

# KAMENSKY RUBINSTEIN HOCHMAN & DELOTT, LLP

Fall 2005 LAW UPDATE

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### ***ESTATE PLANNING: DO YOU HAVE THE NECESSARY DOCUMENTS IN PLACE TO PROTECT YOUR FAMILY?***

Personal financial planning should include properly drafted wills and/or trusts to provide for death, illness and incapacity and to establish the distribution format for one's assets, to minimize estate taxes and to dispose of one's assets as desired instead of in accordance with the laws of intestacy as designated by the State. Dying without a will can create additional financial burdens for family members, including undesired distribution of assets, reduction of assets that may pass to a spouse, the designation of guardians for your children other than those desired, additional bonding costs and other expenses incidental to probate that can tie up an estate for months or years.

To avoid such adverse consequences, maintain the following documents in good order:

**Power of Attorney.** A durable Power of Attorney will allow a designated individual to act on one's behalf during any periods in which one is unable to act for oneself. Upon the occurrence of a prolonged illness or short term inability to act, this Power of Attorney can be utilized to maintain business and personal commitments in proper order.

**The Living Will.** A Living Will provides a statement to doctors and family members that in the event of incurable disease, unnecessary life sustaining procedures will not be implemented to prolong the eventuality of death.

**Last Will and Testament.** In order to personally control the distribution of assets, a will must be prepared to designate an executor and the person or corporation qualified to act on one's behalf after death and to administrate the final matters relative to business and personal affairs. A Will also assures for the appointment of guardians for the benefit of minor children and provides appropriate care and maintenance of assets on behalf of such children.

**Grantor Trust.** A Grantor Trust or Living Trust is a vehicle that can simplify the transfer of assets without the delay or expense of probate. The Trust maker or Grantor retains the right to amend, revoke or terminate the Trust. All assets that

would normally pass through the estate are transferred to the Trust during the Grantor's lifetime to avoid the process of proving ownership to those assets after the Grantor's death and to enable the Successor Trustee to immediately undertake asset management. During the Grantor's lifetime, all income is taxed directly to the Grantor, but upon the Grantor's death the Trust generally provides for additional Trusts with specific beneficiaries designated by the Grantor. This Trust may also provide numerous tax advantages to family members or beneficiaries after one's death.

### ***PENSION: ANESTHESIOLOGISTS BEWARE***

If you are an anesthesiologist and a member of a group where any of the physicians own an interest in a surgery center, you may be impacted by certain pension rules.

An anesthesia group typically maintains a qualified retirement plan, while surgery centers maintain plans that generally provide smaller benefits, if they maintain any plan at all. The Internal Revenue Service could treat the anesthesia group and the surgery center as a single employer for qualified retirement plan purposes, since: (1) there is an ownership link between the anesthesia group and the surgery center; and (2) the anesthesia group and the surgery center perform services for patients in association with one another. If they are treated as a single employer, the qualified retirement plan of the anesthesia group could be subject to disqualification since the surgery center employees may not be receiving a sufficient level of pension benefits.

#### INFORMATION & ARTICLES IN THIS ISSUE

##### SUBMITTED BY:

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David Hochman, Ben Roth, James Shaw

##### NEWSLETTER COORDINATORS:

Lauren Hernandez and Sandra Weisenberg

**KRHD NOTES**

**Ericka L. Adler**, has been elected to serve on the Board of Directors of the Illinois Association of Health Care Attorneys (IAHA). Ericka was a featured speaker at the IAHA quarterly lecture on April 21, 2005 on the topic of "Contractual Joint Ventures: You Thought They Were Safe But Are They?"

**Marvin Kamensky** spoke on November 9, 2004 at the Twenty-Second Annual Health Law Symposium of the Illinois Association of Healthcare Attorneys on the topic of "Physicians and Hospitals: Working Together to Share in Financial Success."

**Ben M. Roth** of our Estate Planning Department was a featured speaker at the National Business Institute in New York City and at the Chicago Bar Association on Trust Law, Estate Planning and Probate.

**Sherwin Rubinstein** regularly speaks with residents regarding negotiation of Employment Agreements. Sherwin spoke at St. Mary of Nazareth Hospital on November 11, 2004, Mercy Hospital and Medical Center on November 18, 2004 and University of Chicago Hospital on May 27, 2005.

**Miles Zaremski** is completing his first term as Chair of the American Bar Association's Standing Committee on Medical Professional Liability. Miles also completed a lecture in March in San Diego for the American College of Legal Medicine on recent federal decisions and was a keynote speaker at the World Congress of Medical Law in Sydney, Australia, where he was a Visiting Professor at the Division of Law of the Macquarie University in Sydney.

**HEALTH CARE: GETTING OUT OF MEDICARE AND MEDICAID THE RIGHT WAY**

Frustrated by payment reductions, compliance risks and paperwork hassles, more and more physicians want to stop dealing with Medicare. Although physicians are not required by law to accept Medicare beneficiaries as patients, once a beneficiary becomes a patient, a physician is prohibited from balance billing or entering into private payment arrangements with a patient *unless* the physician has properly "opted out" of Medicare.

The Balanced Budget Act of 1997 provides physicians the opportunity to "opt-out" of Medicare, but a physician who wants to exercise this option must comply with strict opt-out requirements even if the physician has never enrolled as a Medicare provider. Opting out exempts a physician from the need to submit claims to Medicare for covered services and from balance billing limits, which places caps on the amount a physician can charge a beneficiary. When opting out is accomplished properly, a physician is free to negotiate fees with

Medicare patients through private contracts. For a physician to successfully opt out, there are two (2) general requirements:

- An affidavit, in a form acceptable to Medicare, must be signed by the physician and filed with Medicare acknowledging that the physician will no longer receive payments under Medicare Part B and that all services to Medicare beneficiaries will be provided through private contracts except in the case of emergency care to a beneficiary who does not have a contract. Although affidavits can be submitted at any time, opt-outs are processed by Medicare to be effective only on a quarterly basis. Opt-outs are for two (2) year periods and physicians must file renewals for the opt-out to remain in force. Recently this requirement was relaxed, and it is now possible to terminate the opt-out agreement but only within the initial ninety (90) days;
- A written contract must be entered into between each Medicare beneficiary and the physician, in a form acceptable to Medicare.

There are significant issues to consider before a physician makes a decision to opt out of Medicare such as the financial impact, the administrative burden of private contracts and their renewals, the need to alter billing procedures to guard against inadvertent submission of Medicare claims and review of existing managed care arrangements and medical staff requirements to ensure they do not require Medicare participation. In addition, there are penalties and consequences if a physician either does not properly comply with the requirements to opt out or continues to submit claims to Medicare after opt out including nullification of all private contracts with beneficiaries which will: require refunds, bar the physician's ability to file claims with Medicare for the remainder of the opt out period and create a black-out on reapplying for opt out status until the end of the original 2 year term.

It is easier to exit Medicaid than Medicare. To exit Medicaid, a physician may send a voluntary termination form to the Illinois Department of Public Aid ("IDPA") to terminate participation. A major mistake that physicians often make is to submit a resignation during an IDPA investigation or proceeding or to fail to defend a proceeding based on the willingness to be terminated from Medicaid. Unfortunately, this latter approach will almost assuredly lead to exclusion from Medicare and other managed care plans as well.

***HEALTH CARE/LITIGATION: UPDATE ON MEDICAL RESTRICTIVE COVENANTS***

Two recent appellate court decisions in which KRHD has been involved in successful appeals have confirmed the viability, and vulnerability, of medical restrictive covenants. In the first case, an experienced cardiologist practicing in and around Chicago Heights, Illinois, and Hammond, Indiana, hired an associate physician, directly out of his cardiology fellowship. After two (2) successful years, the parties began negotiating a partnership agreement, but were unable to come to terms. As a result, the associate resigned and immediately set up a competing practice within the fifteen (15) mile restrictive covenant area. Dr. X immediately filed suit and moved for a temporary restraining order seeking to enforce the associate's restrictive covenant. In his defense, the associate argued that, based upon the Carter-Shields decision, restrictive covenants were not enforceable as a matter of law and that Dr. X had materially breached the associate's employment agreement by failing to offer him the partnership terms he had expected. The trial court denied the motion for a temporary restraining order. After a four day trial, a preliminary injunction was entered enforcing the associate's restrictive covenant for its full two (2) year period from the date of the injunction order by the same trial court judge, who acknowledged that he had made a mistake in denying the TRO.

On appeal, the associate argued that: (i) medical restrictive covenants are not enforceable under Carter-Shields; (ii) the specific terms of his covenant were overbroad and unenforceable for a variety of technical and linguistic reasons; and (iii) the trial court erred in finding that there was no material breach by X. However, only days before Dr. X filed his appellate brief, the Supreme Court of Illinois vacated that portion of the Carter-Shields decision holding that medical restrictive covenants are contrary to public policy and consequently, the appellate court rejected each of the associate's contract construction and breach of contract arguments. The preliminary injunction enforcing the associate's restrictive covenant was affirmed in its entirety.

In a second case, Dr. Y was hired to work as an internist for a clinic in 1993 for a period of three (3) years. After the employment agreement expired, the parties spent almost five (5) years attempting to negotiate an equity purchase agreement for Dr. Y, but when those negotiations finally broke off, the clinic terminated Y. KRHD filed a declaratory judgment action on behalf of Dr. Y seeking to have his three (3) year restrictive covenant declared unenforceable, arguing in part that the restrictive covenant had begun to run when the employment agreement terminated in 1996 and that the covenant was inherently vague. The trial court granted summary judgment in favor of Dr. Y, finding in his favor on each of the argued grounds. On appeal, the Second District Appellate court did not need to go any further than Dr. Y's first argument to affirm the trial court's summary judgment decision and found that the covenant was designed to commence running at the time the employment agreement expired. Consequently, the clinic could not enforce the restrictions against Dr. Y more than five (5) years later.

Despite reports of the demise of medical restrictive covenants in the wake of the Carter-Shields decision, these cases demonstrate that such covenants are still viable and will be enforced by Illinois courts. However, the enforcement of medical restrictive covenants is not without obstacles and is particularly difficult in courts located in the Second Appellate District, which seem to look for ways to avoid enforcing restrictive covenants of medical practitioners.

***CORPORATE: BE STRATEGIC WHEN SELLING YOUR BUSINESS***

If you own a business and receive a call from a potential buyer, make sure you follow these steps:

- Find out precisely who is seeking to buy your business and why. Be wary of individuals posing as a buyer to obtain information about your business or who may intend to act as an intermediary without having an actual buyer lined up.
- Once you identify the person who is contacting you and that person's role in a potential sale, the chain of persons involved in the potential sale must be traced back to the actual decision maker or decision makers of the potential buyer. Only when this is done can one be in a position to assess whether there is a serious potential buyer involved.
- Determine whether the potential buyer's interest in your business is financial, strategic, or competitive. A financial buyer is primarily interested in obtaining a good return on its investment and is prepared to walk away from a deal unless it can get a low price. A strategic buyer is looking to fill a niche in its organization. If the fit is suitable, a strategic buyer often will be willing to pay a good price for the acquired company. A competitor may wish to purchase a business to acquire market share or gain access to useful equipment and personnel, or simply to eliminate a competitor. While a competitor might pay a good price, great care must be exercised in dealing with a competitor as a buyer.
- Bring in your professional advisors at the beginning of the process to help find out as much as possible about the potential buyer and its motivations before divulging any information or otherwise proceeding to negotiate a deal.
- Make a realistic assessment of the potential buyer's ability to raise the capital to purchase your business, especially if any payments will be deferred and the buyer does not have significant experience in your industry.
- Execute suitable confidentiality agreements and make sure procedures are in place before any information is shared with a potential buyer. Sensitive information lost to a competitor could jeopardize the ongoing success of the business and should be withheld until the sale is actually closed.
- Don't wait for a potential buyer to call before taking the time to think about selling your business. Consider what your goals for your company are, know your company's value and define any plans to involve your children or other relatives in your company's operations as early as possible.

**HEALTH CARE: DO SAFE HARBORS PROTECT ANYMORE?**

Health care providers should be aware that the safe harbors usually relied upon to assure compliance with the Anti-Kickback Statute may no longer protect “contractual ventures.” In OIG Advisory Opinion No. 04-17, issued December 17, 2004, the OIG asserts that “contractual joint ventures” will violate the Anti-Kickback Statute even if they comply with all applicable safe harbors to the Statute.

The OIG has always been suspicious of joint ventures between those in a position to refer Federal health care business and services, and those who furnish such items and services, especially when most or all of the joint ventures business comes from referrals by the joint venturers in a position to refer to the venture according to the OIG. “Contractual joint ventures” may be deemed to exist even if the parties do not form a new entity, share profits and losses or otherwise enter into an arrangement bearing the traditional hallmarks of a joint venture. This means that even lease arrangements, services agreements or supply contracts may be a “contractual joint venture” when one of the parties to the arrangement has the ability to refer patients for particular items or services covered in the arrangement (the “Owner”) and the other party possesses all of the knowledge and performs all of the work (the “Manager”). The Manager also allows the Owner to bill and collect for items and services, thereby profiting from the Owner’s referrals.

The OIG has specifically identified five (5) signs of potentially problematic “contractual joint ventures:”

- The Owner expands into a related line of business designed primarily to serve the Owner’s existing patient base.
- The Owner’s primary contribution to the venture is patient referrals and the Owner commits little or no financial resources, management, time or effort to the venture and has little or no risk.
- The Manager is an established provider of the same services as the Owner’s new business.
- The Owner and Manager share in the economic benefit of the new business.
- There are exclusivity or non-compete provisions that have the practical effect of locking up the Owner’s referrals.

In Advisory Opinion 04-17, the OIG analyzed a management company affiliation with a pathology lab that contracted with various medical groups to operate pathology laboratories for each separate group on a turn-key basis at a centralized location. The management group provided the medical groups with all necessary space, equipment, management services as well as all technical, professional and supervisory pathology personnel services at the centralized location. Each group would bill and collect for its own laboratory services. The OIG found that the proposed arrangement was a “contractual joint venture” and noted that the medical groups did not actually participate in the operation of the laboratories and would commit almost nothing in the way of financial, capital or human resources.

In its opinion the OIG asserted that even when such arrangements are structured to come within applicable safe harbors, any profit made by the owner would not be protected by any safe harbor. This conclusion is troubling because the OIG was specifically mandated by Congress to create safe

harbors that would insulate parties from liability as long as the arrangements met the safe harbors. The OIG’s opinion now renders the safe harbors virtually meaningless. Until additional guidance is made available, new and existing contractual joint ventures should be structured to adequately increase physician risk so as to avoid OIG scrutiny.

**PENSION: CONTRIBUTE MORE IN 2005**

The IRS has published the following cost of living adjustments for retirement plans:

	<b>2004</b>	<b>2005</b>
Maximum Annual Addition Dollar Limit	\$41,000	\$42,000
Maximum Annual Addition Percentage of Compensation cap	100% of pay	100% of pay
Maximum 401(k) Contribution Dollar Limit	\$13,000	\$14,000
Maximum 401(k) “Catchup” Contribution*	\$3,000	\$4,000
Social Security Taxable Wage Base	\$87,900	\$90,000
Maximum Percentage for Permitted Disparity	5.7%	5.7%
Defined Benefit Plan Maximum Annual Benefit	\$165,000	\$170,000

\*Plan Participants who are 50 or older in 2005 who make the maximum 401(k) contribution may also make a 401(k) “catchup” contribution of \$4,000 in calendar year 2005. The “catchup” contribution does not count as part of the maximum annual addition limit. Accordingly, in calendar year 2005, a participant in a 401(k) profit-sharing plan can make a 401(k) contribution of \$14,000, a 401(k) catchup contribution of \$4,000 and also receive employer contributions of up to \$28,000 for a total of \$46,000.

**ESTATE PLANNING: ANNUAL GIFTS**

Annual gifts continue to be advantageous in 2005. Each taxpayer is allowed to give up to \$11,000 (or \$22,000 in the case of a husband and wife) to as many donees as he or she desires without incurring any gift tax. If your estate is in the 47% estate tax bracket, an \$11,000 gift will save at least \$5,280 in estate taxes. Since the future increase in the value of the gifted property, as well as the income generated from the gifted property, will be removed from your taxable estate at no gift tax cost, the ultimate estate tax savings will likely be greater than this amount.

In addition to the \$11,000 per person annual gift exclusion, an individual may gift \$1,000,000 (or \$2,000,000 in the case of a married couple) in the aggregate during his lifetime without incurring a gift tax. Unlike annual exclusion gifts, estate taxes will not be saved on the gift itself (unless discount techniques, such as a family limited partnership, are utilized), but estate taxes will be saved on the future increase in value of the gifted property as well as on the income generated from the gifted property.