts on its cost report. Specifically, this rule provides that a hospital will be reimbursed for certain "bad debts" (*i.e.,* unpaid Medicare deductible and coinsurance amounts) if it can document that a Medicare patient is indigent or the amounts are not collected after reasonable collection efforts.

CMS provides the following three suggestions for providers to consider when reviewing their discounting practices. First, providers should ensure that all written policies for assisting low-income patients are applied consistently. Second, providers should review their current charge structures to ensure that they are reasonably related to both the cost of the service and to meeting all of the community's health care needs. However, if a provider determines that it is appropriate to reduce its charges based on this review, the provider should consider whether the reduction will reduce Medicare outlier payments, which are based on cost-to-charge ratios, and how other third-party chargebased reimbursement would change. And third, providers should implement written policies regarding when and under whose authority patient debt is advanced for collection.

Recommendations
The guidance issued by CMS and the OIG emphasizes the agencies' overall support of discounting practices for the uninsured and underinsured. The common consideration in both sets of guidance is whether the discounts are based on financial need. In this regard, we recommend the following for providers to consider in assessing the appropriateness of a discount to an individual who is uninsured or underinsured –

1. Determine if the discount is consistent with its charity care policy (a provider's charity care policy should require an individual assessment of financial need);
2. Document its analysis of financial need; and
3. Verify that the discount does not violate state law; for example, Wisconsin Statute § 146.905 generally prohibits the reduction or waiver of coinsurance amounts and deductibles for services that are covered by insurance, unless the waiver is based on financial hardship.

What about waiver of physician charges?
Since the AHA asked the question, this guidance relates to hospital services only. However, much of the discussion of the federal anti-kickback exception for waiver of copay and deductible for financial need would apply, but the safe harbor for Part B waiver is more narrow, applying only to patients eligible for federally subsidized care.

What about waivers or other discounts related to private pay patients (those patients who have "adequate" insurance or employer plan coverage)?
While not expressly the topic of the OIG and CMS guidance, given that the guidance does cover "underinsured" patients, some concern in this area is present. The guidance never defines "underinsured" which begs the question regarding when providers may waive copayments and deductibles for individuals who do not satisfy a "limited means" test. At the least, waivers for private pay patients should be analyzed to rule out that by providing the waiver, the circumstance may act as an inducement for other Medicare or Medicaid paid services. In addition, since waived copayments may need to be accounted for in various "charge" calculations, waived private pay copayment for insured patients do need to be reviewed. Providers also need to evaluate whether the waiver is appropriate under state law (*e.g.* Wis.Stat. § 146.905).
