

## Medicare Resource Based Physician Liability Insurance

### Introduction

Reports across the country indicate rapidly rising Physician Liability Insurance (PLI) premiums. Accordingly, there is an increasing interest in understanding how the Centers for Medicare and Medicaid Services (CMS)<sup>1</sup> methodology for calculating PLI costs reflects changes in PLI premiums. This white paper consists of a brief description of the national payment scale for Medicare and Medicaid and the development of the Resource Based Relative Value Scale for Physician Liability. The focus of this paper is to provide the methodology for calculating PLI Relative Value Units along with a general example of the process. Following the description of the methodology is an outline of the three ways Medicare reimbursements can change to reflect increases in PLI costs. The conclusion highlights the core issue, specifically; that the extent to which actual cost is covered is largely determined by the conversion factor, which decreased in 2002.

### Background

Since January 1, 1992, The Centers for Medicare and Medicaid Services (CMS) has paid physicians for Medicare services using a national payment schedule. This payment schedule relies on uniform relative value units, which are based upon the resources used in furnishing physician services. The Relative Value Unit (RVU) for physician services is comprised of three factors: work (55 percent), practice expense (42 percent) and physician liability insurance (3 percent). The CMS implemented Resource-Based Professional Liability Relative Value Units (RBPLI RVU) in 2000.

### History

Prior to 2000, charge-based data was used to determine the PLI RVUs. In 1994, the Social Security Act Amendments required that CMS develop a methodology and implement resource-based practice expense RVUs, initiated in 2000 and fully effective by 2002. The Resource Based Relative Value Scale for Physician Liability Insurance was developed in 1999. Previously, the product of “base allowed charges” and service specific malpractice expense percentages were used to determine liability costs. In 1999, the CMS contracted with KPMG Consulting to provide support in developing PLI RVUs. The KPMG report *Development of Resource Based Malpractice RVUs*, was reviewed and published, along with proposed PLI RVUs, in the July 22, 1999 *Proposed Rule*. According to the KPMG report, the objective in developing the RBPLI RVUs was to “allocate the malpractice costs of each physician specialty across the procedures that the specialty performs, according to the frequency the specialty performs it.” In other words, for any given procedure, a RVU is assigned in proportion to the average cost of all the physician specialties performing the procedure. CMS finalized this proposal, with relatively few changes, in the November 2, 1999 *Final Rule*. For the 2001 Medicare Payment Schedule, CMS utilized updated premium data to derive new PLI RVUs.

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<sup>1</sup> Formerly the Health Care Financing Administration (HCFA)

## **Methodology**

The resource-based professional liability RVUs are based on:

1. The national average premium for each specialty
2. Risk factors for each specialty
3. A malpractice RVU for each CPT code
4. An adjustment for budget neutrality

### *National Average Premium for Each Specialty*

The primary determinates of physician liability costs are physician specialty, level of surgical involvement, and the individual's malpractice history. In determining the resource-based malpractice RVUs, CMS decided that the value should reflect both costs associated with the physician specialty and the level of surgical involvement. To determine cost, CMS<sup>2</sup> collected malpractice premium data for the top 20 Medicare physician specialties measured by dollars of reimbursement. Due to the inconsistencies between states' definition of the risk class, the data was initially based on comparisons of spending by Medicare Part B among 20 specialties. For the 1999 Proposed Rule, a national average of professional liability premium was calculated for each specialty using 1996-1998 data. Premiums were for a \$1 million / \$3 million mature claims-made-policy, a policy covering claims made rather than services provided during the policy term. CMS collected malpractice premium data for twenty specialties. For other specialties, CMS utilized premium weighted average risk factors of five selected malpractice insurers.

### *Risk Factor for Each Specialty*

To determine the level of surgical involvement, CMS calculated risk factors for each specialty to reflect the differences in specialties' exposures to risk. Some specialties have two risk factors, recognizing the different risks between surgical and non-surgical services. This process required a common method for classifying different risk categories. The majority of malpractice insurers use five-digit codes developed by the Insurance Services Office (ISO) codes. Medicare uses its own system of specialty classification for payment. Therefore, it was necessary to map the Medicare categories to the ISO codes and insurer risk classes. While the majority of insurers have ISO codes, most insurers have their own categories for risk classes. To assure consistency, the risk classes of St. Paul Companies, one of the oldest and largest malpractice insurers were used. Medicare specialties were then crosswalked to ISO codes and St. Paul's risk classes. Risk factors were based on national average premiums for each physician specialty.

In a few cases, CMS crosswalked one specialty's risk factor to another specialty. For example, neuropsychiatry was crosswalked to psychiatry. Risk factors (non-surgical and surgical) were calculated for each specialty by dividing the national average premium for each specialty by the national average premium for the specialty with the lowest average

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<sup>2</sup> CMS contracted with Allied Technology Group Incorporated (Allied). Allied used an OMB-approved survey to collect physician specialty sub-state region specific malpractice data from 1995. Fifty-five companies from 50 states, Puerto Rico and the District of Columbia were surveyed. On average, data represented approximately 77 percent of the physician PLI premiums paid in each state.

premium. For example, the thoracic surgery risk factor is 8.14 compared to psychiatry at 1.31. CMS applied the surgical risk factors to surgical codes and non-surgical risk factors to all other codes. CMS also applied the surgical risk factor to the cardiology catheterization, angioplasty and electrophysiology codes, since these procedures were considered invasive and should therefore be valued based on the surgical risk factor. In the case of OB/GYN services, the higher obstetric premiums and risk factors were used for obstetrical services, while the lower gynecology risk factor was used for all other services.

#### *Malpractice RVU for Each Code*

Risk factors for each specialty were calculated by dividing the national average premium for each specialty by the national average premium for the specialty with the lowest average premium. This risk factor was then multiplied by the percentage of services provided by a particular specialty. The total risk factor for a particular service is the sum of the products of the risk factors and the percentage of services.

CMS determined that the work RVU was the best proxy for risk since the work RVU correlates time, intensity, and difficulty of service. Therefore, the total risk factor for a given service is multiplied by the work RVU to account for differences in the risk-of-service. If the work RVU were not used, then all services performed exclusively by a particular specialty would have the same PLI RVU. Therefore, the work RVU serves as a proxy to reflect the different risk among services. CMS acknowledged that work RVUs may not be the ideal determination of risk-of-service and has requested suggestions for other indicators. In instances where the work RVU equaled zero, CMS retained the current professional liability RVUs.

#### *Maintaining Budget Neutrality*

The law requires that changes to the payment schedule RVU be budget neutral. The previous charge-based malpractice RVU and current resource-based malpractice RVU were constructed using entirely different methodologies and data not directly related to each other. Therefore, to ensure that the total PLI RVUs under the resource-based methodology equal the total PLI RVUs under the charge based methodology, the new values were adjusted. The unadjusted resource-based PLI RVUs were multiplied by 0.0172 to maintain budget neutrality.

As the professional liability component is only 3.2% of the total payment amount, the initial impact in the 2000 implementation to specialties was minimal. While Emergency Medicine had a 2.7% increase in total payment, all other specialties did not increase or decrease by more than 1%.

#### **Calculating PLI RVU**

The following is an example of how a PLI RVU is calculated for a CPT code:

The percentage of a specific service to be performed by each specialty is based on Medicare frequency data.

|            |                 |     |
|------------|-----------------|-----|
| Example:   |                 |     |
| Code 12345 | Family Practice | 20% |
|            | Dermatology     | 50% |
|            | Plastic Surgery | 30% |

This percentage is then multiplied by each specialty's risk factor

|                 |              |             |
|-----------------|--------------|-------------|
| Example:        |              |             |
| Code 12345      |              |             |
| Family Practice | .20 x 1.73 = | 0.35        |
| Dermatology     | .50 x 1.12 = | 0.56        |
| Plastic Surgery | .30 x 6.57 = | <u>1.97</u> |
| Total           |              | <b>2.88</b> |

The sum of the products for all specialties for the procedure yield a specialty-weighted PLI RVU reflecting the weighted professional liability costs across all specialties for that procedure.

This number is then multiplied by the procedure's work RVU to account for differences in risk-of-service.

$$2.88 \times 2.50(\text{Work RVU}) = 7.20$$

The raw unadjusted PLI RVU is then adjusted for budget neutrality.

Example:

$$7.20 \times 0.0172 = .12 \text{ PLI RVU for Code 12345}$$

### **Changing Medicare PLI Payments**

Recently, there have been reports across the country of rapidly rising PLI premiums. As a result, there has been an increased interest in understanding how Medicare recognizes PLI costs, and how flexible the Medicare payment methodology is to reflect changes in PLI premiums. It must be remembered that the Medicare payment schedule recognizes the relative costs of providing services, not the actual costs. CMS has recognized that Medicare payments for PLI costs may not cover actual costs since "The purpose of the resource-based malpractice RVUs is not to guarantee each physician an absolute return of malpractice costs. It is rather to construct malpractice RVUs based on the relative malpractice costs among services."

Currently, there are three ways Medicare reimbursements can change to reflect increases in PLI costs. However, two of these methods involve a considerable lag time and do not benefit a particular physician group without an equal offset from others. First, changes in premiums in geographic areas can be reflected in updates to the Geographic Practice Cost Index (GPCI). If a particular geographic area were experiencing rising premiums, these new costs would be reflected when the GPCI is updated every three years. However, the changes to the GPCIs are budget neutral meaning that any increases must be offset with

corresponding decreases in other areas. The second way to reflect changes is through adjustments to the individual PLI RVUs. The PLI RVUs may be adjusted through the collection of updated national PLI premium data, which is scheduled to occur every five years. However any changes to the actual RVUs would also be budget neutral, typically resulting in redistribution among specialties.

The last way for the payment system to reflect changes in PLI premiums is by changes in the conversion factor. The annual conversion factor update is partially based on changes in the Medicare Economic Index (MEI), which measures inflation in medical practice costs. The PLI premiums are included in the MEI, and currently account for 3.2% of total costs reflected in the index. Other costs include medical equipment, supplies, physician time, and payroll. To the extent that national average malpractice premiums are increasing, the data will support an increase in the conversion factor over and above what it would have been without the premium increases.

The MEI, however, is only one element of the complicated Medicare payment update formula. Although PLI cost increases will be reflected in the MEI, other factors such as Medicare spending caps on physician payments may cause a reduction in the conversion factor. This is due to a flawed Medicare payment formula known as the sustainable growth rate system (SGR). The SGR system is comprised of expenditure targets for physician services based on a number of factors including the growth in the U.S. Gross Domestic Product. If the actual expenditures exceed the target, the Medicare payment update may be as much as 7 percent below the MEI. If actual expenditures are below the target, the update may be up to 3 percent above the MEI. Linking Medicare spending for physicians' services to the GDP is inappropriate, as there is not a relationship between the overall economic performance and the health needs of Medicare beneficiaries.

While primary determinants of liability premiums are physician specialty, level of surgical involvement and individual physician's malpractice history, the extent to which the actual cost is covered is determined largely by the conversion factor. The decrease in the conversion factor by 5.4 percent in 2002 only heightens the concern that Medicare payments may not cover the cost of providing care. Acknowledging the conversion factor is low and decreasing, the AMA is committed to researching and ensuring that the data used for updating the conversion factor are accurate. The AMA is currently working to replace this flawed Medicare payment update formula with a new system.