

Physicians drop health insurers

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A small but growing number of physicians, fed up with declining reimbursement rates and managed care hassles, are starting to selectively contract with commercial insurers, continuing with some and dropping others.

Published March 2003

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Anecdotal evidence from across the state shows that the selective contracting is too fragmented to be called a trend. Nevertheless, the fact that it is occurring at all signals a significant step in the evolution of managed care in Pennsylvania.

A number of physicians, particularly in the Philadelphia area, are taking matters into their own hands, venturing forward with new business models such as fee-for-service payments from patients and up-front "access fees" to buy a doctor's undivided attention.

These are among the more concrete signs of the state's shift over the last 10 years from tightly controlled managed care to a more relaxed environment. They join other indicators that have occurred in recent years, including the move to PPOs, point-of-service plans and open-access HMOs.

Recent examples of physicians proactively deciding with whom they would or would not do business include:

- Clinical Care Associates, a nonprofit subsidiary of the University of Pennsylvania Health System in Philadelphia, recently began two specialty practices, one of which does not participate with any insurance

companies and the other which participates only with Medicare. While the two specialty practices are staffed by one doctor each, CCA is the largest primary care network in the five-county Philadelphia region.

- In the west, UPMC Health System decided in August 2001 to stop participating with Aetna. UPMC officials said they ended their relationship with Aetna because of low and late reimbursements as well as numerous denials of care.

- **Martin Bergman M.D.**, a rheumatologist in Ridley Park, Delaware County, ended his participation with Independence Blue Cross last Nov. 1. IBC patients represented about 70 percent of his practice, but Bergman said he took the step when he realized IBC was reimbursing him about 65 percent of the Medicare rate for his office visits.

- **Robert Weiss M.D.**, a Philadelphia-based primary care physician, formed Total Access Medical Inc. with six other investors to help doctors start "boutique" practices. Weiss still accepts most insurance but in addition now charges patients \$2,000 annually for round-the-clock access. The size of his practice dropped from about 2,800 patients to 300.

Sherry Migliore, director of consulting for PMSCO Healthcare Consulting, a division of the Pennsylvania Medical Society, said that while it's rare in Pennsylvania for a physician to drop a major insurer altogether, she does see selective contracting.

"I don't know of a lot of physicians who have wholesale dropped out of everything. It's a pretty bold step. I don't have any clients who do that now, but I do have many who pick and choose who they will participate with," she said.

Multiple Reasons for Change

Interviews with physicians and analysts across the state pinpoint several factors behind the changes.

For starters, the state's malpractice crisis has clearly tipped the scales for many physicians. With rates continuing to skyrocket and no immediate remedy in sight, a number of doctors said they simply could not afford to continue accepting reimbursements from

commercial insurers and Medicare that did not cover or come close to their costs.

Second, Medicare reimbursements continue to decline. Because commercial insurance rates generally follow, doctors have - and will continue to face - a double-whammy on their practice revenue levels. In addition, Medicare's physician payments are projected to fall by 12 percent over the next three years, spurring some physicians to consider limiting the number of Medicare patients they treat.

It is not immediately apparent why more physicians in southeast Pennsylvania, compared with the rest of the state, appear to be bucking the dominance of managed care insurers. Perhaps one reason, some analysts speculate, is that commercial insurers tend to reimburse *below* Medicare levels in the eastern part of the state, thereby giving physicians more of an impetus to go it alone. In central and western Pennsylvania, many observers say, commercial insurers tend to still pay 105 to 110 percent of Medicare.

Finally, some physicians have reached their limits on working 15-hour days, making their patients wait for appointments, and fighting to collect payment from some insurers. For doctors who can't or don't want to retire, cutting the size of their practice by opting out of an insurance plan is one way to improve their quality of care and life.

"Physicians today feel like they're spending 100 percent of their time seeing patients and they're exhausted when they finish the day," said Ralph Biddle, president of Philadelphia-based Medical Program Development Inc., a Philadelphia consulting firm that helps physicians determine if they can downsize and rearrange the payer mix of their practices.

"They're getting 50 to 60 percent of their value back from the payers. And now comes the kicker, they pay 30 percent of *that* for a staff of billing people to collect the money from the payers. There isn't a business in this country that would do that," said Biddle.

Doing the Math

But opting out of an insurer's plan - particularly one of the Pennsylvania Blues plans - is not a decision that any practitioner makes on a whim.

The numbers speak for themselves, according to Pennsylvania Medical Society figures: Independence Blue Cross holds 76 percent of the commercial market in the five-county Philadelphia area. Capital Blue Cross holds 58.2 percent of the 21 counties of Central Pennsylvania; Highmark Blue Cross Blue Shield maintains about a 65 percent market share in the 29-county western Pennsylvania region; and Northeast Blue Cross has about 63 percent in northeastern Pennsylvania's 12 counties.

Bergman, a Ridley Park rheumatologist, said his decision to drop Independence Blue Cross "was not an easy choice or something that I did lightly."

"But when I realized that IBC's average payment (for an office visit) was about 65 percent of Medicare, I realized that I could see one-third fewer patients and be just as well off and not be running along like a maniac," the 48-year-old solo practitioner said.

"I looked at my practice, did the math and realized that I couldn't live with the two-for-one sale, so I decided to jump. ... I was too busy for my own health and my patients' health," he added.

The move cuts his patient load from about 1,000 to 500. It also cut patients' waiting time for an appointment to one week from eight to 12 weeks before.

Now, about 20 percent of Bergman's patients are insured by IBC, but they pay out-of-pocket for his services.

Bergman said his fee schedule is "not that much higher than Medicare," and that his staff will still bill Independence Blue on patients' behalf.

Medicare patients make up about one-third of his practice and the remaining 50 percent are patients covered by other insurers, such as Cigna.

Incredibly, Bergman said he needs to achieve only 70 percent of his former practice's size to maintain about the same revenue levels as he had before.

But he added that continued referrals from his colleagues are critical for his business model to work. "I still depend upon their goodwill," he added.

Bergman said he has no regrets and that he believes that while most physicians think such a move is impossible to make, they might be surprised if they did the math.

"People out here think I'm crazy. 'How can you do it? It's IBC,' they ask. My answer is 'because I can do it.' But I can't tell anyone how to run his or her practice. Everyone has to look at their own numbers to see what's right for them," Bergman said.

Really Going Solo

For Clinical Care Associates, the numbers weren't adding up either.

The large primary care practice, which handles about 900,000 patient visits annually, wanted to begin rheumatology and addiction medicine specialty practices.

For the rheumatology practice, "we felt that reimbursement and expenses in that subspecialty practice precluded us from having a practice that was financially viable," said **Ronald Barg M.D.**, CCA's senior medical director.

"Based on that, we felt we had to not accept inadequate reimbursement levels. The fact that we had an established rheumatologist with a patient following gives us the ability to do that - it would be a different strategy for someone not in that position," Barg said.

The practice opened in Bala Cynwyd last Oct. 1 with one physician. It accepts only Medicare reimbursement, "which we wouldn't say is adequate, but in this market, Medicare is the top of the list because third-party payers in general pay a level significantly less than Medicare," Barg said.

CCA's addiction medicine practice, which opened Jan. 1 in Ardmore, does not accept any type of commercial or government insurance.

Barg said addiction services are "particularly

amenable to the fee-for-service structure" because there are many people who would like more personalized, private behavioral health services.

The practice uses a straight fee-for-service billing schedule.

In addition, CCA is planning on launching five "boutique" primary care practices that will require an annual "access" fee, but will accept some insurance plans. Those practices, the first of which should be opened by July, would service a limited number of patients so the physicians' services could be more personalized.

Barg said he cannot predict whether the two established practices - or the boutique practices - will be successful.

But he said that it is hoped they will be somewhat profitable so that they can, in effect, subsidize other parts of the University of Pennsylvania Health System that are not profitable, such as providing indigent care.

He added that such practices - the boutiques and the two that don't accept commercial insurance - "are never going to become the major thrust of a large, nonprofit health system."

"Clearly, it's not in our business plan to disenroll most of our network. Our overall mission is not to make money but to deliver quality care and to participate in graduate and undergraduate education. The dilemma here is to do that in a financially viable fashion," Barg said.

Investing in Change

For Weiss, a Philadelphia primary care physician, neither his workload nor the business side of his practice was very viable.

"I was seeing 30 to 40 patients a day, was on call every third night and every other weekend. I had 14-hour days and on weekends was catching up. I was seeing so many patients that I reached a point where I realized that if I continued in that manner, there will be a quality issue," said the 61-year-old physician.

So after talking with other physicians, some patients and friends, Weiss and six business partners formed a company called Total Access Medical. Three of the investors, including Weiss, are physicians and the remaining four are Philadelphia businessmen.

As of Nov. 1, Weiss, through Total Access Medical, began charging all of his patients \$2,000 annually. He continues to accept most major insurance except for Medicare - a move he made due to strict Medicare regulations that prohibit the practice of "balanced billing," meaning billing patients directly for what Medicare doesn't reimburse.

Weiss said Total Access Medical's lawyers felt that the federal government might construe the \$2,000 access fee as balanced billing if Weiss also requested Medicare reimbursement for services delivered to Medicare patients.

Thus, the practice's Medicare patients pay the \$2,000 fee only and Weiss does not bill Medicare for services he delivers to them.

His practice, which is the pilot practice in Total Access Medical's business plan, has gone from treating about 2,800 patients to 300, but he expects to ultimately have 600 patients.

For their \$2,000, patients have "access to me 24/7 - house calls, meeting patients in the emergency room, access by phone or cell phone," Weiss said.

"I am totally involved with patient care and I'm able to follow up carefully," he said, adding that he is on call 24 hours a day.

But Total Access Medical handles all business functions of Weiss's practice, including advertising it, signing leases, as well as guaranteeing a salary. It's the salary guarantee as well as the other back-office functions that Total Access performs that have allowed Weiss to maintain his income level despite the loss of patients.

"There is enough money in this model that the stress of being on call all the time will be compensated by increased income. You have a better quality of life, you're satisfied on a professional basis with how you deliver care, and you're financially compensated

better than you've ever been," he said.

But several physicians, including Weiss, said they don't expect boutique medicine to become the norm of care, simply because it's out of the range of many patients' finances.

"I think it's in a relatively early stage and something that's being discussed widely and that will happen. But it's never going to become the dominant player," Barg said.

"The reality is that the majority of people don't have the discretionary money to afford this style of care, so I don't think there's a concern that people will be priced out of the market.

"I think this will be a small, tiny fringe that represents one to two percent of health care delivery," Barg added.

A How-to Primer

Somewhat ironically, it is today's preferred provider organization that gives doctors the ability to drop an insurer - and still allows patients to get reimbursed, albeit at lower levels, for some services from that insurer.

With PPOs being the fastest growing insurance product in the nation, it raises the question whether more doctors will become increasingly proactive in selective contracting - knowing that their patients can still receive reimbursement from an insurer with whom their doctor does not contract.

"The dentists have had this right for years," Biddle said.

"You go to the dentist and they'll tell you: 'We don't process insurance payments. We'll be happy to give you a signed treatment form. The insurer may or may not pay you, but we expect a check when you walk out the door,'" he said.

Biddle said he counsels his physician clients on a number of issues to help them decide whether canceling a contract with a major insurer is the right decision for them.

He said a surprisingly large number of doctors have no cost-accounting method in their practices, meaning they have no idea how much it costs to deliver care to a Highmark patient, for example.

For starters, doctors have to decipher how much they spend to deliver care.

"A physician needs to ask: If I do procedures in the office, what was my cost of goods for these patients, what were my labor costs to clinically treat these patients and what were my labors costs to recover the money," Biddle said.

"A physician has to have this information before he can make an informed decision to change some of the things he's doing," he added.

Once those basic costs and revenues are known, the physician needs to determine which procedures he or she can continue doing at what cost.

And to opt out of a major insurer's contract successfully, a doctor has to do a much better job marketing to patients he has and doesn't have and he has to pay "a whole lot more attention to the satisfaction levels of patients," Biddle said.

Western Pa. Climate

But as some physicians in the east are actually setting up boutique practices and dropping out of major insurance plans, doctors in western Pennsylvania seem to still be debating their options.

"I talk with a lot of practice managers of larger practices in the area and we may say in the hallway 'gee, wouldn't we like to (drop out of an insurer's plan)', but nobody even seriously considers it," said Lisa Simonton, executive director of Renal Endocrine Associates, a 12-physician practice in Bloomfield, Allegheny County.

"There may be a few practices who have, but I don't know who they are. It certainly seems as though there's no major move in this part of the state" to cancel contracts with insurers, said Ms. Simonton, who also chairs the practice manager section of the Allegheny County Medical Society.

Lee McCormick M.D., a primary care doctor in Brentwood, Allegheny County, agreed.

"Western Pennsylvania is not quite as competitive (as Philadelphia), at least among physicians, so we all have tended to go along with the flow," said McCormick, a past president of the Pennsylvania Medical Society.

UPMC Health Plan's decision in 2001 to cancel its contract with Aetna remains the most visible case of selective contracting in the western part of the state.

As the dominant provider system, UPMC has about 1,300 physicians in its University of Pittsburgh Physicians subsidiary and another 380 doctors in its Community Medicine Inc. unit.

While Aetna insured about only about one percent of UPMC's patients, "I think it was a very difficult decision for the system" because it was so sweeping, encompassing all the system's hospitals, physicians and its Monroeville surgery center, said Alan Green, executive director and chief administrative officer of UPMC Community Medicine Inc.

Perhaps one reason that western Pennsylvania doctors continue to contract with most of the big insurers is because those insurers - Highmark, HealthAmerica, UPMC Health Plan and Aetna - generally tend to reimburse better than Medicare for some procedures.

But Medicare remains a wild card in the reimbursement picture. Under current law, Medicare's physician payment rates are to drop by 12 percent over the next three years, amounting to about \$17,396 in reimbursement losses per physician in Pennsylvania, according to the American Medical Association.

That comes on top of a 5.4 percent payment cut in 2002.

Nevertheless, while a recent AMA national survey showed that about half of physicians said they will limit the number of Medicare patients they treat in 2003, the outlook in Pennsylvania remains unclear.

"Medicare is now the driving force and it's become the gold standard," Green said.

"In Western Pennsylvania, it is not a small portion of anybody's business. With the economics of today's environment, (dropping out of Medicare) would be committing suicide," Green said.

Northeast and Central Pennsylvania

The climate in the central and northeastern parts of the state is somewhat different, analysts contend, because while the Blues still dominate each region, other insurers have a chunk of the market, too.

In central Pennsylvania, for example, Capital Blue Cross has a 58 percent market share, while HealthAmerica holds 15 percent and Highmark almost eight percent.

"In central Pennsylvania, it's pretty much on equal footing. You have Capital Blue Cross and Capital Blue Shield, HealthAmerica and Aetna U.S. Healthcare," said PMSCO's Migliore.

"It's much more competitive in this area and physicians have more options to walk away because they're not so married to one large payer," she said.

In Northeastern Pennsylvania, Northeast Blue Cross commands 63.4 percent of the market and Geisinger holds almost 20 percent.

But no matter what the market share, today's market forces are pushing physicians to think about whether they can do business at reimbursement levels where they now stand.

Greg Kile, executive director of the Lehigh Valley Physician Hospital Organization, said he's heard over the past year "that there's more sensitivity around" reimbursement rates than previously.

"There's more so than I've heard in the past. Malpractice is driving that and I am beginning to hear physician pushing back on some of those rates," he said.

"I think some of that may exist in the Lehigh Valley, primarily around specialty areas where you don't have an adequate number of physicians. Supply and demand comes into play," Kile said.

He said one large neurology group a few years ago canceled its contract with Aetna and "didn't necessarily suffer from it."

"Through the 1990s, the dynamics of the market have changed. With the Blues splitting, there's a great deal more competition in the Valley compared with the 90s," Kile added.

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