



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



[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: July 21, 2020

Posted: July 24, 2020

[Name and address redacted]

Re: OIG Advisory Opinion No. 20-04

Dear [Name redacted]:

We are writing in response to your request for an advisory opinion regarding a charitable organization's proposal to purchase or receive donations of unpaid medical debt owed by qualifying patients from certain types of health care providers and then forgive that debt (the "Proposed Arrangement"). Specifically, you have inquired whether the Proposed Arrangement would constitute grounds for the imposition of sanctions under the civil monetary penalty provision prohibiting inducements to beneficiaries, section 1128A(a)(5) of the Social Security Act (the "Act"), or under the exclusion authority at section 1128(b)(7) of the Act or the civil monetary penalty 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, the Federal anti-kickback statute.

You have certified that all of the information provided in your request, including all supplemental submissions, 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, although 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, the Office of Inspector General (“OIG”) would not impose administrative sanctions on [name redacted], 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. In addition, the OIG would not impose administrative sanctions on [name redacted], under section 1128A(a)(5) of the Act in connection with the Proposed Arrangement. 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 for an advisory opinion or supplemental submissions.

This opinion may not be relied on by any persons other than [name redacted], the requestor 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

[Name redacted] (“Requestor”) is a 501(c)(3) charitable organization that locates, buys, and forgives individual patients’ medical debt. According to Requestor, medical debt has reached crisis levels. Requestor cites to a Kaiser Family Foundation survey that details many of the ripple effects of medical debt, including skipping necessary medical care, foregoing necessities like groceries, and bankruptcy.¹

Requestor asserts that hospital bills are one common source of medical debt for patients. According to Requestor, hospitals collect far less than the amounts billed to patients each year (including amounts billed to self-pay patients and amounts billed to patients for balances due after insurance payments). Requestor indicated most hospitals have a financial assistance policy, but not all patients who would qualify apply for such assistance. Other patients who cannot pay their medical debt may not have qualified for assistance at the time the hospital rendered the care. Requestor certified that, in its experience, most hospitals write off uncollectible accounts as bad debt,² while 30 to 35 percent of hospitals sell portfolios of uncollectible accounts to debt purchasing companies. These debt purchasing companies continue to try to collect the debt from patients. Requestor stated that any debt that is written off or otherwise not forgiven or paid may remain on a debtor patient’s credit report for a period of seven years.

¹ See Kaiser Family Foundation, *The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey* (Jan. 2016), available at <https://www.kff.org/wp-content/uploads/2016/01/8806-the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey.pdf>.

² For purposes of this opinion, “uncollectible account” means the portion of a patient’s medical debt that the hospital was unable to collect after completing its own collection efforts process.

Currently, Requestor works with debt purchasing companies to screen for medical debt that meets Requestor’s criteria for forgiveness. Requestor certified that it uses an objective, anonymous process to identify debt to forgive; neither patients nor donors can petition to have specific debt forgiven. Specifically, Requestor seeks to forgive medical debt for people who: (i) have incomes that are less than 200 percent of the Federal poverty level;³ (ii) have hardships that make paying off the medical debt difficult or impossible (e.g., medical debt amounting to more than 5 percent of gross income); or (iii) are insolvent, with liabilities exceeding their assets. Debt that belongs to individuals who meet Requestor’s aforementioned criteria, or any additional criteria included in the Proposed Arrangement as further described in footnote 5, is considered “Qualified Medical Debt.”

Once Qualified Medical Debt accounts are identified, Requestor negotiates at arm’s length to buy those accounts for fair market value from the debt purchasing company. Requestor certified that “fair market value” for Qualified Medical Debt is very low because the debt is unlikely to be collected. After Requestor acquires the Qualified Medical Debt, Requestor forgives it completely, ensuring that the debt is reported as “paid in full” and the derogatory mark is removed from the patient’s credit report. Requestor informs the patient by letter that the debt has been forgiven and the patient’s credit report has been updated. To date, Requestor has forgiven more than \$2 billion of medical debt.

Requestor receives donations from individual donors, philanthropists, foundations, faith-based organizations, and corporations to be used for medical debt forgiveness. The donors are permitted to make certain broad requests for debt forgiveness (e.g., medical debt in connection with patients who are veterans, children, or residents of a particular state or medical debt related to a broad disease category, such as “cancer”), but donors may not earmark donations to forgive: (i) debt for particular patients, (ii) debt for patients with a particular insurance status; (iii) particular types of medical debt (e.g., inpatient vs. outpatient); (iv) debt owed to particular providers or groups of providers; or (v) any other category of debt that relates in any way to health insurance status or type of treatment. Donors receive only high-level reports regarding how their donation was used (e.g., if a donor designated the donation for children in a particular state, the report would indicate the number of children and the amount of debt abolished); reports do not include personally identifiable information.

Under the Proposed Arrangement, Requestor would purchase or receive a donation of inpatient and outpatient debt directly from hospitals and certain other providers (“Providers”),⁴ instead of

³ The Federal poverty level refers to the guidelines developed by the U.S. Department of Health & Human Services, available at <https://aspe.hhs.gov/poverty-guidelines>.

⁴ Specifically, Requestor would purchase or receive donations of debt from all constituent components of hospital systems, including, without limitation, debt from physicians affiliated with the system (i.e., debt from physicians that is included in a hospital system’s accounts

buying the debt from debt purchasing companies. This medical debt could have been incurred by patients who, when they received services, were uninsured and could include cost-sharing or other amounts owed by patients who had private or public insurance, including Federal health care programs. Any medical debt that Requestor would consider purchasing or receiving through donation would be debt that the Provider already attempted and failed to collect either through its own billing and collection process or by using one or more collection agencies. If debt is related to Medicare services, Requestor certified that the debt would be “uncollectible” under Medicare bad debt rules.

Requestor and the Provider would work with a HIPAA-compliant third-party vendor of data and analytical services to identify debt that meets the objective criteria for forgiveness. Requestor would continue to apply similar criteria for acquiring the medical debt directly from a Provider that it currently uses to acquire medical debt from a debt purchasing company.⁵ Requestor’s financial need assessment would be made on the basis of the patient’s current financial status, without regard to the patient’s financial status at the time services were provided or when the debt was incurred. Under the Proposed Arrangement, all certifications set forth above with respect to donors and donations would continue to apply, including but not limited to the prohibition on donors earmarking donations to forgive: (i) debt for particular patients, (ii) debt for patients with a particular insurance status; (iii) particular types of medical debt (e.g., inpatient vs. outpatient); (iv) debt owed to particular providers or groups of providers; or (v) any other category of debt that relates in any way to health insurance status or type of treatment, and Requestor would use the same process for notifying patients that it has forgiven the patient’s medical debt.

As a condition of participation, providers would agree not to publicize the sale or donation of debt to Requestor, and Requestor would not identify Providers by name in promotional or marketing materials that are available to the public. However, when explaining the Proposed Arrangement to potential Provider partners, Requestor may, with permission, provide the names of other Providers that have sold or donated medical debt to Requestor. If the Provider is a hospital, Requestor would require the hospital to agree to offset the proceeds of any sale of Medicare bad debt against the hospital’s reimbursable Medicare bad debt expense.

receivable). In addition, Requestor would acquire and forgive debt from independent physician practices with more than 50 practitioners. Requestor would not acquire debt from other entities, such as skilled nursing facilities, unless an entity was a constituent component of a health system.

⁵ Requestor certified that the eligibility criteria may vary from Provider to Provider and may evolve over time (e.g., Requestor might adopt the particular Provider’s published financial assistance policy or criteria that apply to all providers in their home state). Requestor certified that the criteria would not include factors such as utilization, profitability, or treatment type and would be applied uniformly to screen all debt from that particular Provider.

II. LEGAL ANALYSIS

A. Law

The anti-kickback statute makes it a criminal offense to knowingly and willfully 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. See, e.g., United States v. Nagelvoort, 856 F.3d 1117 (7th Cir. 2017); United States v. McClatchey, 217 F.3d 823 (10th Cir. 2000); United States v. Davis, 132 F.3d 1092 (5th Cir. 1998); United States v. Kats, 871 F.2d 105 (9th Cir. 1989); United States v. Greber, 760 F.2d 68 (3d Cir. 1985), cert. denied, 474 U.S. 988 (1985). Violation of the statute constitutes a felony punishable by a maximum fine of \$100,000, imprisonment up to ten 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 civil monetary penalties 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.

Section 1128A(a)(5) of the Act (the “Beneficiary Inducements CMP”) provides for the imposition of civil monetary penalties against any person who offers or transfers remuneration to a Medicare or State health care program (including Medicaid) beneficiary that the benefactor knows or should know is likely to influence the beneficiary’s selection of a particular provider, practitioner, or supplier of any item or service for which payment may be made, in whole or in part, by Medicare or a State health care program (including Medicaid). The OIG may also initiate administrative proceedings to exclude such party from the Federal health care programs. Section 1128A(i)(6) of the Act defines “remuneration” for purposes of section 1128A(a)(5) as including “transfers of items or services for free or for other than fair market value.”

Section 1128A(i)(6)(A) includes an exception for the waiver of coinsurance and deductible amounts by a person, if (i) the waiver is not offered as part of any advertisement or solicitation; (ii) the person does not routinely waive coinsurance or deductible amounts; and (iii) the person waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need or fails to collect coinsurance or deductible amounts after making reasonable collection efforts.

B. Analysis

Under the Proposed Arrangement, Requestor would purchase (or receive as a donation) Qualified Medical Debt directly from Providers. Some of the Qualified Medical Debt that Requestor would forgive could be incurred on items or services reimbursable by Federal health care programs. Requestor's forgiveness of a patient's debt that was donated or sold to Requestor by a Provider, if known to the patient, could induce such patient to seek items or services from that Provider or could influence the patient's future selection of the Provider. Therefore, the Proposed Arrangement implicates both the Beneficiary Inducements CMP and the anti-kickback statute. We note that the exception to the definition of "remuneration" under the Beneficiary Inducements CMP for certain waivers of coinsurance and deductible amounts would not apply to the Proposed Arrangement because that exception applies only to providers or suppliers to whom copayments or deductibles are owed. No patients owe coinsurance or deductible amounts to Requestor, and therefore Requestor would not be waiving coinsurance or deductible amounts under the Proposed Arrangement. In addition, no safe harbor to the anti-kickback statute would apply to the Proposed Arrangement. However, for the combination of the following reasons, we would not impose sanctions under the Beneficiary Inducements CMP in connection with the Proposed Arrangement, and we find the Proposed Arrangement to be sufficiently low risk under the anti-kickback statute.

First, while our analysis focuses on the Proposed Arrangement, and not any remuneration flowing from a Provider to a patient who owes medical debt, we note that, based on Requestor's certifications, any waivers by Providers of cost-sharing amounts under the Proposed Arrangement would not be routine. Our concerns regarding routine waivers of Medicare cost-sharing amounts are longstanding, and health care providers that waive Medicare cost-sharing amounts for reasons unrelated to individualized, good faith assessments of financial hardship may be held liable under the anti-kickback statute. See, e.g., Special Fraud Alert: Routine Waiver of Copayments or Deductibles Under Medicare Part B, 59 Fed. Reg. 65,372, 65,374 (Dec. 19, 1994). However, under the Proposed Arrangement, Requestor would forgive debt only after: (i) a Provider attempted and failed to collect the debt; and (ii) an individualized financial need determination. Therefore, neither the debt forgiveness by Requestor nor the cost-sharing waiver, if any,⁶ by a Provider would be routine. This lowers the risk of unlawful inducements to purchase future items and services paid for by Federal health care programs or influence of the beneficiary's future selection of the Provider.

Second, as a condition of participating in the Proposed Arrangement Providers would have to agree not to publicize the sale or donation of debt to Requestor. In addition, it would be Requestor, not the Provider, who notifies the patient that his or her debt has been paid in full. Therefore, the patient may have limited or no knowledge of the Provider's role in the

⁶ We note that, if a Provider were to sell (rather than donate) debt to Requestor instead of selling the debt to a debt purchasing company, the cost-sharing amounts would not necessarily be "waived."

abolishment of the patient's debt. While patients whose debt is already forgiven might have a sense of goodwill towards the Provider, Providers would have a limited ability to use this program as a tool to generate future business.

Third, the Proposed Arrangement should not lead to increased costs to Federal health care programs. This debt forgiveness would take place only after the Provider rendered the services with the expectation of collecting payment and attempted to collect payment. Purchasing or receiving a donation of debt after it is incurred and deemed uncollectible does not carry the same risks as agreeing to subsidize an ongoing payment obligation or waiving a payment obligation in advance.

Fourth, purchasing or receiving a donation of debt directly from the Provider instead of from a debt purchasing company does not materially impact the risk of the Proposed Arrangement. As a general matter, it is in the Provider's financial interest to try to collect the medical debt. If the Provider is unable to collect the debt, in the absence of the Proposed Arrangement, the Provider either would write off the debt or sell it to a debt purchasing company. If that patient account meets Requestor's criteria for debt forgiveness and is selected, and Requestor follows the safeguards set forth in its certifications, the end result to both the Provider and the patient is the same whether Requestor purchases the debt from a debt purchasing company or purchases or receives a donation of debt from the Provider.

Finally, donors would have only limited control over how their donations to Requestor are used to forgive medical debt. Although donors could designate the donation to be used for certain broad categories of patients, donors would not be permitted to restrict donations for certain types of treatments or otherwise target particular patients, treatment types, or patients covered by a particular type of insurance.

For the combination of the foregoing reasons, we would not impose sanctions under the anti-kickback statute or the Beneficiary Inducements CMP in connection with the Proposed Arrangement.

III. CONCLUSION

Based on the facts certified in your request for an advisory opinion and supplemental submissions, we conclude that, although 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, the OIG would not impose administrative sanctions on [name redacted], 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. In addition, the OIG would not impose administrative sanctions on [name redacted], under section 1128A(a)(5) of the Act in connection with the Proposed Arrangement. 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 for an advisory opinion or supplemental submissions.

IV. LIMITATIONS

The limitations applicable to this opinion include the following:

- This advisory opinion is issued only to [name redacted], the requestor 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 by a person or entity other than [name redacted], to prove that the person or entity did not violate the provisions of sections 1128, 1128A, or 1128B of the Act or any other law.
- 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, including, without limitation, the physician self-referral law, section 1877 of the Act (or that provision's application to the Medicaid program at section 1903(s) of the Act).
- 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 [name redacted], 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 [name redacted], with respect to any

action that is part of the Proposed Arrangement 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,

/Robert K. DeConti/

Robert K. DeConti
Assistant Inspector General for Legal Affairs