The Three Faces of Retainer Care:
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INTRODUCTION

Retainer care arrangements allow patients to pay a retainer directly to a physician's office in order to obtain special access to care.[1] Practices usually convert to retainer status by

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*Associate Professor, Seton Hall University Law School. Many thanks to Jesse Goldner, Tim Greaney, Sandra Johnson, Timothy Jost, Russell Korobkin, Kristen Madison, Timothy McBride, Wendy Parmet, Nicolas Terry, Sidney Watson, Vicki Williams, Eric Claeys, Adam Mossoff, Adam Kolber and other participants at the St. Louis University Health Law Scholars Workshop for their comments. Charles Sullivan, Peter Schuck and Richard Murphy also provided very challenging and helpful comments. I had many instructive conversations with colleagues John Jacobi, Kathleen Boozang, Carl Coleman, Margaret Gilhooley, and Gaia Bernstein in the Seton Hall Health Law and Policy Program. I also wish to thank Mohammed Azeez, Jorge Margaritas, and Matthew Tuttle for excellent research assistance. This project was generously supported by the Seton Hall University Law School Summer Research Stipend.

[1] Controversies over retainer care extend even to its name. Congress chose the term "concierge care" in the 2003 Medicare Modernization and Prescription Drug Act. 42 U.S.C.A. § 1395cc (2005); U.S. GOV. ACCOUNTABILITY OFFICE, PHYSICIAN SERVICES: CONCIERGE CARE CHARACTERISTICS AND CONSIDERATIONS FOR MEDICARE 1 (2005) [hereinafter GAO REPORT]. This term is unsatisfactory because opponents have tried to brand retainer arrangements a mere bauble of the wealthy by using the term "concierge care," or the more common "boutique medicine." At the other extreme, proponents of retainer care choose terms that go beyond euphemism into express approbation (such as "innovative practice design") or misleading synecdoche (such as "personalized preventive care"). *See* Russ Allen, *Doctors on Retainer Catch On*, RISK & INSURANCE, Mar. 1, 2005, at 20. "Retainer care" seems to be the best neutral term for discussing the financing arrangements analyzed in this article.

concentrating their attention on those willing to pay a retainer fee, and dropping the majority of their patients, who are left to be absorbed by other practices.[2] Also known as "boutique medicine," "concierge care," or "innovative practice design," retainer practices have drawn thousands of enthusiastic patients.

They have also provoked scrutiny from politicians[3] and consumer groups.[4] Few recent developments in the business of medicine provoke emotional conflicts like concierge care. Concierge physicians are thrilled to break out of the vise of managed care, lavishing medical attention where they used to face the stark choice of rationing or involuntarily donating their services. Critics decry an ever-widening gap between haves and have-nots, and view concierge care as one more excess for the wealthy in an age of increasing medical scarcity.

To be sure, there are some irreconcilable ideological differences between the two camps. Concierge physicians welcome a commodified tiering of primary care that their

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[2] Robert M. Portman, *Concierge Care: Back to the Future of Medicine?*, 15 HEALTH LAW 1 (2003); Avram Goldstein, *Doctors on Call–for a Hefty Retainer*, WASH. POST, Jan. 24, 2003, at B1. For a discussion of three models of boutique medicine, *see* John R. Marquis, *Legal Issues Involved in Concierge Medical Practices,* HEALTH LAWYERS NEWS, April 7, 2005, at 8.

[3] Both Congress and the Department of Health and Human Services have expressed concern about the access issues raised by the practices, and at least some affected states have responded with investigations and regulation. At the national level, several bills have been offered to prevent physicians in retainer practices from participating in Medicare. Senator Bill Nelson of Florida and Representative Benjamin Cardin of Maryland have introduced four bills so far. None has gotten out of committee, and none appears likely to do so, though these legislators have managed to require the GAO to study the spread of concierge care and have held hearings on the topic. Nevertheless, Congressional attention to the topic has managed to spur interest at HHS. *Consumer-Directed Doctoring: The Doctor Is In, Even If Insurance Is Out*, Hearing Before the Joint Economic Committee, Congress of the United States, April 28, 2004.

[4] See, e.g., Sidney M. Wolfe, *A New Health Care Gimmick: Concierge Medicine*, 19 HEALTH LETTER 10, at 1-2 (Oct. 2003); John Carrol, *Concierge Care by Any Name Raises Ethical Concerns*, MANAGED CARE MAGAZINE 15 (Nov. 2003), *available at* http://www.managedcaremag.com/archives.

opponents only grudgingly accept. Yet differences also arise because the opposing sides have not adequately acknowledged the *diversity* of concierge care services. Retainer contracts cover three analytically distinct actions: preventive care, queue-jumping, and amenity-bundling. Most commendably, concierge physicians are aggressively counseling their patients on how to avoid getting ill, by developing preventive health plans and monitoring problematic behavior. More questionably, they are trading enhanced access for cash—a clear example of queue-jumping relative to their previous business practices and the standard of primary care prevalent in the US. Most troublingly, they are bundling medical care with unrelated amenity services (such as lavish waiting rooms and comfort for the "worried well") in order to avoid legal and regulatory bars on "balance billing" and multiple standards of care.

Each of these "faces" of concierge care deserves a different legal response. Nearly all serious health policy analysts agree that preventive care is underfunded in the United States. To the extent concierge physicians are closing that gap, they ought to be encouraged. However, concierge marketing of "queue jumping"—the ability to see one's doctor far more quickly—and for far longer—than the norm, requires state and federal oversight for a number of reasons. Tiering in the health insurance market has already eroded the primary "end" of health insurance: subsidizing the unhealthy, unlucky, and sick with funds from the healthy, lucky, and well.[5] Concierge care threatens to accelerate that process, promoting "exit" from a managed care system where "voice" is ever more necessary. Medicare policymakers realized the dangers of such a dynamic long ago when they proscribed "balance billing," a practice that allowed doctors to charge patients themselves for parts of bills that Medicare did not cover. Both Medicare and private insurers

[5] John V. Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311 (1997) ("The origins of health insurance in both the United States and Europe involved pooling funds and sharing risk."); Andrew Stark, *In Sickness and in Health: Health Insurance in America*, DISSENT MAG. 22 (Fall 2005) ("When it comes to private insurance, apparently, Democrats would have the rich subsidize the sick; Republicans seem largely content to have the healthy subsidize the poor.").

should enforce balance billing rules against concierge doctors in order to prevent insurance programs from subsidizing ever-more fragmentation of the risk pool.

Finally, concierge physicians' bundling of medical services with unnecessary amenities presents a troubling dynamic already reflected in the growing demand for cosmetic physical and mental enhancements. Some states have begun taxing or otherwise discouraging these diversions of medical personnel. They should consider similar efforts to discourage concierge physicians' efforts to bundle the sale of medical care with unnecessary amenities, a practice driven more by marketing efforts and legal concerns than actual medical care.

This article bases these policy prescriptions on an analysis of current retainer care practices (Part II) and regulation (Part III). Part IV suggests a resolution of the leading current legal controversy over retainer care, the applicability of Medicare balance billing rules to retainer payments. Part V addresses retainer care physicians' complaints about current and proposed regulation, developing a normative framework for further interventions proposed in Part VI. Although states have taken some promising steps toward mitigating the worst aspects of retainer care conversions, taxation may be the only policy tool sufficiently targeted to reduce incentives for queue-jumping and amenity-bundling while promoting innovation in preventive care.

II. THE RISE OF RETAINER CARE

Boutique medicine did not arise in a vacuum. A variety of pressures on providers and consumers of medical care have led to demand for more intense and personal primary care. The development of cost-containment measures has left many physicians complaining about a lack of autonomy.[6] Patients have complained about five-minute office visits, officious staff,

[6] See, e.g., Eve A. Kerr, *How Satisfied Are Physicians and Patients When Medical Groups Control Access to Care?,* April 1997, at http://www.rwjf.org/reports/grr/023332s.htm ("Primary care physicians are significantly less satisfied with the quality of care they are able to deliver to patients covered by capitated contracts than those covered by other payment sources.").

interminable waits,[7] and a general lack of concern about their welfare.[8] Even if these concerns lack empirical foundation, *consumer perceptions* of a decline in the availability and quality of primary care have sparked a great deal of anxiety.[9] Retainer care options address this need by providing "Marcus Welby" style medical care to their patients.

Part A below describes the background trends in the health care system that have given rise to retainer care, including time pressures on physicians, consumers' demand for more services, and insurers' efforts to placate both groups by offering more ala carte and tiered coverage options. Physician and patient dissatisfaction with the strictures of managed care has led to many important trends in health care financing, including increased tiering and consumer choice in health plans. Part B explains how retainer care works, focusing on the ways in which retainer physicians intensify tiering and consumer choice trends.

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[7] Gina Kolata, *Sick and Scared, and Waiting, Waiting, Waiting*, N.Y TIMES, Aug. 20, 2005, A1 (describing waits to see doctors, once in the doctor's office, and for follow-up visits).

[8] Josh Fischman, *Who Will Take Care of You?*, U.S. NEWS AND WORLD REPORT, 46 (January 31, 2005). ("Research has shown that a good conversation that thoroughly explores problems and possible treatments means better health. . . . [The] relationship [between physician and patient] has clearly been shown to affect diagnostic accuracy, adherence to treatment plans, and patient satisfaction.").

[9] Some commentators have suggested that this is merely a matter of perception. *See* Gottfried and Sloan, *The Quality of Managed Care: Evidence from the Medical Literature*, 65 FALL LAW & CONTEMP. PROBS. 103, 103 (2002). ("The empirical evidence from the medical literature does not support the allegations of unsafe practices made against MCOs by proponents of patient protection legislation. This finding holds despite data suggesting that generalists, who occupy a privileged position as gatekeepers in many MCOs, are less proficient than specialists in the latter's areas of expertise, because such a fact does not appear to translate into worse specialty care for patients in managed care plan.").

A. Background Trends: Resistance to Managed Care

After an extraordinary increase in health care spending in the 1960s and 1970s,[10] managed care arose in the 1980s in response to payors' worries over increasing costs.[11] Insurance plans controlled by doctors and hospitals had few incentives to limit medical care or its attendant costs.[12] Managed care plans promised to reduce waste by leveraging the bargaining power of plan members in negotiations with service providers to drive down the costs of services and to disapprove treatment options with doubtful benefits.[13]

Of course, it is a rare medical procedure that offers *no* benefit.[14] Disputes have arisen, provoking resistance to managed care cost-cutting from physicians (who resent the diminution of their autonomy) and state legislatures (which have begun to force disclosure of physician financial incentives and to require

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[10] DAVID DRANOVE, THE ECONOMIC EVOLUTION OF AMERICAN HEALTH CARE 34 (2000) ("At the start of the 1990s, before MCOs [managed care organizations] took over, private sector health spending was rising by more than 10 percent annually, and many experts predicted that health care would account for 20 percent of the GDP by the year 2000. . . . Thanks to MCO's . . . total spending on health care remains below 14 percent of GDP.").

[11] Alain C. Enthoven, *The History and Principles of Managed Competition*, HEALTH AFFAIRS 24, 26 (1993) (describing the economic consequences of a traditional fee-for-service health care system); Clark C. Havighurst, *The Backlash Against Managed Health Care: Hard Politics Make Bad Policy*, 34 IND. L. REV. 395, 400 (2001).

[12] Thomas H. Greaney, *Managed Care: From Hero to Goat*, 47 ST. LOUIS U. L. J. 217, 217 (2003) ("At the outset of the [1990's], most observers heralded managed care as the solution to spiraling costs and a guarantor of quality.").

[13] Clark Havighurst, *The Backlash Against Managed Health Care*, *supra* note 11, at 401.

[14] The classic health care economics term for this is "flat of the curve" care, which increases expenses but offers virtually no hope of improving outcomes. For such a curve, the x-axis measures spending, and the y-axis measures some health outcome, such as Quality-Adjusted Life-Years. ALAIN C. ENTHOVEN, HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COST OF MEDICAL CARE 6 (1980).

coverage of certain care).[15] Despite this resistance, capitation systems[16] and other pressures to contain costs have already pervasively influenced physicians' interactions with patients.[17] Many primary care physicians must see at least 25 to 30 patients a day[18] in order to clear between $100,000 and $300,000 per year

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[15] See Peter Jacobson, *Who Killed Managed Care? A Policy Whodunit*, 47 ST. LOUIS U. L.J. 365 (2003); David A. Hyman, *Regulating Managed Care: What's Wrong with Patient's Bill of Rights,* 73 S. CAL. L. REV. 221 (2000) (listing examples, such as "drive-by delivery" legislation); David Dranove, THE ECONOMIC EVOLUTION, *supra* note 10. (objecting to these laws as technology-insensitive and speculating about the technological advances that would have been deterred had "drive-by hernia" surgeries been outlawed twenty years ago).

[16] "Capitation is a method of reimbursement in which a fixed sum of money is paid per enrollee by the purchaser to the provider. This sum of money is expected to cover specified services for every enrollee for a defined period of time." Treatment Improvement Exchange, *Financial Considerations*, *available at,* http://tie.samhsa.gov/TAPS/TAP16/Tap16chap4.html (last visited Feb. 25, 2006); *see also* HALL, BOBINSKI, AND ORENTLICHER, THE LAW OF HEALTH CARE FINANCE AND REGULATION 314-330 (2005) (discussing capitation payment plans).

[17] C. Jackson, *Premium Practice: When Patients Pay Top Dollar For Exclusive Care,* AMEDNEWS, Sept. 17, 2001, *available at* http://www.ama-assn.org/amednews/2001/09/17/bisa0917.htm; Marian Hawryluk, *Boutique Medicine May Run Afoul Of Medicare Rules*, *American Medical News*, April 8, 2002; William Hoffman, *Fed Up, Some Doctors Turn To 'Boutique Medicine,'* ACP-ASIM OBSERVER, Oct. 2001, *available at* http://www.acponline.org/journals/news/pastobis.htm; *Boutique Medicine: Elitist or Egalitarian?*, 19(23) PHYSICIAN'S WEEKLY 10, June 10, 2002, ("'Primary care physicians average between 20 and 30 patient visits each day. But the average number of 'patient contracts,' adding in phone calls and 'paper shuffles,' is over 110. In the last ten years, physician income has declined while the workload has increased.").

[18] Katherine Hobson, *Doctors Vanish From View*, U.S. NEWS AND WORLD REPORT, 50 (January 31, 2005). The average primary care physician sees 25 people a day. *Id.* Economic pressure on physicians results from a number of factors, including "reduced reimbursement rates, increased overhead costs, and higher premiums for liability insurance." *Id.*

in pre-tax income.[19] Some claim that, in response to many health plans' per-patient payment methodology, doctors are beginning to shun the sickest patients, who take up more time than healthier peers.[20] If a doctor fails to follow this strategy, scheduling may leave her with little more than 15 minutes per patient visit, regardless of the severity of the problem complained of or the complexity of the patient's health history.

Both empirical evidence and anecdotal accounts suggest that primary care physicians are not happy with these developments.[21] Many consider the strictures of managed care practice at best an inconvenience and, at worst, a reason for leaving the practice of medicine altogether.[22]

Given massive deficits and federal budget cutting, public funding of medical care is likely to become even more "managed" than private insurers' plans. Physicians are frustrated by concomitant government-imposed cost constraints—and since federal and state governments account for at least 40% of health

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[19] "In 2003, the median income for primary care physicians was $156,902. For general surgeons . . . it was $264,375. . . Busy orthopedic surgeons, cardiologists . . . and radiologists frequently earn more than half a million dollars a year." Atul Gawande, *Piecework: Medicine's Money Problem*, THE NEW YORKER, Apr. 4, 2005.

[20] Newt Gingrich, *A Health Threat We're Not Treating Don't Let Doctors Rig the Market for Specialty Hospitals*, WASH. POST, Nov. 12, 2005, at A25 (Physicians are tending to burden community hospitals with the risky, expensive procedures, while referring the less expensive cases to the specialty hospitals in which they have a financial interest, despite Stark anti-kickback statutes that discourage such "cherrypicking.").

[21] Brian Vastag, *Physician Dissatisfaction Growing*, 286 JAMA 781 (2001); Robert Wood Johnson Foundation, *Time Pressures Leave Doctors Dissatisfied*, *available at* http://www.rwjf.org/reports/grr/027069.htm ("If Massachusetts mirrors the nation, physicians' job satisfaction has taken a hit in the past 15 years, according to a study sponsored by the Agency for Healthcare Research and Quality in conjunction with the Robert Wood Johnson Foundation.").

[22] American Academy of Family Physicians, *Comparison of Primary Care Positions*, *available at* http://www.aafp.org/match/graph05.html (last visited Feb. 26, 2006) (documenting entry in (and exit from) the field).

care spending in the U.S., these strictures are becoming increasingly important.[23]

Those reliant on public health insurance programs, such as Medicaid and Medicare, have had even more cause for concern. Objecting to low reimbursement rates, some doctors refuse to treat Medicaid and even Medicare patients.[24] Each program can be complex and intimidating to beneficiaries. As Medicaid costs continue to rise, federal and state budget cuts are leaving many vulnerable citizens outside the health care system altogether.[25] Both programs' expenditures are increasingly scrutinized by auditors eager to penalize overbilling, fraud, and abuse of the system.[26] Though necessary, fraud and abuse law has grown so complex that it is becoming a trap for the unwary.[27] These laws may chill not only fraud, but also aggressive care that risks being deemed excessive or abusive in the current legal climate.[28]

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[23] Thomas Bodenheimer & Keven Grumbach, *Paying for Health Care*, 272 JAMA 634 (1994) (quoted in HALL, BOBINSKI, AND ORENTLICHER, THE LAW OF HEALTH CARE FINANCE AND REGULATION 167 (2005)).

[24] *See* William Buczo, *Provider Opt-out Under Medicare Private Contracting*, HEALTH CARE FIN. REV., Winter 2004-2005, at 43.

[25] John Jacobi, *Dangerous Times for Medicaid*, Seton Hall Public Law Research Paper No. 45, *available at* http://ssrn.com/abstract=845084 (last visited Feb. 25, 2006) (Many Medicaid reforms proposed in 2005 "would lessen our commitment to care for the poor and disabled, in some cases pushing vulnerable people out of public coverage.").

[26] *See*, e.g., ALICE G. GOSFIELD, MEDICARE AND MEDICAID FRAUD AND ABUSE (2005) (a 606 page guide on the topic).

[27] James F. Blumstein, *The Fraud and Abuse Statute in an Evolving Health Care Marketplace: Life in the Health Care Speakeasy*, 22 AM. J. L. & MED. 205 (1996) (arguing that the vagueness and breadth of these statutes grant "enormous prosecutorial discretion, which is subject to abuse.").

[28] *See* Jeremy Fine Bollinger, *Doctoring Fraud & Abuse: Enforcement of the Stark and Anti-Kickback Law in Physician Recruitment May be Bad for Your Health*, 38 LOY. L.A. L. REV. 485, 513 n. 158 (2004) (discussing perverse incentives created by Medicare fraud and abuse laws).

Meanwhile, patients are demanding more care and less restrictions on their choice of procedures and providers. Although managed care plans have begun to meet this demand by offering subscribers PPO plans and other more flexible options, survey evidence reveals dissatisfaction with the health care system as a whole:

> In a nationwide survey of more than 2,000 adults published last fall, 55 percent of those surveyed said they were dissatisfied with the quality of health care, up from 44 percent in 2000; and 40 percent said the quality of care had gotten worse in the last five years.[29]

Patients have even begun to question the utility of hard-won gains in autonomy, such as increased ability to choose treatment options.[30] Opaque and even perverse rationing mechanisms for care ranging from vaccinations to hospitalization have raised resentment and concern.[31]

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[29] Benedict Carey, *In the Hospital, a Degrading Shift from Person to Patient*, N.Y. TIMES, Aug. 16, 2005, at A1. The survey was conducted by Harvard University, the federal Agency for Healthcare Research and Quality and the Kaiser Family Foundation, an independent nonprofit health care research group. *Id.*

[30] *See, e.g.,* BARRY SCHWARTZ, PARADOX OF CHOICE: WHY MORE IS LESS 32-33 (2004) ("When it comes to medical treatment, patients see choice as both a blessing and a burden. . . . [T]he prospect of a medical decision has become everyone's worst nightmare of a term paper assignment, with stakes infinitely higher than a grade in a course."); Jan Harris, *Awash in Information, Patients Face a Lonely, Uncertain Road*, N.Y. TIMES, Aug. 14, 2005 ("Dr. Russo, [a] West Orange, N.J., internist who sees 5,000 patients a year, applauds patients who do their homework. But, he noted, especially when patients are researching treatment options, they flop down in his office, feeling inundated.").

[31] *See,* e.g., Mark V. Pauly, *Improving Vaccine Supply and Development*, 24(3) HEALTH AFFAIRS 680 (2005) (describing federal government's repeated recent failures to properly stock and distribute flu vaccine); Benedict Carey, *In the Hospital, a Degrading Shift from Person to Patient*, N.Y. TIMES, Aug. 16, 2005, at A1 (noting rising

Payors' pressure for cost containment has also riled patients. Worried by increasingly harried or unresponsive doctors, they are demanding change. Insurance plans have begun to oblige some of these demands. Wary of constantly being cast as the heavy in the drama of health care cost containment, managed care organizations have begun incentivizing cost consciousness instead of imposing strict command and control-style restrictions on coverage.[32] Cost-sharing, preferred provider options, and other strategies have emerged in order to widen the scope of treatments and personnel available to insureds.

Of course, these new options have a price, and they are only available to those who pay for them.[33] Insurers are "tiering" their offerings, providing consumers with more control over the range of services they can demand and the depth of coverage they desire. One of the most important ways of financing new coverage options for consumers is "segmentation of services through financial incentives."[34] In exchange for greater choice, consumers bear more financial risk in two complementary ways:

> [H]orizontal segmentation, in which consumers are induced to choose the richness of coverage based on

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levels of patient dissatisfaction with hospital visits and unclear admittance criteria).

[32] Henry Greely, *Direct Financial Incentives in Managed Care: Unanswered Questions*, 6 HEALTH MATRIX 53 (1996); Mark Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431 (1988) [hereinafter Hall, *Institutional Control*]; Mark Hall, *Rationing Health Care at the Bedside,* 69 N.Y.U. L. REV. 693 (1995)*;* David Orentlicher, *Paying Physicians More To Do Less: Financial Incentives To Limit Care,* 30 U. RICH. L. REV. 155 (1996); Andrea K. Marsh, *Sacrificing Patients For Profits: Physician Incentives To Limit Care And Erisa Fiduciary Duty*, 77 WASH. U. L.Q. 1323, 1342 (1999).

[33] *Special Issue: The Managed Care Backlash*, 24 J. HEALTH POL., POL'CY & L. 873 (1999).

[34] John V. Jacobi, *After Managed Care: Gray Boxes, Tiers and Consumerism*, 47 ST. LOUIS L.J. 397, 403 (2003) (citing James C. Robinson, Web Exclusive, *Renewed Emphasis on Consumer Cost Sharing in Health Insurance Benefit Design*, HEALTH AFF., Mar. 20, 2002, at W139, W140, *at* http://www.healthaffairs.org/WebExclusives/2103Robinson.pdf.).

> variable employee cost share, and vertical segmentation, in which consumers within plans are induced to choose providers based on variable employee cost share.[35]

Each type of segmentation is designed to encourage cost-consciousness among "consumers" of health care, while opening up new vistas of care options for those able to pay for them. Insureds act as partners with the plan in calibrating more precise trade-offs of cost and quality.[36]

This growing trend toward "consumer choice" in health care raises the stakes of retainer medicine regulation.[37] To the extent retainer practices avoid serious regulatory scrutiny, they will likely encourage innovators who want to make health insurance more a defined contribution than a defined benefit system. So far, consumer driven health plans, health savings accounts, and cash-only practices have not become widespread. However, Congressional and wonkish enthusiasm for these plans remains high, as evidenced by recent incentives for HSA's embedded in the Medicare Modernization and Prescription Drug Act of 2003.[38] Whether by design or incidentally, health savings accounts will be a great boon to the development of cash-only practices that evade managed care strictures.[39] All these developments create fertile ground for entrepreneurs seeking compensation for levels of care they deem necessary or desirable for patients.

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[35] *Id*. at 403

[36] *Id*. ("As the rate of differential and the number of tiers increases, co-payments and co-insurance seem less a gentle nudge to conform to the plan's network design than a mechanism to pass through discounts arranged between the plan and providers.").

[37] REGINA HERZLINGER, CONSUMER-DRIVEN HEALTH CARE: IMPLICATIONS FOR PROVIDERS, PAYERS, AND POLICY-MAKERS 10 (2004) (documenting trend toward consumer choice in health care).

[38] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1201, 117 Stat. 2469 (2003).

[39] Rhonda L. Rundle*, Pay-as-you-go M.D.: The Doctor is In, But Insurance is Out*, WALL ST. J., Nov. 6, 2002, at A1 (describing advantages of cash-only practices).

B. Physician and Patient Experiences with Retainer Care

The trends toward tiered insurance plans and cash-only practices and converge in retainer care or concierge medicine, which offers patients the chance to contract directly with physicians for services not covered by insurance plans.[40] The services are diverse; they range from "same or next-day appointments" to "private waiting rooms."[41] The fees for concierge care also vary widely, depending on the reputation of the doctors involved and the level of care received. A "top-of-the-line" practice, which accepts no insurance payments, may

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[40] Retainer care, concierge medicine, and boutique medicine all designate the same phenomenon. When it mandated a study on the topic in 2003, Congress defined concierge care as

> 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.

42 U.S.C.A. 1395cc (2004). Jennifer Russano provides a good narrative account of various retainer-financed practices. *See* Russano, *Is Boutique Medicine a New Threat to American Healthcare or a Logical Way of Revitalizing the Doctor-Patient Relationship?*, 17 J. LAW & POL'Y 313, 322 (2005).

[41] GAO REPORT, *supra* note 1, at 15. The GAO concedes that this survey is not necessarily representative; however, over half the sample responded. *See also* Abigail Zuger, *Before You Die, Determine What You're Paying For*, N.Y. TIMES, Oct. 30, 2005, at 26 ("According to [concierge patient] Dorothy Lipson, resident of Del Ray Beach, Florida, the niceties can make all the difference . . . all appointments, tests, and treatments were coordinated by the concierge practice").

cost $20,000 per patient per year; more modest services may only cost several hundred dollars annually.[42]

Though a small "cash-only" movement has been opting out of the managed care system since its inception, retainer medicine only emerged in the mid-1990's in Seattle.[43] Since then, it has spread to a number of (mostly urban) areas.[44] Though "top-of-the-line" retainer practices offer extraordinary amenities, they also tend not to take insurance or to require clients to file their own insurance claims.[45] However, the majority of retainer practices depend on both retainer payments and insurance reimbursement.[46] They market more modest services: preventive

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[42] Of the practices surveyed by the GAO, "the amount of the concierge care membership fee ranged from $60 to $15,000 a year for an individual, with about half of respondents charging individual annual membership fees of $1,500 to $1,999." GAO REPORT, *supra* note 1, at 4. Note that the fees follow a classic bell-curve distribution, rather than a bimodal distribution that would be expected if practices were concentrated as high and low-end types. *Id.*, at 13.

[43] Gregory M. Lamb, *Gold-Card Health Care: Is It Boon Or Bane?*, CHRIST. SCI. MON., May 17, 2004, at 12. Dr. John Blanchard, president and cofounder of the American Society of Concierge physicians, has stated:

> The current model of healthcare delivery, particularly in the primary-care setting, is dysfunctional, to say the least. You're shuttled through offices like cattle. This is not the way healthcare was designed. The quality of healthcare is based largely on the integrity of the patient-physician relationship – and that relationship breaks down in a high-volume healthcare setting.

Id.

[44] *See* GAO REPORT, *supra* note 1, at Appendix B (providing geographical depiction of retainer care prevalence).

[45] *See* G. Caleb Alexander, Jacob Kurlander, and Matthew K. Wynia, *Physicians in Retainer ("Concierge") Practice: A National Survey of Physician, Patient, and Practice Characteristics*, 20(12) J. GEN. INTERN. MED. 1079, 1082 (2005).

[46] *See* Concierge Family Medicine Practice, *Every Patient is a VIP to Us*, http://www.conciergefamilymedicine.com (conventional health insurance is still recommended by cash-only practices in order to cover

care, comprehensive physicals, helpful staff and coordination of care, and guaranteed attention from a dedicated physician within twenty-four hours of a request for care. [47]

The divergence between high- and low-end practices is a difference not only of degree, but also (at least for the law) of kind. By opting out of the insurance system altogether, the high-end practices are purchasing a great deal of autonomy. However, they also run the risk of being classified as insurers themselves, provoking the whole gamut of state regulation that such classification entails.[48] Lower-end practices can avoid that risk by focusing on insured patients. However, they risk running afoul of Medicare regulations prohibiting balance billing or false claims, or of insurance contracts that condition reimbursements on similar strictures.[49] Part IV below deals with these concerns in more detail.

Retainer medicine has provoked controversy in part because of the abrupt transition many practices have made to it. Steven Flier's story is typical. Disgruntled by time pressure, falling reimbursement rates, and insurers' interference with treatment options, Dr. Flier and his partners transitioned their practice into Personal Physicians HealthCare in 2000. They cut their panels by two -thirds or more, each offering a very high level of primary and preventive care to the first 300 patients willing to pay a $4,000 annual fee. Patients unable to pay the retainer fee were understandably perturbed, and widespread media coverage followed.[50] A similar dynamic has played out in many cities.

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out-of office expenses such as hospitalization, emergency-room visits, and diagnostic tests).

[47] "Dedicated" in the sense of "your personal physician," not merely "loyal" or "devoted."

[48] *See* discussion in Part VI.A. below; *see also* Carol M. Ostrom, *Concierge Physicians Medical Model Growing*, SEATTLE TIMES, May 28, 2004, at B1.

[49] *See, e.g.,* Dukakis v. Massachusetts Medical Society, 815 F.2d 790 (1st Cir. 1987) (holding Medicare's "reasonable charge" requirements constitutional).

[50] A recent news report on retainer care gives examples of physicians who permit "volunteer work" or who "grandfather in" extant patients who really want to stay with their practices. Amy Zipkin, *The Concierge Doctor Is Available (at a Price)*, *supra* note 50, at A6.

The American Medical Association has closely followed the boutique medicine trend and guardedly endorsed physicians' right to convert to retainer practices.[51] The AMA conducted a survey of both concierge- and non-concierge-funded physicians in order to better understand the practice's appeal to some of its members.[52] According to this survey, "50% of the retainer physicians said they thought they were offering more diagnostic and therapeutic services than traditional practices," and "70% of retainer physicians said they were doing better [financially] in this type of practice than they had in traditional practice."[53] It's not hard to see why, given the numbers: "Retainer physicians saw an average of 11 patients per day; nonretainer physicians saw an average of 22 patients."[54] As the GAO report notes, these patients' retainer payments in excess of insurance reimbursements average between $1,500 and $2,000 per year.

About the only downsides for doctors mentioned in the AMA survey and GAO report are the disapproval of colleagues

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[51] The CMS report is more positive than the CJEA report, but neither condemn retainer care. *Compare* Council on Ethical and Judical Affairs, *Report of the Council on Ethical and Judical Affairs: Retainer Practices* (2003), *available at* http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_3a03.pdf *with* Council on Medical Services, Report of the Council on Medical Services, *available at* http://www.ama-assn.org/ama1/pub/upload/mm/372/cms902.doc (CMS REP. NO. 9-A-02 (2002)).

[52] Jennifer Silverman, *Retainer practices reporting better care,* FAMILY PRACTICE NEWS, June 1, 2005, at 71. (reporting that "the AMA mailed out surveys to 144 physicians from retainer practices--also known as concierge or boutique medicine practices--and received 83 responses. As a control group, researchers mailed surveys to 463 primary care physicians in non-retainer practices from the AMA's master list, and received 231 responses. Data were collected between December 2003 and February 2004.") The primary source data have not yet been released; they are "still unpublished and have been in review since January 2005." *Id*.

[53] *Id*. The only apparent downsides were legal worries and reputational concerns. *See* Silverman, *Retainer practices reporting better care, supra* note 52, at 72 ("When queried about the potential risks of a retainer practice, respondents from both groups expressed concern that society and their peers would disapprove of their decision to start a retainer practice.").

[54] *Id*.

and the legal uncertainty surrounding this new method of health care finance.[55] Many of the physicians surveyed by the AMA were concerned about societal and collegial condemnation of boutique care.[56] The GAO reports repeated pleas from doctors for guidance from HHS on the legality of their practice, or a list of "safe harbor" practices that will not provoke regulators' scrutiny.[57] Scholars of law and norms would likely be quick to note the mutually reinforcing character of these concerns.[58] Widespread disapproval of concierge practices may rest on the conflation of a legal with a normative definition of good medical practice, while regulators themselves have likely gotten involved because of the concerns raised by doctors themselves and the more progressive medical associations. If either legal or normative concerns quickly clear up, retainer care could spread much more quickly than it has since its inception.

Neither the GAO nor the AMA surveyed the *patients* of concierge practices.[59] Perhaps their names were unavailable or

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[55] *Id*.

[56] *See* Silverman, *Retainer practices reporting better care, supra* note 52, at 74 ("'You risk having people look down their noses at you,' Dr. Wynia said. In a surprising statistic, '5% of people in retainer practices thought they should be discouraged' from pursuing this approach.' Indeed, several participants at the meeting told this newspaper that their employer or practice partners did not know that they were attending a conference on concierge care. More than half of retainer physicians and 80% of nonretainer physicians thought that concierge care created a risk of a more tiered system of access to health care. Loss of patient diversity and insurance contracts and legal challenges were other concerns cited by the survey respondents.")

[57] GAO REPORT, *supra* note 1, at 21.

[58] *See*, e.g., Kristin Madison, *Government, Signaling, and Social Norms*, 2001 U. ILL. L. REV. 867, 880 (2001) (discussing how normative order serves as an extralegal mechanism for influencing behavior).

[59] However, another study did focus on the demographic mix of patients at concierge practices. According to a recent survey, "Retainer physicians . . . reported caring for few patients on Medicaid compared to nonretainer physicians . . . [and] minority patients were also under-represented in most of these practices." G. Caleb Alexander, Jacob Kurlander, and Matthew K. Wynia, *Physicians in Retainer ("Concierge") Practice: A National Survey of Physician, Patient, and*

retainer physicians were unwilling to encourage scrutiny of a delicate new financing arrangement. There are essentially two views of patient experiences. Skeptics charge that these health care consumers are merely buying the appearance of better care, without any objective contribution to their health. Proponents of concierge care tend to view market demand as revelation and proof of the value of the service.[60] There is some empirical evidence for the claim; according to one reporter, "patients buying these higher levels of personal care have been renewing on a better-than-90-percent annual basis in many practices."[61]

Of course, there's no such thing as a free lunch—where do the patients unable or unwilling to afford the retainer care premium go? Hundreds of panelists are often dropped by a practice in its transition to the retainer model. Both the AMA and the GAO report that nearly all of these individuals are "absorbed into nearby practices," particularly because retainer care is now only prevalent in urban areas where there are plenty of doctors.[62] Despite these assurances, concerns about consumer protection, access to care, and public insurance budgets have led to increasing regulatory and journalistic scrutiny of boutique practices.

III. CONTROVERSY OVER FEDERAL REGULATION

State and federal policymakers are slowly beginning to realize the potentially corrosive distributive impact of boutique medicine.[63] The federal Medicare program is the most important

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Practice Characteristics, 20(12) J. GEN. INTERN. MED. 1079, 1083 (2005) [hereinafter *National Survey*].

[60] *Advocates say 'concierge medicine' is like having the neighborhood doctor back; critics call it elitist*, N.Y. NEWSDAY, Jan. 1, 2005, at B6.

[61] Russ Allen, *Doctors on Retainer Catch On*, RISK & INSURANCE, Mar. 1, 2005, at 21.

[62] *See* CMS REPORT, *supra* note 51, at 3; GAO REPORT, *supra* note 1, at 14.

[63] Carol M. Ostrom, *Retainer Fees' Spark Warning, supra* note 48, at B1; Sandi Doughton, *State Looks Askance at Extra Fees for Doctors*, SEATTLE TIMES, Aug. 12, 2003, at B1; Howard Gleckman, *Want a Doctor Who Treats You Like Royalty?*, BUS. WKLY., May 6, 2002; Uwe E. Reinhardt, *Doctors Are More Interested in Having Higher*

factor here, as it has construed the concierge care retainer as a charge to patients beyond the normal rate in at least one case.[64] Sections A and B below describe extant efforts to regulate concierge care. Federal regulation currently has the perverse incentive of inducing physicians' to bundle retainer care with amenities, in order to characterize the retainer as a charge for amenities, rather than a second charge for covered services Medicare already paid for. Unfortunately, the very double-billing rules designed to enhance access to medical care in the 1980s are now actually encouraging tiering in the service of their evasion.

A. An Ambiguous Federal Stance

Many members of Congress have claimed that retainer billing practices are crude evasions of balance billing rules.[65] According to these legislators and some consumer advocates, retainer practices violate the balance billing rules by effectively getting paid twice for the same service.[66] The basic contention here is that Medicare beneficiaries with retainer plans are not only being charged the normal fee for services (which is basically limited, and paid for, by Medicare), but are also being charged whatever fraction of their annual concierge care fees can be reasonably allocated to the service. For example, consider a

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Incomes than Providing Better Health Care, 324 BRIT. MED. J. 1335 (2002).

[64] "Concierge practices say they adhere to the law by ensuring that their fees pay only for services not covered by insurance or Medicare." Pam Belluck, *Doctors' New Practices Offer Deluxe Service for Deluxe Fee*, N.Y. TIMES, Jan. 15, 2002, at A1; *see also.* Editorial, *Boutique Medicine*, N.Y. TIMES, Jan. 17, 2002, A28. Critics believe this may be evasion (and not mere avoidance) of balance billing rules.

[65] Letter from Representative Henry Waxman to Tommy Thompson, Secretary of Human Health Services, Mar. 4, 2002, at 2, on file with author. ("In 1989, as part of the OBRA [Omnibus Budget Reconciliation Act], Congress legislated that "[n]o person may bill or collect an actual charge for the [Medicare] service in excess of the limiting charge." This "limiting charge" now stands at 115% of the Medicare rate. By conditioning the receipt of all Medicare services on an annual fee, however, "exclusive" physician practices seem to violate this law.").

[66] *Id*.

hypothetical retainer patient with Medicare who visits her physician 5 times a year and pays a retainer fee of $3,000 annually. If Medicare sets a $200 reimbursement limit, which the physician collects, it appears that the patient is not simply being billed for that $200, but also for $600 additionally for each visit (with an amount of the retainer proportionally applied to each visits).[67]

Conditions on Medicare funding provide important leverage for the federal government to influence the American health care system.[68] Participating providers must follow a complex set of rules for reimbursement.[69] Over 70% of concierge physicians contacted by the GAO participate in Medicare, so the program provides some leverage over the development of retainer care. Medicare regulation may also provide a model for large private insurers to assure that they are not subsidizing the tiering of the health care system.[70]

Though HHS's response to critics of retainer care was initially skeptical,[71] HHS officials have issued some warnings to

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[67] Paul Ginsburg, president of the Center for Studying Health System Change, has claimed that this strategy is "the equivalent of an end run around Medicare rules." Michael Romano and Laura B. Benko, *These doctors and their affluent patients find themselves in exclusive company*, MODERN HEALTHCARE, Oct. 22, 2001, at 38.

[68] BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS & PROBLEM 736 (4th ed., 2001).

[69] *Id*.

[70] According to one journalist, "Private insurers, which often follow Medicare's lead, may also join the fray. Anthem Blue Cross Blue Shield has barred Virginia doctors from soliciting or accepting additional payments from patients insured by the company. Most insurers in the state say they're waiting to see if the insurance commissioner comes up with new rules." Carol M. Ostrom, *Retainer Fees' Spark Warning, supra* note 48, at B1.

[71] Thompson letter to Waxman, et al., *supra* note 65, at 4 (accepting concierge physicians' assertion that the retainer payments only compensated for noncovered services). Thompson has since left the Department of Health and Human Services, and has become the chairman of MDVIP's "Committee on Cost Reduction Through Preventive Health Care." *See* MDVIP, *Press Release*, at http://mdvip.com/pressReleaseThompson.asp (last visited Feb. 24, 2006).

providers about potential violations of the law.[72] The Center for Medicare and Medicaid Services ("CMS") and the Office of the Inspector General ("OIG") of HHS are currently developing a regulatory response designed to protect the interests of Medicare beneficiaries.

> CMS outlined its position on concierge care in a March 2002 memorandum to CMS regional offices that CMS officials told us remains current as of June 2005. The memorandum states that physicians may enter into retainer agreements with their patients as long as these agreements do not violate any Medicare requirements. For example, concierge care membership fees may constitute prohibited additional charges if they are for Medicare-covered items or services. If so, a physician who has not opted out of Medicare would be in violation of the limits on what she or he may charge patients who are Medicare beneficiaries.[73]

The "additional charges" mentioned are prohibited by "balance billing rules," which prevent doctors from charging an amount

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[72] Carol M. Ostrom, *Retainer Fees Spark Warning, supra* note 48, at B8. "The federal government is warning physicians they could face penalties or even expulsion from Medicare if they charge those patients for covered services. What are these services? Medicare's fraud alert isn't spelling it out, but a Minneapolis doctor was busted for charging a fee for services such as "coordination of care" and "extra time" with patients. 'Medicare beneficiaries are entitled to certain services from their physician,' said Greg Demske, a chief in the Office of the Inspector General. If the physicians are asking for extra money for those services, then that's a problem.'")

[73] Robert M. Portman, *Back to The Future of Medicine*, *supra* note 2, at 12. ("The Medicare statute requires physicians to submit claims for all procedures performed on Medicare patients, even if they do not accept assignment. It also prohibits physicians who accept assignment of a patient's claim from charging more than the Medicare fee schedule amount. Those who do not accept assignment are prohibited from charging more than 115% of the fee schedule amount.").

above Medicare care limits, getting reimbursement from Medicare, and then charging patients for the balance remaining.[74]

The balance billing rules arose out of Congressional concern about potential barriers to access to care for poor and lower middle class Medicare beneficiaries.[75] Without such rules, physicians could condition services to Medicare patients on the payment of additional charges that would undermine the programs' efforts to provide reasonably-priced health care to all.

Under Medicare balance billing rules, participating physicians' charges are limited by the fee schedule prescribed by the program.[76] Under the relevant statute, physicians who accept assigned claims are prohibited "from charging more than the Medicare fee schedule amount."[77] Physicians who "do not accept assignment are prohibited from charging more than 115% of the fee schedule amount."[78]

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[74] Markian Hawryluk, *Boutique Medicine May Run Afoul of Medicare Rules*, *supra* note 18 (citing 42 U.S.C. § 1395w-4(g)(2)(C) (2000)); *see also* Jennifer Russano, *Is Boutique Medicine a New Threat, supra* note 41, at 322.

[75] "Recognizing that many of the poor could not afford to pay medical bills, the original Medicare and Medicaid legislation prohibited physicians from balance billing those Medicare beneficiaries who were also eligible to receive Medicaid benefits. For all others, however, Medicare allowed physicians to bill more than the Medicare payment for services on a claim-by-claim basis until 1983. Since 1983, physicians have been given the choice to participate or not to participate under the Participating Provider (PAR) Program, for which they are given several incentives to enroll." David C. Colby, Thomas Rice, Jill Bernstein, and Lyle Nelson, *Balance Billing Under Medicare: Protecting Beneficiaries and Preserving Physician Participation*, 20 J. HEALTH POL. POL'Y & L. 49, 51 (1995).

[76] *See* 42 U.S.C. § 1395w-4(g)(2) (2005); Robert M. Portman, *Concierge Care: Back to The Future of Medicine*, *supra* note 2, at 12. ("The Medicare statute requires physicians to submit claims for all procedures performed on Medicare patients, even if they do not accept assignment. It also prohibits physicians who accept assignment of a patient's claim from charging more than the Medicare fee schedule amount. Those who do not accept assignment are prohibited from charging more than 115% of the fee schedule amount.").

[77] *Id*. at 4.

[78] *Id*.

To the extent that they implicate balanced billing concerns, retainer practices could also violate the False Claims Act.[79] The Congressional sponsors of legislation to keep retainer care practitioners out of the federal Medicare system claim that these physicians "routinely submit erroneous bills to the government."[80] To return to the hypothetical scenario above, they insist that the bill for each visit of the retainer care patient is actually $700, not $200, and that its representation to the government as the latter is merely a fiction designed to avoid the strictures of balance billing rules.[81] Retainer care proponents'

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[79] According to the False Claims Act,

> Any person who—
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> (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government . . . 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
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> ***
>
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus three times the amount of damages which the Government sustains because of the act of that person

31 U.S.C. § 3729 (2005). Critics of retainer care characterize the bill to the government as a "false claim" that has already been paid for by the retainer. *See* Waxman Letter, *supra* note 65, at 4.

[80] Waxman Letter, *supra* note 65, at 4.

[81] "OIG [the Office of the Inspector General at the Department of Health and Human Services] has addressed the consequences of noncompliance with Medicare billing requirements. In March 2004, HHS OIG issued an alert 'to remind Medicare participating physicians of the potential liabilities posed by billing Medicare patients for services that are already covered by Medicare.' GAO REPORT, *supra* note 1 at 27. The alert stated that "charging extra fees for already covered services abuses the trust of Medicare patients by making them pay again for services already paid for by Medicare." Id. As an example, the alert referred to a Minnesota physician who paid a settlement and agreed to stop offering personal health care contracts to patients for annual fees of $600." *Id*.

response to this accusation closely tracks their line on the balance billing rules. They claim that the services they offer are not covered by Medicare, so they are not properly billed as Medicare claims.[82]

B. Covered or Noncovered Services?

A leading retainer care trade association claims that the retainer is a payment for "better service, not better medical care."[83] This characterization is important, because "'If participating physicians decide they want to charge patients additional fees they should be mindful that they are subject to civil money penalties if they request any payment for already covered services from Medicare patients other than the applicable deductible and coinsurance.'"[84] Medicare covered services include all "items and services . . . reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."[85]

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[82] Society for Innovative Medical Practice Design, *Report to the General Accounting Office*, Aug. 2004, at 15. (copy on file with author).

[83] Secretary of Health and Human Services Tommy Thompson Letter, *supra* note 65, at 2; Robert M. Portman, *Concierge Care: Back to the Future of Medicine*, *supra* note 2, at 5.

[84] Acting Principal Deputy Inspector General Dara Corrigan, *Office of the Inspector General Alerts Physicians About Added Charges for Covered Services*, OIG ALERT, at http://www.oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA033104 AssignViolationI.pdf [hereinafter *Corrigan Memorandum*] (implying that the concierge amenities at issue fall outside the scope of "Medicare covered services" and thus should not be subject to "balance billing" scrutiny.).

[85] 42 U.S.C. § 1395y (2005). There are of course a long list of exceptions, codified in subparagraphs appearing after this portion of the stature. Most important for our purposes are the many preventive services that Medicare is now covering, including "prostate cancer screening; bone mass density measurement; diabetic self-management; mammography screening; glaucoma screening; pap smears; an initial physical examination; cardiovascular screening blood tests; diabetes screening tests; and hepatitis B, pneumococcal, and flu shots."

The distinction between covered and noncovered services is a term of art of federal health care financing. Medicare tends to follow the diagnosis and management codes developed by the American Medical Association.[86] Unfortunately, neither regulations nor guidance documents appear to clarify application of this legal distinction to retainer care.[87] However, close examination of the lists of services offered by concierge practices discloses that at least some of them are likely covered Medicare services, as HHS itself determined in at least one case in Minnesota.[88] In that case, the OIG provided three examples of potentially covered services illicitly charged for by a concierge physician: "coordination of care with providers, a comprehensive assessment and plan for optimum health, and extra time spent on patient care."[89] Unfortunately, the alert did not specify whether

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FURROW, ET AL., HEALTH LAW, *supra* note 68, at 736 (citing 42 U.S.C. § 1395y(a)(1)(A)).

[86] The statute establishes a substantive legal standard for Medicare coverage. 42 U.S.C. 1395y(a)(1)(A) (2000). There are also regulatory criteria for National Coverage Determinations. 65 Fed. Reg. 31124 (May 16, 2000) (citing 42 USC 1395y(a)(1)(A) for authority to avoid coverage of services "not reasonable and necessary.").

[87] Joan R. Rose, *A Caution Light for Concierge Practices*, 81(10) MED. ECON. 22 (May 21, 2004). Each "improper request" to a patient for payment can result in a $10,000 fine, plus treble damages. Carol M. Ostrom, *Retainer fees spark warning, supra* note 48, at B1.

[88] *Corrigan Memorandum, supra* note 84, at 1-2 (("For example, the OIG recently alleged that a physician violated his assignment agreement when he presented to his patients--including Medicare beneficiaries – a 'Personal Health Care Medical Care Contract' asking patients to pay an annual fee of $600. While the physician characterized the services to be provided under the contract as 'not covered' by Medicare, the OIG [Office of the Inspector General] alleged that at least some of these contracted services were already covered and reimbursable by Medicare. Among other services offered under this contract were the 'coordination of care with other providers,' 'a comprehensive assessment and plan for optimum health,' and 'extra time' spent on patient care. OIG alleged that based on the specific facts and circumstances of this case, at least some of these contracted services were already covered and reimbursable by Medicare.").

[89] *Id*.

only one, or all, of these services was (or were) covered under Medicare.[90]

In the case of the third or so concierge practices with retainer fees below $1,000 per year, it is perhaps believable that patients would be willing to pay such a fee for more courteous staff, a nicer waiting room, monogrammed slippers, and other non-care-related amenities.[91] However, as fees mount, such a sharp distinction between care and customer service is harder to defend.[92]

IV. RESOLVING THE BALANCE BILLING CONTROVERSY BY DISAGGREGATING RETAINER CARE

In order to resolve the controversy over whether retainers are prohibited payments for covered services, or permitted payments for noncovered services, it is important to disaggregate the range of services provided by retainer care physicians.

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[90] *Id*.; see also GAO REPORT, *supra* note 1, at 15. GAO could not get clarification despite interviewing the relevant personnel at HHS. *Id*. ("HHS OIG did not indicate which, if any, of those three services were already covered by Medicare. The resulting uncertainty, about which features of the Minnesota physician's concierge agreement formed the basis for HHS OIG's allegation that he violated the Medicare program's prohibition against charging beneficiaries more than the applicable deductible and coinsurance, generated concern among some concierge physicians.")

[91] *See also* Jennifer Russano, *Is Boutique Medicine a New Threat to Access?, supra* note 41, at 336. ("If boutique medical practices provide their patients with bonuses such as heated towel racks, free hotel rooms, [and] special bathrobes, these amenities could violate the federal anti-kickback statute or the Health Insurance Portability and Accountability Act prohibiting such inducements. However, since these amenities are offered after payment of a retainer, it is likely that they will be seen as services provided in exchange for payment and not as an 'inducement.'").

[92] As the GAO Report notes, "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." GAO REPORT, *supra* note 1, at 22.

Section A below develops a taxonomy, while Section B applies that categorization to the legal issues at hand.

A. Three Faces of Retainer Care

Retainer care physicians offer a wide range of services, as this survey from the Government Accountability Office shows:

Features Offered by Concierge Physicians, October 2004[93]	
Feature	% offering feature
Same- or next-day appointments for nonurgent care	99
24-hour telephone access	99
Periodic preventive-care physical examination	99
Extended office visits	96
Access to physician via e-mail	94
Access to physician via cell phone or pager	93
Wellness planning	93
Nutrition planning	82
Coordination of medical needs during travel	82
Patient home or workplace consultations	78
Smoking cessation support	77
Preventive screening procedures	72
Newsletter	71
Stress reduction counseling	67
Private waiting room	63
Mental health counseling	60
Online or other electronic access to personal records	42

Though many commentators have directed praise or blame at retainer care *as a whole,* these statistics show that there are many distinct services offered by concierge physicians. I believe they may be usefully categorized as

[93] From GAO REPORT, *supra* note 1, at Appendix A.

> 1. Preventive care (designed to prevent illness or moderate the effects of chronic illness);
> 2. Queue-jumping (designed to grant privileged access to superior health care); and
> 3. Amenity-bundling (designed to enhance the value of queue-jumping and preventive care by combining them with comforts, luxuries, and positive experiences).

I describe each of these categories below.

1. Preventive Care

Nearly all retainer care practices responding to the GAO survey offer "periodic preventive-care physical examinations."[94] High percentages also offered "wellness planning" and "nutrition planning."[95] Concierge physicians are particularly proud of this dimension of their practice. Bernard Kaminetsky, a concierge physician who has testified before Congress and been profiled in the New York *Times*, has frequently argued that his practice *saves* the health care system money by minimizing hospitalizations and emergency room visits via careful monitoring of patients and constant availability.[96] He and other concierge physicians claim that, after years of feeling they could never meet their own high standards due to pressures from managed care, they can finally rest assured that they have

[94] GAO REPORT, *supra* note 1, at 15 (Of the concierge physicians responding to the survey, periodic preventive care, along with same or next-day appointments and 24-hour telephone access, were the most frequently reported features).

[95] 93% offered wellness planning, and 82% offered nutrition planning. *Id*. Other practices report the following preventive measures: "smoking cessation support" (77%); "preventive screening procedures" (72%); "stress reduction counseling" (67%); and "mental health counseling" (60%). *Id*.

[96] Bernard Kaminetsky, *Testimony of Bernard Kaminetsky, M.D., before the Joint Economic Committee of Congress*, April 28, 2004, *available at* http://jec.senate.gov/_files/KaminestskyTestimony04282004.pdf (only 55% of recommended preventive care is administered, and only 52% of recommended screening, presumably leading to increased out-patient care and healthcare costs).

provided all potentially helpful primary medical care that their patients need.

Beyond any particular preventive intervention, the availability and constancy of retainer care also promises significant preventive effects. A retainer physician can keep closer tabs on an array of potentially troublesome developments in a patient's weight, habits, or bloodwork. Advice on prevention from a trusted physician may also be far more effective than a rote catechism of self-care offered by a harried practitioner.

Concierge care deserves to be encouraged to the extent that retainer payments fund the type of preventive health care that many public and private insurers have so far been unable or unwilling to fund. Cancer screenings, vaccinations, cardiac rehabilitation, and anti-obesity and anti-smoking behavioral modification techniques undoubtedly occur at suboptimal rates. Many harried primary care physicians simply do not have the resources to provide them. If some entrepreneurs among them can inspire patients to pay for these socially beneficial programs, regulatory agencies should not stand in their way.

2. Queue-Jumping

Beyond preventive care, retainer care physicians also offer far quicker and lengthier access to ordinary care. Nearly all of those responding to the GAO survey offer "same- or next-day appointments for nonurgent care," "24-hour telephone access to physicians," and "extended office visits."[97] Nearly as many offer access to physicians via e-mail, cell phones, or pagers.[98] Many concierge physicians "coordinate medical needs during travel," or visit their patients at their home or workplaces.[99] A smaller number offer "priority for diagnostic medical tests in affiliated facilities."[100]

Given most concierge physicians' commitment to a "unitary standard of care," such patients are not "skipping in front of" other patients within concierge practices. However,

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[97] GAO REPORT, *supra* note 1, at 15 (Table 2). These features are often reported as the most important features distinguishing concierge practices from more traditional primary-care practices.

[98] *Id*.

[99] *Id*.

[100] *Id*. (27%).

they only attained this level of care by effectively outbidding those unable or unwilling to pay the required retainer. Moreover, considering the baseline of primary care availability, they are far "ahead" of those in non-concierge practices. The average American waits several days for an office visit, is subjected to more delays once at the doctor's office, and more than half of such visits last less than 20 minutes.[101] By contrast, concierge patients get near-immediate access, through both traditional visits, house-calls, and even e-consultations and phone calls.[102]

The term "queue-jumping" usually refers to individuals' effort to spend their way past the "lines" for rationed care in order to get immediate attention. The term has been most commonly used in analyses of "parallel" public and private health care systems, such as those prevailing in the United Kingdom, where the ten percent or so of the population that buys private insurance can use it to fund access to physicians whose attention they would normally need to wait weeks or months to get.[103]

Given that the overall mix of public and private spending in the United States has led to waits, on average, for primary care, there is a rather direct analogy between queue-jumping via concierge care in the U.S. and queue-jumping via private insurance or private payment in primarily public systems. But to be analytically rigorous, it's helpful to distinguish between jumping the queue to get *rapid access* and jumping ahead to more *intense, lengthier, or more expert* office visits. The latter issues raise interesting problems, which might be developed by thinking about the *extant,* somewhat random, distribution of above-average primary care.

Before concierge care, we may assume that *some* doctors were giving care as intense, expert, and dedicated as concierge physicians. However, the distribution of such doctors was

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[101] Josh Fischman, *Who Will Take Care of You? supra* note 8, at 46.

[102] Bill Sonn, *Concierge Medicine Physicians Weigh Financial, Ethical Issues*, PHYSICIANS PRACTICE DIGEST, 2002, *available at* http://www.shands.org/professional/ppd/practice_article.asp?ID=23.

[103] Michael Calnan, *The NHS and Private Health Care*, 10 HEALTH MATRIX 3, 16 (2000) (discussing parallel public and private health systems in the United Kingdom).

somewhat random. Perhaps some clung to an older standard of care, limiting their panels even as managed care squeezed effective compensation per patient. Some were in rural areas where there just weren't that many patients to treat. Some were just exceptionally energetic. Getting such a doctor was desirable, but left to chance and individual initiative, as people sought out recommendations of a "good" physician from family, friends, and coworkers. The sick (and perhaps the worried well) could be counted on to expend real energy in finding an exceptional primary care physician; those needing less care would probably not find the effort worth their while.

Admittedly, the informal "sorting" of doctors has always tracked class distinctions in the United States. The better-off are more likely to have the time, connections, and skills necessary to find quality primary care. Some of the best-off have long opted for "cash-only" practices, upon which the toniest retainer care practices have been modeled. Retainer care promises to expand the scope of the commodification of primary care quality. No longer do merely those wealthy enough to go "cash only" have the opportunity to command the attention of retainer doctors. As the buying power of this class expands, the doctors most capable of taking advantage of it via retainer care are likely to be the best doctors, or at least those with a superior reputation.[104] Retainer

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[104] Robert A. Berenson, *Consumer-Directed Doctoring*, Capital Hill Hearing Testimony to the House Joint Economic Committee, Federal Document Clearing House Congressional Testimony (April 28, 2004).

> [I]t is likely that relatively healthy, affluent individuals would be the group most likely to opt out of comprehensive insurance products, leading to high insurance costs for those whose health problems give them no choice but to remain in the basic health insurance pool. As healthier families and individuals opt out of traditional insurance coverage, those remaining in comprehensive health plans would be more expensive to insure. This will lead to destructive market segmentation, driving up premiums for traditional coverage even further and setting off a spiral of adverse selection. The comprehensive health

patients are likely to want, not merely more time from a physician, but also *quality* time with a*quality* physician.

These likely dynamics point to distinct facets of the "queue-jumping" so important to the retainer care model. Retainer payments guarantee a) quicker access to care—the classic definition of queue-jumping familiar from countries with parallel public and private systems. But they also promise b) better health care, when they permit payors to leverage buying power into access to more skilled or dedicated physicians. Retainer patients are thus relatively advantaged (vis a vis nonretainer patients) by gaining *quicker* access to *better* care.

3. Amenity-Bundling

Yet just how far can retainer care physicians' standard of care diverge from the normal standard? Some commentators have been skeptical, pointing out that virtually any decent primary care practice will provide patients with a call service and quick attention (or a referral to a emergency room) in case of a serious problem.[105] As mentioned above, several commentators suggest that current levels of dissatisfaction with managed care relate more to perception than reality. Perhaps a great deal of the dissatisfaction stems from the near-automatic anxiety generated for many by today's health care system. For those already sick, the prospect of grappling with billing disputes and officious staff might be enough to keep them away from the doctor altogether.

As their moniker suggests, concierge physicians try to make the interactions with the health care system more like the lavish treatment at a fine hotel. Over half of those responding the GAO survey offered a "private waiting room."[106] Thirty-one percent offered "home delivery of medication by physician or

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> insurance option would become unaffordable precisely for those who need its protection.

Id.

[105] Robert M. Portman, *Concierge Care: Back to the Future of Medicine, supra* note 2, at 3.

[106] GAO REPORT, *supra* note 1, at 15 (63% of respondents claimed to offer this feature).

office staff."[107] Concierge practices generally pride themselves on making interactions between staff and patients as amenable and productive as possible.

Some sensationalistic media reports have also focused on the more extravagant "perks" of concierge patients: monogrammed bathrobes, heated towels, and slippers. Although these reports probably don't accurately represent the patient experiences at most concierge care practices, they suggest the direction of competition in the future. Health care is often characterized by economists as an experience good--a service whose value is hard to judge critically until after it's been rendered—or a credence good, whose value can really only be judged by experts.[108] To the extent discriminating consumers want to compare concierge practices, they will often have little to go by other than the appearance of doctors' offices and the perks they provide.

Would competition on amenities be a good development? There are several reasons to doubt that. Amenity bundling, like many statutory and regulatory requirements for managed care coverage which stymie the provision of more "cut-rate" offerings, can be deeply inegalitarian. Clark Havighurst's critique of "managed care" mandates (which require health plans to cover procedures like *in vitro* fertilization) applies *a fortiori* to amenity bundling:

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[107] Admittedly, this is not a "luxury" for those unable to get to a pharmacist. Unfortunately, the GAO survey does not reveal what percentage of retainer patients taking advantage of this service were not able to get to the doctor.

[108] William M. Sage and Peter J. Hammer, *A Copernican View of Health Care Antitrust*, 65-Fall LAW & CONTEMP. PROBS. 241, 270 n. 104 (2002) ("Many health care services are what economists call credence goods, meaning that consumers cannot necessarily assess their quality even after consuming them.") (citing Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 951-52 (1963)). With "credence goods, there exists an information asymmetry between buyers and sellers, leading to consumers never knowing the extent of goods that they actually need." Winand Emons, *Credence Goods and Fraudulent Experts*, *available at* http://www.rje.org/abstracts/abstracts/1997/Spring_1997._pp._107_119.html.

> [T]he elite classes, including many self-proclaimed consumer representatives as well as organized professional groups . . . design and maintain a system that meets their own particular needs but leaves less privileged citizens who are not qualified for publicly financed care with a Hobson's choice: either coverage for 'Cadillac' care or no health coverage at all. Ruled as it is by and for dominant elites, the U.S. health care system imposes large, unfair, and unnecessary economic burdens on ordinary working people.[109]

Scholars outside health law also raise concerns about amenities. As Lior Strahilevitz has demonstrated, "exclusionary amenities" are widely used by housing developers in order to discourage "unwanted" groups from affecting the character of the neighborhood, without running afoul of antidiscrimination laws.[110] For example, a condominium association which only wants childless singles and couples to join may write into the relevant covenant a requirement that all residents subsidize a variety of amenities such families are unlikely to use.[111] Luxurious amenities may be valuable to those who can afford them, but also tend to increase already troubling trends toward economic apartheid.[112] Though some may be inevitable in the housing market, health care should not be conditioned on one's ability to purchase lavish services unrelated to therapeutic ends.

The problem lies not only in the substance of amenity-bundling, but also in its form. Bundling has provoked antitrust

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[109] Clark Havighurst, *How the Healthcare Revolution Fell Short* 65 LAW AND CONTEMP. PROBS. 55, 86 (2002).

[110] Lior Strahilevitz, *Exclusionary Amenities in Residential Communities* (Univ. of Chicago, Law & Economics, Working Paper No. 250, 2005), at 2 ("People interested in residential homogeneity inevitably will try to thwart integration using creative substitutes for overt discrimination.").

[111] Id., at 1.

[112] CHUCK COLLINS AND FELICE YESKEL, ECONOMIC APARTHEID IN AMERICA 31 (2000) (discussing inequality and public health).

scrutiny in certain industries.[113] Since the rest of concierge care services often are not available outside a package including amenities, they are offered in a particularly tight type of bundling.[114] Admittedly, it would be difficult to apply recent doctrine on "bundled discounts" to retainer practices given their lack of market power, and their failure to market the components of retainer care separately in the past.[115] Yet perhaps the very difficulty of such an analysis suggests the need for valuing the component part of retainer care more carefully.[116] As Section B below shows, often amenities are emphasized not simply for their own sake, but to provide "something else to bill for" to avoid liability for double billing for covered services.

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[113] David S. Evans and Michael Salinger, *Why Do Firms Bundle and Tie? Evidence from Competitive Markets and Implications for Tying Law*, 22 YALE J. REG. 37 (2005); Daniel L. Rubinfeld, *3M's Bundled Rebates: An Economic Perspective*, U. CHI. L. REV. 243 (2005) (discussing leading case *3M v. LePage's*.).

[114] Bruce H. Kobayashi, *Does Economics Provide a Reliable Guide to Regulating Commodity Bundling by Firms? A Survey of the Economic Literature*, 1 J. COMPETITION L. & ECON. 707, 708 n.2 (2005) (charting six types of bundling, based on whether components are available separately or not).

[115] Thomas A. Lambert, *Evaluating Bundled Discounts*, 89 MINN. L. REV. 1688, 1689 (2005) (explaining that leading recent antitrust cases addressed "bundled discounts", which occur "when a seller offers a collection of different goods for a lower price than the aggregate price for which it would sell the constituent products individually."). Since the concierge physicians aren't presently selling amenities separately, it would be very difficult to determine whether suspect "bundled discounting" actually occurred.

[116] And, perhaps, the chilling effects of antitrust liability here. A rational seller might decide to vigorously resist any decomposition of a package of goods it sells in order to avoid liability for bundling if it later decides to sell them together. Just as balance billing rules may unintentionally promote the bundling of amenities into retainer care packages, so too might potential antitrust liability for bundling unintentionally chill the constructive efforts of sellers to break a package of retainer services into its component parts. Worries over the unintended consequences of regulation drive the conclusion, in Part VI below, that targeted taxation of the troubling parts of retainer care probably amount to the best regulatory response at this time.

B. What are the Retainer Payments For?

Nevertheless, amenity-bundling is likely to persist, because amenities play an important role in the business model of concierge physicians: they provide legal cover for the assertion that retainer payments are compensation for noncovered services. Strategic concierge physicians tend to assure that their contracts specify that retainer payments are only made in consideration for uncovered amenity and preventive care.[117] For example, Personal Physicians HealthCare hired attorney Michael Blau to legally restructure their practice in order to distinguish payments for ordinary medical services and those for preventive and amenity care:

> Personal Physicians HealthCare PC was formed to provide healthcare services and contracts with all of the various insurance payers. Its structure was almost identical to that found in the physician's office; and as a corporation, it was authorized to offer all medically necessary covered services.
>
> Personal Physicians HealthCare LLC was formed as a client services corporation that charges the $4,000 annual fee. This umbrella of services would also cover PPHC's in-house nutritionist and personal trainer, the doctor-patient communication system of email and cell phone access and other PPHC custom-designed patient services.[118]

[117] *See*, e.g., MDVIP Membership Agreement (section entitled "Medical Care Services Excluded from Annual Membership Fee") (attachment to Waxman letter).

[118] Gregory L. Stoller and Christopher Ferrarone, *The Patient is Always Right: Personal Physicians Healthcare* 8 (2004) (copy on file with author). The "dual structure" was also used for accounting purposes. " '[M]ost insurance plans cover medically necessary house calls However, if the house call is for the patient's convenience, then it is not covered under insurance and would be "paid for" by the patient's annual fees from the LLC.'" *Id*.

One of the founders of this "dual structured" practice explains that the arrangement works in part because "LLC buys time from the PC so that our doctors are not busy."[119]

Groups like PPHC would like to characterize all these LLC payments as being "for" noncovered preventive and amenity care, even if they dwarf the amount paid directly for insurance-covered medical care and the relevant doctors spend more time on the latter than the former. The mere legal form or labeling of payments should not dispose of questions about what they are actually for.[120] Some of the amenities offered by retainer physicians are merely "better services," but it is unlikely that retainer patients paying several thousand dollars annually are merely paying for monogrammed bathrobes or friendlier office staff. Rather, these are payments for medical care itself.

Retainer care services may be usefully categorized as amenity, preventively therapeutic, and directly therapeutic. Given extant patterns of Medicare funding, we can predict that those services falling into the last category would likely qualify for Medicare coverage, and those in the first would likely fall outside the program's purview. Certainly the categories don't directly map onto coverage decisions, which are inevitably idiosyncratic given the degree of discretion vested in the Secretary by the statute.[121] However, given the number of retainer care services that reasonably fall into the "directly therapeutic" category, the OIG could reasonably presume that at

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[119] *Id.*

[120] Michael Romano*, If you have to ask, you can't afford it; Boutique practices getting a hard look from government, doctors' group*, MODERN HEALTHCARE, March 25, 2002; *Lawmakers challenge legality of "boutique medicine,* CLINICIAN REVIEWS, May 1, 2002, at32 (Leading Democratic Congressmen "requested a review of the legality of these practices," because "current law states that providers who do not accept the Medicare fee schedule can charge no more than 115% of the Medicare rate for a covered service.").

[121] *Goodman v. Sullivan*, 712 F. Supp. 334, 338 (1989) ("Congress delegated to the Secretary the authority to promulgate regulations for administering the Medicare program, 42 U.S.C. § 1395hh(a) (2005), and provided the Secretary with great discretion in determining what items or services will be covered under Medicare Part B.")

least part of the retainer fee charged at many practices is supplementing Medicare payment for covered services.[122]

Many defenders of concierge care claim that the retainers only pay for "better service," not better health care. This nomenclatural smoke screen has obscured what's really objectionable about concierge care: the bidding away of primary care resources by those wealthy enough to "jump the queue" effectively created via tacit managed care rationing. To the extent concierge physicians are bundling amenities with retainer care in order to avoid legal liability for double billing, law is encouraging the worst distributive consequences of the retainer care trend. Bundled amenities only tend to make concierge care more unaffordable, and serve no legitimate therapeutic purpose.

Admittedly, the valuation of each facet of retained services will be difficult. But to the extent the distinction is a sham, insurers should step in to avoid subsidizing the type of struggle for positional advantage (in access to care) that queue-jumping is likely to encourage. For patients with insurance, retainer payments raise the type of "double payment" concerns addressed by Medicare's balance billing rules, the False Claims Act, and similar provisions in private insurance contracts. The relevant authorities should scrutinize these arrangements in order to minimize the extent to which public and private insurers are subsidizing retainer conversions primarily designed to provide priority access. These conversions serve only to fragment the risk pools that insurance is designed to unify.

The Medicare program can be powerful policy lever for encouraging retainer practices to concentrate on preventive care and to avoid promoting the kind of frenzy for position that

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[122] GAO REPORT, *supra* note 1, at 18. HHS has issued a memorandum that "states that retainer agreements could be problematic if they attempt to substitute for Medicare supplemental insurance policies. CMS officials reported encountering problems with physicians offering unregulated supplemental policies in the mid-1990s. In June 2005, CMS officials told [the GAO] that, while such substitutions are not allowed, they are no longer concerned that retainer arrangements are being used as substitutes for Medicare supplemental insurance." *Id*. The GAO unhelpfully fails to cite to the date or title of the memo it refers to, and a search of the HHS website for the document has proven fruitless. Kenneth T. Bowden II and Lawrence L. Foust, *Advanced Issues in Provider/Payer Managed Care Contracting and Negotiations* 12 (2005) (file on copy with author).

"queue-jumping" for ordinary medical care may cause.[123] A majority of retainer physicians responding to the GAO's survey participate in the Medicare system, and retainer patients skew toward the elderly. By cutting out reimbursements for ordinary medical care already paid for by retainer fees, HHS could reduce the financial appeal of the retainer model, as well as its potential to increase queue-jumping. Part VI below suggests some methods of decomposing the value of the different facets of retainer care.

V. SHOULD RETAINER CARE BE FURTHER REGULATED?

Though Medicare has great influence over the U.S. health care system, it does not exhaust the potential range of regulatory responses to retainer care. Balanced billing rules may also prove to be too blunt an instrument to simultaneously diminish queue-jumping and promote preventive care. Other options, including state regulation, may achieve health policy goals in a more nuanced way.

Before examining these options, it is important to address the normative question—*should* retainer care be further regulated? Any fair approach to this question requires a careful airing of the concerns of concierge physicians and their patients.

Retainer care physicians' complaints about regulation break down into four main types. First, many argue that retainer care is simply too insignificant a phenomenon to merit sustained attention from regulators. They also argue that gains in time and compensation from concierge care will encourage more medical students to become primary care physicians. Finally, retainer care physicians argue that they treat some of the sickest patients, and it is unconscionable to deny treatment options to those willing and able to afford them.

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[123] Admittedly, if Medicare requirements get too burdensome, HHS risks losing influence over them to the extent that retainer practices exit the public insurance program altogether (and perhaps become "cash only"). *See* William Buczo, *Provider Opt-out, supra* note *25*, at 43. There are many anecdotal accounts of physicians "about to opt out of the system entirely" due to insurers' burdensome administrative requirements. However, a recent study suggests that few providers recently given the option to opt-out of Medicare. *Id.*

Parts A through D below elaborate these concerns and critically examine them. Although advocates of retainer care make some compelling arguments for permitting it in a certain range of cases, a tailored regulatory response is essential to mitigating its worst effects.

A. A Self-Limiting Phenomenon?

Proponents of retainer care have tried to deflect regulation by insisting that it is a "self-limiting" phenomenon that would only threaten access to care if it were to become widespread.[124] A nascent phenomenon in health care finance, retainer medicine has not yet affected the vast majority of providers or patients. The GAO's report, one of the most comprehensive so far, stated that "The small number of concierge physicians makes it unlikely that the approach has contributed to widespread access problems."[125] Some predict that is likely to remain the case for the foreseeable future. According to one leading academic and policy advisor, though "[c]oncierge care may remain attractive to a limited number of high income-individuals. . . it is not likely to become an important component of the American health care system."[126]

This characterization of retainer care is essential to its current justification. As the AMA's Council on Ethics and Judicial Affairs warns, if boutique medicine were to become widespread, or even to "take over" a certain market, it would certainly raise concerns about access.[127] But the AMA's Council on Medical Practice downplayed such concerns, and both

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[124] Troyen Brennan summarizes these responses (from health lawyers and the AMA) in a seminal article on the topic. Brennan, *Luxury Primary Care: Market Innovation or Threat to Access?*, 346 NEW ENG. J. MED. 1165, 1167 (2002).

[125] GAO REPORT, *supra* note 1, at 24.

[126] Stuart Altman, *Concierge-style health care perks not likely to revolutionize medical services field*, http://my.brandeis.edu/news/item?news_item_id=100466&show_release_date=1 (Describing speech by Stuart Altman, a leading health care economist and co-chairman of The Massachusetts Governor's and Legislative Health Care Task Force. Massachusetts has been one of the least interventionist states with respect to retainer care.)

[127] CEJA REPORT, *supra* note 51, at 3.

advisory groups claimed that the value of pluralism in consumer and provider options outweighs any negative effects of retainer conversions.

As of mid-2005, about 250 physicians have concierge practices.[128] The largest concierge care network, MDVIP, based in Boca Raton, Florida, "has 85 doctors in 14 states serving 27,000 patients."[129] The GAO reports a continuous growth in retainer practice since its inception in 1996.[130] Nevertheless, the same report concludes that "The small number of concierge physicians makes it unlikely that the approach has contributed to widespread access problems." [131] The Medical Practice Committee of the American Medical Association goes further on the prevalence question, deeming retainer medicine an "inherently self-limiting" phenomenon:

> The phenomenon of retainer practice is inherently self-limiting. The more physicians charge for their services, the smaller the demand for their services. Retainer practices will generate higher costs for those patients who are willing and able to pay for higher levels of service, but not necessarily for those patients who cannot afford those higher levels of service. These economic realities limit any potential for widespread adoption of retainer practice and any potential for growth in retainer practice to adversely impact patient access to care.[132]

This analysis suggests that, like most other luxury goods, retainer care will simply be enjoyed by a small elite and will not divert

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[128] Amy Zipkin, *The Concierge Doctor is Available (at a Price)*, *supra* note 50, at 6.

[129] *Id.*

[130] *See* GAO REPORT, *supra* note 1, at Appendix C (charting rate of prevalence of retainer practices).

[131] The GAO was directed to study concierge care pursuant to the Medicare Improvement, and Modernization Act of 2003.

[132] F. Maxton "Mac" Mauney, *Report of the Council on Medical Service*, *available at* http://www.ama-assn.org/ama1/pub/upload/mm/372/cms902.rtf (site last visited March 1, 2006).

resources from others. Or if it becomes widespread, physicians will flood into the market and increased supply will bring costs down.

This simple model of supply and demand ignores several peculiarities of the market for professional services in general, and medical care in particular. On the supply side, the number of doctors available cannot rapidly increase simply because a new model of financing increases demand for their services. Supply is rigidly limited by restrictions imposed both on the number of medical schools and on the number of residencies available after undergraduate medical education.[133] On the demand side, the dynamics of positional goods and auction effects are poised to push retainer care toward a "tipping point" of ever-increasing bidding for physician services.[134] The economics of positional goods suggests the rapidity with which bidding wars for superior professional services can escalate in response to changes in the financing patterns of markets for knowledge-based services.[135]

It is odd to hear proponents of boutique medicine use its rarity as a rationale for not regulating it, since legal controls (or uncertainty over their application) may themselves be the *reason* for its rarity. Much health care financing innovation is driven by the legal system—including the statutes governing Medicare, state insurance law, and the mass of regulations and guidance documents that interpret those laws. It is no surprise that

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[133] *See* KENNETH M. LUDMERER, A TIME TO HEAL: AMERICAN MEDICAL EDUCATION FROM THE TURN OF THE CENTURY TO THE ERA OF MANAGED CARE 214 (1999) (on the role of the "Liaison Committee on Medical Education," "established in 1942 as a cooperative effort of the Association of American Medical Colleges and the Council on Medical Education and Hospitals of the American Medical Association.")

[134] ROBERT H. FRANK, CHOOSING THE RIGHT POND: HUMAN BEHAVIOR AND THE QUEST FOR STATUS 7 (1985) (noting that positional goods are "sought after . . . because they compare favorably with others in their own class"); FRED HIRSCH, SOCIAL LIMITS TO GROWTH 1-12 (1976) (positing that the pursuit of self-interest to advance "to a higher place among one's fellows" results in an overconsumption of private goods, reducing the overall net social utility).

[135] *See*, e.g., Robert Frank's discussion of the polarization of incomes among dentists in, *infra* note 150 .

physicians, uncertain of the legal status of retainer medicine, have not rushed to embrace the idea.[136] But if the relevant authorities were to decisively adopt a laissez-faire position, they would greatly diminish the marginal cost of conversion to the retainer model caused by legal uncertainty. Legal uncertainty is itself a major cause of the current scarcity of boutique practices, and it is simply disingenuous to argue that the former should be eliminated on account of the latter.

Supporters of concierge care have argued that retainer arrangements are not significant enough to regulate because they only affect a small number of providers. However, regardless of the degree of diversion of resources *now* occurring, boutique medicine is likely to prove much more attractive to upper and middle class consumers of health care as it gains in notoriety.[137] As soon as one person in a reference group purchases concierge care, their peers are likely to ask: "How can I deny this to myself? Or my children?"[138] Given the special significance of health care, there are many consumers who will accept nothing less than the "best" available. As boutique health care creates new opportunities to break through extant "ceilings" (upper limits) of care generated by public and private insurance systems, it generates new channels for the wealthy to bid away resources from pooled risk purchasers.

For example, when considering several brands of insurance with similar patterns of coverage, a rational consumer

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[136] Reporting on its survey of retainer physicians, the GAO reported that "Various strategies for concierge care practice design have been developed to help concierge physicians avoid potential Medicare compliance problems, but most of our survey respondents expressed a need for more information from HHS to guide them." GAO Report, *supra* note 1, at 17.

[137] Mike Norbut, *Appeal of Retainer Practices: Boutique Care Goes Mainstream*, AMERICAN MEDICAL NEWS, August 4, 2003, *available at* http://www.ama-assn.org/amednews/2003/08/04/bisa0804.htm.

[138] *See,* e.g., TIMUR KURAN, PRIVATE TRUTHS, PUBLIC LIES: THE SOCIAL CONSEQUENCES OF PREFERENCE FALSIFICATION 6 (1995) (describing bandwagon effects of informational cascades in presidential primaries and the fashion world); THORSTEIN VEBLEN, THEORY OF THE LEISURE CLASS 12 (1905); DAVID BROOKS, BOBOS [BOURGEOIS BOHEMIANS] IN PARADISE (2004).

would naturally consider the reimbursement policies of each and the degree of access to doctors they permit. Few would want to be part of an aggressively cost-containing plan, if only because doctors would be more likely to avoid them as patients.[139] To the extent the plan limited or delayed reimbursement, their attractiveness as a patient *relative to* other insureds would drop.[140] Conversely, to the extent the plan guaranteed quick or generous reimbursement for procedures, an insured's *relative* attractiveness as a patient would increase.[141]

Since most large insurance companies' business plans require them to spread risk over thousands of subscribers for each particular product they offer, they do not yet offer a very wide variety of specifically tailored plans to subscribers.[142] The average large employer, for instance, only offers a few different plans to its employees.[143] However, with the rise of concierge care, medical practices are cutting out the middleman and offering a tailored version of insurance directly to their patients.[144]

In this way, retainer medicine permits consumers to distinguish themselves even further in the pool of insured

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[139] BARRY R. FURROW ET AL., HEALTH LAW, *supra* note 68, at 762.

[140] Mark O. Hielper & Brian C. Dunn, *Irreconcilable Differences: Why the Doctor-Patient Relationship Is Disintegrating at the Hands of Health Maintenance Organizations and Wall Street*, 25 PEPP. L. REV. 597, 606 (1998).

[141] Deven C. McGraw, Student Author, *Financial Incentives to Limit Services: Should Physicians Be Required To Disclose These To Patients?*, 83 GEO. L.J. 1821, 1839 (1995).

[142] BARRY R. FURROW ET AL., THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE 201 (4th ed., West 2001).

[143] BARRY R. FURROW ET AL., HEALTH LAW, *supra* note 68.

[144] William Hoffman, *American College of Physicians, ACP-ASIM Observer, October 2001*, *available at* http://www.acponline.org/journals/news/oct01/new_model.htm. In order to avoid state regulation of insurance plans, many retainer practices dispute this characterization of the fee, claiming that it is simply a fee for "better service," not for "medical care" itself. I give some reasons for skepticism about that characterization in Part VI below (discussing the recent history of state insurance regulation applicable to provider-sponsored organizations (PSO's)).

patients. Whereas before one could only buy the best health plan one's employer offered, concierge care permits one to leverage such a plan into extraordinary primary care and lavish related services.[145] Meanwhile, the retainer collected by those offering this level of service allow them to treat fewer patients while making the same (or, often, more) income than they made when only third-party insurers paid.[146]

Therefore, concierge care intensifies the pressures for relative position already present in the insurance market. As more consumers opt for the concierge model, less doctors are available to the rest of the market. The resulting scarcity makes the concierge model all the more *relatively* attractive, portending a self-reinforcing exodus from third-party insurance *simpliciter* to the type of third-party-payor + retainer-payment model.

The combined effects of supply restrictions and positional competition (by physicians, for income, and patients, for care) raise the possibility that concierge care conversions may be a self-reinforcing, rather than a self-limiting, phenomenon. Looking back on the literature on the conversion of non-profit hospitals to for-profit status over the past decade or so, it is remarkable how often the terms "rapid," "sudden," and "revolutionary" are used to describe the development.[147] Of course, commentators had several explanations for the apparent inevitability of the trend once it was well-established. The for-profit chains skimmed off the most profitable work; they had far

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[145] Vasilios J. Kalogredis, *Physician's News Digest, Should You Consider Concierge Medicine?*, http://www.physiciansnews.com/business/204.kalogredis.html (Feb. 2004).

[146] Andrew Haeg, *Minnesota Public Radio, Top Shelf Health Care- If You Have the Money*, http://news.minnesota.publicradio.org/features/200206/24_haega_concierge care/ (June 24, 2002).

[147] *See* ROBERT KUTTNER, EVERYTHING FOR SALE: THE VIRTUES AND LIMITS OF MARKETS 126 (1996) ("Historically, one segment of the hospital industry was for-profit, but such hospitals were invariably locally owned. In less than a decade, the vast majority have now become owned by absentee companies, usually the result of merger-and-acquisition binges orchestrated by entrepreneurs.") (citing *Balance Sheets that Get Well Soon,* BUS. WEEK, Sept. 4, 1995 (80-84).

more access to capital necessary for technology-intensive care, and thereby initiated a competitive dynamic that severely disadvantaged non-profits.[148] The same trends are now fueling the rise of specialty hospitals, which only perform surgeries with very high profit margins.[149] These market dynamics may also direct the most profitable patients toward retainer care.

Doctors feel increasingly pressed for time with their family or outside-work interests, and for money to pay off education debt and malpractice insurance. Few will reject an opportunity to increase income *and* leisure simultaneously without serious thought. MDVIP appears so confident of the trend that it has even attempted to franchise its business model. More subtle, but just as powerful, pressures are also important. Any given primary care physician's frame of reference for her "correct" or "fair" compensation will usually include the other doctors in her area who work around the same amount as she does.[150] Once one concierge care practice begins reporting extraordinarily high incomes, it should not be surprising if others follow suit. Indeed, if retainer care were to become widespread, insurance practices may start taking the compensation into account in their reimbursement levels, much as restaurant owners depend on waiters' tips to supplement inadequate wages.

Thus retainer care threatens to intensify already-existing trends toward polarization of incomes in professional services. Previous tiering made specialty practice more remunerative than

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[148] *Id.*

[149] David Armstrong, *A Surgeon Earns Riches, Enmity by Plucking Profitable Patients*, WALL ST. J. 1 (Aug. 2, 2005) ("The debate [over surgeon Larry Teuber's Black Hills Surgery Center] mirrors national concerns about specialty hospitals, which are typically doctor-owned for-profit facilities that focus on a narrow range of services. Critics say specialty hospitals harm hospitals that serve poorer and sicker patients, and lead to waste of health care dollars by driving people to get unneeded surgery.").

[150] See Robert H. Frank, *The Frame of Reference as a Public Good,* 107 ECON. J. 1832 (1997). Frank discusses how satisfaction is often directly related to one's relative position. In a society where nearly all doctors work long hours, no one doctor doing so is likely to feel dissatisfied about his or her situation. However, once a sector within the profession begins to work less, at the same (or greater) pay, dissatisfaction is likely to arise.

primary care; now primary care itself is becoming more stratified. Consider the story of dentists, health professionals whose reliance on "out-of-pocket" payments has been greater than that of physicians for some time. Among dentists in the 1980's, there

> was a dramatic shift in the distribution of their earnings about the median. Whereas fewer dentists earned incomes in the moderately high range of $60,000 to $120,000, the numbers increased sharply at both the low and high ends of the earnings spectrum.[151]

Robert Frank gives a number of explanations for the trend, including the decline in demand for "primary dental services" (due to increased fluoride use), the rise in demand for cosmetic dentistry, and a decline in the number of students accepted annually to dental school (from around 6,000 in 1982 to 4,000 in 1994). Each of these has parallels in a primary medical care field affected by retainer care: consumers increasingly seeking direct access to specialists (via PPOs) and "cosmetic" amenities like better waiting rooms and staff treatment, and a declining number of primary care hours available. A practitioner aware of trends in fields like dentistry, sales, and law would be cautious about missing out on a chance not only to enhance her current position, but also to avoid consignment to the bottom of the physician income scale (where those who fail to entrepreneurially market their services seem increasingly likely to go).

[151] ROBERT H. FRANK, WINNER TAKE ALL SOCIETY 89 (1995).

B. Physician Shortage?

Advocates of retainer care may accept all the arguments made in Part A above, and turn them into another, more forward-looking argument for concierge medicine. Even if rapid increases in primary care physician incomes cause painful adjustments now, they will eventually draw more doctors to the field. To the extent they improve doctors' salaries and living conditions, retainer practices may divert health care dollars to a cash-strapped primary care system (and, presumably, away from the specialty care that has come to dominate both medical school curricula and the professional aspirations of the most ambitious medical students).

Several sources have documented a decline in the number of new physicians choosing primary care (although there appeared to be a slight uptick in the late 1990s as managed care began directing funds to these frontline doctors as gatekeepers). [152] Presumably, opportunities for a "lifestyle" practice in primary care may cause some would-be dermatologists and radiologists to reconsider their specialization. [153] More pointedly, those who are strongly motivated by monetary gain may be led away from traditional specialty choices back to primary care.

This article does not attempt to assess the wisdom of drawing more physicians away from specialty practice and into primary care.[154] However, even if one concedes the desirability

[152] 2001 was the fourth straight year that the amount of medical school seniors choosing primary care dropped. American Academy of Family Physicians, *Comparison* of Primary Care *Positions*, *available at* http://www.aafp.org/match/graph05.html (last visited Feb. 26, 2006).

[153] These very competitive residencies are in fields that are often chosen by those concerned about controlling their hours. Sid Kircheimer, *Med Students More Likely to Choose Specialties Based on Lifestyle*, WebMD Medical News (Sept. 2, 2003), *available at* http://my.webmd.com/content/article/73/82011.htm (last visited Feb. 26, 2006).

[154] There has been a great deal of controversy over the proper number of physicians in the United States. There were alarming reports of an impending physician shortage in the 1960s. KENNETH LUDMERER, TIME TO HEAL, *supra* note 126, at 398. The federal

of this goal, the spread of retainer care seems a singularly inefficient way of achieving it. Physicians in the U.S. already earn two to three times as much as their counterparts in Europe.[155] To the extent retainer care incentivizes physician training by reducing workload, it would tend to exacerbate the primary care physician shortage. Retainer doctors see between one-tenth and half of the panels borne by their non-retainer peers.[156] Moreover, they primarily serve the type of sophisticated, wealthy health care consumers who seem best able to navigate the health care system on their own.[157] Finally, there

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government responded by increasing funding of undergraduate and graduate medical education. *Id.*, at 401. Proponents of managed care claim that the program "worked too well," producing a glut of overcapacity that third-party payers have only begun to wring out of the system. DAVID DRANOVE, THE ECONOMIC EVOLUTION, *supra* note 11, at 54. Commenting on the decline in medical school applications in the mid-1990's, Dranove later admits that "with the complex combination of incentive problems in the market, it is impossible to determine whether we have too few or too many physicians, or receive too few or too many services." *Id.*, 129.

[155] Gawande, *Medicine's Money Problem*, *supra* note 20 (noting average primary care physician salary of about $155,000 in 2003); Paul Krugman, *The Medical Money Pit*, N.Y. TIMES, April 15, 2005, at A16 (noting that American physicians earn two to three times as much as their European counterparts).

[156] John D. Goodson, a primary-care physician and associate professor at Harvard Medical School, puts it this way: "'Think about this in a macro way. . . Say you lose 10 or 15 percent of your doctors. In the overall system, you end up reducing by a significant percentage the patient-hours of care, and everyone else who's left behind is suddenly working harder. There is already a shortage of primary-care docs. What's to prevent any doctor from starting to charge fees? The whole thing could mean the Balkanization of American medicine." Goodson, quoted in Devin Friedman, *Dr. Levine's Dilemma*, N.Y. TIMES MAG., May 5, 2002, at 23.

[157] *See* G. Caleb Alexander, Jacob Kurlander, and Matthew K. Wynia, *Physicians in Retainer ("Concierge") Practice: A National Survey of Physician, Patient, and Practice Characteristics*, 20(12) J. GEN. INTERN. MED. 1079, 1083 (2005) [hereinafter *National Survey*] ("[W]e found that retainer physicians have smaller proportions of patients with diabetes, and perhaps other chronic diseases, than do their nonretainer counterparts and they care for fewer African-American and

appear other, less stratifying alternatives available—such as expanding the number of medical schools, the number of doctors they train, or the number of foreign nationals permitted to practice in the United States.[158]

Despite these options, groups like the AMA would likely point to falling medical school applications as evidence that the present level of compensation, prestige, and leisure available to physicians is not enough to incentivize the lengthy and costly educational investment medical practice now demands. [159] However, given the limited number of patients that retainer doctors see, it seems very inefficient to use this type of financing arrangement to counteract the trend. Since retainer care is primarily being adopted by more established practices, it seems just as likely the physician-hours brought "off line" by retainer conversions will swamp the putative wave of new applicants drawn to practice by retainer care. The retainer care model only permits doctors to increase income and leisure time by reducing the number of patients they see—sometimes quite dramatically.[160] Finally, and most importantly, the number of slots in undergraduate and graduate medical education are fixed,

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Hispanic patients. Given that minorities are already underserved and at risk for worse health outcomes, our findings suggest that retainer practices could contribute to tiering of health care and to disparities in health care according to race as well as wealth.).

[158] *See*, e.g., Mexican Physician Pilot Program, CAL. BUS. & PROF. CODE § 853 (discussed in Jeremy Fine Bollinger, *Doctoring Fraud & Abuse, supra* note 29, at 513).

[159] Randal C. Archibold, *Applications To Medical Schools Decline For Second Straight Year*, N.Y. TIMES, Sept. 2, 1999, at A23 (noting that factors in the decline include "a more difficult job market for medical school graduates, and complaints by doctors of excessive paperwork and a loss of autonomy brought on by the growth of managed care." Additionally, "Jordan Cohen, president of the American Association of Medical Colleges, agreed that the economy might explain the decline but also blamed the growth of managed care.").

[160] *See* Alexander, et al., *National Survey, supra* note 157, at 1082 ("Retainer physicians have much smaller patient panels (mean 898 vs 2303 patients, $P<.0001$) than their nonretainer counterparts, and care for fewer African-American (mean 7% vs 16%, $P<.002$), Hispanic (4% vs 14%, $P<.001$), or Medicaid (5% vs 15%, $P<.001$) patients.").

and there are far more applicants than slots for each.[161] Even if retainer care somehow motivated a massive increase in the number of medical school applications, its proponents identify no mechanism that would lead to a commensurate increase in the capacity of medical schools to educate them.[162]

C. Treating the Sickest Patients?

Proponents of concierge care claim that it takes upon itself a reverse moral hazard that ultimately alleviates pressures on the health care system. Given a simple model mapping demand for health care to willingness to pay, only those patients needing the most attention from the health care system should be willing to pay for concierge care. This is a potentially powerful argument given the concentration of health care costs among the

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[161] "U.S. medical schools graduate roughly 17,000 new physicians every year, out of over 45,000 students a year who apply." *The Doctor Quota*, J. COMMERCE, March 4, 1997, at 8A (describing "campaign" by U.S. doctors to "restrict the number of foreign-trained physicians in the United States."). The AMA strictly controls the number of medical schools, and "There are still two applications for every opening at medical school, and, on average, the academic qualifications of applicants hasn't changed. So there is still a cadre of highly qualified, dedicated, and smart people going to medical school." Barzansky, quoted in Sid Kircheimer, *Med Students More Likely to Choose Specialties Based on Lifestyle*, WEBMD MEDICAL NEWS (Sept. 2, 2003), *available at* http://my.webmd.com/content/article/73/82011.htm (last visited Feb. 26, 2006).

[162] Indeed, the medical profession's tight control over the number of doctors is the main cause of the current primary care physician shortage. *See* Uwe E. Reinhardt, *The Economic and Moral Case for Lettting the Market Determine the Health Workforce*, in THE US HEALTH WORKFORCE: POWER, POLITICS, AND POLICY 8 (Ellen Osterweis, et al., eds., 1996) (arguing that "advocate[s] for artificial limits on entry into the profession ought to be able to explain . . . [to] the thousands of qualified and highly motivated American youngsters who have vainly sought entry into medical school and who quite probably would have been willing to practice medicine at rates much below those now customary in the profession [why] their rejection serves the nation's best interest.")

chronically ill (i.e., the sickest 10% of the population).[163] If retainer physicians are treating the sickest patients, they may well be reducing demand for health care to the same extent their retainer care conversions reduce the supply of primary care physician-hours.

There are several reasons to doubt this possibility. Although health care costs *in general* may be concentrated among the chronically ill, there is little evidence that primary care demand is similarly focused on this group. More directly, given the high percentage of retainer physicians reporting more leisure time after the transition to concierge care, it seems incongruous to attribute to them the assumption of the burden of the sickest. As the most recent comprehensive study of retainer practices noted,

> [C]ritics of retainer practices have argued that these practices might attract wealthier and healthier patients (the "worried well") rather than sick patients with complex illnesses, who tend to be less wealthy but who might benefit most from the additional attention retainer practices can offer. . . . [W]e found that retainer physicians have smaller proportions of patients with diabetes, and perhaps other chronic diseases, than do their nonretainer counterparts and they care for fewer African-American and Hispanic patients.[164]

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[163] John V. Jacobi, *Consumer-Drirected Health Care and the Chronically Ill*, 38 U. MICH. J. L. REFORM 531, 572 (2005) ("Consider how consumer-driven care will affect spending for those on the upper end of the consumption curve--the 10 percent accounting for 70 percent of the cost. Those with severe acute and chronic illnesses will incur costs that dwarf their HSA contribution and deductible. Despite the savings gained by transferring these initial costs to the sickest members, sponsors gain no cost-saving value from HSAs for the lion's share of annual health expenditures.")

[164] Alexander, et al., *National Survey, supra* note 157, at 1082. The authors of the study do concede that "Our data are limited to physicians' estimates of their patients' demographic and illness characteristics and therefore do not allow for examination of case-mix severity in detail." *Id.*

To understand demand for retainer medicine, we should focus less on the concentration of care on the chronically ill and more on the concentration of resources in the hands of the wealthiest.

D. Freedom of Contract?

In the face of these challenges, retainer care advocates are likely to fall back on freedom of contract. To the extent that powerful private insurers have attempted to perform the roles of rationing and cost-containment required of national governments, it is not surprising that consumers are attempting to contract around their strictures in order to purchase care.[165] Even if retainer care has doubtful positive social impact, why shouldn't individual patients and doctors have the right to contract with each other for retainer services?

Retainer care advocates take some comfort in the existence of "parallel private systems" of health care that exist in nearly all nations with a dominant national health care system.[166] As Timothy Jost has observed,

> In countries with universal public health services (the Beveridge model), persons who purchase private health insurance do so in order to obtain health services more quickly and conveniently, in more pleasant settings, or from more prestigious

[165] Timothy Stoltzfus Jost, *Why Can't We Do What They Do? National Health Reform Abroad,* 32 J. L. MED. & ETHICS 433, 434 (2004) ("Access to health care would no longer depend on belonging to a social insurance plan (which was usually, in some sense, employment-related), but rather would be free at point-of-service to all residents. Thus, universal coverage was created independent of the economic or employment status of any individual.").

[166] Jost, *supra* note 165, at 435 ("social-insurance and national health insurance nations usually allow for individuals the choice to carry private insurance. France and Austria, for instance, requires mandatory coverage for the entire population, while Germany and the Netherlands requires participation in social insurance programs for only the indigent.").

> professionals than is possible under the public system to which they also have access.[167]

Even the Quebec health care system, which had long attempted to discourage "contracting around," has now been forced to permit it due to a recent Canadian Supreme Court ruling.[168]

Given that even the most egalitarian national insurance systems permit the wealthy to purchase either more immediate access to health care or better health care, restrictions on boutique medicine in the United States's highly privatized system might seem incongruous. If the Canadian Supreme Court has decreed a fundamental right to purchase health care above and beyond that provided by the state, even at the cost of diverting suppliers away from the system overall,[169] how can a sensible American

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[167] Timothy Stoltzfus Jost, *Managed Care Regulation: Can We Learn From Others? The Chilean Experience,* 32 U. MICH. J. L. REFORM 863, 864 (1999) (citing Deborah J. Chollet & Maureen Lewis, *Private Health Insurance: Principles and Practice*, in INNOVATIONS IN HEALTH CARE FINANCING 104-09 (George J. Schieber, ed., 1997)) (describing the role of private health insurance in 10 OECD and 36 non-OECD countries). Jost explains that "In the United Kingdom, for example, persons rely on private insurance normally to permit queue-jumping for certain kinds of surgery, while in Australia private insurance pays for hospital care in private facilities. In some countries with social health insurance systems (the Bismark model), on the other hand, private health insurance is limited to persons, usually with high incomes, who are not legally obligated to participate in the national social insurance program. This is the situation, for example, in Germany and the Netherlands." *Id.*

[168] Jacques Chaoulli and George Zeliotis v. Attorney General of Quebec and Attorney General of Canada, 2005 SCC 35 (CanLII) (2005) (holding that sections of the Health Insurance Act which outlawed private medical insurance violated the right to personal inviolability as guaranteed by the Quebec Charter of Human Rights and Freedoms).

[169] This diversionary impact is a well-documented phenomenon. *See* Michael Calnan, *The NHS and Private Health Care*, 10 HEALTH MATRIX 3, 16 (2000) (noting that parallel private system in the United Kingdom "redistribute[d] access to resources and manpower in favour of better off patients of working age who live in London and South East England" as "[t]he more privileged sick (in terms of income, class and

commentator propose to limit the same process here? There are three main reasons why retainer care in these single payer systems poses less of a concern than it does in the United States.

First, each of the nations that permits tiering also provides universal insurance. Though the United States has a patchwork of law, charity, and government assistance that assures *eventual* care to everyone once their condition reaches a certain level of seriousness (or once they are impoverished enough), this patchwork does not assure the same level of social provision for the neediest prevalent in more social democracies.[170] Therefore, concerns about diversion of care are not nearly as pronounced in these countries as they are in the United States. And recent studies have demonstrated that even in these systems, there are significant diversionary concerns.[171]

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power) have been 'substituted' for the less fortunate sick who remain on NHS lists").

[170] *See* Jacobi, *Ends of Health Insurance*, *supra* note 5, at 315 ("While many European countries maintain pockets of private insurance or are experimenting with competitive components to a statutory health insurance system, only the United States relies on a competitive private marketplace and voluntary coverage to provide health insurance to the majority of its citizens.").

[171] Michael Calnan, *The NHS and Private Health Care*, 10 HEALTH MATRIX 3, 17 (2000) ("Certainly, the claims that the introduction of market economy principles into the NHS in 1991 has led to a two-tier system of care (patients registered with fund holding practices have easier access to care than those in non-fund holding practices). This might have been one of the reasons why the new Labour government has abolished the internal market and fund holding."); J. Cullis, *Waiting Lists and Health Policy*, in RATIONING AND RATIONALITY IN THE NATIONAL HEALTH SERVICE 23-27 (S. Frankel and R. West, eds., 1993); Canadian Health Services Research Foundation, *Myth: A parallel private system would reduce waiting time in the public system*, *available at* http://www.chsrf.ca/mythbusters/pdf/myth17_e.pdf (arguing that England and Australia both have private systems, and that it's been determined that waits for public health care are longest in areas that have the most private coverage.); Canadian Health Services Research Foundation, *Private Care and Public Waiting*, *available at* http://www.aha.asn.au/publications/articles/issues/ahr_29_1_0205/ahr_29_1_087-093.asp (last visited Feb. 26, 2006) (reaching the conclusion that private care leads to longer public waits.); *Parallel Private Health*

Second, nearly all of these countries enjoy lower levels of "background inequality" than the United States. As Robert Frank has argued, positional bidding dynamics are most pronounced in countries with high levels of inequality.[172] There is simply more discretionary income to spend on health care, leading to greater potential diversion of resources once the wealthy start bidding on enhanced access to a pool of primary care physicians whose supply is relatively fixed in the short and medium term.[173]

Finally, more progressive income taxation in these universal systems dampens supply-side pressures toward concierge care as well. As advocates of laissez-faire never tire of reminding us, higher income tax rates reduce the incentive to

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Insurance in Australia: A Cautionary Tale and Lessons for Canada, *available at* ftp://repec.iza.org/RePEc/Discussionpaper/dp515.pdf (an Australian study reaching the conclusion that a second, private tier creates more problems than it solves, most notably a decrease in public access to health care.).

[172] *See* FRANK AND COOK, THE WINNER TAKE ALL SOCIETY 216 (1995) (proposing progressive taxation to reduce the inequality that exacerbates positional pressures).

[173] "Estimates suggest that as one's income increases by some percentage, the demand for health insurance also increases, but at roughly half that rate." Joseph P. Newhouse & Charles E. Phelps, NEW ESTIMATES OF PRICE AND INCOME ELASTICITIES OF MEDICAL CARE SERVICES, IN THE ROLE OF HEALTH INSURANCE IN THE HEALTH SERVICES SECTOR 261 (Richard N. Rosett, ed., 1976). "Medical tourists" from the "first world" are promoting the segmentation of the health sector in many countries. *Health Care Systems and Approaches to Health Care Report*, *available at* http://www.ghwatch.org/2005 report/B1.pdf ("Health care systems in some countries are being segmented even further by the processes of globalization– in India, Mexico and South Africa private providers cater to foreign 'medical tourists' from high-income countries or from high-income groups in low- and middle-income countries. The assumption behind these policies is that it is more efficient and equitable to segment health care according to income level – a public sector focused on the poor and a private system for the rich that allows the public sector to focus on the poor. But there is no evidence that such a system is more equitable or efficient. The greater likelihood is that it would result in increased inequality as the middle-classes opt out of public sector provision, take their financial resources and stronger political voice with them, and leave the public service as a 'poor service for poor people.'").

maximize one's income. We can therefore expect the higher income tax rates in social democracies to diminish physicians' incentive to switch to a concierge model.

VI. CRAFTING A TAILORED REGULATORY RESPONSE

The concerns raised in Part V above suggest that retainer care deserves more, not less, regulation. Part IV suggested a principled way for the Medicare program to discourage concierge care by applying balanced billing rules. The federal government could also seek to apply the False Claims Act. Since the fee is flat, a patient seeking to "amortize her investment" might go to the doctor very frequently. Unnecessary visits might constitute "services substantially in excess of the patient's needs," which cannot be compensated in accordance with that act.[174] Finally, if concierge services are offered to Medicare beneficiaries at below-market rates, they may constitute "inducements" forbidden under the relevant fraud and abuse laws.[175]

Yet there is a cost to such federal regulation. Overly aggressive federal interventions could squelch all forms of retainer care. Most of the physicians pioneering retainer

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[174] ALICE G. GOSFIELD, MEDICARE AND MEDICAID FRAUD, *supra* note 27. (paraphrasing 42 USCA § 1320a-7(b)(6) (2005)).

[175] 42 U.S.C. § 1128A(i)(5) (2004); 42 C.F.R. 1003.101 (2004). For a brief account of inducement provisions, *see* OIG Bulletin, *Offering Gifts and Other Inducements to Beneficiaries*, http://www.oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf, Aug. 2002 ("The OIG will apply the inducement prohibition against the following: inexpensive gifts that have a retail value of no more than $10 individually, and no more than $50 in the aggregate annually per patient." Also included are a series of statutory and regulatory exceptions. *See also* Jennifer Russano, *Is Boutique Medicine a New Threat, supra* note 40, at 336 ("If boutique medical practices provide their patients with bonuses such as "heated towel racks, free hotel rooms, [and] special bathrobes," these amenities could violate the federal anti-kickback statute or the Health Insurance Portability and Accountability Act prohibiting such inducements. However, since these amenities are offered after payment of a retainer, it is likely that they will be seen as services provided in exchange for payment and not as an "inducement."").

practices are committed professionals whose first priority is providing quality health care. They are pioneering innovative preventive care, and at least that aspect of retainer care deserves to be encouraged.

Is there a way to craft a more tailored regulatory response? In conditions of uncertainty, policymakers often turn to the states as "laboratories of democracy." Concentrated in big cities on the coasts, retainer care practices have already attracted some scrutiny from state regulators. These embryonic interventions, as well as established state practices in cognate areas of health care "tiering," provide a good starting point for discussion of future regulation of retainer care.

The real challenge for policymakers is to craft a *tailored* regulatory response to retainer care that discourages queue-jumping and amenity-bundling while promoting preventive care. States have begun to do so by characterizing retainer practices as insurance providers. However, given the legal complexity of this strategy, insurance regulation may not prove an effective way of tailoring regulation. Rather, taxation targeted at the queue-jumping and amenity-bundling aspects of retainer care would provide a more effective response. Already applied to cosmetic surgery and specialty hospitals, such taxation of retainer care—particularly when directed at assuring access for the poor—would assure some principled results from the tiering retainer care is entrenching.

A. Retainer Care Agreement as Insurance Contract?

Since they sell unlimited amounts of physician time in return for a flat fee, concierge care agreements have been deemed a form of insurance in several states.[176] As the deputy

[176] Sandi Doughton, *State Looks Askance at Extra Fees for Doctors*, *supra* note 63, at B1 ("A draft ruling from the Insurance Commissioner's Office says certain retainers and other charges are illegal. Doctors who require insured patients to pay retainer fees for routine medical care are violating state law, says a draft ruling from the Washington Insurance Commissioner's Office. And "concierge" health services, under which clients pay a flat rate for personalized medical care, may be illegal if they're not licensed as health insurers, the commissioner's office says."

commissioner of insurance in Washington stated, "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."[177] Even if a doctor purposely limits her panels to a low number, she risks simultaneous demands for care from two or more patients.[178] Furthermore, retainer practices might go out of business before they can fulfill their promise to provide care.[179] Each of these risks is reminiscent of the types of problems insurers often have to bond or reinsure against.[180]

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[177] Peter Neurath, *Medical Retainer Fees Violate Law, Ruling Says: State Law Bars Doctors From Charging Extra Fees*, PUGET SOUND BUSINESS JOURNAL, August 1, 2003, *available at* http://seattle.bizjournals.com/seattle/stories/2003/08/04/story6.html?t=printable. The relevant state official, Deputy Insurance Commissioner Berendt, conceded that "No rules prevent doctors from charging extra for optional services that aren't already covered by the patient's health insurance, such as nutritional counseling, valet parking or 24-hour cellphone access to doctors, Berendt said. It's also fine for doctors to charge special fees to patients who aren't covered by insurance." She also elaborated that "[t]he fee is paid by the patient regardless of the amount of services provided [and] even if no services are provided. These arrangements result in a transfer of risk and, in essence, are insurance agreements." Id. Office of Insurance Commissioner for the State of Washington, *Forum for Review of Draft Technical Advisories to Health Carriers and their Participating Providers* (August 12, 2003), *available at* http://www.insurance.wa.gov/special/accessfees/removed/public%5Fforum%5Fpresentation.ppt (last visited Feb. 26, 2006).

[178] Steven Flier did this when he began PPHC; "We intentionally set the panel very low, at about 300 patients per physician." Quoted in Ferrarone and Stoller, *supra* note 118, at 6. Some "platinum" concierge practices may only contract with 50 families per physician. *Id.*

[179] Though I have not yet found examples of large upfront fees paid in exchange for "lifetime care," it is interesting to note that one of the earliest insurance plans involved the exchange of an assurance of a lifetime of care in return for investment in its infrastructure.

[180] Robert M. Portman, *Back to the Future of Medicine, supra* note 2, at 3 (2003) ("To the extent that concierge practices charge their members a fixed, prepaid amount for a bundle of guaranteed services, they could be found to be providing insurance in violation of state law.") Any insurance provider must be registered with the state and

Washington [181] and New Jersey [182] have been most aggressive, issuing rules and interpretations that tightly regulated retainer care. Other states have issued warnings and guidances, but have done little to actually intervene. [183] If they were regulated as insurers, retainer practices would have to satisfy potentially onerous capitalization requirements, and could not be

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bonded against the possibility it cannot provide the services/coverage purchased in advance in consideration for the premium.

[181] *Id.* According to Portman, "the Washington Insurance Commissioner has issued a pair of draft technical assistance advisories in which it has determined that health care providers entering into arrangements to provide a package of health care services for a fixed, pre-paid fee must first obtain a certificate of registration from the state as either a health care service contractor or health maintenance organization. In a separate draft advisory, the commissioner concluded that health care providers that require patients to pay access fees to receive services covered by their health insurance are acting in violation of state laws requiring providers and plans not to charge more than the covered amount and to hold patients harmless from any amounts not covered by insurance."

[182] Bowden and Foust, *Advanced Issues in Provider/Payer Managed Care*, *supra* note 115. ("During the summer of 2003 insurance regulators in Washington State circulated two draft advisories warning against 'access' fees and regulators in New Jersey issued a bulletin ordering providers to immediately terminate charging patients access, retention, or service fees.").

[183] Some appear to tacitly, if not explicitly, endorse boutique medicine as a legitimate new method of health care financing. *See* Robert M. Portman, *Concierge Care: Back to the Future of Medicine*, *supra* note 2, at 6. ("The Massachusetts Department of Insurance investigated Personal Physicians Health Care for discriminating against patients who couldn't afford its annual fee but apparently found no violation of state insurance laws as long as beneficiaries were advised that insurance would not cover the extra fees. The Massachusetts Board of Registration in Medicine, which licenses Massachusetts physicians, also reportedly found nothing illegal about concierge practices.") According to Flier, he repeatedly met with state officials before launching the pioneer Boston retainer practice, Personal Physicians HealthCare, and currently retains lobbyists to assure favorable regulatory treatment. Ferrarone and Stoller, *supra* note 118, at 10.

as flexible in choosing their panels.[184] Concierge practices have aggressively lobbied for exceptions or favorable interpretations of the relevant laws, and appear to have stalled legal interventions in two states.[185]

For example, the state of Washington initially moved rather aggressively to characterize retainer practices as insurers, [186] thereby requiring them to certify that they are financially prepared to deal with the "risks" of the practice.[187]

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[184] Sandi Doughton, *State looks askance at extra fees for doctors*, *supra* note 63, at B1.. ("[I]f doctors want to provide a broad range of medical services for a set fee, they may need to be licensed and regulated as insurers. The state requires insurers to prove they are financially healthy and not likely to go out of business and leave consumers with no medical care, [Deputy Insurance Commissioner] Berendt said. The state also makes it difficult for insurers to kick out patients.").

[185] Sandi Doughton, *State looks askance at extra fees for doctors*, *supra* note 66, at B1.

[186] *Id.* ("Seattle Medical Associates doesn't get any money from Medicare or other insurance companies. If patients are referred to specialists outside the group, those specialists bill insurance or Medicare separately. But according to the commissioner's preliminary rulings, the group may require a state insurance license, because it operates somewhat like an insurance company.")

[187] *See* Kenneth T. Bowden and Lawrence Foust, *Advanced Issues in Provider/Payer Managed Care, supra* note 115, at 6 ("Without referring to its companion advisory regarding the business of insurance, the latter advisory offered that access fees could be charged to patients without violating statutory hold harmless provisions if the services offered for the fee were truly noncovered and the fees were optional. Mandatory fees could be charged when the patient is uninsured, the provider is non-participating, or the patient is covered under an indemnity policy that does not require use of a participating provider. The draft advisories have been withdrawn before being finalized. In addition, the Insurance Commissioner withdrew the pursuit of H.B. 2815 in the 2004 Washington Legislature in order to "develop legislation that would address the needs of everyone." *See also* John R. Marquis, *Legal Issues Involved in Concierge Medical Practices*, *supra* note 3, at 18 (also implying that the Washington Insurance Commissioner is currently trying to develop a consensus on regulation of retainer care, due to the Washington State Medical Society's

One regulator has also attempted to undermine the legal basis of conversions to retainer care, stating that "it's illegal to force patients who have health insurance to pay a retainer fee simply to keep their existing doctor or to get services their health-care policy already guarantees."[188] After retainer physicians and clients registered their vehement opposition to such rules, the "draft technical assistance advisories" announcing the agency's position disappeared from the state government's website, and officials have announced an effort to find "common ground."

New Jersey regulators also began with an aggressive approach, but failed to garner support from the politicians. The New Jersey Department of Health and Human Services and Department of Banking and Insurance have issued a memorandum prohibiting insurers from contracting with doctors who require patients to pay fees for access, even when fees are for additional services.[189] The Departments asserted that New Jersey's "non-discrimination" laws prevent practitioners participating in managed care networks from conditioning access to their clinic on retainer-like payments.[190] However, it is difficult to assess the legal force of this document, and it is hard

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successful opposition to the Insurance Commissioner's effort to get the legislature to "codify the content" of its advisories as a statute).

[188] Michael and Laura B. Benko, *These doctors and their affluent patients find themselves in exclusive company*, *supra* note 67, at 38. ("Paul Ginsburg, president of the Center for Studying Health System Change, a Washington-based research group, says there's nothing to stop a physician from charging wealthy, fee-for-service clients whatever they choose. The problem, he says, arises when companies such as MDVIP offer services only to members, thus denying access to many longtime patients either unwilling or unable to pay the annual fees.").

[189] *See* Holly Bakke and Clifton Lacy, *Impermissible Practice of Retainer Medicine by Network Physicians, available at* http://www.state.nj.us/health/hcsa/bulletins/joint2003-02.pdf

[190] "Rather, the Departments' position is that retainer agreements are inconsistent with the requirement that all provider agreements subject to New Jersey law assure that in-network providers do not discriminate in treatment of members or covered persons." *New Jersey DHSS/DOBI Bulletin*, citing N.J.A.C. § 8:38-15.2(b)8 and N.J.A.C. § 8:38A-4.15(b)7.

to find evidence that retainer care has been eliminated in New Jersey.[191]

Regulation of retainer practices as insurance may be on shaky ground legally as well as politically. Such regulation hinges on an assertion that retainer practices bear risk in a manner similar to that of traditional insurers.[192] However, it is easy to imagine ways of contracting out of such risk. For example, a retainer contract might promise 24/7 attention, *unless* another member of the plan demanded the physician's attention immediately before one calls. Or it might shift the risk of insolvency onto the patient, or effectively disguise the transfer of risk by having the patient pay in arrears instead of in advance. Finally, even though sick patients may be very demanding of their primary care physician's *time,* the physician is not promising the broad range of services traditionally packaged by insurers. If the baseline contract for additional services is legal, it is difficult to see how these limitations on service would be forbidden. Professor Thomas Mayo has questioned Washington state's application of its insurance laws to retainer practices:

> In what sense do the doctors take on risk? The care isn't pre-paid with the retainer; only access is pre-paid. The patient's health insurer is going to be tapped for the care, and no part of the insurer's risk is being shifted downstream to the physician. Granted, there is some risk that the demand for services at any given time might outstrip the physician's ability to schedule, but that's not a financial risk, is it?[193]

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[191] John R. Marquis, *Legal Issues Involved in Concierge Medical Practices, supra* note 3, at 18.

[192] This is an attractive "peg" to hang regulation on, since many retainer practices contract for an unknown amount of care for a fixed annual fee. The retainer physician risks taking on extraordinarily demanding patients who may well demand far more care than average.

[193] *See* Mayo, *Medical retainer fee (a/k/a "boutique medicine") nixed in Washington*, HEALTHLAWBLOG, August 5, 2003, *available at* http://healthlawblog.blogspot.com/2003/08/medical-retainer-fee-aka-boutique.html. Nevertheless, one practitioner warns that any retainer practice which "provides unlimited physician office visits" might end up being regulated as an insurer. Robert M. Portman, *Concierge Care: Back to the Future of Medicine, supra* note 1, at 5 ("Unlike physician

Some mid-1990s guidelines regarding the regulation of "provider sponsored organizations" echoed this distinction, noting that providers could commit to potentially unlimited amounts of their own time (in return for a fee), and this would not represent financial risk.[194]

B. Targeting Queue-Jumping and Amenity-Bundling via Taxation

Given the legal uncertainty surrounding the regulation of concierge care agreements as insurance, another tool of legal intervention is likely necessary. An indisputably positive facet of extant retainer care practices provides an important clue on where to look. Some boutique medicine practitioners use the time gained from retainer practice to provide pro bono care—a model well-established in legal practice.[195] Moreover, some large retainer practices, such as one based at Tufts University, directly subsidize access to care for the disadvantaged. Instead of "passing the retainer fee from wealthy patients to wealthy

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networks or IPAs, which have generally been found not to be insurance companies because there is another risk bearing entity in the chain of treatment and payment--i.e., a health insurer or HMO--is subject to state insurance regulations, concierge practices that do not accept insurance and provided prepaid medical care may be perceived as the only risk bearing entity in the patient's chain of care.").

[194] Allison Overbay and Mark Hall, *Insurance Regulation of Providers That Bear Risk*, 22 AM. J.L. & MED. 361 (1996); Edward B. Hirshfeld, et al., *Structuring Provider-Sponsored Organizations: The Legal and Regulatory Hurdles*, 20 J. LEGAL MED. 297 (Sept. 1999); John S. Conniff, *Regulating Managed Health Care Provider Sponsored Organizations*, 16 J. INS. REG. 377 (1998). Federal regulation has also sparked academic commentary. See, e.g., Michael O. Spivey, *Developing Provider-Sponsored Organization Solvency Standards Through Negotiated Rulemaking*, 51 ADMIN. L. REV. 261 (1999).

[195] Jennifer Silverman, *Retainer practices reporting better care*, *supra* note 52, at 71 ("Charity care for retainer physicians averaged 9.14 hours per months versus 7.48 hours per month for nonretainer practices.").

physicians, the hospital is using the money to subsidize the hospital's primary care practice."[196]

To the extent these countervailing, socially conscious practices arise out of retainer care, we might say that it causes "difference principled" tiering, after the famous proviso of Rawls's *A Theory of Justice* (stipulating that any increase in inequality was acceptable to the extent it raised the welfare of the least well off).[197] It is doubtful that such "difference principled" tiering currently outweighs the "brute tiering" that denies the services of retainer doctors to those who cannot afford their fees. However, states can begin using targeted taxation to alleviate brute tiering and promoting "difference principled" tiering arising out of retainer care.

For example, states have already addressed the diversion of medical resources to nonmedical ends via tax policy in the context of plastic surgery. New Jersey has imposed a 6 percent tax on cosmetic plastic surgery procedures.[198] Illinois has been considering a similar effort with redistributive designs—funds from a "vanity tax" would be earmarked for medical research.[199] A similar tax on the amenities bundled into concierge care

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[196] This is the Tufts-New England Medical Center plan featured in Steve Smith, *The Boutique Medicine Boom: Perspectives on the Growth of a Controversial Trend*, PRACTICE BUILDERS, Sept./Oct. 2003, at 1.

[197] JOHN RAWLS, A THEORY OF JUSTICE 62 (1971) ("All social values--liberty and opportunity, income and wealth, and the bases of self-respect--are to be distributed equally unless an unequal distribution of any, or all, of these values is to everyone's advantage."). I have coined the term "difference principled" to designate tiering that is both principled, and in accord with Rawls's theory of justice.

[198] N.J.S.A. § 54:32E-1 (2005) ("There is imposed and shall be paid a tax of 6% on the gross receipts from a cosmetic medical procedure, which shall be paid by the subject of the cosmetic medical procedure . . . ."); see also Susan Jones, *New Jersey Taxes Cosmetic Surgery*, CNSNEWS, July 1, 2004, *available at* http://www.cnsnews.com/ViewNation.asp?Page=%5CNation%5Carchive%5C200407%5CNAT20040701a.html (last visited Feb. 26, 2006).

[199] Beth Kapes, *Vanity Tax Would Fund Stem Cell Research*, COSMETIC SURGERY TIMES, May 1, 2005, *available at* http://www.cosmeticsurgerytimes.com/cosmeticsurgerytimes/article/articleDetail.jsp?id=157357 (last visited Feb. 26, 2006).

agreements would help assure that some portion of the money spent to divert medical resources to nonmedical ends would itself be diverted back toward genuine health care.

Admittedly, valuation problems are sure to arise. Just as New Jersey regulators have been skeptical about retainer physicians' ability to distinguish between ordinary medical care (meriting insurance reimbursement) and retainer services (paid for by retainer fees), critics of my proposal may charge that retainer clients are paying for the entire experience of retainer care and that no particular aspect of that experience can be disaggregated from the whole and given a market value. However, as the diversity of concierge practices increases, it should be easier to perform the type of hedonic pricing that has allowed economists to, for example, price the value of an eighth-story view of a park.[200] No one sells "eighth-story views of parks" on eBay, but economists can compare the prices of very similar apartments with and without such views and develop a rough sense of how much the view itself contributes to the value of the property.[201] Similarly, we can begin to assess the value of a given retainer perquisite by comparing the cost of joining that

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[200] *See* Maureen L. Cropper and Wallace E. Oates, *Environmental Economics: A Survey*, 30 J. ECON. LIT. 675, 703-710 (discussing how "the price of a house or job can be decomposed into the prices of the attributes that make up the good, such as air quality," and assessing methods of such decomposition, including wage-amenity studies, hedonic labor markets, and hedonic travel costs). *See also* Brian Binger et al., *The Use of Contingent Valuation Methodology in Natural Resource Damage Assessments: Legal Fact and Economic Fiction*, 89 NW. U. L. REV. 1029 (1995); F.B. Croos, *Natural Resource Valuation*, 42 VAND. L. REV. 269 (1989); David McKay, *CERCLA's Natural Resource Damage Valuation Provisions: A Comprehensive and Innovative Approach to Protecting the Environment*, 45 WASH. & LEE L. REV. 1417 (1988).

[201] In the hedonic pricing method, "an attempt is made to estimate an implicit price for environmental attributes by looking at real markets in which these characteristics are effectively traded. Thus, 'clean air' and 'peace and quiet' are effectively traded in the property market since purchasers of houses and land do consider these environmental dimensions as characteristics of property." PEARCE AND MORAN, THE ECONOMIC VALUE OF BIODIVERSITY 67 (1995).

practice with the cost of joining a practice that offers all but that perquisite.

Less ambitiously, regulators may just ask for an accounting of the cost of the amenities provided by the retainer practice. Personal Physicians HealthCare of Boston has spent at least a million dollars on a luxury waiting area appointed with fine furniture and art.[202] A rough accounting of the practice resources and physician time devoted to amenity services should provide some basis for a tax on them.

Some forward-looking retainer practices have begun to recognize and counteract their negative effects on access to care. For example, one teaching hospital in Massachusetts has used retainers to fund its charity care.[203] To the extent a retainer practice takes on this type of redistribution itself, it might be exempted from taxation designed for the same ends.[204] Furthermore, a state may decide not to tax retainer revenues that support preventive care services not covered by insurance.

Taxation is an important policy tool here because increasing numbers of retainer physicians may evade insurance-leveraged regulation by becoming "cash-only."[205] This latter

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[202] Ferrarone and Stoller, PPHC Case Study, *supra* note 118, at 10.

[203] *See* Jennifer Russano, *Is Boutique Medicine a New Threat*, *supra* note 41, at 323.

[204] Another example is the cataract clinic in India mentioned in an article generally supportive of concierge care. The author mentions a "scenario whereby the profits from the boutique practiced were used to finance a second practice that provided the same service, same world-class technology and cutting edge methods, minus a few of the red carpet frills to the population of poor patients. A fantasy? Hardly, it exists right now, in India in a practice founded by Dr. Govindappa Venkataswamy over twenty five years ago. His Aravind Eye Hospital is now performing 180,000 cataract operations a year, 70 percent of them for free." Justin C. Matus, *Boutique Medicine: Good medicine with a bad taste or just bad medicine?* , *available at* http://www.aameda.org/MemberServices/Exec/Articles/winter03/boutiquemedMatus.pdf , citing JOAN MAGRETTA, WHAT MANAGEMENT IS (2002).

[205] Oklahoma has, for instance, considered taxing specialty hospitals directly. S.B. 621, 2003 Leg., 49th Sess. (Okla. 2003); H.B. 1188, 2003 Leg., 49th Sess. (Okla. 2003). Specialty hospitals have raised concerns because they divert the most lucrative cases to

development may raise even more serious concerns regarding access to care, since cash-only practices often consist of a very small number of clients paying a very large retainer. For example, under one Seattle plan, each physician takes on 50 families per year, at a cost of 20,000 per family, grossing one million dollars per year. Because of their extremely restricted scope, these practices raise concerns similar to those raised by amenity services: namely, the diversion of medical resources to nonmedical ends.[206]

VII. CONCLUSION

Most of the physicians pioneering retainer practices are committed professionals whose first priority is providing quality health care. Unfortunately, what is professionally and personally rewarding for these doctors may harm society as a whole.

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specialized centers that usually do not provide the level of community services expected from general hospitals. *See* U.S. GEN. ACCOUNTING OFFICE, SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, SERVICES PROVIDED, AND FINANCIAL PERFORMANCES, GAO REP. NO. 04-167 (Oct. 2003); William Lynk and Carina Longely, *The Effect of Physician Owned Surgicenters on Hospital Outpatient Surgery*, 21(4) HEALTH AFF. 215 (Jul./Aug. 2002); FURROW ET AL., HEALTH LAW, *supra* note 68, at 918 (discussing state taxation and regulation of specialty hospitals).

[206] The nonmedical end here is the *absolute* assurance of the retainer customers that they will be able to call on their retained physician in case of illness. Steven Flier of PPHC reports that, even with a panel of 300 patients, he has never had two conflicting demands on his time in his 3 years of retainer practice. Stoller and Ferrarone, *Personal Physicians Healthcare*, supra note 118, at 12. Demanding a panel of one-sixth this size (as one very exclusive Seattle practice does) makes the physician retained less a doctor than a courtier, whose primary value derives not from the medical services offered but rather from the sense of assurance and superiority flowing from the client's ability to "reserve" the time of a skilled professional so absolutely. *See* Friedman, *supra* note 156 ("[I]sn't there a decreasing rate of return on the amount of time spent with a single patient? At some point, paying more attention to someone won't really make him or her healthier; it will just satisfy a desire to be pampered. The new practice could end up being more about extravagant service for relatively wealthy people than about effective medical care.").

Retainer medicine raises difficult policy questions because it combines a set of eminently sensible incentives (for more primary care physicians providing a higher quality of care) with financing methods that further stratify access to care and threaten to generate a positional bidding war for supplemental, provider-sponsored insurance.

So far, legal disputes over concierge care have focused on whether retainer payments constitute "balance billing" for services covered by Medicare. This article has suggested a way to resolve that issue, by disaggregating retainer services into preventive care, queue-jumping, and amenity-bundling. To the extent a retainer practice can plausibly claim that its patients' retainers are funding noncovered preventive care and amenities, they should be safe from liability for balance billing. But to the extent the retainer is funding quicker access to better care, it is a second charge for services already covered by insurance.

Given the importance of queue-jumping to the boutique medicine business model, most retainers would constitute balance billing under the approach proposed in this article. Federal regulators could leverage such violations into more aggressive efforts to discourage retainer practices, including prosecution under the False Claims Act. For now, though, such a strategy appears ill-advised. Regulation of retainer care should instead focus on a targeted discouragement of queue-jumping and amenity-bundling via taxation. Such an approach would only raise the price of retainer care, and not ban it outright. Moreover, it could be neutral toward (or perhaps even subsidize) personalized preventive care.

Of course, a nuanced approach should not be a complacent one. Left unregulated, the battle between cost-cutting insurers and revenue-maximizing doctors may result in inefficiencies bordering on cruelty. As the commodification of medicine advances, we might see hints of its future development in service industries where business imperatives have been untrammeled by social objectives. Consider the following account of fare structures and service in French railways:

> It is not because of the few thousand francs which would have to be spent to put a roof over the third-class carriages or to upholster the third-class seats that some company or other has open carriages with

> wooden benches . . . .What the company is trying to do is to prevent the passengers who can pay the second-class fare from travelling third class; it hits the poor, not because it wants to hurt them, but to frighten the rich . . . . And it is again for the same reason that the companies, having proved almost cruel to third-class passengers and mean to the second-class ones, become lavish in dealing with first-class passengers. Having refused the poor what is necessary, they give the rich what is superfluous.[207]

As "budgetary crises" lead to further cuts in Medicaid, the uninsured "third-class" of American health care consumers is sure to suffer more privations.[208] Managed care has made the "second-class" insured uncomfortable enough to find the blandishments of "first class" retainer care appealing, even at a price tag of several thousand dollars annually. Given positional pressures to "keep up with the Joneses," the well-off (or those who would like to appear so) are likely to find retainer care a necessary accoutrement of their social station—or at least a way of controlling their schedule in a manner expected of contemporary professionals.

There is no doubt they will be getting value for their money: most retainer physicians are committed to providing the

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[207] Jules Dupuit, *On Tolls and Transport Charges* 23 (International Economic Papers No. 11, Elizabeth Henderson trans., 1962), quoted in James Boyle, *Cruel, Mean, or Lavish? Economic Analysis, Price Discrimination and Digital Intellectual Property*, 53 VAND. L. REV. 2007 (2000). *See also* BARBARA EHRENREICH, FEAR OF FALLING: THE INNER LIFE OF THE AMERICAN MIDDLE CLASS 34 (1989) (discussing the role fear plays in motivating class distinctions).

[208] *See* Bob Herbert, *Curing Health Care Costs: Let the Sick Suffer*, N.Y. Times (Sept. 1, 2005) (describing cuts to TennCare program); WALL ST. J., *Taming the Medicaid Monster,* Aug. 23, 2005; Gardiner Harris*, Gee, Fixing Welfare Seemed Like a Snap*, N.Y. TIMES, June 19, 2005, 4. Though many Medicaid "reformers" claim that increasing spending on the program amounts to a "fiscal crisis," they appear hesitant to admit the degree to which the "crisis" arises from discretionary choices to cut taxes on income not derived from labor.

highest quality of primary care. But as those fortunate enough to opt for retainer care exit the dominant system, those left behind lose a powerful voice for reform within it. Those who pay retainer fees "jump the queue" of rationing tacitly imposed by managed care, and provide a market for the bundling of basic or preventive health care with luxurious amenities. Targeted regulation may not eliminate these effects, but it can check them.