

Profiting by Discounting Physician Fees: Is Your Medical Association Working for You or against You?

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Some consumers wonder why their doctor's hands seem to be tied up in red tape like "pre-authorizations" for medicines, and paperwork that seems to interfere with their treatment. Some physicians have noticed that their "reimbursements" from preferred provider organizations (PPOs) are diminishing. Is there a fundamental flaw in the PPO business model?

Maybe.

A PPO is not an insurance company. A PPO sells products to insurance companies (and other payers) that typically include "access" to a group of physicians at discounted prices. A PPO may also sell rationing programs that incorporate medical "necessity" reviews. A PPO's customers (i.e. the sources of a PPO's revenue) are insurers, employer self-funded health plans, and third-party administrators, not physicians or consumers.

At its 2012 annual meeting, the California Medical Association (CMA) discussed a network of PPOs called the Foundations for Medical Care (FMCs) that is related to some of CMA's chartered county medical associations and operates under an umbrella PPO organization called the California Foundation for Medical Care (CFMC).

As is typical of a PPO, the CFMC/FMCs network acts as a broker that gets physicians to agree to accept discounted payments. The CFMC/FMCs network then sells these discounts to its clients—those who pay medical bills such as insurance companies, employers, and unions.

When organized medicine engages in the PPO business, some think it is akin to this hypothetical situation: Derek Jeter, the Yankee baseball hero, lets Agent Steve negotiate his contract with the Yankees. Unbeknownst to Jeter, the Yankees promise Agent Steve a finder's fee that is more lucrative the less the Yankees have to pay Jeter. Steve is a Hall-of-Famer baseball legend, too. Jeter never imagines that a great guy like Steve might act against the interests of his colleague.

At its meeting, CMA leaders had an opportunity to review an invoice showing that the Los Angeles FMC (LAFMC), which used to be run by the Los Angeles County Medical Association, earned a \$1,170.64 finder's ("access") fee from one of its clients, the USA Managed Care Organization in March of 2004 (See Figure 1). Physician bills were "repriced" by LAFMC in return for 6% of the \$23,137.44 that physicians (and other providers) were not paid. For example, if a physician billed \$100 and was paid \$60, the "savings" were \$40. LAFMC received 6% of such "savings": $\$40 \times 6\% = \2.40 . Notice that the fee earned by LAFMC was calculated as a percentage of what was *not* paid to the physician, rather than what was paid. The economic incentive for LAFMC was to negotiate the lowest possible fee schedule with "its" physicians in order to maximize its revenue.

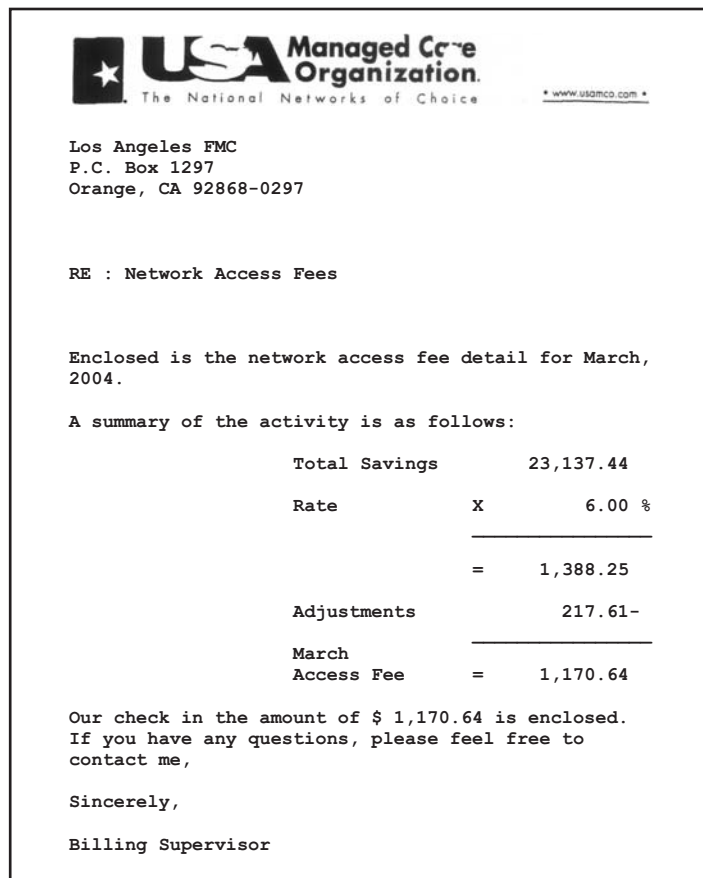


Figure 1

Although LACMA made a good-faith effort to close LAFMC, some California county medical associations and physician leaders still have relationships with CFMC/FMCs, a PPO network that spans the state; see www.cfmnet.org. CFMC/FMCs gets physicians to agree to give discounts. CFMC/FMCs then sells "access" to these discounts on physician charges to its real clients—insurers, unions, and others who pay medical bills. Why pay retail? Rent a doc for 120% of Medicare—tops.

The actual dollar amount of a PPO's access fees may seem small—a few percent of the tens of millions of dollars earned by physicians—but that is the wrong focus. Consider the tens of millions not paid to physicians, which is the advantage that insurers are buying. The incentives created by commissions that are calculated based on underpayments to physicians are precisely the opposite from incentives that would be created by commissions based on payments to physicians.

Explanations of benefits typically do not report access fees, medical reviews, and other processing fees to physicians or to consumers. Some CMA members want CFMC/FMCs to account for its revenue and expenditures as well as that of all related entities.

Do such fees simply cover the cost of processing claims? There is no way to know. In return for such "savings," an insurer would likely be willing to pay high fees. To the extent that these are higher than actual administrative costs, the PPO could spend them on take-home bonuses that reward a few insiders. Is this occurring in the CFMC/FMC network? There is no way to follow the money. It is not possible to determine how much money insiders might take out in the form of salaries, fringe benefits, expenses, consulting fees, or other devices because the books of some CFMC/FMCs subsidiaries (in which it appears most of the business is transacted) are closed and their IRS filings are private.

There are multiple relationships between CMA, the CFMC/FMCs network, and physician leaders. Many physician leaders may not know or do not understand what CFMC/FMCs is doing. Other leaders have known for years that the CFMC/FMCs network partially finances some county medical associations. In 2004, the CEO of the California Medical Association wrote that CFMC/FMCs is "still county [medical association] affiliated. CMA and CFMC are not directly connected governance-wise.... Many counties still make a huge non-dues revenue stream out of their foundations, and pay their MEC Exec [executive directors] with such funds in large part.... Riverside, Tulare, and others still take great advantage of them..." (personal communication).

According to public records, the executive director of the Riverside County Medical Association is also the CEO of California Foundation for Medical Care (the umbrella PPO of the CFMC/FMCs network), and the CEO of the Riverside Foundation for Medical Care, which is one of the state's largest FMCs. Both Riverside entities are nonprofits, whose IRS Forms 990 are thus publicly available. (See www.guidestar.org.) Forms 990 for 2010 report that this individual worked 40 hours per week for Riverside FMC and 40 hours per week for Riverside County Medical Association—and received no compensation from either entity. CFMC is a company whose tax returns are private, as are those of the related entities of Riverside FMC: Foundation Administrative Services, Inc., Inland Empire Foundation for Medical Care, and UFMC Health Systems, Inc. All these entities have the same address and the same agent for service of process: the Riverside County Medical Association executive director. (See <http://kepler.sos.ca.gov/>.)

CFMC's own website advertises an average 36% "savings" (non-payments) to primary care physicians for inpatient services, and an average 32% "savings" (non-payments) to specialists for outpatient services. (See www.cfmnet.org/Information.asp) CFMC's CEO distributed a market analysis for a specific potential client to other CFMC/FMCs network executives, some of whom are also executive directors of county medical associations. Two hundred thousand claims were analyzed. Physicians submitted charges of \$29,312,639.38 and were "allowed" payments of \$12,790,284.98. The average non-payment ("discount" or "network savings") on these claims was an "impressive" 48%. Assuming the CFMC/FMCs network contract with this potential client to be similar to Los Angeles FMC's contract with its client, USA Managed Care Organization, CFMC/FMCs' 6% "access" fee would have been about \$1 million.

CFMC/FMCs has lots of clients.

Is a PPO the sort of business that organized medicine should be in at all: selling physician services at discounts in return for commissions that tend to be more lucrative the less physicians are

paid? Should any part of organized medicine that runs a PPO be given any more trust or respect from practicing physicians than any other insurance middleman?

Although some consumers who purchase PPOs may enjoy cheaper medical care, others may find it harder to get the services that they need. In addition to selling price discounts and/or "repricing" of claims, some PPOs also sell utilization reviews/case management. A reviewer, who is sometimes anonymous, reads a patient's confidential medical record in order to find a reason to deny payment for the treatment recommended by the patient's own doctor.

The CFMC/FMCs network is in this business, too. For example, the Pacific Foundation for Medicare Care (www.pfmc.org/medicalreview.asp) advertises, "Health plans and self-insured employers can reduce the cost of their claims by using PFMC's medical review services.... Types of issues addressed include: ... Medical necessity...and appropriateness of care rendered."

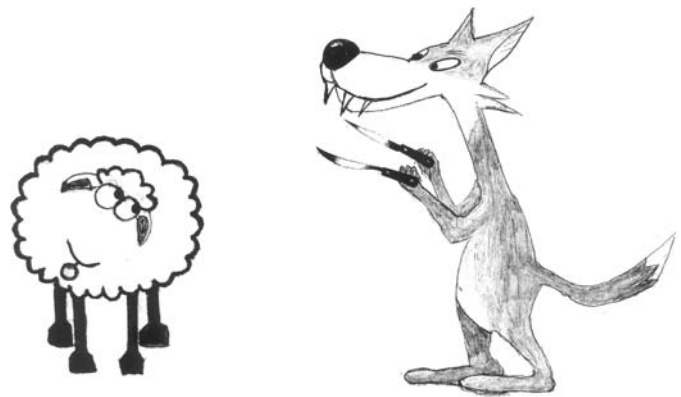
Many practicing physicians spend hours of uncompensated time battling with PPO medical directors and clerks to get patients the medications and services that they need. Many physicians—and consumers—might be shocked to learn that insurers can buy these "Dr. No" medical "necessity" reviews from a company related to some county medical associations.

Doctors need unfettered authority to make medical decisions that are best for their own patients. Consumers expect privacy, not circulation of their confidential medical records. Doctors and patients can and should have the ability to agree on the price of medical care in a transparent manner.

Who will promote these cornerstones of professionalism if business interests of some influential medical associations as well as some physician leaders conflict with these basic principles?

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**An invitation to dinner
To some is delight
But, beware conflicts of interest
Because they just might**

**Lead to betrayal and gourmet's remorse
When the guest finds out
That he's the main course**