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## Risk Retention Groups Require Patients to Sign No-Malpractice Contracts

As malpractice insurance premiums continue to rise for doctors, they have begun to take actions that reduce the patients' rights and may increase their own risk in certain areas. Specifically, insurance costs for OBGYNs have risen as much as double for base rates over the past four years, and the rates for other medical professions are not far behind those. To limit their premium costs, some doctors are now abandoning traditional insurance carriers and joining risk-retention groups. The groups are owned by policy holders rather than investors and offer doctors lower premiums by not focusing on profits, unlike a traditional insurance company. There are, however, two large downsides to the groups: the minimal capital requirements are often lower than those of traditional insurance companies and, more importantly, many require patients to sign no-malpractice contracts.

By maintaining a lower amount of capital, risk retention groups can provide only a lower amount of protection to doctors, and some states do not license the groups under state guarantee funds, which will pay a claim on a doctor's behalf if an insurer becomes insolvent. This could not only translate to

insolvency issues, but also could place doctors on the hook for malpractice costs, and ultimately, could leave patients with little recourse if their physician cannot pay. All of these issues lead many risk retention groups to require patients to sign no-malpractice contracts in an attempt to limit their liability on the front end.

A no-malpractice contract generally requires patients to preemptively agree to not sue their doctor for malpractice in a traditional court of law and as a substitute settle for binding arbitration to correct any disputes. The contracts often have additional provisions limiting the amount of damages that a patient can recover. In the event of malpractice arbitration, the physician and the patient each select an arbitrator and then jointly agree on a third arbitrator. There are no appeals and the arbitrators are often experts in the field of medicine at question. Arbitrations are not typically as patient friendly in the outcome as are courts and juries and some view the process as an attempt by doctors to intimidate patients.

Although a majority of doctors still operate under traditional insurance schemes, risk retention groups are gaining popularity.

## HIPAA Regulations Issued on Wellness Programs

The Departments of Treasury, Labor, and Health and Human Services have jointly issued regulations clarifying how employers can structure wellness programs to comply with the non-discrimination requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Wellness programs are employer-sponsored initiatives that provide educational, mental, or physical fitness activities to promote the health and well-being of employees and their families. These programs help increase

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## HIPAA Regulations Issued on Wellness Programs

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employee productivity, reduce sickness in the workplace, and reduce healthcare costs.

The HIPAA requirements break the plans into two categories with separate rules for each. The first category is for the programs that offer rewards based on health factors, and the second is for the programs that offer rewards not based on health factors. Health factors include a participant's health status, medical condition, claims experience, medical history, genetic information, evidence of insurability, or disability. No wellness programs can discriminate against participants and beneficiaries because of the health factors regardless of how the reward program is structured.

Examples of programs with reward incentives not based on health factors include:

- A program that reimburses all or part of the cost for memberships in a fitness center.
- A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.
- A program that encourages preventive care through the waiver of the co-payment or deductible requirement under a group health plan for the costs of, for example, prenatal care or well-baby visits.
- A program that reimburses employees for the costs of smoking cessation programs without regard to whether the employee quits smoking.
- A program that provides a reward to employees for attending a monthly health education seminar.

These programs do not have to meet any extra requirements beyond the anti-discrimination requirements to be valid.

Programs requiring participants to satisfy a standard related to a health factor to receive a reward must meet five additional requirements.

(1) The total reward given to a plan participant for all wellness programs is limited. The reward must not exceed 20% of the total cost of coverage of the plan. This limit is designed to prevent rewards or penalties so large as to have the effect of denying coverage or creating too heavy a financial penalty for those who do not meet the standard related to the health factor.

(2) The program must be reasonably designed to promote health. This means that the program must have a reasonable chance of improving the health of the participant, is not overly burdensome, is not a scheme for discriminating based on a health factor, and is not highly suspect in the methods chosen to promote wellness.

(3) An employee must be eligible for the reward at least once per year.

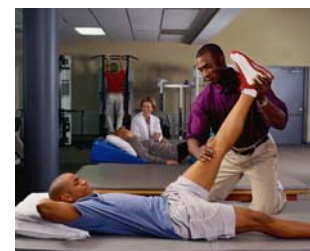
(4) The program must provide a reasonable alternative standard for obtaining the reward for any individual who cannot satisfy the original standard because it is either unreasonably difficult for the participant to meet the standard or that it is medically inadvisable for the person to attempt to meet the standard. The program may require a verification statement from the participant's physician before he opts out of the general standard.

(5) All plan materials describing the terms of the program must disclose the availability of the general alternative standard as required in (4).

Although abiding by the guidelines set out above will ensure that the wellness program is legal as far as HIPAA is concerned, the new regulations do not guarantee that the program will meet the standards set out by other legislation, including the Americans with Disabilities Act. If you have questions regarding a wellness program at your company, HIPAA in general, or any other health law concern, please contact Blake Madison at [bmadison@tannerguin.com](mailto:bmadison@tannerguin.com) or (205) 633-0246.



*“These programs help increase employee productivity, reduce sickness in the workplace, and reduce healthcare costs.”*



## Massachusetts Health Care Plan Could Speed Health Care Reform

A new health insurance law took effect in Massachusetts on July 1<sup>st</sup> that could accelerate health care reform throughout the nation – if the plan works. The law requires all residents to have health insurance or face increasing tax penalties and divides the population into three sections based on income. The first section, the poorest, making less than the federal poverty level, is eligible for free care. The second level, consisting of people making up to three times the federal poverty level (at most \$30,630 for an individual or \$61,950 for a family of four), can enroll in state subsidized plans. The last group, those making more than three times the federal poverty level, can choose their own coverage from new, lower-cost private plans if not already insured.

Although the state has already enrolled about 130,000 formerly uninsured residents, most of them in the free or subsidized plans, it estimates that there are another 160,000 residents still uninsured and not eligible for the subsidized plans. The low cost, private plans

can run as much as several hundred dollars a month. Because of the costs associated with the new plan, some skeptics are questioning whether many residents with income in the third tier of the program will be willing to purchase healthcare on their own. Others are waiting to see businesses' reactions to the new law. Some employers are expected to drop all medical benefits to save money, especially if they believe that workers will be eligible for the state subsidized or free programs. On the other hand, some employers are expected to boost their benefits to retain and attract employees.

At this point, only time will tell the reception from the residents of Massachusetts. The critical group that will either help this plan to prosper or will quickly sink it are those in the highest level required to fund their own insurance. If the state can get them on board, then the opportunity for plans of this nature to become present, if not prevalent, throughout the country, will increase greatly.

*“Some employers are expected to drop all medical benefits to save money...”*

### Seminars

If you are interested in having a Tanner & Guin attorney speak to your group or company on health law related issues, please call Blake Madison at (205) 633-0246.

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