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Retainer-Based Physicians: Characteristics, Impact, and Policy Considerations

*A study conducted by staff from NORC at the University of
Chicago and Georgetown University for the Medicare
Payment Advisory Commission*

Retainer-Based Physicians: Characteristics, Impact, and Policy Considerations

Final Report

NORC
at the UNIVERSITY OF CHICAGO

Submitted to:

Cristina Boccuti
Medicare Payment Advisory Commission

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March 2010

MedPAC Task Order E4058967

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Executive Summary

Retainer-based medicine, also called concierge medicine, boutique medicine, or direct care, is a practice model in which physicians charge each patient a monthly or annual fee, or retainer. In exchange, doctors limit the number of patients they see, offering greater access, longer appointments, and more personalized care to their patients. Typically, the fee also covers some care, including annual physicals or "wellness exams," and sometimes other primary care. This report examines the characteristics of retainer physicians and their patients, as well as the impact of this practice model on Medicare beneficiaries and its relationship to state and federal laws and regulations. We draw on a literature review as well as 28 interviews with experts in the field, beneficiary advocates, and individual physicians.

There are three major models of retainer medicine. In the first and probably most common model, which we call "fee for extra services," a patient pays an annual fee to be part of a physician's patient panel. The patient receives an annual physical in exchange for this fee, but continues to pay for office visits other than the physical. Most of these physicians participate in Medicare and accept private insurance. In the second, which we call "fee for care," the patient pays a fee that covers all primary care provided by the physician. Patients do not pay per-visit fees, and physicians typically do not charge Medicare or insurance. In a third, "hybrid" model, physicians continue to see non-retainer patients, while charging a fee to some of their patients for increased services. A typical retainer fee appears to be about \$1,500 to \$2,000, although the physicians we interviewed charge from \$600 to \$5,400.

Most retainer physicians offer an in-depth annual physical, lasting an hour or longer, which focuses on preventive care. Retainer practices also emphasize that their patients have increased access to their physicians. This usually includes longer office visits, same-day visits, and access to physicians' cell phone numbers. Physicians may also visit patients in the hospital or at home more often than in a non-retainer setting.

To accommodate this increased access and longer visits, retainer physicians have much smaller patient panels than non-retainer physicians. The physicians we interviewed had between 100 to 425 patients, compared to over 2,000 before starting or joining a retainer-based practice. Other studies have reported a larger average number of patients in retainer-based practices.

We found listings for 756 retainer-based physicians, which could be seen as a lower limit for the number of physicians practicing this model of care. This is an increase from the 146 retainer physicians identified by the U.S. Government Accountability Office (GAO) for a 2005 report. We identified retainer practices in all but 11 states, but they tend to be concentrated in urban areas. We found the most retainer practices in the metropolitan areas of Los Angeles, Miami, and Washington, DC; Naples, Florida, has the most retainer physicians as a proportion of the population.

The vast majority of retainer physicians are in primary care. Among those we interviewed, all had at least 7 years of experience, but had been in a retainer practice for fewer years. About three-fifths are in solo practice. The largest retainer practices that we found included 7 physicians.

Most retainer physicians said the extra time they spend with patients is the most attractive and important aspect of the model for them. They have more time and are experience less stress than in their previous practices; several said this practice model had kept them in primary care. Some said they make more money than they did in a non-retainer practice, but others said they make a similar amount for far less work and stress.

Because the field of retainer medicine is so new, there have not been extensive studies to compare patient outcomes between retainer care and standard care. Several of the people we interviewed gave examples of cases where they believed the extra attention patients received in a retainer practice resulted in better outcomes or more continuity of care. Some also believed they were providing care in a lower-cost way, by keeping patients out of the emergency room, making fewer specialist referrals, or duplicating fewer labs. One said he prefers to practice retainer medicine, but does not think the patients in his retainer practice are better off medically than they were in his former practice. This is a question that could benefit from further research, as it is not possible to draw conclusions about outcomes based on interviews with 16 physicians.

While some of the physicians we interviewed felt the demographics of their patient panel had not changed, those who did notice patterns described two categories of patients who were more likely than others to opt to remain in a retainer-based practice. One category, often portrayed in media reports about retainer medicine, was high-income patients for whom “time is more important than money.” In addition, physicians said patients with complex medical conditions or multiple chronic conditions had been more likely to stay with their practice. We heard from several physicians that some of their elderly patients' children paid their retainer fees, either to ensure continuity of care or to acquire the increased level of care and reassurance that the retainer physician offered.

We spoke with many beneficiary advocates, and none was aware of retainer medicine creating population-level problems with access to care. However, they spoke of a few individual Medicare beneficiaries for whom the decision over whether to stay with a physician and pay a retainer fee was very difficult. Among the physicians we interviewed, there was a wide range in estimates of the number of Medicare beneficiaries in their patient panels, from fewer than 20 percent to over 60 percent of patients.

Several states have taken specific regulatory or legislative action to clarify the rules under which retainer-based practices must operate. The primary Medicare policy relating to retainer medicine is a memorandum issued by the Office of the Inspector General (OIG), Department of Health and Human Services, clarifying that any extra charges by physicians must be for non-covered services. As a result, many retainer physicians clearly state that their retainer fee primarily covers the extensive annual physical, which is not covered by Medicare.

Retainer-Based Physicians: Characteristics, Impact, and Policy Considerations

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This report examines the characteristics of retainer medicine and its growth since the first retainer-based practice, MD² (MD Squared), opened in 1996 in Seattle.¹ As this report discusses, many variations on this basic construct have evolved since MD² pioneered the concept, as participation in retainer medicine has grown. We examine the characteristics of retainer physicians and their patients, as well as the impact of this practice model on Medicare beneficiaries and its relationship to state and federal laws and regulations.

To gather this information, we began with a literature review. In particular, this study builds on two prior surveys of retainer-based physicians. A 2005 report from the U.S. Government Accountability Office (GAO), *Physician Services: Concierge Care Characteristics and Considerations for Medicare*, reported the results of a fall 2004 survey of 112 retainer physicians. GAO also interviewed government officials and representatives of Medicare beneficiary advocacy groups and reviewed relevant laws, policies, and available data on access to physician services.² A survey of 144 retainer and 463 non-retainer physicians conducted by researchers in 2005 provided data on physician demographics, size and case-mix of patient panels, services offered, and the characteristics of retainer practice development.³

In addition, we conducted 28 interviews: 12 interviews with management and advocacy organizations, physician policy experts, and beneficiary organizations, and 16 interviews with individual retainer physicians (see Appendix for details on selecting these physicians). In reporting on these interviews, we emphasize that the small number of interviews in this exploratory study limits our ability to generalize to all retainer-based practices. Nevertheless, we suggest that the interviews, especially when combined with findings from other studies, allow us to draw some conclusions about retainer-based practices.

¹ Hoffman, William. "Fed up, some doctors turn to 'boutique medicine'" *American College of Physicians-American Society of Internal Medicine Observer*, October 2001.

² U.S. Government Accountability Office (GAO). "Physician Services, Concierge Care Characteristics and Considerations for Medicare." Report No. GAO-05-929, August 12, 2005.

³ Alexander, Caleb, Jacob Kurlander, and Mathew Wynia. "Physicians in Retainer ("Concierge") Practice, A National Survey of Physician, Patient, and Characteristics, *Journal of General Internal Medicine* 20, no. 12 (2005): 1079-83.

Design of Retainer-Based Practices

Three models of retainer practice can be broadly defined based on the types of services that are provided to participating patients. However, even within those three main models, there is a great deal of variation in practice management, services offered, fees charged, and acceptance of insurance. Physicians also differ on how they wished to characterize or refer to their practices. Some objected to the term “concierge care” and others preferred it. Several were more apt to stress the preventive care aspect of the practice. A number said they prefer the term “direct practice.” Their preferences were not necessarily correlated with their practice models. In this report, we have selected terms that seem to characterize the most important aspect of each model.

Practice Models

We made an effort to interview physicians using each of the general practice models that we identified. The proportion of physicians in our sample may not be representative of all retainer physicians.

Fee for extra services. In this model, a patient pays a fee to be part of a physician’s patient panel. The patient receives an annual physical in exchange for this fee and may receive other services that generally are not covered by insurance, such as enhanced preventive care, but continues to pay for office visits other than the physical. The physician may or may not accept private insurance for office visits.

Six of the 16 physicians we interviewed used this practice design, including three solo practitioners, one two-person practice, and two small hospital-based groups comprising three or four physicians who practice within a larger medical center. This practice design is also the model used by the management company working with the most retainer physicians, MDVIP.

Fee for care. The fee that the patient pays in this model covers all primary care that is provided by the physician. Some fee for care patients purchase high-deductible insurance for services they may need beyond the primary care. Some fee for care physicians negotiate with employers who pay the fee on behalf of their employees. Generally, fee for care physicians do not accept private insurance.

We interviewed six physicians using this design, in both solo and group practices. This model is slightly newer than the fee for extra services model. It was pioneered in 1997 by a Seattle physician who went on to found Qliance, which is now a seven-physician practice, one of the largest we found in this study. The Qliance practice was mentioned by several physicians we interviewed as a practice arrangement they were aware of.

Hybrid models. Some physicians offer their patients a choice of retainer or more traditional non-retainer practice options. The hybrid model may represent a decision on the part of the physician to keep the practice open to all types of patients, either because of a commitment to keep seeing patients who cannot or will not pay the retainer fee or because of a calculation that a full retainer practice is not financially viable. In other instances, the hybrid model may be adopted as part of a transition strategy as a physician builds a retainer practice.

We interviewed four physicians using the hybrid design. All were either solo or two-person practices. Three of the four offered the “fee for extra service” retainer option with a non-retainer option. The fourth is a retainer practice that offers patients several levels of membership (VIP, VIP Silver, and VIP Gold). Both “fee for extra service” and “fee for care” options are available. In the more successful hybrids, the differences between services available to retainer and other patients are apparent. In one practice, for example, the physician provides all of the services for retainer patients, but other patients mostly see the physician assistant. Practitioners in the less successful hybrid practices noted that because they treated everyone the same way there was little incentive for patients to pay the retainer fees. One noted that she knew she was not being smart from a business perspective, but that it was difficult for her and her staff to maintain two different practice styles.

Practice Management

Several national organizations are associated with the management of retainer practices. The largest and perhaps best known is MDVIP, which specializes in helping physicians make the transition to the “fee for extra services” practice model and then helps manage the practices. In 2009, MDVIP represented about 350 physicians and 120,000 patients. MDVIP physicians generally sign five-year contracts with the organization. Their patients typically pay an annual fee of \$1500, one-third of which goes to MDVIP. As MDVIP has become better known, a number of physicians have designed their practices based on the MDVIP model, but do not contract with the organization.

Other organizations, such as Signature MD, also offer management services for physicians seeking a similar design. Among organizations working with hybrid practices, the Concierge Choice franchise is perhaps the most well known. Some of the physicians we interviewed had turned to smaller regional or local management firms.

Many physicians establish and maintain retainer practices on their own. Several physicians spoke of having conducted research or consulted attorneys before they made the switch to retainer practices. The Society for Innovative Medical Practice Design (SIMPD), which has several hundred members, was cited by a number of the physicians with whom we spoke as having been a particularly helpful resource when they began thinking about opening or making a transition to a retainer practice.

We spoke with two physicians in larger groups who described themselves more as employees of a firm than as partners in a practice. These physicians are paid a salary, and are not very aware of the billing practices of their groups. It was not clear how much they may share in the profits of these firms when they do well.

Services Offered

Most retainer physicians offer an in-depth annual physical that is an hour or longer and focuses on preventive care. This physical often includes many tests that might not be included in a shorter physical. For example, a “fee for extra services” doctor we talked with described tests that are part of the physical patients get in her office: breathing, hearing, and complete vision tests, EKGs for everyone, a large battery of blood tests including tests for heart conditions, screening for Alzheimer’s, depression, and

sleeping problems, discussions of diet and other health matters. The time she allots for a physical has increased from 30 minutes in a non-retainer setting to 90 minutes in her current practice, which was fairly typical among the physicians we interviewed. Some doctors practicing the “fee for care” model also spoke about providing more complete physicals, but stressed that they only order the tests or provide the counseling that they think each patient may need.

Retainer practices emphasize that their patients have increased access to their physicians. As one physician put it, “What they get is access to us and basically they are buying our time.” Another said, “I sell myself.” Commonly, retainer patients are given physicians’ cell phone numbers so they can reach their doctors directly at any hour. Many also encourage their patients to communicate with them by email. Many of the doctors reported that they are able to visit patients in the hospital more frequently than they did in their non-retainer practices, and some make home visits.

In addition, most retainer physicians offer much longer office visits than in a typical physician’s office. Many physicians described a typical visit as lasting half an hour. Same or next day appointments are usually available. None of the physicians with whom we spoke mentioned that they provide particularly upscale facilities or amenities for patients, but several said that they may have only one patient in the office at the time of the visit.

Other preventive services that retainer practice may offer include nutrition and wellness programs, smoking cessation services, and more patient education. Two doctors mentioned that they provide a personalized CD with medical information for each patient. A couple of doctors mentioned that they review their patients’ medications and one noted that she will make house calls to help with medication management.

Several physicians said they see their patients for services they might have referred to a specialist when they practiced in a non-retainer setting. They also reported being more involved when a patient does go to a specialist: they are able to ensure that they get reports back from specialist, review the reports, and often discuss the results with the patient before the patient makes a decision about how to proceed. A few even attend some specialist appointments with their patients. Several of the physicians we interviewed also talked about their ability to make referrals to well known specialists such as those at the Mayo clinic, either because of their own connections or those of the management firm they use.

Fees

The fee charged by retainer practices varies widely. In the 2004 GAO survey the annual membership fee ranged from \$60 to \$15,000 among the respondents, with fees averaging about \$1,500.⁴ In the 16 practices interviewed for this report, annual fees for adults ranged from almost \$600 to \$5,400. Most were in the \$1,500 to \$2,000 range. Five of the 16 doctors we interviewed charge different fees for different types of patients. In two cases, charter members of the retainer practice pay lower fees than others. In three cases the fee is based on age. One of those practices further differentiates fees, charging higher fees for patients who see internists than for those who see family practitioners. And

⁴ GAO, “Physician Services, Concierge Care Characteristics and Considerations for Medicare.”

one doctor reported that her practice charges more for all Medicare patients because Medicare reimbursement rates are so low. Finally, as described above, one of the hybrid practices charges different fees for different levels of service.

In addition to the annual retainer fee, “fee for extra services” practices charge for visits beyond the annual physical. The charge may be a flat fee, such as \$30 or \$50 per visit, or it may be a charge similar to what a non-retainer practice would charge. As discussed in the next section, some practices accept insurance for these fees, and others do not.

Most of the physicians we interviewed said they see a small number of patients who do not pay fees or who pay reduced fees. Two physicians reported, for example, that they continue to see some of the patients who were in their practices before they transitioned to retainer practices, but could not afford the new fees. Several offer discounts for couples. Two will see the children of their retainer patients under certain circumstances without charge.

There are references in the literature to some very high-end practices that charge \$10,000 to \$20,000 per year.⁵ These practices cater to wealthier patients who can afford the substantial retainer fee, and often offer more amenities, including one practice that provides “heated towel racks, marble showers and personally monogrammed robes.”⁶ These practices typically keep a much smaller patient panel size, even compared to other concierge practices. For example, MD² limits patient panel size to no more than 50 individuals or families.⁷ We also heard about a few high-end practices, including one run by plastic surgeons and one located in a hotel, which market their services to older patients who want to be “active and vital” and are interested in “age rejuvenation.”

Acceptance of Health Insurance

Retainer practices vary in their patient health insurance and Medicare policies. One-fourth of the physicians responding to the GAO report said that they did not bill any patient health insurance, including Medicare. As discussed in a later section, most of those not taking Medicare had taken the formal step of opting out of the Medicare program.

All of the “fee for extra services” practices that we interviewed are participating providers for Medicare. All but one accept private insurance; this approach to insurance is a standard part of the model for organizations such as MDVIP. One of the “fee for extra services” physicians we interviewed also accepts Medicaid patients (and waives their retainer fee for those patients). Several of the physicians who currently accept Medicare said that they have thought about opting out because of the current low fees or proposed fee cuts they have heard about.

⁵ Zuger, Abigail. “For a Retainer, Lavish Care by 'Boutique Doctors'” *New York Times*, October 30, 2005.

⁶ Belluck, Pam. “Doctors' New Practices Offer Deluxe Service for Deluxe Fee.” *New York Times*, January 1, 2002.

⁷ Hoffman, William. “Fed up, Some Doctors turn to 'Boutique Medicine'” *American College of Physicians-American Society of Internal Medicine Observer*, October 2001.

By contrast, none of the “fee for care” practices we interviewed accepts private insurance. One of the six practices accepts Medicare, but is considering a change in policy because of the low reimbursement rates and because of concerns about Medicare regulations. Having already dropped other types of insurance, he notes that he has consistently been advised to drop out of Medicare as well, but has not yet done so because he wants to continue to provide hospice care, an aspect of his practice that he finds particularly rewarding.

All of the hybrid practices participate with Medicare, and three of the four accept private insurance. For these practices, these insurance relationships may be even more important because they continue to see patients who are not paying the retainer fee.

Transitioning a Practice to Retainer-based Care

Physicians who choose to move to a retainer model may make the transition in different ways, and these choices may have different impacts on the patients that had been seeing the physician in a non-retainer setting. The most common scenario we heard from the physicians we interviewed was those who left a group practice to start a one- or two-physician retainer practice. The patients who chose not to follow these physicians were generally accommodated by the original group practice. Some retainer physicians mentioned that the group they left hired a new physician to replace them, and all of their patients were transferred to this new physician. These physicians often expressed that it was important to them that they had helped to hire a replacement before they left their groups.

Others who had left group practices said their patients were absorbed more generally by the group, without being directed to a specific replacement. These physicians were generally less clear on how that process had worked.

Two physicians who had already been in solo practice did not have a specific physician or group to which they referred their patients. Instead, patients who decided not to pay the retainer fee were given a list of other physicians in the area. MDVIP has a standard protocol they use for the retainer practices they manage. They work with physicians to inform their current patients about the transition they are about to make. They send letters to the patients and invite them to attend information sessions to learn more about the new practice. They also offer to talk individually with patients who may have questions about the transition. As part of the transition process, current patients are given a list of physicians in the area who have agreed to accept new patients. Physicians who have large practices and may not be able to accommodate all of their interested patients in the new practice offer their patients the chance to sign up for the retainer practice on a first-come-first-served basis. The process lasts for several months.

We also heard from one physician about her policy that during the transition that she would continue to see patients with current medical problems until the problems were resolved even if the patient chose not to become part of the retainer practice. For example, she would follow a patient who had been hospitalized until the episode was resolved. Patients with ongoing conditions such as diabetes had to pay the retainer fee to obtain ongoing care.

Two of the physicians we interviewed initially started a retainer practice, not having been in an office-based practice immediately prior. Rather than having to turn away patients, the primary issue for these physicians was recruiting patients.

The physicians practicing in a hybrid model now have some patients who pay a retainer fee, but they also continued to see all of the patients who chose not to pay the fee.

Characteristics of Retainer-based Physicians

The retainer-based practice design that we have described has been growing, and is geographically widespread. In this section, we look at the location, size, and other characteristics of retainer-based practices, as well as some of the physician attitudes we encountered surrounding retainer practice.

Number of Retainer-based Physicians

Almost a decade and half after it began, retainer-based care still remains a relatively small niche. It is difficult to determine the number of retainer-based practices in the United States because no single entity tracks the number of these practices. However, the number of retainer practices appears to be growing. For a 2005 report, the GAO found 146 retainer-based physicians. They estimated that the total number of physicians practicing retainer-based care had increased by more than 10 times from 1999 to 2004.

In 2004 and 2005, most estimates put the number of retainer-based doctors at approximately 250, with some estimates as high as 500.^{8,9} By 2008, one report estimated the number of retainer-based doctors at about 1,000 practicing physicians.¹⁰ The experts we spoke with varied in their estimates of the current number of retainer-based physicians. The highest estimate was 2,500, but two others were in the range of 1,000 to fewer than 1,500. None believed a claim that has circulated in the press that there are 5,000 retainer-based physicians currently in practice.^{11,12}

For this project, we conducted a web-based search for retainer-based physicians in the fall of 2009 (see Appendix for details). We compiled this list through lists available on the websites of the Society for Innovative Medical Practice Design, MDVIP, Concierge Choice, an online directory at <http://conciergemds.com/>, and news stories about retainer-based care. Through these methods, we were able to identify 756 physicians listed as having a retainer-based practice. It is important to note that this list represents a minimum number of physicians in this type of practice. It is likely that there are physicians who are practicing this model of care without being listed in any of these sources.

⁸ Tyre, Peg. "House Calls." *Newsweek*, February 7, 2005.

⁹ Zipkin, Amy. "The Concierge Doctor Is Available (at a Price)." *New York Times*, July 31, 2005.

¹⁰ Jenkins, Chris L. "Unwelcome Surprise- Fairfax Doctors' Shift to Boutique Care Leaves Patients Weighing Options." *Washington Post*, March 18, 2008.

¹¹ Sack, Kevin. "Despite Recession, Personalized Health Care Remains in Demand." *New York Times*, May 10, 2009.

¹² Beck, Melinda. "Health Matters." *Wall Street Journal*, February 14, 2009.

Retainer-based medicine does continue to be a primarily urban phenomenon. All but a dozen of the physicians on our list practice in a metropolitan area.¹⁵ One respondent speculated that because this model of care only attracts a small percentage of the population, retainer-based practices are most likely to be successful in large population centers.

In fact, half of the retainer physicians on our list are concentrated in just 11 metropolitan areas (Exhibit 2). All of the ten largest cities in the US have at least 10 retainer physicians. But there are far smaller MSAs with more physicians in this type of practice. For example, there are 16 retainer physicians in the Naples, Florida, area, which has a population of just 315,000. Exhibit 3 shows the MSAs with the highest ratio of retainer physicians to population.

Exhibit 2. MSAs With Ten or More Retainer Physicians Identified

Metropolitan Statistical Area	Retainer Physicians Identified	% Of Retainer Physicians Identified	Retainer Physicians Identified Per 100,000 Population
Los Angeles, CA	71	9%	0.55
Miami-Fort Lauderdale, FL	58	8%	1.07
Washington, DC	46	6%	0.86
Atlanta, GA	29	4%	0.15
New York, NY	29	4%	0.54
Seattle, WA	29	4%	0.87
Baltimore, MD	27	4%	1.01
Phoenix -Scottsdale, AZ	26	3%	0.61
Boston, MA	24	3%	0.53
Philadelphia, PA	22	3%	0.38
Richmond, VA	22	3%	1.80
Las Vegas, NV	20	3%	0.47
San Francisco, CA	20	3%	1.07
Chicago, IL	19	3%	0.20
San Diego, CA	18	2%	0.60
Dallas-Fort Worth, TX	16	2%	0.25
Naples, FL	16	2%	5.08
Cincinnati, OH	11	1%	0.27
Portland, OR	11	1%	0.50
Riverside-San Bernardino, CA	11	1%	0.51
Houston, TX	10	1%	0.17
MSAs with Fewer than 10 Physicians	89	29%	0.28
TOTAL	756	100%	0.40

¹⁵ Non-metropolitan concierge physicians include practices in Beaufort, SC; Islamorada and Key West, FL; Greenville, TN; Kailua Kona, HI; Ocean City, MD; Nevada City and St. Helena, CA; Sedona, AZ; New London, NH; Clayton, GA; and St. Francisville, LA.

Exhibit 3. MSAs With the Highest Ratio of Identified Retainer Physicians to Population

Metropolitan Statistical Area	Retainer Physicians Identified	Population	Retainer Physicians Identified Per 100,000 Population
Naples, FL	16	315,258	5.08
Carson City, NV	1	54,867	1.82
Richmond, VA	22	1,225,626	1.80
Wausau, WI	2	130,962	1.53
Santa Barbara, CA	6	405,396	1.48
Wheeling, WV	2	144,847	1.38
Las Vegas, NV	20	1,865,746	1.07
Miami-Fort Lauderdale, FL	58	5,414,772	1.07
Baltimore, MD	27	2,667,117	1.01
Charleston, SC	6	644,506	0.93
Barnstable Town, MA	2	221,049	0.90
Jackson, TN	1	112,685	0.89
Ventura, CA	7	797,740	0.88
Seattle, WA	29	3,344,813	0.87
Washington, DC	46	5,358,130	0.86

Physician Characteristics

Specialty. The vast majority of retainer physicians are primary care physicians. Of the 333 physicians for whom we were able to collect specialty information, more than three quarters were internists, and a fifth specialized in family medicine. This pattern is fairly consistent with the findings of previous studies.¹⁶ We did find a few specialists, however, including a cardiologist in Florida, two endocrinologists (one in Arizona and one in Washington), a nephrologist in Massachusetts, and an obstetrician/gynecologist in Florida.

¹⁶ In the GAO survey, about three fourths reported a specialty of general internal medicine and about one fourth reported family practice; Alexander *et al* found the following shares: general internal medicine (62%), family practice (28%), internal medicine subspecialties (8%), and other fields (1%).

Exhibit 4. Identified retainer physicians, by specialty

Specialty	Retainer Physicians Identified	As % of Identified Physicians with Specialty Information
Internal Medicine	255	77%
Family Medicine	70	21%
Pediatrics	2	1%
Endocrinology	2	1%
General Practice	1	<1%
Cardiology	1	<1%
Nephrology	1	<1%
OB/GYN	1	<1%
Not available	423	
TOTAL	756	

Time in practice. Most retainer-based physicians are not new to the profession. In the GAO survey, the average length of time in medical practice was 19 years. Among the 16 retainer-based physicians that we interviewed, the average time in practice was 16 years. A quarter of our respondents had been in practice for only seven to ten years.

Reflecting the more recent development of the retainer-based model, among our 16 respondents, the average time practicing as a retainer-based physician was about 3 years.

Size of practice. Of the 756 retainer physicians we identified, about three-fifths appear to be in solo practice, since no other physician on our list has the same address. This is consistent with the physicians we interviewed, who were mostly in solo practice.

About a fifth of retainer physicians were listed with just one other name at the same address. The remaining fifth of retainer physicians on our list were at the same address as three or more other retainer physicians. The practices with the highest number of physicians on our list include Qliance in Seattle (7 physicians at one address and 1 in a satellite office), Sandy Springs Internal Medicine in Atlanta (7 physicians), a practice in Boca Raton, Florida (7 physicians), and Partner MD in Richmond, Virginia (6 physicians in one office and 2 in a satellite office). A few retainer-based physicians practice in academic settings within larger university-based practices.

Physician Motivation and Satisfaction

Advocates of retainer-based medicine describe the change to this model of practice as having a large impact on physician satisfaction. For example, MDVIP invites physicians to “Love practicing medicine again.” Our interviews suggest that this promise is fairly accurate. Most respondents for this project

were highly dissatisfied in their previous practice, and they enjoy their retainer-based practice much more. One (not an MDVIP participant) literally told us, “I like medicine again.”

Time with patients. The overwhelming majority of the physicians we interviewed described wanting to spend more time with patients as their primary motivation for choosing to become a retainer-based physician. Most described intense frustration with seeing “more and more patients for shorter periods of time.” With more time to get to know patients and coordinate care, retainer-based physicians believe they are doing a better job for their patients. They develop individual relationships, know their problems, can do research and follow-up, and can talk for long enough to uncover other issues that might not come up in a shorter office visit. Several told us things like, “this is the kind of doctor I envisioned myself being” and “I’m practicing the way I was trained to practice medicine.”

However, a few physicians told us that while they spent more time with each patient, the quality or content of the care they were providing had not fundamentally changed. These respondents felt that patients were paying more for access and “hand-holding” than for a different level of medical care.

Stress and burnout. Many physicians noted that the extra time they have to spend with patients makes their jobs much less stressful. Physicians described being mentally and physically drained at the end of the day in their prior practices. Some were working until very late in the evening in non-retainer practice; one reported making rounds at the hospital at 10:00 PM. In their retainer-based practices, by contrast, physicians reported having time and energy at the end of the day to spend time with their families or pursue other activities. One told us, “I love waking up and going to work...and I’m a happy person with my family too.”

Three of the physicians we interviewed had been looking into leaving private practice altogether when they decided to try a retainer-based practice; they had been exploring jobs with health plans, pharmaceutical companies, or in public policy. Two other respondents had already left office-based practice and came back to become retainer-based physicians. Some of these physicians talked about the role that retainer medicine may be able to play in increasing the supply of primary care physicians, even though each retainer physician sees many fewer patients. Two of the physicians we interviewed were involved in training medical students. Both felt strongly that they were important role models for students who might take an interest in primary care. One said his students tell him, “You are the only happy internist we’ve met.”

Compensation. Only a few respondents named making more money as a primary motivation for becoming a retainer-based physician, though some readily admitted that they were in fact making more money. Several respondents reported their income was similar to what it had been before (or even less), but that they were working less and much happier. One was dissatisfied with his income and questioned whether retainer-based practice was viable in his area.

On-call schedule. When asked to name the downsides of retainer-based practice, many physicians said constantly being on call was the hardest aspect. Most of the physicians we interviewed had given their patients their cell phone number and are effectively on call 24 hours a day, 365 days a year. Some reported taking phone calls while on vacation, but had identified someone (a physician’s assistant or

another physician) who could see patients in person during their absence. Others reported feeling that they couldn't take vacations because they wanted to be available to visit patients in the hospital, or because their patients expected to be able to see them in the office. However, while physicians reported being on call as a drawback to this type of practice, they said it was worth the tradeoff. A few noted that while they must be available, they do not get many calls at odd hours because their patients respect their time and know that they can reach their doctors easily during office hours.

Patient Panel Characteristics

Size of patient panel. Retainer physicians tend to have smaller patient loads and fewer appointments daily, compared to their non-retainer counterparts. The retainer physicians who responded to the GAO survey reported having, on average, 491 patients. The average number of patients physicians had the year before they started their retainer-based practice was 2,716. Physicians responding to the GAO survey also reported seeing fewer patients per day: the average number of patients seen on a typical day fell from 26 in the year before they started their retainer practice to 10 at the time of the survey. Similarly, retainer physicians responding to the survey conducted by Alexander *et al.* (2005) reported having fewer patients compared to their non-retainer counterparts (mean value of 898 patients compared to 2303 patients). They also reported seeing about half as many patients daily.

The respondents we interviewed had even smaller patient panels than reported in the earlier surveys. Among the retainer-only physicians that could estimate their panel size, patient panels ranged from 100 to 425 patients. The average size was about 250 patients, just over a tenth of the average panel size these respondents reported having before starting their retainer-based practice (2265 patients). The physicians using hybrid models had kept a much larger patient panel, but had many fewer retainer patients.

Over half of our respondents wished their practice size was larger. Many thought 400 patients per physician would be ideal, although some were happy to have 250 or so patients. A few were aiming for a patient panel of 600 (which is the target set by MDVIP). There have been some isolated reports of retainer-based practices that have had to close for lack of patients. For example, according to a press report, one physician who opened a retainer-based practice in the Boston area in 2005, an area that already had several retainer-based practices, was not able to fill his practice, and eventually closed it.¹⁷

Patient characteristics. Some of the physicians we interviewed felt that the demographics of their patient panel had not changed significantly when they started their retainer-based practice. However, some did notice patterns.

Several physicians felt that the patients who joined their retainer practices tended to be more complicated and time intensive: patients with complex medical conditions or multiple chronic conditions. As one physician put it, "these are people who have had some serious travel through the healthcare system, and they want to put in money to have an advocate." This physician had noticed

¹⁷ Kowalczyk, Liz. "No patient rush to 'concierge' practices." *Boston Globe*, April 15, 2005.

that in particular, she seemed to have many more patients with cancer than she had before starting her retainer practice.

In addition, some physicians said a notable minority of their patients were “executive types,” people for whom “time is more important than money.” However, several noted that a patient's decision to follow a physician to a new retainer practice did not seem to be perfectly correlated with income. These physicians had seen wealthy patients decline to sign up, and less wealthy patients decide to stay and pay the retainer fee. A number of the physicians we interviewed felt it was important to stress that retainer practices were not elite practices.

Among the physicians we interviewed, there was a wide range in estimates of the number of Medicare beneficiaries in their patient panels, from fewer than 20 percent to over 60 percent of patients. GAO reported that about 35 percent of the patients in the practices of the retainer physicians responding to this question were Medicare beneficiaries.¹⁸ Several of the physicians we interviewed noted that they had Medicare beneficiaries in their patient panel whose retainer fees were paid by their children.

Impact on Beneficiaries

As the number of retainer practices has grown, so has interest in how consumers – those who do and do not participate in the practices – may be affected by the trend. The physicians we interviewed, as well as representatives of management, professional, and beneficiary organizations, responded to our questions on this topic. Their comments primarily concerned the issues of quality of care and access to care.

Quality of Care

Preventive care. As noted earlier, because the field of retainer medicine is so new, there have not been extensive studies to compare patient outcomes between retainer care and standard care.¹⁹ Some proponents of retainer practices say that extensive tests performed during annual physicals can lead to an early diagnosis of medical problems that might otherwise have gone unnoticed. The counter-argument is that while extensive tests may find a problem early, they can also create false positives and lead to unnecessary and invasive tests and procedures.²⁰ Patients may receive more preventive services in retainer practices than other practices since physicians have more time to spend with each patient and to research and implement new procedures. A couple of physicians with whom we spoke were exploring the use of new patient education materials or regimens such as a weight-loss program.

¹⁸ This count includes patients who were non-concierge patients in hybrid practices. GAO, “Physician Services, Concierge Care Characteristics and Considerations for Medicare.”

¹⁹ Ruiz, Rebecca. “Should You Dump Your Primary Care Physician?” *Forbes Magazine*, January 14, 2009.

²⁰ Hobson, Katherine. “Do You Need to Be as Healthy as a President? You can get a 'Presidential Physical' for \$1,400, but the extra tests might not be a good idea.” *US News and World Report*, May 23, 2008.

Continuity of care. A recurring theme in the literature and in our interviews is that retainer practices can improve continuity of care.^{21,22} Several physicians we interviewed provided examples of interactions with patients that were particularly gratifying in this regard. For example, one spoke about meeting a patient at the emergency room and being able to provide a history for the emergency room doctor. Others spoke about accompanying patients to their appointments with specialists or about helping with arrangements for patients who needed care while traveling. In each of these cases the physician was involved and aware of all of the services the patient was receiving. We also know from the interviews that some adult children pay retainer fees so that they can be confident that the care for their parents will be coordinated.

A few physicians referred to the concept of a “medical home” when they described the care they provide. One said, “They talk about creating a medical home for people... People feel welcome here. They come and get great care. I think it is better care.” Another noted, however, that while he is providing more services for each of his patients and that they and he may feel better about how the care is delivered, he does not think that the patients in his retainer practice are better off medically than they were in his former practice.

Reduction in service use. Several physicians said they saw a reduction in service use outside their office as a result of more thorough primary care. One noted, “I’m also convinced that it saves money. I keep [patients] out of the ER, the hospital, the nursing homes...There is no question I don’t duplicate as many labs, I can check what I have.” MDVIP has analyzed state data on hospital service utilization and concludes that utilization is generally lower for the patients of MDVIP doctors compared to other doctors. However, the patient populations in this study were not risk adjusted. As noted earlier, there is a dearth of independent studies comparing outcomes for different practice types.

Quality of care for the broader population. The availability of extended office visits is seen by some as improving quality of care, but commentators have noted that providing longer visits for a select group of patients that are not particularly sick does not necessarily advance the health of communities overall.²³ Even if the more extensive care offered by retainer physicians does result in better outcomes for retainer patients, it could be seen as discriminatory against those who cannot afford to pay the retainer fees.²⁴ A number of individuals have expressed the concern that the availability of retainer practices may be a factor that widens the gap in health care quality that already exists between the wealthy and the poor, creating a two tiered medical system.^{25,26,27} Although the American Medical Association

²¹ Russano, Jennifer. “Is Boutique Medicine a New Threat to American Health Care or a Logical Way of Revitalizing the Doctor-Patient Relationship?” *Washington University Journal of Law and Policy* 17 (2005): 313.

²² Linz, Anthony, Paul Haas, Fleming Fallon, and Richard Metz. “Impact of Concierge Care on Healthcare and Clinical Practice.” *Journal of the American Osteopathic Association* 105, no 11 (2005): 515-520.

²³ Kaminetsky, B and Jacobson, J, *Is “Boutique Medicine” Ethical? Physician’s Weekly* January 7, 2002, <http://www.physweeklyarchives.com/pc.asp?issueid=2&questionid=2>

²⁴ Kaminetsky and Jacobson, “Is ‘Boutique Medicine’ Ethical?”

²⁵ Jenkins, Chris L. 2008. “Unwelcome Surprise- Fairfax Doctors’ Shift to Boutique Care Leaves Patients Weighing Options.” *Washington Post*, March 18, 2008.

website has some information on establishing retainer practices, the AMA has also developed guidelines that indicate it is unethical for the quality of care to be dependent on a patient's ability to pay extra fees. "It is important that a retainer contract not be promoted as a promise for more or better diagnostic and therapeutic services," states the AMA's Code of Ethics. The document also points out that "Physicians have a professional obligation to provide care to those in need, regardless of ability to pay, particularly to those in need of urgent care. Physicians who engage in retainer practices should seek specific opportunities to fulfill this obligation."²⁸

Access to Care

Greater access to physicians for patients who join retainer practices. For patients who enroll, increased access to physicians is one of the most appealing aspects of retainer practices. Physicians note that patients who require a lot of reassurance are among those most likely to join retainer practices. Patients appreciate being able to reach their doctors at any time, to be seen soon after they request an appointment, and to be able to spend as much time as they feel they need with their doctors. The care coordination aspect of the practice is particularly appealing to individuals or families coping with multiple medical issues.

Physician supply. Typically, primary care physicians maintain panels of 2,000 or more patients. Retainer practices number 600 or fewer patients. At a time when there are concerns about a shortage of primary care physicians,^{29,30} the prospect of having more primary care physicians see fewer patients raises questions about the impact of retainer medicine on the supply of primary care in the broader community. The physicians we spoke with understood this issue. Some were not concerned because they practice in areas where there is no shortage of primary care providers. Others acknowledged that there may be a shortage of physicians in their community, but noted that they found other doctors willing to take their patients when they transitioned to retainer practices.

Some observers have suggested that retainer medicine could actually improve access in some cases by salvaging the careers of frustrated physicians and deferring their decision to leave practice.³¹ A few of the physicians we spoke with expressed this sentiment; they had been researching other jobs at the same time they were considering becoming retainer physicians. Others had started retainer practices after working in jobs that did not involve direct care for a panel of patients. Several of the physicians

²⁶ Sandra J. Carnahan, "Concierge Medicine: Legal and Ethical Issues," *Journal of Law, Medicine & Ethics*, vol. 35, no. 1 (Spring 2007): 211-215.

²⁷ Brennan, Troyen. "Luxury Primary Care – Market Innovation or Threat to Access?" *New England Journal of Medicine* 346, no. 15 (2002): 1165-1168.

²⁸ American Medical Association. Code of Medical Ethics: Opinion 8.055 - Retainer Practices. Adopted June 2003.

²⁹ Colwill, JM, JM Cultice, and RL Kruse. "Will Generalist Physician Supply Meet Demands Of An Increasing And Aging Population?" *Health Affairs* 27, no. 3 (2008): w232-w241.

³⁰ Steinbrook R. "Easing the shortage in adult primary care--is it all about money?" *New England Journal of Medicine* 360, no. 26 (2009):2696-9.

³¹ Linz, *et al.* "Impact of Concierge Care on Healthcare and Clinical Practice."

with whom we spoke also told us that they thought that retainer medicine could help attract more medical school graduates to primary care as students saw how fulfilling a retainer practice could be.

Access for patients who decide not to join their physician's retainer practice. For this project, we spoke with several individuals who are aware of beneficiary perceptions and concerns, including people who work at both national and local organizations that represent or advocate on behalf of Medicare consumers. Most respondents said that they had not heard from their constituents about access problems related to retainer practices. That may be because currently it affects a very small portion of the population, and also because beneficiaries may not think to go to one of these organizations when faced with a physician practice asking them to join as a retainer patient. Some organizations could point to particular geographic areas locally where there is notable activity; two respondents said they had had “a small number of calls” at particular points in time from constituents who had concerns about retainer care. For example, they reported that if one doctor in a community switches to retainer medicine, patients may call asking for assistance finding a new doctor.

There are indications that individual physicians’ transitions to retainer medicine can be difficult for patients in some cases. For example, we heard about the particular appeal of having a retainer physician provide care for a relative with Alzheimer’s disease, but we also heard about families that were distressed when Alzheimer’s patients who had had established relationships with their physicians were faced with the choice of paying retainer fees or having to leave a practice. In at least one case a family that was struggling financially was trying to decide if they should cut back on other things so they could keep the patient with the current doctor who was transitioning to retainer care.

State and Federal Laws and Regulations

Because retainer practices are structured differently than other medical practices, physicians must be sure that the financial arrangements they use do not violate state and federal laws and regulations. Any retainer physicians who treat Medicare patients must be aware of the limitations imposed by Medicare’s policies on balance billing. States have also created laws and regulations on insurance and balance billing that have implications for retainer medicine; in a few cases, states have acted specifically to allow or restrict this kind of practice.

State Laws and Regulations

In the eyes of some observers, retainer practices may fall under the purview of various state laws, including state insurance laws, patient abandonment laws, and balance billing limits.³²

Retainers as insurance. Retainer practices, especially those offering bundles of guaranteed services under the “fee for care” model, could be challenged for providing insurance in violation of state law. For example, a practice that collects a fee in advance and guarantees to provide all needed primary care services for that fee could be considered as providing insurance. In this situation, the physician practice

³² Portman, Robert M., and Kate Romanow, “Concierge Medicine: Legal Issues, Ethical Dilemmas, and Policy Challenges,” *Journal of Health & Life Sciences Law* 1, no. 3 (2008): 3-38.

is at risk if the patient needs more services than expected, and the patient is at risk for getting neither the services nor a refund of the fee should the practice close.

If a retainer practice were judged subject to state insurance laws, it would be required to comply with various regulatory requirements, such as maintaining reserve funds and complying with filing requirements. For example, Washington State requires that insurers doing business in the state maintain between \$4 million and \$5 million in capital plus surplus funds and must file with the state an annual statement that includes financial information.³³

In the past decade, at least four states have studied or addressed the issue of whether a retainer-based practice might be considered insurance.³⁴ Florida determined in 2001 that MDVIP practices were not providing insurance, perhaps because they did not provide unlimited services, and thus did not require an insurance license. The Maryland Insurance Administration completed a similar study in 2009. They outlined a set of recommendations to help retainer practices avoid a finding that they are “engaged in the business of insurance.” The essence of these principles is that the retainer fee covers only a limited number of office visits and that visit fees are appropriate to the market value of the visits provided.³⁵

By contrast, insurance commissioners in Washington and West Virginia made determinations that retainer practices were assuming risk and thus could be subject to insurance regulation. Legislatures in these two states took action to avoid this situation. West Virginia created a pilot program in 2006 to allow physicians to charge a prepaid fee for primary and preventive services. Washington State passed a law in 2007 to recognize that the risk involved in retainer practices is limited and create a “safe harbor” allowing these practices to continue. This law requires the practices to register, file an annual statement with the insurance commissioner, and comply with certain consumer protections.³⁶

A physician in one “fee for care” practice mentioned structuring the practice to avoid the appearance of providing insurance. Rather than providing absolutely unlimited services, the practice sets a very high annual limit on the number of visits covered by the retainer fee. While it is highly unlikely that a patient would ever reach this limit, the practice believed this would protect them both financially and against any accusation of running an insurance program.

Patient dumping laws. Many states also have patient abandonment laws that impose requirements, such as adequate notice, when a physician terminates a relationship with a patient. Guidelines established by the American Medical Association also impose an obligation on physicians to assist patients who choose not to remain after a conversion to a retainer practice. The guidelines call for physicians to help with transitions to new physicians and to continue treatment until a safe transition

³³ Portman and Romanow, “Concierge Medicine: Legal Issues, Ethical Dilemmas, and Policy Challenges.”

³⁴ Ibid.

³⁵ Maryland Insurance Administration, *Report on “Retainer” or “Boutique” or “Concierge” Medical Practices and the Business of Insurance*, MIA-2008-12-002, January 2009.

³⁶ Washington State Office of the Insurance Commissioner, “Health Care Retainer Practices: HB 1818/SB 5716,” Fact Sheet, February 2007.

can be accomplished. Our interviews with both physicians and consumer groups suggest that transitions have not been a major problem.

Balance billing laws. Retainer practices must also ensure that they do not violate other state laws. In a few states, physicians who have contracts with HMOs and some other health plans are prohibited in certain circumstances from collecting payment from patients for balance bills, that is, amounts (other than insurance copayments and deductibles) that exceed the insurer's paid amount.³⁷ In the absence of such state laws, physicians who participate in a plan's network may also be obligated by their contract not to collect balance bills. Many physicians with retainer practices, however, do not participate in HMO networks, while some that do act to make sure that retainer fees apply only to services not covered by insurance.

A related issue arose in at least two states, where health departments questioned the legality of retainer fees.³⁸ In 2003, New Jersey's health department announced that physicians participating in the networks of HMOs or PPOs could not charge retainer fees on the grounds that all patients under these health plans must be treated equally. The department concluded that services of retainer-based practices would not be available to plan members not able to afford the retainer fees. New York's health commissioner also raised discrimination issues in a 2004 statement and concluded that retainer fees charged for services already covered by insurance would be considered double billing.

One attorney interviewed for this study suggested that the types of rulings seen in Maryland and New York effectively rule out use of the "fee for care" model of retainer practice in those states. He suggested that "the sole biggest threat to that kind of concierge practice comes from state insurance commissioners" and finds that they are harder to operate in states where insurance commissioners are oriented toward a more regulatory approach and where local medical associations have less political clout. But even in states that discourage a "fee for care" model of retainer practice, other models appear to remain viable provided they spell out clearly what is covered under the retainer fees.

Medicare Regulations

Retainer physicians who wish to see Medicare patients have two basic options. One is to take the formal step of opting out of Medicare entirely. The other is to maintain a relationship with the program, but take the steps necessary to stay within the restrictions imposed by Medicare's billing limits.

Opting out of Medicare. The Balanced Budget Act of 1997 included a provision allowing physicians to opt out of Medicare for a two-year period (renewable for additional periods). Physicians taking this step must file paperwork with CMS and commit not to submit claims to Medicare for any patient, other than in emergency situations. Opt-out physicians who wish to treat Medicare beneficiaries must enter into written contracts with them. Under this contract, the Medicare beneficiary agrees not to submit to

³⁷ Hoadley, Jack, Kevin Lucia, and Sonya Schwartz, "Unexpected Charges: What States Are Doing about Balance Billing," California HealthCare Foundation, April 2009, <http://www.chcf.org/topics/healthinsurance/index.cfm?itemID=133916>

³⁸ Portman and Romanow, "Concierge Medicine: Legal Issues, Ethical Dilemmas, and Policy Challenges."

Medicare (or to Medicare supplement insurance) claims for any non-emergency services provided by the physician. In these “opt out” situations, there is no restriction on the physician's charges.

Opting out is relatively uncommon; GAO reported that in 2004 about 3,000 physicians nationwide had opted out of Medicare (less than 1 percent of the number of physicians who participate in Medicare).³⁹ They found that about one-fifth of the retainer physicians they surveyed had taken this approach; our interviews showed a similar proportion. However, one respondent believed that “many more are opting out all the time.”

In some cases, physicians who have opted out of Medicare may recommend that their Medicare patients get certain expensive services from a provider who does participate in Medicare. For example, one physician who had opted out of Medicare told us she refers her Medicare patients elsewhere for the shingles vaccine, which typically costs about \$150, so the vaccine will be covered by Medicare. In contrast, she will typically just bill her Medicare patients for a \$17 flu shot, and they will pay for it out of pocket. Some other physicians who had opted out of Medicare mentioned that they cover the cost of the flu shot as part of the annual physical that is covered by their retainer fee.

Working with Medicare. Physicians who do not opt out are subject to Medicare’s billing limits under one of two scenarios. Physicians who accept Medicare assignment agree not to charge the patient any amounts beyond the Medicare fee schedule amount (participating physicians are those who sign an agreement under which they take all Medicare patients on assignment). Over 99 percent of all Medicare claims are paid on assignment. Physicians who do not take assignment for a particular claim must limit any extra billing (balance bills) to no more than 9.25 percent of the Medicare Fee Schedule amount received by those with participating physician agreements. Any billing above this limiting charge can be prosecuted under the False Claims Act.

The question for retainer practices is whether retainer fees are extra charges and in violation of the balance billing rules. In 2002, the Secretary of HHS wrote a letter to Representative Henry Waxman stating his interpretation of the rules that “insofar as the retainer fee is truly for noncovered services, such fees would not appear to be in violation of Medicare law.”⁴⁰ In response to further queries on this issue, the HHS Office of the Inspector General issued an “OIG Alert” to retainer physicians about such fees in 2004.⁴¹ The Alert reiterated that extra payments are allowed only when services are not covered by Medicare. Further, the OIG clarified that services such as “coordination of care with other providers,” “comprehensive assessment and plan for optimum health,” or “extra time” spent on patient care could potentially be considered covered as part of Medicare services; they are not enough in and of themselves to justify charging a retainer fee. The alert cited the case of one physician who had been found in violation of his assignment agreement for charging patients an additional fee for those services.

³⁹ GAO, “Physician Services, Concierge Care Characteristics and Considerations for Medicare.”

⁴⁰ Letter from Tommy G. Thompson, Secretary of Health and Human Services, to Henry A. Waxman, May 1, 2002.

⁴¹ Office of Inspector General. “OIG Alerts Physicians about Added Charges for Covered Services.” OIG Alert, March 31, 2004.

One respondent who advises retainer practices felt that Medicare's policy in this area could still be much clearer. "Every physician who goes into this is at risk," this person said. However, most of the physicians interviewed for this project seemed to understand the policy, and were comfortable that they were adequately separating services covered and not covered by Medicare. Another individual who advises retainer practices stated that it was simple: "I make sure that patients know that anything that is done for them that is covered by Medicare will be billed [to Medicare]...you look at how you bill and what you bill for, if you don't bill for something that is covered by Medicare then you would be in trouble."

The service that retainer physicians typically point to as the Medicare non-covered service that they provide in exchange for their retainer fee is an annual physical. However, Medicare does pay for a physical within the first year of Medicare eligibility, often referred to as a "Welcome to Medicare" physical (see text box). Several physicians stated that they had developed policies for dealing with patients in their first year of Medicare, so that they will not run afoul of the OIG's interpretation of Medicare's rules. These could include offering additional services to those patients, or waiving the retainer fee for the patient's first year in Medicare.

One physician we interviewed charges a higher retainer fee for Medicare patients – an approach that seems to challenge Medicare's billing limit more than most others. The practice charges a retainer of \$300 for non-Medicare patients under age 45; \$500 for non-Medicare patients ages 45 and over, and \$850 for Medicare beneficiaries. However, other practices successfully meet Medicare's requirements that the retainer fee be for non-covered services even with fees that are double or more this practice's Medicare retainer.

Because a \$1500 to \$2000 retainer fee seems disproportionate to the cost of providing a 90-minute physical, some experts believe it is still implicitly a higher fee for Medicare-covered services, paying for access to the physician.⁴² As a way to address this concern, one expert that we interviewed suggested that a cap could be put on the amount that physicians are allowed to charge for an annual physical. Presumably, this cap might be lower than current typical retainer fees.

If Congress were to expand Medicare coverage to include an annual wellness visit, these boundary issues would become even more difficult. Coverage for an annual visit might seem to eliminate the most common service provided under the annual retainer fee. One physician asked about this situation said, "If annual physicals are covered, I might leave MDVIP. A lot of my patients say that they can't pay the fee. As more drop out, the more difficult it will be to pay for the practice and overhead costs." Others, however, thought that there are other non-Medicare covered preventive services of value to their patients that they will be able to offer in exchange for the retainer fee as long as the current interpretation of balance billing rules is in place. For example, some retainer physicians already include non-covered services such as weight loss counseling or travel medicine as part of list of services covered by their retainer fee.

⁴² Russano, "Is Boutique Medicine a New Threat to American Health Care?"

The Welcome to Medicare Physical

Every Medicare beneficiary is entitled to an initial preventive physical examination within 12 months of enrolling in Part B. The exam includes the following services:

- **Review of Individual's Medical and Social History.** This includes past medical history, family history, current medications and supplements, history of alcohol, tobacco, and illicit drug use, diet, and physical activity.
- **Review of Individual's Risk Factors for Depression and Other Mood Disorders.** Current or past experiences with depression or other mood disorders are obtained via an accepted screening instrument.
- **Review of Individual's Functional Ability and Level of Safety.** Hearing impairment, activities of daily living, falls risk, and home safety are assessed.
- **A Physical Examination.** This includes height, weight, and blood pressure; visual acuity screening; measurement of body mass index; and other factors based on the individual.
- **End-of-Life Planning.** Verbal or written information is provided to the beneficiary regarding advance directives.
- **Education, Counseling, and Referral Based on the Previous Five Components.** This might include counseling on diet if the individual is overweight, education on prevention of chronic diseases, and smoking and tobacco-use cessation counseling.
- **Education, Counseling, and Referral for Other Preventive Services.** The beneficiary receives a brief written plan, such as a checklist, for obtaining appropriate screenings and other preventive services that are covered as separate Medicare Part B benefits.
- **Optional: Screening Electrocardiogram.** As appropriate, Medicare will also cover EKGs associated with the initial physical.

Adapted from: Centers for Medicare and Medicaid Services, 2009. "The ABCs of Providing the Initial Preventive Physical Examination." Accessed at http://www.cms.hhs.gov/MLNProducts/Downloads/MPS_QRI_IPPE001a.pdf

Federal Action on Retainer Practices

In 2003 and 2005, several members of Congress introduced or cosponsored bills that would have prohibited physicians from charging retainer fees. No action was taken, and it appears that no similar bills have been introduced in more recent Congresses. In the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the Congress directed the GAO to study concierge care and its impact on Medicare patients. The GAO report, published in 2005, concluded that the “small number of concierge physicians makes it unlikely that the approach has contributed to widespread access problems.”⁴³ In its comments on that report, DHHS noted its agreement with GAO’s findings and stated that it would continue to monitor the trend. No specific information is available on monitoring activities.

⁴³ GAO, “Physician Services, Concierge Care Characteristics and Considerations for Medicare.”

Appendix: Methodology

We conducted 28 structured interviews to examine the characteristics and trends in retainer-based care and to obtain a variety of perspectives on its current and potential impact on Medicare. In addition, we reviewed the existing academic literature, government reports, media reports, information from relevant websites, and Medicare rules that are pertinent to retainer-based physicians.

Literature Review

We conducted a comprehensive literature review to gather background information on the trends and characteristics of retainer-based medicine and to develop a list of retainer physicians across the country. We performed the literature search using a general Internet search engine, academic search engines, and a search of national and local news media. These searches were conducted using the terms “boutique,” “retainer,” “direct,” or “concierge” combined with “physician,” “care,” “medicine,” or “practice.” Through our search, we identified relevant academic literature, news articles, government reports, promotional material, and websites. We found approximately 20 journal articles on retainer practices and over 50 news articles, in addition to other relevant literature.

List of Concierge Physicians and Practice Characteristics

We developed a database of physicians publicly listed as concierge practices by major management firms, SIMPD, an online directory of retainer practices, as well as others identified through web searches for practices and news and journal articles about practices and trends. We gathered information on the practice’s location, affiliation with a management firm and, to the extent possible, the physician’s specialty. We identified 125 physicians through the SIMPD directory, 303 through the MDVIP directory, 95 through the Concierge Choice directory, and 233 from other sources.

Interviews

To learn more about the trends and characteristics of retainer medicine, we conducted telephone interviews with physicians, experts in physician policy and trends, and representatives of physician groups, beneficiary organizations, and organizations that provide management or membership services for retainer practices. We conducted key informant interviews with two experts in retainer care policy and trends, an expert in physician policy, the heads of two management or membership organizations (one other organization declined to participate), representatives of a national physician organization, and six representatives from national and local beneficiary organizations. Seven other beneficiary counselors who we contacted told us that their experience with this issue was so limited that they would not be good candidates to interview.

To gain a physician perspective, we interviewed 16 physicians about their decisions and experiences related to retainer medicine. The physicians on our list were divided into four groups, according to their affiliation with SIMPD, MDVIP, and Concierge Choice, and those physicians unaffiliated with any of the three organizations. We then randomly selected physicians from each list to be contacted via fax, phone and/or email. A majority of the practices received an initial fax requesting participation, followed by a

phone call. A second follow-up phone call was usually made if there had been no response for a few days. In the few cases where email addresses were available, an email was sent requesting participation and was followed by a phone call if there was no response. We had 7 positive responses from SIMPD physicians out of the 20 contacted; 3 from MDVIP physicians out of the 20 contacted; 2 from Concierge Choice physicians out of the 16 contacted; and 4 from other physicians out of the 14 contacted. This represents a total of 16 completed interviews out of 70 doctors contacted. Interviews took place over the phone and lasted for approximately 30 minutes. In most cases, the interviews were conducted by one of the team's senior researchers following a common protocol, with a research assistant taking notes. Participants received an incentive payment of \$125 for their time. All procedures were approved by Institutional Review Boards at NORC and Georgetown University.