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President's Message
As we enter the second quarter of 2013, I would like to review the year-end 2012 highlights. In general, 2012 was a spectacular year. AMS RRG exceeded its growth targets, saw a decrease in frequency and severity of claims, and was able to pay a $33 per share dividend. Some of the company’s financial highlights include:

- Assets greater than $705 million, up approximately $13 million from 2012
- Gross Written Premium (GWP) of $40.75 million
- Surplus of $51.12 million (after dividend), up approximately $3 million from 2012

Steady Rates
Consolidation in the industry continues, but at a slower rate than in the past couple of years. A key difference in today’s market is that the major insurance companies are single-line insurers, (e.g., The Doctors Company, ProAssurance, etc.) as opposed to multi-line insurers such as Travelers, St. Paul, etc. When the multi-line insurers exited the medical liability insurance market in the early 2000’s, rates were driven up dramatically. Because medical liability insurance is the core business of the single-line insurers, we don’t expect them to exit the market so any increase in rates will occur slowly over a longer period of time. Additionally, net reform efforts in many states have positively impacted claims frequency and severity, keeping rates low. Therefore, we expect to continue to see rates hold steady for the foreseeable future.

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An Accelerating Trend

Facility Fee Factors in Purchase Price

Service in physician's office:
Payment to physician: $68.97
Total: $68.97

Service in outpatient department: (employed physician office)
Payment to physician: $45.17
Payment to hospital: $71.33
Total: $116.50

Other anecdotal reports reveal patients receiving bills which have markedly increased due to the facility fee, particularly for those who have large deductibles and copays. The facility fee is not approved for a physician visit. This issue has caught the attention of other medical organizations and hospitals.

There is no doubt that the ultimate goal of all health care practitioners is to improve patient outcomes. Attorney's want better outcomes as well, because happy, satisfied patients correlate to fewer lawsuits filed against health care providers. While performance standards, professional guidelines or protocols of care are often employed in an attempt to improve outcomes, as an attorney, it is problematic to review or give advice regarding them because that could affect the standard of care.

The Rise of Performance Standards

Emergency physicians and emergency medicine groups execute agreements with their hospital partners which place performance standards and core measures directly on the physicians in the practice. Most medical specialty organizations and institutions require some form of clinical performance measurement as well. For example, the American College of Cardiology and the American Heart Association have recommended core measures for treating patients with ST segment MI and non ST segment MI. Those cases used to represent the majority of cases filed against emergency room physicians, but in the past five years, the "missed MI" cases out of the emergency department are very few. Now, with the institution of the "code STEMI" in the pre-hospital care environment, and the hospital cath labs responding immediately, patients are having better outcomes and heart muscle salvage.

Many of these core measurements are used by the Centers for Medicare & Medicaid Services (CMS) for post review of the quality of care delivered to Medicare patients. While many practitioners would argue that CMS is merely looking for an avenue to deny payment to those facilities that do not follow the criteria, CMS would argue it is only seeking better outcomes for its beneficiaries, including decreased hospital admissions. Unfortunately, many times these performance criteria are promulgated by committees or hospitals as "standards of care," which further expose medical staff members.

Performance Standards vs. Standards of Care

The term "standards of care" is a legal term used in courts of law to determine a practitioner's duty to a patient. Standards of care are determined by jury, judge and/or expert testimony. In contrast, clinical performance measurements by hospitals, medical specialty committees and professional review organizations to provide a "roadmap" for practitioners to consider. As recommendations that change over time, these guidelines should not set policy. They should never be considered as hard evidence in a medical malpractice lawsuit.

It is recommended that any clinical protocols or guidelines set up for mid-level practitioners, physicians, or other health care providers have language that allows for the flexibility to use his or her own independent medical judgment.

Tips for Writing Clinical Guidelines

In writing such guidelines, we suggest the following:

- Each clinical guideline should have the following language at the beginning of the page:

  "These guidelines are tools and considerations for the practitioner’s use and are not intended to suggest or dictate medical standards of care. Each patient has individualized medical needs, and each practitioner must use his or her own professional independent judgment in medical decision making for each patient’s treatment plan of care.”

With this language at the beginning of each clinical recommendation, you can respond accordingly. If asked in deposition testimony, you can state you know of the guidelines, but you determined that your patient, Jane Doe, needed different treatment modalities, and you were acting in the best interest of the patient at the time of care.

- Use caution in using words such as “practitioners shall always” or “practitioner shall ensure that.” Again, the wording must give flexibility for the practitioner and should not denote absolute terms.

- Nursing policies can be somewhat more problematic, yet required by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and nursing boards. Nurses are accustomed to policies and procedures, which they strictly construe. For example, instead of a policy that states, “Vital signs shall be measured every two (2) hours,” a departure from which would be considered a violation of hospital policy, it is possible, allow patient autonomy to better define the guidelines. It would be better to state, “Vital signs shall be measured according to the acuity of the patient or as ordered by the physician.” In this manner, nurses are not charged with taking repeat vital signs on non-acute patients or patients who do not require it.

Get Involved

Whatever term is used — core measurements, performance standards or clinical guidelines — these policies are here to stay. It is in the practitioner’s best interest to assist in the development of these measurements in their hospitals and/or their specialty organizations to draft reasonable and medically sound criteria that gives flexibility and allows practitioners to continue to determine individual patient care requirements.

For questions regarding the above, please contact Steve Shapiro, MD at (866) 520-6896. The term “standard of care” is a legal term used in courts of law to determine a practitioner’s duty to a patient. Standards of care are determined by jury, judge and/or expert testimony. In contrast, clinical performance measurements by hospitals, medical specialty committees and professional review organizations to provide a “roadmap” for practitioners to consider. As recommendations that change over time, these guidelines should not set policy. They should never be considered as hard evidence in a medical malpractice lawsuit.
Facility Fee Factors in Purchase Price

Regarding the last point above, to further reduce the upfront costs to purchase a practice, hospitals can use the facility fees they receive to bolster physician reimbursement. Following is an example of how the facility fee affects reimbursement as published by the Medicare Payment Advisory Commission and reprinted in The Seattle Times on November 3, 2012.

**Service in physician’s office:**
- Payment to physician: $68.97
- Total: $68.97

**Service in outpatient department: (employed physician’s office)**
- Payment to physician: $85.37
- Payment to hospital: $71.13
- Total: $156.50
- Other anecdotal reports reveal patients receiving bills which have markedly increased due to the facility fee, particularly for those who have large deductibles and copays where the facility fee is not approved for a physician visit. This issue has caught the attention of the Medicare Payment Advisory Commission, who notes that these fees will add $1 billion a year to Medicare spending by 2020. In addition to Medicare, local governments have taken notice. A bill introduced in the Vermont Senate by Kevin Mullin designed to allow hospitals that buy local doctors from charging these fees did not pass. That said, Tom Nickels of the American Hospital Association noted that the issue “is clearly in play.” As a result, these facility fees, which have been helpful in scaling many deals, are currently under significant regulatory review.

Medical Malpractice Coverage After a Sale

Once a practice is purchased, different approaches to malpractice insurance exist. In a study published by AON in October of 2012 and presented at the American Society for Healthcare Risk Management (ASHRM), 80% of employed physicians whose practices were purchased moved their malpractice coverage into the hospital’s captive. Thirteen percent of these physicians’ hospital systems used a mix of commercial insurance and their own captive while 7% left their existing providers to purchase coverage. Hospital risk is significantly different than physician risk from a medico-legal liability standpoint. This distinction and other challenges described below must be considered by both the physician and the hospital prior to any consolidation.

- 67% of hospitals will not provide malpractice coverage for prior acts so the physicians are required to purchase a “tail” to cover these acts. This coverage can average approximately two times the physician’s current premium and reduce the financial viability of any deal. Interestingly, only 2% of hospitals surveyed noted that they would provide prior acts coverage in most or all circumstances.

- It is common for physicians to have their malpractice limits increased once they are employed by a hospital. Of employed physicians, only 54% carried insurance of $1 million dollars per occurrence or less, while 37% carried limits of $5 million dollars per occurrence or more. The anticipated effect is that the physician now becomes a much deeper “pocket” to go after than when they were not employed.

- Physicians will need to understand how the cost of their insurance is allocated to them, particularly if they are now carrying higher limits at higher charges.

- Hospitals will find that, with an increasing number of physicians, greater burdens will be placed upon their self-insured funds. Reinsurance costs, as well as administrative costs, will increase, and the potential savings from having a self-insurance fund may be offset by the increased risk and decreased ability to spread it over more territories and more specialties. Several bad physician claims could significantly affect any potential gains achieved by purchasing the physician’s practice.

AMS RRG Consolidation Counsel

As uncertainty generates anxiety, knowledge creates opportunity. Physicians as a whole are entrepreneurial and will always look for opportunities to maximize the value their practice brings to them, their families and their patients. As your long-term insurance solution, AMS RRG can answer any questions you have to help you better understand your medico-legal insurance options as you contemplate future scenarios.

**Performance Standards: Improving Quality to Decrease Risks**

There is no doubt that the ultimate goal of all health care practitioners is to improve patient outcomes. Attorneys want better outcomes as well, because happy, satisfied patients correlate to fewer lawsuits filed against healthcare providers. While performance standards, professional guidelines or protocols of care are often employed in an attempt to improve outcomes, as an attorney, it is problematic to review or give advice regarding them because plaintiff attorneys will try to use these documents as “standards of care,” even if that is clearly not the intent. For example, if a protocol dictates that a patient is to have antibiotics on board within a specific time of the onset of symptoms, and the antibiotic is given twenty minutes after the time period required, is that considered a violation of the standard of care?

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President’s Message continued from front page

Feedback Welcome
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We look forward to another great year as we progress through 2013.

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AMS RRG President’s Message

by Richard B. Welch

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