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Frank Pasquale

University of Maryland Francis King Carey School of Law, fpasquale@law.umaryland.edu

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7 Yale Journal of Health Policy, Law, and Ethics 39 (2007).

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The Three Faces of Retainer Care: Crafting a Tailored Regulatory Response

Frank Pasquale*

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 focusing 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.³

* Frank Pasquale, J.D., is Associate Professor of Law, Seton Hall Law School. The author would like to thank 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, and the American Society of Law, Medicine, and Ethics Annual Health Law Professors Conference at the University of Maryland for their comments. Charles Sullivan, Peter Schuck, John Jacobi, Kathleen Boozang, and Richard Murphy also provided very challenging and helpful comments.

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 (West 2006). See also U.S. GAO, PHYSICIAN SERVICES: CONCIERGE CARE CHARACTERISTICS AND CONSIDERATIONS FOR MEDICARE (2005) [hereinafter GAO REPORT]. This term is unsatisfactory because opponents have tried to brand retainer arrangements as 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 & INS., Mar. 1, 2005, at 20. "Retainer care" seems to be the best neutral term for discussing the financing arrangements analyzed in this Article.

2. Robert M. Portman, *Concierge Care: Back to the Future of Medicine?*, 15 HEALTH L. 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 retainer practices, see John R. Marquis, *Legal Issues Involved in Concierge Medical Practice*, HEALTH LAW NEWS, Mar. 2005, at 18, 18-19.

3. Nicole C. Brambila, *Paying a Top Price for Health: Patients Giving Docs Retainers for 'Concierge' Medical Service*, DESERT SUN, Feb. 12, 2006, at A1 ("Costs and services differ – from

They have also provoked scrutiny from politicians⁴ and consumer groups.⁵ Few recent developments in the business of medicine provoke emotional conflicts like retainer care does. Retainer care 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 retainer care as one more excess for the wealthy in an age of increasing medical scarcity.⁶

To be sure, there are some irreconcilable ideological differences between the two camps. Retainer care physicians welcome a commodified tiering of primary care that their opponents only grudgingly accept. Yet differences also arise because the opposing sides have not adequately acknowledged the *diversity* of retainer care services. Retainer contracts cover three analytically distinct actions: preventive care, queue-jumping, and amenity-bundling.⁷ Most commendably, retainer care 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 United States. Most troublingly, they are bundling medical care with unrelated amenity services (such

as little as \$60 a month to \$15,000 a year. The peace of mind that comes with having a doctor available 24/7 is money well spent, several of St. Louis' patients said.”).

4. *Consumer-Directed Doctoring: The Doctor Is In, Even if Insurance Is Out: Hearing Before the J. Econ. Comm.*, 108th Cong. (2004) [hereinafter *Consumer-Directed Doctoring*]. Both Congress and the Department of Health and Human Services (HHS) have expressed concern about the access issues raised by these practices, and some affected states have responded with investigations and regulation. A recent statute requires the Government Accountability Office (GAO) to study the spread of retainer care and to hold hearings on the topic, spurring interest on the topic at HHS. 42 U.S.C.A. § 1395cc, *supra* note 1; GAO REPORT, *supra* note 1.

5. See, e.g., John Carroll, *Concierge Care by Any Name Raises Ethical Concerns*, MANAGED CARE MAG., Nov. 2003, available at <http://www.managedcaremag.com/archives/0311/0311.concierge.html>; Sidney M. Wolfe, *A New Health Care Gimmick: Concierge Medicine*, HEALTH LETTER, Oct. 2003, at 1, available at http://www.citizen.org/documents/hl_oct2003.pdf.

6. Jennifer Russano, *Is Boutique Medicine a New Threat to American Health Care or a Logical Way of Revitalizing the Doctor-Patient Relationship?*, 17 WASH. U. J.L. & POL'Y 313, 329 (2005) (“A huge gap in health care already exists between the wealthy and the poor. Accordingly, many opponents of boutique medicine argue that its ‘effect on access’ to care – access that is already so disjointed – is the main problem. If a large number of doctors begin charging retainer fees to access their care, access to health care will become a problem. In effect, boutique care will begin to widen the existing gap in the United States health care system, polarizing the wealthy from everyone else.”). See also *id.* at 322-23 (describing how practices differ in their willingness to accept Medicare to defray the costs of treatment).

7. See *infra* Section III.A.

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 retainer care deserves a different legal response. Nearly all serious health policy analysts agree that preventive care is underfunded in the United States.⁸ To the extent retainer care physicians are closing that gap, they ought to be encouraged. However, retainer care 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.⁹ Retainer care threatens to accelerate that process, promoting “exit” from a managed care system where “voice” is ever more necessary.¹⁰

Medicare policymakers realized the dangers of such a dynamic long ago when they proscribed “balance billing,” a practice that allowed doctors to charge

8. Rebecca J. Cook, *Antiprogesterin Drugs: Medical and Legal Issues*, 42 MERCER L. REV. 971, 983 (1991) (“For historic reasons, reinforced by modern jurisprudence, the federal government and state legislatures have resisted funding many health services, including preventive care.”).

9. John V. Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311, 315 (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., Fall 2005, at 47, 47 (“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.”).

10. Albert O. Hirschman categorized responses to crises as either “exit” or “voice”:

[S]ocial actors who experience developing disorder have available to them two activist reactions and perhaps remedies: exit, or withdrawal from a relationship that one has built up as a buyer of merchandise or as a member of an organization such as a firm, a family, a political party, or a state; and voice, or the attempt at repairing and perhaps improving the relationship through an effort at communicating one’s complaints, grievances, and proposals for improvement.

ALBERT O. HIRSCHMAN, *RIVAL VIEWS OF MARKET SOCIETY* 77 (1986). The dichotomy between exit/voice and economics/politics is similar to that of system/lifeworld in Habermas’s work; systems coordinate social action “behind the backs” of actors, while “social integration” requires a common lifeworld to ground discussions about a commonly understood course of action. JÜRGEN HABERMAS, 2 *THE THEORY OF COMMUNICATIVE ACTION* (Thomas McCarthy trans., 1984). Hirschman characterizes exit and voice as complementary “ingredients of democratic freedom” necessary for effective consumption and citizenship. HIRSCHMAN, *supra*, at 79. In the context of health care, those who are buying their way out of a failing managed care system are “exiting”; this Article tries to show the ways in which their “voices” within the current system might be more socially beneficial than the exit strategy.

patients themselves for parts of bills that Medicare did not cover.¹¹ Both Medicare and private insurers should enforce balance billing rules against retainer care physicians in order to prevent insurance programs from subsidizing further fragmentation of the risk pool.¹²

Finally, retainer care 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.¹³ They should consider similar efforts to discourage retainer care 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 and regulation, in Parts I and II, respectively. Part III suggests a resolution of the leading current legal controversy over retainer care, the applicability of Medicare balance billing rules to retainer payments. Part IV addresses retainer care physicians' complaints about current and proposed regulation, developing a normative framework for further interventions proposed in Part V. 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 and diffusion of preventive care.

I. THE RISE OF RETAINER CARE

Retainer practices 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 of a lack of autonomy.¹⁴ Patients have

11. David C. Colby et al., *Balance Billing Under Medicare: Protecting Beneficiaries and Preserving Physician Participation*, 20 J. HEALTH POL. POL'Y & L. 49, 51 (1995) ("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.").

12. Jennifer Silverman, *Legal Expert Highlights Potential Risks of Concierge Care*, INTERNAL MED. NEWS, Sept. 1, 2005, at 6 ("Although Medicare is usually the 800-pound gorilla in these situations, it's private insurers that currently pose the biggest risks to these practices.").

13. Minnesota legislators are currently attempting to pass a bill that would extend the sales tax to certain cosmetic procedures. See H.F. 2603, 84th Leg. Sess. (Minn. 2006).

14. See, e.g., JAMES WOOD, ROBERT WOOD JOHNSON FOUND., HOW SATISFIED ARE PHYSICIANS AND PATIENTS WHEN MEDICAL GROUPS CONTROL ACCESS TO CARE? (1997),

complained about five-minute office visits, officious staff, interminable waits,¹⁵ and a general lack of concern about their welfare.¹⁶ 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.¹⁷ Retainer care options address this need by providing “Marcus Welby” style medical care to their patients.¹⁸

Section I.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 à la 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. Section I.B explains how retainer care works, focusing on the ways in which retainer physicians intensify tiering and consumer choice trends.

A. Background Trends: Resistance to Managed Care

After an extraordinary increase in health care spending in the 1960s and 1970s,¹⁹ managed care arose in the 1980s in response to payors’ worries over

<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.”).

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

16. Josh Fischman, *Who Will Take Care of You?*, U.S. NEWS & WORLD REP., Jan. 31, 2005, at 46 (“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.”).

17. Some commentators have suggested that this is merely a matter of perception. See Joseph Gottfried & Frank A. Sloan, *The Quality of Managed Care*, 65 L. & CONTEMP. PROBS. 103, 136-37 (2002) (“The empirical evidence from the medical literature does not support the allegations of unsafe practices made against [managed care organizations (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 plans.”).

18. See Internet Movie Database Inc., Plot Summary for “Marcus Welby, M.D.,” <http://imdb.com/title/tt0063927/plotsummary> (last visited Dec. 10, 2006) (“The show is about doctors Marcus Welby, a general practitioner and Steven Kiley, Welby’s young assistant. The two try to treat people as individuals in an age of specialized medicine and uncaring doctors.”).

19. DAVID DRANOVE, *THE ECONOMIC EVOLUTION OF AMERICAN HEALTH CARE* 34 (2000) (“At

increasing costs.²⁰ Insurance plans controlled by doctors and hospitals had few incentives to limit medical care or its attendant costs.²¹ 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.²²

Of course, it is a rare medical procedure that offers *no* benefit.²³ 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 coverage of certain care).²⁴ Despite this resistance, capitation systems²⁵ and other pressures to contain costs have already pervasively influenced physicians' interactions with patients.²⁶ Many primary care physicians must see at least

the start of the 1990s, before MCOs 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.”).

20. Alain C. Enthoven, *The History and Principles of Managed Competition*, 12 HEALTH AFF. 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).

21. 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.”).

22. Havighurst, *supra* note 20, at 401.

23. 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. See, e.g., ALAIN C. ENTHOVEN, HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COST OF MEDICAL CARE 6 (1980).

24. See DRANOVE, *supra* note 19, at 62 (objecting to these laws as technology-insensitive and speculating about the technological advances that would have been deterred had “‘drive-through’ appendectomies and hernia surgery” been outlawed twenty years ago); David A. Hyman, *Regulating Managed Care: What’s Wrong with a Patient Bill of Rights?*, 73 S. CAL. L. REV. 221, 247 (2000) (listing examples, such as “drive-through delivery” legislation); Peter Jacobson, *Who Killed Managed Care? A Policy Whodunit*, 47 ST. LOUIS U. L.J. 365 (2003).

25. See Stephen Moss, *Purchasing Managed Care Services for Alcohol and Other Drug Treatment*, 16 Technical Assistance Publications ch. 4 (2002), <http://tie.samhsa.gov/TAPS/TAP16/Tap16chap4.html> (“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.”). See also MARK A. HALL ET AL., THE LAW OF HEALTH CARE FINANCE AND REGULATION 314-30 (2005) (discussing capitation payment plans).

26. See Markian Hawryluk, *Boutique Medicine May Run Afoul of Medicare Rules*, AM. MED.

twenty-five to thirty patients a day²⁷ in order to clear between \$100,000 and \$300,000 per year in pre-tax income.²⁸ 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 of a doctor's time than healthier patients. If a doctor fails to follow this strategy, scheduling may leave her with little more than fifteen 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.²⁹ Many consider the strictures of managed care practice at best an inconvenience and, at worst, a reason for leaving the practice of medicine altogether.³⁰

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 forty percent of health care spending in the United States,³¹ these strictures are becoming

NEWS, Apr. 8, 2002; William Hoffman, *Fed Up, Some Doctors Turn To 'Boutique Medicine'*, AM. C. PHYSICIANS - AM. SOC'Y INTERNAL MED. OBSERVER, Oct. 2001, available at <http://www.acponline.org/journals/news/pastobis.htm> (click on link for Oct. 2001 issue); Cheryl Jackson, *Premium Practice: When Patients Pay Top Dollar for Exclusive Care*, AM. MED. NEWS, Sept. 17, 2001, available at <http://www.ama-assn.org/amednews/2001/09/17/bisa0917.htm>. See also *Boutique Medicine: Elitist or Egalitarian?*, PHYSICIAN'S WKLY., June 10, 2002, at 10 ("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.").

27. Katherine Hobson, *Doctors Vanish From View*, U.S. NEWS & WORLD REP., Jan. 31, 2005, at 50. The average primary care physician sees twenty-five people a day. Economic pressure on physicians results from a number of factors, including reduced reimbursement rates, increased overhead costs, and higher premiums for liability insurance.

28. See Atul Gawande, *Piecework: Medicine's Money Problem*, NEW YORKER, Apr. 4, 2005, at 44 ("In 2003, the median income for primary-care physicians was \$156,902. For general surgeons . . . it was \$264,375 . . .").

29. ROBERT CRUM, ROBERT WOOD JOHNSON FOUND., TIME PRESSURES LEAVE DOCTORS DISSATISFIED (2002), available at <http://www.rwjf.org/reports/grr/027069.htm>; Brian Vastag, *Physician Dissatisfaction Growing*, 286 JAMA 781 (2001) ("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.").

30. AM. ACAD. OF FAMILY PHYSICIANS, 2006 NATIONAL RESIDENT MATCHING PROGRAM, graph 5 (2006), available at <http://www.aafp.org/match/graph05.html> (documenting entry into and exit out of the field).

31. Thomas Bodenheimer & Kevin Grumbach, *Paying for Health Care*, 272 JAMA 634, 638

increasingly important.

Individuals 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.³² 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.³³ Auditors eager to penalize over-billing, fraud, and abuse of the system increasingly scrutinize the expenditures of both Medicare and Medicaid.³⁴ Though necessary, fraud and abuse law has grown so complex that it is becoming a trap for the unwary.³⁵ These laws may chill not only fraud, but also aggressive care that risks being deemed excessive or abusive in the current legal climate.³⁶

Meanwhile, patients are demanding more care and fewer restrictions on their choice of procedures and providers. Although managed care plans have begun to meet this demand by offering subscribers Preferred Provider Options (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 [in Fall 2004], 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.³⁷

(1994).

32. See William Buczko, *Provider Opt-Out Under Medicare Private Contracting*, HEALTH CARE FIN. REV., Winter 2004-05, at 43, 47-49.

33. John Jacobi, *Dangerous Times for Medicaid*, (Seton Hall Pub. L. Research Paper No. 45, 2005), available at <http://ssrn.com/abstract=845084> (arguing that 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).

34. See, e.g., ALICE G. GOSFIELD, *MEDICARE AND MEDICAID FRAUD AND ABUSE* (2005).

35. 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).

36. See Jeremy Fine Bollinger, *Doctoring Fraud & Abuse: Enforcement of Stark and the Anti-Kickback Law in Physician Recruitment May Be Bad for Your Health*, 38 LOY. L.A. L. REV. 485, 505-08 (2004) (discussing perverse incentives created by Medicare fraud and abuse laws).

37. Benedict Carey, *In the Hospital, a Degrading Shift from Person to Patient*, N.Y. TIMES, Aug. 16, 2005, at A1. The survey discussed 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.

Patients have even begun to question the utility of hard-won gains in autonomy, such as increased ability to choose treatment options.³⁸ Opaque and even perverse rationing mechanisms for care, ranging from vaccinations to hospitalization, have raised resentment and concern.³⁹

Pressure from payors for cost containment has also riled patients. Worried by increasingly harried or unresponsive doctors, they are demanding change. Insurance plans are now responding to 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.⁴⁰ Cost-sharing, PPOs, and other strategies have emerged in order to widen the scope of treatments and personnel available to those who are insured.

Of course, these new options have a price, and they are only available to those who pay for them.⁴¹ 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

38. See, e.g., BARRY SCHWARTZ, *THE 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 Hoffman, *Awash in Information, Patients Face a Lonely, Uncertain Road*, N.Y. TIMES, Aug. 14, 2005, at A1 (“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.”).

39. See, e.g., Mark V. Pauly, *Improving Vaccine Supply and Development: Who Needs What?*, 24 HEALTH AFF. 680 (2005) (describing federal government’s repeated recent failures to properly stock and distribute vaccines); Carey, *supra* note 37 (noting rising levels of patient dissatisfaction with hospital visits and unclear admittance criteria). Opaque rationing criteria tend to raise anxieties and opposition to public health measures as they defeat the transparency usually considered a *sine qua non* of legitimate distributive schemes.

40. See Henry T. Greely, *Direct Financial Incentives in Managed Care: Unanswered Questions*, 6 HEALTH MATRIX 53 (1996); Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 480-504 (1988) [hereinafter Hall, *Institutional Control*]; Mark A. Hall, *Rationing Health Care at the Bedside*, 69 N.Y.U. L. REV. 693, 772-76 (1994); Andrea K. Marsh, *Sacrificing Patients For Profits: Physician Incentives To Limit Care and ERISA Fiduciary Duty*, 77 WASH. U. L.Q. 1323, 1327-34 (1999); David Orentlicher, *Paying Physicians More To Do Less: Financial Incentives To Limit Care*, 30 U. RICH. L. REV. 155, 158-60 (1996).

41. For discussion of a number of articles discussing the cost of these options, see generally *Special Issue: The Managed Care Backlash*, 24 J. HEALTH POL. POL’Y & L. 873 (1999).

incentives.”⁴² 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 variable employee cost share, and vertical segmentation, in which consumers within plans are induced to choose providers based on variable employee cost share.”⁴³ 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. Insured persons act as partners with the plan in calibrating more precise trade-offs of cost and quality.⁴⁴

This growing trend toward “consumer choice” in health care raises the stakes of retainer care regulation.⁴⁵ 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.⁴⁶ So far, consumer driven health plans, health savings accounts (HSAs), and cash-only practices have not become widespread.⁴⁷ However, congressional and wonkish

42. John V. Jacobi, *After Managed Care: Gray Boxes, Tiers and Consumerism*, 47 ST. LOUIS U. L.J. 397, 402 (2003) (citing James C. Robinson, *Renewed Emphasis on Consumer Cost Sharing in Health Insurance Benefit Design*, HEALTH AFF. – WEB EXCLUSIVE, Mar. 20, 2002, at W139, W140, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.139v1>).

43. Jacobi, *supra* note 42, at 403.

44. *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.”).

45. REGINA E. HERZLINGER, CONSUMER-DRIVEN HEALTH CARE: IMPLICATIONS FOR PROVIDERS, PAYERS, AND POLICY-MAKERS 3-23 (2004) (documenting trend toward consumer choice in health care).

46. A defined benefit pension plan promises a certain level of payments to its members upon its retirement. A defined contribution plan permits members to contribute to various investment plans, and upon retirement the member can draw down these funds. By analogy, a defined benefit health plan specifies a series of services covered (whatever the cost). A defined contribution plan, such as a health savings account, would permit members to contribute to savings accounts (which are usually treated favorably via the tax system) and to then draw them down for medical bills. The Florida Medicaid program has reportedly decided to gradually switch from a defined benefit to a defined contribution model. See Robert Pear, *U.S. Gives Florida a Sweeping Right To Curb Medicaid*, N.Y. TIMES, Oct. 20, 2005, at A1. The program contributes a set amount to a managed care program for the recipient, which is then responsible for all covered services to the recipient. The cost reduction is supposed to come from the insurer’s freedom to make economical decisions on how to deliver the best care; they have a lot less oversight than the state does.

47. HSAs, usually paired with high-deductible health insurance plans, have been promoted by the current administration and in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 as a way of encouraging health care consumers to take more responsibility for their medical costs. See Medicare Modernization and Prescription Drug Act, Pub. L. 108–173, tit. XII,

enthusiasm for these plans remains high, as evidenced by recent incentives for HSAs embedded in the Medicare Modernization and Prescription Drug Act of 2003.⁴⁸ 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.⁴⁹ All of these developments create fertile ground for entrepreneurs seeking compensation for levels of care they deem necessary or desirable for patients.

B. Physician and Patient Experiences with Retainer Care

The trends toward tiered insurance plans and cash-only practices converge in retainer care, which offers patients the chance to contract directly with physicians for services not covered by insurance plans.⁵⁰ The services are diverse; they range from “same or next-day appointments” to “private waiting rooms.”⁵¹ The fees for

117 Stat. 2469 (2003) (codified as amended in scattered sections of 26 U.S.C.). Employees can contribute a fixed amount each month to the HSA, then use these funds to cover medical bills. Despite government policy designed to encourage them, HSAs have not yet been particularly popular. *See, e.g.,* Anne Belli, *Health Accounts Slow To Catch on with Employers*, HOUSTON CHRON., Feb. 12, 2006, at B1 (“Employers are ‘dabbling, they’re all looking’ at HSAs . . . [b]ut the jury is still out.” Brett Haugh, a principal at Houston-based Employee Benefit Solutions, noted that in a local employer survey conducted by the consulting firm last year, only 8 of the 137 respondents said they were offering their workers health savings accounts. In Houston, interest in HSAs is beginning to emerge, but is still very small, Haugh said. ‘Employees just don’t gravitate toward HSA plans.’”). *But see* AM. MED. ASS’N COUNCIL ON MED. SERV., UPDATE ON HSAS, HRAS, AND OTHER CONSUMER-DRIVEN HEALTH CARE PLANS (2005), available at <http://www.ama-assn.org/ama1/pub/upload/mm/372/i-05cmsreport3.pdf> [hereinafter AMA CMS REPORT] (suggesting increasing interest in HSAs).

48. Medicare Prescription Drug, Improvement, and Modernization Act of 2003 § 1201.

49. Rhonda L. Rundle, *Pay-as-you-go M.D.: The Doctor Is In, but Insurance Is Out*, WALL ST. J., Nov. 6, 2003, at A1 (describing the advantages of cash-only practices).

50. Retainer care, concierge medicine, and boutique medicine all designate the same phenomenon. When it mandated a study on the topic in 2003, Congress defined retainer 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 (West 2006). Jennifer Russano provides a good narrative account of various retainer-financed practices. *See* Russano, *supra* note 6, at 321-27.

51. GAO REPORT, *supra* note 1, at 15. The GAO concedes that this survey is not necessarily

retainer 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 cost up to \$15,000 per patient per year; more modest services may only cost several hundred dollars annually.⁵²

Though a small “cash-only” movement has been opting out of the managed care system since its inception, retainer care only emerged in the mid-1990s in Seattle.⁵³ Since then, it has spread to many, mostly urban, areas.⁵⁴ 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.⁵⁵ However, the majority of retainer practices depend on both retainer payments and insurance reimbursement.⁵⁶ They market more modest services: preventive 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.⁵⁷

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

representative; however, over half the sample responded. *See also* Abigail Zuger, *Before You Buy, Determine What You're Paying For*, N.Y. TIMES, Oct. 30, 2005, at 26.

52. 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.

53. *Id.* at 5 (“The origins of this practice approach are often traced to a medical practice founded in Seattle, Washington, in 1996.”). *See also* Gregory M. Lamb, *Gold-Card Health Care: Is It Boon Or Bane?*, CHRISTIAN SCI. MONITOR, May 17, 2004, at 12 (quoting Dr. John Blanchard, president and cofounder of the American Society of Concierge physicians, as stating: “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.”)

54. *See* GAO REPORT, *supra* note 1, at 10, fig. 1 (providing geographical depiction of retainer care prevalence).

55. *See* G. Caleb Alexander et al., *Physicians in Retainer (“Concierge”) Practice: A National Survey of Physician, Patient, and Practice Characteristics*, 20 J. GEN. INTERNAL MED. 1079, 1082 (2005) [hereinafter *National Survey*].

56. *See, e.g.*, Concierge Family Medicine, <http://www.conciergefamilymedicine.com> (last visited Dec. 10, 2006) (indicating that conventional health insurance is still recommended by cash-only practices in order to cover out-of office expenses such as hospitalization, emergency-room visits, and diagnostic tests).

57. “Dedicated” in the sense of “your personal physician,” not merely “loyal” or “devoted.”

autonomy. However, they also run the risk of being classified as insurers themselves, which would subject them to the whole gamut of state regulation that such classification entails.⁵⁸ 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.⁵⁹ Part IV below deals with these concerns in more detail.

Retainer care has provoked controversy in part because of the abrupt transition many practices have made to it. Steven Flier's story is typical.⁶⁰ 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 number of patients by two-thirds or more, each offering a very high level of primary and preventive care to the first three hundred patients willing to pay a \$4000 annual fee. Patients unable to pay the retainer fee were left to find another physician. A similar dynamic has played out in many cities.

The American Medical Association (AMA) has closely followed the retainer care trend and guardedly endorsed physicians' right to convert to retainer practices.⁶¹ The AMA conducted a survey of both retainer- and non-retainer-funded physicians in order to better understand the practice's appeal to some of

58. See Carol M. Ostrom, 'Concierge Physicians' Medical Model Growing, SEATTLE TIMES, May 28, 2004, at B1; discussion *infra* Section V.A.

59. See, e.g., Mass. Med. Soc'y v. Dukakis, 815 F.2d 790 (1st Cir. 1987) (holding Medicare's "reasonable charge" requirements constitutional).

60. Liz Kowalczyk, *For \$4,000, Doctor's Devotion – 2 Boston Internists to Offer More Access*, BOSTON GLOBE, Dec. 13, 2001, at A1 ("With doctors under pressure to see more patients in less time, Dr. Steven Flier and Dr. Jordan Busch want to provide a more personal sort of medical care: long appointments on the same day patients call. Access to the doctors on their cellphones at any hour. And, when a patient needs to see a specialist, they want to go along and interpret. So the two Boston internists have decided to open a medical practice that offers all of these extras - for an annual fee of \$4,000 per patient. Reacting against a managed health care system that increasingly stresses volume, Flier and Busch will bring a controversial new brand of medicine to Boston. The two doctors plan to quit their practices with Beth Israel Deaconess Medical Center and open Personal Physicians HealthCare, which will charge individuals \$4,000 and families \$7,500 a year for amenities and access provided on top of regular medical care. They will reduce their normal patient loads from several thousand to 300 each in order to spend more time with patients. Those who can't afford the fee - or aren't among the first 300 to sign up - must find new physicians.").

61. The CMS report is more positive than the CEJA report, but neither condemns retainer care. Compare COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, RETAINER PRACTICES (2003), available at http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_3a03.pdf [hereinafter CEJA REPORT], with F. MAXTON "MAC" MAUNEY, COUNCIL ON MED. SERV., SPECIAL PHYSICIAN-PATIENT CONTRACTS (2002), available at <http://www.ama-assn.org/ama1/pub/upload/mm/372/cms902.doc>.

its members.⁶² 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.”⁶³ It is not hard to see why, given the numbers: “Retainer physicians saw an average of 11 patients per day; non-retainer physicians saw an average of 22 patients.”⁶⁴ As the GAO report notes, these patients’ retainer payments in excess of insurance reimbursements average between \$1500 and \$2000 per year.

The only downsides for doctors mentioned in the AMA survey and GAO report are the disapproval of colleagues⁶⁵ and the legal uncertainty surrounding this new method of health care finance.⁶⁶ Scholars of law and norms would likely be quick to note the mutually reinforcing character of concerns about morality and legality.⁶⁷ Far from operating in separate spheres, perceptions of legality and morality often interrelate and mutually reinforce one another, particularly in the

62. Jennifer Silverman, *Retainer Practices Reporting Better Care*, FAM. PRAC. NEWS, June 1, 2005, at 71 (“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 nonretainer practices from the AMA’s master list, and received 231 responses. Data were collected between December 2003 and February 2004.”). As of late 2006, the primary source data had not yet been released; they are “still unpublished and have been in review since January 2005.”

63. *Id.* The only apparent downsides were legal worries and reputational concerns. *See id.* 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.”).

64. *Id.*

65. *See id.* 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.”).

66. *Id.* *See also* Steven M. Goldstein, *The Legal Risks of Boutique Medicine* (July 2003), <http://www.sackstierney.com/articles/boutique.htm> (emphasizing the legal uncertainty of boutique medicine practices).

67. *See, e.g.*, Kristin Madison, *Government, Signaling, and Social Norms*, 2001 U. ILL. L. REV. 867, 879-80 (reviewing ERIC A. POSNER, *LAW AND SOCIAL NORMS* (2000)) (discussing how normative order serves as an extralegal mechanism for influencing behavior); Cass R. Sunstein, *Social Norms and Social Roles*, 96 COLUM. L. REV. 903, 944-47 (1996) (describing the contextual basis of judgments on norms).

highly regulated field of health care finance.⁶⁸

For example, the GAO reports repeated pleas from doctors for guidance from the Department of Health and Human Services (HHS) on the legality of their practice, or a list of “safe harbor” practices that will not provoke regulators’ scrutiny.⁶⁹ These pleas relate not only to the doctors’ legal concerns, but also amount to lobbying for a governmental imprimatur on retainer care. Widespread disapproval of retainer practices may rest on the conflation of a legal with a normative definition of good medical practice – i.e., a sense of the “wrongness” of the project may be driven by its perceived lack of legality.⁷⁰ If legal concerns are quickly cleared up, normative concerns may diminish, leading retainer care to spread much more quickly.

Neither the GAO nor the AMA surveyed the *patients* of retainer practices.⁷¹ Perhaps their names were unavailable or 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 retainer care tend to view market demand as revelation and proof of the value of the service.⁷² 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.”⁷³

Of course, there is some downside: Where do the patients unable or unwilling to afford the retainer care premium go? Hundreds of patients are often

68. See TIMUR KURAN, *PRIVATE TRUTHS, PUBLIC LIES: THE SOCIAL CONSEQUENCES OF PREFERENCE FALSIFICATION* (1995) (discussing the interrelation of laws and norms and developing a “cascade model” of their interrelation).

69. GAO REPORT, *supra* note 1, at 17-20.

70. Here, again, Sunstein, *supra* note 67, at 944-47, is helpful. As Sunstein notes, the social meaning of an action is driven by context, and by what other similarly situated actors are doing. In a society of generous individuals, actions that appear entirely natural in our society might seem downright avaricious. By contrast, in a society of avaricious individuals, generosity may look like a sign of weakness. If HHS quickly gives its imprimatur to retainer practices, it risks artificially accelerating retainer care conversions by affirming their legitimacy, and thereby setting off a chain reaction of new perceptions of their normality.

71. However, another study did focus on the demographic mix of patients at retainer practices. According to a recent survey, “Retainer physicians . . . reported caring for few patients on Medicaid compared to non-retainer physicians . . . [and] minority patients were also under-represented in most of these practices.” *National Survey*, *supra* note 55, at 1081.

72. See *Shop Talk on Boutique Medicine*, N.Y. NEWSDAY, Jan. 1, 2005, at B2.

73. Allen, *supra* note 1, at 20.

dropped by a practice in its transition to the retainer model.⁷⁴ 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.⁷⁵ Despite these assurances, concerns about access to care and public insurance budgets have led to increasing regulatory and journalistic scrutiny of retainer practices.

II. CONTROVERSY OVER FEDERAL REGULATION

State and federal policymakers are slowly beginning to realize the potentially corrosive distributive impact of retainer care.⁷⁶ The federal Medicare program is the most important factor here, as it has construed the retainer as a charge to patients beyond the normal rate in at least one case.⁷⁷ Sections II.A and II.B below describe extant efforts to regulate retainer care. Federal regulation currently has the perverse incentive of inducing physicians to bundle retainer

74. Susan H. Thompson, *Doctors Always in for Members of Practice*, TAMPA TRIB., Feb. 16, 2003, at 1 (“When doctors convert their practices, they may cut caseloads, dropping hundreds of patients.”).

75. See MAUNEY, *supra* note 61, at 2. See also GAO REPORT, *supra* note 1, at 14-15.

76. See, e.g., Uwe E. Reinhardt, *Doctors are More Interested in Having Higher Incomes than Providing Better Health Care*, 324 BRIT. MED. J. 1335 (2002); 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. WK. ONLINE, May 6, 2002, http://www.businessweek.com/magazine/content/02_18/b3781606.htm; Carol M. Ostrom, *‘Retainer Fees’ Spark Warning*, SEATTLE TIMES, Apr. 14, 2004, at B1.

77. See OFFICE OF INSPECTOR GEN., OIG ALERTS PHYSICIANS ABOUT ADDED CHARGES FOR COVERED SERVICES (2004), available at <http://www.oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA033104AssignViolationI.pdf> [hereinafter OIG ALERT] (“[T]he 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.”); Pam Belluck, *Doctors’ New Practices Offer Deluxe Service for Deluxe Fee*, N.Y. TIMES, Jan. 15, 2002, at A1 (“Concierge practices say they adhere to the law by ensuring that their fees pay only for services not covered by insurance or Medicare.”). See also Editorial, *Shop Talk on Boutique Medicine*, N.Y. TIMES, Jan. 17, 2002, at A28 (arguing that doctors should not feel the need to charge more to give high quality care). Critics believe this may be evasion (and not mere avoidance) of balance billing rules.

care with amenities, in order to characterize the retainer as a charge for amenities, rather than a second charge for services covered by Medicare. Unfortunately, the double-billing rules designed to enhance access to medical care in the 1980s are now encouraging tiering in the service of their evasion.

A. An Ambiguous Federal Stance

Some members of Congress have claimed that retainer billing practices are crude evasions of balance billing rules.⁷⁸ According to these legislators and some consumer advocates,⁷⁹ retainer practices violate the balance billing rules by effectively getting paid twice for the same service.⁸⁰ 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 retainer care fees that can be reasonably allocated to the service. For example, consider a hypothetical retainer patient with Medicare who visits her physician five times a year and pays a retainer fee of \$3000 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 \$400 additionally for each visit (with an amount of the retainer proportionally applied to each visit).⁸¹

Conditions on Medicare funding provide important leverage for the federal

78. Letter from Representative Henry Waxman to Tommy Thompson, Sec'y of Health and Human Servs. (Mar. 4, 2002) (on file with author) [hereinafter Waxman Letter] ("In 1989, as part of the Omnibus Budget Reconciliation Act (OBRA), 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.").

79. See Anthony J. Linz et al., *Impact of Concierge Care on Healthcare and Clinical Practice*, 105 J. AM. OSTEOPATHIC ASS'N 515, 517 (2005) ("Medical ethicists and consumer advocates have voiced ethical concerns regarding the creation of a two-class system of medicine based on willingness and ability to pay."); Rachel Brand, *'Concierge' Docs Cater to Service-Minded Patients; Membership Fees Raise Questions Among Regulators*, ROCKY MTN. NEWS, Sept. 11, 2004, at 1C ("Some states prohibit 'balance billing,' where patients must pay the difference between what an insurer pays and the doctor charges. The Office of Inspector General warned in a March letter that concierge medicine may constitute just that for Medicare patients."); Wolfe, *supra* note 5.

80. Brand, *supra* note 79.

81. 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." See Michael Romano & Laura B. Benko, *These Doctors and Their Affluent Patients Find Themselves in Exclusive Company*, MOD. HEALTHCARE, Oct. 22, 2001, at 38.

government to influence the American health care system.⁸² Participating providers must follow a complex set of rules for reimbursement.⁸³ Over seventy percent of retainer care 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.⁸⁴

Though HHS officials were initially skeptical of critics of retainer care, they have since issued some warnings to providers about potential violations of the law.⁸⁵ 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 retainer 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, retainer 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

82. For a similar discussion regarding the federal government’s ability to influence Medicaid funding, see BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS & PROBLEMS* 736 (4th ed., 2001).

83. *Id.*

84. 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.

Ostrom, *supra* note 76.

85. *See id.* 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 is not 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.” *See also* Ctrs. for Medicare & Medicaid Servs., *OIG Alert About Charging Extra for Covered Services, Medicare Learning Network Matters*, available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0421.pdf> (“Participating physicians, suppliers, and providers who consider charging Medicare patients additional fees 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.”). The Medicare Learning Network Matters bulletin on the topic appears to be a re-affirmation of the 2004 OIG Alert on covered services, which it cites.

violation of the limits on what she or he may charge patients who are Medicare beneficiaries.⁸⁶

The “additional charges” mentioned are prohibited by “balance billing rules,” which prevent doctors from charging an amount above Medicare care limits, getting reimbursement from Medicare, and then charging patients for the balance remaining.⁸⁷

The balance billing rules arose out of congressional concerns about potential barriers to access to care for poor and lower middle class Medicare beneficiaries.⁸⁸ 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.⁸⁹ Under the relevant statute, physicians who accept assigned claims are prohibited “from charging more than the Medicare fee schedule amount.”⁹⁰ Physicians who “do not accept assignment are prohibited from charging more than 115% of the fee schedule amount.”⁹¹

To the extent that they implicate balanced billing concerns, retainer practices could also violate the False Claims Act.⁹² The congressional sponsors of

86. GAO REPORT, *supra* note 1. *See also* Portman, *supra* note 2, at 4 (“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.”).

87. Hawryluk, *supra* note 26 (citing 42 U.S.C. § 1395w-4(g)(2)(C) (2000)). *See also* Russano, *supra* note 6, at 322 (discussing the legal consequences of such arrangements).

88. *See* David C. Colby et al., *Balance Billing Under Medicare: Protecting Beneficiaries and Preserving Physician Participation*, 20 J. HEALTH POL. POL’Y & L. 49, 51 (1995) (“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.”).

89. *See* 42 U.S.C.A. § 1395w-4(g)(2) (West 2005); Portman, *supra* note 2, at 4.

90. Portman, *supra* note 2, at 4.

91. *Id.*

92. According to the False Claims Act:

Any person who—

(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;

legislation to keep retainer care practitioners out of the federal Medicare system claim that these physicians “knowingly submit erroneous bills” to the government.⁹³ To return to the hypothetical scenario above, they insist that the bill for each visit of the retainer care patient is actually \$600, 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.⁹⁴ Retainer care proponents respond to this accusation by claiming that Medicare does not cover the services they offer, so they are not properly billed as Medicare claims.⁹⁵

B. Covered or Non-covered Services?

A leading retainer care trade association claims that the retainer is a payment for better service, not better medical care.⁹⁶ This characterization is important, because “[i]f 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.”⁹⁷ Medicare-covered services include all “items and services . . . reasonable and necessary for

(2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government . . .

...

is liable to the United States Government for a civil penalty of not less than \$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 (2000). 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 78, at 3.

93. Waxman Letter, *supra* note 78, at 3.

94. See GAO REPORT, *supra* note 1, at 27 (“OIG 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.’”). 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.*

95. AM. SOC’Y OF CONCIERGE PHYSICIANS, PATIENT FINANCED MEDICINE: PAST, PRESENT AND FUTURE 12 (2004) (on file with author).

96. Waxman, *supra* note 78, at 2.

97. CORRIGAN MEMORANDUM, *supra* note 77 (quoting Acting Principal Deputy Inspector General Dara Corrigan, 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).

the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”⁹⁸

The distinction between covered and non-covered services is a term of art of federal health care financing. Medicare tends to follow the diagnosis and management codes developed by the AMA.⁹⁹ Unfortunately, neither regulations nor guidance documents appear to clarify application of this legal distinction to retainer care.¹⁰⁰ However, a close examination of the lists of services offered by retainer care practices discloses that at least some of them are likely covered Medicare services, as HHS itself determined in at least one case in Minnesota.¹⁰¹ In that case, the OIG provided three examples of potentially covered services illicitly charged for by a retainer care physician: “coordination of care with other providers, a comprehensive assessment and plan for optimum health, and extra time spent on patient care.”¹⁰² Unfortunately, the alert did not specify how many of these services were covered under Medicare.

In the case of the one-third or so retainer care practices with retainer fees below \$1000 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

98. 42 U.S.C. § 1395y (2000). There is, of course, a long list of exceptions, codified in subparagraphs appearing after this portion of the statute. 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.” See FURROW ET AL., *supra* note 82, at 684.

99. The statute establishes a substantive legal standard for Medicare coverage. See 42 U.S.C. 1395y(a)(1)(A) (2000). There are also regulatory criteria for National Coverage Determinations. See 65 Fed. Reg. 31,124 (May 16, 2000) (citing 42 U.S.C. 1395y(a)(1)(A) for authority to avoid coverage of services “not reasonable and necessary”).

100. See Joan R. Rose, *A Caution Light for Concierge Practices*, MED. ECON., May 21, 2004, at 22. Each “improper request” to a patient for payment can result in a \$10,000 fine, plus treble damages. See Ostrom, *supra* note 76.

101. See OIG ALERT, *supra* note 77, at 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 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.”).

102. *Id.* (internal quotation marks omitted).

slippers, and other non-care-related amenities.¹⁰³ However, as fees mount, such a sharp distinction between care and customer service is harder to defend.

III. 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 non-covered services, it is important to disaggregate the range of services provided by retainer care physicians. Section III.A below develops a taxonomy, while Section III.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 GAO shows:

Table 1: Features Offered by Concierge Physicians, October 2004¹⁰⁴

<i>Feature</i>	<i>% Offering Feature</i>
Same- or next-day appointments for non-urgent 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

103. See Russano, *supra* note 6, 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.’”) (internal citations omitted).

104. GAO REPORT, *supra* note 1, at 15 tbl.2.

THE THREE FACES OF RETAINER CARE

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 retainer care physicians. They may be usefully categorized as:

- (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).

Each of these categories is described below.

1. Preventive Care

Nearly all retainer care practices responding to the GAO survey offer “periodic preventive-care physical examinations.”¹⁰⁵ High percentages also offered “wellness planning” and “nutrition planning.”¹⁰⁶ Retainer care physicians are particularly proud of this dimension of their practice. Bernard Kaminetsky, a retainer care 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.¹⁰⁷ He and other retainer care 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 provided all potentially helpful primary medical care that their

105. *Id.* at 15 (reporting that periodic preventive care and physical examinations, along with same or next-day appointments and twenty-four-hour telephone access, were the most frequently reported features by retainer care physicians who responded to a survey).

106. Ninety-three percent 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.* at 15 tbl.2.

107. *See Consumer-Directed Doctoring*, *supra* note 4, at 46 (statement of Bernard Kaminetsky), (testifying that only fifty-five percent of recommended preventive care and fifty-two percent of recommended screening is administered, presumably leading to increased out-patient care and health care costs).

patients need.¹⁰⁸

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.¹⁰⁹

Retainer 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.¹¹⁰ 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.

108. *See id.* at 51 (“Because of the time I now have for preventive care, and the trust engendered, I am not subject to . . . fear [of malpractice suits]. My patients and I recognize that whatever the outcome, I gave them my best.”); Soc’y for Innovative Med. Practice Design, *Why Should Physicians Join This Movement?* (2006), <http://simpd.org/physicians.htm> (“Since 1996, physicians in the United States have been experimenting with new practice structures that take them out of the treacherous waters of third party controlled care and allow them to once again take care of their patients directly, with decisions controlled by doctors and patients, not by spreadsheet mavens and government bureaucrats. The key principle that allows these practices to exist is the notion that when patients buy their care directly from their physician, high quality care becomes possible, often at far lower prices than the existing healthcare market will permit.”).

109. *See* Claude Solnik, *Doctors Give Patients the Boca Raton, Fla.-Based MDVIP Treatment*, LONG ISLAND BUS. NEWS, May 19, 2006, at 1 (“[Patients at retainer-care practices] probably do get better care, because the physician spends more time with [them],” said Lawrence Lioz, a partner at accounting firm Margolin, Winer & Evans in Garden City. “The patient care probably is a step up. But there’s a cost.”).

110. *See Consumer-Directed Doctoring*, *supra* note 4, at 46-47 (statement of Bernard Kaminetsky) (suggesting that normal-sized medical practices do not have the time needed to provide basic preventive care to patients); Kimberly S.H. Yarnal et al., *Primary Care: Is There Enough Time for Prevention?* 93 AM. J. PUB. HEALTH 635 (2003) (reporting that basic preventive services at [the U.S. Preventive Services Task Force (USPSTF)] recommended frequencies are commonly missed in a traditional primary care setting under the present health care scheme). *See also* Barnaby J. Feder, *New Priority: Saving Feet of Diabetics*, N.Y. TIMES, Aug. 30, 2005, § F5 (“[R]esearch suggests that anywhere from fifty percent to eighty-five percent of [the roughly 50,000] diabetic foot amputations [that occur each year] are preventable.”).

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.”¹¹¹ Nearly as many offer access to physicians via e-mail, cell phones, or pagers.¹¹² Many retainer care physicians coordinate medical needs during travel, or visit their patients at their home or workplaces.¹¹³ A smaller number offer “priority for diagnostic tests in affiliated medical facilities.”¹¹⁴

Given most retainer care physicians’ commitment to a unitary standard of care, such patients are not “skipping in front of” other patients within retainer practices.¹¹⁵ However, 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-retainer practices. The average American waits several days for an

111. GAO REPORT, *supra* note 1, at 15 tbl.2. These features are often reported as the most important features distinguishing retainer care practices from more traditional primary-care practices.

112. *Id.*

113. *Id.*

114. *Id.* at 16 tbl.2 (stating that twenty-seven percent of retainer care physicians offer this service).

115. The AMA’s Council on Ethical and Judicial Affairs has mentioned that retainer care physicians ought to provide the same standard of care to the patients in their practice who are incapable of paying the retainer. See CEJA REPORT, *supra* note 61, at 5 (“Physicians who engage in mixed practices, in which some patients have contracted for special services and amenities and others have not, must be particularly diligent to offer the same standard of diagnostic and therapeutic services to both categories of patients.”). See also Sandra J. Carnahan, *Law, Medicine, and Wealth: Does Concierge Medicine Promote Health Care Choice, or Is It a Barrier to Access?*, 17 STAN. L. & POL’Y REV. 121, 139–40 (2006) (“[P]hysicians who have split their practices may be violating their provider agreements when they give preferences to their concierge patients. For example, a standard Blue Cross Blue Shield provider agreement provides: ‘Physician shall provide Covered Services to Members in the same manner, quality and promptness as services are provided to Physician’s other patients.’ Physicians provide their concierge patients an expedited appointment process, often a waiting room for the exclusive use of concierge patients, and other amenities that regular patients would not receive. Even assuming the quality of medical services was the same for both categories of patients, concierge physicians are essentially contractually bound to their access-fee patients to ‘prefer’ them over their regular patients with respect to appointment preference and amount of time spent, which may violate the anti-discrimination provision of the provider agreement.”); Hoffman, *supra* note 26 (“[P]hysicians like Dr. Kaminetsky, who sees both types of patients at his practice in Boca Raton, Fla., insist that all their patients are treated equally . . .”).

office visit, is subjected to more delays once at the doctor's office, and more than half of such visits last less than twenty minutes.¹¹⁶ By contrast, retainer patients get near-immediate access through traditional visits, house-calls, and even e-consultations and phone calls.¹¹⁷

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.¹¹⁸

Given that the overall mix of public and private spending in the United States has led to waits, on average, for primary care¹¹⁹ there is a rather direct analogy between queue-jumping via retainer care in the United States and queue-jumping via private insurance or private payment in primarily public systems. But to be analytically rigorous, it is helpful to distinguish between jumping the queue to get *rapid access* and jumping ahead to get more *intense, longer, 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 retainer care, we may assume that *some* doctors were giving care as

116. See generally Fischman, *supra* note 16, at 46 (discussing difficulties in the physician-patient relationship).

117. See Bill Sonn, *Concierge Medicine: Physicians Weigh Financial, Ethical Issues*, PHYSICIANS PRAC. ONLINE, Feb. 2004, <http://www.physicianspractice.com/index.cfm?fuseaction=articles.details&articleID=483>.

118. See 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).

119. In 1999, a Kaiser Family Foundation survey of insured adults younger than sixty-five years found that twenty-seven percent of people with health problems had difficulty gaining timely access to a clinician. KAISER FAMILY FOUND., NATIONAL SURVEY OF CONSUMER EXPERIENCES WITH HEALTH PLANS: SUMMARY OF FINDINGS AND CHART PACK (2000), available at <http://www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13510>. From 1997 to 2001, the percentage of people reporting an inability to obtain a timely appointment rose from twenty-three to thirty-three percent. BRADLEY C. STRUNK & PETER J. CUNNINGHAM, CTR. FOR STUDYING HEALTH SYS. CHANGE, TREADING WATER: AMERICANS' ACCESS TO NEEDED MEDICAL CARE, 1997-2001 (2002), available at <http://www.hschange.com/CONTENT/421/>. In 2001, forty-three percent of adults reporting an urgent condition were occasionally unable to receive care as soon as they desired. JANET GREENBLATT, AGENCY FOR HEALTHCARE RESEARCH & QUALITY, STATISTICAL BRIEF NO. 08: ACCESS TO URGENT MEDICAL CARE: 2001 (2002), http://www.meps.ahrq.gov/mepsweb/data_files/publications/st8/stat08.pdf.

intense, expert, and dedicated as retainer care physicians. However, the distribution of such doctors was somewhat random. Perhaps some clung to an older standard of care, limiting their number of patients 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.¹²⁰ 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.¹²¹ Retainer patients are likely

120. See INST. OF MED., *UNEQUAL TREATMENT: WHAT HEALTHCARE PROVIDERS NEED TO KNOW ABOUT RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE* (2002), available at <http://www.iom.edu/Object.File/Master/4/175/Disparitieshcproviders8pgFINAL.pdf> ("[M]any recent news reports indicate that racial and ethnic minorities receive lower healthcare quality than whites, even when they are insured to the same degree and when other healthcare access-related factors, such as the ability to pay for care, are the same."). The correlation between primary care and class distinctions was evidenced by a 2002 survey which found that minority adults, whether they had insurance or not, were less likely than whites to have a regular doctor. For more information, see *Coverage and Access: Minorities More Likely than Whites to Report Difficulty Communicating with Care Providers, Face Other Barriers, Survey Says*, DAILY HEALTH POL'Y REP., Mar. 7, 2002, available at http://www.kaisernetwork.org/Daily_reports/rep_index.cfm?DR_ID=9888.

121. *Consumer-Directed Doctoring*, *supra* note 4, at 45 (statement of Robert A. Berenson, Senior Fellow, Healthy Policy Ctr., The Urban Inst.) ("[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 insurance option would become unaffordable precisely for those who need its protection."). See also Martin

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.¹²² Retainer patients are thus relatively advantaged (vis-à-vis non-retainer 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? 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. As mentioned above, several commentators suggest that current levels of dissatisfaction with managed care relate more to perception than reality.¹²³ Perhaps a great deal of the dissatisfaction stems from

Solomon, *The Doctor Will Not See You Now*, GATHER.COM, Aug. 5, 2006, <http://www.gather.com/viewArticle.jsp?articleId=281474976772872> (asserting that a patient searching for a new doctor will have to settle for a young doctor who is new to the community because the more experienced doctors have either converted to the retainer model, or have stopped accepting new patients).

122. A simple economic model of the quality of physician services would project that the best physicians would be the best paid. While this is obviously not true universally, it is likely probabilistically true enough to warrant these concerns. There is some empirical evidence that retainer care physicians are disproportionately more experienced and more expert. See Solomon, *supra* note 121. We can, for instance, assume that only an established practice can convert to the retainer model, since usually only that practice would have a base of customers it could solicit for retainer fees.

123. See Robert J. Blendon et al., *Understanding the Managed Care Backlash*, 17 HEALTH AFF. 80, 84, (1998) (“A majority (55 percent) of people in managed care say that they are at least ‘somewhat worried’ that if they were sick, their health plan would be more concerned about saving money than about what is the best medical treatment; 34 percent of those with traditional health insurance feel this way. When asked about specific examples, taken from news stories, of dramatic events that might be considered statistical outliers, the public’s perception is that these are fairly common occurrences. For example, two-thirds of Americans believe that a health maintenance organization (HMO) holding back on a child’s cancer treatment is something that happens ‘often’ (26 percent) or ‘sometimes’ (40 percent); only 23 percent think that this happens ‘rarely.’ Two in five (39 percent) think that newborn babies are often sent home after just one day because of a managed care plan’s policy, in spite of mothers’ concerns about their children’s health; another third (34 percent) think that this occurs ‘sometimes’; only 18 percent think that this happens

the near-automatic anxiety generated for many by today's health care system.¹²⁴ 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.¹²⁵

As their moniker suggests, concierge care 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 to the GAO survey offered a "private waiting room."¹²⁶ Thirty-one percent offered "home delivery of medication by physician or office staff."¹²⁷ Retainer 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 retainer patients: monogrammed bathrobes, heated towels, and slippers.¹²⁸ Although these reports probably do not accurately represent the

'rarely.' These perceptions of managed care are reflected in the ratings of the industry compared with other health care groups.").

124. A June 2005 Lake Snell Perry Mermin survey revealed that "[r]ising health care costs are voters' number one *economic* concern at 27 percent, followed by wages not keeping up with costs (18%), a secure retirement (14%), higher taxes (12%), rising gas prices (9%), paying off debt (7%), losing your job (5%), and expenses like child care and college (4%)." CELINDA LAKE & DANIEL GOTOFF, LAKE SNELL PERRY MERMIN DECISION RESEARCH, OVERVIEW OF RECENT RESEARCH ON THE ECONOMY 2 (2005), available at http://www.ourfuture.org/docUploads/lake_poll_july2005.pdf. See also Ross Douthat & Reihan Salam, *The Party of Sam's Club: Isn't it Time the Republicans Did Something for Their Voters?*, WKLY. STANDARD, Nov. 14, 2005, available at <http://www.weeklystandard.com/Content/Public/Articles/000/000/006/312korit.asp> (stating that the country's health care system may be the greatest source of anxiety for many families).

125. See Jean P. Fisher, *Pinched by Medical Bills*, NEWS & OBSERVER, Jul. 11, 2004 ("But families reported situations such as being contacted by collection agencies, postponing a major household purchase such as a car or borrowing money to pay health-care bills. Consumers also said they had to forgo doctor's visits or leave prescriptions unfilled because they had no money to pay or feared racking up additional medical bills."). For reporting on patients' perspectives of excessive wait times in doctors' offices and their inability to obtain timely appointments, see GREENBLATT, *supra* note 119; KAISER FAMILY FOUND., *supra* note 119; STRUNK & CUNNINGHAM, *supra* note 119; and Michael Goitein, *Waiting Patiently*, 323 NEW ENG. J. MED. 604 (1990).

126. See GAO REPORT, *supra* note 1, at 15 tbl.2 (reporting that 63% of respondents claimed to offer this feature).

127. *Id.* 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.

128. Carnahan, *supra* note 115, at 121-22 ("['Concierge'] patients receive a varying array of services that are not typically covered by insurance, such as access to their personal physician twenty-four hours a day, seven days a week, immediate or same-day appointments, their

patient experiences at most retainer care practices,¹²⁹ they suggest the direction of competition in the future. Health care often is characterized by economists as an “experience good” – a service whose value is hard to judge critically until after it has been rendered – or a “credence good,” whose value really only can be judged by experts.¹³⁰ To the extent discriminating consumers want to compare retainer care practices, they often will 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 that 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:

[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.¹³¹

Scholars outside health law also raise concerns about amenities. As Lior Strahilevitz has demonstrated, “exclusionary amenities” are widely used by

physician’s personal cell phone number and e-mail address, extensive executive-type annual physicals, some preventive care services, and, in some cases, spa-like amenities such as robes, slippers, and refreshments.”). See also *Shop Talk on Boutique Medicine*, *supra* note 77 (stating that some retainer care practices provide patients with monogrammed bathrobes and heated towel racks).

129. Since most retainer care practices now charge fees between \$1500 and \$2000 annually, they probably cannot afford such amenities. See GAO REPORT, *supra* note 1, at 13. Since the GAO Report does not even mention them in its survey of services offered by retainer care practices, they are likely rare. *Id.* at 15-16.

130. See William M. Sage & Peter J. Hammer, *A Copernican View of Health Care Antitrust*, 65 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, consumers are never sure about the extent of the good they actually need.” Winand Emons, *Credence Goods and Fraudulent Experts*, 28 RAND J. ECON. 107 (1997).

131. Clark C. Havighurst, *How the Health Care Revolution Fell Short*, 65 LAW & CONTEMP. PROBS. 55, 86 (2002).

housing developers in order to discourage “unwanted” groups from affecting the character of the neighborhood, without running afoul of antidiscrimination laws.¹³² For example, a condominium association that 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.¹³³ Luxurious amenities may be valuable to those who can afford them, but also tend to increase already troubling trends toward economic apartheid.¹³⁴ Though this trend 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. Whatever one thinks of Havighurst’s critique of managed care mandates, it fits amenity bundling in retainer care exceptionally well.

The problem lies not only in the substance of amenity-bundling but also in its form. Bundling has provoked antitrust scrutiny in certain industries.¹³⁵ Since the rest of retainer care services often are not available outside a package including amenities, they are offered in a particularly tight type of bundling.¹³⁶ 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.¹³⁷ Yet perhaps the very difficulty of such an analysis suggests the need for valuing the component part of retainer care more carefully.¹³⁸ As Section III.B below shows, often amenities are

132. See Lior Jacob Strahilevitz, *Exclusionary Amenities in Residential Communities*, 92 VA. L. REV. 440 (2006) (“People interested in residential homogeneity inevitably will try to thwart integration using creative substitutes for overt discrimination.”).

133. See *id.* at 441.

134. CHUCK COLLINS & FELICE YESKEL, *ECONOMIC APARTHEID IN AMERICA* 31 (2000) (discussing inequality and public health).

135. David S. Evans & Michael Salinger, *Why Do Firms Bundle and Tie? Evidence from Competitive Markets and Implications for Tying Law*, 22 YALE J. ON REG. 37 (2005); Daniel L. Rubinfeld, *3M’s Bundled Rebates: An Economic Perspective*, 72 U. CHI. L. REV. 243 (2005) (discussing leading case *LePage’s Inc. v. 3M*, 324 F.3d 141 (3d Cir. 2003)).

136. Bruce H. Kobayashi, *Does Economics Provide a Reliable Guide to Regulating Commodity Bundling by Firms? A Survey of the Economic Literature*, 4 J. COMPETITION L. & ECON. 707, 708 n.2 (2005) (charting six types of bundling, based on whether components are available separately or not).

137. 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 retainer care physicians are not presently selling amenities separately, it would be very difficult to determine whether suspected “bundled discounting” actually occurred.

138. 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

emphasized not simply for their own sake, but to provide “something else to bill for” to avoid liability for double billing for covered services.

B. What Are the Retainer Payments For?

Amenity-bundling is likely to persist because amenities play an important role in the business model of retainer care physicians by providing a legal basis (however tenuous) for the assertion that retainer payments are only compensation for non-covered services. Strategic retainer care physicians tend to assure that their contracts specify that retainer payments only are made in consideration for uncovered amenity and preventive care.¹³⁹ For example, Personal Physicians HealthCare (PPHC) 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 average 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.¹⁴⁰

One of the founders of this “dual structured” practice explains that the

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, stated *infra* in Part V, that targeted taxation of the troubling parts of retainer care probably amount to the best regulatory response at this time.

139. See, e.g., Personalized Primary Care Membership Agreement, available at www.personalizedprimarycare.com/membership_reg/membership_form.pdf (last visited Dec. 10, 2006) (section entitled “Medical Care Services Excluded from Annual Membership Fee”).

140. GREGORY L. STOLLER & CHRISTOPHER FERRARONE, THE PATIENT IS ALWAYS RIGHT: PERSONAL PHYSICIANS HEALTHCARE 8 (2004), available at www.bc.edu/schools/csom/bcbi/meta-elements/pdf/persphy.pdf. The “dual structure” was also used for accounting purposes. As retainer care physician Steven Flier explains in the piece, “[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.*

arrangement works in part because “LLC buys time from the PC so that our doctors are not busy.”¹⁴¹

Groups like PPHC would like to characterize all these LLC payments as being “for” non-covered 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.¹⁴² 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 categorized usefully 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 do not map directly onto coverage decisions, which are inevitably idiosyncratic given the degree of discretion vested in the Secretary of HHS by the statute.¹⁴³ However, given the number of retainer care services that reasonably fall into the “directly therapeutic” category, the OIG reasonably could presume that at least part of the retainer fee charged at many practices is supplementing Medicare payment for covered services.¹⁴⁴

141. *Id.* (internal quotation marks omitted).

142. See Michael Romano, *If You Have To Ask, You Can’t Afford It; Boutique Practices Getting a Hard Look From Government, Doctors’ Group*, MOD. HEALTHCARE, Mar. 25, 2002; *Lawmakers Challenge Legality of “Boutique Medicine”*, 12 CLINICIAN REV., May 2002, at 32 (noting that leading Democratic Congressmen “requested a review of the legality of these practices,” because “[c]urrent 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.”).

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

144. GAO REPORT, *supra* note 1, at 18 n.26. HHS has issued a memorandum stating 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. See KENNETH T. BOWDEN II & LAWRENCE L. FOUST, *ADVANCED ISSUES IN PROVIDER/PAYER MANAGED CARE CONTRACTING AND NEGOTIATIONS* 12 (2005) (copy on file with author).

Many defenders of retainer care claim that the retainers only pay for “better service,” not better health care. This nomenclatural smoke screen has obscured what is really objectionable about retainer care: the bidding away of primary care resources by those whose wealth permits them to opt out of the rationing mechanisms of managed primary care. To the extent retainer care 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 retainer care more unaffordable and serve little to no therapeutic purpose.¹⁴⁵

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 a powerful policy lever for encouraging retainer practices to concentrate on preventive care and to avoid promoting the kind of wasteful competition that “queue-jumping” for ordinary medical care may cause.¹⁴⁶ A majority of retainer physicians responding to the GAO’s survey participate in the Medicare system, and retainer patients skew toward the elderly.¹⁴⁷ By cutting out reimbursements for ordinary medical care already paid

145. Some theorists of positional goods have suggested that this diversion of health resources away from those unable to afford them actually amounts to a competitive advantage for the diverters. See Harry Brighouse & Adam Swift, *Equality, Priority, and Positional Goods*, 116 ETHICS 471, 479 (2006) (“[H]ealth . . . [may] indeed have a competitive, and hence positional, aspect. The value to me of my health does depend on how healthy others are. In the land of the blind, the one-eyed man is king. This is a case of a latent positional good.”). On this Darwinian account, the diverters of the primary care are the “one-eyed men,” and the rest of the system is left “blind.”

146. 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 Buczko, *supra* note 32, 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 give physicians the option to opt-out of Medicare. *Id.* at 57.

147. “On average, Medicare beneficiaries represented about thirty-five percent of the total

for by retainer fees, HHS could reduce the financial appeal of the retainer model, as well as its potential to increase queue-jumping. Part V below suggests some methods of decomposing the value of the different facets of retainer care.

IV. 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 retainer care 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.¹⁴⁸ Second, they argue that gains in time and compensation from retainer care will encourage more medical students to become primary care physicians.¹⁴⁹ Third, retainer care physicians argue that they treat some of the sickest patients, and should be praised instead of penalized for developing long-standing care relationships.¹⁵⁰ Finally, libertarians believe it is unconscionable to deny treatment options to those willing and able to afford them.¹⁵¹

Sections IV.A through IV.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 mitigate 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

number of patients – retainer and non-retainer – that responding retainer care physicians reported having in their care as of October 2004.” GAO REPORT, *supra* note 1, at 21.

148. *See infra* Section IV.A.

149. *See infra* Section IV.B.

150. *See infra* Section IV.C.

151. *See infra* Section IV.D.

to become widespread.¹⁵² A nascent phenomenon in health care finance, retainer care has not yet affected the vast majority of providers or patients. The GAO's report, one of the most comprehensive so far, stated that "[t]he small number of retainer care physicians makes it unlikely that the approach has contributed to widespread access problems."¹⁵³ Some predict that is likely to remain the case for the foreseeable future. According to one leading academic and policy advisor, "[c]oncierge care may remain attractive to a limited number of high income-individuals . . . [i]t is not likely to become an important component of the American health care system."¹⁵⁴

This characterization of retainer care is essential to its current justification. As the AMA's Council on Ethics and Judicial Affairs warns, if retainer care were to become widespread, or even to "take over" a certain market, it would certainly raise concerns about access.¹⁵⁵ But the AMA's Council on Medical Service downplayed such concerns, and both 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 retainer practices.¹⁵⁶ The largest retainer care network, MDVIP, based in Boca Raton, Florida, "has 85 doctors in 14 states serving 27,000 patients."¹⁵⁷ The GAO reports a continuous growth in retainer practice since its inception in 1996.¹⁵⁸ Nevertheless, the same report concludes that "[t]he small number of retainer care physicians makes it unlikely that the approach has contributed to widespread access problems."¹⁵⁹ The Council on Medical Service of the AMA goes further on the prevalence question, deeming retainer care an "inherently self-limiting" phenomenon:

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

153. GAO REPORT, *supra* note 1, at 24.

154. *Concierge-Style Health Care Perks Not Likely To Revolutionize Medical Services Field*, Says Stuart Altman, BRANDEIS NEWS, Jan. 10, 2002, available at http://my.brandeis.edu/news/item?news_item_id=100466 (describing a speech by Stuart Altman, a leading health care economist and co-chairman of The Massachusetts Governor's and Legislative Health Care Task Force).

155. CEJA REPORT, *supra* note 61, at 4.

156. Amy Zipkin, *The Concierge Doctor is Available (at a Price)*, N.Y. TIMES, July 31, 2005, at C6.

157. *Id.*

158. See GAO REPORT, *supra* note 1, app. II (charting the rate of prevalence of retainer practices).

159. *Id.* at 17. The GAO was directed to study retainer care pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

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.¹⁶⁰

This analysis suggests that, like most other luxury goods, retainer care will simply be enjoyed by a small elite and will not divert 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.¹⁶¹ 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.¹⁶² 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.¹⁶³ It is odd to hear proponents of retainer care 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

160. MAUNEY, *supra* note 61, at 2.

161. 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) (discussing 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.”).

162. 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 over consumption of private goods, reducing the overall net social utility).

163. See, e.g., ROBERT H. FRANK & PHILIP J. COOK, *WINNER TAKE ALL SOCIETY* 96-97 (1995) (discussing the polarization of incomes among dentists).

guidance documents that interpret those laws. It is no surprise that physicians, uncertain of the legal status of retainer care, have not rushed to embrace the idea.¹⁶⁴ 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 retainer practices, and it is simply disingenuous to argue that the former should be eliminated on account of the latter.

Supporters of retainer care have argued that retainer arrangements are not significant enough to regulate because they will only affect a small number of providers.¹⁶⁵ However, regardless of the degree of diversion of resources *now* occurring, retainer care is likely to prove much more attractive to upper and middle class consumers of health care as it gains in notoriety.¹⁶⁶ As soon as one person in a reference group purchases retainer care, their peers are likely to ask: "How can I deny this to myself? Or my children?"¹⁶⁷ Given the special significance of health care, there are many consumers who will accept nothing less than the "best" available. As retainer 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 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.¹⁶⁸ To the extent the plan limited or delayed reimbursement, their attractiveness as a patient *relative to* other insured persons would drop.¹⁶⁹ Conversely, to the extent the plan

164. 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 problems with Medicare compliance, but most GAO survey respondents expressed a desire for more information from HHS to guide them. See GAO Report, *supra* note 1, at 17.

165. See MAUNEY, *supra* note 61, at 4.

166. See Mike Norbut, *Boutique Care Goes Mainstream*, AM. MED. NEWS, Aug. 4, 2003, at 18.

167. For an economic analysis of the spread of spending norms, see, e.g., DAVID BROOKS, BOBOS [BOURGEOIS BOHEMIANS] IN PARADISE (2000); JULIET SCHOR, THE OVERSPENT AMERICAN (1998); THORSTEIN VEBLEN, THEORY OF THE LEISURE CLASS 35-36 (1992); NICHOLAS XENOS, SCARCITY AND MODERNITY 85 (1989) (discussing competitive consumption). For a critical analysis of the limits of parental obligation to children, see ADAM SWIFT, HOW NOT TO BE A HYPOCRITE: SCHOOL CHOICE FOR THE MORALLY PERPLEXED (2003).

168. FURROW ET AL., *supra* note 82, at 595-97.

169. Mark O. Hiepler & Brian C. Dunn, *Irreconcilable Differences: Why the Doctor-Patient Relationship is Disintegrating at the Hands of Health Maintenance Organizations and Wall Street*,

guaranteed quick or generous reimbursement for procedures, an insured person's *relative* attractiveness as a patient would increase.¹⁷⁰

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.¹⁷¹ The average large employer, for instance, only offers a few different plans to its employees.¹⁷² However, with the rise of retainer care, medical practices are cutting out the middleman and offering a tailored version of insurance directly to their patients.¹⁷³

In this way, retainer care permits consumers to distinguish themselves even further in the pool of insured patients. Whereas before one could only buy the best health plan one's employer offered, retainer care permits one to leverage such a plan into extraordinary primary care and lavish related services.¹⁷⁴ Meanwhile, the retainers 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.¹⁷⁵

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

The combined effects of supply restrictions and positional competition (by physicians, for income, and patients, for care) raise the possibility that retainer care conversions may be a self-reinforcing, rather than a self-limiting,

25 PEPP. L. REV. 597, 606 (1998).

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

171. See BARRY R. FURROW ET AL., *THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE* 201 (4th ed. 2001).

172. See FURROW ET AL., *supra* note 82.

173. See Hoffman, *supra* note 26. 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 V of this Article (discussing the recent history of state insurance regulation applicable to provider-sponsored organizations (PSOs)).

174. See Vasilios J. Kalogredis, *Should You Consider Concierge Medicine?*, PHYSICIAN'S NEWS DIG., Feb. 2004, available at <http://www.physiciansnews.com/business/204.kalogredis.html>.

175. See Andrew Haeg, *Top-Shelf Health Care – If You Have the Money* (Minnesota Public Radio broadcast June 24, 2002), available at http://news.minnesota.publicradio.org/features/200206/24_haega_conciergecare/.

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.¹⁷⁶ 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 more access to capital necessary for technology-intensive care, and thereby initiated a competitive dynamic that severely disadvantaged non-profits.¹⁷⁷ The same trends are now fueling the rise of specialty hospitals, which only perform surgeries with very high profit margins.¹⁷⁸ 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.¹⁷⁹ Few will reject an opportunity to increase income *and* leisure simultaneously

176. 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 Zachary Schiller, *Balance Sheets that Get Well Soon*, *BUS. WEEK*, Sept. 4, 1995, at 80-84).

177. See *id.*

178. David Armstrong, *A Surgeon Earns Riches, Enmity by Plucking Profitable Patients*, *WALL ST. J.*, Aug. 2, 2005, at 1 (“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.”).

179. See Linz et al., *supra* note 79, at 516 (“Physician dissatisfaction with the typical selective contracts used in HMOs, or managed care programs, have emerged as an impetus in the development of the concierge care model. Standard contracts often impose discounted fees that require physicians to rapidly increase their number of patient visits per day, compelling brief visits that are typically limited to an average of five to ten minutes per person Many physicians note that the managed care contracts cause much frustration for them as they attempt to deliver competent care to their growing number of patients, counteract rising financial costs, preserve personal and family time, and cope with the legal constraints and malpractice threats that are common with managed care.”); Ken Carlson, *Loan Repayment Carrot Helps Keep Doctors: Awards in Exchange for Staying in Area*, *MODESTO BEE*, May 20, 2006, at B1 (“Young physicians may have as much as \$200,000 in education debt, while trying to pay for malpractice insurance and other startup expenses for a practice. ‘That kind of debt burden is actually dissuading young physicians from choosing a practice in primary care, pediatrics and family medicine,’ said Dr. Peter Broderick, director of the Stanislaus Family Medicine Residency Program. ‘Those practices tend to be the lowest compensated.’”).

without serious thought. MDVIP appears so confident of the trend that it has even attempted to franchise its business model.¹⁸⁰ 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 approximately as many hours as she does.¹⁸¹ Once one retainer 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.¹⁸²

Thus, retainer care threatens to intensify already-existing trends toward polarization of incomes in professional services. Previous tiering made specialty practice more remunerative than 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.¹⁸³ Among dentists in the 1980s, 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

180. See Allen, *supra* note 1 (“Retainer medicine has spread beyond select markets on the east and west coasts. Boca Raton-based MDVIP has helped to set up about 60 physicians in retainer-medicine franchises in 10 states – offering the doctors expensive assistance in transitioning to, maintaining, and building such practices. Using the MDVIP identity as part of their marketing, the practices agree to a maximum of 600 patients per physician and a charge of \$125 per month, per person.”).

181. 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.

182. See Michael Kinsman, *Gratuity Mystery*, *SAN DIEGO UNION-TRIB.*, Nov. 12, 2006 (“Tips are the lifeblood of minimum-and low-wage workers in service industries. Without the promise of tips, restaurant and bar owners say they would be hard-pressed to pay high enough wages to attract workers for many jobs.... [S]ome companies attempt to use tips to drive down labor costs. Restaurant owners often use tips to subsidize the low salaries of employees who don’t interact with the public.”).

183. See FRANK & COOK, *supra* note 163, at 97 (“Although we cannot measure the precise extent to which growing inequality among dentists is the result of [processes of positional competition], this much seems clear: The available data rule out changes in human capital as a significant explanation.”).

ends of the earnings spectrum.¹⁸⁴

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).¹⁸⁵ Each of these has parallels in a primary medical care field affected by retainer care: consumers increasingly seeking direct access to specialists (via Preferred Provider Options) 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).¹⁸⁶

B. Physician Shortage?

Advocates of retainer care may accept all the arguments in Section IV.A above, and turn them into another, more forward-looking argument for retainer practices. 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 increase in the late 1990s as managed care began directing funds to these frontline doctors as

184. *Id.* at 89.

185. *Id.* at 96-97 (“Jim Bader, editor of the *Journal of Dental Education* . . . notes that although the demand for primary dental services has declined slightly as a result of fluoride use, there has been strong growth in the demand for cosmetic, consumer-oriented dentistry Taken together these changes appear to have created ample opportunity for self-reinforcing [winner-take-all effects], like the ones that have characterized competition for top positions in other fields, to have expressed themselves in dentistry as well.”).

186. Positional competition for income can include both a desire to get ahead of others, and a desire not to fall behind. Each motivation can lead to self-reinforcing dynamics that polarize income. See Brighthouse & Swift, *supra* note 145, at 475.

gatekeepers).¹⁸⁷ Presumably, opportunities for a “lifestyle” practice in primary care may cause some would-be dermatologists and radiologists to reconsider their specialization.¹⁸⁸ 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.¹⁸⁹ However, even if one concedes the desirability of this goal, the spread of retainer care seems a singularly inefficient way of achieving it. Physicians in the United States already earn two to three times as much as their counterparts in Europe.¹⁹⁰ 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 one-half of the patients borne by their non-retainer peers.¹⁹¹ Moreover, they primarily serve the type of sophisticated, wealthy health care

187. 2001 was the fourth straight year that the number of medical school seniors choosing primary care dropped. AM. ACAD. OF FAMILY PHYSICIANS, *supra* note 30.

188. Those concerned with controlling their hours often choose these very competitive residencies. See Sid Kircheimer, *Fewer People Want To Be Doctors: Med Students More Likely to Choose Specialties Based on Lifestyle*, WEBMD MEDICAL NEWS, Sept. 2, 2003, <http://my.webmd.com/content/article/73/82011.htm>.

189. 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. See LUDMERER, *supra* note 161, at 398. The federal 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. See DRANOVE, *supra* note 19, at 54. Commenting on the decline in medical school applications in the mid-1990s, 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.* at 129.

190. See Gawande, *supra* note 28; Paul Krugman, *The Medical Money Pit*, N.Y. TIMES, Apr. 15, 2005, at A16 (noting that American physicians earn two to three times as much as their European counterparts).

191. 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 ten or fifteen 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.

Devin Friedman, *Dr. Levine’s Dilemma*, N.Y. TIMES MAG., May 5, 2002, at 23 (internal quotation marks omitted).

consumers who seem best able to navigate the health care system on their own.¹⁹² Finally, there 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.¹⁹³

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.¹⁹⁴ 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.¹⁹⁵ Finally, and most importantly, the number of slots in undergraduate and graduate medical education are fixed, and there are far more applicants than slots for each.¹⁹⁶ Even if retainer care somehow motivated a

192. See *National Survey*, *supra* note 55, at 1082 (“[W]e found that retainer physicians have smaller proportions of patients with diabetes, and perhaps other chronic diseases, than do their non-retainer counterparts and they care for fewer African-American and 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.”).

193. See, e.g., Bollinger, *supra* note 36, at 513 (discussing the Mexico Physician Pilot Program).

194. See 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.”).

195. See *National Survey*, *supra* note 55, at 1079 (“Retainer physicians have much smaller patient panels (mean 898 vs. 2303 patients, $P < .0001$) than their non-retainer 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.”).

196. “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. COM., Mar. 4, 1997, at 8A (describing a “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 “[t]here 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.” Kircheimer, *supra* note 188 (quoting Barbara Barzansky, author of 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.¹⁹⁷

C. Treating the Sickest Patients?

Proponents of retainer care may claim that it takes upon itself a reverse moral hazard that ultimately alleviates pressures on the health care system. Under traditional moral hazard analysis, asymmetric information between purchasers and providers of health insurance can permit the former to take advantage of the latter.¹⁹⁸ 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 retainer care. This is a potentially powerful argument given the concentration of health care costs among the chronically ill (i.e., the sickest 10% of the population).¹⁹⁹ 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

study indicating that applications to the nation's medical schools have decreased since 1997).

197. 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 Letting the Market Determine the Health Workforce*, in *THE U.S. 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 incomes much below those now customary in the profession [why] their rejection serves the nation's best interest.").

198. See Malcolm Gladwell, *The Moral Hazard Myth*, *NEW YORKER*, Aug. 29, 2005 ("'Moral hazard' is the term economists use to describe the fact that insurance can change the behavior of the person being insured Insurance can have the paradoxical effect of producing risky and wasteful behavior. Economists spend a great deal of time thinking about such moral hazard for good reason. Insurance is an attempt to make human life safer and more secure. But, if those efforts can backfire and produce riskier behavior, providing insurance becomes a much more complicated and problematic endeavor.").

199. See John V. Jacobi, *Consumer-Directed 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 ten percent accounting for seventy 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.").

costs *in general* may be concentrated among the chronically ill, there is little evidence that primary care demand is similarly focused on this group.²⁰⁰ More directly, given the high percentage of retainer physicians reporting more leisure time after the transition to retainer 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 non-retainer counterparts and they care for fewer African-American and Hispanic patients.²⁰¹

To understand demand for retainer care, 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.²⁰² 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?²⁰³

200. *See id.*

201. *National Survey*, *supra* note 55, at 1082. The authors of the study do concede that their “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.*

202. *See* 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.”).

203. Eugene Volokh goes so far as to characterize this as a constitutional right to “medical self-defense.” Eugene Volokh, *Medical Self-Defense, Prohibited Experimental Therapies, and Payment for Organs*, 120 HARV. L. REV. (forthcoming 2007). However, he notes that distributive concerns could lead to a qualification of the right via regulatory price ceilings. *Id.* at 25 (“The ‘rich outbidding others’ concern . . . only supports capping payments at the level that all funders would

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.²⁰⁴ 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 professionals than is possible under the public system to which they also have access.²⁰⁵

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.²⁰⁶

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 retainer care in the United States’ 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

pay, likely the level at which they’ll still be saving money by getting an organ instead of paying for long-term dialysis.”). *See also* Frank Pasquale, *Medical Self-Defense or Bidding War*, Concurring Opinions, Nov. 13, 2006, available at http://www.concurringopinions.com/archives/2006/11/notes_on_medica.html.

204. *See* Jost, *supra* note 202, at 435 (“Countries that have national health insurance programs cover all of their citizens and long-term residents, although in most countries individuals can choose to carry private insurance and obtain services privately. Some countries with social insurance funds, such as France or Austria, cover their entire populations as well. Others, however, such as Germany and the Netherlands, only require people whose income falls below a certain level to be part of the social insurance program.”).

205. 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: PROCEEDINGS OF A WORLD BANK CONFERENCE 104-09* (George J. Schieber ed., 1997)) (describing the role of private health insurance in ten Organisation for Economic Co-operation and Development (OECD) and thirty-six non-OECD countries). *See also* Jost, *supra*, at 864 (“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.”).

206. *Chaoulli v. Attorney General of Quebec*, [2005] S.C.R. 791 (Can.) (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).

state, even at the cost of diverting suppliers away from the system overall,²⁰⁷ how can a sensible American 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, all of the nations that permit tiering also provide 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.²⁰⁸ 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.²⁰⁹

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

207. This diversionary impact is a well-documented phenomenon. *See, e.g.*, Calnan, *supra* note 118, at 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 power) have been ‘substituted’ for the less fortunate sick who remain on NHS lists”).

208. *See* Jacobi, *supra* note 9, 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.”).

209. *See, e.g.*, John Cullis, *Waiting Lists and Health Policy*, in RATIONING AND RATIONALITY IN THE NATIONAL HEALTH SERVICE 23-27 (S. Frankel & R. West eds., 1993); Calnan, *supra* note 118, at 17 (“[T]he 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.”); Stephen J. Duckett, *Private Care and Public Waiting*, 29 AUSTL. HEALTH REV. 87 (2005), available at <http://proquest.umi.com/pqdlink?Ver=1&Exp=1032011&FMT=7&DID=814702051&RQT=309&fc=1#fulltext> (reaching the conclusion that private care leads to longer public waits); Can. Health Servs. Research Found., *Myth: A Parallel Private System Would Reduce Waiting Time in the Public System* (2005), available at http://www.chsrf.ca/mythbusters/pdf/myth17_e.pdf (arguing that England and Australia both have private systems, and that it has been determined that waits for public health care are longest in areas that have the most private coverage); JEREMIAH HURLEY ET AL., PARALLEL PRIVATE HEALTH INSURANCE IN AUSTRALIA: A CAUTIONARY TALE AND LESSONS FOR CANADA, INST. FOR THE STUDY OF LABOR, Discussion Paper No. 515 (2002), <ftp://repec.iza.org/RePEc/Discussionpaper/dp515.pdf> (reaching the conclusion that a second, private tier creates more problems than it solves, notably it decrease in public access to health care).

inequality.²¹⁰ There is 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.²¹¹

Finally, more progressive income taxation in these universal systems dampens supply-side pressures toward retainer care as well.²¹² As advocates of laissez-faire never tire of reminding us, higher income tax rates reduce the incentive to maximize one's income.²¹³ We can therefore expect the higher income tax rates in social democracies to diminish physicians' incentive to switch to a retainer model.

210. See FRANK & COOK, *supra* note 163, at 213 (proposing progressive taxation to reduce the inequality that exacerbates positional pressures).

211. See 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) ("Estimates suggest that as one's income increases by some percentage, the demand for health insurance also increases, but at roughly half that rate."). "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*, in GLOBAL HEALTH WATCH 2005-2006: AN ALTERNATIVE WORLD HEALTH REPORT 55, 63 (Claudia Lema et al. eds., 2006), available at <http://www.ghwatch.org/2005report/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.'").

212. For a good list of countries providing more comprehensive insurance than the United States, see DANIEL CALLAHAN & ANGELA A. WASUNNA, *MEDICINE AND THE MARKET* 89 (2006). See also Chiara Bronchi & Flip de Kam, *The Income Taxes People Really Pay*, OECD OBSERVER, Apr. 1999, at 13, available at <http://www.oecdobserver.org/news/fullstory.php3?aid=77> (in the chart provided, only South Korea and Hungary had lower income taxation than the U.S.); Timothy Stoltzfus Jost, *Our Broken Health Care System and How to Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537, 538 (2006) ("[T]he quality of the health care Americans receive is no better, and in some respects worse, than that provided in many other countries that spend far less on health care and yet provide it for all of their citizens.").

213. See Christine Jolls, *Behavioral Economics Analysis of Redistributive Legal Rules*, 51 VAND. L. REV. 1653, 1655 ("[T]he animating feature of both lawyers' and economists' analyses of tax schemes is their potential to distort people's work incentives.").

V. CRAFTING A TAILORED REGULATORY RESPONSE

The concerns raised in Part IV suggest that retainer care deserves more, not less, regulation. Part III suggested a principled way for the Medicare program to discourage retainer 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.²¹⁴ Finally, if retainer services are offered to Medicare beneficiaries at below-market rates, they may constitute “inducements” forbidden under the relevant fraud and abuse laws.²¹⁵

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 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.²¹⁶ These embryonic interventions 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. Washington state began to do so by characterizing

214. GOSFIELD, *supra* note 34, at (paraphrasing 42 U.S.C.A. § 1320a-7(b)(6) (West 2006)).

215. See 42 C.F.R. 1003.101 (2004). For a brief account of the inducement provisions, see OFFICE OF INSPECTOR GEN., SPECIAL ADVISORY BULLETIN: OFFERING GIFTS AND OTHER INDUCEMENTS TO BENEFICIARIES (2002), available at <http://www.oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf>. See also Russano, *supra* note 6, 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.’”).

216. Carnahan, *supra* note 115, at 122 (“[C]oncierge physicians face numerous legal obstacles from state insurance regulators, private insurers, and the federal government.”). See also *National Survey*, *supra* note 55, at 1080 (stating that retainer care practices continue to form across the country, with the greatest concentration found in large cities and coastal states, particularly Washington and Florida).

retainer practices as insurance providers.²¹⁷ 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 achieving access for the poor – would assure some principled results from the tiering that retainer care is intensifying.²¹⁸

A. Retainer Care Agreement as Insurance Contract?

Since they sell unlimited amounts of physician time in return for a flat fee, retainer care agreements have been deemed a form of insurance in several states.²¹⁹ As the Deputy Insurance Commissioner in Washington stated, “[t]he 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.”²²⁰ Even if a doctor purposely limits her patients to a low number,

217. See Carnahan, *supra* note 115, at 132-34 (“In Washington State, the Office of the Insurance Commissioner (OIC) became concerned that this model may run afoul of state laws that required insurers of health care to have a certificate of registration. The OIC’s position was that the arrangement whereby patients paid a fixed fee for the receipt of all primary care services, including future services, transferred risk from the patient to the provider.”); Office of the Ins. Comm’r of Wash., *Engaging in Activities Requiring a Certificate of Registration*, 1 Technical Assistance Advisory Draft (2003), available at http://www.insurance.wa.gov/special/accessfees/removed/provider_plans_draft_taa.doc.

218. Note that even advocates of retainer care concede this tiering effect. See, e.g., AMA CMS REPORT, *supra* note 47, at 2 (“Although critics appear to suggest that retainer practice is a radical departure from the way care is currently financed and delivered, a multitiered system of care already exists in the United States, with higher levels of service going to those patients whose health benefit plans offer a wider array of benefits or less parsimonious rates of payment.”).

219. See, e.g., Doughton, *supra* note 76 (“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.”).

220. Peter Neurath, *Medical Retainer Fees Violate Law, Ruling Says*, PUGET SOUND BUS. J., August 1, 2003, available at <http://seattle.bizjournals.com/seattle/stories/2003/08/04/story6.html>. Deputy Insurance Commissioner Beth Berendt said 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.* See also Office of Ins. Comm’r for the State of Wash., *Forum for Review of Draft Technical Advisories to Health Carriers and their Participating Providers* (2003), available at <http://www.insurance.wa.gov/special/accessfees/removed/public%5Fforum%5Fpresentation.ppt>.

she risks simultaneous demands for care from two or more patients.²²¹ Furthermore, retainer practices might go out of business before they can fulfill their promise to provide care.²²² Each of these risks is reminiscent of the types of problems insurers often have to bond or reinsure against.²²³

Washington²²⁴ and New Jersey²²⁵ have been most aggressive, issuing rules and interpretations that discouraged retainer care. Other states have issued warnings and guidance, but have done little to actually intervene.²²⁶ If they were regulated as insurers, retainer practices would have to satisfy potentially onerous

221. Steven Flier and Jordan Busch did this when they began PPHC, intentionally limiting themselves to about 300 patients per physician. STOLLER & FERRARONE, *supra* note 140, at 7 (quoting Flier and Busch). Some retainer practices may contract with even fewer families per physician. *Id.* at 13-14.

222. 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.

223. See Portman, *supra* note 2, at 4 (“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 bonded against the possibility it cannot provide the services/coverage purchased in advance in consideration for the premium.

224. See *id.* at 5 (indicating that 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.”)

225. BOWDEN & FOUST, *supra* note 144 (“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.”).

226. Some appear to tacitly, if not explicitly, endorse retainer care as a legitimate new method of health care financing. See, e.g., Portman, *supra* note 2, at 5 (“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 insurance providers and state officials before launching the pioneer Boston retainer practice, Personal Physicians HealthCare, and currently retains lobbyists to assure favorable regulatory treatment. See STOLLER & FERRARONE, *supra* note 140, at 15-16.

capitalization requirements, and could not be as flexible in choosing their group of patients.²²⁷ Retainer practices have aggressively lobbied for exceptions or favorable interpretations of the relevant laws, and appear to have stalled legal interventions in two states.²²⁸

For example, the state of Washington initially moved to characterize retainer practices as insurers,²²⁹ thereby requiring them to certify that they are financially prepared to deal with the “risks” of the practice.²³⁰ 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.”²³¹ 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 politicians. The New Jersey Department of Health and

227. See Doughton, *supra* note 76 (“[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, [Washington Deputy Insurance Commissioner Beth] Berendt said. The state also makes it difficult for insurers to kick out patients.”).

228. *Id.*

229. *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.”).

230. See BOWDEN & FOUST, *supra* note 144, at 7 (stating that the Insurance Commissioner permitted retainer care “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 Marquis, *supra* note 2, at 18 (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 successful opposition to the Insurance Commissioner’s effort to get the legislature to “codify the content” of its advisories as a statute).

231. Romano & Benko, *supra* note 81, 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.”)

Human Services and Department of Banking and Insurance issued a memorandum prohibiting insurers from contracting with doctors who require patients to pay fees for access, even when fees are for additional services.²³² 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.²³³ However, it is difficult to assess the legal force of this document, and it is hard to find evidence that retainer care has been eliminated in New Jersey.²³⁴

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.²³⁵ 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

232. Holly Bakke, Dep't of Banking & Ins. State of N.J. (DOBI), & Clifton Lacy, Dept. of Health & Senior Services (DHSS), State of N.J., DOBI/DHSS Bulletin 2003-02 (Aug. 8, 2003), available at <http://www.state.nj.us/dobi/bullet03.shtml> [hereinafter DOBI/DHSS Bulletin].

233. *Id.* at 2 ("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.").

234. Silverman, *supra* note 12, at 6 ("Health departments and insurance commissioners pose another credible risk to [retainer] practices. In 2003, New Jersey's health department found that physicians who already had contracts with HMOs were requiring HMO patients to pay an annual fee to get into their practices. . . . New Jersey asserted that this requirement was illegal, even though the fee in these practices was limited to services that were clearly not covered by the health plan. 'They're stating, 'We don't care if the service is covered by the health plan or not. It's illegal if you charge that 'poll tax' for a patient to get into the practice,' Mr. Marquis said.'").

235. 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.

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?²³⁶

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.²³⁷

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

Given the legal uncertainty surrounding the regulation of retainer 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 retainer care practitioners use the time gained from retainer practice to provide pro bono care – a model that is well established in legal practice.²³⁸ 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 physicians, the hospital is using the money "to subsidize the hospital's primary care practice."²³⁹

To the extent these countervailing, socially conscious practices arise out of

236. Thomas Mayo, *Medical Retainer Fee (a/k/a "Boutique Medicine") Nixed in Washington*, HealthLawBlog (Aug. 5, 2003), http://healthlawblog.blogspot.com/2003_08_01_healthlawblog_archive.html. Nevertheless, one practitioner warns that any retainer practice which "provides unlimited physician office visits" might end up being regulated as an insurer. See Portman, *supra* note 2, at 4-5 ("Unlike physician networks or IPAs [Independent Practice Associations], 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 – [that] 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.").

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

238. See Silverman, *supra* note 62 ("Charity care for retainer physicians averaged 9.14 hours per month versus 7.48 hours per month for nonretainer practices.").

239. 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*, PRAC. BUILDERS, Sept.-Oct. 2003, at 1.

retainer care, we might say that it causes “difference principled” tiering, after the famous proviso of Rawls’ *A Theory of Justice*, which stipulates that any increase in inequality is acceptable to the extent it raises the welfare of the least well off.²⁴⁰ 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 promote “difference principled” tiering arising out of retainer care.

For example, states have already addressed the diversion of medical resources to non-medical ends via tax policy in the context of plastic surgery. New Jersey has imposed a six percent tax on cosmetic plastic surgery procedures.²⁴¹ Illinois has been considering a similar effort with redistributive designs – funds from a “vanity tax” would be earmarked for medical research.²⁴² A similar tax on the amenities bundled into retainer care agreements would help assure that some portion of the money spent to divert medical resources to non-medical 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 retainer 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.²⁴³

240. JOHN RAWLS, *A THEORY OF JUSTICE* 54 (1999) (“All social values – liberty and opportunity, income and wealth, and the social 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.

241. N.J. STAT. ANN. § 54:32E-1 (West 2006) (“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 Susan Jones, *New Jersey Taxes Cosmetic Surgery*, CNSNews, July 1, 2004, <http://www.cnsnews.com/ViewNation.asp?Page=%5CNation%5Carchive%5C200407%5CNAT20040701a.html>.

242. Beth Kapes, *Vanity Tax Would Fund Stem Cell Research*, COSMETIC SURGERY TIMES, May 1, 2005.

243. See Maureen L. Cropper & Wallace E. Oates, *Environmental Economics: A Survey*, 30 J. ECON. LIT. 675, 703-10 (1992) (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

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.²⁴⁴ Similarly, we can begin to assess the value of a given retainer perquisite by comparing the cost of joining that 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 its office’s infrastructure, including a luxury waiting area appointed with fine furniture and art.²⁴⁵ 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, Tufts University hospital, a teaching hospital in Massachusetts, has used retainers to fund its charity care.²⁴⁶ To the extent a retainer practice takes on this type of redistribution itself, it might be exempted from taxation designed for the same ends.²⁴⁷ Furthermore, a state may decide not to tax retainer revenues that support

costs). See also Brian R. 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); Frank B. Cross, *Natural Resource Damage Valuation*, 42 VAND. L. REV. 269 (1989); David A. McKay, *CERCLA’s Natural Resource Damage Provisions: A Comprehensive and Innovative Approach to Protecting the Environment*, 45 WASH. & LEE L. REV. 1417 (1988).

244. See DAVID PEARCE & DOMINIC MORAN, *THE ECONOMIC VALUE OF BIODIVERSITY* 71 (1994) (stating that 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.”).

245. See STOLLER & FERRARONE, *supra* note 140, at 10.

246. See Russano, *supra* note 6, at 323.

247. Another example is a cataract clinic in India mentioned in an article generally supportive of retainer care. The author mentions

[a] scenario whereby the profits from the boutique practice 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, Am. Acad. of Med. Adm’rs, *Boutique Medicine: Good Medicine With a Bad Taste or Just Bad Medicine?*, <http://www.aameda.org/MemberServices/Exec/Articles/winter03/boutiquemedMatus.pdf> (citing JOAN MAGRETTA, *WHAT MANAGEMENT IS* (2002)) (last visited Dec.

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.”²⁴⁸ This latter 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 fifty 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 non-medical ends.²⁴⁹

CONCLUSION

The appeal of retainer care arrangements to physicians is undeniable. Unfortunately, what is professionally and personally rewarding for retainer care physicians may harm society as a whole. Retainer care raises difficult policy questions because it combines positive incentives (for more primary care physicians providing a higher quality of care) with financing methods that further stratify access and threaten to generate a bidding war for supplemental, provider-sponsored insurance.

Legal disputes over retainer care have tended to focus 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

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248. Specialty hospitals have raised concerns because they divert the most lucrative cases to specialized centers that usually do not provide the levels of community services expected from general hospitals. See FURROW ET AL., *supra* note 82, at 217-18 (discussing state taxation and regulation of specialty hospitals); U.S. GEN. ACCOUNTING OFFICE, SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, SERVICES PROVIDED, AND FINANCIAL PERFORMANCE, GAO REP. NO. 04-167, at 4 (2003); William J. Lynk & Carina S. Longley, *The Effect of Physician Owned Surgicenters on Hospital Outpatient Surgery*, 21 HEALTH AFF. 215 (2002).

249. The non-medical 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 three years of retainer practice. See STOLLER & FERRARONE, *supra* note 140, at 12. Demanding a panel of less than this size 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 191 (“[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.”).

services into preventive care, queue-jumping, and amenity-bundling. To the extent a retainer practice can plausibly claim that its patients' retainers are funding non-covered 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 retainer care business model, most retainers would constitute violations of 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 budgetary crises lead to further cuts in Medicaid, the uninsured third-class of American health care consumers is sure to suffer more privations.²⁵⁰ 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 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 can check them.

250. See Bob Herbert, *Curing Health Costs: Let the Sick Suffer*, N.Y. TIMES, Sept. 1, 2005, at A23 (describing cuts to TennCare program); Gardiner Harris, *Gee, Fixing Welfare Seemed Like a Snap*, N.Y. TIMES, June 19, 2005, § 4, at 3; Robert Kuttner, *Taming the Medicaid Monster*, BOSTON GLOBE, Feb. 16, 2006, at A19; John Jacobi, *supra* note 33 (arguing that many proposed Medicaid reforms would, in addition to weakening Medicaid, also weaken the safety net for the uninsured.).

