

LAW, MEDICINE, AND WEALTH: DOES CONCIERGE MEDICINE PROMOTE HEALTH CARE CHOICE, OR IS IT A BARRIER TO ACCESS?

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INTRODUCTION

An unconventional form of health care is slowly, but persistently, making itself known. Over the past three years, a small but growing number of physicians have distanced themselves from the constraints of cost-conscious managed care and reduced their patient loads significantly in order to provide primary medical services to a select number of patients able and willing to pay for a more personalized method of health care delivery. This form of medical practice is known by various names, most commonly “conciERGE medicine,” “conciERGE care,” “boutique medicine,” “access fee practice,” or “retainer practice.”¹

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1. These terms are used interchangeably throughout this article, although the term “conciERGE” is used most often. The federal government is partial to “conciERGE care.” See U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-05-929, PHYSICIAN SERVICES: CONCIERGE CARE CHARACTERISTICS AND CONSIDERATIONS FOR MEDICARE (2005). The American Medical Association refers to this practice form primarily as “retainer practice.” See CODE OF MED. ETHICS, RETAINER PRACTICES § 8.055E (Am. Med. Ass’n 2004). The media tends to prefer either “conciERGE” or “boutique.” See, e.g., Abigale Zuger, *For a Retainer, Lavish Care by ‘Boutique Doctors,’* N.Y. TIMES, Oct. 30, 2005, at A1; Amy Zipkin, *The ConciERGE Doctor Is Available (At A Price),* N.Y. TIMES, July 31, 2005, at B6; Ron Roel, *Shop Talk on Boutique Medicine,* NEWSDAY (USA), Dec. 31, 2004, at B2; Carol M. Ostrum, *ConciERGE Physicians’ Medical Model Growing,* SEATTLE TIMES, May 28, 2004, at B1; Carole Fleck,

In its most common business model, physicians charge patients an initial fee, varying from a few hundred to over a thousand dollars a month, for access to the services of their personal “concierge” physician. Upon payment of the access fee, patients receive a varying array of services that are not typically covered by insurance, such as access to their personal physician twenty-four hours a day, seven days a week, immediate or same-day appointments, their physician’s personal cell phone number and e-mail address, extensive executive-type annual physicals, some preventive care services, and, in some cases, spa-like amenities such as robes, slippers, and refreshments. In addition to the access fee, patients (or their insurers) are responsible for the cost of all office visits and medical services provided by the physician. This per-patient fee allows the concierge physician to accept far fewer patients and spend more time per patient than is feasible in the world of managed care.

The dark side of this new practice form is that for the physician with a traditional managed care practice, conversion to a concierge practice may mean that as many as two thousand to three thousand of the physician’s former patients who cannot afford the fee must now look elsewhere for another primary care physician at a time when primary care physicians are in short supply and fewer physicians are accepting Medicare patients. And, concierge physicians face numerous legal obstacles from state insurance regulators, private insurers, and the federal government.

Concierge practices continue to form across the country, with the greatest concentration found in large cities and coastal states, particularly Washington and Florida.² Although some practices have not been successful, many others have flourished.³ Some physicians, lured by the possibility of fewer patients, greater income, and more leisure time, have nonetheless hesitated to convert their practices, fearful that managed care organizations will drop them from their networks or that state or federal regulators will make this practice form illegal. Other physicians are attracted by what they perceive as an opportunity

Want Your Doctor to Pamper You? Pay Extra, AARP BULLETIN, Oct. 2004, at 32 (using both concierge and boutique terms). Disturbed that the more frequently used “concierge physicians” had an elitist and somewhat negative connotation, the Society for Innovative Medical Practice Design (SIMP), a trade organization for concierge medical practices, engaged in extensive brainstorming in an effort to come up with a more appropriate name. According to its spokesperson, Dr. Garrison Bliss, they were unable to do so. Ultimately, they decided to continue to use the term “concierge” because “everybody knows what it means.” Garrison Bliss, Address at the SIMPD National Conference on Concierge Medicine (May 5-6, 2005).

2. See G. Caleb Alexander, et al., *Physicians in Retainer (“Concierge”) Practice: A National Survey of Physician, Patient, and Practice Characteristics*, 20 J. OF GEN. INTERNAL MED. 1079, 1080 (2005) [hereinafter *Physicians in Retainer Practice*].

3. One fast-growing national network, MDVIP, a Florida based medical franchise, boasts seventy-five physicians in fifteen states serving “tens of thousands” of patients. See *infra* note 42, (discussing MDVIP). See also MDVIP, *Concierge Medicine*, <http://mdvip.com> (follow “View our NEW Informational Video” hyperlink).

to practice better medicine, but they are troubled over the ethics of dropping hundreds of their patients from their practices, and they are worried that they may garner peer or community disapproval.⁴

Even if former patients can be placed with other physicians and legal impediments are overcome, the question remains whether this form of practice is merely a dalliance of the wealthy, which will control itself through economic and market forces, or whether it presents a serious impediment to access to health care, particularly for elderly Americans dependent on Medicare.

This article explores the legal, ethical, and policy implications of concierge medicine. Part I of this article examines the forces that have induced concierge physicians to reject the restrictions of managed care and move toward a more independent practice form; Part II discusses potential legal impediments from state insurance regulators, private insurers, and federal regulators; Part III examines the ethical implications of concierge medicine; and Part IV reflects on the potential effects of concierge medicine on access to health care and proposes that although wealthy persons may choose the manner in which they wish to receive their medical care, private insurers ought not to include concierge physicians in their plan networks, and concierge physicians should be prohibited from charging Medicare patients access fees.

PART I. WHY CONCIERGE MEDICINE?

A. MANAGED CARE FAILURES

During the rise of modern medicine, from the 1940s until the early 1990s, physicians controlled health care policy as well as the delivery of health care,⁵ providing medical care on a fee-for-service basis. Physicians set the charges for their services and billed the patient or insurer. Bills were paid with little interference from insurers. In a fee-for-service system, the physician's financial incentive is to provide more care, so long as payment is forthcoming. Neither the patient nor the physician has any incentive to control costs, because the entire health care bill is paid by a third-party insurer, except for the premium charge.⁶ Only the physician's ethical obligation to exercise reasonable medical

4. See Troyen Brennan, *Concierge Practice and the Profession's Contract with Society*, AMA VIRTUAL MENTOR, Nov. 2003, <http://www.ama-assn.org/ama/pub/category/11560.html> (expressing concern that physicians who convert to concierge practices, terminating many long-standing physician-patient relationships in the process, "risk losing [their] special voice in matters surrounding the organization of health care.")

5. See Peter D. Jacobson, *Who Killed Managed Care? A Policy Whodunit*, 47 ST. LOUIS U. L.J. 365, 368 (2003).

6. *Id.*

skill and judgment in the best interest of the patient serves as a check on the system.⁷ Every medical decision, however, is also a spending decision, and under the fee-for-service system, physicians had virtually unfettered freedom to spend the money of others, providing services in the absence of oversight as to their medical necessity.⁸

Managed care was touted as the answer to all that was wrong with fee-for-service health care insurance. The Managed Care Organization (MCO) transformed health care by combining the financing of health care with the delivery of clinical services in order to cut costs and improve quality. Instead of paying a separate fee for each service, the patient (or her employer) paid a monthly premium in exchange for the coverage and provision of defined medical benefits. These managed care plans were considerably more cost effective than traditional fee-for-service insurance plans, catching the eye of employers who sought to purchase health care plans for their employees, or to self-insure. Cost cutting was particularly evident in the Health Maintenance Organization (HMO), which imposed upon providers and patients a number of practices that limited the amount of medical care patients received. HMOs controlled costs through utilization review,⁹ prior and concurrent review of hospital admissions,¹⁰ coverage determinations,¹¹ primary care gatekeeping,¹²

7. *See* Pegram v. Herdrich, 530 U.S. 211, 218 (2000) (reviewing the history of fee-for-service medicine and managed care).

8. *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 24 (1982). Of the ability of physicians essentially to create their own demand, and thus set their own income, Starr wrote:

By augmenting demand and controlling supply, greater professional authority helped physicians secure higher returns for their work. . . . The sick cannot easily disengage themselves from relations with their doctors, nor even know when it is in their interests to do so. Consequently, once they have begun treatment, they cannot exercise that unfettered choice of sellers which characterizes free markets. *Id.*

9. In the utilization review process, the medical necessity of specific treatment decisions is reviewed by a decision-maker other than the treating physician. *See* BARRY R. FURROW ET AL., THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE 255 (5th ed. 2004) [hereinafter HEALTH CARE ORGANIZATION AND FINANCE]. Utilization review is an attempt to control costs by eliminating medical services deemed by reviewers to be wasteful and unnecessary. *Id.* For an overview of the defining features of the HMO, *see* Pegram v. Herdrich, 530 U.S. 211, 218-19 (2000).

10. HMO requirements for prior and concurrent review are typically part of a utilization-review program that may include pre-admission review prior to elective hospital admissions, admission review within seventy-two hours of emergency admissions, continued stay review, second opinions, and other programs. *See* HEALTH CARE ORGANIZATION AND FINANCE, *supra* note 9, at 255.

11. In making its coverage determinations, the HMO must scrutinize specific contractual provisions to assure that the request for services falls within the scope of services covered by the contract. *See generally* Mark Hall et al., *Judicial Protection of Managed Care Consumers: An Empirical Study of Insurance Coverage Disputes*, 26 SETON HALL L. REV. 1055 (1996) (presenting an empirical analysis of judicial determinations of health care

and the issuing of guidelines about appropriate levels of care. Patient choice of primary care providers was limited to the plan's closed panel of physicians. HMOs paid their physicians by capitation,¹³ which rewarded them for providing less care, and penalized them for what might be excessive treatment. Capitation payment was often accompanied by other financial incentives to provide less care, such as bonuses or withholds.¹⁴ Even in a less "managed" MCO structure, such as a Preferred Provider Organization, physicians had to discount their fees, and their decision-making remained subject to some utilization review.¹⁵

During the early years, managed care plans enticed physicians to sign contracts by promising them that they would make up for reduced fees by increasing their patient load, due to managed care's popularity with employers. Physicians, however, needed little coaxing. Due to an oversupply of providers that existed at that time, physicians scrambled to sign contracts for fear that they would be unable to sustain their practices outside of managed care's widening umbrella.¹⁶

coverage disputes).

12. Patients must choose a primary care physician (such as an internist or a family physician) who then acts as the "gatekeeper" for access to hospital and specialty services. These services are not covered by the health care plan unless the referral to the hospital or specialist is made by the gatekeeper. *See* HEALTH CARE ORGANIZATION AND FINANCE, *supra* note 9, at 208.

13. Under the capitated method of reimbursement, the physician (or physician group) receives a flat fee per member per month to manage all of the care needed by each plan member for whom the physician is the primary care provider. The amount does not vary based on the volume or the value of the services actually rendered. Thus, the physician either assumes the risk that the patient will need more care than the plan has paid for, or reaps the rewards if the patient is healthy and needs little or no care. *See* HEALTH CARE ORGANIZATION AND FINANCE, *supra* note 9, at 259.

14. The HMO may pay a provider a bonus for achieving specific financial goals, such as keeping expenditures lower than projections, or clinical goals, such as the physician's adherence to preventative-health guidelines. In a withhold arrangement, the HMO retains a portion of the providers' compensation for services rendered, which is returned to the physician after the performance of established goals. *See* AM. HEALTH LAWYERS ASS'N, FUNDAMENTALS OF HEALTH LAW 249 (3d ed. 2004).

15. A Preferred Provider Organization (PPO) is composed of a system of health care providers who agree to provide their services to subscribers on a discounted fee-for-service, or case-rate basis. PPO subscribers do not have to choose a PPO provider, but they face financial disincentives for going outside the system. Utilization controls are used for some services, such as hospital admissions. *See id.* at 243.

16. *See* Harold S. Luft, *Why Are Physicians So Upset About Managed Care?*, 24 J. HEALTH POL. POL'Y & L. 957, 959 (1999). The author writes that "the fear of being left out was probably more of a motivation to sign than the promise of more patients." But managed care plans rejected very few physicians because they were "pressured by purchasers to have a broad network of providers in order to minimize [negative] patient reaction" to this new form of health care. Thus, the promise of any significant number of new patients never materialized, and many physicians felt "taken" as a result. *Id.*

Managed care organizations enjoyed a generally positive image with the public during their rise in the 1980s.¹⁷ By the 1990s, however, MCOs' popularity began to wane. Their cost-cutting practices fostered dissatisfaction among both patients and providers. Contributing substantially to managed care's negative public image was the tendency of the media to sensationalize stories of unwitting patients whose lives were jeopardized or lost by a managed care organization's denial of coverage.¹⁸ People began to distrust their managed care organizations and to perceive that perhaps they were not getting the care they needed.

Physicians did little to quell their patients' fears; they suffered from their own dissatisfactions with managed care. Managed care changed the role of physicians in the delivery of health care by engaging in what physicians saw as interference with their medical decision-making. They came to resent being "managed" and saw the requirement that they request approval for treatment as personally and professionally demeaning.¹⁹ Physicians found themselves buried in paperwork, since plans required them to bill the plan and not the patient; physicians were inundated with the administrative requirements of dozens of managed care plans, each with a different claims form.²⁰ Physicians no longer had sole access to their patients' private health information upon which their medical decisions were made, and their overall social status and economic potential was and is diminished by managed care practices.²¹ At the same time, physicians feared that disagreements with plans over appropriate medical care would mark them for deselection from provider lists, which could harm their reputation and standing in the medical community and cause significant economic loss as patients would be forced to choose another physician from the list.²²

17. See Clark C. Havighurst, *The Backlash Against Managed Health Care: Hard Politics Make Bad Policy*, 34 IND. L. REV. 395, 398 (2001) (discussing policy implications of the managed care backlash).

18. *Id.* at 397 (suggesting that the managed care backlash was fueled by "attention-seeking journalists, opportunistic politicians, self-styled consumer advocates, and plaintiff's lawyers sensing HMOs' blood in the water . . .").

19. Harold S. Luft, *Why Are Physicians So Upset About Managed Care?*, 24 J. HEALTH POL. POL'Y & L. 957, 963 (1999). Luft writes that even though "the vast majority of requests for services [are] approved, and most denials are" related to coverage issues, the requirement itself is "demeaning" to physicians. Luft refers to the pre-approval practice as the "1-800-MOTHER-MAY-I" model of telephone approval. *Id.*

20. *Id.*

21. See Peter Jacobson, *Who Killed Managed Care? A Policy Whodunit*, 47 ST. LOUIS U. L.J. 365, 370 (2003). Professor Jacobson's article examines the role of physicians, patients, employers, legislatures, the media, health insurers, and hospitals in the demise (or at least diminishment) of managed care, before concluding that the managed care industry has essentially self-destructed by allowing negative perceptions to fester uncountered. See *id.* at 370-94.

22. MCO-provider contracts typically allow for the MCO to terminate a physician

A significant source of continuing dissatisfaction is the decline in income experienced by primary care physicians²³ in recent years, at a time when wages and salaries in the United States were increasing.²⁴ Data from the American Academy of Family Physicians (AAFP) show that the mean yearly income before taxes of family physicians decreased 12.4%, or \$20,000, between 1995 and 2003.²⁵ Income decreases are due to a combination of factors, including managed care restraint on the utilization of physician services, its pressure on physicians for lower prices,²⁶ rising overhead costs, rising malpractice costs, and falling Medicare and Medicaid reimbursement.²⁷ Without congressional intervention, physicians participating in Medicare can expect pay cuts of approximately 4.5% per year for six years beginning in January 2006,²⁸ even

from its provider list without cause at the expiration of a specified notice period. Invoking this contractual provision is known as deselection. See Richard S. Liner, *Physician Deselection: The Dynamics of a New Threat To The Physician-Patient Relationship*, 23 AM. J.L. & MED. 511, 512 (1997).

23. A primary care physician is defined as “a generalist physician who provides definitive care to the undifferentiated patient at the point of first contact and takes continuing responsibility for providing the patient’s care.” American Academy of Family Physicians, *Primary Care*, <http://www.aafp.org/x6988.xml>. Primary care includes the specialties of family medicine, general internal medicine, and general pediatrics. *Id.*

24. See Marie C. Reed & Paul B. Ginsburg, *Behind the Times: Physician Income, 1995-1999*, Center For Studying Health System Change Data Bulletin No. 24, (Mar. 2003), at <http://www.hschange.org/CONTENT/544> [hereinafter PHYSICIAN INCOME] (reporting that between 1995 and 1999, while the wages and salaries from other professions were rising sharply, average net income for primary care physicians, adjusted for inflation, dropped 6.4%). The study discussed in this article is based on the Center for Studying Health System Change Community Tracking Study Physician Survey involving a nationally representative survey of 12,000 practicing physicians. *Id.*

25. See Jan Carter, *What Makes a High-Earning Family Physician?*, FAM. PRAC. MGMT., July-Aug. 2005, available at <http://www.aafp.org/fpm/20050700/16what.html>. The AAFP annual Practice Profile Survey illustrates the decrease in physician before-tax income: 1995 (\$161,000); 1996 (\$160,000); 1997 (\$154,000); 1998 (\$151,000); 1999 (\$148,000); 2000 (\$146,000); 2001 (\$141,000); 2001 (\$141,000); 2002 (\$146,000); 2003 (\$141,000). *Id.*

26. See PHYSICIAN INCOME, *supra* note 24.

27. See *Huge Hit to MD Income Likely if Medicare 4.5% Cut Takes Effect*, PHYSICIAN COMPENSATION REPORT, Dec. 2003, available at http://www.findarticles.com/p/articles/mi_m0FBW/is_12_4/ai_110675322 (noting that doctors are looking at “concierge-like” fees and revenue-sharing deals with hospitals due to declining income resulting from falling Medicare reimbursement and rising malpractice costs). See also Robert M. Portman, *Concierge Care: Back to the Future of Medicine?*, 15 No. 5 HEALTH LAW 1, 1 (2003) (noting that some physicians have turned to concierge medicine due to dwindling income and increasing practice costs).

28. 2005 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS, ANNUAL REPORT 19 (2005) available at <http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2005.pdf> (reporting projected decrease in physician payments of just under 5% for six consecutive years, 2006 through 2011). The Trustees’ Report explains that “[m]ultiple years of significant reductions in physician payments per service are very unlikely to occur before legislative changes intervene, but these payment reductions are

though practice costs will go up 15%.²⁹ And primary care physicians are particularly disheartened at managed care's under-valuation of their services as compared to other specialties. Although primary care physicians are seeing more patients per week than other specialists, their average income is lower,³⁰ and pay increases lag behind that of other specialists.³¹

Not least among their complaints is that physicians increasingly have too little time to spend with their patients. Primary care physicians frequently carry patient loads in excess of 3000.³² Family physicians average twenty to thirty patient visits per day, with a weekly average of 127.7 patient contacts in various settings, including office, hospital, and nursing home visits, and supervision of home health, nursing home, and hospice patients.³³ They spend an average of 40.2 hours per week in patient care, leaving little time for administrative duties or personal needs.³⁴ According to 2001 research from the

required under the current law payment system and are reflected in... this report." *Id.*

29. David Glendinning, *Medicare Trustees: Gloomy Forecast for Physician Reimbursement Rates*, AM. MED. NEWS, Apr. 2005, at 1, available at <http://www.ama-assn.org/amednews/2005/04/11/gv110411.htm> (reporting statement of American Medical Association President-Elect J. Edward Hill that at the same time Medicare physician payments are being cut, "the costs of running a practice and caring for patients will go up 15%").

30. ROBERT GRAHAM CTR., THE UNITED STATES PRIMARY CARE PHYSICIAN WORKFORCE: UNDERVALUED SERVICE (2003), available at <http://www.graham-center.org/x469.xml>. As a group, primary care physicians are outnumbered by specialists, yet they provide more office-based visits than specialists. In 1999, a family physician with an average yearly net income (after expenses, before taxes) of \$144,700 had an average of 122.9 patient visits per week; a gastroenterologist with an average income of \$299,200 sees an average of 89.9 patients per week; a cardiologist, at \$315,500 per year, sees 92.4 patients per week, and an orthopedic surgeon at \$335,800 sees 114.3 patients per week. *Id.*

31. Edward S. Salsberg & Carl J. Getto, AMA Section on Medical Schools: Planning for the Physician Workforce (Dec. 2001), <http://www.ama-assn.org/ama1/pub/upload/mm/44/speakersumi-01.doc>. The starting income for a resident from a primary care specialty is increasing at a rate considerably slower than other specialties. For example, in New York, primary care starting income rose from \$106,000 to \$110,000 over four years, from 1998 to 2001. During the same time period, the starting salary for a non-primary care physician increased from \$130,000 to \$149,000. Similarly, in California between 2000 and 2001, starting income for primary care physicians increased from \$110,000 to \$114,000, as compared to the more lucrative increase from \$152,000 to \$160,000 for non-primary care physicians. *Id.*

32. See, e.g., Bill Sonn, *Concierge Medicine Physicians Weigh Financial, Ethical Issues*, http://www.shands.org/professional/ppd/practice_article.asp?ID=233 (referencing patient load of 4,000); Virginia Commonwealth University, *Patient Load per Active Primary Care Physician in Virginia* (2001) (reporting average primary care patient load from 1800 to 3900), <http://www.primcare.vcu.edu/manpower/sld004.htm>.

33. American Association of Family Physicians, *Average Number of Family Physician Visits per Week and Average Number of Patients in Various Settings* (2005) (reporting results of May 2004 survey responses of 1,469 active members), <http://www.aafp.org/x768.xml>.

34. See American Association of Family Physicians, *Average Number of Hours Spent*

Center for Studying Health System Change, 34% of physicians reported that they have inadequate time to spend with their patients, up from 28% in 1997.³⁵

Physicians resent that they are expected to do preventive care with their patients, but managed care patient loads do not allow them sufficient time to perform the required services. A Duke University research study showed that if primary care physicians were to perform all of the preventive care services suggested by the United States Preventive Services Task Force,³⁶ which sets the “gold standard” for preventive care, they would have to spend 7.4 hours of every workday doing nothing but preventive care, leaving approximately 30 minutes for critical and chronic-disease care.³⁷

In this climate of discontent, physicians began to search for innovative ways to distance themselves from managed care controls generally and the HMO straightjacket in particular.

in Patient Care or Patient-Related Service During the Most Recent Complete Week of Practice by Family Physicians (2005), <http://www.aafp.org/x769.xml>.

35. Sally Trude, *So Much to Do, So Little Time: Physician Capacity Constraints, 1997-2001*, TRACKING REPORT NO. 8 (2003), available at <http://www.hschange.com/CONTENT/556/?topic=topic09>. The author reports that in 2001, physicians spent 46.6 average weekly hours in direct-patient care, up from 44.7 hours in 1997. *Id.* Direct-patient care includes “face-to-face contact with patients, as well as patient record keeping and office work, travel time to see patients, and communication with physicians, hospitals, pharmacies and others on patient’s behalf.” *Id.* Although the time spent on patient care has increased somewhat since 1997, the proportion of physicians reporting that they do not have adequate time to spend with their patient rose from 28% in 1997 to 34% in 2001. Researchers attribute this change to the availability of diagnostic and treatment options and to an increase in the number of patients living longer with chronic illnesses requiring complex coordination of care. *Id.* Thus, physicians may be spending more time on patient-care activities generally, but have less face-to-face time in which to explain options to their patients. *Id.*

36. The United States Preventive Services Task Force (USPSTF), sponsored by the Agency for Healthcare Research and Quality (AHRQ), was convened in 1984 and is comprised of an independent panel of experts in prevention and primary care. These private sector experts assess the scientific evidence on the effectiveness of a broad range of preventive services and make recommendations including screening, counseling, and preventive medications for primary care physicians, based on the age, gender, and risk factors for disease of their patients. See U.S. Preventive Services Task Force, *About United States Preventive Services Task Force*, Feb. 2005, <http://www.ahcpr.gov/clinic/uspstfab.htm>.

37. See Kimberly Yarnall et al., *Primary Care: Is There Enough Time for Prevention?*, 93 AM. J. PUB. HEALTH 635, 637 (2003). The goal of the researchers in this Duke University Medical Center study was to discover the amount of time required if a primary care physician were to provide all 25 preventive services recommended by the USPSTF that are needed by the average patient in a family practice waiting room. The researchers used census figures to fashion a model physician patient panel, with an age and sex distribution (including children) similar to that of the U.S. population. Their results established that a physician would have to spend 1773 hours per year, or 7.4 hours per working day, in order to satisfy the USPSTF recommendations. Their obvious conclusion was that physicians did not have time to comply with preventive services recommendations. See *id.*

B. Concierge Medical Practice Structures

The goal of a physician converting from a traditional managed care practice to a concierge practice is simple: reduce the patient load significantly, but equalize the loss of income (and hopefully increase income) by collecting more money from each patient. Consequently, those physicians with the most exclusive practices take the fewest patients and charge the highest fees.

Most concierge physicians are primary care physicians who have an ongoing relationship with their patients, although a growing number of pediatricians, cardiologists, and others with continuing-patient relationships are converting to concierge medicine.³⁸ Three medical practice designs prevail at present, although variations exist within each model.

In the most common concierge practice design, the physician charges a flat monthly or yearly fee—the access fee, or retainer fee—that allows the patient access to medical services covered by the patient's insurance plan, plus a variety of other services, both medical and non-medical.³⁹ Retainer fees vary, as do the number of patients per physician and the services provided. As representative examples, one concierge medical practice charges its patients a \$4,000 annual fee, or \$6,000 per couple, and limits the number of patients to 300 per physician.⁴⁰ Another charges \$2,000 per patient annually, \$3,500 for a husband and wife, and serves 200 patients;⁴¹ another, \$1,500 per person with a practice limited to 600 patients;⁴² and another charges a comparatively

38. Mike Norbut, *Retainer Model Slowly Spreading to Specialties*, AM. MED. NEWS, Oct. 25, 2004, at 19 (discussing retainer practice physicians in the specialties of cardiology, obstetrics-gynecology, and pediatrics).

39. See Wayne J. Guglielmo, *How to Set Up A Concierge Practice*, MED. ECON., Aug. 2003, at 64; Vasilios J. Kalogredis, *Should You Consider Concierge Medicine?*, PHYSICIAN'S NEWS DIG., Feb. 2004, <http://www.physiciansnews.com/business/204.kalogredis.html>. See also Jennifer Russano, Note, *Is Boutique Medicine A New Threat to American Health Care or a Logical Way of Revitalizing the Doctor-Patient Relationship?*, 17 WASH. U. J.L. & POL'Y 313, 321-22 (2005) (describing concierge medical practice structures).

40. See Guglielmo, *supra* note 39, at 64 (describing OneMD, a two physician concierge practice in Louisville, Kentucky).

41. *Id.* at 65 (describing the concierge practice of AccessMD in Wellesley, Massachusetts).

42. *Id.* at 66 (describing the concierge practice of Florida based MDVIP). Perhaps the largest and best-known model of this type is MDVIP, a medical franchise marketing a business model and providing support services to approximately seventy-five MDVIP physicians in fifteen states, serving "tens of thousands" of patients. See MDVIP, Concierge Medicine, <http://www.mdvip.com> (introductory video). MDVIP charges an on-going service fee of \$500 per patient for its help and initial cash outlay in assisting its physicians in converting their traditional practices to concierge practices. See also Guglielmo, *supra* note 39, at 64, 66. MDVIP physicians promise to limit their patient panels to no more than 600 patients, unlike physicians in traditional practices who may have 2,000 to 3,000 patients. See MDVIP, Physician Inquiries, <http://www.mdvip.com/physicianIndex.asp> (noting that physicians reduce their practice size to no more than 600 patients). The retainer fee of

reasonable \$480 per patient per year, with a limit of 800 patients.⁴³

The services provided for the retainer fee are similarly variable, possibly including: same-day or next-day appointments; extended office hours, including Saturdays; twenty-four-hour, seven-day-a-week access by cell phone or pager; house calls; coordination of care with specialists, including accompanying the patient to the specialist visit; preventive health and wellness services; telephone and e-mail consultations; physical examinations; uncrowded waiting rooms with upscale decor, beverages and snacks, and occasional spa amenities such as robes and slippers.⁴⁴

Physicians choosing this model typically continue to accept various forms of insurance for covered care and co-payments for office visits, and they continue to participate in preferred provider organizations and other private insurance networks.⁴⁵ Patients, however, are responsible for paying the difference between what their insurer pays for covered services and what the physician charges for covered and non-covered services.

A second form of concierge practice accepts a set fee for providing all primary medical care as needed, as well as preventive services and counseling in order to best manage the patient's overall well-being. One such premium practice charges \$13,200 for individuals (\$20,000 per couple), plus \$2,000 for each child thirteen to college age.⁴⁶ Physicians practicing within this model typically do not bill insurance, essentially providing all primary care and preventive services for the retainer fee. Those with smaller retainer fees may accept cash in addition to the retainer for medical services not covered by the retainer fee. Patients are encouraged to maintain private insurance for specialty care, hospitalization, and diagnostic and laboratory work. If services are covered by insurance, patients are required to submit their own claims to their

\$1,500 per person per year includes access to a personal MDVIP physician for necessary medical care in case of illness, as well as a comprehensive physical examination, a personalized health care plan, same-day or next-day appointments, no waiting time on appointment day, a direct cell phone or contact number for twenty-four hour seven day a week access to the physician, and coordination of care in the emergency room or with needed specialists. *See* MDVIP, Concierge Medicine, <http://www.mdvip.com> (introductory video).

43. Renaissance Health in Arlington, Massachusetts, charges \$40 per month, or \$480 per year, with the physicians' practice limited to 800 patients. Telephone interview with Renaissance Health physician in Arlington, Mass. (June 7, 2005).

44. *See* Dana Leidig, *Concierge Medicine: A New Specialty?* TEXAS MEDICAL LIABILITY TRUST REPORTER Mar.-Apr. 2005, at 1-2, available at <http://www.tmlt.org/publications/resources/Reporter/MarchApril05.pdf>.

45. *See* Mike Norbut, *Appeal of Retainer Practices: Boutique Care Goes Mainstream*, AM. MED. NEWS, Aug. 4, 2003, at 19.

46. Cheryl Jackson, *Premium Practice: When Patients Pay Top Dollar for Exclusive Care*, AM. MED. NEWS, Sept. 17 2001, at 12 (describing the retainer fee for the services of MD2 (pronounced "MD Squared"), a concierge practice in the Seattle, Washington area believed to be the first of such practice models, operating since 1996).

insurers for reimbursement.⁴⁷ In addition to providing medical and preventive care, these physicians also provide an array of additional services, such as twenty-four-hour-a-day, seven-day-a-week physician availability, same day service, no-wait appointments, and even house calls. Most physicians using this model have opted out of Medicare.⁴⁸

A third, though less common, concierge medical practice design is reminiscent of the pre-insurance fee-for-service model. Patients must pay a flat fee for each office visit, in addition to paying the physician's charge for medical services provided during the visit. Some patient amenities common in the models discussed above, such as same day or immediate access to the physician, an extended office visit, and possibly other coordination of care, are available to the patient, but on a per-visit basis as opposed to a monthly or yearly basis. For instance, the patient may pay \$100 in advance to access the services of the physician; then the physician either bills the patient for medical services, or submits the claim to the patient's insurer.⁴⁹

PART II. LEGAL OBSTACLES TO CONCIERGE MEDICINE

A. Conflicts with State Laws

1. Physicians Operating as Insurers

The path ahead for concierge physicians is neither straight nor smooth. Physicians could find themselves in conflict with state insurance laws if they are viewed as unlicensed insurers of health care, or shown as violating state law in their billing practices.

Those physicians who structure their practice to provide all primary care services for a set periodic or annual fee have attracted the attention of state insurance regulators. In Washington State, the Office of the Insurance Commissioner (OIC) became concerned that this model may run afoul of state laws that required insurers of health care to have a certificate of registration.⁵⁰ The OIC's position was that the arrangement whereby patients paid a fixed fee

47. See John R. Marquis et al., *Legal Issues Involved in Concierge Medical Practices*, HEALTH LAWYERS NEWS, Mar. 2005, at 18,19 [hereinafter *Legal Issues*].

48. For a discussion of the legal difficulties inherent in concierge practices and Medicare participation, see *infra* Part II C 1.

49. See *Legal Issues*, *supra* note 47, at 18-19 (discussing the most common medical practice designs).

50. See Washington Office of the Insurance Commissioner, Engaging in Activities Requiring a Certificate of Registration (Technical Assistance Advisory Draft) 1 (2003), http://www.insurance.wa.gov/special/accessfees/removed/provider_plans_draft_taa.doc.

for the receipt of all primary care services, including future services, transferred risk from the patient to the provider.⁵¹ If a patient were frequently and seriously ill, the physician would be obligated to provide needed services for the same fee as would be paid by the healthy patient who needed few or no services. In the opinion of the OIC, this arrangement was the same or similar to that of the physician who provides medical services to a patient who is covered by an insurance contract from a licensed health carrier.⁵² Thus, if physicians are accepting risk and insuring the patient's care, they risk criminal prosecution unless they have the certificate of registration required by a health care service contractor or an HMO.⁵³ As a practical matter, concierge physicians deemed to be health care service contractors or HMOs likely would be unable to meet eligibility criteria for a certificate of registration, which includes, among many onerous requirements, that they provide documentation of an initial net worth of one million dollars,⁵⁴ and thereafter maintain a minimum net worth equal to three million dollars.⁵⁵

Undoubtedly, the OIC was concerned with who would bear responsibility for providing these prepaid medical services if the practice were to become insolvent. A Draft Technical Advisory setting out the concerns of the OIC was circulated to interested parties, followed by a public meeting at which the Washington State Medical Association (WSMA) vigorously opposed the OIC's position as "a misguided interpretation of the statutes."⁵⁶ At the meeting,

51. *Id.*

52. *Id.*

53. WASH. REV. CODE § 48.44.015 (2005) imposes a criminal misdemeanor penalty upon one who holds herself out to be a health care service contractor without a certificate of registration. A health care service contractor is defined as a corporation, group, or association who "accepts prepayment for health care services from or for the benefit of person or groups of persons as consideration for providing such persons with any health care services." WASH. REV. CODE § 48.44.010(3) (2005). Health care services are broadly defined by statute to include "medical, surgical, dental, chiropractic, hospital, optometric, podiatric, pharmaceutical, ambulance, custodial, mental health, and other therapeutic services." Similarly, a certificate of registration is required by a Health Maintenance Organization (HMO), defined in part as any organization that provides "comprehensive health care services . . . on a per capita prepayment basis or on a prepaid individual practice plan . . ." through contractual arrangements, except for co-payments or deductibles. WASH. REV. CODE § 48.46.020(1) (2005). Comprehensive health care services refer to emergency and preventive care, as well as basic consultation, diagnostic, and therapeutic services. WASH. REV. CODE § 48.46.020(2) (2005).

54. WASH. REV. CODE § 48.46.030 (2005) sets forth the eligibility requirements for a certificate of registration. In addition to solvency and continuing net worth requirements, the entity must provide its enrollees a meaningful role in policy making procedures, afford participants a grievance process, disclose financial interests and provide financial statements, provide detailed description of assurance programs, and other requirements. *Id.*

55. *See* WASH. REV. CODE § 48.46.235(1) (a-c) (2005) (requirement to maintain minimum net worth).

56. *See* WASHINGTON STATE MEDICAL ASSOCIATION, "Access Fee"/ "Boutique"/

attended by many supportive patients who related their personal positive experiences, the WSMA argued in favor of the concierge practice model.⁵⁷ To date, no legislation has been enacted into law, although the OIC has indicated it may address its concerns in the future.⁵⁸ In the interim, the Washington OIC indicated that it would work individually with medical practices offering medical services for a mandatory access fee, to review their particular practice model and to resolve any regulatory issues.⁵⁹

In general, the legal position for physicians providing all primary care medical services for a fee is unsettled. Lawyers advising these physicians are at the behest of state legislatures that could, at any time, define these practices to be insurers of health care, and thus operating illegally. Presently, legal efforts focus on making these practices look less like insurance companies and more like fee-for-services practices. Such advice typically includes collecting access fees on a periodic rather than yearly basis after services have been provided, and providing for cancellation of patient contracts by either patient or physician at any time, with “unused” fees prorated and refunded.⁶⁰ And, the practice would look less like a risk-assuming capital arrangement, if the physician-patient contract limited the number of patient visits per year, holding the patient responsible for paying for additional visits.⁶¹ Payments for luxury “enhanced” or non-medical services would not be the concern of state officials. On the other hand, what of the very healthy patients who require few or no services? Attempts to characterize the fee paid by these patients as payment for services already provided would be troublesome. Certainly, value exists in the peace of mind one may have in knowing that if medical services were required, one could quickly access one’s personal physician and receive medical care, along with other amenities or special considerations. In this light, however, the arrangement looks more like insurance.

2. Unlawful Discrimination

Health care plans that continue to include concierge physicians in their physician networks may be promoting questionable discriminatory practices in violation of state insurance laws or administrative regulations. Typically, state

“Concierge”/ “Retainer” Practices Update 1 (2004), <http://www.wsma.org/memresources/PRCAccessFees.pdf>.

57. *Id.*

58. *Id.*

59. See WASHINGTON OFFICE OF THE INSURANCE COMMISSIONER, FORUM FOR REVIEW OF DRAFT TECHNICAL ADVISORIES TO HEALTH CARRIERS AND THEIR PARTICIPATING PROVIDERS 1 (2003), <http://www.insurance.wa.gov/special/accessfees/removed/publicforumpresentation.ppt>.

60. See *Legal Issues*, *supra* note 47, at 22.

61. See *id.* at 26 n.14.

statutes prohibit health care plans from discriminating among members of the same health class when setting rates, and from making distinctions among individuals of the same health class with respect to the type of coverage available to them.⁶² Concierge physicians offering additional services, however, provide a distinctive type of health care not equally available to all members, since many members would not be able to pay the retainer fee. Moreover, the New York Commissioner of Health has postulated that HMOs contracting with concierge physicians may be discriminating against some plan members on the basis of source of payment.⁶³ For example, a plan may have enrollees who are covered by their employer, but their total income is sufficiently low that they also qualify for Medicaid. In such instances, the employee's share of the premium, deductibles, or co-payments may be paid under the state's Medicaid program. These enrollees would not be able to afford to pay a network concierge physician an access fee in order to obtain covered services, and certainly Medicaid would not pay the fee. Thus, HMO enrollees whose care is partially paid for through a Medicaid program would not have access to network concierge physicians, which may constitute discrimination based on the source of payment.⁶⁴

B. Conflicts with Private Health Plans

The ability of physicians to contract with MCOs varies from state to state, as health care insurers weigh the policy implications of including concierge physicians in their networks. And because plans set their own policies, concierge physicians may be viewed differently from one plan to another.

Concierge physicians offering medical services for a fee typically do not accept insurance payment, and are not troubled by restrictive provisions in

62. See, e.g., N.Y. COMP. CODES R. & REGS. tit. 11, § 52.40(i)(1) (2005) ("Rates shall not unfairly discriminate between cases of the same class."); 28 TEX. ADMIN. CODE § 21.702 (a)(1)(2005) (prohibiting discrimination between individuals of the same class in "refusing to insure, or refusing to continue to insure, or limiting the amount, extent, or kind of coverage...."); N.J. STAT. ANN. § 17B:30-12(d) (West 2005) (providing that "[n]o person shall make or permit any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such policy or contract, or in any other manner whatever.").

63. See Letter from New York Commissioner of Health to health insurance industry CEOs (April 16, 2004), available at http://www.wnj.com/marquis/NY_DeptofHealth.pdf.

64. *Id.* In his letter, the Commissioner of Health used a similar example to illustrate how health care plans could discriminate based on source of payment. The Commissioner, in referring specifically to concierge practices, stated that: "[T]he agreement between the plan and the provider should avoid permitting arrangements that are *or may appear* discriminatory to enrollees." (emphasis added). The Commissioner's letter concluded by asking HMOs to discourage any form of concierge practice among their network physicians. *Id.* at 3.

provider agreements. But most concierge physicians continue to seek provider contracts with health plans better to attract patients with health insurance who are willing to pay an additional fee for additional services. Even physicians reducing their patient load from 3000 to 600 will do better at attracting patients willing to pay the access fee if they are part of a health care delivery network. This is so because most people receive their health insurance through their employment, and either must choose a physician within their plan's network, or may save money by choosing a plan physician.

1. Hold-Harmless Clauses

Concierge physicians contracting with health plans are at risk for violating the hold-harmless clause typically found in provider contracts. A hold-harmless clause is a provision in a physician agreement with a managed health care organization that obligates the physician to look only to the organization and not its plan enrollees for payment for services covered by the plan other than co-pays, coinsurance, or deductibles that the physician is allowed to collect under the patient's benefit plan.⁶⁵ When physicians charge an access fee to patients, however, it may appear that the physician is holding the patient responsible for paying for services that are already covered by the plan, in violation of the hold-harmless clause. Although the hold-harmless clause is limited to services covered by the plan,⁶⁶ and not to any additional, non-

65. See, e.g., TEX. INS. CODE ANN. § 843.361 (Vernon 2003) ("A contract or other agreement between a health maintenance organization and a physician or provider must specify that the physician or provider will hold harmless for payment of the cost of covered health care services if the health maintenance organization does not pay the physician or provider for those services."). A health maintenance organization is broadly defined in Texas as one that "arranges for or provides to enrollees on a prepaid basis a health care plan. . . ." TEX. INS. CODE ANN. § 843.002-14 (Vernon 2003). The Texas Administrative Code provides an example of an approved hold-harmless clause: "Physician/Provider hereby agrees that in no event, including, but not limited to non-payment by the HMO, HMO insolvency, or breach of this agreement, shall (physician/provider) bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against subscriber, enrollee, or persons other than HMO acting on their behalf for services provided pursuant to this agreements. This provision shall not prohibit collection of supplemental charges or co-payments made in accordance with the terms of (applicable agreement) between HMO and subscriber/enrollee." TEX. ADMIN. CODE tit. 28, § 11.901 (2005).

66. For example, a standard Blue Cross Blue Shield Primary Care Physician Affiliation Agreement provides that its hold-harmless provision does not prohibit the physician "from collecting charges for supplemental benefits or Co-payments or Deductibles, where appropriate, or for non-Covered Services delivered to members on a fee-for-service basis." *Primary Care Physician Affiliation Agreement for Blue Choice* (on file with author). This agreement further provides that: "It is recognized that Members may consent to receive services which are not Covered Services or are not authorized by [BCBS] and therefore, may be payable by Member." *Id.* This particular provision is from a Primary Care Physician Affiliation Agreement for Blue Choice, a point-of-service product offered by Blue Cross and

covered services, the two are not always easily distinguishable. For example, one service almost universally provided by concierge physicians to their patients is twenty-four hour access to the physician, seven days a week, by giving the patient the physician's home or cell phone number. Yet a typical provision in a standard primary care affiliation agreement provides: "Access to Covered Services - Physician shall make necessary and appropriate arrangements to ensure the availability of Covered Services to Members on a twenty-four (24) hours per day, seven (7) days per week basis."⁶⁷ The insurer could take the position that the physician is violating the hold-harmless clause. Yet, it is not likely that any physician signing the agreement actually believes that to comply with her contract obligation, she must provide her personal home telephone number to her patients in case they have a question in the middle of the night. More likely, the parties contemplated that the obligation would be satisfied by a third-party answering service that relays emergency or urgent care messages to the physician, or for non-emergencies, suggests an appointment during business hours. Other gray areas concerning covered versus non-covered services include physical examinations and coordination of care with specialists. Although a health plan may cover a physical examination, the one provided by the concierge physician to his access-fee paying patient may be considerably more extensive, include more time discussing results and concerns, and be offered more frequently. Similarly, although a health plan may expect that its primary care physicians will refer their patients to specialists when appropriate, the concierge physician may make the specialist appointment for the patient and accompany the patient to the visit, a service that is typically beyond the physician's contractual obligation.

Over concerns that concierge physicians may be violating the hold-harmless provisions of their provider contracts, the Washington State Insurance Commissioner drafted and circulated a technical assistance advisory cautioning providers charging mandatory access fees that they may face significant legal problems.⁶⁸ The draft advisory, which to date has not been officially issued, would limit the ability to charge such fees to physicians who did not participate in any managed care network, or to charging the fee only to patients who are either uninsured, or with whose insurance carrier the physician has no

Blue Shield (Michigan) through its contract with Blue Care Network, a health maintenance organization. *See id.*

67. *Id.*

68. Office of the Insurance Commissioner, *Mandatory "Access Fee" Practices T-03-0, (Technical Assistance Advisory Draft)* 1 (2003), <http://www.insurance.wa.gov/special/accessfees/removed/access%5Ffees%5Fdraft%5Ftaa.pdf>. In the draft advisory, the Commissioner took the position that if a provider participating in a health carrier's network requires patients to pay a mandatory access fee for care that is covered by the terms of the provider's contract, it would violate WAC 284-43-320(a), which is the hold-harmless provision statutorily required to be in all contracts between providers and health carriers or health plans. *Id.*

contractual relationship.⁶⁹ In the draft advisory, the Commissioner went one step further. Even though he recognized that the statutorily required hold-harmless provision applied only to covered services, he interpreted this to mean that physicians could charge patients a fee for optional, non-covered services, only as long as patients could still obtain covered services without paying any additional charge.⁷⁰ This interpretation would, of course, eliminate the ability of physicians to limit their practices only to health plan patients who pay the access fee.

Health commissioners in two other states, New York and New Jersey, have been quite clear in their opinion that concierge physicians within health care networks are engaging in impermissible practices. In a joint memorandum issued to insurers and managed care plans by the New Jersey Department of Banking and Insurance and the Department of Health and Senior Services, the Commissioners took the position that concierge services ought to be immediately terminated because most of the services provided with the access fee could not be readily distinguished from services they were contractually obligated to provide pursuant to network provider agreements.⁷¹ Similarly, the New York Department of Health has informed health insurers that it considers such typical access fee services as twenty-four-hour coverage, case management, and coordination of necessary referrals to be a duplication of services that physicians are already contractually obligated to provide, and are not enhanced or concierge benefits.⁷² Adding to the confusion, private insurers and health plans within the same state may take differing positions with respect to including concierge physicians within their networks. In 2003, Massachusetts-based Harvard Pilgrim Health Care announced that, for policy reasons, it would no longer accept physicians charging access fees into its network of 21,000 physicians.⁷³ Other health insurers within Massachusetts

69. The draft advisory states: "Providers may charge patients mandatory access fees in the following situations: (1) the provider is not contracted with the patient's health carrier; (2) the provider does not participate in any health carrier's network; (3) the patient is covered under an indemnity insurance policy that does not require the use of a network or participating provider; or (4) the patient is uninsured." *Id.*

70. See WASH. REV. CODE § 48.43.085 (2005) (providing that a health carrier may not prohibit its enrollees from contracting for services outside the health care plan). The draft technical advisory, *Mandatory "Access Fee" Practices*, states that this statute allows providers "to charge an *optional* fee for services or amenities not covered by the patient's benefit plan as long as patients may still obtain covered services without paying the additional charge." See *supra* note 68 at 2 (emphasis added).

71. See New Jersey Dept. Of Health and Senior Services, *Impermissible Practice of Retainer Medicine by Network Physicians Bulletin 2003-02 1* (2003), http://www.state.nj.us/dobi/bulletins/blt03_02dhss.pdf

72. See Letter from New York Commissioner of Health, *supra* note 63 (warning health industry executives that concierge physicians may be impermissibly double billing enrollees by offering covered services for an additional fee).

73. See Bonnie Darvies, *Access Fees Have Physicians Moving Cautiously*, AM. COLL.

and most other states have not taken a firm position against concierge physicians, and continue to carry them in their networks.

2. Unlawful Discrimination

Health carriers are required to maintain plan networks that assure enrollees' access to network physicians. New Jersey's Department of Health and Senior Services Commissioner has interpreted the state's network adequacy standards to provide every covered person with access to any network physician that has an opening in her patient panel without payment of any fee, other than cost-sharing required by the plan.⁷⁴ The Commissioner's opinion is that network adequacy standards are violated by concierge physicians when they accept only patients able to pay the access fee, even if the access fee is limited to services that are not covered by the health plan.⁷⁵

In addition, insurers typically require their network physicians to assure that medical services will be available to all of their enrollees without unreasonable delay.⁷⁶ Plans that include concierge physicians who have split their practices and see both concierge patients and traditional managed care plan subscribers may not be in compliance with required assurances because these physicians may cause regular patients to experience an unreasonable delay in order to give non-emergency priority appointments to concierge patients.⁷⁷

Moreover, physicians who have split their practices may be violating their provider agreements when they give preferences to their concierge patients. For

OF PHYSICIANS, April 2004, <http://www.acponline.org/journals/news/apr04/access.htm>.

74. See New Jersey Department of Health and Senior Services, *Impermissible Practice of Retainer Medicine by Network Physicians Bulletin*, *supra* note 71 (“[A] physician’s decision to institute a panel limitation based in whole or in part upon a member’s or covered person’s willingness (or ability) to purchase a retainer contract is not acceptable when that physician participates in a carrier’s network.”).

75. *Id.* (“The physician essentially is charging an entrance fee to his or her practice. This is not consistent with the regulations governing network-based delivery systems in New Jersey.”).

76. See, e.g., WASH. ADMIN. CODE § 284-43-200 (1998) (Washington administrative code provision requiring that in order to have an adequate network “[a] health carrier shall maintain each plan network in a manner that is sufficient in numbers and types of providers and facilities to assure that all health plan services to covered persons will be accessible without unreasonable delay.”).

77. See *id.* Washington Office of the Insurance Commissioner, in its *Mandatory “Access Fee” Practices T-03-0 (Technical Advisory Draft) 1 (2003)*, stated that “providers who will not supply covered services unless an enrollee pays these additional fees will not be recognized by OIC for the purpose of determining compliance with the network adequacy standards in WAC 284-43-200.” See *supra* note 68. To date, this draft advisory has not become official.

example, a standard Blue Cross Blue Shield provider agreement provides: “Physician shall provide Covered Services to Members in the same manner, quality and promptness as services are provided to Physician’s other patients.”⁷⁸ Physicians provide their concierge patients an expedited appointment process, often a waiting room for the exclusive use of concierge patients, and other amenities that regular patients would not receive. Even assuming the quality of medical services was the same for both categories of patients, concierge physicians are essentially contractually bound to their access-fee patients to “prefer” them over their regular patients with respect to appointment preference and amount of time spent, which may violate the anti-discrimination provision of the provider agreement.

C. Conflicts with Federal Laws

1. Medicare’s Balance Billing Prohibition

In 2002, a small group of Democratic congressmen focused on concierge physicians who treated Medicare patients, charging them a substantial fee for access to care in the first instance, then billing Medicare for their office visits. The group’s spokesperson, Representative Henry A. Waxman, sent a letter, cosigned by the others, to Department of Health and Human Services Secretary Tommy G. Thompson (the “Waxman Letter”).⁷⁹ The letter expressed the congressmen’s concern over what they characterized as “a growing national problem of physicians overcharging senior citizens in the Medicare program” and urged the Secretary to bar these physicians from Medicare participation.⁸⁰ The primary import of the letter was its claim that these physicians were engaged in unlawfully billing Medicare in excess of Medicare allowable rates.

A physician wishing to participate in the Medicare program must choose between two forms of participation. First, the physician may be a “participating provider” by taking assignment of the patient’s claim for benefits. In this instance, the physician agrees to accept the Medicare allowable charge in full payment for the service provided, except for applicable deductible and

78. *Primary Care Physician Affiliation Agreement for Blue Choice*, *supra* note 66.

79. Letter from Representatives Henry A. Waxman (D-CA), Sherrod Brown (D-OH), Pete Stark (D-CA), Benjamin Cardin (D-MD), and Senator Richard Durbin (D-IL) (Mar. 4, 2004).

80. Letter from Henry A. Waxman et al. to Secretary Tommy G. Thompson (Mar. 4, 2002) (on file with author). Although concerned with this new form of practice overall, the Waxman Letter focused specifically on the Florida-based medical franchise, MDVIP, and their plans to expand this form of practice to additional states in the coming year. *Id.* at 1. MDVIP requires a patient to pay a \$1500 access fee (\$3000 per couple) before seeing his doctor. *Id.* at 2.

coinsurance.⁸¹ Second, a physician may be a “nonparticipating provider,” in which case the physician can choose on a case-by-case basis whether or not to take assignment of a patient’s claim for benefits. As a nonparticipating provider requesting reimbursement directly from Medicare, the physician will receive only 95% of the Medicare allowable charge for the covered service. If, however, the non-participating physician does not file a claim for reimbursement with Medicare, the physician may charge the patient up to a maximum of 115% of the Medicare allowable rates (the “limiting charge”) and collect that amount from the patient, in addition to applicable deductible and coinsurance.⁸² Patients filing their own claims with Medicare are limited to reimbursement at the Medicare allowable rate.

Physicians wishing to set their own fee schedules for Medicare patients must opt out of the Medicare program entirely and enter into private contracts with their Medicare patients. If properly done, physicians may set their own fees for services, unencumbered by Medicare billing limitations. A physician who opts out, however, may not bill Medicare for anything for a period of two years. The patient is also not allowed to submit any claim for benefits to Medicare for services received from a physician who has opted out of Medicare.⁸³

In the Waxman letter, the congressmen reasoned that if a patient pays an access fee of \$1,500 per year and visits her physician five times for Medicare covered medical services billed to Medicare at \$100 per visit, the patient has paid a total of \$2,000 for one year’s worth of medical services. This, said the congressmen, amounts to \$400 for each of the five visits, representing a substantial overcharge to the patient, and clearly excessive of the Medicare “limiting charge.” The response of Secretary Thompson was brief and not particularly illuminating. He stated that it was not clear whether this practice form violated the law, but the “limiting charge,” he explained, applied only to

81. 42 U.S.C.A. §§ 1395u(i)(1)-(2) and §§ 1395u(b)(3)(B)(ii) (2005) (defining “assignment-related basis” and “participating physician” as one who accepts the Medicare allowable amount as the full charge for the service provided).

82. 42 U.S.C.A. §§ 1395w-4(g)(1)(A)(I) (2005) (“No person may bill or collect an actual charge for the service in excess of the limiting charge described in paragraph (2) for such service.”). 42 U.S.C.A. §§ 1395w-4 (2005)(g)(2)(C) (defining “limiting charge” as “115 per cent of the recognized payment under this part for nonparticipating physicians. . .”).

83. See 42 U.S.C.A. § 1395a(b) (2003) (allowing a physician to enter into a private contract with a Medicare beneficiary, provided no claim for payment is submitted and no reimbursement is received from Medicare); 42 U.S.C.A. § 1395a(b)(2) (2003) (requiring physician’s private written contract with beneficiary to state that the physician’s charges are not limited by the Medicare rules, and that the beneficiary may not submit any claim for reimbursement to Medicare); 42 U.S.C.A. § 1395a(b)(3)(B) (2003) (requiring the physician to file an affidavit with the Secretary affirming the physician will not submit any claim for any service provided to any Medicare beneficiary, or receive reimbursement for any service, for a two year period); see also 42 C.F.R. §§ 405.405-455 (2005) (regulations governing private contracting with Medicare beneficiaries).

covered services. Thus, these physicians should not be in violation of any Medicare laws so long as the retainer fees did not include any covered services.⁸⁴

Concierge physicians accepting assignment for all Medicare payable services may be violating their assignment agreements and subject to civil money penalties and program exclusion, if they request any payment from their patients other than the Medicare allowable fee for covered services.⁸⁵ Similarly, nonparticipating physicians may be subject to substantial penalties and program exclusion if they bill patients in excess of the “limiting charge” for covered services.⁸⁶ The government’s prosecution of Medicare fraud and abuse is persistent and aggressive, and HHS can assess civil monetary penalties for a long list of behaviors that grows with every annual budget reconciliation act.⁸⁷ Thus, the ability to differentiate strictly between Medicare covered and non-covered services is paramount.

Concierge physicians continuing to participate in the Medicare program may face considerable difficulty in assuring that services they provide for the

84. Letter from Tommy G. Thompson, Secretary of Health and Human Services, to the Rep. Henry A. Waxman (May 1, 2002) (on file with author). Enclosed with the letter was a copy of a memorandum from the Centers for Medicare & Medicaid Services to all of the CMS Regional Administrators. The memorandum directs that, in response to inquiries from physicians or their representatives regarding Medicare’s position on retainer fee agreements, physicians should be told that Medicare neither approved nor disapproved the agreements, physicians should be mindful of Medicare requirements, and physicians “should be advised to seek legal counsel to ensure that agreements comply with the law.” Memorandum of March 26, 2002 from Thomas Grissom, Director of Center for Medicare Management to all Regional Administrators (on file with author).

85. 42 U.S.C.A. § 1320a–7a (2003) Civil monetary penalties, provides: (a) Improperly filed claims: Any person . . . that— . . . 2) knowingly presents or causes to be presented to any person a request for payment which is in violation of the terms of (A) an assignment under section 1395u(b)(3)(B)(ii) of this title, or . . . (C) an agreement to be a participating physician or supplier under section 1395u(h)(1) of this title . . . ; (7) . . . shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than \$10,000 for each item or service. . . . In addition, such a person shall be subject to an assessment of not more than 3 times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim. . . . In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the Federal health care programs . . . and to direct the appropriate State agency to exclude the person from participation in any State health care program.

86. *Id.*

87. See generally HEALTH CARE ORGANIZATION AND FINANCE, *supra* note 9, at 636–37. In 2003, the federal government won or negotiated over \$1.8 billion in judgments and settlements of health care fraud matters, and the HHS and OIG excluded more than 3,000 providers and suppliers from participation in federal health care programs. See DEP’T OF HEALTH AND HUMAN SERVS. AND DEP’T OF JUSTICE HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM ANNUAL REPORT (2003), <http://www.oig.hhs.gov/publications/docs/hcfac/hcfacreport2003A.htm#1>.

access fee do not overlap with Medicare's covered services. This is particularly true in light of Medicare's recent preventive care additions. One of the strong marketing approaches for concierge physicians is that the access fee will cover periodic physical examinations and other preventive care that is often not covered by insurance. And, historically, Medicare offered few preventive services. However, beginning January 1, 2005, Medicare added a one-time physical examination to its growing list of covered preventive care, as well as diabetes screening, supplies, and self-management training. Also new is cardiovascular screening.⁸⁸ Faced with the growing list of Medicare covered preventive services, concierge physicians will have difficulty offering anything other than pampering-type services and expedited appointments for their access fee, without running afoul of Medicare "limiting charges." Even though Medicare's physical examination is available only on a one-time basis, and a concierge-practice access fee may typically cover physical examinations on a considerably more frequent basis, the physician would have to confirm that her patient is no longer eligible for the Medicare covered physical or risk violation of the Medicare laws.

On March 31, 2004, the Office of the Inspector General (OIG) issued a Medicare "Fraud Alert" that focused on concierge practices.⁸⁹ The purpose of the alert was to warn Medicare participating physicians of their potential liability for billing Medicare patients for services that are already covered by Medicare, other than applicable deductible and coinsurance. The impetus for the alert was a recent settlement reached between OIG and a Minneapolis internist who, in the transition of his practice from traditional to concierge, presented his patients with a medical care contract requiring patients to pay a \$600 annual fee for access to medical care.⁹⁰ The alert noted that the physician's contract characterized the services to be provided for the \$600 fee

88. See "One Time Welcome to Medicare Physical Exam", at <http://www.Medicare.gov/health/overview.asp>. Beginning January 1, 2005, Medicare covers a one-time "Welcome to Medicare" physical examination within the first six months after signing up for Part B (physician services). In addition to those mentioned above, preventive services now include screening tests for breast, cervical, vaginal, colon and prostate cancer; immunizations for flu, pneumonia, and hepatitis B for those at risk, bone mass measurement; and glaucoma screening. *Id.* However, a 2004 Government Accountability Report, in referring to the upcoming preventive care examination, noted that "[c]overing a one-time preventive care examination does not ensure . . . that beneficiaries will receive the recommended preventive services they need over the long term or consistently improve health or lower costs." *Medicare Preventive Services: Most Beneficiaries Receive Some but Not All Recommended Services*, GAO-04-1004T (2004), <http://www.gao.gov/docsearch/abstract.php?rptno=GAO-04-1004T>.

89. OFFICE OF THE INSPECTOR GENERAL, OIG ALERTS PHYSICIANS ABOUT ADDED CHARGES FOR COVERED SERVICES (2004), <http://www.oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA033104AssignViolationI.pdf> (hereinafter *OIG Alert*).

90. See Markian Hawryluk, *Alert Warns of Medicare Conflict for Concierge Practices*, AM. MED. NEWS, Apr. 19, 2004, at 5.

as not covered by Medicare. These services included coordination of care with other providers, a comprehensive assessment and plan for optimum health, and “extra time” spent on patient care.⁹¹ OIG alleged that, based on the facts of this case, at least some of the services were already covered and reimbursable by Medicare.⁹² Therefore, said OIG, each contract presented to a Medicare patient constituted a request for payment for services already covered by Medicare and was a violation of the physician’s assignment agreement. The OIG alert reported that, in order to resolve the allegations, “the physician agreed to pay a settlement amount to OIG and to stop offering these contracts to his patients.”⁹³ Although OIG took no position on the legality of concierge practices in general, the alert illustrates the fine line between Medicare-covered and not-covered services, and the precarious position of concierge physicians who continue to participate in Medicare. In all likelihood then, concierge physicians will opt out of Medicare and their services will be unavailable to Medicare patients who do not pay an access fee.⁹⁴

2. The False Claims Act

A physician who bills the Center for Medicare and Medicaid Services (CMS) for an amount that does not reflect the true charge to the patient violates the False Claims Act. This act imposes liability upon any person who knowingly presents to the government a fraudulent claim for payment or makes a false statement in order to have a claim approved for payment.⁹⁵ One who

91. *OIG Alert*, *supra* note 89.

92. *Id.*

93. *Id.* The physician agreed to pay a \$53,400 fine, without any admission of wrongdoing. He also agreed he would not ask Medicare beneficiaries to pay an extra fee for the services described in the contract. Editorial, *Keeping it Ethical: Retainer Practices Have Rules and Restrictions*, AM. MED. NEWS, May 3, 2004, at 23.

94. Given the potential for balance billing or federal fraud violations, the safest route for concierge physicians may be to opt out of the Medicare program. Yet concierge physicians who have opted out of Medicare continue to woo Medicare patients because these older persons are often among the wealthier in our society and can better afford the access fee. In such instances, patients pay out-of-pocket for primary care medical services, without reimbursement, as well as the yearly access fee. Concierge physicians typically establish a referral arrangement with Medicare-participating physicians, and refer their patients when particularly expensive diagnostic or laboratory procedures are needed; these services can then be paid for by Medicare. Interview with three concierge physicians (anonymous) who have opted out of Medicare, Society for Innovative Medical Practice Design Conference, Dallas, Texas (May 6, 2005).

95. 31 U.S.C.A. § 3729 (1994). (“(a) Liability for certain acts.—Any person who— (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; . . . is liable to the United States Government for a civil penalty of not less than

violates the act is liable to the government for a civil money penalty of \$5,000 to \$10,000, plus treble the amount of damages sustained by the government.⁹⁶ In the context of concierge practices, a False Claims Act violation would be a derivative claim, dependent upon whether a physician charging Medicare patients an access fee violates his assignment agreement or, for nonparticipating providers, the limiting charge as discussed above. When the physician bills Medicare for the allowable charge and also collects the access fee from the patient, it could be said that the physician's bill does not reflect the true amount of the charge to the patient, which may violate the False Claims Act.

3. HIPAA's Patient Inducement Provision

Physicians converting their practices from traditional to concierge, hoping to recruit their new patient panel from among their current patients, typically send a letter to all patients explaining the reasons for changing to a concierge practice and describing the new services that will be provided for the retainer fee. When engaged in this and similar marketing practices, and particularly with respect to their Medicare patients, concierge physicians must be cognizant of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provision directed at physicians (and others) who aim to influence patients in their choice of provider. HIPAA prohibits a physician from giving any remuneration that the physician "knows or should know is likely to influence" a patient to receive any item or service payable by a federal health care program.⁹⁷ "Remuneration" is defined to include any waiver of coinsurance or deductible, and transfers of items or services for less than fair market value, or for free.⁹⁸ A physician may be subject to a civil money penalty of up to \$10,000 for each item or service billed to Medicare in violation of this provision, as well as an assessment of damages to the government up to three times the amount billed.⁹⁹ On August 29, 2002, OIG published a "Special Advisory Bulletin" for the purpose of alerting the health care industry to acceptable practices in light of HIPAA's patient inducement prohibition.¹⁰⁰

\$5,000 and not more than \$10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person . . .").

96. *Id.*

97. Social Security Act § 1128A(a)(5), 42 U.S.C.A. § 1320a-7a(a)(5) (2003) applies to any person who "offers to or transfers remuneration to any individual eligible for benefits . . . that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under" a federal health care program.

98. Social Security Act § 1128A(g)(i)(6), 42 U.S.C.A. § 1320a-7a(g)(i)(6) (2003).

99. Social Security Act § 1128A(a)(7), 42 U.S.C.A. § 1320a-7a(a)(7) (2003).

100. Office of Inspector General, *Offering Gifts and Other Inducements to Beneficiaries*, Special Advisory Bulletin (2002), <http://www.oig.hhs.gov/fraud/docs/>

OIG explained that providers who offer gifts to Medicare patients may have an economic incentive to offset the costs of any gifts by providing unnecessary services that may be billed to Medicare.¹⁰¹ The OIG announced its intention to interpret HIPAA's patient inducement provision to allow providers to offer inexpensive gifts or services having a retail value of no more than \$10 per individual patient, and no more than \$50 in the aggregate annually per patient.¹⁰²

The issue for the concierge physician is whether the "extra" amenities provided to their patients constitute "remuneration" that may influence the patient's choice of provider. So long as the access fee is not set below the fair market value of the services provided for the fee, concierge physicians should have no difficulty with the HIPAA patient inducement provision. The line is less clear where additional items or services are added; thus, physicians must be careful in their patient contracts to document exactly what is included for the access fee. Ironically, it is those concierge physicians who have the lowest access fees who must be more vigilant not to provide services that, due to a low access fee, might be characterized as a gift.

D. Legislative Attempts to Limit Concierge Medicine

Several legislative attempts to limit the ability of physicians to charge access fees to Medicare patients have been unsuccessful.¹⁰³ Resistance to

alertsandbulletins/SABGiftsandInducements.pdf.

101. *Id.*

102. *Id.* The "Special Advisory Bulletin" sets forth what it terms "bright-line guidance," stating: "First, the OIG has interpreted the prohibition to permit Medicare or Medicaid providers to offer beneficiaries inexpensive gifts (other than cash or cash equivalents) or services without violating the statute. For enforcement purposes, inexpensive gifts or services are those that have a retail value of no more than \$10 individually, and no more than \$50 in the aggregate annually per patient." *Id.* This guideline is subject to a few narrowly described exceptions that do not have specific application to concierge physicians.

103. The first legislative attempt to limit concierge practices was a bill introduced by Senator Bill Nelson (with six co-sponsors) that would amend the Social Security Act to "prohibit Federal funds from being used to provide payments under a Federal health care program to any health care provider who charges a membership or any other extraneous or incidental fee to a patient as a prerequisite for the provision of an item or service to the patient." *See Equal Access to Care Act of 2001*, S. 1606, 107th Cong. (2001).

In 2002, within weeks of receiving the Secretary's seemingly unconcerned response to their letter (the Waxman letter) stating concerns over potentially illegal billing practices of concierge physicians, Reps. Cardin, Waxman, and Brown (joined by Reps. Stark and Kleczka) introduced into the House, the Medicare Equal Access to Care Act of 2002. Like the previous year's Senate bill, this bill would have amended the Social Security Act to "prohibit physicians and other health care practitioners from charging a membership or other incidental fee (or requiring purchase of other items or services) as a prerequisite for the provision of an item or service to a Medicare beneficiary." This bill added an enforcement provision, allowing for sanctions, and an exclusionary period up to two years. *See Medicare*

legislation was undoubtedly due, at least in part, to the lack of empirical information regarding concierge practices and their patients. That Congress was concerned, however, was evident when, in December 2003, with the passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, it required the Government Accountability Office (GAO) to undertake a study on concierge medical practices. Congress directed the United States Comptroller General to determine the frequency with which Medicare beneficiaries are using concierge physicians, and whether this practice form has reduced access to services provided to Medicare beneficiaries through the Medicare program.¹⁰⁴ The GAO report, released in August 2005, concluded that, although concierge physicians practiced in twenty-five states, and their number had grown ten-fold since 2003, these physicians were still too few in number in relation to the total number of physicians accepting Medicare patients “to present a systemic access problem for Medicare beneficiaries at this time.”¹⁰⁵ HHS, in commenting on a draft of the GAO report, indicated that it remained interested in the development of concierge care, and it would “continue to follow this area to evaluate whether any further steps are indicated.”¹⁰⁶

Equal Access to Care Act of 2002, H.R. 4752, 107th Cong. (2d Sess. 2002) (terminated in Committee); *see also* Medicare Payment Restoration and Benefits Improvement Act of 2003, H.R. 26 § 542, 108th Cong. (2003) (prohibiting incidental fees and required purchase of non-covered items or services); Equal Access to Medicare Act of 2003, S. 345, 108th Cong. (2003) (prohibiting physicians and other health care practitioners from charging a Medicare beneficiary a membership or other incidental fee, or requiring the purchase of other items or services, as a prerequisite for receiving covered medical services).

104. *See* Pub. L. No. 108-173 § 650, 117 Stat. 2066, 2331 (2003). The statute provides: Sec. 650 GAO Study and Report on the Propagation of Concierge Care . . . (a) Study.—(1) in General.—The Comptroller General of the United States shall conduct a study on concierge care . . . to determine the extent to which such care (A) is used by Medicare beneficiaries. . . ; and (B) has impacted upon the access of Medicare beneficiaries. . . to items and services for which reimbursement is provided under the Medicare program . . . (2) Concierge Care.—In this section, the term “concierge care” means an arrangement under which, as a prerequisite for the provision of a health care item or service to an individual, a physician, practitioner. . . or other individual— (A) charges a membership fee or another incidental fee to an individual desiring to receive the health care item or service from such physician, practitioner, or other individual; or (B) requires the individual desiring to receive the health care item or service from such physician, practitioner, or other individual to purchase an item or service. . . .

105. UNITED STATES GOVERNMENT ACCOUNTABILITY OFFICE, GAO-05-929, PHYSICIAN SERVICES: CONCIERGE CARE CHARACTERISTICS AND CONSIDERATIONS FOR MEDICARE 9, 11, 26 (2005).

106. *Id.* at 26.

PART III. THE ETHICS OF CONCIERGE MEDICINE

A. Patient Abandonment

Most concierge physicians begin the transition from managed care to concierge care by sending a carefully crafted letter to their patient panel explaining their reasons for adopting a concierge practice form, and explaining the access fee and the new structure. In making the transition, physicians pare down their patient panel, typically eliminating 75% to 90% of patients at prior managed care levels.¹⁰⁷ In many cases, patient levels are reduced from over 3000, down to a few hundred. Perhaps, then, the most compelling inquiry is an ethical one. What is each physician's responsibility to and for the roughly 2500 patients who must now find their health care elsewhere?

Under the common law rule, a physician is under no legal obligation to render services to anyone.¹⁰⁸ Thus, a physician's duty to treat arises out of the exceptions to the general rule, such as a contractual obligation, or a physician-patient relationship. Rarely is the physician-patient relationship the result of a negotiated, arms-length transaction; rather, the relationship is typically one of implied contract, entered into somewhat informally and without conscious thought. The relationship is established when a patient secures an appointment with her physician, or otherwise indicates her intent to seek medical services, with the physician's corresponding intent to provide those services.¹⁰⁹ The

107. See AMERICAN MEDICAL ASSOCIATION COUNCIL ON MEDICAL SERVICES, *Special Physician-Patient Contracts*, Report No. 9-A-02 (2002), available at <http://www.ama-assn.org/ama/pub/category/3778.html> (describing retainer medical practices as restricting patient-physician ratio to between 10% and 25% of managed care levels).

108. See *Childs v. Weis*, 440 S.W.2d 104 (Tex. Civ. App. 1969). The *Childs* case is probably the most cited case for the general proposition that, absent a physician-patient relationship, a physician has no duty to treat one who seeks services. The plaintiff in *Childs*, while returning from a visit to another county, came to the emergency room in labor. The duty nurse telephoned the physician who was apparently on call, informing him that there was "a negro girl in the emergency room having a bloody show and some labor pains," but she lived in another county where she had a regular doctor. The physician told the nurse to have the woman call her own doctor. The nurse told the woman she would have to go to her own doctor in her hometown. The baby was born in the car an hour after leaving the hospital, but died twelve hours later. *Id.* at 105. In granting summary judgment for the physician (in this obviously pre-EMTALA case), the court held that, as a matter of law, no physician-patient relationship existed where the doctor never examined the woman, and in fact had neither seen nor spoken to her at any time. *Id.* at 106. It is no accident that the case cited most often for the "no duty to treat" rule has overtones of racial or economic bias, or both.

109. *Jones v. Malloy*, 412 N.W.2d 837, 841 (Neb. 1987). For example, in *Jones*, the court expressed the formation of the common law physician-patient relationship as follows: "As a practical matter, health professionals cannot be required to obtain express consent before each touch or test they perform on a patient. Consent may be express or implied;

physician's obligation to treat the patient continues so long as the patient needs medical treatment for the particular illness that gave rise to the relationship. The patient is free to terminate the physician at any time.¹¹⁰ When the physician chooses to terminate the relationship, however, she must give the patient reasonable notice of her desire to terminate so that the patient can find another doctor.¹¹¹ If the physician terminates the relationship while the patient continues to require medical treatment, the physician may be liable if she does not give the patient sufficient time to locate another doctor.¹¹² In some jurisdictions, termination of the physician-patient relationship requires only that ending the relationship will not adversely affect the patient's medical treatment, or make the patient's condition worse.¹¹³

In the case of the physician who desires to convert his practice to a concierge model, the fact that the physician's motivation is at least partly, or even primarily economic, is of no consequence.¹¹⁴ Thus, at least so far as abandonment law is concerned, so long as a doctor gives the patient sufficient notice, he may stop treatment for essentially any reason, including retirement, vacation, or inability or unwillingness of the patient to pay the access fee.¹¹⁵

Aside from abandonment law, physicians converting their practices from

implied consent may be inferred from the patient's action of seeking treatment or some other act manifesting a willingness to submit to a particular course of treatment." *Id.* at 841.

110. *See, e.g.*, *Ricks v. Budge*, 64 P.2d 208, 211 (Utah 1937).

111. *Id.* at 211-12.

112. *Id.*

113. *See Modla v. Parker*, 495 P.2d 494, 497 (Ariz. Ct. App. 1972) (finding no case of abandonment where there was neither proof nor allegation that the hospital or its staff did anything to "actively retard [the patient's] treatment or worsen his condition," where the attending physician had "difficulties" with the patient and had discharged the patient and terminated the case before the patient was "cured"). The implication here is that absent an emergency or critical condition, a physician may terminate the relationship even without notice.

114. *Ricks*, 64 P.2d at 212. In that case, the plaintiff sought and received treatment for a severely infected hand from Dr. Budge, for which he was hospitalized for four days. Since the hand seemed to be healing, Dr. Budge discharged the plaintiff with instructions to return if the hand got worse. A few days later, he again sought treatment for his hand, which by this time had broken skin, and was bleeding and oozing pus. The doctor told him he needed to return at once to the hospital for surgery, and he did so. While he was in the hospital, but before surgery, the doctor notified him that he would not perform surgery because the plaintiff had failed to pay an old outstanding medical bill. *Id.* at 210. The plaintiff then left the hospital, and walked two blocks in the rain to another hospital where his by then red and swollen arm required emergency surgery. *Id.* at 210-11. Ultimately, the plaintiff's finger was amputated. *Id.* at 211. The court found that the plaintiff and Dr. Budge had a continuing physician-patient relationship that still existed at the time the plaintiff was discharged for his past-due bill. The court was not concerned that the reason for the discharge was economic – only that the doctor had not given sufficient notice to the plaintiff to allow him to make other arrangements. *Id.* at 212.

115. *See* Mark A. Hall, *A Theory of Economic Informed Consent*, 31 GA. L. REV. 511, 528-29 (1997).

traditional to retainer fee have an ethical obligation not to neglect their patients,¹¹⁶ to support continuity of care for their patients,¹¹⁷ and to facilitate their transfer to another physician.¹¹⁸ The AMA's Office of the General Counsel suggests that in order to remain within ethical guidelines, as well as avoid a claim of patient abandonment, a physician, in addition to giving early notice and explaining the reasons for termination, ought to provide specific resources and recommendations to a patient on locating another physician.¹¹⁹ The AMA, in response to concerns over physicians converting to retainer practices, has clarified that physicians have an ethical obligation to take affirmative steps to assist their sickest and most vulnerable patients in finding other care, and that if no other physician can be found in the local community, the physician may be ethically obligated to continue treating the patient without the retainer fee.¹²⁰

B. The Physician's Free Choice

A basic principle of medical ethics is that physicians may choose their patients as they wish, as well as the environment in which they practice medicine.¹²¹ This freedom of choice is limited by ethical constraints requiring

116. CODE OF MED. ETHICS, NEGLECT OF PATIENT § 8.11E (Am. Med. Ass'n 2004) (advising that "[o]nce having undertaken a case, the physician should not neglect the patient").

117. *See* CODE OF MED. ETHICS, TERMINATION OF THE PHYSICIAN-PATIENT RELATIONSHIP § 8.115 (Am. Med. Ass'n 2004) (advising that physicians must support continuity of care for their patients and that when they withdraw from a case, they must give notice to the patient or other responsible person "sufficiently long in advance of withdrawal to permit another medical attendant to be secured").

118. *See* CODE OF MED. ETHICS, RETAINER PRACTICES § 8.055 (Am. Med. Ass'n 2004).

119. AM. MEDICAL ASS'N, OFFICE OF THE GENERAL COUNSEL, DIV. OF HEALTH LAW, ENDING THE PATIENT-PHYSICIAN RELATIONSHIP (1998), *at* <http://www.ama-assn.org/ama/pub/category/4609.html>. AMA legal advice on appropriate procedures for terminating the physician-patient relationship includes giving the patient written notice by certified mail and giving the patient a valid reason for the termination. In addition, the physician ought to continue to treat the patient for at least thirty days to allow time for the patient to locate another physician, and patient records ought to be transferred without cost. *Id.* at 1-2.

120. Code of med. ethics, retainer practices § 8.055E (Am. Med. Ass'n 2004). *See also* Am. Medical Ass'n, Report of the Council on Ethical and Judicial Affairs, Retainer Practices, CEJA Report 3-A-03, at 4 (2003), http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_3a03.pdf.

121. The nine principles of medical ethics are standards of honorable physician conduct that are the basis for the Opinions that make up the AMA Code of Medical Ethics. Principle VI provides: "A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care." PRINCIPLES OF MEDICAL ETHICS VI, <http://www.ama-assn.org/ama/pub/category/2512.html>.

physicians to respond as best they can to an emergency, and by ethical admonishments against invidious discrimination or discrimination against patients with infectious diseases.¹²² Freedom of choice is also subject to contractual obligations requiring that the physician treat certain patients, except when patient care would be compromised by the contractual agreement.¹²³ In addition, the AMA Code of Medical Ethics states that physicians may be justified in refusing to treat a present or potential patient on three grounds: the patient's needs are beyond the physician's competence; the patient's request for specific treatments is neither medically appropriate nor beneficial to the patient; and the treatment sought by the potential patient is not compatible with the physician's personal religious or moral beliefs.¹²⁴

Absent from the circumstances under which a physician may ethically reject a potential patient is the patient's inability to pay a fee for non-medical services in order to access the medical services of the physician in the first instance. According to the AMA's Council on Ethical and Judicial Affairs (CEJA), a physician's right to choose her patients arises out of two principles. First, physicians have the freedom of association that is guaranteed to all Americans, and they don't lose this by virtue of their professional status.¹²⁵ Second, because medical professionals are in a position superior to their patients with respect to medical decision-making, they have significant autonomy within the physician-patient relationship. The purpose of this autonomy, however, is not to further the physician's self-interest; rather, it is granted for the purpose of assuring that patients receive the best possible care.¹²⁶ Thus, freedom of association is not without ethical restraint, and the exercise of physician autonomy in choosing patients based on their ability to pay the retainer fee may be a misuse of their professional autonomy.

Physicians choosing a retainer-fee practice may say that the best interests of their patients are served by having more time to spend with them. Some may choose this form of practice because they believe that they cannot provide optimal care under the patient load of a typical managed care provider, and that some patients may benefit from preventive services included in the access fee and from procedures or diagnostic tests that are not covered by insurance, but

122. AM. MED. ASS'N, REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, POTENTIAL PATIENTS: ETHICAL CONSIDERATIONS 4-A-00 (2000), http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_4a00.pdf. (physicians cannot refuse to care for patients based on race, gender, sexual orientation, or any other criteria that would constitute invidious discrimination).

123. *Id.*

124. *Id.*

125. *Id.*

126. *Id.* at 2. The CEJA report explains that "[t]he purpose of the exercise of autonomy in this [medical decision making] context is not the furtherance of the physician's interests, but those of the patient." *Id.*

which may be appropriate for them. Still, an undeniable tension exists between the physician's right to choose whom he will treat, and his ethical obligation to act in the best interests of present and potential patients. Moreover, the AMA's CEJA has suggested that in deciding whether to take on a new patient, physicians should consider the patient's need for care along a continuum. If the patient needs life-sustaining care, such as dialysis, or care necessary to sustain functioning health, such as resetting a bone, the physician's obligation to treat is great. If the patient requires only medical services that would be useful to sustain health, such as allergy treatments or purely discretionary services, such as cosmetic procedures, the physician's obligation to take the new patient is reduced.¹²⁷ In a retainer practice, however, the physician's primary consideration is not the need of the patient for medical services, but the ability of the potential patient to pay the access fee. Again, tension exists between the physician's ethical considerations in choosing new patients, and the inherent structure of retainer practices.

A physician's ethical obligations are not restricted to AMA precepts. Surely physicians have an ethical obligation to treat a reasonable number of patients in return for their graduate medical education that, to a not insignificant extent, is subsidized by the United States taxpayer through the Medicare program.¹²⁸ Medicare dollars are used to pay the salaries of residents and teaching staff, to maintain classroom space, and to pay for items such as additional diagnostic tests ordered by trainees treating the sicker population that is served by teaching hospitals.¹²⁹ In addition, through their status as physicians licensed by the State, physicians enjoy the exclusive ability to perform medical procedures and prescribe medications. This state-endowed status ought to obligate physicians to serve their communities in a less exclusive fashion than is exhibited by those concierge physicians serving only a small number of wealthy patients.

127. *Id.* at 4; *see also* CODE OF MED. ETHICS, POTENTIAL PATIENTS § 10.05E (Am. Med. Ass'n 2004) ("Greater medical necessity of a service engenders a stronger obligation to treat.").

128. *See* Michael Gusmano & Mark Schlesinger, *The Social Roles of Medicare: Assessing Medicare's Collateral Benefits*, 26 J. HEALTH POL. POL'Y & L. 37, 41 (2001); *see also* Bobby Jindal & Tom Dowdal, *Medicare's Role in Financing Graduate Medical Education*, 281 JAMA 1228, 1228 (1999), <http://jama.ama-assn.org/cgi/content/full/281/13/1228>.

129. Jindal & Dowdal, *supra* note 128. Since its inception in 1966, Medicare dollars have been used to subsidize resident training and graduate medical education. *Id.* Medicare reimburses direct medical education costs, such as resident and teaching staff salaries and maintenance of classroom space, on a cost basis. *Id.* Indirect medical education costs, which include the extra diagnostic tests necessary in a teaching hospital, are paid by adding a fixed percentage to the payment the hospital receives for the procedure from the Medicare program. *Id.*

C. The Patient's Free Choice

The role of individual patient choice in choosing providers cannot be ignored because, generally, people are entitled to the choices they can afford. When a person chooses to subscribe to a health maintenance organization, he makes that choice understanding that he will face limitations on which physicians will be available to him, as well as limitations on choosing which hospital or other health-care service provider to use. In that sense, an individual may be free to choose a physician that does not participate in his particular health plan, with the knowledge that he will be obligated to pay for services received that might have been covered by his health insurance, had he chosen otherwise. By the same reasoning, individuals have the right to dispose of their financial resources in a manner of their own choosing, and if individuals wish to spend discretionary income on an access fee to obtain the physician of their choice, they should be allowed to do so. Even beyond non-medical luxury or pampering services, the concept of free choice would dictate that individuals have the right to privately contract with their physicians to pay for medical services that they may desire, such as heart scans and genetic testing, but that are not medically indicated.¹³⁰

But physicians converting from a traditional practice to a retainer practice do so with the expectation that a sufficient number of their current patients will pay the fee and remain with the practice. Indeed, some patients may welcome the increased time and attention they can expect to receive from their physician, and if the fee is reasonable for them, or at least worth the financial sacrifice, they may willingly decide to enter into a retainer contract with the physician. Many patients, however, may find that their "free choice" is constrained by concerns that if they choose not to pay the fee, their medical care may be interrupted or otherwise compromised. Given patient perception of a threat to the continuity of their medical care, patients may feel coerced to pay the fee. In addition, a patient faced with a deadline for finding another physician may feel pressured to enter into the retainer contract. A patient faced with the prospect of traveling a longer distance for medical appointments and developing a new relationship with another physician, may feel she has little choice but to pay the retainer fee.¹³¹ Although the AMA has cautioned that

130. See AM. MED. ASS'N HOUSE OF DELEGATES, POLICY PATIENT AND PHYSICIAN RIGHT TO PRIVATELY CONTRACT FOR HEALTH CARE § 380.989H (Am. Med. Ass'n 2004), http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/H-380.989.HTM (stating that "any patient, regardless of age or health care insurance coverage, has both the right to privately contract with a physician for wanted or needed health services and to personally pay for those services.").

131. See AM. MED. ASS'N COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, RETAIN PRACTICES, RPT. 3-A-03 (2003), http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_3a03.pdf.

physicians converting to retainer practices “must not exert undue pressure on patients to agree to the arrangement,”¹³² the situation faced by a patient who has been notified that she must either pay an additional fee to retain her physician, or move on, is inherently coercive. Thus, again, a tension exists between the ethical obligation of the physician not to pressure the patient, and the reality of a retainer practice that, in all likelihood, will only be successful if a sufficient number of current patients remain with the physician.

D. Access to Medical Care

Another potential conflict exists between conversion to a retainer practice and the physician’s ethical obligation to “support access to medical care for all people.”¹³³ Overall access to medical care in a community may be compromised when a physician converts to a retainer practice that serves a patient panel now reduced by as many as 2500 patients. Similarly, the physician’s ethical obligation to provide some indigent care¹³⁴ seems antithetical to a retainer practice made up of wealthier patients. The AMA, in providing ethical guidance for physicians converting to retainer practices, cautioned that these physicians “should seek specific opportunities to fulfill this obligation.”¹³⁵ Moreover, because most practices are located in large and affluent communities, minorities are significantly underrepresented in concierge practices.¹³⁶ Predominantly wealthy patient panels may exacerbate the well-documented disparity in health care for minorities that already exists.¹³⁷

On the other hand, retainer practice physicians may be in a better position to provide indigent care than are their more overworked colleagues, and no evidence exists that these physicians are less likely than others to provide

132. CODE OF MED. ETHICS, RETAINER PRACTICES § 8.055E (Am. Med. Ass’n 2004).

133. CODE OF MED. ETHICS, PRINCIPLE IX (Am. Med. Ass’n 2004).

134. CODE OF MED. ETHICS, CARING FOR THE POOR § 9.065E (Am. Med. Ass’n 2004) (providing that “[a]ll physicians should work to ensure that the needs of the poor in their communities are met,” and that physicians in poor communities ought to be able to rely on the assistance of physicians in the close-by, more prosperous communities).

135. CODE OF MED. ETHICS, RETAINER PRACTICES § 8.055E (Am. Med. Ass’n 2004).

136. See PHYSICIANS IN RETAINER PRACTICE, *supra* note 2, at 1080 (majority of retainer physicians report patient panels with 0% to 5% African-American and Hispanic patients).

137. INST. OF MED., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE (Brian D. Smedley et al. eds., 2003) (demonstrating racial and ethnic minorities are less likely to receive routine medical procedures and receive a lower quality of health services); HENRY KAISER FAMILY FOUNDATION, KEY FACTS: RACE, ETHNICITY, AND MEDICAL CARE (2003) (presenting evidence of racial and ethnic differences in health insurance, access to primary care, and treatment for specific medical conditions), available at <http://www.kff.org/minority/health/upload/Key-Facts-Race-Ethnicity-Medical-Care-Chartbook.pdf>.

indigent care. To the contrary, a recent research study showed that retainer practice physicians may be slightly more likely than others to provide some indigent care.¹³⁸ Indeed, a frequent complaint of physicians overburdened with too many patients is that they have no time to provide indigent care. Even so, providing some indigent care would not offset the potential for an overall reduction in access to medical care in the community and the potential to exacerbate the existing disparity in health care treatment. Thus, ethical tension remains between a retainer practice that, by design, provides care to a relative wealthy few and the physician's obligation to support access to care for all people.

PART IV. REFLECTIONS AND A PROPOSAL

Physicians converting to concierge practices are, for the most part, caring professionals who do not have a single motivation. In one sense, self-interest propels them to seek a higher income, better working conditions, and more time with their families. But most physicians would claim also that the impetus for the move is the desire to preserve professional integrity—that in the face of managed care cost cutting combined with Medicare's diminishing reimbursement levels, they cannot do their best by their patients.

Heavy-handed managed care practices and diminishing reimbursements, aided by an unsympathetic media, have to some degree eroded trust and confidence in our health care system.¹³⁹ Distrust is evident in the many state and federal regulatory attempts to address problems within the private and public health care industries. No doubt concierge physicians and their patients hope for some restoration of trust through a redefined physician-patient relationship. Concierge patients perceive that they will receive needed medical attention, which at least by inference, was not available to them under the conventional managed care system. Concierge patients may trust their physicians more, their trust flowing naturally from the societal position of the medical professional,¹⁴⁰ but also from the assumption that they are paying for

138. See PHYSICIANS IN RETAINER PRACTICE, *supra* note 2, at 1080.

139. See Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463 (2002) (explaining the nature and significance of trust in the law generally, and in health care law in particular). Hall is at the fore of an emerging trust movement in health law. The present article, however, is not meant to weigh in on the legitimacy of this viewpoint or, to the extent that trust is defined as faith rather than consumer confidence, the opposing viewpoint as espoused by Robert Gatter. See Robert Gatter, *Faith, Confidence, and Health Care: Fostering Trust in Medicine Through Law*, 39 WAKE FOREST L. REV. 395, 445 (2004) (explaining that health policy driven by trust-as-faith rather than trust-as-confidence is not necessary and may be potentially destructive).

140. Medicine has always occupied a special position in our society. For an excellent chronicle of how the medical profession rose to a position of political influence, cultural authority, and economic power in the United States see PAUL STARR, *THE SOCIAL*

better care.¹⁴¹ Trust alone may go far in advancing positive outcomes for concierge patients.¹⁴² Although no evidence directly relates time spent with physicians to favorable patient outcomes, studies do indicate that good communication between patient and physician, and patient participation in medical decisions affecting their health, lead to better patient compliance with treatment recommendations.¹⁴³

Better communication includes physician behaviors that presumably require spending more time with their patients, such as empathy, reassurance, support, more time spent on history-taking, explanations of treatment, even

TRANSFORMATION OF AMERICAN MEDICINE (1982).

141. The AMA deems it unethical for concierge practices to present themselves as offering a higher quality of care than conventional practices. See CODE OF MED. ETHICS, RETAINER PRACTICES, *supra* note 135. The AMA cautions that “it is important that a retainer contract not be promoted as a promise for more or better diagnostic and therapeutic services. *Id.* Physicians must always ensure that medical care is provided only on the basis of scientific evidence, sound medical judgment, relevant professional guidelines, and concern for economic prudence. *Id.* Physicians who engage in mixed practices, in which some patients have contracted for special services and amenities and others have not, must be particularly diligent to offer the same standard of diagnostic and therapeutic services to both categories of patients. *Id.* All patients are entitled to courtesy, respect, dignity, responsiveness, and timely attention to their needs. *Id.* Concierge practices, however, either expressly, or at least inherently, do promise better health care. For example, the website for MD2, a Seattle concierge practice, states that “MD2 provides an exceptional alternative for those individuals who are not willing to compromise the quality of their health care” and “[w]e are pleased to offer a medical program available to a select few that is dedicated to exceptional service and superior quality. . . .” See MD2 Home Page, <http://www.md2.com/md2.html>.

142. See Hall, *supra* note 139 at 479-80. “[T]he doctor himself is a placebo or a therapeutic agent, regardless of the particular technique used or its independent, biochemical effectiveness, since interaction with a caring and expert practitioner appears to activate dimly understood healing mechanisms that strengthen more active and visible modalities.” Anthony L. Suchman & Dale A. Matthews, *What Makes the Patient-Doctor Relationship Therapeutic? Exploring the Connixional Dimension of Medical Care*, 108 ANNALS INTERNAL MED. 125, 125-30 (1988) (citing W. R. Houston, *The Doctor Himself as a Therapeutic Agent*, 11 ANNALS INTERNAL MED. 1416, 1417 (1938)).

143. See Rainer S. Beck et al., *Physician-patient Communication in the Primary Care Office: A Systematic Review*, 15 J. AM. BOARD OF FAM. PRAC. 25, 31-34 (2002). Researchers reviewed twenty-two studies completed between 1975 and 2000 of verbal and non-verbal communication between primary care patients and their physicians. *Id.* They found that certain verbal and nonverbal physician behaviors are associated with both short-term and long-term favorable patient outcomes. *Id.* Physician behaviors studied included empathy, reassurance and support, patient-centered questioning techniques, increased visit time, more time spent on history-taking, explanations of treatment, and humor. *Id.* Researchers examined the content of physician-patient communication, focusing on the problems of daily living, social relations, feelings, and patient emotions. *Id.* They also considered time spent on health education and information sharing, as well as the friendliness and courtesy exhibited by the physician. *Id.* They found that these verbal and nonverbal physician behaviors were positively associated with short-term and long-term patient outcomes. *Id.*

humor, and talking about the problems of daily living.¹⁴⁴

That many concierge practices appear to be operating successfully is proof that this practice form fills a market need. Yet, from an economic viewpoint, one would expect the proliferation of retainer practices to be self-limiting. Higher prices lead to smaller demand, and few families can afford, or would choose to pay, the \$24,000 per year for a family of four commanded by MD2. If the growth of such high-end practices is self-limiting, the number of non-retainer patients who are pushed into the health care market in search of other primary care physicians should be similarly limited. The present apparent ability of non-retainer patients to find other care, however, is likely due to the clustering of most concierge practices in large metropolitan areas that have greater overall physician availability.¹⁴⁵ Physician availability is substantially more limited in less-populated areas. In rural areas, quite possibly even a single conversion of a physician practice to a concierge practice could result in an adverse impact on patient access to care.¹⁴⁶ And, given the flexible range of access fees, any apparent self-limiting of concierge practices is as likely due to physician hesitation in an uncertain legal environment as to market control.

It is not entirely accurate to say that a proliferation of retainer practices would create a multi-tiered system of health care, with the poor at the bottom. To a considerable extent, health care in America is already stratified. Those fortunate enough to receive health care through their employer may have some choice of health plans, such as a low cost HMO or a higher cost POS plan. Similarly, employees with PPO plans may have a choice between the more cost effective standard plan, or an “elite” plan that provide more coverage with more providers, for a higher price. And, those with no health insurance are already at the bottom of the system. Viewed in this light, retainer practices make only one more contribution to existing inequalities.

More troublesome, however, is the issue of patient access to primary care

144. *See id.* The perception that concierge patients are getting better care may be just that. In a June 2002 report on concierge medicine and retainer contracts from the AMA’s Council on Medical Service, the Council expressed concern that “physicians who substantially reduce their patient panels may risk diminishment of their clinical proficiency.” AM. MED. ASS’N COUNCIL ON MED. SERVICES, *supra* note 107.

145. *See* PHYSICIANS IN RETAINER PRACTICE, *supra* note 2, at 1080 (noting that most concierge practices are in large cities and coastal states).

146. A county is designated as a Primary Care Health Professional Shortage Area (PCHPSA) if it has a population-to-primary-care-physician ratio of more than 3500 to 1. THE ROBERT GRAHAM CTR., THE UNITED STATES RELIES ON FAMILY PHYSICIANS, UNLIKE ANY OTHER SPECIALTY (2000), <http://www.graham-center.org/x160.xml>. In 2000, the United States had 3082 PCHPSAs. *Id.* If family physicians were not counted in the total number of physicians practicing in areas not designated PCHPSAs, an additional 1332 counties would qualify as PCHPSAs. *Id.* *See also* Am. Acad. of Family Physicians, *Rural Practice, Keeping Physicians In*, March 2002, <http://www.aafp.org/x16635.xml> (discussing the shortage of physicians in rural areas).

if legal impediments disappear and concierge medicine continues to grow. A physician reducing her patient panel from 3000 to 500 must send 2500 patients into the market in search of a new primary care physician. Although the reduction in the number of patients varies from practice to practice, an AMA survey found that, on average, concierge physicians care for 1405 fewer patients than other primary care physicians.¹⁴⁷ A proliferation of concierge physicians could flood the market with patients searching for a new primary care physician. Economic theory would predict that a greater demand for primary care physicians would create a greater supply—that more medical students would choose internal, family, or other primary care specialties. And, because patients in the market in search of physicians carry their access to health care dollars with them, those dollars are available to pay for more primary care physicians.

The demand for primary care physicians is already outpacing the supply. The trend of medical students choosing their specialties has been away from primary care for the last several years. For example, at its peak in 1997, 89.1% of family medicine positions offered were filled compared to 2005, when only 82.4% of these positions were filled.¹⁴⁸ The number of U.S. seniors matching into family medicine residency programs has decreased for the ninth consecutive year, from 72.6% of positions filled with U.S. seniors in 1996 to a mere 40.7% in 2005.¹⁴⁹ And, while fewer medical students are choosing primary care specialties, 80% of physicians over fifty years of age are considering retiring from full time clinical practice in the next five years.¹⁵⁰ To a not insignificant extent, the declining interest in primary care specialties is related to the changing reward structure in medicine brought about by managed care and the loss of control over professional autonomy.¹⁵¹

147. PHYSICIANS IN RETAINER PRACTICE, *supra* note 2, at 1080.

148. See Mona M. Singer & Robert L. Beran, *Results of the National Resident Matching Program for 2005*, 80 ACAD. MED. 610, 610-12 (2005). Although the 2005 percentage of positions filled represents an increase from 78.8% in 2004, the increase is due primarily to international student interest. *Id.*

149. See *id.*

150. See AM. MED. ASS'N, 2004 HEALTH CARE TRENDS: AN ENVIRONMENTAL ANALYSIS (2004), <http://www.ama-assn.org/ama1/pub/upload/mm/41/ea00.pdf> (referencing a survey conducted by Merritt Hawkins & Associates); see also Marsha Austin, *Some Worry About Doctors Retiring Early, Shortage Fears Called Premature*, DENVER POST, June 10, 2002, at C-01.

151. See Ray E. Dorsey et al., *Influence on Controllable Lifestyle on Recent Trends in Specialty Choice by US Medical Students*, 290 J. AM. MED. ASS'N. 1173, 1175-76 (2003). The objective of this study was to determine whether and to what degree changes in the specialty preferences of U.S. senior medical students was due to "controllable lifestyle and other specialty-related characteristics." *Id.* at 1173. After controlling for income, work hours, and years of training, the researchers concluded that students are changing their preference to those specialties that have a controllable lifestyle. *Id.* The study shows that significantly fewer U.S. senior medical students are choosing the family practice specialty as their top

Of even greater concern is the potential effect of concierge medicine on Medicare eligible seniors, most of whom will be hard pressed just to pay rising Part B premiums. The population in the United States is growing older. In 2010, the first baby boomers turn 65, and by 2030, seniors eligible for Medicare will number 70 million, or 20% of the total population.¹⁵² By age 65, an average individual has at least one chronic disease such as hypertension or arthritis, typically managed by a primary care physician.¹⁵³ And seniors who have multiple chronic conditions have the highest number of physician visits.¹⁵⁴ Anticipated declines in Medicare payment rates herald primary care physician shortages for Medicare patients. Under current law, physicians are facing projected payment reductions of nearly 5% per year for six consecutive years, beginning in 2006.¹⁵⁵ According to an American Medical Association member survey conducted in February and March of 2005, 56% of physicians surveyed said they would reduce their Medicare caseloads if cuts for 2006 were implemented as planned. Thirty-eight percent indicated they would accept fewer new Medicare patients, and 18% would drop existing Medicare patients from their current loads.¹⁵⁶ And, if multiple years of cuts were implemented as planned, 47% indicated they would stop providing care to Medicare patients.¹⁵⁷ Add to these projections the primary care physicians who have opted out of Medicare to pursue concierge practices, and the outlook for primary care for Medicare patients is increasingly gloomy. Thus, although concierge medicine cannot be blamed for the dearth of primary care physicians, this practice form has the potential to exacerbate existing shortages, and could contribute significantly to reduced access to health care for managed care and Medicare patients.

For some physicians, the exclusivity of a concierge practice may be a panacea, allowing for more time, fewer patients, better preventive care, higher income, and improved quality of life. Constrained only by the economies of supply and demand, those physicians who wish to function outside of the existing managed care structure and provide both medical and luxury services to their patients, should be allowed to do so, as long as they remain cognizant of state laws regulating insurance.

choice. In 1996, 16.1% of students chose family practice as their top choice. That number declined steadily each year, to 12.2% in 2000. *Id.* at 1175. The decline for family practice was more significant than for any other specialty areas. *Id.* at 1176.

152. See AM. MED. ASS'N, 2004 HEALTH CARE TRENDS: AN ENVIRONMENTAL ANALYSIS, *supra* note 150, at 5.

153. *Id.* at 8-9.

154. *Id.*

155. See THE BOARDS OF TRUSTEES, FED. HOSP. INS. AND FED. SUPPLEMENTARY MED. INS. TR. FUNDS, ANN. REP. 19 (2005), <http://www.cms.hhs.gov/publications/trusteesreport/tr2005.pdf>.

156. *Id.*

157. *Id.*

But concierge medicine is not a solution to what ails our health care system, and should not be encouraged as simply another choice *within* the existing private managed care or governmental health care structure. In reality, this exclusive practice form is merely a product of a groaning system; a symptom that the current structure is unstable. Concierge medicine is the product of a system of health care delivery that highlights system failings.¹⁵⁸

What, then, is the role of law? Most concierge physicians ought to be able to structure their practices in compliance with existing state and federal laws. With careful legal advice, they can avoid the earmarks of being in the business of insurance by collecting fees periodically rather than yearly, not in advance, and allowing patients to terminate their contracts at will, with refund of the remaining portion of the access fee. Through careful separation of covered from non-covered services, concierge physicians may remain compliant with the hold-harmless provisions of private health care plans, and with Medicare's balance-billing prohibition. So long as physicians do not offer free amenities to attract their patients, they would not run afoul of HIPAA's patient inducement provision.

But even if physicians can overcome most legal obstacles, will our national health policy be improved, or at least unaffected, if concierge medicine flourishes among the wealthy; or does it potentially pose a substantial barrier to health care access for those who cannot afford to pay? The law should promote those systems and relationships that improve our health care system, whether that means restoring, or at least preserving confidence in our health care system and in physician-patient relationships, promoting an environment conducive to better communication between patients and their doctors, or legislating necessary preventive care. Health policy ought to focus on two tasks: (1) determining the best model of care that produces the most favorable outcomes, and (2) determining how best to pay for it, whether privately or through government programs.

Concierge practices that aim to foster physician-patient relationships through increased availability to, and time with, their patients, and that provide increased preventive care and disease management, may well result in better outcomes for their patients. And concierge medicine's focus on preventive care may also be the key to controlling health care costs.¹⁵⁹ But, to the extent

158. See generally Phyllis Griffin Epps, *Champagne Health Care and Caviar Dreams: Boutique Medicine in the United States* (2002), <http://www.law.uh.edu/healthlawperspectives/managed/020220Champagne.html>.

159. On July 6, 2005, the concierge medicine franchise MDVIP announced that former U.S. Department of Health & Human Services Secretary Tommy G. Thompson will chair the MDVIP Committee on Cost Reduction through Preventive Healthcare. Said Secretary Thompson, "It is essential that our nation reorient the delivery of primary care to prevent illness at the front end, instead of spending untold billions of dollars for treatment at the back end." Press Release, Tommy G. Thompson, Former U.S. Secretary of Health & Human

concierge medicine offers positive solutions for better health, these solutions ought to be incorporated into existing private and governmental frameworks. The current relatively passive legal environment, however, serves only to encourage more physicians to escape the constraints of managed care and return to the unrestrained fee-for-service model that produced the very abuses that managed care was meant to address in the first instance. State and federal legislators should not remain idle while physicians withdraw badly needed services from their communities in order to set up elite practices serving a segment of wealthy patients, while at the same time taking advantage of private and public mechanisms that supply them with potential patients or allow them to supplement their split practices. Managed care networks contracting with concierge physicians provide them with a steady source of enrollees from which they can cherry-pick the wealthiest, and usually healthiest, patients for their elite practices, leaving behind a comparatively sicker population for other physicians to absorb.¹⁶⁰ Moreover, tacit approval of concierge medicine by private managed care, and the acceptance of concierge physicians into their networks fosters discrimination among enrollees in the manner in which care is received, and reduces overall access to care. To avoid cherry-picking and its resulting discrimination against less healthy patients, state regulators must assure that managed care organizations limit provider networks to those physicians who will be available to their enrollees without an extra charge. State regulators can accomplish this either by strictly interpreting hold-harmless clauses in provider contracts,¹⁶¹ or through their authority to set network adequacy standards.¹⁶² Although some MCOs have voluntarily adopted a policy against carrying concierge physicians in their networks,¹⁶³ state regulation and enforcement is necessary to assure that all network providers are available to MCO enrollees on an equal basis, without an additional access charge.

Services To Chair MDVIP Committee On Cost Reduction Through Preventive Healthcare (July 6, 2005), <http://www.mdvip.com/pressReleaseThompson.asp>.

160. See U.S. DEPT. OF HEALTH & HUMAN SERVS., OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION, HEALTHY PEOPLE 2010: A SYSTEMATIC APPROACH TO HEALTH IMPROVEMENT, http://www.healthypeople.gov/Document/html/uih/uih_bw/uih2.htm#goals. (stating that “disparities in income and education levels are associated with differences in the occurrence of illness and death, including heart disease, diabetes, obesity, elevated blood lead level, and low birth weight. Higher incomes permit increased access to medical care, enable people to afford better housing and live in safer neighborhoods, and increase the opportunity to engage in health-promoting behaviors”); see also George A. Kaplan et al., *Inequality in Income and Mortality in the United States*, 312 BRITISH MED. J. 999, 999 (1996) (presenting research showing a “significant negative correlation between the percentage of total household income received by the less well off 50% of persons in each state, and all causes of mortality. . .”).

161. See discussion *supra* Part II.B.1.

162. See *id.*

163. See *id.*

More importantly, physicians participating in the Medicare program should be prohibited from using that program to attract wealthier, healthier patients able to pay the access fee, leaving other physicians to absorb the less healthy Medicare patients. Allowing concierge physicians continued participation in the Medicare program would lead to a tiered system based on wealth, and a reduction in overall access to services that did not previously exist in traditional Medicare. Unfortunately, previous legislative attempts to bar concierge physicians from charging access fees to Medicare patients have been unsuccessful,¹⁶⁴ and future legislation is not likely until Congress has evidence that concierge medicine has reduced access to care for Medicare patients. As is clear from the recent GAO report, the number of concierge practices is still too few in comparison to the total number of physicians serving Medicare patients to register any impact on access to care.¹⁶⁵ HHS, however, has indicated its intent to continue to monitor the growth of concierge care.¹⁶⁶ Assuming these practices continue to grow at their current pace, their impact on access to care will be more measurable. At such time, Congress should be more amenable to legislation prohibiting physicians from charging membership or other incidental fees as a prerequisite for receiving covered Medicare services. Concierge physicians should not be allowed to charge access fees to Medicare patients unless they have opted out of the Medicare program and entered into private payment contracts with their patients. Medicare dollars should go to physicians who provide patients free access to their services.

Discussion of how to fix the current system is often circular, going back to the beginning of what “ought to be” in the first instance – a system of reform built on a bedrock of universal health care coverage that provides a basic core package of necessary health care services to all Americans. In the interim, the managed care baby should not be thrown out with the bath water. To the extent that heavy patient loads discourage trusting relationships and provide little time for necessary preventive care, managed care organizations must reduce patient loads. Through market pressures, or legislation if necessary, physician reimbursement levels must be brought to a level that attracts and retains physicians within the system. Likewise, Medicare must provide physician reimbursement at levels that will encourage physicians to open their practices to more Medicare patients rather than fewer. Reduced patient loads and increased reimbursement levels ought to increase the number of primary care physicians in the market. Better overall practice conditions should encourage more medical students to choose primary care specialties. An increase in the availability of primary care physicians should, in turn, serve to keep patient loads manageable. Lighter patient loads would allow physicians to rekindle the

164. See discussion of federal legislative attempts *supra* Part II.D.

165. See *id.*

166. *Id.*

physician-patient relationship and spend the time necessary with patients to assure that they receive sufficient preventive care, counseling, and encouragement. Better primary and preventive care should, in turn, lead to fewer chronic diseases and a reduced need for specialty physicians. Better primary and preventive care for everyone would make available health care dollars that were formerly spent on expensive emergency care for the uninsured and expensive treatment for advanced disease that could have been detected and treated earlier. In the end, more Americans get healthier for fewer dollars—and all (or mostly) without an access fee.

CONCLUSION

Medical students seek principled guidance from practicing physicians, and those physicians look to their more experienced peers. The message sent by concierge physicians is that the only way to “reclaim the heart and soul of medicine” and to establish meaningful relationships with one’s patients, while at the same time enjoying a reasonable income, is to care for those with the most resources.¹⁶⁷ This message is not appropriate for today’s medical students. Neither is it appropriate as a national health care policy. To the extent lessons are to be learned from concierge medicine, they should be the focus of improvements to the current system. Unaided by state and federal law and by private managed care, concierge medicine will, and should, remain restricted to those few wealthy persons who are its natural focus.

167. See Martin Donohoe, Commentary, *Retainer Practice: Scientific, Social Justice, and Ethical Perspectives*, VIRTUAL MENTOR (2004), <http://www.ama-assn.org/ama/pub/category/12249.html>.

