Surviving Without Liability Insurance—1 Year Later

BY MARY ELLEN SCHNEIDER
Senior Writer

For a little more than a year, Mark Macumber, M.D., has been conducting a health policy experiment—operating his medical practice without liability insurance.

"The most surprising and rewarding thing is the response I get from the patients," said Dr. Macumber, a family physician in Berwyn, Ill., and Chicago.

It's been a year full of surprises for Dr. Macumber since he opened his family medicine practice in September 2003 in Berwyn with no medical liability coverage (CLINICAL PSYCHIATRY NEWS, Feb. 2004, p. 112). Today, he is breaking even and has opened a second location in Chicago.

When he started, he knew he couldn't afford the $40,000 liability premium he would have to pay; he also wanted to draw attention to the skyrocketing malpractice rates many physicians must pay. That's still the case, he said, but his experience has also driven the issue of access to health care to the top of his priority list, he said.

"It started out about medical malpractice, but it's really about access," Dr. Macumber said.

Since most patients' insurance companies require physicians to carry liability insurance, he doesn't bill insurance companies and, instead, offers his services for a reduced fee—$40 for an average office visit. Patients with insurance can still submit claims to be reimbursed by their insurance company, but Dr. Macumber won't deal with the paperwork.

About 25%-33% of his patients have health insurance, but most are uninsured. Some patients come to see him because they support what he's doing; others have said they want continuity and are sick of changing doctors every year. For still others, it's cheaper to see him at $40 a visit than it is to pay the copayments or coinsurance associated with their health plans.

COURTESY DR. MARK MACUMBER

Dr. Mark Macumber "went bare" because he couldn't afford malpractice insurance and wanted to draw attention to high rates.

Some patients come to him because they want the confidentiality he provides by not filing information with insurance companies.

And for Dr. Macumber, cutting out insurance companies means more time, more money, and less aggravation. "I'm so relieved I don't have to deal with that at all," he said.

Because he does not have to spend time dealing with insurance companies, Dr. Macumber said he can afford to spend 20-40 minutes with each patient.

Not accepting insurance also means that he can charge whatever he wants, including giving someone a break on his or her bill, or even bartering for care. He can also choose to charge for telephone calls, though he hasn't done that yet. He already charges patients about $10 to fill out paperwork.

Dr. Macumber's practice has been a safety net for those patients who don't qualify for Medicaid and don't have insurance, said Ellen Brull, M.D., president of the Illinois Family Physicians Association.

Although Dr. Macumber initially received a lot of publicity for practicing without insurance, the other aspect of his practice is that he is providing a medical home for the uninsured, she said.

But Dr. Brull said she would still rather work to fix the system than see more physicians follow Dr. Macumber's experiment. "The whole system is so flawed, it needs to be revamped," she said.

Although Dr. Macumber's practice is rapidly growing and becoming financially viable, he still doesn't recommend that other physicians follow in his footsteps.

"I'm not going without malpractice insurance because I want to go without malpractice insurance," he said. Once liability insurance becomes affordable, he plans to get it.

Dr. Macumber said he got to really see how destructive the medical liability compensation system had gotten when he decided to practice without it. But he sees traditional tort reform strategies, such as damage caps, as a gut response from physicians who feel angry and cornered.

"Tort reform is nice, but the system itself is flawed on so many levels," he said.

The medical liability system is a barrier to improving quality and to reporting and learning from our mistakes, he said. Dr. Macumber said that he believes that the answer is a set of comprehensive reforms that address the current system's economic, practice, and ethical problems.

"What he's doing is very interesting and it's obviously risky, but it is something that challenges the status quo," said Patrick Tranmer, M.D., professor of clinical family medicine at the University of Illinois at Chicago (UIC), where Dr. Macumber holds a clinical faculty appointment in family medicine. ■

GAO: Medicare Call Centers' Correct Responses Have Flatlined

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

WASHINGTON — Two years after the Government Accountability Office scolded Medicare for the inaccurate information its carrier call centers provided to physicians, a follow-up report finds that call-center performance has deteriorated even more.

In its February 2002 report, "Medicare: Communications With Physicians Can Be Improved," the GAO noted that customer service representatives at Medicare carriers' call centers "rarely provided appropriate answers to questions, answering only 15% of our test calls completely and accurately."

In a July 2004 report, the agency got right to the point: "Only 4% of the responses GAO received in 300 test calls to 34 call centers were correct and complete."

In addition, the report noted, "[The Center for Medicare and Medicaid Services'] efforts to provide oversight of carrier call centers are inadequate." For instance, in 2002 the agency carried out only one evaluation of a carrier's telephone services; in 2003, there were none.

Stephanie Huff, government affairs analyst for the Medical Group Management Association (MGMA), said her organization was not surprised by the results. At MGMA, "we have two people specifically designated to deal with member calls, and a lot of time is spent sidestepping the call center process," she said. "We will call CMS directly to get answers to questions our members have."

The American Medical Association also agreed with the study results. "While the Medicare call centers' inability to correctly answer physicians' questions is troubling, sadly, it is not surprising," Dr. J. James Rohack, chair of the AMA's board of trustees, said in a statement. "The GAO report confirms longstanding complaints from physicians about the lack of clear and reliable guidance on complex Medicare policy questions."

The report's authors attributed the call centers' problems to a variety of factors, including:

► **Fragmented information.** "When responding to Medicare inquiries from providers, customer service representatives (CSRs) rely on fragments of information from multiple electronic sources," such as both CMS and carrier Web sites, the report said. They also use various paper documents, including the Medicare carrier manual, program memorandums, carrier bulletins, and "printed Medicare program information, including policy changes, which CMS estimates at about 200 per year."

For a question about billing for services delivered by therapy students, the CSRs who were contacted referred callers to 13 different documents. "Twelve of the references were either incorrect or did not include all of the information needed to give a correct and complete answer," the report said. The 13th document was in a "Q and A" format, and it "included our specific test question but without the complete answer. Fragments of the answer, however, were located earlier in the document… It was evident to us that without reading the entire document, it would be plausible for the CSR to have read the test question and mistakenly given the caller the wrong answer, while assuming that the response given was correct and complete."

► **Difficulties in retaining CSRs.** The report noted that an internal CMS study found the turnover rate for carrier call center CSRs to be as high as 23% from calendar years 1999 through 2001 for all of CMS's call centers. "This is significantly higher than the attrition rate for CMS's call centers for beneficiaries … which one CMS official estimates is close to industry standards—about 10%. Although there are no more recent data, CMS officials view this as troubling."

CMS is currently trying out two initiatives to help CSRs, but neither of them is likely to help the representatives answer policy-oriented questions from providers, the report said. For instance, CMS has retained a consulting firm to write explanatory articles about new Medicare policies, but is not doing anything special to help CSRs get easy access to them.

"Although these articles contain citations to regulations and laws, for example, they are not electronically linked to the policies they describe," the report noted. "In addition, the policies they support are not annotated to reflect that an article exists … Moreover, there are no plans to publish articles for the majority of existing policies."

The report included several recommendations for improvement, including routinely screening and triaging calls by routing complex policy-oriented questions to staff with the expertise to adequately address them, developing clear and easily accessible policy-oriented materials to assist CSRs and making sure the materials are electronically searchable, and establishing an effective monitoring program for call centers to assess CSRs' performance.

Ms. Huff of MGMA applauded the recommendations. "The recommendations would be a quick and easy way for CMS to reduce its administrative burdens," she said.

In its response to the GAO report, CMS generally agreed with the recommendations. For example, the agency said it "will soon issue a requirement that all call centers create a tiered approach to answering provider inquiries." That approach, which CMS hopes also will help with retention by creating opportunities for promotion, is expected to begin in fiscal year 2005. ■