Third Party Administration (TPA) Fee Explanation

Brief Explanation: There is a once a year charge for all the extra paper work, phone calls and hassles from your insurance company, pharmacy, mail order pharmacy or other “third party” (any entity besides you and me)

Let me begin with an historical overview to bring you from where we (you, the patient, and I, the physician) began from.

1.) By the 20th century, physicians were paid directly by patients using cash. In the last century, various ways of payment have developed and evolved. Besides cash, the patient could pay for services using check, credit card or debit card. About 40 or 50 years ago, health insurance was developed as another kind of insurance product, that would assist the patient in paying for doctor's services. For those of you old enough to remember, the patient paid by whatever means until the deductible portion was met and then the insurance paid a percentage of the balance. The patient then paid the remainder of the fees until they met a ceiling at which point the insurance paid 100% of the doctor's fees. The doctor was paid what he billed. In the late 1960's insurance companies noticed that doctor's fees varied based on geography and decided that they would pay what they thought was a REASONABLE amount based on what they saw nationwide. They eventually called this "usual and customary" but they never explained (even when asked to) how this was arrived at.

2.) Then HMO's and PPO's were developed as a way of restraining health care costs. Insurance companies were quite crafty in how this was structured and how they presented it to both the public, private companies and to the physicians. The public was told that the insurance companies would help keep health care costs affordable. Private companies were told that it would keep their benefit boosts (health insurance costs) stable and predictable. Doctors were told that it would improve cash flow and make the health care system more efficient. But in effect, it gave the insurance companies more control. We doctors could either participate in the different plans or not. Those of us who chose not to participate soon learned that patients had been mislead into thinking that they could only see the physicians on the "preferred provider list" and that if the doctor they had seen for years was not on the list, they had to change physicians. Employers no longer offered employees the option of the traditional insurance, so due to both of these factors, physicians not participating in insurance HMO's or PPO's lost patients. It therefore became a matter of participating in PPO's and HMO's, and giving the insurance companies control or going out of business. I know because I was in this situation. Physicians formed large groups in order to attempt to have some leverage with insurance companies, but this was futile. (Once again, I know because I was in this situation.)

3.) Over the past 20 years, insurance companies gradually decreased how much they paid for services to the point where they paid only a percentage more than one of the lowest payers--Medicare. Some insurers even tried to pay specialists less than Medicare. Specialists who respected themselves declined to participate in these plans and this sort of "tug-of-war" goes on today. (Ever wonder why the specialist you saw a few years ago is not on the list of your insurance company today? It's because they have tried to decrease their payments to a point that the specialists had to decline their contracts.)

4.) More layers of cost control have been introduced--mail order pharmacies, outside pre-certification companies, third party quality control companies and medication formularies. We physicians have had to accept dealing with more and more of these "third parties" in addition to the original third party, the health insurance company. None of these additional services were requested of us when we signed contracts with the insurance companies, nor have they offered to pay physicians for the time it is taking to deal with all of these. If you think we have any ability to negotiate with the insurance companies to be paid for this service, you are mistaken-- their attitude is basically "here's the contract, take it or leave it". A few years ago another third party was introduced-- Medicare Part D-- the prescription benefit.

5.) More and more time is now spent dealing with all of these third parties and NONE of this is paid for. As I have only two things of value or that can be valued--my expertise and my time--it has come to the point that I can no longer remain in business if I do not bill for this extra time AND expertise that is used in dealing with these other demands. One may say "Other physicians are not charging this, why are you?". Well, there are a few other physicians who are charging for this and those that do not basically are not respecting themselves or valuing their time by not doing so.

6.) Therefore there is an annual Third Administration Fee of $125 paid by all patients. Families and couples are given a discount. Couples fees are $200 and Families fees are $300. The only exceptions will be if you do not have any insurance coverage or I am not contracted with your insurance plan. The fee can be paid in advance or at the time of your first contact with the office, whether this be at the time of an office visit, nurse contact (injections, BP checks), lab evaluation or phone call.

This fee is **not** part of your insurance or Medicare benefits and can not be billed to your insurance-- it is **because** of your insurance.

By signing below, I acknowledge that I have read, understand and accept the fee listed above.

_____ _____

Printed Name Date

_____ _____

Signature Date