OIG Approves Medical Malpractice Insurance Subsidy Arrangement

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On December 30, 2004, the Department of Health and Human Services’ Office of Inspector General (OIG) issued Advisory Opinion 04-19 (“Advisory Opinion”).1 The Advisory Opinion analyzed a medical malpractice insurance subsidy arrangement between a hospital and two physicians and concluded that although the arrangement potentially implicated the federal anti-kickback statute,2 the OIG would not impose sanctions. Only those individuals who requested the Advisory Opinion may rely on its conclusions. However, the Advisory Opinion sheds some light on the potential acceptability of medical malpractice insurance subsidy arrangements under the anti-kickback statute.

The regulations implementing the anti-kickback statute already provide a safe harbor provision for certain obstetrical malpractice insurance subsidies.3 Subject to certain conditions, this safe harbor allows a hospital to pay all or a part of the medical malpractice insurance for an obstetrician. However, no safe harbor provision protecting malpractice insurance subsidies paid to non-obstetrician practitioners or to obstetricians who do not meet the criteria for the obstetrical subsidy safe harbor currently exists. Because the Advisory Opinion allowed an obstetrical subsidy, it suggests that the OIG might be willing to introduce a new safe harbor for malpractice insurance subsidies beyond the one previously approved for obstetricians.

2 42 U.S.C. § 1320a-7b(b) (2005).
In the arrangement analyzed by the OIG in the Advisory Opinions, two neurosurgeons (the Physicians) were on staff at a hospital (the Hospital). The Physicians had malpractice insurance coverage from Carrier A, which was expiring on May 18, 2003. Two weeks before the expiration of the insurance, Carrier A informed the Physicians that the Carrier would not renew their coverage. The Physicians had “claims made coverage,” which meant that the insurance would not cover any claims made after the expiration of the policy, even if the incident giving rise to the claim occurred while the insurance policy was in force. The Physicians would need to buy “tail” coverage to protect themselves from any claims brought after the May 18, 2003, expiration date.

Carrier A offered to extend tail coverage to the Physicians at no charge provided they retired from medical practice. If the Physicians continued to practice, they would be required to pay for the tail coverage and would need to obtain a new policy to cover the claims that might arise from their ongoing practice. The cost of the tail coverage and new claims policy was significantly higher that the premiums the Physicians had been paying with Carrier A. The Physicians informed the Hospital that they would both retire immediately.

Several factors led the Hospital to believe that the immediate retirement of the Physicians would be detrimental to the health of the local population. The Hospital functioned as a hub for neurosurgical procedures in their county. The nearest hospital providing neurosurgical services was forty-five miles away. The Physicians had provided the community access to neurosurgical care. And, in the two years prior to May 2003, the Hospital had attempted, without success, to recruit new neurosurgeons to the area.
As a result, the Hospital and Physicians entered into an arrangement in which the Hospital would subsidize the Physicians’ malpractice insurance for two years. The agreement required the Physicians to purchase tail coverage from Carrier A and claims made coverage for their on-going practice from Carrier B. Each policy allowed the purchase of tail coverage from Carrier B when the initial coverage period ends. The Hospital agreed to pay for Carrier A’s entire tail coverage policy, a portion of the increased premiums for Carrier B’s claims made coverage, and all or a part of the tail coverage premium from Carrier B when the Physicians stop practicing medicine in the area. Even with the Hospital subsidy, the Physicians have a net increase in the amount they will pay for insurance coverage. The Hospital is not subsidizing the entire increase in the premiums caused by the shift from Carrier A to Carrier B.

The Hospital certified that the amount of premium paid did not take into account any volume or value of business generated by the Physicians for the Hospital, that the Physicians are not required to refer patients to the Hospital, and that the Physicians may furnish services at other sites and still be covered by the subsidized malpractice insurance policy. In addition, the Physicians agreed to maintain a full-time neurosurgical practice in the community, to take neurosurgical calls for the Hospitals’ emergency room, to participate in hospital committees, to continue to provide care to Medicare and Medicaid patients, and to cooperate with the Hospital’s efforts to recruit an additional neurosurgeon.

In the Advisory Opinion, the OIG noted that this arrangement potentially implicated the anti-kickback statute because the subsidy payments might be utilized to reward high referral volume or to influence future referral volume to the Hospital.
However, the OIG also noted that there had been dramatic premium increases and carrier withdrawals from the malpractice insurance market and that a prohibition against insurance subsidies might limit access to health care. Balancing these two interests, the OIG allowed the arrangement, citing several reasons.

First, the OIG reasoned that the agreement was in response to an urgent and immediate need. Had the agreement not been implemented, the community would have been left without local access to neurosurgical services. The Physicians were notified of the non-renewal of coverage only two weeks prior to the policy expiration. The Hospital was facing an imminent loss of neurosurgical staff.

Second, the OIG reasoned that the arrangement was structured to prevent a financial windfall to the Physicians. Each Physician would incur greater malpractice insurance expenses than they had for the previous year. The Hospital was not making up the entire difference, but rather a portion of the Physicians’ increased costs.

Third, the Hospital imposed obligations on the Physicians as consideration for the subsidy. The OIG believed that these obligations reduced the risk of an undue benefit to the Physicians under the arrangement.

Finally, the fact that the subsidized malpractice insurance covered sites other than the Hospital reduced the risk that the subsidy is actually remuneration for referrals. The Physicians are free to refer patients to other Hospitals for services and to perform services at locations other than the subsidizing Hospital.

Although the Advisory Opinion was limited to the requesting entities and the facts of the case, the Advisory Opinion suggests that physicians and hospitals may have room
to structure future subsidy arrangements. The arrangements would need to be tailored to address the concerns identified by the OIG in the Advisory Opinion, including:

- The arrangement is made without regard to the volume or value of future or past referrals;
- The subsidy is limited to a fixed, short period of time;
- The subsidized policy covers the physician at locations beyond the subsidizing hospital;
- There is a significant need in the community for the type of service the physician provides;
- The arrangement does not merely provide a financial bonus to the physician; and
- The arrangement requires the physician to serve the medically indigent or underserved population.

Hospitals considering entering into malpractice insurance subsidy arrangements should review the Advisory Opinion and structure their arrangement to address the OIG’s concerns. Hospitals also may wish to consider requesting an advisory opinion clarifying the application of the anti-kickback statute to the proposed arrangement.

The health care community should watch for additional guidance on the issue of medical malpractice insurance subsidies. As insurance rates increase and carriers pull out of specific markets, the need for these types of arrangements will continue to increase. The Advisory Opinion may signal CMS’ acceptance of the need for malpractice insurance subsidies and the need to address subsidies to non-obstetrician providers in the form of a new safe harbor.