TO LEAVE OR NOT TO LEAVE

I have been in private practice since 1993 and had my fair share of experience with managed care companies. In the initial years, we enjoyed a straightforward relationship with companies and their HR departments. They appointed us as part of their panel of doctors, we billed them and they called us if there were any difficult situations pertaining to their employees or our bills. They understood the boundaries on confidentiality clearly and were often very helpful when their employees were very ill.

A SHIFT IN MODEL

Things started to change when the trade unions sent a delegation to the US to look at managed care and their Health Maintenance Organizations. They came back with lots of observations and ideas about how managed care would help to control escalating healthcare costs.

In 1994, the National Trades Union Congress (NTUC) started a managed care scheme which was parked under their insurance arm. The idea was novel at that time; GPs would be paid a fixed sum monthly (capitation) for each member regardless of whether the patient showed up or not and the pooled amount would be used to treat those who turned up sick. For those with chronic diseases, the amount payable per member would be increased.

It would have worked out well, provided each clinic had a sizeable pool of patients. Unfortunately, in order to be fair, they opened the scheme to all GPs in Singapore and the pool of patients per GP was very low. Those GPs with very few patients in their pool would end up with losses if unfortunately a couple of the patients were sick very often.

Concurrently, with the arrival of managed care, other insurance companies were alarmed that NTUC Income had entered this arena. In the insurance business, the hospitalisation and surgery (H & S) insurance was the big ticket item. If there were few claims in a year, the risk taken by the insurance company could end up with a sizeable amount of returns. NTUC's entry into outpatient care was seen by other insurance firms as a threat to their business and so ICS insurance (or AVIVA, as it is known today) and AIA took the plunge. The start of managed care schemes or corporate outpatient insurance was seen as a way to retain a slice of the lucrative H & S pie. Very often, the mentality of the schemes was that of a loss leader to attract corporate customers to sign up for the total package.

Several of our classmates who are GPs also got together to form a managed care company in order to compete against other groupings

and today, that company is MHC Healthcare. A look at their website's home page shows that the company has now linked up 1,550 clinics in both Singapore and Malaysia.

Throughout the years, we saw how the managed care landscape has evolved. The schemes got bigger through recruitment of more GPs, while each GP saw their share of private patients eroded by managed care patients. Individual GPs or groups of GPs saw their corporate contracts taken away by the managed care companies or third party administrators (TPAs). Competition among the TPAs intensified and the conditions under which the GPs operated grew onerous and somewhat oppressive.

GROWING CONCERNS

SMA received complaints from members that the healthcare contracts were onerous and asymmetrical in favour of the TPAs. In 2009, SMA formed a workgroup to look at the contracts that these companies signed with the GPs. We had the help of our legal advisors who vetted the contracts and we eventually published an advisory on managed care contracts (https://goo.gl/J0ELPp).

We found that TPAs erected a wall between the patients, GPs and employers. The GP could not refuse to see the patient and the patient-doctor confidentiality was eroded by the contracts as information was released to the TPAs for purposes of audit, statistic and disputes. The TPAs could also decide on what is "not medically necessary".

The TPAs could also direct the referral of the GP to whichever specialist they had struck a deal with. Payments to GPs were also arbitrarily delayed and in many situations, decided by the TPA. The most prevalent practice was to only pay the GP when the employer has paid the TPA. The fee structures were opaque; there were markups on the GP's bills to the employer on top of administrative fees charged to the GP. There were built-in mechanisms to cap and constraint the GP's fees. Claim submissions were difficult with deadlines imposed and late claims were dismissed and unpaid. Liabilities were imposed on GPs, with the doctors indemnifying the TPAs against disputes and claims. Very often, the risk was also taken by the GP where in the case that an employer goes bankrupt, the TPA will not pay the GP his fees.

When I chaired the workgroup in 2009, I had already terminated my relationships with TPAs a few years earlier. I recall a conversation with my accountant when I was seeing patients belonging to a TPA and the volume was approximately 200 patients a month. When my accountant informed me that I was subsidising the TPA, I promptly gave notice and terminated my contract with the TPA. The patients who were seeing me created an uproar with the TPA and the CEO of the TPA called me to get me to reinstate my contract. I told him that I was subsidising him and that if he did not change the terms of the contract, I will not reinstate. Needless to say, he never called me back.

I remember that I did not miss the cash flow as the TPA was taking a long time to pay me. It did, however, free up a lot of time for me to spend on my private patients and I was glad to have terminated my relationship with the TPA. Today, I still retain a few of my direct corporate contracts that have been working with me since 1993. These companies continue to value our relationship over the decades and see no need to put a TPA between us.

CONCLUDING WORDS

So the message is found in the following questions you have to ask yourself:

- How important is the TPA contract to your practice?
- What does it mean in terms of revenue and expenses?
- Would the loss of revenue be compensated by freeing up resources and time to service private patients?
- Are there alternatives to this contract?
- Is the practice of medicine under the constraints of this contract what you want for the patient?

I hope you will seriously think about the issues, think strategically, take a brave step, bite the bullet and do what is right. ◆

PROFILE

TEXT BY

DR CHONG YEH WOEI

Dr Chong was SMA President from 2009 to 2012 and is a member of the 57th SMA Council. He has been in private practice since 1993 and has seen his fair share of the human condition. He pines for a good pinot noir, loves the *FT Weekend* and of course, wishes for world peace...