TAX-EXEMPT ENTITIES

SEC Disclosure Reform and Senator Grassley’s Suggestion That Tax Exemption Give Way to Charitable Activity Tax Deductions and Credits

With the passage of the Securities Acts Amendments of 1975 (Tower Amendment), Congress limited the regulatory scheme for municipal securities (including conduit borrowers such as 501(c)(3)s borrowing through state or local bond issuing authorities). The Securities and Exchange Commission (SEC) staff is considering whether to recommend that the SEC propose legislation to repeal the Tower Amendment, which generally prevents the SEC from regulating the municipal bond market, and seek an explicit grant of authority to regulate the municipal bond market directly. SEC staff believes that additional control over municipal bond disclosure and accounting standards is necessary.

The apparent goal is to make exempt bond disclosure more like corporate disclosure with respect to timeliness and quality. Arthur Levitt, former SEC chairman, in recent testimony before the Senate Committee on Banking, Housing, and Urban Affairs has endorsed this reform effort based on his belief that (1) many participants in the municipal debt market – insurers, rating agencies, financial advisors to issuers, underwriters, hedge funds, money managers and even some issuers -- have abused the protection granted by Congress from SEC regulation, and (2) the tax-exempt debt and derivative products sold today are substantially the same as those sold in the corporate markets.

Historically, efforts to reform the Tower Amendment have been unsuccessful given the low level of municipal bond defaults and fraud claims. However, the increasing size and complexity of the municipal bond market, coupled with recent rating agency failures and the financial crisis, has provided new impetus for regulation and review. Additionally, current investigations into derivatives, bid rigging, pay-to-play and other scandals, such as the New York Attorney General’s pension fund investigation, may impact efforts to alter the regulatory playing field. Municipal bond borrowers should keep a vigilant eye on this issue.

If the disclosure changes weren’t enough of a concern, Sen. Chuck Grassley (R-Iowa) suggested in a May 12 roundtable discussion on healthcare reform hosted by the Senate Finance Committee that exempt hospitals should become taxable and receive tax deductions or credits for their charitable activities. Sen. Grassley’s comments were framed against the prospect that universal coverage would result in a substantial decline in uncompensated care. In the roundtable, Leonard Burman, Director of the Tax Policy Center, went further and argued that hospitals’ exempt debt should be limited -- as the subsidy is inefficient and largely inures to the benefit of the bondholders rather than the tax-exempt entities.

For more information, please contact Robert M. Wolin, rwolin@bakerlaw.com or 713.646.1327.
Build America Bonds for State and Local Government Hospitals

The Internal Revenue Service recently provided guidance on the Build America Bonds, which were authorized by the American Recovery and Reinvestment Act of 2009. These bonds allow state and local governments to issue taxable bonds in 2009 and 2010, in lieu of issuing tax-exempt bonds.

Build America Bonds generally include any taxable state or local governmental bond other than a bond issued to support a private activity. Consequently, Build America Bonds may not be used for a financing that benefits a private party, including 501(c)(3) healthcare organizations, but may be issued by hospitals that are owned by governmental entities. Build America Bonds may be structured as either tax credit bonds or direct payment bonds. Tax credit bonds provide a federal tax credit to the bondholder equal to 35 percent of the taxable interest they receive. Direct payment bonds provide the state or local government issuer with a federal subsidy equal to 35 percent of the interest paid on the bonds. Tax credit bonds may be used to finance any government purpose for which tax-exempt governmental bonds might be issued. Direct payment bonds, on the other hand, may be used only to finance capital expenditures.

For more information, please contact Robert M. Wolin, rwolin@bakerlaw.com or 713.646.1327.

The Charity Case Requirement For Hospital Property Tax Exemptions

Hospitals throughout the United States generally are accorded the benefits of a charitable exemption from various state and local ad valorem property taxes. The Provena Covenant Medical Center case, which currently is pending before the Illinois Supreme Court, has attracted national attention due to the denial of real estate tax exemption in large measure because of an inadequate demonstration of a certain level of free or discounted medical care. A paper authored by Ted Bernert and Chris Swift and presented last week by Ted Bernert to the State & Local Tax Committee of the ABA Section of Taxation examined the role of a "charity case" requirement, meaning a certain level of "free or discounted medical care" as a condition to hospitals obtaining charitable exemptions from property taxes.

The paper concluded that cases and statutes in the states surveyed show that a nonprofit institution involved in the prevention and treatment of illness does not necessarily qualify as a charitable organization for property tax purposes. Some additional element of benefit to the community is required. Some courts have applied a court-imposed limitation on the charitable exemption solely by reference to a quantified charity care requirement (i.e., a percentage of charity care patients compared to the total population of patients that must be served or a percentage of free care to total revenue). Several state supreme courts, however, rejected the narrow focus on free care in favor of an examination of the totality of the circumstances. At least two states, Pennsylvania and Texas, incorporate quantified free or indigent care standards into the statutes, but those statutes also include consideration of potential benefits for the community that are not limited to providing free services. The litigation currently pending in Illinois, Ohio and other states will determine if court-imposed quantified levels of charity care may be applied in the absence of statutory enactments.

For more information, please contact Edward J. Bernert, ebernert@bakerlaw.com or 614.462.2687, or Christopher J. Swift, cswift@bakerlaw.com or 216.861.7461.
HEALTHCARE REFORM

Second Roundtable Addresses Options for Expanding Coverage

On May 5, 2009, Sen. Max Baucus (D-Mont.) held the second of a series of roundtables on healthcare reform intended to facilitate discussion between members of the Senate Finance Committee and industry experts and leaders regarding the development of a comprehensive reform bill. This second session, which focused on expanding healthcare coverage, addressed numerous options aimed at reforming the individual and small group insurance markets. Chairman Baucus has said that the roundtables "will preview many of the policies the Committee will be considering in its June markup."

Second Policy Options Paper Offers Details for Reforming Everything Including the Kitchen Sink

On May 11, 2009, the second of three expected policy options papers on health system reform was released by the Senate Finance Committee. The second paper (Options Paper) addresses options for expanding coverage, increasing competition in the insurance markets, reforming the Medicaid and SCHIP programs and creating incentives for preventative care, wellness and the creation of a medical home.

With respect to insurance reform, the Options Paper discusses new ratings proposals for micro-group (2-10 employees) and non-group insurance aimed at leveling the playing field among plans. Insurance companies would be required to issue micro-group and small-group (11-50 employees) insurance plans and there would be no bar for individuals with pre-existing conditions. Similar to the Massachusetts model, micro-groups could purchase insurance through a Health Insurance Exchange (Exchange) once a federal rating was established. The Secretary of the U.S. Department of Health and Human Services (HHS) would be responsible for certain components of the Exchange, including developing standards for enrollment applications, marketing requirements and the format used to present insurance options and networks. The Exchange would be available to individuals for enrollment, conceptually, in hospitals, schools, emergency rooms and other locations for outreach purposes. The Options Paper also conceived of the development of multiple Exchanges and the involvement of state insurance commissioners in establishing the Exchanges.

Standardized benefits would be required in the non-group and small group market, including preventative and primary care, emergency services, hospitalization, physician services, outpatient services, day surgery, diagnostic imaging and maternal and newborn care. Plans would be prohibited from establishing lifetime limits on coverage or annual limits on any benefits. A proposed tax credit would be available for low income taxpayers (between 100 and 400 percent of the federal poverty level (FPL)) who purchase health insurance through the Exchange. Eligible low-income individuals, including employees of small and large businesses, would be able to use the credit to purchase health coverage through the Exchange. A small business insurance tax credit based upon a firm’s size and average employee earnings also is proposed.

Recognizing several major holes that would need to be addressed with regard to a public insurance plan, the Options Paper discusses whether to mandate participation by providers, how providers might be reimbursed, how a network would be created, whether reserve funds would be required or whether or not the premiums collected would be required to cover costs or if any shortfall would be subsidized by the U.S. Treasury. Public options might take the form of a Medicare-like plan, a third party administrator plan option, or a state-run public plan. The Options Paper also discussed an alternative that abandons the public plan option altogether, relying instead on expanded coverage through insurance market reform and regulation.

With respect to Medicaid, the Options Paper makes clear that eligibility would be standardized for all parents, children and pregnant women below 150 percent FPL ($33,000 a year for a family of four). Alternatives outlined in the Options Paper for the Medicaid program include increasing coverage through the existing structure, through the Exchange or through a combination of the existing structure and the Exchange. No proposals are offered to change the structure of SCHIP prior to its current reauthorization period (through September 30, 2013). The Options Paper indicates that additional coverage options would be available to low-to-moderate income levels as the Exchange becomes fully operational. Conceptually, once the Exchange is up and running, SCHIP enrollees would obtain their primary coverage through the Exchange, with secondary benefits being paid for by the SCHIP program, with specific federal-state cost-sharing outlined in legislation. The Options Paper also addresses specific details on FMAP, Medicaid 1115 waiver and transparency requirements and prescription drug benefits.

Disproportionate share hospital (DSH) funds would be distributed directly by the Centers for Medicare and Medicaid Services (CMS) to qualifying hospitals. In addition to claims data already submitted, hospitals would submit data to CMS related to the level of uncompensated care provided. The Secretary of HHS would identify specific services eligible for DSH payments through regulation and would determine and pay the appropriate reimbursement rates for Medicare services and uncompensated care. The Options Paper also acknowledges a possible reallocation of DSH funds among states.
In addition to fair share buy-in proposals, the Options Paper provides several alternatives for incentivizing preventative services and healthy lifestyles, including a tax credit for employers who provide a "qualified wellness program" for their employees during a taxable year.

As with the first options paper, the range of ideas in the second Options Paper, is wide and some concepts are laid out in more detail than others. Healthcare providers should stay engaged and watch carefully to see how these proposals may impact their ability and the manner in which they deliver care to their patients.

A third roundtable addressing the financing of healthcare reform was held on May 12, 2009, and Baker Hostetler will provide an analysis of the options paper released in connection with this topic in the next issue of the Health Law Update.

The health reform train has left the station and there appears to be no turning back. There does not appear to be a significant constituency that does not believe that healthcare reform will pass, in some form, this year.

For more information on ways to remain one step ahead of this process, please contact Susan Feigin Harris, sharris@bakerlaw.com or 713.646.1307, or Kathleen P. Rubinstein, MPA, Policy Analyst, krubinstein@bakerlaw.com or 713.276.1650.

Medicare Payment Changes Detailed in Obama’s Line-Item Budget Request

The Obama Administration formally released the President’s line-item budget request to Congress on May 7, 2009. Building upon the budget blueprint released by the White House earlier this year [see the March 5, 2009, issue of the Health Law Update], the line-item budget provides greater detail and insight into the President’s goals and initiatives for healthcare in FY 2010 and beyond.

The Obama budget calls for the establishment of a Health Reform Reserve Fund of approximately $600 billion over ten years. Financing healthcare reform under the President’s budget would be through a combination of new revenue generated from changes in federal taxes and savings derived principally from the Medicare program as described in greater detail below.

Similar approaches for reforming the Medicare payment system were discussed in the first of three "policy options papers" released by the Senate Finance Committee on April 28, 2009 [see the April 30, 2009, issue of the Health Law Update], indicating a like-mindedness between Congress and the administration with respect to a number of proposed payment changes. When viewed in conjunction with the President’s budget request, these proposals offer a preview of where the Medicare program may be heading, and by implication, how it might be used by the administration and Congress to leverage greater healthcare reform. Adding to this mix is a newly released report from the Medicare Trustees projecting complete insolvency of the Hospital Insurance (HI) Trust Fund by 2017.

The following highlights some of the details from the President’s line-item budget request with respect to proposed payment changes for Medicare providers, physicians and insurance plans:

* **Hospital Quality Incentive Program** -- Linking a portion of Medicare payment for inpatient services to a hospital’s performance on specific quality measures. The portion of payments linked to performance would be 5 percent in 2011, phasing to 15 percent in 2015. Payments not earned back would be split equally between a pool to fund additional quality incentives and the Medicare HI Trust Fund.

* **Hospital Readmissions** -- Beginning in FY 2012, decreasing payments for targeted conditions and procedures by 30 percent for hospitals with readmission rates exceeding the 75th percentile, if the patient is readmitted within 30 days of discharge due to complication or related diagnosis. Public reporting of readmission rates would begin in FY 2013.

* **Bundled Payments** -- Beginning in FY 2013, bundling Medicare payments for inpatient hospital services and post-acute care within 30 days of discharge. A single payment would be made to hospitals to cover the costs of both the acute and post-acute care services.

* **Physician-Owned Specialty Hospitals** -- Prohibiting new physician-owned hospitals from seeking reimbursement for services furnished beneficiaries referred to the hospital by a physician with a financial interest in the hospital. Existing physician-owned hospitals would be grandfathered if they meet certain criteria, but would be prohibited from expanding.

* **Physician Payment** -- Allocating $311.1 billion over ten years to "reflect the Administration’s best estimate of what the Congress has done in recent years for physician payments." While stating that this estimate "does not suggest it should be a future policy" and that the administration would "support comprehensive, but fiscally responsible reform" to the physician payment formula, the ten-year budget estimate appears to be an intended effort by the administration to buy
sufficient time to "explore the breadth of options available under current authority to facilitate such reforms including an assessment, both substantively and legally, of whether physician administered drugs should be covered under the payment formula."

**Physician Bonus Eligible Organizations (BEOs)** -- Permitting physicians to form voluntary groups for coordinating care to Medicare beneficiaries. BEOs would receive incentive payments if they improve the quality of care for patients and produce savings.

**Imaging Services Payments** -- Requiring prior authorization from radiology benefit managers for use and payment of advanced imaging services.

**Home Health Adjustments and Payments** -- Establishing a planned case-mix adjustment; providing a zero percent market basket update beginning in FY 2010; rebasing payments in FY 2011.

**Competitive Bidding for MA Plans** -- Establishing a competitive bidding system in which Medicare Advantage (MA) payments are based on the average of plan bids submitted to Medicare. MA benchmarks would be set equal to the average MA plan bid in each county. Bids would be weighed by plan enrollment in the previous year.

**Other Budget Priorities and Initiatives**

**Drug Pricing** -- Establishing a regulatory pathway for generic versions of biologic drugs with a period of exclusivity guaranteed for the original innovator product consistent with Hatch-Waxman law. Brand biologic manufacturers would be prohibited from reformulating existing products into new products ("ever-greening") to restart the exclusivity process.

**Facility Survey and Certification** -- Providing an 18 percent increase over FY 2009 for health facility surveys and certification. Survey frequencies will double for accredited hospitals and increase to no less than once every three years for ESRD facilities in FY 2010. Long-term care hospitals and home health agencies will continue to be surveyed under their statutorily mandated frequencies. Hospice, rural health clinics and ambulatory surgical centers will be surveyed at least once every six years.

Two user fees will be established to finance the increase in survey and certification activity. A "revisit user fee" would be charged to facilities cited for deficiencies during initial certification, recertification or substandard complaint surveys. A "recertification user fee" would be charged to all participating healthcare facilities at the time of their periodic recertification surveys. Recertification user fees would be phased in over a three-year period to a level equal to 33 percent of costs, on average.

**Fraud and Abuse** -- Allocating a net increase of $6 million over FY 2009 to the Office of Medicare Hearings and Appeals which projects a 36 percent increase in claims in FY 2010 resulting from the permanent expansion of the Recovery Audit Contractor (RAC) program and a $1.7 billion increase over five years to the Health Care Fraud and Abuse Program for regulatory and enforcement activity.

The President’s line-item budget request follows on the heels of a recent congressional budget agreement that provides reserve funds for reform and includes reconciliation instructions on the Senate side to limit debate and enable reform to pass with a simple majority should legislative efforts stall by October 15, 2009. This congressional budget agreement also overrides a scheduled 21 percent reduction in Medicare fees for physicians in FY 2010 by extending the physician payment "fix" for two years.

For more information, please contact Susan Feigin Harris, sharris@bakerlaw.com or 713.646.1307, or Kathleen P. Rubinstein, MPA, Policy Analyst, krubinstein@bakerlaw.com or 713.276.1650.

**Health Industry Groups Pledge to Reduce Spending**

In a letter sent to President Obama on May 11, 2009, a group of industry stakeholders representing hospitals, physicians, health insurers, drugmakers, medical device makers and labor representatives pledged to decrease the annual spending growth rate in healthcare by 20 percent for an estimated savings of $2 trillion or more. To respond to this challenge, the groups wrote that they are "developing consensus proposals to reduce the rate of increase in future health and insurance costs through changes made in all sectors of the healthcare system" with a focus on administrative simplification, standardization and transparency. President Obama has set a deadline of June 1, 2009, for the stakeholder group to submit specifics on their proposals for reducing healthcare spending and costs.

For more information, please contact Susan Feigin Harris, sharris@bakerlaw.com or 713.646.1307, or Kathleen P. Rubinstein, MPA, Policy Analyst, krubinstein@bakerlaw.com or 713.276.1650.
FRAUD ENFORCEMENT AND RECOVERY ACT PASSES HOUSE

The Fraud Enforcement and Recovery Act of 2009 (S. 386), introduced by Sen. Patrick J. Leahy (D-Vt.) to improve enforcement against mortgage fraud, securities fraud, financial institution fraud and other frauds related to federal programs also includes several amendments to the federal False Claims Act (FCA) to address what Congress views as the court’s misinterpretation of the intent of the FCA. The bill has passed the House and Senate overwhelmingly. The Senate and the House versions now are in the reconciliation process.

In Allison Engine Co. v. United States ex rel. Sanders, 128 S.Ct. 2123 (2008), the U.S. Supreme Court held that to be liable under the FCA for false statements or conspiracy, the defendant must have made the statement with the intent of getting a false claim paid or approved by the government itself and not merely by an intermediate entity that would be paying the claim with government funds. [See the June 12, 2008, issue of the Health Law Update.] The bill proposes to eliminate terminology that has been construed to limit FCA violations to actual knowledge that the claims will be paid by the government. [See the March 19, 2009, issue of the Health Law Update.] The amendment to section 3729(a)(1), if enacted, will be retroactive to June 7, 2008, two days before the Supreme Court’s Allison Engine decision. In addition, the bill rejects the court’s limiting interpretation of the FCA in United States ex rel. Totten v. Bombardier Corp., 380 F.3d 488 (D.C. Cir. 2004). In Totten, the court found that "under the plain language of Section 3729(a)(1) claims must be presented to an officer or employee of the government" for FCA liability to attach. The bill redefines the term "claim" to clarify that subcontractors submitting false claims are covered under the FCA without regard to whether they deal directly with the government. The passage of this bill, as amended, would provide the government with broader enforcement powers under the FCA.

For more information, please contact B. Scott McBride, smcbride@bakerlaw.com or 713.646.1390, or Summer D. Swallow, sswallow@bakerlaw.com or 713.646.1306.

IOM COMMITTEE ISSUES CONFLICT OF INTEREST REPORT AND RECOMMENDATIONS

On April 28, 2009, the Committee on Conflict of Interest in Medical Research, Education, and Practice for the Institutes of Medicine (IOM) published a report discussing financial conflicts of interest involving physicians and researchers (Medicine) and the pharmaceutical, medical device and biotechnology companies (Industry), that made a number of recommendations for preventing conflicts of interest.

The report, entitled "Conflict of Interest in Medical Research, Education, and Practice," contains the following suggestions (among others) for mitigating potential conflicts of interest between Industry and Medicine:

- Medical institutions (e.g., academic medical centers, professional societies, patient advocacy groups, medical journals) should establish conflict of interest committees and policies that require disclosure and management of individual and institutional financial ties to Industry.

- The content, format and procedures for disclosing financial relationships of physicians and researchers with Industry should be standardized.

- Congress should create a national reporting program requiring pharmaceutical, medical device and biotechnology companies to publicly disclose all payments to physicians, researchers, healthcare institutions, professional societies, patient advocacy and disease groups and continuing medical education providers.

- Researchers should not be permitted to conduct research involving human subjects if they have a financial interest in the outcome of the research (unless they are essential for the safe and appropriate conduct of the research).

- Academic medical center and teaching hospital faculty should not be permitted to accept gifts, make presentations that are controlled by Industry, claim authorship for ghost-written publications or enter into consulting arrangements without written contracts specifying that services will be paid at fair market value.

- Medical centers should restrict visits by Industry sales people and limit use of drug samples to financially needy patients.

- A new funding system for continuing medical education (CME) should be established so that the CME system will be free of Industry influence.
• Community-based physicians should be prohibited from accepting meals, gifts, drug samples or presentations from Industry sources.

• Organizations (e.g., professional societies) that develop clinical practice guidelines should be prohibited from accepting direct Industry funding for guideline development and exclude individuals with conflicts of interest from panels that develop the guidelines.

• Health insurers, accrediting bodies and government agencies should develop incentives for policy change.

• HHS should develop a research agency to create a stronger evidence base for future conflict of interest policies.

For more information, please contact B. Scott McBride, smcbride@bakerlaw.com or 713.646.1390, or Krista Barnes, kbarnes@bakerlaw.com or 713.646.1352.

TEXAS COURT HOLDS RECRUITMENT AGREEMENT DOES NOT CREATE HOSPITAL RESPONDEAT SUPERIOR LIABILITY

In a recent case, the Fort Worth Court of Appeals held that a physician recruitment agreement that provided a physician with an income guaranty, sign-on bonus and relocation reimbursement did not make the hospital liable for the malpractice liability of a physician under the doctrine of respondeat superior. A provider may be held liable under the doctrine of respondeat superior for the acts of its agent or employee, even though the provider did not commit a wrongful act itself, if the provider controls or had the right to control the details of the agent or employee’s work.

The plaintiffs in this case alleged that the recruitment agreement evidenced the hospital’s control over the physician with respect to the following obligations: (1) provide on-call emergency room coverage; (2) engage in the full-time practice of medicine in the community; (3) maintain complete and accurate medical records for patients seen at the hospital; (4) maintain active staff privileges at the hospital; (5) not enter into a similar recruitment arrangement with any other hospital; (6) provide a reasonable level of charity care; (7) negotiate with managed care providers with whom the hospital participates; (8) cooperate with the hospital’s compliance efforts; and (9) provide information necessary for audits, tax filings and other financial and regulatory matters, including calculations under the income guaranty.

The court held that the provisions, rather than evidencing a right of control over the physician’s practice, largely ensured that the recruited physician would have a financially viable practice in the hospital’s service area and the money the hospital advanced the physician would be safeguarded through repayment or emergency room coverage. As to the compliance obligations, the court held that requiring one to comply with applicable law does not amount to a right of control. With respect to the physician’s obligations to (1) negotiate with managed care providers with whom the hospital participates; (2) maintain active staff privileges at the hospital; and (3) provide on-call emergency room coverage, the court held that the provisions attempt to control an outcome, rather than the details of the physician’s work, and consequently, do not provide a basis for respondeat superior liability. This is an important distinction for avoiding respondeat superior liability in many cases.

The plaintiffs also tried to show that the physician was an employee of the hospital because (1) the physician used hospital equipment instead of his own in surgery; (2) a hospital employee assigned operating rooms used by the physician and scheduled the physician’s patients’ surgical procedures; and (3) the hospital employed and assigned the nurses who assisted the physician in surgery. The court found that the foregoing acts did not show that the hospital controlled or had the right to control the details of the physician’s work, as the physician was free to use his own tools and the patient was billed separately by the hospital for its services.

Undeterred, the plaintiffs finally tried to hold the hospital responsible for the physician’s acts under the doctrine of ostensible agency as a result of the hospital’s advertising campaign, the physician’s badge and scrub suit and a donor’s plaque in the emergency room area. Ostensible agency allows a hospital to be held responsible for its agent’s conduct if the hospital’s conduct caused a patient to reasonably believe that the physician was an employee of the hospital and the patient relied on the fact that the physician appeared to be the hospital’s agent. The court held that the physician was not the hospital’s agent in this case largely based upon evidentiary problems of the plaintiffs and the fact that the hospital’s forms contained an express acknowledgement that the physicians providing care did not work for the hospital. Farlow v. Harris Methodist Fort Worth Hospital, No. 2-07-423-CV (Tex. Civ. App. May 7, 2009). Providers should assure that their forms contain an express acknowledgement that the physicians providing care do not work for the hospital, where applicable, to help avoid ostensible agency.

For more information, please contact Robert M. Wolin, rwolin@bakerlaw.com or 713.646.1327.
ROBERT M. WOLIN ELECTED DIRECTOR FOR THE JOHN P. MCGOVERN MUSEUM OF HEALTH AND MEDICAL SCIENCE

Houston partner Robert M. Wolin has been elected to a two-year term on the Board of Directors for the John P. McGovern Museum of Health & Medical Science, also known as The Health Museum, a member institution of the world-renowned Texas Medical Center. In his role on the board, Mr. Wolin will guide, support and advocate for the mission and vision of The Health Museum, which educates the public on wellness and the health sciences through a variety of interactive programs and exhibits. The 26-member board includes Houston area leaders in business, law, research, technology, medicine and community service.

EVENTS CALENDAR

May 21, 2009

Cleveland Of Counsel Tom Campanella will serve as the Keynote Speaker at the Annual Regional Conference of the Healthcare Financial Management Association of Northeast, Ohio, speaking on the topic of "Healthcare Policy at the National and State Level."

May 26, 2009

Washington, D.C. Of Counsel Terry Connerton will speak at the International Pension & Employee Benefits Association on "Financial Crisis and Pension Funds: Problems and Solutions," in Athens, Greece.

About Baker Hostetler's National Healthcare Team

Baker Hostetler is at the forefront of national law firms providing clients involved in every facet of healthcare delivery across the country with comprehensive legal counsel of remarkable responsiveness, creativity, quality and value. We understand the unique needs of the industry, and are dedicated to helping clients achieve their strategic and operational goals and resolve day-to-day operating issues through our experience, knowledge and national perspective. Supported by more than 600 attorneys and professionals in 10 cities coast to coast, our multi-disciplinary Healthcare Team offers clients nationwide strength across a diverse array of practice areas including Medicare and Medicaid reimbursement, regulatory compliance, fraud and abuse counseling, government investigations, subpoenas and audits, FDA, pharmaceuticals and biotechnology, tax and exempt organization laws, export controls, ERISA, management labor and employment, finance and business transactions, antitrust, lobbying, and commercial litigation, among others.

Baker & Hostetler LLP publications are intended to inform our clients and other friends of the Firm about current legal developments of general interest. They should not be construed as legal advice, and readers should not act upon the information contained in these publications without professional counsel. The hiring of a lawyer is an important decision that should not be based solely upon advertisements. Before you decide, ask us to send you written information about our qualifications and experience. © 2009 Baker & Hostetler LLP