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Safe Harbors for Fee Reductions

by John S. Hoff

Safe harbors are supposed to protect the field from unwarranted application of the so-called fraud and abuse provisions. The harbors are constantly under construction and are becoming ever more baroque in appearance.

The Inspector General of the Department of Health and Human Services recently issued new safe harbor regulations concerning incentives given by health care plans to attract members and discounts obtained by health care plans from their participating providers.[1] These clarify and supplement an interim final rule issued in 1992.

Incentives (such as waiver of copayments) are intended to attract enrollees. The question, therefore, is whether they are made to induce patients to obtain services in violation of the anti-kickback statute. On the other side of the coin, are discounts given by providers to attract Medicare and Medicaid patients a violation? This issue, of course, affects providers more directly.

The new safe harbor rules on provider incentives are more opaque than they need be. They are a reflection of the upside-down world of health care that views price reductions with suspicion. But if a provider wanted to give a health care plan a discount—and felt the need to be docked in a safe harbor—they are important.

The new safe harbor provides that a reduction in the price a provider charges to a plan is not "remuneration" (the word used in the statute) if a number of conditions are met.

First, only health plans that meet certain definitions may obtain the discounts. The plan must be paid a premium or fee to furnish or arrange for health care services under agreement with providers, and it must: 1) operate under a contract with HCFA or a Medicaid program, or under demonstration authority approved by HCFA or the Medicaid program; 2) be subject to state regulation of its premiums; 3) be an employer (for its retirees) or union fund (for union members); or 4) administer a plan under contract with the employer or union fund and be "licensed" in the state.

If a plan meets any of these definitions, it may accept price reductions as part of its contract with a provider, on certain further conditions. Medicare and Medicaid, not surprisingly, can be charged only the amount agreed upon, and the discount cannot be recouped from other Medicare or Medicaid patients.

If the plan does *not* have a contract with HCFA or the Medicaid authority or is not acting under demonstration authority, the contract with the provider must be for at least one year (whether or not the provider is paid on a capitated basis). The contract cannot contain optional termination provisions (except as necessary to comply with changes in the law). Where there is no contract with Medicare or Medicaid, in addition the agreement with the provider must specify the services subject to the price reduction and who will bill the program, and it must include a schedule of fees to be charged. (In the case of a capitated provider, this would be the amount per enrollee to be paid to the provider.) The fee schedule must remain in effect for the term of the agreement, unless Medicare or Medicaid approves a different rate. Withhold pools and risk incentive pools are not protected if the plans have not contracted with Medicare or Medicaid.

Risk-based plans that *do* have contracts with HCFA or a Medicaid agency must also have contracts with their providers, but there is no required minimum duration, no requirement for a fee or capitation schedule, and no explicit limitation on the discount mechanism.

Providers who meet these conditions, as applicable, will be able to discount their fees without having to worry about prosecution for illegal kickbacks (although this may not be their main concern in granting discounts).

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REFERENCE

[1] 61 *Fed. Reg.* 2122 (January 25, 1996).