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 practicing 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 (FAMILY PRACTICE NEWS, Nov. 1, 2003, p. 1). 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," he 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 who have insurance can still submit claims to be reimbursed by their insurance company.

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.

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.

Not accepting insurance also means that he can charge whatever he wants, including giving someone a break on a 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 remarked.

COURTESY DR. MARK MACUMBER

Dr. Mark Macumber, shown here with his wife, says he plans to get liability insurance when it becomes affordable.

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 is 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 a barrier 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), who works with Dr. Macumber at the university.

Dr. Macumber, who holds a clinical faculty appointment in the family medicine department at UIC, has spoken to students and residents about his practice setup—though he is careful not to recommend it.

So far none of the residents has expressed an interest in practicing without insurance, Dr. Tranmer said, but it's good for them to hear about a practice that is doing things differently, including how Dr. Macumber runs his office with fewer employees and charges lower rates. ■

Beware of the Recruiting Prohibitions Under Stark II Law

BY JOYCE FRIEDEN
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BALTIMORE — The newest round of regulations implementing the Stark self-referral legislation has two provisions of particular interest to doctors: one on physician recruitment and the other on in-office ancillary services, several speakers said at a forum sponsored by the American Health Lawyers Association.

Physician recruitment "is clearly the biggest new exception," said Kevin McAnaney, a lawyer in Washington. Under this phase of Stark II, which took effect in July, a hospital or federally qualified health center can pay to recruit a physician, provided that he or she is either a new physician or is relocating from outside the geographic area, defined as "the area comprised of the lowest number of contiguous zip codes from which the hospital draws at least 75% of its inpatients."

The relocation provision applies to the doctors' offices, not their residences, and they must either move 25 or more miles away or have 75% new patients in their practice as a result of the move.

"Some people say that the only thing you have to do to meet the exception is meet one of the second two requirements—75% new patients or move 25 miles from the old location. [But] I think you have to move into the geographic service area *and* meet one of those tests," he explained.

Baltimore lawyer Sanford Teplitzky agreed. "You have to recruit from outside the geographic area into the geographic area," he said. For example, "the hospital can't get someone from outside and bring him to one of their satellite facilities that falls outside that [geographic area], even if there's a community need and a community benefit."

'The requirement says services must be billed by the supervising physician, the group, or an entity "wholly owned by such physician or group."'

Another important exception has to do with in-office ancillary services. Mr. McAnaney warned, however, that the exception applies to some services but it "does not cover most [durable medical equipment], enteral and parenteral nutrients, supplies, and equipment."

He noted that under the regulation, "if the physician personally performs the services, it would not be [considered] a referral. What exactly that means remains to be fleshed out by [the Centers for Medicare and Medicaid Services], but I would not advise physicians to try to provide [durable medical equipment] personally."

The language in the statute generally says that services eligible for the exception "are those which are integrally tied to the core practice of the physician," Mr. Teplitzky said. "That's become fairly controversial. In some cases physicians have wanted to [include] things that normally they would never do, but would refer their patient to someone else for and they would provide the service or supplies and would bill for them.

"I believe this is an area that's going to be subject to some fair amount of scrutiny ... of physicians who are trying to bring things into their practice that they would not ordinarily do, but they go out and hire a doctor as an independent contractor to come in so they could bill it through their service," he continued.

To be eligible for the exception, the service also has to meet two other criteria, according to Mr. McAnaney:

► **Supervision.** "Basically, the service has to be performed by or supervised by the referring physician, another member of the group, or a physician in the group," he said, noting that the supervision standard has been quite controversial in the past.

► **Building.** First, the building where the services are performed "has to be a [real structure]—no mobile equipment," Mr. McAnaney said. Second, the services must be performed "in the same building where group practice is, basically has a full-time office there, open at least 35 hours per week, with the referring physician providing services 30 hours per week."

If the physician practices in several offices and goes to a different one each day, "you could also provide services in the same building where the referring physician has an office that's open at least 8 hours per week and where the referring physician regularly practices there," he continued.

Then there is the case where the practice has an office that's open 8 hours per week and a group physician regularly practices there at least 6 hours per week. But in that case, two additional tests must be met: The referring physician must be present to order the designated health services during the patient visit, or a group physician must actually be present when the designated health service is furnished.

On the billing side, "the requirement says services must be billed by the supervising physician, the group, or an entity 'wholly owned by such physician or group,' " Mr. McAnaney said. "The place where this sometimes raises some questions is there are more and more shared facilities or shared equipment in the same building. They still have to meet these requirements, so you have to make sure you can bill for the equipment and you meet those standards." ■