Executive Overview

On December 30, 2004, the Office of the Inspector General (“OIG”) issued an advisory opinion (the “Opinion”) protecting a hospital’s subsidization of professional liability insurance payments for two neurosurgeons on the hospital’s medical staff. Despite the pressures that hospitals are facing to assist physicians with increased insurance premiums, the Opinion is based upon unique facts (including the terms of the subsidy) and, thus, does not provide wide latitude for hospitals to provide malpractice subsidies. Moreover, the Opinion does not address Stark Law compliance or tax-exemption issues.

Factual Background

The hospital in question is sole provider of neurosurgical services in a 45-mile area. The physicians in question are the only neurosurgeons on the hospital’s medical staff. The Opinion makes a point of indicating that the physicians provide a substantial amount of care to Medicaid and indigent patients. The Opinion also notes that the hospital had made a number of attempts to recruit additional neurosurgeons to the community without success.

Two weeks prior to the renewal deadline, the physicians’ malpractice carrier surprised the physicians by notifying them that it would not renew the coverage. Instead, the insurance carrier offered to provide tail coverage to the physicians free of charge but only if the physicians immediately retired. Thus, the physicians faced the decision to either retire with free tail coverage or to remain in practice, find new insurance coverage and forego the opportunity for free tail coverage. The latter option was made more unattractive by the fact that new coverage would cost substantially more. The Opinion indicates that these facts created a “powerful financial incentive” for the physicians to retire and that the physicians’ expressed intent to retire immediately was “especially credible and potentially harmful to the local patient population.”

The Arrangement

In light of these factors, the hospital agreed to subsidize the physicians’ malpractice insurance costs as follows:

1. The hospital paid the entire cost of tail coverage from the original insurance carrier;
2. The hospital paid 75% of the cost differential between the physicians’ new insurance policy premium and its original insurance policy premium; and
3. The hospital agreed to pay all or part of the cost of tail coverage from the new insurance carrier should the physicians not obtain free tail coverage in the future.

The hospital also agreed to provide premium subsidies in the second year in the event community need persisted and the physicians faced significant premium increases during the second year. Finally, the aggregate amount the hospital agreed to provide was capped. In return, the physicians agreed to:

- Maintain a full-time neurosurgery practice in the community
- Take neurosurgical call for the hospital’s emergency department
- Participate on assigned hospital committees
- Continue to provide care to Medicare beneficiaries

1. OIG Advisory Opinion No. 04-19.

2. The new insurance carrier did not significantly increase the premium in year two and, thus, the hospital did not provide an additional subsidy.
3. The Opinion does not indicate whether the physicians were required to take such call by the hospital’s medical staff bylaws.
• Provide at least as much Medicaid and/or indigent care as they provided prior to the arrangement
• Cooperate with the hospital in recruiting additional neurosurgeons

**OIG’s Analysis**

The OIG explicitly recognized the effect that decreasing availability of professional liability insurance, compounded with increased premiums for such insurance, have on access to certain medical services. Despite its historical concern that hospitals’ subsidization of malpractice premiums may be used to influence referrals (particularly when offered in a selective manner) and the failure of the arrangement to satisfy the safe harbor for malpractice subsidies, the OIG stated it would not impose sanctions against the hospital and physicians.

Specifically, the OIG found the following protections sufficient to reduce the risk that the arrangement constituted payment for referrals:

- The physicians had a “substantial financial incentive” to retire
- The arrangement was a temporary and urgent measure to avoid a gap in local availability of neurosurgical services that would have resulted if the physicians retired
- The situation arose with little time to explore other options
- The arrangement was designed to solve an immediate need and was of a limited duration
- The physicians were required to incur additional premium expenses and, as such, did not receive a “significant financial windfall”
- The risk of undue benefit to the physicians was reduced as the physicians were required to perform certain services in consideration for the subsidy
- The subsidized insurance covered services at sites other than the hospital

**Implications for Your Organization**

The Opinion represents the second advisory opinion issued in the last four months protecting malpractice premium subsidies. The earlier opinion (OIG Advisory Opinion No. 04-11) protected subsidization of malpractice premiums for obstetricians. In that case, the proposed arrangement met all of the safe harbor requirements for malpractice subsidies except one – the requirement that the obstetricians serve a primary care health professional shortage area (“HPSA”). The OIG nonetheless protected the arrangement as the area served had three other HPSA designations (low income, migrant agricultural workers and homeless individuals).

While the earlier opinion does not represent a significant departure from the limited applicability of the safe harbor, it is interesting to note that the OIG does not even discuss the safe harbor requirements in the recent Opinion. The OIG does note the underserved nature of the community – a critical element in both opinions. Despite this, however, the Opinion should not be viewed as granting wide-latitude to provide malpractice subsidies to all physician specialties in underserved areas.

In the Opinion, the OIG relied not only on the underserved nature of the community, but also the fact that:

- The insurer’s non-renewal decision was made at the last minute and left the physicians and the hospital without time to consider other alternatives
- The insurer also provided the physicians with a significant incentive to retire, which made retirement a credible and viable alternative

In fact, the manner in which the Opinion is drafted suggests that the hospital requested the advisory opinion after the arrangement was already in place.

Hospitals also should be mindful that the Opinion does not address the Stark Law implications of the particular malpractice subsidy arrangement. The arrangement clearly would not comply with the Stark Law exception for malpractice subsidies, as that exception requires compliance with the Anti-Kickback Statute safe harbor (i.e., obstetrical malpractice subsidies in primary care HPSAs). In addition, the facts suggest that the arrangement would not satisfy the exception for retention payments in underserved areas. This leaves little room for compliance short of the personal services exception or the fair market value exception. Specifically, there is no mention as to the actual dollar amounts the hospital provided (these are redacted in the Opinion) or the value of the services the physicians agreed to provide to the hospital in return for the subsidy. Accordingly, no determination was made that

---

the payments from the hospital were fair market value for the services received.

The arrangement described in the Opinion also raises the issue of whether any private inurement/private benefit or intermediate sanctions concerns were created. While there appears to be a strong community benefit argument behind the arrangement, it is difficult to predict how the IRS would view the subsidy.

In sum, the Opinion indicates that in limited situations malpractice subsidies may be permitted. Hospitals, however, should proceed cautiously with any arrangements and should ensure that any arrangement is reviewed not only for Anti-Kickback Statute compliance, but also Stark Law and tax-exemption requirements.

**Health Care Group**

Keith R. Anderson  
kanderson@gcd.com  
312-569-1278

James A. Barker, Jr.  
jbarker@gcd.com  
202-230-5166

Stephen Boochever  
sboochever@gcd.com  
518-452-8787

Jennifer R. Breuer  
jbreuer@gcd.com  
312-569-1256

L. Edward Bryant, Jr.  
ebryant@gcd.com  
312-569-1259

Eileen M. Considine  
econsidine@gcd.com  
518-452-8787

John J. D’Andrea  
jdandrea@gcd.com  
518-452-8787

James Domzalski  
jdomzalski@gcd.com  
518-452-8787

Ramy Fayed  
rfayed@gcd.com  
202-230-5175

Jeffrey T. Ganiban  
jganiban@gcd.com  
202-230-5150

D. Louis Glaser  
lglaser@gcd.com  
312-569-1262

Philip D. Green  
pgreen@gcd.com  
202-230-5109

L. Robert Guenthner, III  
rguenthner@gcd.com  
312-569-1263

Rebecca Hirslej  
rhirslej@gcd.com  
202-230-5107

Tiana L. Korley  
tkorley@gcd.com  
312-569-1265

Holley Thames Lutz  
hlutz@gcd.com  
202-230-5126

Robert W. McCann  
mccann@gcd.com  
202-230-5149

Ashley E. McKinney  
amc McKinney@gcd.com  
312-569-1266

Mehta, Mina  
mmehtha@gcd.com  
312-569-1273

C. Brooks Newman  
cbnewman@gcd.com  
312-569-1275

Neil S. Olderman  
nolderman@gcd.com  
312-569-1279

Paul Seltman  
pseltman@gcd.com  
202-230-5630

Elizabeth Stottlemyer  
estottlemyer@gcd.com  
202-230-5156

T.J. Sullivan  
tsullivan@gcd.com  
202-230-5157

Douglas B. Swill  
dswill@gcd.com  
312-569-1270

Kelley M. Taylor  
ktaylor@gcd.com  
202-230-5127

Paul L. Uhrig  
puhrig@gcd.com  
202-230-5129

Robert J. Waters  
rwaters@gcd.com  
202-230-5152