

HEALTH LAW UPDATE



SUMMER 2002

A VICIOUS CIRCLE: THE DISTURBING REALITY OF FLORIDA'S BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION PLAN

By Kirk S. Davis
kdavis@akerman.com

In 1988, the Florida Legislature enacted the Florida Birth-Related Neurological Injury Compensation Plan. This plan applies to births that occurred on or after January 1, 1989, and provides benefits to the parents of an infant who suffers a birth-related neurological injury and requires continual, life-long custodial care and rehabilitation during their lifetime. It was the intent of the legislature to provide compensation, on a no-fault basis, for a limited class of catastrophic injuries that result in unusually high costs for custodial care and rehabilitation, and therefore applies only to birth-related neurological injuries suffered by an infant during childbirth. The statute was designed to reduce medical malpractice claims and insurance premiums for those who provide obstetrical services in the State of Florida.

The first determination that must be made before parents (or claimants) receive any plan benefits is that the injury constitutes a birth-related neurological defect in the child. This is ordinarily done during the investigation prior to any lawsuit being filed against the obstetrical providers. The requirements are clear, and they include that the infant must have suffered an injury to the brain or spinal chord caused by oxygen deprivation or mechanical problems during the course of labor, delivery, or resuscitation.

The concept sounds simple. However, some administrative law judges hearing these cases have interpreted the statute in a way that shifts the burden from the parent (claimant) - who should be required to show that the injury falls under the statute — to the association or the obstetrical care providers involved.

At the outset, claimants who try to file a circuit court action against health care providers in the case are rejected because the circuit court cannot have jurisdiction until the administrative court determines whether the injury falls under the statute. If that determination is made, the claimant may attempt to remove the case from the administrative courts so that they can seek a monetary remedy that can be far more lucrative than the lifelong child care benefits provided by the association under the statute. To move the case into circuit court, the claimant often tries to show that the health care provider did not give the obstetrical patient proper "notice" as to the patient's rights and limitations under the Florida Birth-Related Neurological Injury Compensation Plan. Notice is usually given via provided to the patient prior to childbirth.

Recently, some administrative law judges have focused on whether proper notice was provided to the patient, rather than first determining whether the defect is a birth-related neurological injury as required under the statute. Once the judge determines that notice was not provided, the case is immediately kicked out from within the administrative courts and the claimants can then pursue monetary damages in circuit court. In some cases that have gone to circuit court, the typical brochure was provided to the patient but the administrative judges did not find that to be sufficient.



Kirk Davis is an attorney in the firm's Tampa office. He is Board Certified in healthcare law and focuses his practice in the areas of litigation, healthcare and administrative law.

Essentially, what occurs is that some administrative law judges are failing to determine whether the infant suffered a birth-related neurological injury as the statute requires.

This application of the statute has cast a dark shadow on legislation that was intended to provide hope to those experiencing the tragedy of a birth-related neurological injury.

THE PREVENTION OF LOSS

(Reprinted with the permission of the Florida Medical Business Journal)

By Valerie Goodwin Larcombe, JD, MHA
vlarcombe@akerman.com

Every physician is cognizant of the potential for loss resulting from claims for professional negligence. In today's health care environment, physicians must also be cognizant of the potential for loss incurred as a result of disciplinary actions brought by Florida's Board of Medicine (the "Board"), or even investigations by the state/federal government regarding physician reimbursement. To minimize the possibility of becoming involved in any of the above scenarios, one of the most important loss prevention techniques is accurate, thorough and timely documentation.

There are various torts for which a physician may be sued by a patient. Two of the most common causes of action are professional negligence and failure to obtain informed consent. Florida has strict statutory provisions which guide the process for filing and sustaining allegations of professional negligence.ⁱ Whenever a physician thinks that the possibility of a lawsuit may exist or whenever medical records are requested from a patient who has had an adverse outcome, the physician should immediately notify his/her insurance carrier.

Another common allegation made by plaintiffs is that the physician failed to obtain the patient's "informed consent." Patients have a right to be informed of the material benefits, risks and the alternatives to treatment including foregoing the treatment altogether.ⁱⁱ Note, Florida's Medical Consent Law precludes recovery against a Florida licensed physician if the physician obtained the patient's consent in accordance with accepted standards of medical practice and a reasonable person based on the information provided by the physician would have a general understanding of the treatment, its risks, benefits and alternatives. ***Obtaining informed consent from a patient is the physician's dutyⁱⁱⁱ and is a process that should not be undermined. Obtaining valid written informed consent from the patient constitutes good medical practice, grants one immunity under Florida's Medical Consent Law, and helps to establish a trusting physician-patient relationship.***

Disciplinary actions can be expensive. In the State of Florida, there are many grounds that may constitute the basis of disciplinary action. Plaintiffs are required to notify the Board of Medicine of each and every suit filed against a physician for medical negligence.^{iv} Hospitals in the State of Florida are also required to notify the Board of Medicine of certain restrictions of the physician's medical staff appointment and corresponding privileges.^v It is through these notification processes that a physician may find himself the subject of scrutiny by the Board of Medicine. Physicians may minimize the risk of financial loss by obtaining insurance that (at a minimum) covers the costs of defending a licensure action. Such policies are usually underwritten as part of a professional liability policy but may be obtained as a stand alone policy. Further, if a notice of an investigation or query from the licensure Board is received, the physician should seek counsel to help formulate a response. The initial response will become the basis for any subsequent Board action and is vital to managing the risk of loss of licensure.

In today's health care environment, medical records are heavily scrutinized by other providers, payers, regulatory agencies, lawyers and others. The federal government considers fraud as its top priority second only to violent crime. Thus, there has never before been more scrutiny of reimbursement to physicians for the services they provide, especially whether those services are considered medically necessary and appropriate. Many physicians are putting corporate compliance plans in place to ensure adherence to applicable laws and regulations. An essential loss prevention technique for preventing or minimizing scrutiny of reimbursement for services rendered is accurate, thorough and timely documentation.

The following guidelines are offered to promote the likelihood that a physician's records can successfully withstand scrutiny.

- ***Be clear.*** Say what you mean and mean what you say.
- ***Be timely.*** The quality of observation fades over time.

- ***Be accurate.*** Accuracy includes a sufficient amount of detail to demonstrate who did what, when, why and with what results.
- ***Identify yourself and others.*** Time and date all entries.
- ***Do not alter, erase or obliterate medical record entries.*** The date, time of correction and the initials of the individual making the correction should be specifically noted. In Florida, this is extremely important as a practitioner convicted of fraudulent altering, defacing or falsifying medical records commits a misdemeanor. Such conviction is also grounds for restriction, suspension or termination of licensure.^{vi}
- ***Consult counsel before correcting the record where litigation is threatened or pending.*** At a minimum, counsel should be consulted regarding prospective corrections.

Rigorous adherence to the foregoing guidelines cannot guarantee that you will never be sued or subjected to scrutiny by a regulatory agency. Good documentation, however, can reduce costs and increase the likelihood of a successful outcome.



Valerie Larcombe is an attorney in the firm's West Palm Beach office. She is a Board Certified healthcare attorney and focuses her practice in the areas of corporate and healthcare law.

- See, Chapter 766 Florida Statutes (1998).
- Canterbury v. Spence, 150 U.S. App. D.C. 263; 464 F.2d 772; (U.S. App. 1972), cert. denied, 409 U.S. 1064, 34 L. ed. 2d 518 (U.S. 1972).
- Public Health Trust of Dade County v. Valcin, 507 So.2d 596, 601 (Fla. 1987)
- F.S. § 766.106(2) (1998).
- F.S. § 395.0193 (1998).
- F.S. §§ 395.302, 775.082 and 775.083 (1998).

RESEARCH COMMUNITY EXPECTED TO PROVIDE COMMENTS REGARDING MODIFICATION OF PRIVACY RULES

By Valerie Goodwin Larcombe, JD, MHA
 vlarcombe@akerman.com

The Federal Policy for the Protection of Human Subjects (the “Common Rule”) and the Food and Drug Administration (“FDA”) regulations govern the conditions under which most research involving human subjects is conducted in this Country (the “Research Rules”). The Research Rules set forth the responsibilities of an institutional review board to review, approve and monitor research protocols. Among its responsibilities is the obligation to ensure that the informed consent process minimizes the risks of research including an individual’s right to privacy. The Research Rules also provide for waiver of the informed consent process if certain conditions are met.

The Standards for Privacy of Individually Identifiable Health Information (the “Privacy Rule”) are intended to supplement the Research Rules. In general, a covered entity may use or disclose protected health information (“PHI”) for research if the subject authorizes the use/disclosure. In addition, a covered entity may use/disclose protected health information without the research subject’s authorization if an IRB or privacy board grants a waiver. Whether the use/disclosure is pursuant to an authorization or waiver, each of the authorization or waiver must meet certain criteria set forth in the Privacy Rule.

The proposed modifications to the Privacy Rule were published March 27, 2002 (the “Proposed Modifications”). With respect to research, the Proposed Modifications are intended to be consistent with the Common Rule. The Proposed Modifications clarify issues raised by the research community including the authorization/waiver process, transition rules for compliance and the safe harbor for the utilization of “de-identified” information.

The Department of Health and Human Services (the “Department”) acknowledges comments and concerns that several of the Privacy Rule’s criteria for the waiver of a research subject’s authorization are redundant, confusing and/or inconsistent in relation to the Common Rule’s informed consent waiver criteria. Accordingly, the Proposed Modifications seek to modify the Privacy Rule’s current waiver criteria to maintain uniform standards for all research and to ensure that the Privacy Rule’s waiver process for the disclosure of protected health information works more “seamlessly” with the Common Rule.

The Department of Health and Human Services further proposes to simplify the authorization process. Under the current Privacy Rule, an individual authorization form for a research use/disclosure of existing protected health information may not be combined with a research informed consent document or a research involving treatment form. The Proposed Modifications eliminate the requirement to obtain a separate authorization for such research. The Proposed Modifications also clarify that the Privacy Rule allows an authorization to use/disclose protected health information to be combined with another authorization or informed consent document. The Proposed Modifications also provide that for treatment-related research, a covered health care provider may condition the research-related treatment upon the individual’s authorization.

The Department’s Proposed Modifications also address commentary regarding the transition process for compliance. In an effort to preserve vital on-going research the Department will permit a covered entity to use/disclose PHI for a specified research study whether the PHI was created or received before or after the effective date of compliance as long as the covered entity had obtained the individual’s valid express permission. Further, research to which an individual consented or for which an IRB granted a waiver will be grandfathered.

The Proposed Modifications to the Privacy Rule do not address the research community’s concern regarding the current scope of the term “de-identified” information. The Privacy Rule expressly allows the use/disclosure of protected health information which has been “de-identified.” Protected Health Information is considered de-identified if it meets certain statistical criteria or if each of eighteen identifiers set forth in the Privacy Rule’s safe harbor are removed. The safe harbor includes the elimination of certain demographic subdivisions smaller than a state. Comments from the research community indicate that such a broad definition of “de-identified” information renders the safe harbor useless to various forms of records research. The Department acknowledges the importance of research activities but states in the preamble that it is not convinced of the need to modify the safe harbor. Instead, the Department requested comment on an alternative approach that would permit useful disclosure of a limited data set which does not include facially identifiable information but in which certain identifiers would remain. Currently, such limited data exceptions would apply only to research for purposes of public health and health care operations.

CMS DELAYS EFFECTIVENESS OF A PORTION OF FINAL STARK REGULATIONS

By Marshall R. Burack
mburack@akerman.com

On December 3, 2001, the Centers for Medicare & Medicaid Services (CMS; formerly known as the Health Care Financing Administration) announced that it was delaying a portion of the final Stark regulations, which were scheduled to become effective on January 4, 2002. CMS acknowledged that the regulatory definition of when physician compensation was “set in advance” could result in hospitals and other health care providers being forced to restructure or renegotiate thousands of physician contracts. Recognizing that the definition of when compensation is “set in advance” could be overly restrictive and could cause unnecessary disruption to existing contractual relationships, CMS determined to postpone for one year the effectiveness of a sentence in the final Stark regulations which states that percentage compensation arrangements do not constitute compensation that is “set in advance” if the percentage compensation is based on fluctuating or indeterminate measures.

BACKGROUND:

On January 4, 2001, CMS issued the long-awaited final Stark regulations. These regulations had initially been proposed in January 1998. It had taken three years for CMS to issue final regulations due, in part, to the large volume of comments and criticism which CMS received regarding the proposed regulations. The final regulations reflected significant revision of the previously proposed regulations.

The purpose of the regulations is to implement and to clarify the statutory provisions of the Stark law, which prohibits physicians from referring Medicare or Medicaid patients for certain designated health services to an entity with which the referring physician (or a member of his or her family) has a financial relationship. In adopting the final regulations, CMS stated that it had endeavored to create “bright line” rules that are easily applied, while providing the health care industry with as much flexibility as possible. In order to give physicians a reasonable time to familiarize themselves with the regulations and to restructure their business arrangements to comply with the new regulations, CMS delayed the effective date of the final regulations for one year, until January 4, 2002.

DEFINITION OF “SET IN ADVANCE” IS TOO RESTRICTIVE:

Notwithstanding the three years spent by CMS reviewing comments and revising the proposed rules, CMS recently realized that at least one portion of the final regulations may be inappropriate, and that the effective date of this portion of the regulations must be further delayed.

Under the Stark law, if a physician has a financial relationship with a health care entity, the physician may not refer Medicare or Medicaid patients to that entity for designated health services unless one of the several exceptions contained in the Stark law is applicable. Many of the exceptions that apply to compensation relationships require that the amount of compensation be “set in advance.”

In response to comments on the restrictive definition of the term “set in advance” set forth in the proposed regulations, CMS relaxed the definition. Whereas the proposed regulations required that the aggregate amount of compensation to be paid over the term of an agreement must be set in advance, the final regulations permitted time-based or unit-of-service based payments. In other words, if a physician were paid a specified amount per hour, or per procedure, such compensation would meet the requirement that compensation must be “set in advance,” even though the aggregate compensation payable over a particular period was not set in advance, but, rather, would vary with the amount of time worked or the number of procedures performed.

On the other hand, the final regulations flatly stated that compensation that is determined by calculating a percentage of a fluctuating or indeterminate amount, such as revenues, collections or expenses, is not “set in advance.” Thus percentage compensation payments do not satisfy the Stark law exception.

Based upon comments received after issuance of the final regulations, CMS apparently has finally realized that many hospitals and other health care entities utilize a compensation methodology whereby physicians are paid for their professional services using a formula that takes into account a percentage of revenues, collections or some other fluctuating amount. If the final regulations were to become effective as written, thousands of physician contracts containing percentage compensation arrangements would have to be restructured or renegotiated.

DELAYED EFFECTIVENESS:

To avoid unnecessary disruption to existing contractual arrangements, CMS announced it is postponing for one year, until January 6, 2003, the effectiveness of one sentence in the final regulations which states that percentage compensation arrangements do not constitute compensation that is “set in advance.” During the interim one year period, CMS will reconsider the matter and publish further guidance. In the meantime, compensation which is determined on a percentage basis will continue to be considered to be “set in advance” for purposes of compliance with the Stark law.

It appears that CMS has recognized, at the 11th hour, that, even as liberalized in the final regulations, the definition of “set in advance” is still too restrictive and would cause many legitimate contractual arrangements be in violation of the Stark law. Look for CMS to liberalize the definition of “set in advance” on a permanent basis. Hopefully, while it is reviewing this particular issue, some of the other overly restrictive elements of the final Stark regulations may also become subject to review and revision.



Marshall Burack is an attorney in the firm's Miami office. He focuses his practice in the areas of corporate, securities, mergers and acquisitions, private equity, venture capital and healthcare law.

DETERMINING TAXABILITY: NEW IRS REGULATIONS FOR EXEMPT ORGANIZATIONS

By Henry H. Raattama, Jr.
hraattama@akerman.com

The IRS issued several sets of Regulations during 2002 that are of interest to the exempt organization (“EO”) community. The Regulations contain no dramatic changes or surprises, however, these new Regulations do set out rules that EOs need to know in order to avoid unrelated business income tax and excise tax. Following is a brief overview of these Regulations.

FINAL INTERMEDIATE SANCTIONS REGULATIONS - TD8978:

The Internal Revenue Code (Section 4958) imposes a 25% excise tax on a disqualified person who enters into an excess benefit transaction with a public charity (Section 501(c)(3) - not a private foundation) or a civic organization (Section 501(c)(4)). By disqualified person, they mean a person who is employed by an EO who has a substantial degree of influence within the organization such as a manager, member of the board of directors or a major contributor. The IRS determines whether there is in fact an excess. In addition, a 10% excise tax is imposed on a manager of a public charity or civic organization who knowingly permits the organization to enter into an excess benefit transaction. In short, it is possible to have a situation where both the disqualified person and the manager are subject to an excise tax for the same contribution.

This law is part of the Taxpayer Bill of Rights 2 (Public Law No. 104-168) enacted in 1996. Since then, the IRS has published Proposed Regulations (REG-246256-96) in 1998, then published Temporary and Proposed Regulations in 2001. However, on January 22, 2002, with few changes to the previous published Regulations, the IRS issued Final Regulations.

In the preamble to the Final Regulations, the IRS provides a useful and fairly complete explanation of why changes were or were not made. Listed below are the highlights of the Final Regulations:

- The Final Regulations clarify that a hospital management company is a disqualified person when it functions like the managed organization’s president, CEO or COO.
- The standard applicable to an organization manager’s participation in an excess benefit transaction has been liberalized in favor of the manager.
- The definition of a governmental entity has been clarified. Intermediate Sanctions do not apply to governmental entities.
- Donor Advised Funds (“DAF”) are not mentioned in the Final Regulations. There was some consideration to including guidance as to when a DAF or advisor would be a disqualified person. This is probably good news because by not being mentioned, the DAF is not considered a disqualified person, thus, not subject to an excise tax.
- The “first bite of the apple” rule is retained. In other words, the IRS concedes the holding of United Cancer Council.
- The Final Regulations disregard expense reimbursements paid under a Reg. Section 1.62-2(c) accountable plan. This expands the IRC Section 132 exclusion. In other words, these expense reimbursements are disregarded for purposes of determining whether an employer received an excess benefit.
- Safe Harbor Clarified - The Final Regulations expressly state that a single person may constitute a committee or body for purposes of the safe harbor approval of contracts. This is useful in setting compensation under the safe harbor.
- Revenue sharing transactions remain reserved. Although revenue sharing is considered by Legislation to be a type of excess benefit transaction, it will not be subject to excise tax until the IRS publishes the Regulations to enforce it.

CORPORATE SPONSORSHIPS - TD8991:

When an exempt organization receives money from a donor and in return allows the donor to be named the exclusive sponsor of an event, the payment may or may not be taxable unrelated business income (UBI). In 1991, the IRS took the position that a payment by Mobil to the Cotton Bowl Athletic Association was UBI because in exchange for the payments,

Mobil was named the exclusive sponsor of the Cotton Bowl (the game was named the Mobil Cotton Bowl). The IRS and exempt taxpayers argued about the taxability of sponsorship payments until 1997 when Congress enacted IRC Section 513(i). IRC Section 513(i) says “sponsorship payments” are not UBI and the definition of “sponsorship payments” was left to the Regulations. Proposed Regulations were published by the IRS in 2000 and Final Regulations were published on April 25, 2002.

Sponsorship payments to exempt organizations fall into several categories which by definition may be taxable UBI in some cases and not in others. The difference between what is UBI and what is not is determined by the degree of the “substantial return benefit.” That is, EOs that receive sponsorship payments and in exchange provide a benefit to the donor. The IRS then determines if the “benefit” to the donor is substantial enough to warrant taxability. EOs that receive sponsorship payments and in exchange provide a benefit to the donor, such as hyperlinks to the donor’s website, exclusivity sponsorship of an event, etc., should familiarize themselves with the Final Regulations. Listed below is a brief overview.

Exclusive Provider Arrangement. A payment in exchange for being the sole provider of a product will generally be considered UBI. For example, if a hospital enters into an agreement with ABC Drink under which the hospital will sell only ABC Drink beverages at its annual golf tournament, the payment will generally be UBI. On the other hand, if the sponsorship payment is solely for the recognition of the donor, like naming ABC Drink the exclusive sponsor of the golf tournament, then this will not create UBI.

Interactive Websites. The issue here is whether a hyperlink or banner on a website is an acknowledgment (not UBI) or advertisement (UBI). In an example in the Regulations a hyperlink to a donor’s website is deemed an acknowledgment (not UBI). In another example, the same hyperlink would be considered an advertisement and UBI because the exempt organization “endorses” the donor’s products. “We serve ABC Drink because it is the best”

De Minimis Benefits. A de minimis benefit provided a donor will not be considered a substantial return benefit and, thus, the donor’s payment will not be UBI. The Proposed Regulations limited de minimis to benefits valued at less than \$79, however, the Final Regulations change that to 2% of the payment. In other words, if the IRS determines that the return benefit is worth less than 2% of the payment, it will be considered de minimis and, therefore, not UBI.

SECTION 457 - PLANS/NONQUALIFIED EMPLOYEE BENEFITS - REG. - 105885-99:

Employees of Section 501(c)(3) employers may make pre tax (i.e., defer tax) contributions to IRC Section 403(b) tax sheltered annuities. The maximum contribution is \$11,000 per year. Prior to 1986, employees could also enter into nonqualified deferred compensation arrangements with EO employers that would allow the employee to defer any amount of income. In 1986, Congress then enacted IRC Section 457.

Under IRC Section 457, an exempt organization employee may not enter into a nonqualified deferred compensation arrangement, but the exempt organization could sponsor an IRC Section 457 plan under which employees could make pre tax (i.e., defer tax) contributions to the plan up to \$11,000 per year. However, the IRC said the \$11,000 limit was reduced dollar for dollar by contributions to IRC Section 403(b) tax sheltered annuities. In other words, the employee was limited to up to \$11,000 per year between the two plans. As a consequence, there was little incentive for an EO to adopt an IRC Section 457 plan.

EGTERRA (The Economic Growth and Tax Relief Reconciliation Act of 2001) removed the dollar for dollar offset. Now, an employee can contribute \$11,000 to a Section 403(b) plan and \$11,000 to a Section 457 plan, thus, doubling the employee’s pre tax contribution limit. On May 8, 2002, the IRS issued Proposed Regulations on Section 457 as follows:

- The plan is sponsored by an exempt organization.
- The plan is a “top hat” plan (that is, a plan for a select group of highly compensated or managerial employees).
- The plan limits contributions to \$11,000 per year.

The Proposed Regulations also cover the application of IRC Section 83 and “substantial risk of forfeiture” rules to deferral plans sponsored by EOs. The new rules appear to put an end to EO’s use of nonqualified stock option plans.

Employee benefit is a complex topic. Suffice it to say, EOs now have a new set of rules to digest in the area of executive compensation. These rules, as well as the “split dollar” insurance notice (Notice 2002-8), provide guidance in the nonqualified employee plan arena.



Henry Raattama is an attorney in the firm’s Miami office. He focuses his practice in the areas of healthcare, tax, trusts and estates, capital transactions, corporate law and charitable and tax-exempt organizations.

In This Issue:

- A Vicious Circle: The Disturbing Reality of Florida's Birth-Related Neurological Injury Compensation Plan
- The Prevention of Loss
- Research Community Expected to Provide Comments Regarding Modification of Privacy Rules
- CMS Delays Effectiveness of a Portion of Final Stark Regulations
- Determining Taxability: New IRS Regulations for Exempt Organizations

DISCLAIMER: The material published herein consists of highlights of recent developments and information pertinent to the clientele of Akerman, Senterfitt & Eidson and is for general information only. It is not to be construed as legal counseling or advice on any matters noted.

Healthcare Practice

The Healthcare Practice Group at Akerman Senterfitt is chaired by a Board Certified healthcare attorney and includes approximately twenty-five practitioners representing each of the Firm's eight offices. The Healthcare Practice Group is actively involved in representing hospitals and hospital systems, nursing homes, physician groups and individual physicians in all specialties, free-standing surgery centers, imaging centers, durable medical equipment companies, physician practice management companies, dialysis companies and home health agencies.

Members of Akerman Senterfitt's Healthcare Practice Group have assisted healthcare industry clients in a wide variety of matters including Medicare and Medicaid reimbursement issues, compliance with fraud and abuse laws and regulations and Stark Law guidelines, the development and implementation of corporate compliance plans, privacy and consent issues, responding to subpoenas, audits and investigations, defense of fraud and abuse cases, antitrust advice, acquisitions and divestitures of healthcare facilities and businesses, licensure of facilities and healthcare practitioners, certificate of need and other regulatory matters, mental health law, guardianships, physician contracts, managed care contracting and medical staff credentialing including the preparation of Medical Staff Bylaws and the handling of medical staff disciplinary matters.

The Healthcare Practice Group also has extensive experience in federal and state tax planning for and the formation of charitable foundations and exempt organizations. In addition to representing its healthcare clients with "healthcare" issues, the Firm's broad range of experience allows its attorneys to represent healthcare clients in related areas such as employment law, public finance, antitrust, bankruptcy and legislative issues. The Firm's healthcare attorneys are able to draw on their broad experience and to assist clients not only with legal matters but also with strategic planning in a rapidly changing healthcare environment.

HEALTH LAW UPDATE

2650 North Military Trail
Suite 240
Boca Raton, Florida 33431
(561) 912-9008

Las Olas Centre II
350 East Las Olas Boulevard
Suite 1600
Ft. Lauderdale, Florida 33301
(954) 463-2700

50 North Laura Street
Suite 2500
Jacksonville, Florida 32202
(904) 798-3700

SunTrust International Center
One Southeast Third Avenue
28th Floor
Miami, Florida 33131
(305) 374-5600

Citrus Center, 17th Floor
255 South Orange Avenue
Orlando, Florida 32801
(407) 843-7860

301 South Bronough
Suite 200
Tallahassee, Florida 32301
(850) 222-3471

First Union Building
100 South Ashley Drive
Suite 1500
Tampa, Florida 33602
(813) 223-7333

Esperante Building, Suite 400
222 Lakeview Avenue
West Palm Beach, Florida 33401
(561) 653-3000



www.akerman.com