DEPARTMENT OF HEALTH AND HUMAN SERVICES **Office of Inspector General**

Washington, D.C. 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: December 30, 2004

Posted: January 6, 2005

[Name and address redacted]

Re: OIG Advisory Opinion No. 04-19

Dear [name redacted]:

We are writing in response to your request for an advisory opinion regarding a malpractice insurance subsidy arrangement between your hospital and two neurosurgeons (the "Arrangement"). Specifically, you have inquired whether the Arrangement constitutes grounds for the imposition of sanctions under the exclusion authority at section 1128(b)(7) of the Social Security Act (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.

You have certified that all of the information provided in your request, including all supplementary letters, 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 the 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, but that the Office of Inspector General ("OIG") will not impose administrative sanctions on [requestor name redacted] or [requestor 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 Arrangement. This opinion is limited to the Arrangement and, therefore, we express no opinion about any ancillary agreements or arrangements disclosed or referenced in your request letter or supplemental submissions.

This opinion may not be relied on by any persons other than [requestor name redacted] and [requestor name redacted], the requestors of this opinion, and is further qualified as set out in Part IV below and in 42 C.F.R. Part 1008.

1. FACTUAL BACKGROUND

[Requestor name redacted] and [requestor name redacted] (collectively, the "Hospital") operate several health care facilities in [location redacted].[1] The Hospital's facilities include [hospital name redacted] and [hospital name redacted], the only acute care and ambulatory hospitals offering surgical services in [location redacted]. According to the Hospital, [location redacted] is experiencing extreme problems with decreased malpractice insurance availability and increased malpractice insurance premiums.

At the inception of the Arrangement, there were two neurosurgeons on staff at the Hospital and in the area. These two neurosurgeons, [physician name redacted] and [physician name redacted] (the "Physicians"), practice together as [physician practice name redacted].

The Physicians had medical malpractice liability insurance coverage from the [insurance carrier name redacted] (the "Original Carrier") that was set to expire on May 18, 2003. The Physicians had been purchasing insurance from the Original Carrier for seven years and expected the coverage to be renewed. However, approximately two weeks before the expiration date, the Original Carrier informed them that it would not renew their coverage.[2] The insurance the Physicians had purchased was a "claims-made" policy, meaning it covered

---

[1]For ease of reference in this advisory opinion only, [requestor name redacted] and [requestor name redacted] and all other affiliated entities owned or controlled in whole or in part, directly or indirectly, by either of them are sufficiently related to be treated as a single entity, which will be referred to individually and collectively as the "Hospital."

[2]To the best knowledge of the Hospital, the termination was unrelated to the Physicians' claims history or any issues related to quality of care.

claims brought during the coverage period, but did not cover claims brought after the conclusion of the coverage period, even if the action giving rise to the claim occurred during the coverage period. Liability protection for claims brought after the conclusion of the coverage period of the claims-made policy would require "tail coverage."

When the Original Carrier informed the Physicians that it would not renew their policies, it offered to provide tail coverage at no charge, provided that the Physicians retired from medical practice. According to the Hospital, the value of this tail coverage was estimated to be $[number redacted] per physician. If the Physicians continued practicing, the Original Carrier would not provide this tail coverage without charging this fee. Thus, if they remained in practice, the Physicians would need to obtain malpractice liability insurance to cover claims arising from their ongoing practice, as well as additional coverage for any claims brought based on prior conduct. The new coverage would cost substantially more than the prior coverage, and the Physicians' malpractice insurance premium expenses would increase significantly. The Physicians informed the Hospital that they would both retire immediately, unless the Hospital subsidized their malpractice insurance expenses.

According to the Hospital, several factors rendered the Physicians' expressed intent to retire immediately especially credible and potentially harmful for the local patient population. First, the availability of free tail coverage from the Original Carrier created a powerful financial incentive for the Physicians to accelerate their retirement. The Hospital functions as a hub for neurosurgical services for the county in which it is located, as well as several neighboring counties. The Hospital has represented that it has depended on the Physicians to ensure the community's access to neurosurgical services, especially for emergency care. The Hospital also represents that the next closest hospitals providing neurosurgical services are located 45 miles away. Also, the Physicians provide a substantial amount of care to Medicaid and indigent patients. In the two years prior to entering into the Arrangement, the Hospital had attempted to recruit new neurosurgeons to the area without success.[3]

In light of these considerations, the Hospital entered into the Arrangement, whereby the Physicians agreed to continue practicing neurosurgery and the Hospital agreed to subsidize

[3]Since entering into the Arrangement and submitting their initial request for an advisory opinion, the Hospital has successfully negotiated to bring a newly trained neurosurgeon to the community beginning in the summer of 2004. No opinion has been sought, and we express no opinion regarding, the Hospital's arrangements with the newly recruited neurosurgeon.

their malpractice insurance expenses.[4] Pursuant to the Arrangement, the Physicians purchased claims-made insurance policies from the [insurance carrier name redacted] (the "New Carrier") to cover claims arising from their ongoing practice and purchased tail insurance policies from the Original Carrier to cover claims brought based on their prior practice.

Each Physician's claims-made policy from the New Carrier is nonretroactive and covers only claims that arise from actions occurring during the period of coverage from the New Carrier. These policies do not include tail coverage to underwrite claims stemming from actions during the coverage period but brought after the conclusion of the coverage period. However, each policy does include a provision allowing for the purchase of tail coverage from the New Carrier when the policy ends. The terms of the tail policies, including cost and timing of purchase, may vary depending on how much longer the Physicians continue to practice neurosurgery and to purchase claims-made coverage from the New Carrier.

As described more particularly below, under the Arrangement, the Hospital agreed to subsidize: (i) the entire cost of tail coverage from the Original Carrier; (ii) a portion of the increased premiums for claims-made coverage from the New Carrier; and (iii) all or part of the costs of tail coverage from the New Carrier, as described more fully below (hereinafter collectively referred to as the "Premium Support"). Under the Arrangement, the Physicians still incur increased out-of-pocket expenses for their malpractice insurance, as the Premium Support covers only part of the net increase in premiums for claims-made coverage and neither Physician previously paid a distinct fee for tail coverage.

Specifically, the first year Premium Support equaled the entire cost of the tail coverage plus 75% of the differential between the Physicians' new and prior premium expenses. In the aggregate for both Physicians, these payments amounted to $[number redacted] to pay for tail coverage and $[number redacted] to subsidize the new claims-made policies. Given the time constraints under which the Arrangement was implemented, the Hospital paid the first year's Premium Support to the Physicians upon documented proof of the Physicians' expenditures.

The Arrangement also provided for additional Premium Support payments in the second year of the Arrangement if the community need persisted and the Physicians again faced significant premium increases. However, the New Carrier did not significantly increase the

---

[4]This opinion is limited to the two-year term of the Arrangement. The Hospital's successful recruitment of a new neurosurgeon substantially reduces the risk that the Hospital will again face imminent loss of neurosurgical services when the Arrangement ends.

cost of the Physicians' claims-made policies for the second year of the Arrangement. As such, the Hospital did not provide a subsidy for the Physicians' purchase of this second year of claims-made coverage. The Hospital will pay for additional tail coverage, if required, at the conclusion of the second year of the Arrangement, setting a cap for such subsidy at $[number redacted]. The Hospital anticipates that such additional tail coverage will only be required if the Physicians retire at the conclusion of the Arrangement.[5] If the Hospital makes any subsidy payments for this additional tail coverage, the payments will be made directly to the insurance carrier and not to the Physicians.

The Hospital has further certified that:

- the amount of the Premium Support does not and will not take into account in any manner the volume or value of any referrals or business otherwise generated by the Physicians for the Hospital;

- the Physicians are not required to refer patients to, or otherwise generate business for, the Hospital; and

- the Physicians may furnish services at sites other than the Hospital, and those services will be covered by the subsidized malpractice insurance.

As consideration for the Premium Support under the Arrangement, the Physicians assumed numerous obligations. In addition to complying with all requirements for maintaining membership on the Hospital's medical staff, the Physicians agreed to:

- maintain a full-time practice in neurosurgery in the community;

- take neurosurgical call for the Hospital's emergency department;

- participate in assigned Hospital committees;

---

[5]The Hospital anticipates that the Physicians will not require additional tail coverage so long as they remain in practice and continue purchasing claims-made coverage. The Hospital asserts that it is a common industry practice for insurance carriers to offer long-term customers free tail coverage upon retirement and expects that, if the Physicians continue to practice for a few years beyond the conclusion of the Arrangement, the New Carrier might make such free tail coverage available to the Physicians. However, at the time of entering into the Arrangement, the Hospital did not know whether the Physicians would ultimately incur additional costs for tail coverage.

- continue to provide care to beneficiaries of the Medicare program;

- provide at least as much Medicaid and/or indigent care as they were providing when they entered into the Arrangement; and

- cooperate with the Hospital's efforts to recruit an additional neurosurgeon or neurosurgeons.

II. LEGAL ANALYSIS

A. Law

The anti-kickback statute makes it a criminal offense knowingly and willfully to 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. United States v. Kats, 871 F.2d 105 (9th Cir. 1989); United States v. Greber, 760 F.2d 68 (3d Cir.), cert. denied, 474 U.S. 988 (1985). Violation of the statute constitutes a felony punishable by a maximum fine of $25,000, imprisonment up to five 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.

B. Analysis

The OIG historically has been concerned that a hospital's subsidy of malpractice insurance premiums for potential referral sources, including hospital medical staff, potentially implicates the anti-kickback statute, because the payments may be used to influence referrals. There is particular concern where subsidies are offered in a conditional or selective manner that reflects referrals from the subsidized practitioners. At the same time, the OIG

has recognized the importance of ensuring access to care by establishing a safe harbor for malpractice premium subsidies provided to obstetrical care practitioners in health professional shortage areas. See 42 C.F.R. § 1001.952(o). Depending on the circumstances, some insurance subsidy arrangements may fit into other safe harbors, such as the employee safe harbor at 42 C.F.R. § 1001.952(i). The Arrangement does not qualify for safe harbor protection.

The OIG is aware that in some geographic areas some physicians are experiencing dramatic malpractice liability premium increases, insurer withdrawals from certain markets, or sudden terminations of coverage for reasons unrelated to claims history. The OIG recognizes the potential adverse impact of these developments on patients' access to medically necessary care.

Mindful of these concerns and for the reasons set forth below, we conclude that the facts and circumstances of the Arrangement, in combination, adequately reduce the risk that the Premium Support under the Arrangement could be an improper payment for referrals or the generation of Federal health care program business.

First, the Arrangement was implemented as a temporary and urgent measure to prevent a gap in the local availability of neurosurgical services that would have resulted had the Physicians, the only neurosurgeons in the area, retired immediately upon termination of their malpractice liability coverage. The Physicians had a substantial financial incentive to retire immediately, given the avoided cost of tail coverage had they done so. The situation arose with little time for the Hospital or the Physicians to explore other options, as the Original Carrier gave only two-weeks' notice of the termination. The Arrangement was designed to solve the Hospital's immediate need and limited to a term of two years. In the first year, the Hospital paid a subsidy to assist the physicians with the costs of claims-made coverage and tail coverage. As the second year Premium Support subsidy was conditioned on continued community need and premium increases, the Hospital did not subsidize the Physicians' expenses for the second year of claims-made coverage. The Hospital also agreed to subsidize any additional tail coverage needed at the conclusion of the Arrangement, but this subsidy may not prove necessary, as the Physicians will only require additional tail coverage if they retire at that time and may be eligible for free tail coverage from the New Carrier.

Second, the Arrangement is structured to prevent a significant financial windfall for the Physicians, as each Physician will have incurred annual malpractice premium expenses during the two-year term of the Arrangement that exceed his expenses in the year prior to entering the Arrangement. Furthermore, although the Hospital made its subsidy payment for the first year Premium Support directly to the Physicians, the payments were based on documented proof of the Physicians' malpractice insurance expenditures. Additionally, if

the Hospital makes any subsidy payments for tail coverage from the New Carrier, such payments will be made directly to the New Carrier and not to the Physicians.

Third, the risk of undue benefit to the Physicians is further reduced because the Physicians are required to perform various services as consideration for the Premium Support, including, for example, call coverage, maintaining a full-time practice, service on Hospital committees, and furnishing Medicaid and indigent care services.

Fourth, the fact that the subsidized malpractice insurance covers services furnished at sites other than the Hospital further minimizes the risk that the Premium Support may be connected to referrals. Although the Physicians are required to be on the Hospital's medical staff, there is no requirement that they refer patients to, or generate business for, the Hospital. The Hospital has certified that the Premium Support under the Arrangement is not, and will not be, based on the volume or value of referrals or other business generated by the Physicians.

For all of these reasons, we conclude that the totality of facts and circumstances surrounding the Arrangement adequately minimizes the risk of fraud and abuse under the anti-kickback statute. We caution that our conclusion relies on the specific facts certified by the Hospital, and that we might reach a different result if we were to review a similar arrangement with different facts.

III. CONCLUSION

Based on the facts certified in your request for an advisory opinion and supplemental submissions, we conclude that the 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, but that the OIG will not impose administrative sanctions on [requestor name redacted] or [requestor 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 Arrangement. This opinion is limited to the Arrangement and, therefore, we express no opinion about any ancillary agreements or arrangements disclosed or referenced in your request letter or supplemental submissions.

IV. LIMITATIONS

The limitations applicable to this opinion include the following:

- This advisory opinion is issued only to [requestor name redacted] and [requestor name redacted], the requestors 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 in any matter involving an entity or individual that is not a requestor of this opinion.

- 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 Arrangement, including, without limitation, the physician self-referral law, section 1877 of the Act, or the Internal Revenue Code.

- 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 [requestor name redacted] or [requestor name redacted] with respect to any action that is part of the 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 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 [requestor name redacted] or [requestor name redacted] with respect to any action 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,

/s/

Lewis Morris
Chief Counsel to the Inspector General