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Health Law Pulse

OIG Provides Limited Guidance On Subsidizing Malpractice Premiums For Obstetricians

On September 9, 2004, the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services (DHHS) issued Advisory Opinion, No. 04-11 regarding a medical center's proposed arrangement (the Proposed Arrangement) to subsidize malpractice insurance expenses for four community-based obstetricians.

The medical center includes a 142-bed hospital and provides services regardless of patients' ability to pay. Among those who provide labor and delivery services at the hospital are four obstetricians who hold staff privileges but are not employees or contractors of the medical center. The obstetricians routinely assist the physicians and nurse midwives at the medical center with particularly high-risk or complicated cases. The obstetricians also assist nurse midwives at a migrant health clinic not affiliated with the medical center but located within its service area. Additionally, the obstetricians are routinely engaged in the full-time practice of obstetrics in the county served by the medical center.

THE ANTI-KICKBACK STATUTE

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. DHHS, however, has created safe harbors that define practices not prohibited under the anti-kickback statute.

SAFE HARBOR FOR OBSTETRICAL MALPRACTICE INSURANCE SUBSIDIES

One of the safe harbors created by DHHS protects payments made by a hospital or other entity to subsidize obstetrical malpractice insurance premiums for practitioners engaging in obstetrical practice in a primary care health profession shortage area (HPSA). Generally, a payment to subsidize all or part of the costs of malpractice insurance premiums for such practitioners will be protected by the safe harbor as long as the following seven standards are satisfied:

1. The payment is made in accordance with a written agreement between the entity paying the premiums and the practitioner, which sets out the payments to be made by the entity, and the terms under which the payments are to be provided
2. The practitioner must certify that during the initial coverage period at least 75 percent of the practitioner's obstetrical patients reside in a HPSA or Medically Underserved Area (MUA) or are part of a Medically Underserved Population (MUP). For each additional coverage period, the same certification must be made regarding the prior coverage period
3. The practitioner is not required to make referrals to, or otherwise generate business for, the entity providing the subsidy
4. The practitioner is not restricted from establishing staff privileges at, referring any service to, or otherwise generating any business for any other entity of his or her choosing

5. The amount of payment may not vary based on the volume or value of any previous or expected referrals to or business otherwise generated for the entity by the practitioner for which payment may be made under a Federal health care program
6. The practitioner must treat obstetrical patients who receive medical benefits or assistance under any Federal health care program in a nondiscriminatory manner
7. The insurance is a *bona fide* malpractice insurance policy or program, and the premium, if any, is calculated based on a *bona fide* assessment of the liability risk covered under the insurance

OIG PERMITS SUBSIDIES FOR THOSE PRACTICING IN LOW INCOME, MIGRANT AGRICULTURAL WORKER AND HOMELESS POPULATION HPSAS

Under the specific facts submitted for purposes of the Opinion, the OIG found that the Proposed Arrangement met all but one condition of the safe harbor. The requirement that obstetricians provide services in a "primary care" HPSA was not met. Rather, the obstetricians provided services in another type of underserved area – a low income, migrant agricultural, homeless population HPSA.

The OIG determined that practicing in a low income, migrant agricultural worker, and homeless population HPSA, instead of a primary care HPSA, does not result in any increased risk of fraud or abuse and did not subject the medical center to sanctions under the anti-kickback statute. The OIG's determination is consistent with the intent of the safe harbor, which is to ensure access to obstetrical care in places for populations that do not have sufficient access.

In addition to meeting the safe harbor requirements, the Proposed Arrangement included several other safeguards, which further reduced the risk of fraud or abuse. First, the insurance subsidies were being provided on a temporary, interim basis for a fixed period. Second, the subsidies covered only the increase in insurance premiums. Each subsidized obstetrician would pay at least as much for malpractice insurance as he or she paid prior to the subsidy program. Third, the subsidized insurance covered the obstetricians even if their services were performed at facilities unaffiliated with the medical center.

It is important that the Opinion emphasized the potential community benefits of the Proposed Arrangement because the obstetricians largely treat underserved patients in a rural area, including patients of a clinic for migrant farm workers, which might not be otherwise possible due to sharply escalating premiums. According to the Opinion, the medical center expects that, in each year of the proposed arrangement, at least 95 percent of the obstetrical patients treated by the subsidized obstetricians will reside in a HPSA or MUA or be part of a MUP.

OIG LETTER POSTED JANUARY 15, 2003

The recent OIG Opinion follows a letter published by the OIG on January 15, 2003 (the Letter), in which the OIG set forth an arrangement by which a hospital could directly subsidize physicians' malpractice insurance premiums without violating the anti-kickback statute.

The arrangement described in the Letter permits subsidies only to current active medical staff (or physicians joining the medical staff that are new to the locality or have been in practice for less than one year). Further, participating physicians are required to perform services for the hospital and give up certain litigation rights. The value of such services and relinquished rights are deemed to be roughly equivalent to the fair market value of the insurance subsidy.

The Letter constructively permits only a small subsidy or no subsidy at all because of the requirement that the physician provide in return something that is equivalent to the fair market value of the subsidy. Although the Letter appears to provide a method for providing subsidies, it is very limiting and is not supported by any statute, regulation or advisory opinion.

CONCLUSION

The OIG concluded that practicing in a low income, migrant agricultural worker, homeless population HPSA, instead of a primary care HPSA, does not result in any increased risk of fraud or abuse and did not subject the medical center to sanctions under the anti-kickback statute. The Opinion, however, is extremely limited and does not provide much guidance regarding the other elements of the safe harbor. Nevertheless, the Opinion reinforced the notion that obstetrical malpractice subsidies will be permitted to the extent that the subsidy helps the delivery of this critical care to underserved areas.

For more information on obstetrical malpractice insurance subsidy issues, please contact Lisa M. Boyle *(co-chair)* or Theodore J. Tucci *(co-chair)*.

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