On April 22, 2004, the American Health Lawyers Association (AHLA) submitted an historic request for clarification on the scope of permitted assistance to physicians to respond to the medical malpractice insurance crisis that has hit several states. AHLA's letter was developed by a task force of AHLA members, chaired by the Chair of our Health Care Department, Gerald M. Griffith. The request is directed at the three agencies that most actively regulate hospital-physician relationships, OIG, CMS and the IRS. After detailing several examples of the crisis in physician coverage, the letter outlines common features of both subsidized and non-subsidized physician programs. Many of these features, particularly in subsidized programs, do not always fit a clear regulatory exception or have clearly defined regulatory limits. To remove these uncertainties and to allow hospitals and physicians to respond more effectively to the crisis in a legally compliant manner, AHLA requested clarification of the effect of these and other program features from the three agencies. Attached for your information are copies of an advisory we have prepared for our clients, AHLA’s press release and the AHLA letters. If you have any questions about this project or features of an existing or planned physician program, please contact Gerald Griffith (313-465-7402), William Cassetta (313-465-7348), William Hochkammer (313-465-7414), Julie Robertson (313-465-7520), Patrick LePine (313-465-7648) or Zachary Fryer (517-377-0731).

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April 22, 2004

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Internal Revenue Service, Exempt Organizations (T:EO)
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Washington, D.C. 20201-0003

Leslie Norwalk, Esq.
Acting Deputy Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW, Room 314G
Washington, D.C. 20201-0004

Dear Mr. Miller, Mr. Morris and Ms. Norwalk:

As we have previously discussed with you, the American Health Lawyers Association (AHLA) is seeking clarification of your agencies' respective positions on various ways in which healthcare facilities may lawfully assist physicians in obtaining malpractice insurance coverage.

The entire healthcare community is affected by the rising cost of malpractice insurance in many states and the negative effects of these skyrocketing costs on access to care. The impact of rising malpractice insurance coverage on physicians' ability to practice medicine, and on hospitals' ability to maintain physician coverage of needed services, is of crucial concern to the healthcare entities served by AHLA member attorneys. Through this letter, the AHLA requests joint clarification from the Internal Revenue Service (IRS), the Office of Inspector General of the Department of Health and Human Services (OIG), and the Centers for Medicare and Medicaid Services (CMS) on permissible assistance that hospitals and other acute and long-term care providers may provide to physicians and other health professionals to lessen the effects of rising malpractice insurance premiums.

AHLA members provide advice to hospitals and physicians on a daily basis regarding how to provide needed care to patients without running afoul of tax exemption, fraud and abuse and self-referral laws. Providing counsel in these areas requires careful analysis of
a complex web of intersecting laws and regulations. Clarification from the IRS, OIG, and CMS on the different fact patterns presented in this letter will help AHLA members advise their clients on this important health policy issue.

**THE MALPRACTICE INSURANCE CRISIS**

Health care providers throughout the United States are facing a crisis in the availability and affordability of insurance to cover their malpractice liability exposures. According to an American Medical Association analysis, nineteen states are currently experiencing an insurance crisis.¹ The AMA report further states that only six states appear to have a stable market for malpractice insurance.² Some of the manifestations of the crisis have been dramatic. For example:

- In Las Vegas, Nevada, the only trauma center in the city closed for ten days during the summer of 2003 because its orthopedic surgeons could not afford malpractice insurance.³
- In Jacksonville, Florida, 19 general surgeons took leaves of absence in May 2003 when proposed state tort reforms did not pass, resulting in the loss of one-third of the city’s hospitals’ general surgery capacity.⁴
- In rural central Mississippi, a hospital closed its obstetrics unit when the five family practitioners who had performed deliveries stopped doing so to avoid a 65% increase in their insurance premiums, causing pregnant women to have to travel 65 miles to the nearest obstetrical ward to deliver.⁵
- One of West Virginia’s major medical centers lost its Level 1 Trauma Center designation for several weeks in fall 2002 because not enough orthopedic surgeons were available to provide coverage, resulting in some patients having to be transported 50 miles or more for treatment.⁶
- In suburban Philadelphia, a trauma center closed for 13 days in December 2002-January 2003 because its orthopedic surgeons and neurosurgeons reported that they could not afford to renew their insurance.⁷
- Statewide in Pennsylvania, malpractice insurance premiums charged by commercial insurers increased anywhere from 80.7% to 147.8% between 1997 to 2001, and an additional 40% to 50.3% in 2002.⁸

² See id.
³ See id. at 6.
⁵ See id. at 14.
⁶ See id. at 15.
⁷ See id.
⁸ See American Medical Association “Medical Liability Reform – NOW!” supra note 1, at 7.

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• In Maryland, only three malpractice insurance carriers are still active in the state in 2004 compared to 15 in 1996.\textsuperscript{9}

• In Texas, only four companies were writing new malpractice coverage in 2002, down from 20 companies writing new coverage in 1999.\textsuperscript{10}

• In Ohio, 5 medical malpractice insurers write nearly 72% of the coverage, they increased rates an average of nearly 30% in 2003 (following average increases of 21.4% in 2001 and 31% in 2002), and 3 of the 5 had experienced recent ratings downgrades.\textsuperscript{11}

Against this background of spiraling premiums and decreasing availability of coverage, more and more physicians find themselves with few, if any, cost-effective options to maintain a stable source of malpractice insurance.\textsuperscript{12} At the same time, the threat to necessary medical services translates these insurance concerns into potential impediments to community access to healthcare services for more and more people.

\textbf{REQUEST FOR CLARIFICATION}

In response to this crisis, many tax-exempt hospitals wish to assist physicians on their medical staffs in obtaining professional liability insurance. The hospitals believe that these arrangements must be implemented immediately to forestall further disruption in the provision of medical services. The proposed assistance to physicians would generally occur in one of the following forms: (a) subsidized programs such as direct cash payments to the physician or the insurance company to defray part or all of the cost of coverage or coverage at other than actuarial or market-based rates through a captive insurance company or other risk retention program owned in whole or in part by the hospital (referred to below as the hospital’s program); or (b) a non-subsidized program such as participation in the hospital’s program at actuarial or market-based rates. The criteria for receiving assistance would not be related to the volume or value of referrals to the facility providing assistance or business generated by the physician receiving assistance.

Following are various specific elements or characteristics that might be included in a malpractice insurance support program. [We realize that some of these requirements may be overlapping, and we have tried to describe various, different approaches that might be used with the expectation that hospitals would not necessarily implement all of these


\textsuperscript{10} See American Medical Association “Medical Liability Reform – NOW!” supra note 1, at 8-9, citing Houston Chronicle, August 3, 2002.


\textsuperscript{12} In this letter, AHLA is seeking clarification of how its members and their healthcare clients can respond to fluctuating costs and availability of medical malpractice coverage and its potential impact on access to quality health care services. We are not attempting to review or seek clarification on the potential underlying causes of the malpractice insurance crisis; that is, we are not intending to enter into the tort reform debate.
requirements. We request that you address the extent to which these or any other elements would be considered to be reasonable or required to meet your agencies’ regulatory concerns.

- **Criteria Applicable to Non-Subsidized Captive Insurance or Other Risk Retention Programs.** If the physician is covered by the hospital’s captive insurance company or other risk retention program (other than a subsidized program described in the next paragraph), the physician will be required to pay a reasonable amount for the coverage based on appropriate actuarial and underwriting guidelines, recognizing that, due to these requirements, expected cost savings of the particular program (e.g., joint defense, allocation of settlement rights, risk management requirements and the captive’s philosophy of operating at break-even in net income) may lead to rates that are reasonable yet lower than prevailing commercial rates due to these factors. Inasmuch as the hospital owns the captive or other insurance vehicle, the physicians would pay a fixed premium, regardless of whether the projected losses prove to be less (or more) than expected.

- **Criteria Applicable to Subsidized Programs.** For assistance that is offered in the form of a subsidized program (e.g., direct cash subsidies or participation in the hospital’s captive insurance plan at other than actuarial or market-based rates), the hospital can demonstrate that the malpractice premium assistance will either (a) help meet an existing community need (e.g., by increasing the number of physicians practicing in a specialty of which there is a current shortage or reasonably anticipated shortage in the community); or (b) otherwise provide a community benefit (e.g., by requiring the assisted physician to provide care to the medically underserved or Medicaid population).

- **Criteria Which May Be Applicable to All Programs.** The hospital may include one or more of the following requirements for risk management and quality of care purposes:

  (a) the hospital/captive may exclude physicians that present a higher indemnity risk due to prior claims experience;

  (b) the hospital/captive may exclude physicians that present an unacceptable quality risk (e.g., if they are suspended, under investigation or in the disciplinary process at any facility, or otherwise involved in a disciplinary or investigatory process being conducted by any state or federal agency);

  (c) physicians may be required to actively engage in medical practice for a specified minimum amount of time per week;
(d) physicians may be required to have a minimum number of continuing medical education hours in risk management courses arranged or approved by the hospital;

(e) physicians may be required to be on the active medical staff of the hospital;

(f) physicians may be required to perform a minimum number of cases at the hospital to show competency;

(g) physicians may be prohibited from performing more than a specified maximum percentage of patient care at another hospital or health care facility (e.g. ambulatory surgery center) where the hospital providing the malpractice assistance cannot control the quality of care or risk management practices;

(h) insurance coverage may be limited to the "four walls" of the hospital, to facilities owned by the hospital, or to the physician's private practice;

(i) the hospital may offer different levels of coverage depending on where services are provided with higher coverage levels being restricted to services provided in facilities owned by or affiliated with the hospital, or circumstances where the hospital may be jointly and severally liable with the physician in a malpractice case or vicariously liable for the physician's actions;

(j) the hospital may limit premium assistance to designated insurance carriers that meet the hospital's requirements regarding financial condition.

While the hospital may impose one or more of these requirements, the hospital would not restrict the ability of the physician to maintain privileges at other facilities, nor would the hospital restrict the physician's ability to exercise independent medical judgment to admit or refer patients to another facility or other provider.

We believe that coordinated guidance from your three agencies based on common fact patterns would be in the best interest of the public, the healthcare community and the AHLA members that provide legal counsel to the healthcare community. Recognizing the importance of this issue to the healthcare community, AHLA believes this issue is so important that it has appointed a task force of member health lawyers to explore these issues and jointly draft this letter. 13 We would like to suggest that the three agencies

13 The members of the task force are: Gerald M. Griffith, Chair of the task force and member of AHLA's board of directors (Honigman Miller Schwartz and Cohn—Detroit, Michigan); S. Allan Adelman, President-Elect Designate of AHLA's board of directors (Adelman Sheff and Smith—Annapolis, Maryland); Douglas K. Amning, Chair of the Tax and Finance Practice Group (Seigfried Bingham Levy
appoint a contact person or persons from each agency to meet with members of our task force. It is our hope that such a meeting would facilitate discussions among the three agencies to fully identify the issues and concerns of the healthcare community as well as to develop an approach that will address the agencies’ concerns. We suggest that a meeting be held among the task force members and the representatives of the three agencies sometime in May 2004. If you are interested in such a meeting, please contact Peter Leibold, Executive Vice President of AHLA, who will be happy to assist in the scheduling of a meeting.

Thank you for your willingness to participate in this project.

Sincerely,

Gerald M. Griffith
Member of the Board of Directors
Chair of Task Force

cc: Joseph Urban (Internal Revenue Service)

PUBLIC INTEREST: "...TO SERVE AS A PUBLIC RESOURCE ON SELECTED HEALTHCARE LEGAL ISSUES"—FROM THE MISSION STATEMENT OF THE AMERICAN HEALTH LAWYERS ASSOCIATION.

The 9,200 members of the American Health Lawyers Association practice in law firms, government, in-house settings, and academia. Their expertise encompasses the entire spectrum of healthcare, including physician services, hospital care, long-term care, healthcare coverage, and consumers. AHLA is a not-for-profit 501(c)(3) professional association that does not engage in advocacy. In its role as public resource on health law, however, the Association from time to time seeks clarification from government agencies on issues that affect the health law community—providers, health plans, and patients. The views in this letter are an effort to seek such clarification and should not be construed as an advocacy position of the American Health Lawyers Association or its members.

Selzer and Gee—Kansas City, Missouri); Elisabeth Belmont, Chair of the Public Interest Committee (Maine Health—Portland, Maine); William H. Maruca, Chair of the Fraud and Abuse Practice Group (Fox Rothschild—Pittsburgh, Pennsylvania); Michael P. Schaff, Chair of the Physician Organizations Practice Group (Wienert Goldman and Spitzer—Woodbridge, New Jersey).
Memorandum

To: Board of Directors of ___________ Insurance Company, Ltd.

From: Honigman Miller Schwartz and Cohn LLP

Re: Regulatory Update: Physician Insurance Programs

Date: April 27, 2004

On April 22, 2004, a task force of the American Health Lawyers Association (AHLA) filed a formal request with three government agencies seeking clarification of the permitted scope of, and conditions on, two general types of physician malpractice insurance programs (subsidized and non-subsidized). The task force, chaired by the Chair of our Health Care Department (Gerry Griffith), was formed in response to growing concerns over the availability and cost of professional liability insurance for physicians in a number of states. In the drafting process, Gerry and the task force considered many characteristics that we have seen in the market and that we have been asked to review in a variety of captive and other physician programs.

Attached to this Memorandum are copies of the request letter and a press release issued by AHLA. The request itself is unique in that it proposes coordinated guidance among three regulatory agencies that administer complex and distinct, yet overlapping, areas of health care regulation. The three agencies are the Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General (OIG) within the Department of Health and Human Services, and the Internal Revenue Service (IRS).

As you know, the three areas of law administered by these agencies (the Stark Law, the Anti-kickback Statute and the inurement/excess benefit rules) include potential restrictions on many business relationships among hospitals and physicians. The AHLA task force is intended to serve as a focal point for facilitating a discussion of the issues among the three agencies and to help communicate the practical concerns of the health care industry in this area. As noted in the press release, the task force has requested a meeting with representatives of these three agencies in May 2004 to initiate that dialogue. Although all of the agencies were receptive to the idea of exploring possible joint guidance, it is a novel process for them and both the exact outcome and its timing may not be known for several months or more.
AHLA Seeks Regulatory Clarifications on Healthcare Facilities’ Efforts to Assist Physicians with Malpractice Insurance Costs

(WASHINGTON, DC) A task force convened by the American Health Lawyers Association (AHLA) has requested joint clarification from three federal agencies on “permissible assistance that hospitals and other acute and long-term care providers may provide to physicians and other health professionals to lessen the effects of rising malpractice insurance premiums.” The clarification was requested in a letter sent to Steven T. Miller, Director, Exempt Organizations branch of the Internal Revenue Service’s Tax Exempt and Government Entities Division; Lewis Morris, Chief Counsel for the Inspector General, Department of Health & Human Services (DHHS); and Leslie Norwalk, Acting Deputy Administrator of DHHS’ Centers for Medicare and Medicaid Services. The letter was signed by Gerald M. Griffith, chair of the AHLA task force and a member of AHLA’s Board of Directors.¹ A copy of the April 22, 2004, letter is attached.

The letter identifies several examples of how the dramatically increasing cost of malpractice insurance is affecting patients’ access to medical care and seeks joint clarification from the agencies on how AHLA’s health lawyer members and the facilities they advise “can respond to fluctuating costs and availability of medical malpractice coverage and its potential impact on access to quality health care services.” AHLA’s members “provide advice to hospitals and physicians on a daily basis regarding how to provide needed care to patients without running afoul of tax exemption, fraud and abuse and self-referral laws. Providing counsel in these areas requires careful analysis of a complex web of intersecting laws and regulations,” the letter notes. AHLA explains that it is “not attempting to review or seek clarification on the potential underlying causes of the malpractice insurance crisis; that is, we are not intending to enter into the tort reform debate.” The letter seeks guidance on how healthcare facilities can assist physicians in dealing with the rising costs of malpractice insurance, regardless of the reasons for those increased costs.

¹ The members of the task force are: Gerald M. Griffith, Chair of the task force and member of AHLA’s board of directors (Honigman Miller Schwartz and Cohn—Detroit, Michigan); S. Allan Adelman, President-Elect Designate of AHLA’s board of directors (Adelman Sheff and Smith—Annapolis, Maryland); Douglas K. Anning, Chair of the Tax and Finance Practice Group (Seigfreid Bingham Levy Selzer and Gee—Kansas City, Missouri); Elisabeth Belmont, Chair of the Public Interest Committee (Maine Health—Portland, Maine); William H. Maruca, Chair of the Fraud and Abuse Practice Group (Fox Rothschild—Pittsburgh, Pennsylvania); Michael F. Schaff, Chair of the Physician Organizations Practice Group (Wilentz Goldman and Spitzer—Woodbridge, New Jersey).
AHLA is a tax-exempt Section 501 (c)(3) educational association, and its letter emphasizes the non-advocacy nature of its communication to the three agencies. Peter M. Leibold, Executive Vice President and CEO of the 9,200-member association, explained that “AHLA does not engage in advocacy. We do, however, have an important public interest component in our mission statement under which we pledge to serve as a public resource on healthcare legal issues. In addition to the various non-partisan forums we provide for discussing legal issues, from time to time we draw upon our members’ expertise to seek clarification from government agencies on issues that affect the health law community—providers, health plans, and patients.”

**Request for Clarifications on Malpractice Coverage Assistance Programs**

In response to the malpractice insurance coverage crisis, AHLA explains, “many tax-exempt hospitals wish to assist physicians on their medical staffs in obtaining professional liability insurance.” Proposed assistance most often would occur in one of two forms:

- **Subsidized programs**, such as discounted insurance rates or direct payments to enable a physician to purchase a malpractice insurance policy; or
- **Non-subsidized programs**, such as participation in the hospital’s self insurance program or captive insurance company at actuarial or market-based rates.

Within the two general types of malpractice insurance support programs, AHLA’s letter identifies various characteristics of assistance programs on which joint clarification from the agencies would be helpful. For example, hospitals that employ subsidized programs, such as direct cash subsidies, might consider such assistance justified because it either (a) addresses an existing community need, such as increasing the number of physicians practicing in specialties with current or anticipated shortages; or (b) otherwise provides a community benefit, such as by requiring a physician who receives assistance to provide services to the medically underserved. Similarly, hospitals and other institutional providers that implement non-subsidized programs, such as covering a physician through the facility’s self insurance program or captive insurance company, might require that the physician pay a reasonable amount for the coverage based on appropriate actuarial and underwriting guidelines, although the amount paid may be lower than commercially available rates.

Examples of characteristics common to both subsidized and non-subsidized programs might include excluding physicians that present a higher indemnity risk due to prior claims experience from participation in the hospital/captive program; requiring that assisted physicians be on the active medical staff of the hospital; and limiting insurance coverage to the “four walls” of the hospital, to facilities owned by the hospital, or to the physician’s private practice.

AHLA requests that the agencies jointly “address the extent to which these or any other elements would be considered to be reasonable or required to meet your agencies’ regulatory concerns.” Clarification in these matters, the letter asserts, “would be in the best interest of the public, the healthcare community and the AHLA members that provide legal counsel to the healthcare community.” AHLA concludes by requesting that each agency appoint contact person(s) on this matter and that the agencies schedule an in-person meeting with members of the AHLA task force to “fully identify the issues and concerns of the healthcare community as well as to develop an approach that will address the agencies’ concerns.”

For information on technical issues in AHLA’s April 22, 2004, letter, please contact:
Gerald M. Griffith, Partner and Department Chair, Honigman Miller Schwartz and Cohn LLP, Detroit, Michigan. Phone: (313) 465-7402; Fax: (313) 465-7403; E-Mail: ggriffith@honigman.com. Peter M. Leibold, AHLA’s Executive Vice President and CEO, may be contacted at: Phone: (202) 833-0777; Fax: (202) 833-1105; E-mail: pleibold@healthlawyers.org.
About the American Health Lawyers Association

The American Health Lawyers Association (AHLA) is the nation’s largest nonpartisan 501(c)(3) educational organization devoted to legal issues in the healthcare field. The Association’s 9,200 active members practice in law firms, government, in-house settings, and academia. They represent the entire spectrum of the healthcare community: physicians, hospitals and health systems, health maintenance organizations, health insurers, managed care companies, nursing facilities, home care providers, and consumers. Health Lawyers provides in-person and “distance learning” educational programs, an annual conference, an award winning Web site, public interest colloquiums, books, practice guides, monographs, the monthly publications Health Law Digest and Health Lawyers News, the quarterly Journal of Health Law, the electronic news service Health Lawyers Weekly, as well as fourteen Practice Groups that focus on specific areas of health law or special employment settings. For additional information, visit our Web site at www.healthlawyers.org.

AHLA is a not-for-profit 501(c)(3) professional association that does not engage in advocacy. In its role as public resource on health law, however, the Association from time to time seeks clarification from government agencies on issues that affect the health law community—providers, health plans, and patients. The views in such communications are an effort to seek such clarification and should not be construed as an advocacy position of the American Health Lawyers Association or its members.