Many geographic regions see malpractice rates level off

Physicians still face malpractice-related compensation challenges

Medical malpractice insurance rates are stabilizing after skyrocketing in the early 2000s, according to an analysis of the Council of Insurance Agents and Brokers quarterly survey of market conditions. According to the survey, average medical malpractice rates increased only 2% in both the first and second quarters of 2005 and remained flat in the third and fourth quarters.

But depending on what geographical area you're talking about, it's not necessarily safe to say the medical practice crisis is behind us, says **Ty Chambers,** executive vice president at Liquid Medical Recruiting, in Irving, TX. For example, "in south Florida, many practices are going bare [without coverage] because it's so bad." Conversely, in most areas of Texas, "it's not an issue whatsoever."

As a result, physicians and groups in troubled areas continue to see their compensation challenged by today's malpractice environment.

Rates compromise bonus pay

"Although physicians' insurance premiums may have leveled off or gone down slightly, they're still at all-time historic highs," says **Paul Greve Jr., JD, RPLU,** senior vice president consultant at insurance broker Willis' healthcare practice. "Second, they are being squeezed by decreased reimbursement—a huge factor." Continuing financial pressures prevent doctors from recouping the increased malpractice premiums they've paid the past several years.

Primary care specialties, for example, may earn $90,000–$150,000 per year but pay as much as $30,000 in malpractice premiums—consuming a huge chunk of their practice income, Greve says. On the other hand, higher-paying, higher-risk specialties such as obstetrics and neurosurgery could spend $100,000–$200,000 on malpractice insurance, he adds.

Surprisingly, "the malpractice crisis has not affected physicians' compensation when it comes to the initial offer, whether it's employment or a guarantee," Chambers says. Although many practices pay recruits' malpractice coverage for the first year, this is a temporary solution, he says.

High insurance rates have affected physicians' pay negatively in connection with production models, Chambers says. For example, a physician may garner a base salary of $200,000, plus a bonus for production above a certain cost threshold.

"That's where they're affected, because that higher premium on the malpractice is calculated into their overhead, creating more costs that they have to overcome in order to receive a production bonus," Chambers says. Therefore, physicians may find themselves having to take more patients to offset the cost of their malpractice premium—and still not reach their full earning potential.

Relocation holds hidden costs

Although many states are experiencing a degree of relief, physicians may be hard-pressed to relocate out of troubled regions, particularly if they hold claims-made malpractice policies. This is because of the exorbitant levels of tail coverage a physician may be responsible for paying before moving to another practice, Chambers says.

Some practices contractually agree to pay this amount for physicians when they leave, but this is the exception more than the rule. More often, the recruiting practice, the physician, or some combination will pay the balance. But whatever amount a practice, hospital, or healthcare organization pays toward a physician's tail coverage likely has to come out of the physician's pocket in some other way.

Chambers provides an example of a 41-year-old general surgeon in Ohio who has been practicing for less than one year and has zero malpractice claims against him. With a higher-than-average malpractice premium of roughly $21,000, he's looking to leave Ohio—but his malpractice tail will cost $55,000. The group looking to hire the surgeon has agreed to pay half of the tail—but has been forced to cut his signing bonus to make the recruitment affordable.

Even with such compromises, a small group or solo physician may find it impossible to recruit a physician with this level of tail coverage. "For them to attract [such a physician], they're going to have to go through a hospital to support them in that recruitment effort," Chambers says.

Sacrifices are widespread

On top of recruiting difficulties, many practices have to

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make difficult business decisions because of this sticky situation.

For example, many physicians have decided to go bare. Large groups that can afford to do so have migrated toward self-insurance vehicles such as captive insurance companies and risk-retention groups over the past five years, Greve says, noting that interest in these options is now slowing.

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Although smaller groups likely don't have the wherewithal to self-insure, they can potentially save money by taking on higher deductibles, Greve says. But don't assume that changing your deductible will have a dramatic effect on your premium, he warns.

Instead, ask your agent to provide several quotes at different deductible levels and see whether assuming more risk is worthwhile, he suggests.

As a rule of thumb, "you begin to get the most bang for your buck with a deductible around $100,000," Greve says. "Anything less than that, and I don't know how much economic benefit you're going to get."

Other practices choose to limit services. Because of the risk and premium expense, growing numbers of obsetricians and gynecologists (OB/GYN) have stopped delivering babies, radiologists no longer perform mammograms, and neurosurgeons have halted taking trauma call, Greve notes. This phenomenon has hurt OB/GYN more than any other specialty, Chambers says. "Good luck if you want to have a baby in downtown Las Vegas because few, if any, OB/GYNs are willing to do a delivery due to the malpractice environment," he adds.

And although OB/GYNs who continue to deliver babies therefore become more marketable and enjoy higher negotiating power, excessive tail coverage may still thwart relocation, Chambers says.

Eastern Carolina Internal Medicine, PA, in Pollocksville, NC, has made its share of malpractice-related sacrifices as well. **Robert Monteiro, MD,** is one of several physicians at his 40-provider practice who, until recently, made monthly trips to local nursing homes to care for the practice's patients who lived there (the practice assigned each physician to one facility to visit regularly).

But in January 2005, the 35-year tradition became im-possible to uphold. The nursing homes' fear of litigation eventually led to 10 or more faxes, phone calls, or other interruptions from nursing home staff every day, Monteiro explains.

"The physician had to be contacted for every little thing that ever happened or had to be documented," he says. "The time it was requiring to manage these patients was equivalent to the amount of time you would spend taking care of somebody who was in the hospital in critical care."

These demands led to hours of uncompensated work in the office, he says. In addition, the Medicare reimbursement rate for a routine monthly nursing home visit without complications at the time was a mere $32.88—with no opportunity to earn more via lab tests or x-rays, which the nursing home billed. In contrast, a routine in-office visit could garner $300, Monteiro says.

Because of these economics, the Eastern Carolina physicians no longer do rounds in nursing homes, although they do still care for their nursing home patients who come to the office or are admitted to the hospital.

Patients who can't get to the office are cared for by the physician director hired by the nursing home to cover the patients.

However, "if there is meaningful reform that occurs, our practice is not averse to returning to the nursing home setting," Monteiro says. "It's not an irreversible decision."

PCR *sources*

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Questions? Comments? Ideas?

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