Legal Risk Seen With Some Retainer-Fee Model Practices

BY JENNIFER SILVERMAN
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DALLAS — Of the existing "concierge" care models, practices that offer fees for noncovered services to patients who have insurance carry the highest legal risk, attorney John Marquis said at a national conference on concierge medicine.

In light of recent actions taken by Congress, state insurance commissioners, and federal agencies, it's clear that authorities are looking out for potential conflicts of interest with this particular care model, said Mr. Marquis, a partner with Warner, Norcross, & Judd, LLP, a Michigan law firm that specializes in concierge-care issues.

There are several models for concierge-care practices. Some opt out of Medicare and private insurance to offer a periodic fee for medical care. Others accept only cash for their services. What seems to attract most of the legal action is the "fee for noncovered services" or FNCS model. These practices accept patients with private insurance or Medicare but also charge a flat fee monthly, quarterly, or annually, he said at the conference, sponsored by the Society for Innovative Medical Practice Design.

Although Medicare is usually the 800-pound gorilla in these situations, now it's private insurance that poses the biggest risks to FNCS-style practices.

In return, patients are promised a smaller patient base, greater access to the physician, and other amenities. For some time, this approach has aroused speculation on whether the physician might be double billing for Medicare patients.

Exactly what the periodic fee pays for is the gray area that incites legal action, Mr. Marquis said. The fact that certain FNCS practices offer preventive care is not a complete answer to the legal issues, given that Medicare covers certain preventive-care services, he said. Home visits are another problem; in many cases, they're also a covered service under Medicare.

Although Medicare is usually the 800-pound gorilla in these situations, it's private insurers that currently pose the biggest risks to these practices.

They can tell a practice, "We don't like what you're doing—boom, you're out," Mr. Marquis said. For an FNCS-style practice counting on insurance reimbursement, "this could be devastating. I have had clients who've essentially decided to not [become a FNCS-style practice] out of fear of being terminated as a result of notifying the insurance companies of what was going on."

The rub is that insurance companies don't need any cause to terminate a plan, he said. "It's a policy business decision that they apparently make, and there's really no clear legal recourse."

Health departments and insurance commissioners pose another credible risk to FNCS practices. In 2003, New Jersey's health department found that physicians who already had contracts with HMOs were requiring HMO patients to pay an annual fee to get into their practices.

The conflict was that many services these FNCS providers were offering were already required to be included in any health insurance plan offered in the state. "The department's main objection was not duplication of service but that these practices were making patients pay" for covered medical care.

In an edict that had the force of law, New Jersey asserted that this requirement was illegal, even though the fee in these practices was limited to services clearly not covered by the health plan. "They're stating, 'We don't care if the service is covered by the health plan or not. It's illegal if you charge that "poll tax" for a patient to get into the practice,' " Mr. Marquis said.

The New York Department of Health raised similar objections, except the state found FNCS-type practices to be illegal on more than one account.

Typically, insurance contracts in the state of New York require that physicians provide 24-hour case management and coordination of necessary referrals. Furthermore, the state has determined that expedited appointments discriminate against patients who don't have the money to pay the fee, he said.

Legislative efforts at the state and federal level to thwart FNCS practices have caused some commotion but so far haven't amounted to much, Mr. Marquis said.

Several years ago, Rep. Henry Waxman (D-Calif.) targeted an FNCS practice, MDVIP, in a letter to Tommy Thompson, then secretary of the Department of Health and Human Services.

"There could be a substantial overlap between services that were covered by Medicare and for which MDVIP was asking patients to pay," Rep. Waxman wrote. Moreover, MDVIP physicians were providing Medicare services to patients but charging them a "poll tax"—"a conditional payment that says, 'Either pay me $1,500, or I will not render Medicare services to you.' "

Secretary Thompson disposed of the conditional fee argument in a one-page statement. "Under current law, physicians have some discretion regarding the patients they choose to accept. While the limiting charge provisions govern physicians' charges for Medicare-covered services, these provisions do not directly affect charges for noncovered services," according to the statement.

Insofar as the retainer fee under such an agreement is truly for noncovered services, such fees would not appear to be in violation of Medicare law, Mr. Thompson continued.

An alert issued by HHS' Office of Inspector General in 2002 reminded physicians that they could "have a problem" if they proposed services to patients in exchange for a flat fee that would otherwise be covered by Medicare. The OIG's chief counsel later clarified that the alert did not specifically take a position on concierge medicine but only addressed fees for covered services and was consistent with the position previously taken by Secretary Thompson.

"At least now we know that the Thompson letter is being enforced—that there are such things as noncovered services, and if we charge for those, that should be okay," Mr. Marquis said.

Several bills have been introduced in Congress that would prohibit physicians from charging a membership fee to a Medicare beneficiary or would forbid physicians from requiring a Medicare beneficiary to purchase a noncovered item or service as a prerequisite for receiving a covered item or service. These bills "never got out of committee," Mr. Marquis said. ■

D.C. Seeks to Cap Damages, Make Other Tort Reforms

BY JOYCE FRIEDEN
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The District of Columbia is the latest in a growing number of jurisdictions trying to combat rising malpractice insurance premiums among physicians, as legislators there battle over whether the best solution is damage caps or increased regulation of insurers.

D.C. Mayor Anthony Williams has proposed legislation that would limit noneconomic damages to $250,000 and expand the city's Good Samaritan law to provide immunity to all health professionals who provide free care.

"The District is home to some of the best medical care in the country," Mayor Williams said when he announced the bill . "This bill is all about ensuring that our residents and visitors always get top-notch care and that our medical community can practice without undue burdens."

Linda Cropp, chair of the District of Columbia City Council and a frequent political adversary of Mr. Williams, has introduced her own medical liability reform bill. Under Ms. Cropp's bill, the city's insurance commission would be required to approve all proposed liability premium increases that exceed a certain percentage, would allow the insurance commissioner to consider a malpractice insurer's current surplus as a factor in rate making, and would authorize refunds for physicians who have paid excessive insurance premiums.

Unlike Mr. Williams, Ms. Cropp said she believed that tort reform wasn't the answer. "The problem is the high [cost] of insurance," she said in a statement. "Payments to patients who sue doctors in the District have declined dramatically, even as doctors and politicians have blamed skyrocketing jury awards for driving up the cost of malpractice insurance and driving doctors out of business."

Ms. Cropp cited a recent analysis by the consumer watchdog group Public Citizen to back up her contention. That analysis found that insurer payouts in the city, when factored for inflation, dropped from $29 million in 2001 to $11 million in 2004, a reduction of more than 62%.

"Did the malpractice insurance rates paid by doctors drop commensurately?" Ms. Cropp said. "No, they did not."

But Victor G. Freeman, M.D., president of the Medical Society of the District of Columbia, disagreed with Ms. Cropp's approach. "Linda Cropp's heart is in the right place," Dr. Freeman, an internist, said in an interview. "She recognizes there is a crisis, and her solution is to make sure there is tighter regulation around medical liability rates in town. Unfortunately, I think she's been misled by Public Citizen and the trial lawyers, because she believes medical liability companies are making huge profits in the city at the expense of physicians."

Dr. Freeman suggested that Ms. Cropp might want to consider that NCRIC (formerly the National Capital Reciprocal Insurance Co.), the liability insurer for 80% of the District's physicians, lost $7 million last year. "If NCRIC wasn't losing money, other companies would come in and compete. They're staying out for one very clear reason: It's bad business to come into the District because of the high jury awards."

The Public Citizen study that Ms. Cropp referred to is one of several studies on malpractice insurance that recently have been published. A study of 27 states appearing in the online version of the journal Health Affairs found that counties in states that had a cap on noneconomic damages had 2.2% more physicians per capita than counties in states without a cap (Health Aff. [Millwood] May 2005:[Epub ahead of print]). The study, which used data from the years 1985-2000, also found that rural counties in states with a $250,000 cap had 5.4% more ob.gyns. and 5.5% more surgical specialists per capita than did rural counties in states with a cap above $250,000.

Health Affairs also published an online study showing that malpractice payouts appear to be growing more slowly than previously thought (Health Aff. [Millwood] May 2005;[Epub ahead of print]). Using data from the National Practitioner Data Bank, Amitabh Chandra, Ph.D., of Dartmouth University, Hanover, N.H., and colleagues found that the average payment—including both settlements and judgments at trial—grew by 4% per year between 1991 and 2003, consistent with increases in other health care costs.

Finally, another recent study found that the adoption of "direct" malpractice reforms—including reducing damage caps—resulted in a 3.3% increase in physician supply.

"In our study, the estimated effect of direct reforms was greater among physicians who practice in nongroup settings," wrote Daniel P. Kessler, Ph.D., of Stanford (Calif.) University, and colleagues (JAMA 2005;293:2618-25). ■