Legal ADVISORY
American Hospital Association™

**Thursday, October 10, 2013**

# POTENTIAL BARRIERS TO HOSPITAL SUBSIDIES FOR HEALTH INSURANCE FOR THOSE IN NEED

## AT A GLANCE

***The Issue:***

A number of hospitals and health systems have inquired about whether it would be permissible to provide subsidies for health insurance for those in need rather than just expensive episodic care. Through the new Health Insurance Marketplaces ("Exchanges") created by the *Patient Protection and Affordable Care Act*, individuals may purchase coverage from participating health plans. Recognizing that an individual's share of the cost of a premium may be prohibitive, even with a federal subsidy, several hospitals and health systems have asked whether there are any legal barriers to offering financial assistance to a patient by paying their health insurance premiums.

***Our Take:***

Our analysis is that there appear to be two potential barriers that could affect the ability of hospitals and health systems to offer this type of assistance: anti-kickback laws and federal tax exemption. Neither the Internal Revenue Service (IRS) nor the Department of Health and Human Services' Office of Inspector General (OIG) have issued guidance that directly addresses this issue. Nor reportedly have they expressed an intention of doing so in the near term. In an effort to assure that neither agency's rules prevent hospitals and health systems that wish to do so from providing such assistance, the AHA plans to ask both the IRS and the OIG for useful guidance.

The attached advisory provides a legal analysis of the relevant provisions of the anti-kickback and tax-exemption laws that could pose a barrier depending on the agencies' inclinations. Our analysis is based on a hospital or health system directly subsidizing the cost of a patient's premium. If a hospital or health system makes a contribution to an unrelated charitable organization that subsidizes coverage for those in need, it may well address any potential concerns of the OIG or IRS. We will request explicit guidance on these arrangements as well.

***What You Can Do:***

Share this advisory with your leadership team, legal counsel and those in your organization responsible for your financial assistance program. If you are considering offering subsidies to pay for health insurance coverage, consider how to incorporate this type of assistance into your financial assistance policies.

***Further Questions:***

Please contact Maureen Mudron, AHA deputy general counsel, at (202) 626-2301 or mmudron@aha.org, or Mindy Hatton, AHA senior vice-president and general counsel, at (202) 626-2336 or mhatton@aha.org.

Legal ADVISORY
American Hospital Association™
Thursday, October 10, 2013

# POTENTIAL BARRIERS TO HOSPITAL SUBSIDIES FOR HEALTH INSURANCE FOR THOSE IN NEED

## BACKGROUND

A number of hospitals and health systems have inquired about whether it would be permissible to provide subsidies for health insurance for those in need rather than just expensive episodic care. Through the new Health Insurance Marketplaces ("Exchanges") created by the *Patient Protection and Affordable Care Act* (ACA), individuals may purchase coverage from participating health plans. Recognizing that an individual's share of the cost of a premium may be prohibitive, even with a federal subsidy, several hospitals and health systems have inquired whether there are any legal barriers to providing premium assistance if they wish to do so. There appear to be two potential barriers that could affect the ability of hospitals and health systems to offer this type of assistance: anti-kickback and federal tax exemption laws.

Neither the Internal Revenue Service (IRS) nor the Department of Health and Human Services' (HHS) Office of Inspector General (OIG) have issued guidance that directly addresses this issue. Nor reportedly have they expressed an intention of doing so in the near term. In an effort to assure that neither agency's rules prevent hospitals and health systems that wish to do so from providing such assistance, the AHA plans to ask both the IRS and the OIG for useful guidance.

This advisory examines the relevant provisions of the federal anti-kickback and tax-exemption laws and their potential effect on the ability of hospitals and health systems to offer financial assistance to patients by paying their health insurance premiums. Our analysis is based on a hospital or health system directly subsidizing the cost of a patient's premium. The patient would be eligible for the offer only if he or she would otherwise qualify for financial assistance under the hospital's financial assistance policy. If a hospital or health system makes a contribution to an unrelated charitable organization that subsidizes coverage for those in need, it may well address any potential concerns of the OIG or IRS. For example, a hospital makes a donation to an existing local charity that makes the decisions regarding eligibility, and the recipient of a subsidy chooses a health plan. We will request explicit guidance on these types of arrangements as well.

## ***AS IT STANDS***

The Exchanges are regulated governmental or nonprofit entities that will operate competitive markets in which qualified individuals and employers may enroll in qualified health plans (QHPs) offered by private health insurers. Any non-incarcerated U.S. citizen or legal resident may enroll in a QHP through one of the Exchanges. The federal government will not directly fund the QHPs, but it will provide income-based premium tax credits and cost-sharing reductions to help individuals afford enrollment in a QHP. Although these are subsidies of the individual's share of costs, they are paid directly to the QHP.

The Exchanges are still relatively early in their development; the initial enrollment period for plans offered through the Exchanges began on Oct. 1, 2013. In addition, because there is no federal requirement that an insurance provider participate in any Exchange, and because Exchange offerings may vary widely by state, it is not yet clear how many plans a patient will have to choose from in a particular case. Whatever the number or types of plans ultimately available to a given patient, however, the hospital would need to ensure that its involvement in paying the subsidies is consistent with federal and state law, including health privacy and conflict of interest rules.

### *Federal Anti-Kickback Statute*

There is some risk that a hospital's payment of a premium subsidy could be viewed as implicating the anti-kickback statute (AKS), particularly if enforcement agencies were to take the position that: 1) an Exchange or a QHP offered through an Exchange is a "Federal health care program" under the AKS, and 2) either the QHP itself or the services or items provided to the patient under the QHP are "services" or "items" that are "purchased" or "ordered" by the patient. Ultimately, the risk of AKS enforcement would depend not only on the resolution of these legal questions -- whether the AKS applies to the activities of an Exchange or QHP -- but also on the consideration of additional factors detailed below that are most frequently cited by the OIG as relevant to deciding whether to pursue enforcement.

**Does the Definition of "Federal Health Care Program" Extend to Exchanges or QHPs?** The AKS defines a "Federal health care program" as "any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government …."[1]

Because the AKS is implicated only when an arrangement involves services or items for which payment may be made "under a Federal health care program," an essential threshold question is whether the proposed premium payment would involve a "Federal health care program." There is uncertainty about whether an Exchange or a QHP is a "Federal health care program." To date, neither the OIG nor any other authority responsible for enforcing the health care fraud and abuse laws has taken a position on this question.

[1] *See 42 U.S.C.* § 1320a-7b(f). The definition excludes the Federal Employees Health Benefits Program.

There are substantial legal questions about whether the AKS definition of a "Federal health care program" applies to an Exchange or to a QHP. With respect to an Exchange, enforcement authorities might take the position that an Exchange satisfies the statutory definition because it is a "program that provides health benefits … directly, through insurance," although an argument could be made that the Exchange is only providing a forum for others to do so. In addition, although the federal government may provide direct funding to support administration of the Exchanges, it is not clear that such funding, which will not finance or reimburse the actual provision of health care, would satisfy the AKS definition.

With respect to a QHP, there is little question that such a plan will "provide health benefits." It is less certain, however, that a QHP will be "funded directly" by the federal government. As noted above, the federal government will provide two kinds of financial support to help individuals enroll in and receive services under a QHP. Although the ACA provides that any applicable premium tax credit or cost-sharing subsidy is to be paid to the plan rather than to the individual enrollee, these payments are nevertheless subsidizing costs that otherwise would be borne by the individual and not by the plan.

It is an open question whether a plan or program can be said to be "funded directly" when the federal government merely pays on behalf of an individual an amount that is otherwise fully payable by that individual. It is also possible that the question whether a QHP is "funded directly" by the federal government will be analyzed differently depending on whether the government provides a premium tax credit or a cost-sharing subsidy. The premium tax credit, because it is a credit against the individual's personal tax liability and must eventually be reconciled with the individual's tax return, may be more appropriately viewed as a payment to the individual than as a payment to the QHP.

If enforcement authorities were to conclude that the federal government's provision of a tax credit or cost-sharing subsidy (or both) constitutes direct funding of a QHP, it would raise an additional question: Does that make the QHP a "Federal health care program" with respect to all enrollees or only with respect to those enrollees who receive a credit or subsidy? While it is unlikely that enforcement authorities will ultimately take the position that the determination varies by enrollee, this question raises yet another point of uncertainty about the extent to which a QHP offered through an Exchange fits the AKS definition.

**Would Payment of a Premium Induce the "Purchase" or "Order" of a "Service" or "Item" By a Patient?** Assuming that either an Exchange or a QHP is a "federal health care program," a separate element of the AKS would require a showing that the proposed premium payment induced a patient to "purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering" a "good, facility, service, or item" for which payment may be made under a federal health care program.

This element of the statute conceivably could be satisfied by the patient's decision to enroll in the QHP itself, but to reach that conclusion, the term "service" or "item" must be

construed to include a health plan itself rather than particular services or items provided under the health plan. Further, the term "purchase" or "order" seemingly would need to be read to include either an individual's decision to enroll in a health plan or the hospital's payment of the premium. Although the OIG or another enforcement authority might adopt such an interpretation, it is not obvious from the statute that these terms should be read so broadly.

Alternatively, this element of the AKS could be satisfied if particular services or items provided to the patient and paid for by the QHP are the "services" or "items" for which payment may be made under a Federal health care program. In that case, however, the decision to provide a service or prescribe or order a drug or other item is not made solely by the patient but rather in conjunction with (or indeed largely by) the individual's health care provider. In light of that intervening decision by the health care provider, there is some doubt as to whether the individual himself has been induced to "purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering" the services or items paid for by the QHP.

**Additional Considerations in Assessing Enforcement Risk under the AKS.** As the OIG has made clear, even when an arrangement potentially implicates the AKS, a number of additional factors must be considered in determining whether that arrangement would in fact constitute a violation of the AKS, and whether the federal government would seek to enforce the AKS against an entity engaged in that arrangement.

First, to make out a violation of the AKS, it must be shown that the person or entity acted with the requisite intent by "knowingly and willfully" offering or paying remuneration to induce purchase of items or services for which payment may be made under a Federal health care program. It is difficult to assess, in the absence of specific factual circumstances, whether it could be shown that the hospital acted with the necessary intent.

Other case-specific considerations also are likely to be highly relevant to the risk of enforcement under the AKS based on a particular arrangement. Out of the dozens of advisory opinions issued by the OIG, a number of recurring factors have emerged as relevant to the OIG's analysis of whether it would pursue enforcement in a given case. Depending on how the proposed premium payment is structured, a number of these factors could reduce the risk of enforcement even if the proposed subsidy were found to implicate the AKS.

The following factors are among those cited favorably in the OIG's advisory opinions.[2]

[2] Congress emphasized the importance of many of these same factors when it instructed the Secretary of Health and Human Services to solicit and publish new and modified safe harbors from enforcement of the AKS. The statute explicitly authorizes the Secretary to consider the first five of these factors in determining whether a safe harbor should be established or modified. *See* Social Security Act § 1128D(a)(2).

- The arrangement would promote public health and/or offer improved quality of care or expanded access to care for vulnerable patient populations;
- The arrangement would not cause overutilization of health care services or increase the provision of unnecessary services;
- The arrangement would not negatively affect competition between health care providers;
- The arrangement would not increase costs to federal health care programs;
- The arrangement would not restrict a patient's choice of provider;
- The benefits of the arrangement would be offered equally to all of a provider's patients; and
- The arrangement appears to be motivated by a legitimate business purpose rather than a bare intent to induce orders or referrals.

In a second advisory opinion, the OIG analyzed a proposal by a large, public health system and its affiliated hospital to offer free acute dialysis treatment to chronic dialysis patients unable to obtain dialysis treatment in their community.[3] There, the OIG emphasized:

- that the hospital would absorb all the costs of providing free services and would not shift those costs to federal programs;
- that the arrangement would bridge a coverage gap and thereby benefit a vulnerable patient group;
- that the hospital was motivated by a "legitimate business purpose" (the need to free up inpatient beds otherwise used by non-paying emergency dialysis patients); and
- that while the provision of free services might produce a "generalized feeling of goodwill toward the Hospital," which could influence the patient's selection of provider in the future, that influence was "speculative and attenuated by circumstances beyond the Hospital's control (e.g., whether the patient would ever require services offered by the Hospital)."

In individual advisory opinions, the OIG has applied these factors to arrangements that include some factual similarities to the proposed premium payment and concluded that it would not impose administrative sanctions based on the AKS. For example, the OIG analyzed a charitable hospital's proposal to subsidize patient cost-sharing for services billed to Medicare and Medicaid because the hospital had a long tradition of providing care without any cost to patients.[4] In its opinion, the OIG emphasized:

- that the subsidy likely would not affect a patient's choice of provider because it would not be advertised or marketed to the general public and would be discussed with patients only after they were admitted for care;

[3] *See* OIG Adv. Op. 07-01 (Jan. 25, 2007).
[4] *See* OIG Adv. Op. 11-01 (Jan. 10, 2011).

- that any harm to federal health care programs would be limited by the fact that the hospital would bear the cost of the subsidized cost-sharing and would not shift the burden to the federal government or other payers or individuals;
- that the subsidy would be offered equally to all patients and therefore could not be used selectively as an inducement to draw lucrative patients; and
- that the subsidy would promote the public benefit of improving access to care for a vulnerable patient population.

A number of the other factors commonly cited by the OIG, if applied to the proposed premium payment, also would appear relevant to assessing the risk of enforcement against a hospital offering such a subsidy. These factors include:

- the risk that the arrangement will lead to overutilization or provision of unnecessary services (arguably low here, where although payment of the premium may allow for additional services to be provided, it would likely reduce the amount of *unnecessary* services);
- the potential impact on the quality of patient care (arguably favorable here, where patients will have access to a much wider array of services – including preventive care – than those available in a hospital emergency room);
- the effect of the arrangement on patients' freedom of choice (arguably favorable here, because it would increase the patient's access to care and would not limit the patient to services provided by the hospital); and
- the potential for adverse effects on competition (arguably low here, where recipients of the premium subsidy would not be limited to services provided by the hospital and, indeed, the hospital may not even participate in the QHP selected by the individual).

Depending on the structure of the proposed premium payment, each of the factors above could affect the risk of enforcement against a hospital under the AKS. It is important to note, however, that the presence or absence of factors cited favorably by the OIG does not necessarily mean that the OIG or other enforcement agencies will or will not pursue enforcement in a particular case. On the contrary, the OIG has cited a wide variety of considerations in assessing whether it would seek enforcement in a particular case and has consistently stated that its decision to pursue enforcement is based on the totality of circumstances surrounding a given arrangement.

**ACA Amendment to the Civil Monetary Penalties (CMP) Statute.** Finally, the ACA provision narrowing the definition of "remuneration" in the CMP statute does not affect the AKS analysis. While the ACA amended the definition of "remuneration" in the CMP statute to exclude "any other remuneration which promotes access to care and poses a low risk of harm to patients and Federal health care programs (as defined in [the anti-kickback statute] and designated by the Secretary under regulations),"[5] Congress did not make a similar change to the AKS.

[5] *See* Patient Protection and Affordable Care Act (ACA) § 6402(d)(2)(B)(iv), codified at 42 U.S.C. § 1320a-7a(i)(6)(F).

## *Tax Exemption Considerations*

**Paying for Patient's Insurance as a Component of a Financial Assistance Policy.** Tax-exempt hospitals are required to comply with the general restrictions that apply to Section 501(c)(3) organizations, to satisfy a "community benefit standard," and to meet the additional requirements for hospitals under Section 501(r).

By paying health insurance premiums on behalf of a patient eligible for assistance, the hospital would be providing the means for patients to secure the benefits of having insurance coverage for their health care needs. This arrangement should be an acceptable means of satisfying the general community benefit standard, and not be prohibited by Section 501(r) requirements regarding financial assistance policies. However, no federal tax authorities have been identified that indicate whether the purchase of insurance or the payment of premiums for patients constitutes financial assistance for purposes of Section 501(r) or otherwise.

**Impermissible Private Benefit.** A tax-exempt hospital also must not engage in "private benefit" transactions that serve private, rather than public, interests. The presence of private benefit, if more than an insubstantial amount, will result in loss of exemption regardless of an organization's charitable purposes or activities.

The proposed arrangement contemplates a tax-exempt hospital paying the applicable health insurance premium to the health plan for the insurance policies issued to these patients. No federal tax authorities have been identified that discuss or address tax-exempt considerations related to this type of proposal. However, because this proposed arrangement provides clients to a health plan, which may not be tax-exempt, the arrangement must be analyzed to make certain no substantial private benefit is provided to a for-profit entity.

If the hospital paid premiums to an existing for-profit health plan on behalf of its patients eligible for assistance, there may be concerns about whether those activities constitute private benefit to the health plan. In some circumstances, adding more insurance clients could result in higher profits for the health plan. Ultimately, it would be necessary to carefully consider whether the public purpose of the arrangement outweighs any private benefits.

On several occasions, the IRS has ruled that paying for or subsidizing liability insurance policies for staff physicians furthers a hospital's tax-exempt status if the hospital would be unable to otherwise recruit qualifying physicians. In those rulings, the IRS noted that any private benefit to the physicians was outweighed by the public purpose of recruiting needed physicians to areas with shortages. In the proposed arrangement, the hospital would be subsidizing patients' insurance costs as part of providing financial assistance. Arguably, the hospital has other ways of satisfying the "community benefit standard" without providing benefits to a for-profit entity. By contrast, in the IRS rulings, furnishing insurance coverage for physicians was essential to recruiting the physicians. Because

the facts are somewhat different, all of the facts and circumstances would need to be reviewed carefully.

## *NEXT STEPS*

In an effort to assure that neither agency's rules prevent hospitals and health systems that wish to do so from providing such assistance, the AHA plans to ask both the IRS and the OIG for useful guidance.

## *FURTHER QUESTIONS*

Please contact Maureen Mudron, AHA deputy general counsel, at (202) 626-2301 or mmudron@aha.org, or Mindy Hatton, AHA senior vice president and general counsel, at (202) 626-2336 or mhatton@aha.org.