PUBLICATION

Medigap Insurer's Contract with Preferred Hospital Network Approved (Yet Again) [Ober|Kaler]

2015: Issue 8

On April 22, 2015, the Department of Health and Human Services, Office of Inspector General (OIG) issued Advisory Opinion 15-05, approving a Medigap insurer's proposed contract with a preferred hospital network. The OIG's approval and analysis is one of a series of OIG Advisory Opinions in which the OIG concludes a Medigap insurer's proposal to contract with hospitals for discounts on its policyholders' Medicare inpatient deductibles posed a sufficiently low risk of fraud or abuse under both the antikickback statute and the civil monetary penalties law (CMP) prohibiting inducements to beneficiaries.

Overview of Facts

The advisory opinion requester, a licensed Medigap insurer (Requester), sought to indirectly contract with hospitals (Network Hospitals) willing to discount all or a portion of Requester policyholders' Part A deductible (a cost otherwise incurred by the Requester). A preferred provider organization (PPO) would administer the hospital network on the Requester's behalf.

To the extent a Requester policyholder received inpatient services at a Network Hospital, the PPO would receive an administrative fee, and a portion of the Requester's savings would be shared with its policyholders. Specifically, policyholders would receive a $100 credit towards their subsequent premium payments. The Requester indicated it intends to inform Policyholders of this savings opportunity in plan materials and marketing materials.

Legal Analysis

Under the terms of the proposed arrangement, the OIG concluded that both the discounts offered on inpatient deductibles by the Network Hospitals and the premium credits offered by the Requester to policyholders with inpatient stays at a Network Hospital presented a low risk of fraud and abuse under the antikickback statute. In doing so, the OIG highlighted the following factors:

- The discount and premium credit offered by the Requester to Network Hospitals and policyholders would not increase or affect Medicare payments;
- The discount was unlikely to increase utilization of services as (a) the discounts would be invisible to policyholders (i.e., the Requester would otherwise cover the Part A deductible if a hospital did not offer a discount), and (b) historically, the waiver of fees for inpatient services has not significantly increased utilization;
- The discount and premium credits were unlikely to unfairly impact competition among hospitals because membership in the PPO hospital network was open to all accredited Medicare-certified hospitals in compliance with state law;
- The discount and premium credits were unlikely to impact professional medical judgment as (a) Requester policyholders' physicians would receive no remuneration under the proposed arrangement

and (b) the Requester's policyholders remained free to receive services at any hospital without additional expense;

- Lastly, the arrangement was deemed transparent by the OIG, as the Requester certified it would inform policyholders of their right to choose any hospital without incurring additional expense.

Similarly, under the CMP prohibiting inducements to beneficiaries, the OIG concluded the premium credits– although a potential inducement to Requester policyholders to receive services at a Network Hospital – presented a low risk of fraud and abuse. Specifically, the OIG determined that the premium credits were sufficiently analogous to benefit plan design differentials in coinsurance and deductible amounts, which the CMP law permits. S.S.A § 1128A(i)(6)(C). In addition, the OIG noted that (a) premium credits earned by certain Requester policyholders were not realized at the expense of other policyholders, and (b) as savings realized by the Requester under the proposed arrangement would be reported to state insurance rate-setting regulators, the arrangement at issue had the potential to lower costs for all policyholders.