Legal Expert Highlights Concierge-Care Risks

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DALLAS — Of the existing "concierge-care" models, practices that offer fees for non-covered 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 non-covered 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.

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, it's private insurers that 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. "I have had clients who've essentially decided to not [become an 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. "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 non-covered 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 non-covered 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 non-covered item or service as a prerequisite for receiving a covered item or service. These bills "never got out of committee," Mr. Marquis said.

A bill in Massachusetts a few years back stated that any preferred-provider arrangement would have to contain a provision barring physicians from charging an access fee to a covered person. Although it did not go anywhere, such legislation would deal a "devastating blow" to FNCS practices if it were ever approved, he said. ■

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