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PRACTICING PHYSICIANS ADVISORY COUNCIL MEETING

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The primary mission of the Office of Inspector General ("OIG") is to investigate and report on the efficiency and effectiveness of the programs of the Department of Health and Human Services, and, in conjunction with the Department of Justice, to enforce various authorities related to health care fraud and abuse involving the Federal health care programs. The OIG does not set Medicare payment policy; that is the responsibility of the Health Care Financing Administration ("HCFA").

The OIG has a longstanding and well-known concern with arrangements pursuant to which health care providers routinely waive coinsurance or copayment (collectively, "copayment") amounts that are required under Medicare, including agreements between insurers and physicians that require physicians to waive Medicare copayment obligations as a condition of participation in an insurance company's network. Arrangements to waive Medicare copayments potentially implicate several criminal and civil statutes, including the Federal anti-kickback statute and the False Claims Act. This is not a new OIG policy. As I am sure the members of this Committee are all too aware, the OIG has repeatedly articulated its concern about any arrangements that operate to waive Medicare copayments routinely.(1)

The OIG has been looking at how that policy applies to situations in which coordination of benefits ("COB") provisions in commercial insurance products can operate, in effect, to waive Medicare copayment obligations when the commercial policy is the secondary insurer and Medicare is primary. We became aware of this issue some time ago as a result of complaints from physicians in California. While we are still trying to ascertain the scope of the problem and gain a better appreciation of the difficulties of insurance benefit administration at the plan and physician levels, we have reached some tentative conclusions.

First, as a legal matter, reconciling Medicare copayment requirements with the COB provisions in commercial insurance products involves a complex interaction of legal authorities. Two distinct Federal laws and regulatory schemes are involved: the Employee Retirement Income Security Act ("ERISA") and the Social Security Act. In addition, state law has historically governed the regulation of commercial insurance (including coordination of benefits). However, for self-funded employer plans, ERISA preempts much state law, although when there is preemption, its scope is not always clear. Finally, there are issues arising under the common law of contracts, including the authority of private parties to alter voluntarily obligations imposed by other laws, such as the Social Security Act.

Despite this analytic complexity, we believe the legal bottom line is clear. The obligation to pay the Medicare copayment is a requirement of the Social Security Act. Federal law governing Federal programs generally trumps any contrary state or contract law. In short, the obligation to pay Medicare copayment amounts is imposed by Federal law; if a plan has assumed a Medicare beneficiary's copayment obligation, the plan should pay the copayment.

Second, we do not believe that every time a secondary insurer's COB provisions result in a waiver of some or all of a Medicare copayment, there is necessarily a violation of law. Historically, COB provisions that are commonly found in insurance policies have occasionally resulted in the waiver of all or part of a Medicare copayment. These occasional

waivers were not necessarily illegal, at least under statutes, such as the anti-kickback statute or False Claims Act, that require intent or knowledge as an element of an offense.

The phenomenal growth of the managed care share of the employer insurance market has changed that equation. Based on the number of complaints from physicians we have received, we believe that in California and some other markets, the physician fee schedules that are being used by some insurance companies for both their commercial and employer product lines are dropping below the Medicare fee schedule for a substantial number of physician and other Part B services. When those fee schedules are combined with the conventional COB provisions in those plans, the result is that plans "free ride" on Medicare, in effect becoming Medigap insurers for nothing.

In short, what used to be an occasional, inadvertent waiver of Medicare copayments is becoming a routine practice affecting potentially large amounts of money and conferring a substantial financial benefit on commercial insurance plans and their customers. While the OIG has no data on the amount of money involved, we note that HCFA found that the significant difference in cost between comparable Medigap and Medicare Select policies was due largely to the fact that the Medicare Select products are permitted to waive Medicare Part A copayments for inpatient hospital services. We would expect the waiver of Part A and Part B coinsurance obligations to involve similar, if not greater, amounts. Multiplied by the number of Medicare beneficiaries covered by a large insurer, the avoided costs of Medicare copayments could be significant.

Third, given the significant financial benefit to plans, we are concerned that some plans are knowingly manipulating these contractual provisions and their administration of these contracts to avoid their obligation to pay Medicare coinsurance for their own financial benefit. For example, we have received several reports that one plan informs physicians that the physicians are responsible for billing Medicare the plan fee schedule amount if that amount is less than the Medicare fee schedule, while at the same time refusing to disclose the plan fee schedule to those same physicians.

Based on our current understanding, the insurance companies seem to be the key players. They dictate the terms of the contracts, set the fee schedules, administer the contracts, and receive the immediate financial benefit of the copayment waivers. As to the physicians, they do not seem to have fully appreciated the contractual arrangements to which they have agreed and do not seem to be willing participants in the COB aspect of these arrangements. We emphasize that the beneficiaries are not liable under any scenario, since both physicians and plans have agreed not to balance bill them.

Fourth, we see two alternatives, either of which would resolve our legal concerns. One option is that the plans could agree to pay the Medicare copayments. The other option is that the plans and physicians could contractually agree to bill Medicare the lower plan fee schedule amount when Medicare is the primary payer; Medicare would pay 80% of the lower amount and the plans would pay the remaining 20%. This alternative would require that plans give physicians the plan fee schedule for the purposes of billing Medicare reasonably in advance and that plans make clear to physicians that they are agreeing to bill Medicare the lower plan fee schedule amount, resulting in lower payments to the physicians than they might otherwise receive for a Medicare beneficiary. Again, the plan would pay a 20% copayment based on the lower billed amount.

Finally, we want to reiterate that our current position is based on incomplete information and may evolve as we develop more information. We would especially welcome input from both the physician community and insurers as to the extent of the disparity between commercial and Medicare fee schedules, the amount of Medicare coinsurance affected, and the practicalities of different solutions, given the complexities of insurance benefit administration both at the plan and physician levels and the widespread dispersion of Medicare beneficiaries among commercial and ERISA group plans that are primarily composed of employees. To the extent possible consistent with law, we need to find a solution that accommodates the practical concerns of benefits administrators and physicians, the needs of employers and commercial insurers, and the requirements of the Medicare program.

1. See, e.g., OIG Advisory Opinion 98-5 (Apr. 24, 1998) (same problem in context of Part A coinsurance for SNFs); Preamble to the 1996 final managed care safe harbors, 61 Fed. Reg. 2122, 2124 (Jan.25, 1996); Special Fraud Alert, "Routine Waiver of Medicare Part B Copayments and Deductibles," 59 Fed. Reg. 65373 (Dec. 19, 1994); Preamble to the 1992 interim final managed care safe harbors, 57 Fed. Reg. 52723, 52727 (Nov. 5, 1992); Preamble to the 1991 final

safe harbors, 56 Fed. Reg. 35952, 35963 (July 29, 1991).