PATIENT FINANCED MEDICINE: PAST, PRESENT AND FUTURE
(GAO Report)

Prepared by the American Society of Concierge Physicians

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The Reappearance of Patient Financed Medicine

Although there is much recent controversy about a form of medical care called variously "Concierge", "Boutique", "Retainer" and "Retail" – these can all be subsumed into the larger concept of patient financed medical care. In many of these practices the patient pays all of the physician fees and in others the physician is paid a monthly fee by the patient while medical care visits and procedures are paid by the patient's insurance company. The history of patient financed care is the history of medical care itself. Over the centuries physicians have almost always been paid by patients, either in currency, services or goods. The alternative to the patient financed structure is health insurance, supported primarily by either taxation or by employer contributions, a healthcare financing design with a history of roughly 100 years. As recently as the 1960's, the vast majority of medical care service payments involved cash transactions between patients and either physicians, hospitals or other purveyors of medical care. In the 1960's, the federal government initiated the first ambitious nationwide publicly funded programs in the United States (see a partial list below) which proliferated and were accompanied by a parallel growth in private healthcare coverage financed primarily by employers. The employers began to offer health insurance as an employee perk because of government mandated wage and price controls during World War II, the Korean War and as recently as the 1970's. Employer financed health insurance is now widely available and is a benefit considered by some as a critical issue in choosing an employer. Because of federal tax laws allowing tax write-offs for employers providing health insurance which are unavailable to individuals, almost all private health insurance is now paid through employers.

	A Partial History of Government Health Insurance
1935	Social Security Act
1950	Congress improves access to medical care for those on public assistance
1960	Kerr-Mills Bill provides medical assistance for the aged
1965	Medicare and Medicaid (Titles 18 and 19 of the Social Security Act) enacted (King-Anderson bill) to cover those over age 64
1973	Scope of Medicare widened to include Social Security or Railroad Retirement Disabled and those with End Stage Renal Disease
1977	Health Care Financing Administration (HCFA) created to administer the Medicare and Medicaid Programs (38 million enrolled, 87% of them used services in 1997)
1997	Medicare Part C (Euphemistically called Medicare + Choice) including HMO, PSO (Provider-Sponsored Org), PPO and limited MSA.

As these forms of health insurance have grown, they have gradually evolved from traditional insurance designs toward national medical management organizations. Although termed insurance, these financial designs are less involved with risk distribution and more focused on financial risk control and management. They require that the insurer be notified of all medical purchases and take responsibility for all but a small portion of physician reimbursement. With the assistance of the National Association of Insurance Commissioners, these government programs (Medicare and Medicaid) and private insurers were permitted to directly contract with, and for all intents and purposes employ physicians in extensive networks. These contracts became progressively more restrictive, eventually evolving to the present forms in which

physicians have no meaningful control over price or reimbursement. In addition, most of these contracts explicitly prohibit physicians from requesting any reimbursement for medical services from patients other than those allowed in the contracts (primarily copays, deductibles and payment for "uncovered" services). Physicians have been largely powerless in attempts to collectively bargain with the insurers and government because of laws prohibiting such bargaining, even though they face some of the wealthiest and best organized corporate financial entities in their negotiations. As the number of private insurers has declined and health insurance markets have consolidated so that 3-5 insurers dominate the market in most regions, the ability of physicians to control their reimbursement has become negligible.

As currently designed, the vast majority of medical care encounters are controlled by highly constrictive contracts and paid for with either government (tax generated) or private (originating for the most part from employer contributions) insurance money. As medical care financing has shifted from a patient financed design to a government and employer financed system, some disturbing and not very surprising trends have appeared:

1) Since the advent of Medicare and private insurance driven medicine, the rate of inflation in medical care has averaged in the double digits annually. The net effect of insurance driven systems is to pour huge amounts of money into the medical marketplace. That money is available to any resourceful vendor of medical services and products. Since the users of the medical system (patients) have little incentive to restrain purchases, the insurer is the only barrier to runaway expenditures. Because of the potential for public embarrassment or even legal suits should the insurer hold the line on spending, it has generally been easier to allow these escalating expenditures and simply raise premiums to cover the increased costs (see Appendix A). In the last ten years (Appendix A), this inflation has continued despite concerted efforts by insurers to control costs. Interestingly, by far the most rapidly growing sector of medical expenses is pharmaceutical costs, growing from 5% to 12% of personal healthcare costs between 1982 and 2002 (Appendix B). Insurers have been particularly unsuccessful at controlling pharmaceutical companies, which are more adept than physicians at extracting large sums from insurers. They have an army of sales people across the United States marketing to physician offices, very aggressive and well financed political lobbying organizations and the financial clout to direct-market to patients via various media channels.

2) Even though medical cost inflation has been remarkable, this cash flow has not necessarily filtered down to physicians, particularly primary care physicians. In the last 10 years primary care physician income has been lagged behind inflation (Appendix E), because of the success of highly restrictive contracting by insurers and rapidly increasing overhead (related mostly to the cost of billing and compliance with insurance company rules and government regulation).

3) As physician income has been controlled, they have also ironically been asked to become per se insurance companies in the form of capitated contracts with "insurers". In an HMO world, the insurer passes its risk to the physician by

paying him a fixed monthly fee regardless of services provided. Physicians begin to subconsciously view sick patients as a cost to be minimized rather than as a person to be helped. It is a world in which harder work and sicker patients translate into reduced profit despite longer hours. To adapt to the new HMO world, physicians began to reinforce barriers to availability and care, particularly for those who will consume the most resources. The tools have included phone systems without an identifiable knowledgeable human being on the other end, various self-help books and online services, prolonged waits for care of non-emergent problems (and sometimes emergent ones as well), reliance upon non-physicians to provide care, and the now infamous 3-5 minute average office visit.

4) As the cost of these highly inflationary insurance designs became unacceptable to taxpayers and employers, insurers have instituted systems to centrally control the use of medications and procedures. These included creation of formularies, pre-authorization of expensive treatments and periodic evaluation of physician "performance" (generally meaning cost of care). These attempts to impose centralized cost controls have failed to slow cost inflation and have reduced the freedom of doctors to customize care for the individual needs of patients. They have also magnified the overhead costs of physicians by increasing documentation requirements and physician time spent trying to understand the directives of multiple insurers, all with different rules.

5) As physicians provide less and less patient responsive care and the cost of premiums increase, the patients have come to realize that their doctor no longer works exclusively for them. This has undermined trust and strained the doctor-patient relationship.

6) As the relationships become strained, experienced physicians are retiring early from medicine and changing professions because they will no longer tolerate the conditions they are forced to work in. In several major cities there are no Internal Medicine physicians over the age of 50, many preferring to switch carreers than continue practicing medicine. The result is a loss of many of the most experienced and effective physicians. Many physicians are counting the days until they can get off the medical assembly line. Frustrated by their inability to provide the type of quality service they desire, they leave the system permanently.

As the quality of patient encounters shrinks, medical office overhead increases, physician salaries dwindle and the cost of care skyrockets - it appears that all involved in medical care have become dissatisfied and a few radicalized. This is the substrate nurturing the current wave of new practice designs.

The Creation of Concierge Care

The first concierge practice was MD^2, founded in 1996 by Howard Maron, M.D. and Scott Hall, M.D. This practice charged its patients up to $1,000 per month and provided a luxurious assortment of services, including house calls in other cities, same-day service, a custom travel kit, 24/7 availability of physicians and access to very experienced and talented physicians. Although their practice was quite small (50 families per physician), it represented a revolutionary shift in both the financing and patient focus of medical care. The term "concierge" was coined by the press and has been used to describe all of the subsequent financial designs, even though few of them have any resemblance to the MD^2 model.

The next monthly fee practice was Seattle Medical Associates (SMA), founded in 1997 by Garrison Bliss, M.D. and Mitchell Karton, M.D., both previous partners of Drs. Maron and Hall. Although SMA had a monthly fee design, it intentionally avoided the upscale design of its predecessor. The maximal monthly fee was $65 and the minimal monthly fee was $15 (teens). Patients who could not afford the fee were offered free or discounted care. This practice, like MD^2 accepted no insurance money and regarded itself as independent of the influence of insurance companies on medical decision making.

Coincident with the above practices, and also arising in the Seattle area, Vern Cherewatenko, M.D. and David MacDonald, D.O. started SimpleCare in 1997. This was a pure fee-for-service design and also accepted no insurance payments. Patients were charged fees comparable to the actual payment physicians would get if they billed the patient's insurance company. Even without an increase in receipts, physicians could expect a significant improvement in real take-home income since they eliminated the cost of insurance billing, which is substantial (often as much as ¼ to ½ of overhead). These physicians stopped participating in insurance contracts and relied exclusively on patient payments. SimpleCare has generated considerable interest in the physician community, currently numbering over 1600 doctors and 24,000 patients nationwide. These practices do not claim to offer VIP or "concierge" care, only a simplified financial design in which the doctor works directly for and is paid by the patient.

MDVIP is the best known of the "concierge" designs. It was founded by Bernard Kaminetsky, M.D. and Robert Colton M.D. in Boca Raton. They incorporated elements of both a monthly fee practice and an insurance financed practice. They accept insurance money for covered services and charge an annual fee of up to $1,500 for non-covered services (such as 24/7 availability to their own physician, an annual executive physical exam and others). As of this writing, there are 52 physicians who have adopted the MDVIP design.

As the primary care physicians have widened the availability of these practices, subspecialty physicians (dermatologists, rheumatologists, gynecologists and others) have begun to form cash-only practices that choose to avoid the contractual controls imposed by government and insurers. Although there are limited examples of which we are aware, all have been successful financially, generating some press but little controversy.

Presently there are hundreds of practices in the United States that have separated from the insurance-driven market. Since this is a grassroots movement, it is impossible to know how

many practices there are and how many patients are affected. The only thing that is certain is that the doctors and patients participate in these practices by choice. Patients want to return to a more personal and convenient interaction with their doctor. Doctors want a doctor-patient interaction unfettered by the demands and red tape of big government and big insurers.

The conflict and controversy has rarely been tied to complaints from patients. There is no evidence that these practices fail to produce on their promise of improved availability of patient care and higher service. Patients are demanding better service – and they are willing to pay for it. The medical care may be the same, but the increase in service is a benefit that improves the patients' overall quality of life. Participating patients have made it clear that they are pleased with these designs, particularly when government regulators have threatened to close them down (1,000 letters available on request.)

Why Monthly Fee Designs?

If you review the details of insurance contracts you will find the reasons for these practice designs. All are attempts to separate from the constraints of government and corporate medical care without injuring or abandoning patients.

Most physicians in practice initially feel that they are willing to stay with insurance systems, even though it is costly, frustrating and annoying. As reimbursement shrinks and paperwork costs increase, they consider adding surcharges to offset the costs of billing. These are specifically disallowed in virtually all insurance contracts.

The next consideration is separating altogether from the insurance contract. This would allow the doctor and patient to provide much less expensive and more responsive care. Unfortunately, since patients would have to go "out of network" to continue with these physicians, the additional cost to the patient may be prohibitive. Many of the insurance contracts include substantial penalties for patients who use out-of-network primary care physicians, including markedly higher co-pays for any laboratory or procedures ordered by the physician, even if these are performed by in-network physicians and labs.

Since many insurance contracts leave open the possibility of charging the patient directly for "uncovered services", many physicians have decided to base their reimbursement upon monthly fees for services which are clearly not reimbursed by insurers. These vary greatly from practice to practice, so much so that this paper cannot provide an exhaustive list. Amongst the services we have seen: increased availability (24/7 physician on call, cell phone, email, no-wait appointments, etc.), annual executive physicals (for Medicare patients, since this is not covered), customized travel kits, assistance in maneuvering through the medical care labyrinth, accompanying patients to their subspecialty appointments, periodic health newsletters, and others. These designs have proliferated because patients theoretically are not punished for receiving care in these practices and there is no need for the physicians to abandon the insurance system altogether. Physicians using these designs can often remain preferred providers, whether or not they chose to bill the insurer for covered services. Ironically, these designs have often been the biggest target of the press and politicians, claiming that they have abandoned the poor to provide luxurious care for the rich, even though some of these designs charge no more than $30 per month to the patient (PolyClinic in Seattle).

Even these quite modest attempts by a few physicians to revive their ability to control price and quality have met substantial resistance, primarily from government and large insurers. Since Washington State and Florida spawned the earliest forms of patient financed practice, they also serve well as examples of resistance:

Last year the Office of the Insurance Commissioner of Washington (OIC) issued Draft Advisories (Appendix C & D) which would have for all intents and purposes made all versions of monthly fee practice illegal unless physicians withdrew completely from insurance contracts. Interestingly, the OIC did not enter the fray because of consumer complaints or the outrage of a public interest organization. Their decision was based upon a <u>single</u> complaint by a major insurer.

One Draft Advisory would have made monthly fee practices illegal by designating them as insurance companies and requiring that they meet the requirements of insurers (including huge bonds and mountains of paperwork). The second Draft Advisory would have made those charging a monthly fee and still taking insurance money for covered services equally illegal, this time because their insurance contracts were interpreted by the OIC as prohibiting "access fees" in order to obtain covered services. This is consistent with the position of many in the insurance industry - that physicians should have no option to increase their charges unless it is permitted by their insurer.

This proposal to dismantle the entire patient financed care movement was met with anger and intense frustration by the patients who were already enrolled in these practices. The Washington OIC has since softened its stance on the pure monthly fee design and is currently working with these practices to create a "safe haven" in law that will clarify the distinction between insurance and monthly physician charges for medical care. Their stance on the "access fee" question is less certain and does not appear to have changed. Unfortunately, if their position remains inflexible it will create a barrier to attempts by physicians to provide higher access care designs that are readily affordable to the vast majority of patients. It will also further reinforce the bars on the contractual cage imposed upon physicians and patients by the cooperative efforts of insurance commissioners and insurance companies over the last 50 years.

At the national level, several bills have been offered to criminalize practice designs that charge a monthly fee and bill Medicare for covered services. Senator Nelson and Benjimen Cardin were the primary initiators of the four bills which have been introduced: Equal Access to Care Act of 2001, the Medicare Equal Access to Care Act of 2002, and the Equal Access to Medicare Act of 2003, Medicare Payment Restoration and Benefits Improvement Act of 2003. None of these bills has passed, in part due to the fact that the bills have fewer than 4 supporters.

If these efforts are successful, the net impact will be to force physicians desiring control of their medical practices to abandon Medicare altogether or to limit the number of new Medicare patients. This could be expected to further reduce the availability of care for Medicare patients nationwide. It would also mean that Medicare patients could not improve their access to care and medical service, even if they chose to spend their own money to do so.

On a more positive note, 2004 has seen the beginning of a sea change in the approach taken by insurers to the problem of health insurance. There are currently ongoing discussions with major health insurance companies to design wrap-around insurance products allowing individuals and employers to purchase higher deductible products that permit patients to purchase their own primary care and apply those costs to their deductible. We see this as a cooperative effort by insurers, physicians and patients to create a higher quality, less expensive and less inflationary insurance design. This has the potential to put control back in the hands of patients and doctors, while reducing overhead and regulatory costs for physicians and insurers alike.

Objections and Responses

Medicare Access to Care

THE ISSUE

When evaluating whether concierge practices violate Medicare law, two major concerns have been brought up surrounding Medicare: a) the concierge practice is forcing the beneficiary to pay to access medical care, and b) the concierge fee constitutes balance billing.

THE LAW

Under applicable Medicare law, physicians may not charge a Medicare beneficiary more than 115% of permitted Medicare rates for Medicare covered services. However, under Section 4507 of the Balanced Budget Act of 1997, physicians may "opt-out" of Medicare and enter into "private contracts" with Medicare beneficiaries. Such contracts allow physicians to charge more than the permitted Medicare rate for what would otherwise be Medicare covered services. Medicare beneficiaries who sign such contracts agree to give up Medicare payment for services provided by the physician and to pay the physician without regard to any limits that would otherwise govern the physician's billing rates. Importantly, Medicare beneficiaries who sign private contracts with one or more physicians may still obtain payment for Medicare covered services from other physicians who have not opted out of Medicare.

MEDICARE FINDINGS

Based upon a request by Senator Nelson, CMS took the initiative to evaluate concierge practices. Their findings state: "The Council currently finds no evidence that …retainer agreements adversely impact the quality of patients' care or the access of any group of patients to care."[1] Furthermore, CMS found that "Retainer practices that structure their fees in compliance with balance billing restrictions …appear to have successfully met current legal and regulatory requirements."

Balance billing

BALANCE BILLING POLICY

Many states have laws that prohibit "balance billing" (i.e. billing the patient the difference between the doctor's charge and the insurer's payment, except for copays and deductibles included in the insurance agreement).

CRITICS POSITION

Critics believe that the benefit plans generally do not exclude coverage for the specific sets of medical services that the physicians offering retainer contracts say they will deliver, but rather, cover costs of medically necessary or appropriate services.[2] In addition, critics claim that the charges submitted to insurance providers are not truly representative of what members are being charged, since the concierge fee constitutes part of the overall fee that patients are paying for medical services.

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[1] CMS Rep. 9-A-2002

[2] NJ DOBI/DHHS Bulletin, August 2003

ARGUMENT

The contracts that physicians sign have multiple stipulations, such as:

1) "Covered services" – means services and supplies provided by the provider for which benefits are available to a Member under the terms of the Members Membership. The fact that a Provider may prescribe, order, recommend, or approve a service does not, by itself, make it a … Covered Service".[3]

2) "In the event Provider recommends that a Member receive services and the Provider knows that such services are not Covered Services, Provider shall inform the Member prior to the provision of such services: (1) that the services are not Covered Services, (2) that the insurance provider will not pay for or be liable for such services, and (3) that the Member will be financially liable to the Provider for such services.[4]

3) Provider shall not require of any Member an advance deposit toward payment for services, except …for deductibles, co-payments, co-insurance, or non-Covered Services.[5]

In no contract is there any agreement or requirement that physicians must personally return all calls; there is no requirement that the patient must not wait more than 5 minutes; there is no requirement that the physician accompany the member to specialist visits. Because these are NOT services that are required or deemed medically necessary, they fall into the category of Non-Covered Services. As such, physicians have the right – according to contractual agreements – to bill on a "fee-for-service" basis for these additional services.

The AMA's position is that since there is no solid line separating personalized services and amenities from reimbursable medical services, a physician should provide retainer contracts that clearly separate the special services that are covered by the retainer fee from the reimbursable medical services.[6] The contract falls under the general contractual view of the patient-physician relationship in which both parties agree on appropriate fees to be charged for pre-defined services. As long as the physician identifies which services the patient is being charged for, and those services do not include services that the insurance carrier deems "Covered Services", there is no visible violation of the balance billing law.

False Claims Act

THE LAW

One of the charges asserted in the Waxman Letter is that concierge medical practices such as MDVIP may violate the False Claims Act, 31 U.S.C. 3729. The False Claims Act is a federal statute of broad application that imposes a civil monetary penalty upon an individual for submitting a false claim to, or otherwise defrauding, the U.S. government. Its provisions clearly would apply to Medicare claims submitted by a physician.

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[3] BCBS & Cigna contracts

[4] BCBS & Cigna contracts

[5] BCBS & Cigna contracts

[6] AMA report for the council on Ethical and Judicial Affairs.

> "Any person who knowingly presents . . . to an employee of the United States Government . . . a false or fraudulent claim for payment" is liable for a civil penalty of not less than $5,000 and not more than $10,000, plus three times the amount of damages sustained by the government.

WHAT CRITICS SAY

The position critics are taking is that the charges submitted to Medicare are not truly representative of what they are charging due to the concierge fee. The addition of the concierge fee would create a "false claim."

ARGUMENT

The decision of this violation must rely upon the decision of which services are covered and non-covered. If a concierge physician is charging a fee and openly identifying which Non-Covered Services that fee applies to, there is no violation of the False Claims Act. On the contrary, it is supported and endorsed by insurance companies themselves:

> "Physician hereby agrees that in no event…shall physician bill, charge, collect a deposit from, seek compensation… or have any recourse against an HMO participant for services provided pursuant to this Agreement. This provision does not prohibit the collection of Copayments, Coinsurance, Deductibles*, or fees for uncovered services delivered on a "fee-for-service" basis*." [7]

As such, unless it can be determined that unless the concierge fee is proven to be directly applied to providing Covered Services, there is no violation of the False Claims Act.

Medical Care is a Right

WHAT CRITICS SAY

Medical care is a right and if people have to pay more for better care, this will reduce access to that entitlement.

ARGUMENT

Although many Americans and most physicians (including those in these new practices) feel that quality medical care should be available to all, viewing medical care as an entitlement to be defined and mandated by government and corporate insurance structures has been a hopeless failure in this country and elsewhere. As explained above, creation of huge insurance systems has wreaked havoc on our economy while disempowering patients and physicians. Medical care is less available and far more expensive than it was when patients paid for their own care and physicians provided charity care for those who could not afford to pay. If the government fulfilled its obligation to the poor by building a care system for their care and protection, the rest of us could regain control of the price and quality of medical care nationwide.

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[7] Cigna HMO contract

Creation of a Multi-tiered Medical System

WHAT POLICY STATES

AMA's *Principles of Medical Ethics* specifically states that physicians have the right to provide multiple methods of delivering medical service at multiple financial levels. The AMA has a long-standing position supporting pluralistic health care:

> Policy H-165.960 states (5) that individuals should have the freedom of choice of physician and/or system of health care delivery and that (7) a pluralistic delivery system is essential.
>
> Policy H-165.913 (2) also supports alternative financing and delivery models by reaffirming the AMA's position in favor of pluralistic health care delivery system to include fee-for-service medicine.

WHAT CRITICS CLAIM

Since critics claim medical care is a "right" of all people, critics claim the existence of concierge practices is creating more subsets of inequality for patients and discriminates against the poor. By focusing on the needs of a relatively small patient population defined by their ability to pay, concierge physicians could exacerbate inequalities in access to care that already exist.

ARGUMENT

CMS[8] found that retainer practices were consistent with the long-standing AMA support of pluralism. Therefore, retainer fees for personalized services appear to be consistent with a system based on pluralistic means of financing and delivering healthcare.

Just as physicians are free to provide alternatives in the delivery and financing of health care, individuals are also free to select supplemental plans for their health care on the basis of an acceptable tradeoff between quality and cost. Patients at concierge practices believe that the benefits they receive are worth the fee that they pay.

Furthermore, to imply that retainer medicine is a drastic departure from the way care is currently delivered and financed is inaccurate. A multi-tiered system of care that depends upon income bracket already exists in the US. Those with lower incomes often work for employers who do not offer medical benefits and consequently cannot afford the astronomical cost of health care on an individual level.[9] If anything, these new practice designs are likely to provide lower cost and more patient oriented alternatives to their current healthcare options.

Finally, economic theory suggests that the most efficient and productive health care system is not likely to be the one with a single level of service, but rather one that offers a broad array of competing medical care delivery designs.[10] There is little reason to believe that a single tiered

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[8] CMS study

[9] The Choice of Secondary Insurance by Medicare Enrolled Members of the Federal Employee Health Plan, by Adam Atherly, PH.D, Curtis Florence, PhD, Kenneth E. Thorpe, PhD.)

[10] CMS study

care system is preferable, or even desirable, any more than it is desirable for everyone to drive the same car or live in the same house. In a medical marketplace, patients with different needs and financial resources create niches that the market can address. There is also room within such a marketplace for government financing of care for the poor, without demanding a one-size-fits-all care design with all of its negative implications.

Patient Abandonment

ETHICAL STANDARDS AND GUIDELINES

Some concern has been raised that physicians converting traditional practices place a burden upon patients who must seek another physician and establish a new relationship. The guidelines set out by the AMA[11] and CMS for closing a practice or terminating a patient are:

1. Give the patient written notice, preferably by certified mail, return receipt requested. "Adequate advance notice" is set by state anywhere from 15 days to 60 days.;
2. Agree to continue to provide treatment and access to services for a reasonable period of time, such as 30 days, to allow a patient to secure care from another physician;
3. Providing resources and/or recommendations to help a patient locate another physician of like specialty;
4. Offering to transfer records to a newly-designated physician upon signed patient authorization to do so; and
5. Facilitate the transfer of their patients – particularly those that are seriously ill

In addition, the AMA released the following guidelines for physicians transitioning their practice:

1) Identify practitioners in the community who are accepting patients; provide your patients with their name and number
2) Physicians must help transfer – at no charge – nonparticipating patients to others. If no others are available, the doctor may be ethically obligated to continue caring for such patients.
3) Do not charge a fee for the copying and transferring of the patient records
4) Providing their patients with adequate advance notice of the changeover.
5) Continue to treat patients who are critically ill and cannot find another physician to treat them without requiring them to pay the concierge fee

WHAT CRITICS SAY

Some feel that physicians converting from a conventional to a retainer practice discriminate unfairly against the practice's patients who will be unable to afford the retainer and should be considered patient abandonment.

ARGUMENT

The AMA Council on Ethical and Judicial Affairs[12] issued recommendations on the ethical responsibilities of physicians considering transitioning to a concierge practice. These guidelines

[11] AMA – "Ending the Patient-Physician Relationship

were adopted as AMA Ethical Policy at the 2003 Annual Meeting of the AMA House of Delegates:

> "In accord with medicine's ethical mandate to provide for continuity of care and the ethical imperative that physicians not abandon their patients, physicians converting their traditional practices into retainer practices must facilitate the transfer of their non-participating patients to other physicians, particularly their sickest and most vulnerable ones. If no other physicians are available to care for non-retainer patients in the local community, the physician may be ethically obligated to continue caring for such patients."

As with any other product or service, changing the price or quality will cause some users of the service to seek another vendor. This is not abandonment by the vendor. A physician who is transitioning from a conventional practice to a concierge practice is no different from a physician closing one practice and opening another 100 miles away. Unless it becomes illegal to raise the price of medical care or vary services, there will always be patients switching from one physician to another in order to get a lower price, better service or a higher level of expertise. The safeguards proposed by the AMA seem more than adequate to protect the patients during these unfortunate transitions.

Quality of Care

WHAT THE GUIDELINES ARE

The AMA's requests that concierge physicians not represent that they "promise more or better diagnostic and therapeutic services."[13] In addition, the ethical guidelines set by the AMA state that the standard of care cannot depend upon the patient's ability to pay. In short, there cannot be a discrepancy in diagnostic and therapeutic decisions between a concierge and conventional patient. It must be clear to the patients that concierge practices are not necessary to attain good medical care.

CRITICS POSITION

The debate arises on whether concierge physicians provide better medical care for their patients than other physicians.

ARGUMENTS

Numerous studies have been conducted in an attempt to quantify Quality of Care. However, significant methodological hurdles persist.[14] Does quality care mean happier patients, more thorough exams, more accurate diagnoses or better outcomes?

One study conducted on the quality of care of physicians found that Quality of Care is a personal thing for physicians – different physicians provide different levels of service at different volumes. Some physicians can practice a high quality of care at a high volume; others are more

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[12] CEJA Report 3 – A-03

[13] (AMA's ethical council)

[14] Developing Quality Indicators For The National Healthcare Quality Report Using Data From The National Center For Health Statistics And The Centers For Disease Control And Prevention; Irma Arispe, PhD, Julia Holmes, PhD

comfortable providing exceptional care in low volume practices. Therefore, it becomes impossible to define a specific limit as to what patient load should be the maximum while not sacrificing quality of care. The most important conclusion was that while the actual quality of care was the same, the PERCEPTION by the patients was significantly different.

A recent study looked at patient perceptions of physician performance.[15] The study evaluated 11 scales that patients use to characterize their experience with physicians:

1) relationship duration,
2) communication quality,
3) health promotion,
4) whole-person orientation,
5) interpersonal treatment,
6) trust,
7) access,
8) visit-based continuity,
9) integration of care,
10) office staff, and
11) other clinical staff.

The study shows that very few of the issues that patients use to measure their overall experience actually apply directly to the technical outcomes. In fact, quite the opposite is true: most factors influencing the patients' perception of quality of care involved interpersonal skills and customer service factors.

The AMA also points out that providing more personalized attention may result in better patient satisfaction, leading in turn to a better understanding of, and compliance with treatment recommendations. The final result may be improved outcomes in certain situations. Therefore, while concierge physicians do not claim to provide better diagnostic or therapeutic treatment, the customer service features they provide may positively effect the patients' perception of the quality of care. As a result, even though the same treatment was provided, the outcome for concierge patients may be better.

Caring For The Uninsured

AMA GUIDELINES

When CMS addressed the concern of caring for the uninsured, they turned to the AMA for guidelines:

> Principle IC of the AMA's Principles of Medical Ethics states "Physicians shall support access to medical care for all people."
>
> Policy H-165.886(1) states that the AMA continues to urge physicians to share in the provision of uncompensated care to the uninsured indigent.

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[15] Measuring Patients' Experiences With Individual Physicians; Dana Gelb Safran, SC.D, Kathy Coltin, M.P.H, Melinda Karp, M.B.A, john M Ogren, M.D., M.D., Angela Li, B.A., William Rogers, Ph.D.

Policy H-380.992 (1) reaffirms the physician's obligation to compassionately consider the patient's ability to pay in setting a fee.

CRITICS POSITION
Critics claim that concierge practices shift their share of uncompensated care to the remaining pool of physicians. They feel that the burden of uncompensated care might be disproportionately borne by conventional fee-based practices. By serving a smaller number of patients, critics say practitioners are shirking their social responsibility to serve patients at all income levels.

ARGUMENT
This claim is assuming that concierge practices are not serving the uninsured or indigent. Contrary to belief, most concierge physicians around the nation provide care to more indigent patients now than they did in their prior practices. In addition, many practices waive the fee for existing patients who wish to follow but are unable to afford the fee.

The medical care system in the United States currently provides only the most rudimentary care for the poor. There is no evidence that these new practices will worsen the situation.[16] There is also reason to believe that these new practices designs will enhance availability of care to all, including the poor and uninsured. Increasing the available care models may eventually enhance the care of all seeking medical care.[17]

Reducing Physician Resources

WHAT CRITICS SAY
Critics claim that concierge practices redistribute resources (ie. the physician supply) from the needy to the affluent. If patient financed models become widespread, there will not be enough doctors in the system to care for those that could not afford it.

ARGUMENT
When this issue was brought up to the AMA, Frank A. Riddick, Fr., MD, chairman of the AMA's Council on Ethical and Judicial Affairs stated: "Physicians have an obligation to meet the needs of the community…. You could do that with 10% of physicians in an area practicing boutique medicine..."[18]

If the claim that concierge practices reduce physician availability to the community by focusing on a smaller segment, we would find that there would be a significant increase in patients without physicians in Seattle. However, if we look at the impact current concierge practices have had on the community, according to the CMS study[19] the evidence to date shows that the patients have been absorbed into conventional practices. Therefore, there is no indication that the presence of concierge practices will limit the ability for the community to access a physician.

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[16] Bliss, cinci article

[17] CMS, Rep. 9-A-2002

[18] Physicians Practice Options, September 15, 2002

[19] CMS, Rep. 9-A-2002

Widespread Adoption of Concierge Medicine

WHAT CRITICS SAY
Several critics have created a concern that concierge medicine will become widespread. If the practice of concierge becomes widespread, it would reduce the access of medical care to those who are less wealthy.

ARGUMENT
If these care models become wide spread, it will be because they serve a much wider spectrum of patients than the wealthy alone. High priced, exotic medical services have a small and limited appeal. If patient supported practices become a dominant force, it will be because they have successfully competed with the existing insurance driven model and that they have provided better care at a lower price. If this occurs, it will not be a disaster for the poor or middle class.

Medical Costs Will Increase

WHAT CRITICS SAY
If a few doctors are permitted to increase fees, then everyone will do it and the cost of care will rise.

ARGUMENT
If doctors are allowed to contract directly with patients again, as they have done over the centuries, the price of medical care is much more likely to fall than rise. Patients and physicians will rely less and less on insurers to cover the cost of routine care, decreasing the money wasted on the extensive documentation and billing costs. Insurance premiums could then decline, reducing the stress on employers and the economy as a whole.

There is nothing about these practice designs that prevents patients from buying and using insurance. Patients are unlikely to decide that they need not pay their insurance premiums. When individuals take responsibility for more of their healthcare costs, insurance company payments can decline, reducing insurance company costs and, eventually, premiums.

Benefits

While many are focusing on the negative aspects of concierge, few have focused on the benefits of the concept.

It Fills a Market Need

Society is demanding interactions to be personal – "the way they used to be." Retainer medicine offers services that are not available in most practices and are not required to be provided by law – namely customer service conveniences. With the advent of retainer practices, patients are able to receive the customer service they have been desiring. Because participation in these practices is voluntary, if patients don't receive the service they want, they simply leave. Therefore, the

market will dictate the success or failure of these practices. If they fail to meet the needs of patients at price they are happy to pay, then they will fail.

Increased Pro Bono Work

Due to the reduction in time required, most physicians practicing concierge medicine make a very specific effort to give more back to the community. Several practices slot up to 30% of their practice for individuals who have no insurance at all and cannot afford to pay medical bills. Other physicians dedicate several hours a week to homeless shelters or other community centers. In fact, several concierge physicians have stated now that they have the time, they give back more now than they did in their conventional practice.

Increased Availability of Physicians to Medicare Patients

Due to the poor reimbursement schedule, many practices have severely limited the number of Medicare patients they treat and have closed their practice to new Medicare patients. As a result, many Medicare patients have a very difficult time finding a physician. Whether they "participate" or not in Medicare, we are not aware of any concierge practice that refuses Medicare patients. If fact, in some areas the only practices accepting new Medicare patients happen to be a patient financed practices.

Patient Satisfaction

> "Doc, you realize your office is a lot like Disney World? It's a three-hour wait for a 20-second ride,"[21]

Patients are frustrated with the current medical care environment, with endless waiting and minimal access to the physicians. Patients of concierge practices rave about their experiences. Thrilled with the personal attention and shocked at the ease of making an appointment, patients feel fortunate to have an alternative.

Potential To Drive Better Care In Conventional Practices

According to CMS, retainer practices may lead to market-driven improvement in quality. CMS admits that while there is no evidence that concierge practices provide a higher level of "quality", patients using retainer services perceive greater value and are willing to pay more of their own money in exchange for the higher value they perceive.

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[21] (Medical Economics, "How to set up a concierge practice: more and more doctors are looking at this alternative to the managed care rat race. If you're interested, here's what you need to know;" August 22, 2003)

In addition, the fact that several concierge practices exist in the same market at different price points suggests that retainer practices "may reach competitive equilibrium that constrains costs and spurs quality improvement." In short, the market is driving the standards of care, encouraging physicians to provide services they desire.

Focus on Improving Quality

> "Most of the talk about quality improvement and measurement occurs in academic circles, when the real action in the real world involves cutting costs, not improving quality." – Norbert I. Goldfield, MD [22]

The reason why concierge practices are successful is they are focusing on what the market is looking for. The perceived quality of the existing system is below expectations for some. Rising health care costs – not improving quality – are currently driving the health care system today. Patient financed practices are driven by the patient. As a result, the physicians focus more on improving the quality of the encounter.

Physician Retention and Recruitment

There has been an exodus of dedicated physician from one of the most personally rewarding of professions because they couldn't make ends meet and they won't tolerate the stresses and demands of the way medicine is being practiced today. Our most experienced physicians are completely leaving the health care system and are changing careers at a time when they are immensely valuable. In many areas, you will not find a single internal medicine physician over the age of 50. Many are retiring even though they enjoy being a physician.

Concierge medicine has provided an alternative to those physicians who feel that they are on an assembly line, with clinic managers admonishing to increase "productivity" and "efficiency." Rather than completely leaving the system with their knowledge, these doctors see an alternative that allows them to practice the way they always dreamed about – focusing more on the patient than paperwork or volume. As a result of these alternatives, physicians are staying in the system rather than leaving it.

Supports the Government Goal of More Patient Funded Insurance

The government has recently made changes that encourages society to assist and "self-fund" their own health care. New products that fall under Section 105 or 106 encourage patients to use savings accounts and evaluate their services more carefully. Insurance plans that encourage users to question procedures based on cost are more predominant. As such, the government is encouraging society to take more responsibility and action pertaining to their own health care

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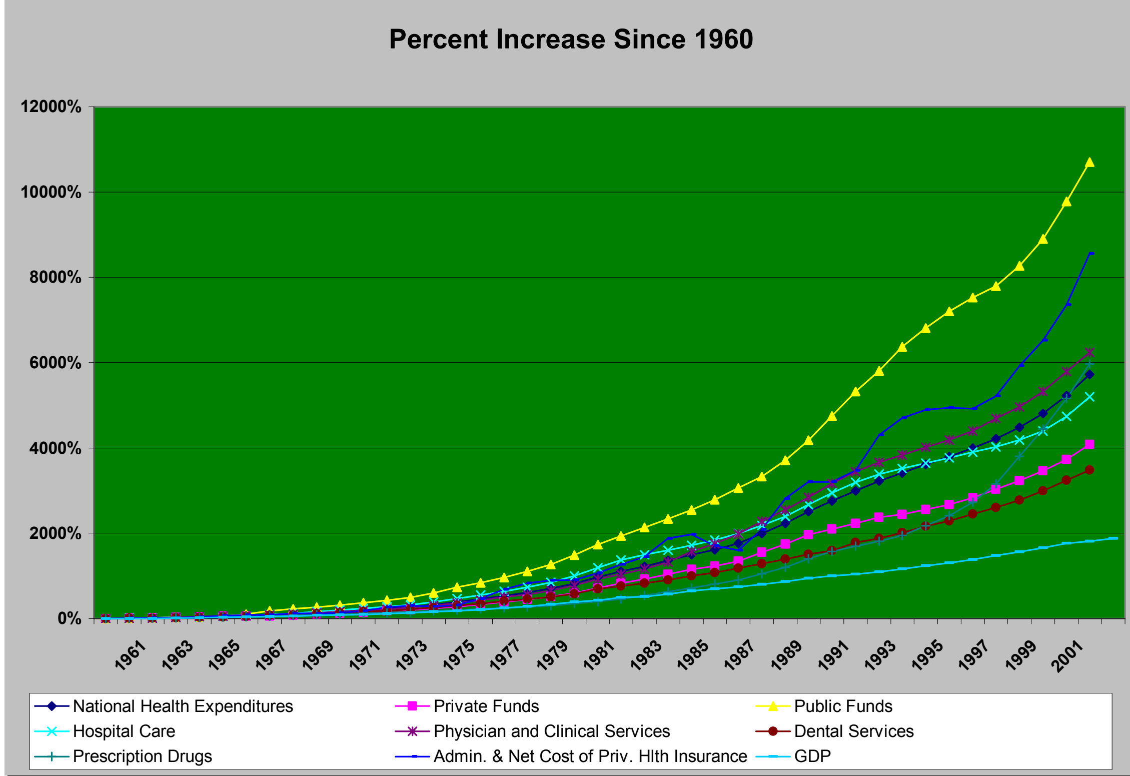
[22] Brightwood-Riverview Health Center (Physician Practice Options, September 15, 2002)

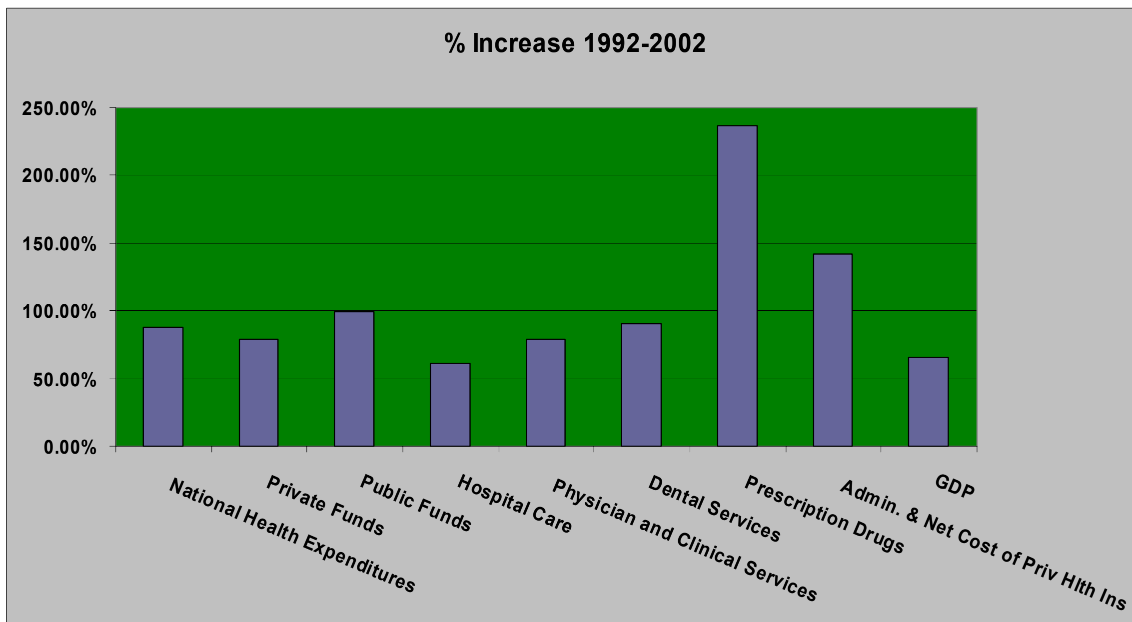
needs. Concierge practices are simply another solution that encourages society to evaluate their individual health care needs and make their own decision on what solution is most appropriate.

Conclusions

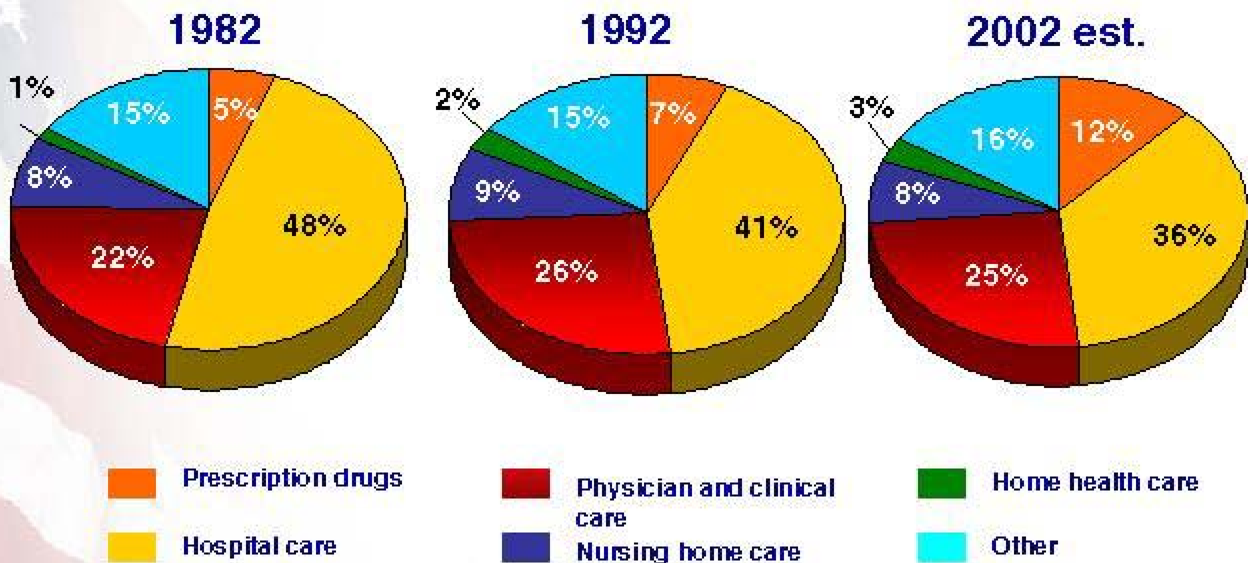
Although patient financed medical care, in its current incarnation, is less than 10 years old and has a trivial impact on the national economy, it has the potential of addressing some of the greatest challenges to healthcare. In his presentation of January 13, 2004, David M. Walker, Comptroller General of the United States said of the upcoming health care system challenges: “With respect to health care, both the private and public sectors are losing ground in their efforts to balance the competing goals of sustainable cost, broad access and good quality.” Although many well-meaning individuals have tried over the last 50 years to substitute the judgment of government and corporate powers over the will of the medical marketplace, it seems abundantly clear that only the marketplace can balance and monitor issues of cost and quality simultaneously and without undue influence by special interests and political power brokers. There are few who feel that the current expensive and complex system serves the needs of either the patients or the providers of healthcare. There are a small number of physicians and patients willing to take the risk and enjoy the benefits of a simple medical marketplace agreement to provide better care for a agreed upon price. It is our hope that these voluntary efforts by doctors and patients will not be infringed upon by the government because they may truly represent the only serious hope that we can create a medical care system in the United States that is at once humane, effective, inexpensive, flexible and self-regulating.

Appendix A





Appendix B



From Health Care System Crisis: Growing Challenges Point to Need for Fundamental Reform. David M. Walker, Comptroller General of the Unites States – January 13, 2004.

Appendix C – TAA – Activities Requiring a Certificate of Registration

TECHNICAL ASSISTANCE ADVISORY
T 03-0__

TO: HEALTH CARE SERVICE CONTRACTORS, HEALTH MAINTENANCE ORGANIZATIONS, ACTIVE ACCIDENT AND HEALTH AND GROUP DISABILITY INSURERS, HEALTH CARE PROVIDERS, AND INTERESTED PARTIES

SUBJECT: ENGAGING IN ACTIVITIES REQUIRING A CERTIFICATE OF REGISTRATION

DATE: July 30, 2003

The Office of the Insurance Commissioner has become aware of certain practice arrangements in the health care provider community that are not allowed under the law unless the providers obtain a certificate of registration issued by this Office.

The OIC has learned that some health care providers enter into arrangements with patients, whereby, in return for a fixed fee paid on a periodic basis, the provider promises to provide health care services that are the same or very similar to those the provider would provide if the patient were covered by an insurance contract from a licensed health carrier. The fee is paid by the patient regardless of the amount of services provided or even if no services are provided. An example of such an arrangement between a patient and a provider or group of providers is one where the patient receives all of his or her primary care services such as unlimited office visits, physical exams, lab tests, routine imaging, and minor surgery for a predetermined, fixed fee. These arrangements result in a transfer of risk and, in essence, are insurance agreements. Providers entering into such arrangements must first obtain a certificate of registration as either a health care service contractor or health maintenance organization, as set forth in the statutes referred to below,

RCW 48.44.015 prohibits any person from engaging in the activities of a health care service contractor without a certificate of registration. RCW 48.44.010(3) defines “health care service contractor” as “any corporation, cooperative group, or association, which is sponsored by or otherwise intimately connected with a provider or group of providers, who or which not otherwise being engaged in the insurance business, accepts prepayment for health care services from or for the benefit of persons or groups of persons as consideration for providing such persons with any health care services.” RCW 48.44.010(1) defines “health care services” to mean and include “medical, surgical, dental, chiropractic, hospital, optometric, podiatric, pharmaceutical, ambulance, custodial, mental health, and other therapeutic services.”

RCW 48.46.027 prohibits any person from engaging in the activities of a health maintenance organization without a certificate of registration. RCW 48.46.020(1) defines “health maintenance organization,” as “any organization … which provides comprehensive health care

services to enrolled participants . . . on a group practice per capita prepayment basis or on a prepaid individual practice plan, except for an enrolled participant's responsibility for co-payments and/or deductibles, either directly or through contractual or other arrangements with other institutions, entities, or persons, . . ." RCW 48.46.010(2) defines "comprehensive health care services" as "basic consultative, diagnostic, and therapeutic services rendered by licensed health professionals together with emergency and preventive care, inpatient hospital, outpatient and physician care, at a minimum, and any additional health care services offered by the health maintenance organization."

This Office has learned that some providers may believe they avoid falling within the definitions of RCW 48.44.010 and 48.46.020 by arranging to collect the set periodic payment after the period in which the services may be provided. However, that does not alter the essence of the transaction, which is that the charge is calculated and incurred prior to the service being rendered and is not tied to the patient's use of the services, regardless of when it is actually collected. The critical element of the transaction is that risk of the patient's utilization of health care services during the period is transferred from the patient to the provider for a set amount. Providers who enter into these arrangements must first obtain a certificate of registration as a health care service contractor or a health maintenance organization.

Each provider arrangement will be subject to investigation by the OIC for the purpose of determining whether registration is required.

Appendix D – Mandatory Access Fee Practices

TECHNICAL ASSISTANCE ADVISORY
T 03-0__

TO: HEALTH CARE SERVICE CONTRACTORS, HEALTH MAINTENANCE ORGANIZATIONS, ACTIVE ACCIDENT AND HEALTH AND GROUP DISABILITY INSURERS, HEALTH CARE PROVIDERS, AND INTERESTED PARTIES

SUBJECT: MANDATORY "ACCESS FEE" PRACTICES

DATE: July 30, 2003

The Office of the Insurance Commissioner (OIC) is aware that a growing number of health care providers, who have participating provider contracts (participating providers), with health carriers are charging additional fees to their patients. These fees are in addition to the usual co-pays, coinsurance, and deductibles allowed under the patient's benefit plan.

The additional fees are often collected by participating providers in return for a variety of different amenities. Some participating providers offer patients "improved access" through same-day office visits, email or telephone consultations with the provider, or 24 hour contact by pager or cell phone. Other providers offer services that may or may not be covered under the patients' health plans. Examples include: health education; newsletters; convenient parking; special tracking and follow-up; or physical examinations.

The OIC cautions participating providers who charge such fees on a mandatory basis, that there may be significant legal problems with these arrangements. If the participating provider requires patients to pay the fee in order to access care which is covered under the terms of the patient's benefit contract, such additional mandatory charges violate the term of the providers' contracts mandated by WAC 284-43-320(2) (a) and may also violate RCW 48.80.030(5).

Providers may charge patients mandatory access fees in the following situations:

- the provider is not contracted with the patient's health carrier;
- the provider does not participate in any health carrier's network;
- the patient is covered under an indemnity insurance policy that does not require the use of a network or participating provider; or
- the patient is uninsured.

Unless a patient can obtain covered services from the participating provider without paying any additional fee, the access fee is considered by the OIC as an additional charge for providing the health care services covered by the enrollee's health plan. This additional charge for covered services is prohibited by RCW 48.80.030(5) and the "hold-harmless" provisions of the provider's contract required by WAC 284-43-320 (2)(a).

RCW 48.43.085 allows providers are entitled 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.

In addition to the violation of the contract between the participating provider and the health carrier, 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.

For questions regarding this Technical Assistance Advisory, please contact Donna Dorris, Health Care Manager at Donnad@oic.wa.gov or (360) 725 -7119.

Appendix E