

Rental Networks (Some of Which Are “Silent PPOs”)

A Hidden Link of Managed Care

By Susan R. Hansen, M.D.

Have you ever wondered how health plans determine whether or not health care is “medically necessary,” or how insurers determine your “contracted” fee or “allowed expense”? If you are curious, read further.

It is advantageous for employers to pay their employees’ benefits, rather than wages, because benefits are not taxed. When an employer gives a \$1 raise in wages, the employer pays about 10 cents extra in payroll taxes (e.g., Social Security, Medicare, et cetera). When an employer raises healthcare benefits by \$1, the employer pays only \$1.

Employers may find it doubly advantageous to have self-funded health plans because they can put the money they would otherwise be paying for their employees’ health insurance premiums to work as investments and sometimes turn a profit. This money may be in the “bank” earning interest, to the extent that the employer avoids spending it on healthcare.

Employers often hire an Administrative Service Organization, such as Blue Cross or UnitedHealth, to collect employee premiums and pay healthcare bills. The employer and the ASO have both financial incentives and fiduciary obligations to be frugal with healthcare premium dollars. Notwithstanding ethical considerations, neither has a professional duty to patients. A sick employee (or family member) will be a financial liability to the employer.

Physicians have special knowledge and skills that we impart to our patients through a covenant of trust. Our professional ethics prohibit us from working for anyone other than our patients in most circumstances. Company doctors used to be legal. For instance, during the Great Depression, some coal mining companies hired physicians, and those who did not send infirm workers back into the mines risked dismissal. Compelling physicians to work for any employer did not work out well in the public’s eye. Now employers cannot readily hire physicians because laws prohibit (bar) the Corporate Practice of Medicine.

There is, however, a way to circumvent the intent of the Bar on the Corporate Practice of Medicine. Rental Networks (related to some insurers, medical associations and societies, hospitals, foundations, IPAs, PPOs, “Silent PPOs,” et cetera) contract with physicians who agree to discount their fees in return for steerage of patients. Rental Networks also contract with physicians who agree

Rental Networks (cont'd)

to practice medicine according to formulas that determine what services are “medically necessary.” The burden of proof is thereby shifted to the treating physician who must convince the Rental Network that the care prescribed is “appropriate” (whatever that means).

Rental Networks then market aspects of the contract they have negotiated with a physician. Rental Networks convert their contract with the physician into an essentially separate *second contract* whereby the **Rental Network is paid by the employer or insurer** to provide “access” to the physician’s Negotiated Fee Rate (typically 120 percent Medicare or less) *and* to provide “access” to the physician’s agreement to adhere to “medical necessity” guidelines. In this way the employer or health plan only pays for “medically necessary” care, and often at deeply discounted rates. The steeper the discount and/or the more restrictive the “medical necessity” guidelines, the more money saved by the health plan, and the higher the “access” fees the Rental Network is able to demand. (The InterQual Criteria, one popular guideline, requires a blood sugar of 800 mg/dl for a diabetic patient to “meet criteria” for hospitalization.)

The going rate to “rent a doc” is about \$4 to \$20 per employee per month or 10 percent of the physician’s fee, some of which pays Rental Network executives and consultants who perform “medical necessity” reviews. The going rate for a “medical necessity” review is about \$75 to \$200 per review. Please note that no matter what the rhetoric, a Rental Network’s paying clients are employers/insurers and *not* patients or physicians. Physicians are transformed into fungible commodities that can be rented, sold, leased, assigned, transferred, or conveyed. At the extreme, a physician’s obligations (and contracted payment rates) may be determined at the end of a devious and dishonest chain of contracts in which one of the links (sometimes the first link) had no authority to bind the physician (better known as a “Silent PPO”).

If a handful of local physicians agree to adhere to “medical necessity” guidelines, even patients who seek care from nonparticipating physicians may be affected because the health plan’s contract with enrollees arguably limits coverage to “medically necessary” care as defined in the separate contract with a few physicians. “Medical necessity” determinations may function simply as a cost containment mechanism. Patients are harmed when medically inappropriate decisions result from defects in the design or implementation of such cost containment programs. Economically or emotionally strained patients may not battle a health plan behemoth—or their own employer—in order to secure pre-authorization or retrospective payment for “medically necessary” services. It is a good economic “gamble” for payers to stall authorization or payment as long as possible.

Rental Networks (cont'd)

Physicians may wish to assert what should be obvious. A physician whom a patient trusts and who is privileged and authorized by society to lay hands on the sick should determine what is “medically necessary,” a decision based on that physician’s education, experience and examination of the patient. The determination of “medical necessity” is the heart and soul of our profession, a privilege that cannot and should not be rented, bought or sold by Rental Networks.

How Rental Networks Propagate

It seems implausible that a physician would give a Rental Network veto power over his/her medical decisions. Physicians often do not realize that they have done so. The very existence of Rental Networks may even be hard to ascertain, so physicians may not know when they “participate” in one. It is akin to tracking down the source of e-mail spam and equally difficult to extricate an unwilling participant. It is also big business. Some Rental Networks claim almost 450,000 “participating” physicians nationwide.

Some Rental Networks are owned, operated or connected in some way to insurance companies (e.g., Blue Cross, Blue Shield, ChoiceCare and Private Healthcare Systems networks). Physicians who participate with these entities may not realize that they have agreed to adhere to “medical necessity” guidelines (and to accept discounted fees) even when they do not contract directly with a patient’s insurance company. For instance, a physician contracted with Blue Shield might be rented to UnitedHealth. In some instances, the Rental Network’s emblem is located on the enrollee’s insurance card and may be the only clue for a physician to identify his/her “participation” status.

Some medical groups/IPAs (or their management companies) may “contract” with Rental Networks on behalf of their physicians. Even if a physician’s group dissolved years ago, “evergreen contracts” may tie a physician to Rental Networks that claim to have “access” to contracts that require the physician to follow “medical necessity” guidelines (and, again, to accept discounted fees). These group “contracts” may be difficult to locate because physicians who demand production of any contract may be instructed by the Rental Network to obtain such documents from their (defunct) medical group. Indeed, “Silent PPOs” can be characterized as networks that buy, sell, or take (not rent) “access” to physicians with whom they do not have a direct contract. These are particularly difficult to trace.¹

¹ Silent PPOs are potentially illegal and indisputably are an issue for physicians. Even those “silent PPOs” that are legal warrant attention, as a matter of policy and fairness. Dr. Hansen certainly makes those points quite clearly. Physicians also should know that there are legal

Rental Networks (cont'd)

Other Rental Networks are related to some county medical associations. For information about the Rental Network related to organized medicine in California (California Foundation for Medical Care or CFMC), see www.cfmnet.org. This site identifies the physicians who belong to this large Rental Network (about 33,000 physicians), and it also posts a sample contract between this Rental Network and hundreds of Clients/Payers whereby physicians are rented to them, covering about 1.1 million employees, for about \$1 to \$4 per employee per month.

Many physicians may be surprised to learn that some county medical associations have the potential to make money by renting out “their” physicians. In 2004, Jack Lewin, M.D., CEO/EVP of the California Medical Association, acknowledged this practice: “... *Many counties still make ... non-dues revenues stream out of their foundations, and pay their MEC Exec (Directors) with such funds in large part...*”

Some respected physician leaders defend organized medicine’s involvement in Rental Networks. For instance, in a 2005 letter to the CMA Board of Trustees Dr. Lewin opined, “... *the foundations offer their members **who sign up** contractual relationships that pay ... at a higher rate than they would otherwise receive directly from health plan contracts...*” He further added that CFMC revenues also benefit members of some county medical associations “... *by reducing dues obligations to fund county activities.*” As such, he denies that these foundations represent “silent PPOs” because “*participating members benefit directly,*” and denies that the “*county societies engaged in foundation networks ... in any way (are) working against the best interests of their members in terms of their CFMC contracts.*”

Nevertheless, other ardent physician supporters of organized medicine believe that this revenue stream, which is dependent on serving the needs of payers as customers, is fundamentally flawed.

Right now it is virtually impossible for physicians to untangle the web of purported contracts that bind them to Rental Networks. Some think that physicians will not be able to extricate our profession from the subterranean Rental Network morass until our leaders eschew their own involvement. Physician leaders (after a frank and thorough disclosure of any conflicts of interest) may wish to consider this question:

protections (Business & Prof. C. 511.3, Health & Safety C. [Knox-Keene] 1375.7, Ins. C. 10178.4, Labor C. 4610) stating that the rights and obligations of the provider shall be governed by the underlying contract between the provider and contracting agent. Enforcing this rule obviously is a problem. CMA ON-CALL document #1907 is a worthwhile reference on “silent PPOs.” David E. Willett, CSA Legal Counsel.

Rental Networks (cont'd)

Are physicians fungible commodities whose personal service contracts can be transferred by brokers who profit by collecting “access” fees from the broker’s payer clients?

How Can Physicians Identify a Connection to a Rental Network?

In order to determine whether you are connected to a Rental Network, look at some Explanations of Benefits for “Network Provider” and “Foundation Physician” (the Rental Network related to CMA). See Figure 1. If you “participate,” you will find a “Y” (for yes). If you “participate,” the **allowed expense** will be the fee that you (or your group) agreed to accept for “**medically necessary**” care. If you are “nonparticipating,” then the **allowed expense** will be less than that which participating physicians receive.

SELF-FUNDED EMPLOYER'S NAME	
EXPLANATION OF BENEFITS	
ISSUE DATE:	
Provider ID: (your TIN or Social Security #)	
<u>NETWORK PROVIDER:</u>	<u>Y</u>
<u>FOUNDATION PHYSICIAN:</u>	<u>Y</u>
Patient Name: Claim ID: SERVICE DATE(S)	 California M.D.s, see cfmcnet.org for more information
MESSAGES:	
01 – This is the amount in excess of the <u>allowed expense</u> for a <u>participating</u> provider.	
ADMINISTERED BY: BIG INSURANCE COMPANY X	

Figure 1.

Rental Networks (cont'd)

A Race to the Bottom

Rental Networks not only market discounted “medical necessity” determinations, but also market discounted physician fees. The “allowed expense” may determine third party reimbursement even for physicians who do not participate in a Rental Network.

Consider this rough analogy. A restaurant owner gives John a few “Dinner for \$1” coupons to distribute in order to fill empty tables on slow nights. John copies the coupons and sells these duplicates to Tom, Dick, and Harry for \$2/coupon (and doesn't mention these “access” fees he earns to the restaurant owner)—a “Rental Network.” George makes copycat coupons and sells them for \$2/coupon—a “Silent PPO.” Before long, every customer who comes to the restaurant has a coupon.

Sam acquires a coupon, eats dinner at a different restaurant, and retrospectively tries to renegotiate the \$15 tab, claiming that “Dinner for \$1” means the bargain is good at any restaurant in town. This analogy describes a “nonparticipating” physician's predicament when an administrator “reprices” physician claims for payment on behalf of payers.

There is a fundamental difference between restaurant bills and healthcare costs. Healthcare costs are prepaid. Consequently, hidden administrative costs such as “access” fees earned by renting-out physicians come from the healthcare premium dollar collected in advance. A select few who do not treat patients have figured out a way to make money by processing claims for physician payment.

According to the April 19, 2006 *Wall Street Journal*, UnitedHealth's story

... shows how an elite group of companies is getting rich from the nation's fraying health-care system. ... They're middlemen who process the paperwork ... and otherwise connect the pieces of a \$2 trillion industry. ... UnitedHealth's main business is offering health plans to employers and Medicare beneficiaries. Bigger employers usually pay employees' medical bills out of their own coffers and hire UnitedHealth to administer the health benefits. ...

The WSJ observed that, “*The middlemen credit themselves with keeping the system humming and restraining costs*” and noted that UnitedHealth's CEO, Dr. William McGuire (a pulmonologist), “*draws \$8 million a year in salary plus bonus*” and has unrealized gains of \$1.6 billion in stock options. Some believe that such rewards come at the expense of physicians who are treated like indentured servants by middlemen who fix physician fees and then market these discounts.

Rental Networks (cont'd)

In 1982, the Arizona attorney general (supported by 40 other state attorneys general) litigated a scheme similar to today's Rental Networks (*Arizona v. Maricopa County Medical Society*). The members of foundations for medical care organized by two medical societies agreed to establish maximum fees the doctors would claim as full payment for health services provided to policyholders of specified insurance plans.²

The U. S. Supreme Court held:

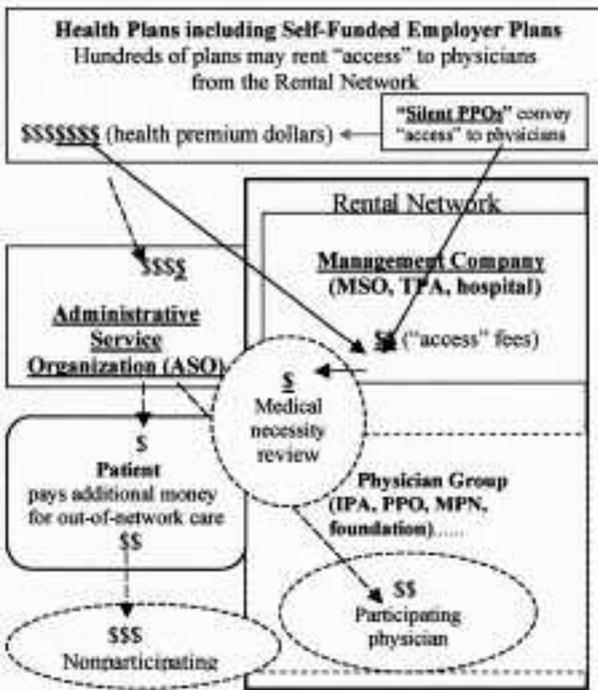
The maximum-fee agreements, as price-fixing agreements, are per se unlawful under 1 of the Sherman Act. ... Horizontal agreements to fix maximum prices are on the same legal—even if not economic—footing as agreements to fix minimum or uniform prices. ... The per se rule is violated here by a price restraint that tends to provide the same economic rewards to all practitioners regardless of their skill, experience, training, or willingness to employ innovative and difficult procedures in individual cases. Such a restraint may also discourage entry into the market and may deter experimentation and new developments by individual entrepreneurs.

Rental Networks (see Figure 2 on the following page) currently seem to have been able to escape the force and effect of this court decision as well as fee-splitting and “capping” laws (splitting a fee with someone other than a physician). Physician payment is diminished in a manner that many consider confiscatory, unconscionable and unconstitutional.

In summary, in my opinion, Rental Networks offer a “medical necessity” vehicle that can be used to the detriment of quality of care for patients, and these same networks also potentially serve as a stealth mechanism to discount deeply physician fees. Ultimately, patients are harmed when derisory compensation drives physicians who provide better-than-average care out of business. Physicians must demand abolition of “access” fees that permit promulgation of Rental Networks by giving middlemen the incentive to rent physicians out.

² This decision did not outlaw Foundation fee schedules. Rather, it simply said that it is not necessary for physicians—the competitors—to develop them. The Foundations assert that the fee schedules utilized in their contracts are developed by others. David E. Willett, CSA Legal Counsel.

Figure 2. An Organizational Diagram of Rental Networks



Legend

- MSO, TPA: Medical Service Organization, Third Party Administrator
- IPA, PPO, MPN: Independent Practice Association, Preferred Provider Organization, Medical Provider Network
- \$: professional expenses accounted for on EOBs or paid by the patient/enrollee
- \$\$: administrative expenses not accounted for on EOBs
- Dashed lines: physician(s)

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