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Cash Only Doctors: Challenges and Prospects of Autonomy and Access

Jeffrey B. Hammond†

With the passage of the Patient Protection and Affordable Care Act of 2010, the American healthcare system is poised to fundamentally change. However, the Affordable Care Act’s passage has made many physicians queasy at the prospect of more bureaucratic control over their professional lives. Hence, a form of ambulatory medicine not seen since before the advent of health insurance, “cash only” medicine, or healthcare encounters fully paid in (usually) the primary care doctor’s office, is beginning to gain more attention among doctors and in the popular press. This Article argues that cash only medicine is a salutary development in the American healthcare system because it allows for more thorough treatment and better patient satisfaction for patients who remain with their doctors once they transition to a cash only model. Further, the Article locates the roots of the current cash only trend in the formula-based system derived by Congress to pay physicians contracted with the Medicare program, and its modifier, the Sustainable Growth Rate, which perennially threatens to precipitously cut already weak Medicare physician reimbursement. The Article also argues that cash only medicine should be welcomed as a means of patient access over against the insurance-dominated system mandated by the Affordable Care Act. These doctors provide access that would be lost entirely should they leave the practice of medicine altogether if unsatisfied with the changes wrought by healthcare reform. Finally, the Article acknowledges that, qua trend, cash only medicine could work to alienate some patients, like economically disadvantaged chronically diseased patients, who do not have the financial wherewithal to purchase all of the healthcare they need nor purchase insurance before the 2014 effective date of the individual insurance mandate.

I. Health Care Reform and the Cash Only Doctor

Attempts at fundamentally reforming America’s health care insurance coverage and payment systems have ended in rancor and political divisiveness not seen in many other areas of national-level policymaking. Theodore Roosevelt was defeated in the 1912

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presidential election, in part because of his revolutionary call for health insurance coverage for all Americans. Franklin Roosevelt’s was spooked from including universal health coverage in the bill authorizing Social Security because an advisor predicted that to add general health coverage would “spell defeat for the entire bill.” Likewise, Harry Truman could not persuade Congress on a universal health plan. System-wide change did not ripen until Lyndon Johnson signed the Medicare and Medicaid Acts in Truman’s hometown of Independence, Missouri in 1965. Subsequent administrations pushed hard for coverage and payment reform, yet their efforts too were rebuffed.

In the build-up to the latest iteration of health care reform - the Patient Protection and Affordable Care Act of 2010 and its companion statute, the Health Care and Education Reconciliation Act of 2010 (collectively, the “Affordable Care Act”), Americans witnessed acrimonious politics at its worst. Though widely proclaimed as the most significant piece of

1 See LeiYU Shi AND DOUGLAS A. SINGH, ESSENTIALS OF THE UNITED STATES HEALTH CARE SYSTEM 58, 59 (2005).


3 See LeIYu Shi AND DOUGLAS A. SINGH, DELIVERING HEALTH CARE IN AMERICA: A SYSTEMS APPROACH, ed. 4TH (2008) (“In 1946, Harry Truman became the first president to make an appeal for a national health care program. Unlike the Progressives, who had proposed a plan for the working class, Truman proposed a single health insurance plan that would include all classes of society.”) See also, O.W. ANDERSON, HEALTH SERVICES AS A GROWTH ENTERPRISE IN THE UNITED STATES SINCE 1875 (1990) and MARGARET F. SCHULTE, HEALTHCARE DELIVERY IN THE U.S.A.: AN INTRODUCTION 125 (2009) (describing stiff resistance to Truman’s plan by the American Medical Association).


health legislation since the Medicare Act, Americans witnessed partisanship not seen since Republicans swept into power in 1994 touting governmental reform under the banner of the “Contract with America.” In a flash point that characterized the reform debate’s divisiveness, a Republican Congressman from South Carolina shouted down President Obama while the President delivered a speech to a joint session of Congress. Similarly, labor unions and interest groups trotted out well worn canards against opponents of the reform legislation, claiming that those opponents hated poor people, and cared nary a whit if America’s 30+ million uninsured could secure coverage, regardless of the veracity of those claims.

Notwithstanding the discord that went into its making, the Affordable Care Act promises to fundamentally change many aspects of healthcare delivery in America. Many businesses now are required to provide health insurance for their employees, or they will be

7 See Frank Newport, Constituents Divided, Highly Partisan on Healthcare Reform (describing an almost three-way split in the American population regarding the advisability of passing a health care reform bill), available at http://www.gallup.com/poll/122234/constituents-divided-highly-partisan-healthcare-reform.aspx (August 11, 2009); see also, RONALD BROWNSTEIN, THE SECOND CIVIL WAR: HOW EXTREME PARTISANSHIP HAS PARALYZED WASHINGTON AND POLARIZED AMERICA (2008) 168 (recounting that former Vice-President Dan Quayle remarked that the “‘Contract with America’ had devolved into a ‘contract with Clinton’”).

8 Representative Joe Wilson (R-SC) shouted “You lie!” from his seat in the House chamber during President Obama’s speech to a joint session of Congress about health care reform. See Carl Hulse, In Lawmaker’s Outburst, a Rare Breach of Protocol, NEW YORK TIMES A26 (September 10, 2010).

9 See Paul Kane, Capital Briefing: News and Analysis from the Hill, Reid faces criticism after comparing health-care reform opponents to civil rights opponents, WASH. POST (December 7, 2009), available at: http://voices.washingtonpost.com/capitol-briefing/2009/12/reid_faces_criticism_after_com.html. Wrote Mr. Kane:

In a prepared floor speech that began Monday’s debate on health care, Reid said the nearly universal Republican opposition to health insurance reform was akin to the efforts to block some of the nation’s most important hallmark civil rights reforms of the past 150 years.

‘You think you’ve heard these same excuses before, you’re right. In this country there were those who dug in their heels and said: Slow down, it’s too early, let’s wait, things aren’t bad enough about slavery. When women want to vote, slow down, there will be a better day to do that,’ Reid said.’
assessed a fine based on each non-covered employee.° Physicians now face much stricter regulatory controls upon their ownership and referral to hospitals that they own and operate. Doctors also face tighter restraints upon patient referrals for simple diagnostic tests provided in their offices. Further, insurers may not longer underwrite for pre-existing medical conditions. Thus, all comers, whether diabetics, cancer patients, or others with debilitating chronic conditions, are now guaranteed coverage. These strictures are among the hundreds outlined in the Affordable Care Act.

To be sure, the centerpiece of the Affordable Care Act is the so-called individual insurance mandate – the requirement that each American secure health insurance coverage, whether from an employer-sponsored plan, a government-funded program, such as Medicare or Medicaid, or through a government-sponsored “exchange”. Though Congress primarily focused upon system access – whether the uninsured, underinsured, and the precariously insured – have some means to afford health care services through insurance, there is a strong thread in the legislation that focuses on the “flip side” of access – physicians, who are, of course, the primary delivery mechanism. Subtler, less well-known provisions of the Affordable Care Act might serve as a relief valve for these beleaguered

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10 See generally, AFFORDABLE CARE ACT §1513(a).

11 See generally, id. at §6001.

12 See id. at §6003.

13 See id. at §1101. The Act’s prohibition is on underwriting for pre-existing conditions in the individual and non-ERISA markets. Both the ERISA and HIPAA statutes prevented pre-existing condition underwriting in group markets. See 29 U.S.C. §1182 (ERISA prohibition on pre-existing condition underwriting for groups) and 29 U.S.C. §1182 (HIPAA prohibition for the same).

14 See generally, id. at §1201(1).

15 See id. at §1501 (for discussion of the individual mandate) and §1311 (for establishment of exchanges).
parts of the delivery system. Medicare reimbursement for select primary care physicians and general surgeons is set to accelerate ten percent from 2011 through 2016. This increase, however, will only provide a marginal benefit compared to full Medicare rates. These physicians (and all other physicians contracted to the Medicare program), are still woefully underpaid.

These interventions are nice, short-term band-aids that cover a deeper, more fundamental problem – Congress has been snookered by the law of unintended consequences. When it created the main mechanism of physician reimbursement, the Resource Based Relative Value Scale, as part of the Omnibus Budget Reconciliation Act of 1989, it was initially designed to support increased primary care physician payment. Its actual effect has been exactly the opposite, though. Primary care doctors have been losing Medicare reimbursement dollars at a much faster rate than their specialist brethren. It is doubtful, though, that Congress desires to change fundamentally the structure of RBRVS since no bill to modify the basic system has been introduced in Congress.

Though the Affordable Care Act does not essentially change Medicare’s physician reimbursement system, it does introduce the possibility of methodology change at the margin. The Act mandates that the Centers for Medicare and Medicaid Services

16 The Affordable Care Act includes several provisions dealing with the healthcare workforce, including §§5401-5405 and several sections dealing with overall healthcare system quality improvement and performance, including §§5501-5509.

17 See id. at §5501 (for practitioners in Health Professional Shortage Areas). See also id. at §5501(a)(1) (in which the statute provides for a 10% system-wide bonus for primary care providers for select “evaluation and management codes”).

18 See, e.g., David Olmos, Mayo Clinic in Arizona to Stop Treating Some Medicare Patients, available at: http://www.bloomberg.com/apps/news?pid=newsarchive&sid=aHoYSI84VdL0 (December 31, 2009) (claiming that Medicare covers only about one-half of the cost of treating Medicare patients at one of the Mayo Clinic’s Arizona outpatient facilities).

19 See Part II, infra.
experiment with new (and sometimes not so new), yet intriguing reimbursement vehicles, such as the Patient Centered Medical Home,\textsuperscript{20} bundled payment,\textsuperscript{21} and the Accountable Care Organization.\textsuperscript{22} These mechanisms are salutary to the extent that they place the doctor’s (and hospital’s) compensation at risk for the quality or result(s) of treatment\textsuperscript{23} or they challenge the doctor’s epistemological commitments in ordering unnecessary or defensive tests or treatments.\textsuperscript{24} However, policymakers do not know, and will not know until several years in the future, at the earliest, whether the reimbursement projects will, in fact, save the Medicare program money or whether doctors (and hospitals) prefer these reimbursement advances over against existing Part A and Part B reimbursement.\textsuperscript{25}

Bundling, with or without the corporate sheltering of the Accountable Care Organization, is not without its critics. For example, ACOs have been likened to managed

\textsuperscript{20} See AFFORDABLE CARE ACT §3021(b)(2)(B)(i).

\textsuperscript{21} See id. at §3023.

\textsuperscript{22} See id. at §3022.

\textsuperscript{23} Risk is involved with bundled payment, as the participating provider(s) is responsible for providing all the care to the enrolled patients for the entirety of the benefit period. See id. at §3023(c )(3)(C)(i)(1). Because the physician is at risk for providing treatment for a set amount of money, it is like managed care’s capitation payment. See FRANK DIAMOND, Accountable Care Organizations Give Capitation Surprise Encore, MANAGED CARE MAGAZINE (September 2009), available at: http://www.managedcaremag.com/archives/0909/0909.accountablecare.html (claiming that “global capitation will be used,” for a projection [word choice] of the Accountable Care Organization considered before the final health care bill was drafted. The principle of global capitation holds true However, In the main iteration of the Accountable Care Organization, the ACO continues to bill Medicare carriers and fiscal intermediaries on a fee-for-service basis, but it shares in any savings created (subject to quality checks) due to more efficient care. See AFFORDABLE CARE ACT at §3022(d)(1)(A).

\textsuperscript{24} For a thoughtful discussion of primary care physicians’ epistemological commitments and how those commitments affect the delivery of healthcare, see Lance Evans and David R.M. Trotter, Epistemology and Uncertainty in Primary Care: An Exploratory Study, 41 FAM. MED. 319, 323, 324 (May 2009).

\textsuperscript{25} From an administrative vantage point, it is hard to imagine that physicians would not prefer bundled payments and the Accountable Care Organization over against current Part B reimbursement, which is dependent, in large part, on patient-driven demand. With mechanisms, the physician receives a set amount of money for each episode period, and then the ACO must provide all the care to the patient for that benefit.
care because they involve a form of capitation payment. While the payment is not the recurring $100 - $200 per member/per month type of payment that was common during the height of managed care, it instead involves a large payment for an episode of care. The onus is then upon the physician to conserve as much of the initial corpus as possible in order to maximize her profit. In this way, the managed care criticism has some cogency. During the 1990s patients frequently and bitterly clamored that their physicians skimped on treatment in order maximize profit. While this criticism is partly unfair, it does have some merit. The doctor who is reimbursed on a bundled basis becomes a gambler with her patient. Does she order one more test or the extra, but not strictly required preventive measure, or does she only treat the acute problem before her, hoping that it won’t get worse? This compromise of her judgment is particularly strong for her chronically diseased patients (who are the main targets of a bundled reimbursement scheme). The doctor might think twice before sending her Type II diabetic patient to the podiatrist for a consult on foot care or a referral to the nutritionist, thinking she can counsel the patient on these non-urgent matters. On the other hand, she might be more willing to make these referrals, hoping that the consultants will keep her patient out of the hospital - for a hospital admission likely would give the doctor a large let net loss for the patient’s benefit period.

26 See Marie T. Currier and Morris H. Miller, Medicare Payment Reform: Accelerating the Transformation of the U.S. Healthcare Delivery System and Need for New Strategic Provider Alliances, 22 HEALTH LAWYER 5 (February 2010).

27 There are several beneficial effects of bundled payment, including forced cooperation between primary care and specialist physicians. It remains to be seen whether generalist participation in ACOs or other bundling reimbursement scheme will devolve into the “gatekeeper” role of early 1990s managed care.

28 See Robert J. Blendon, Understanding the Managed Care Backlash, 17 HEALTH AFF. 84 (July/August 1998).
A problem, of course, with any third-party payment system, even systems as "hands off" as bundling or the Accountable Care Organization, is that some doctors who have either a strong entrepreneurial streak or a deep sense of patient devotion do not want to be beholden to the third-party payer. The old saw is insightful: “He who pays the piper calls the tune.” These independent minded physicians do not want to direct their time or their limited resources to fulfilling byzantine bureaucratic requirements not central to the doctor-patient treatment relationship. In fact, these physicians see the apparatuses of the managed care as affirmatively obstructive of the beneficial treatment they desire to provide their patients. Thus, a pioneering payment movement has developed as a counterweight to managed care penetration and Medicare enrollment. A sizeable number of American physicians have opted out of all third-party reimbursement systems and only take cash or its equivalents for their professional services.  These doctors prefer to trade the simplicity of cash from fewer patients for the administrative complexity and increased marginal costs associated with private and governmental third-party payment. These physicians have reached their private breaking points with the bureaucratization of healthcare, and as a result they reject a large swath of that bureaucratization apparatus.

The budding of this “cash only” movement is a beneficial development in the financing and delivery of American healthcare. Though it will never displace private or government insurance as the main funding mechanisms of healthcare services, its growth

See infra, note ___.

See, e.g., Gail Garfinkel Weiss, Is Cash-Based Medicine the Next Big Thing? MEDPAGE TODAY (March 19, 2009), available at: http://www.medpagetoday.com/PracticeManagement/PracticeManagement/13347; (“Rick Baxley, M.D., a family physician in Orlando, Fla., retained only a third of his 4,900 patients when he decided to break ties with insurers in 2001. Now, however, Baxley has about 4,000 people on his patient roster and sees just 20 to 22 patients a day, down from 40 to 60 in his third-party-payer days”).
signals the strong discontent felt by many American doctors with reimbursement timing and conditions. It also presages mutual desire by doctors and patients to return to deeper and more authentic treatment relationships. When unburdened by preauthorizations, labyrinthine forms and procedures, and interminable telephone calls with clerks – not as sophisticated or educated as the physician, yet who have power to approve or deny treatments upon whim – doctors are free to give more attention to their patients. Whatever the length of the treatment appointment, patients report far more satisfaction with cash-only doctors than physicians who accept insurance.31 Doctors can be more “present” during the appointment, not distracted by administrative tasks often exacerbated by managed care.

The ultimate fate of cash only doctors will not be known for several years. Although the Affordable Care Act mandates that each American procure health insurance by the year 2014,32 it is remains to be seen whether cash only doctors will wither away or whether their number will hold steady or even grow. If patients pay cash in order to receive more immediate physician access and more time with the doctor, it is likely that there will continue to be market demand for cash only doctors.33 Likewise, if doctors continue to be sorely disaffected with their rates of payment and working conditions occasioned by

31 See, e.g., Tony Mecia, Cash For Doctors, WeeklyStandard.com, available at: http://www.theweeklystandard.com/articles/cash-doctors (May 24, 2010) (profiling North Carolina family physician Dr. Brian Forrest who reports “the discovery I made was that by getting rid of administrative, bureaucratic hassles, I was able to do very well financially and at the same time have high patient satisfaction and good quality of care”). Id. The deficiency in the physician reimbursement literature is the dearth of quantitative studies about cash-only doctors. Thus, of necessity, this “story” of cash-only doctors is episodic and attempts to be representative of the general experience of physicians who have taken up cash-only practices.

32 See AFFORDABLE CARE ACT §1501(b).

33 See Robert Lowes, Say goodbye to insurers: it's possible to walk away from third-party payers and still create a satisfying practice, 85 MED. ECON. ___ (“Because doctors with cash-only practices typically book fewer than 20 appointments a day, they spend more time with patients. That's one of the biggest draws of this model. Internist Audrey Corson in Bethesda, MD, says she and her partner, internist Jane Chretien, each see about 12 patients daily, allowing them to take an hour for a comprehensive physical or 30 minutes for an uncomplicated visit.”)
commercial and government insurance, there will likely be market supply of cash only physicians. However, it does seem likely at this point, three years before the implementation of the so-called “individual mandate,” that a patient’s tolerance for the inconveniences suffered in the primary care visit will largely determine whether cash only primary medicine will survive. These patients, many of whose insurance will be subsidized by the federal government, will have to have an extra measure of motivation in order to pay cash for a doctor even with an ostensibly reliable source of insurance.

Further, it is unclear at this point the effect (if any) that cash only ambulatory care will have on systemic health care costs. Most growth in overall healthcare spending in the post-cost reimbursement era has been driven by aggressive use of high technology medicine, referrals to sub-specialists, and plentiful hospital-based end-of-life care. However, increases in the cost of physician services are also an important driver of overall health inflation. This does not mean, though, that primary care physicians’ incomes are

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34 See Thomas Bodenheimer, Primary Care – Will It Survive?, 355 N. ENGL. J. MED. 861 (August 31, 2006) (arguing that patients are sorely disaffected with long wait times, short visits, and generally, narrow access to primary care physicians).

35 See, e.g., Elliot S. Fisher, Julie P. Bynum, and Jonathan S. Skinner, Slowing the Growth of Health Care Costs – The Lessons of Regional Variation, 360 N. ENGL. J. MED. 849, 850 (February 26, 2009) (explaining that regional upward variations in health care costs can be explained, in part, not by mere physician access to high technology medicine, but rather use of high technology medicine and referrals to subspecialists when the patient has relatively stable symptoms). See also, Gerald W. Neuberg, The Cost of End of Life Care: A New Efficiency Measure Falls Short of AHA/ACC Standards, CIRCULATION: CARDIOVASCULAR QUALITY AND OUTCOMES (2009) (noting research from Jack Wennberg, Elliot Fisher, and others from Dartmouth University on the high, and widely varying costs of end of life spending).

36 The accounting and consultancy firm PriceWaterhouseCoopers prepared a report in 2006 for America’s Health Insurance Plans, a trade association for the health insurance industry, in which it reported that that physician services accounted for 24% of overall health costs. This was the largest single component of overall health spending. Further, the report concluded that physician spending grew by 7.8% in 2005. See PriceWaterhouseCoopers, The Factors Fueling Rising Health Care Costs 2006 12 (2006), available at: www.ahip.org/redirect/PwCCostOfHC2006.pdf.
increasing as rapidly overall physician spending.\textsuperscript{37} Despite the recent slight uptick, primary care physicians’ in recent history have \textit{lost} money on an inflation-adjusted basis.\textsuperscript{38}

However, the question of the cash only cost, in any particular patient-physician encounter is an idiosyncratic inquiry, to which a general answer cannot be given. Presumably, cost would be the key factor used by patients when they choose a doctor. However, that is not necessarily the case. Ha Tu and Johanna Lauer report that for the patients who choose a new primary care doctor, “word of mouth” recommendations predominate as the most important aspect of the choice.\textsuperscript{39} Other physician recommendation and the doctor’s presence in insurance provider networks are high in many consumers’ decision matrices.\textsuperscript{40} This suggests that some consumers are cost-insensitive when choosing a doctor and instead choose a physician based on idiosyncratic criteria if a peer, friend, or family member has a positive experience with the physician. Of course, those consumers who have health insurance can afford to be somewhat cost-insensitive about their care. This report does not necessarily speak to those consumers for whom cost is not a primary concern. It is unclear whether cash paying patients are as passive as their insured fellow consumers. Although it stands to reason, however, that if a patient is paying the entire price


\textsuperscript{38} See Reed Ableson, \textit{Doctors’ Pay Fell an Average of 7% In 8 Years, Report Says}, N.Y. TIMES (June 22, 2006) (explaining report from the Center for Studying Health System Change).

\textsuperscript{39} See Ha T. Tu and Johanna Lauer, \textit{Word of Mouth and Physician Referrals Still Drive Health Care Provider Choice}, Center for Studying Health Care System Change, RESEARCH BRIEF, Number 9 2, 3 (December 2008) [cite source?]; see also, Kathleen M. Harris, \textit{How Do Patients Choose Physicians? Evidence from a Nationwide Survey of Enrollees in Employment-Related Health Plans}, 38 HEALTH SERV. RES. 711, 729 (April 2003) (“Overall, the results of this study confirm the image depicted in the previous literature of patients as passive consumers of physician services.”)

\textsuperscript{40} See Tu and Lauer, \textit{Word of Mouth and Physician Referrals Still Drive Health Care Provider Choice}, supra note __ at 3.
of an encounter, the patient would internalize all possible factors that inform that choice. Therefore, the choice of a cash only doctor by a consumer can be a value-laden determination made by the patient with several factors in mind: the perceived health needs of the patient and the ability of the doctor to meet those needs, the “fit” between the patient and the doctor and the doctor’s staff, the doctor’s overall competence, the convenience of the doctor’s location and availability, and of course, the fees charged by the doctor. In other words, “cost” to the patient is not necessarily reducible to the transaction between the patient and the cashier at the end of the office visit. Of course, like in any commercial transaction, the cash only patient may be solely concerned with the price of the encounter and not care about his relationship with the doctor or other care-related factors.

To the extent that a cash paying patient internalizes all of the idiosyncratic reasons for choosing a particular (cash only) doctor, such a patient exemplifies the core tenants of the consumer directed health care (CDHC) movement. In brief, CDHC is the constellation of health care financing options built around the coupling of high deductible health plans and health reimbursement or health savings accounts.41 The main idea behind CDHC is that the patient with more at risk than his peers will make considered decisions before spending on healthcare. In theory, the patient’s ability to gather information empowers him to make wise spending decisions.42 Certainly, not everyone who sees a cash

41 See Melinda Beeukewes Buntin, et. al., Consumer Directed Health-Care: Early Evidence About Effects on Cost and Quality, 25 HEALTH AFF. Web Exclusive, w516, w517 (October 2006), available at: http://content.healthaffairs.org/content/25/6/w516.full. [Need PDF address.]

42 See id. at w51_. As Buntin and her collaborators note, CDHC consumers find and access information about their healthcare at greater rates than do non-CDHC peers. However, according to Buntin, accessing comparative price data is still a problem for CDHC consumers. But, in many cash only encounters, the patient’s only price transparency issue is that of the total cost. Per service charges are oftentimes prominently posted. See, e.g., PriceDoc.Com – Priceline for Doctors – Deal or No Deal, available at: http://www.wellsphere.com/healthcare-industry-policy-article/pricedoc-com-price-line-for-doctors-deal-or-no
only doctor is a classic CDHC consumer. Some cash only patients finance their healthcare on an as-needed or ad hoc basis, and do not annually set aside a large amount of money in a HSA. However, the principles carry over for both types of patients. When a patient spends his own money, he is far more likely to get exactly what he wants from the transaction. If he wants (relatively) cheap healthcare when he needs it, cash medicine provides an outlet. If he wants to develop a relationship with his physician, cash medicine provides the context for rapport.

Although the consumer might act rationally by initially choosing a cash only doctor, that does not mean his choice will turn into a long term doctor-patient relationship. Some cash paying patients will forego needed healthcare because they do not have the resources to finance needed and ongoing doctors’ visits, medicines, or other interventions. It is tragic that patients are compelled to choose between physician oversight of their hypertension, for example, and keeping the power on. However, the cash only doctor provides a point of access for the patient, and a method of financing healthcare delivery. The doctor can rationally choose a method of payment different than the predominant

43 See generally, John C. Goodman, What Is Consumer Directed Health Care ?, 25 HEALTH AFF. Web Exclusive w540 (October 2006), available at: http://content.healthaffairs.org/content/25/6/w540.full. [Need PDF address,]. There are many criticisms of consumer directed health care that could be levied against cash only medicine qua trend. For example, one deficiency of CDHC is that it tends to promote adverse selection, the phenomenon of relatively healthy people opting out of normal insurance products (and into high deductible, CDHC-friendly plans). See Karen Davis, Will Consumer Directed Health Care Improve System Performance?, The Commonwealth Fund Issue Brief 3(August 2004). To the extent that cash only medicine promotes adverse selection, it could be responsible for higher insurance rates for the sicker patients who cannot self-finance all of their healthcare.

44 See John V. Jacobi, Consumer Directed Health Care and the Chronically Ill, 38 U. MICH. J. L. REF. 531, 534 (Spring 2005) (“The adoption of essentially unregulated, simplistic forms of consumer-driven plans will harm individuals with chronic illness, who simply cannot choose to forego necessary, frequent services, and who face impoverishment and/or denial of care under these plans”).
insurance-domination without having to bear the brunt of the patient’s Hobson’s Choice. Any move by a regulatory agency to co-opt a physician’s freedom of contract and force the physician to participate in any particular government insurance plan would be counterproductive at best, disastrous at worst. For example, Massachusetts, whose version of the individual insurance mandate is quite similar to that of the Affordable Care Act, is currently considering a bill in which doctors would be compelled be participating providers in a low-paying, bare bones government plan as a condition of their professional licensure. While no such overt co-optation is present in the Affordable Care Act, doctors are generally unhappy with the Act and the perceived strictures it will place on their practices. Although the predicted mass exodus from the medical profession hasn’t happened yet, enough physicians are disaffected with health care reform as it has currently been passed, that legislators and regulators would be wise to tread lightly around physicians’ autonomy and sense of professional independence.

It is important to note, though, that cash only doctors’ fees vary considerably across the country. For example, some doctors charge near the equivalent of a typical insurance co-payment for an uncomplicated, ten to fifteen minute visit. Of course, other

45 See Mass. Gen. Law ch. 111M §2 (for state version of individual mandate). See also, infra Part III (regarding Massachusetts’ bills that would compel physicians to contract with the state’s baseline insurance).


The majority of physicians (60%) said health reform will compel them to close or significantly restrict their practices to certain categories of patients. Of these, 93% said they will be forced to close or significantly restrict their practices to Medicaid patients, while 87% said they would be forced to close or significantly restrict their practices to Medicare patients…[and]

40% of physicians said they would drop out of patient care in the next one to three years, either by retiring, seeking a non-clinical job within healthcare, or by seeking a non-healthcare related job.
primary doctors charge more, and some charge much more than the relatively modest $30 for the same amount of the doctor’s time.\textsuperscript{48} Unsurprisingly, fees also vary for longer office visits dedicated to giving more attention to the patient’s few problems or adequately treating more or more complex health issues.

It should not come as a shock that cash only doctors have invented clever ways to value their time apart from the increments of ten to fifteen minutes that are the heritage of the coding system mandated by the insurance industry and the Medicare program. For example, one cash only doctor actually starts a stopwatch at the beginning of the patient encounter and charges the patient in increments of two minutes.\textsuperscript{49} While there is no overt pressure from the physician to speed through the exam and diagnosis, the presence of the stopwatch incentivizes both patient and physician to be precise in their discussion of symptoms, diagnosis, and treatment plan. And while novel and out of the ordinary, the stopwatch method gives a great deal of control to the patient to control the cost of the office visit.\textsuperscript{50}

\begin{itemize}
\item \textsuperscript{47} See, e.g., Chen May Yee, \textit{Doc’s cash-only billing bucks the insurance morass}, \textit{Minneapolis Star-Tribune}, available at: \url{http://www.startribune.com/business/83165347.html?page=1&c=y} (January 31, 2010) (noting that Dr. James Eelkema, a Minneapolis area cash only physician, established his practice on the pricing schedule of a $36 charge for one problem and $54 charge for two problems). A recent visit to Dr. Eelkema’s website notes that his prices have gone up. He now charges at minimum $45 for one problem and $70, at minimum, for two problems. \textit{See} home page of Time Wise Medical at: \url{www.timewisemedical.com/home}.
\item \textsuperscript{48} See Jaime Holguin, \textit{COD = Cash Only Doctors: Fed Up With Insurance Red Tape, Doctors Opt For Simple Cash Payments}, available at: \url{http://www.cbsnews.com/stories/2004/04/05/health/main610269.shtml} (April 5, 2004) (profiling Dr. Vern Cherewatenko, who charged $50 for a brief office visit in 2004); \textit{see also}, Nick Perry, \textit{A health plan that covers it all – cash}, \textit{The Seattle Times}, available at: \url{http://seattletimes.nwsource.com/html/localnews/2002180619_cashdocs15m.html} (February 15, 2005) (also profiling Dr. Cherewatenko, and stating that he charged between $50 and $150 for an office visit, depending on the length, and that he outsourced diagnostic tests to other providers who also charged cash), and Fernando Quintero, \textit{Are cash only doctors an Rx for savings?}, \textit{Orlando Sentinel}, available at: \url{http://articles.orlandosentinel.com/2010-05-03/news/os-cash-medical-practices-20100503_1_dr-baxley-health-insurance-high-deductibles/3} (May 3, 2010) (outlining fee structures for Orlando, Florida area cash only medical providers).
\item \textsuperscript{49} See Mecia, \textit{Cash For Doctors}, \textit{supra} note __.
\end{itemize}
Importantly, the cash-only reimbursement movement must be distinguished from its first cousin, sometimes derisively called “concierge care,” or more neutrally “retainer care.” A concierge doctor charges an up-front retainer, usually before any fee-for-service treatment is rendered. While some of the perceived problems with concierge care have been overstated, particularly the effects the concierge doctor has upon access to primary care and insurance markets, the benefits of concierge care remain understated. Like the

50 One viable criticism of cash only medicine is that even the well-informed patient cannot know with precision the cost of the encounter before seeing the doctor, even if the doctor prominently posts his prices. The patient’s condition(s) might be more complicated than originally thought, thus needing a long appointment time. The patient could need (many) laboratory tests he did not anticipate before the visit. Although several cash only doctors have negotiated significant discounts from free standing laboratories, imaging centers, and other vendors of specialty services, there is no way for the patient to fully plan on the final cost of the visit before arriving at the doctor’s office. See supra note, __.

51 See, e.g., Abigail Zugar, For a Retainer, Lavish Care by ‘Boutique Doctors,’ N.Y. TIMES (October 30, 2005), available at: http://www.nytimes.com/2005/10/30/health/30patient.html?pagewanted=1&adxnnlx=1130957666-KH4KWRzQXSeEldpNOQ59sg (“Dr. Bernard Kaminetsky, one of a new breed of ‘concierge’ or ‘boutique’ doctors who, in exchange for a yearly cash retainer, lavish time, phone calls and attention on patients, using the latest in electronic communications to streamline their care”). Id. See also, Frank S. Pasquale, The Three Faces of Retainer Care: Crafting a Tailored Regulatory Response, 7 YALE J. HEALTH POL., LAW. & ETH. 39, n. 1 (choosing “retainer care” as a neutral term over against more highly charged “boutique” or “concierge” medicine, among others).

52 See, e.g., Zugar, For a Retainer, Lavish Care by ‘Boutique Doctors,’ supra note __ (noting patients must pay an annual $1650 fee to be a patient of Dr. Kaminetsky), and Anthony J. Linz, et. al., Impact of Concierge Care on Healthcare and Clinical Practice, 105 J. AM. OSTE. ASSN. 515 (noting that “membership costs for patients using concierge care vary, ranging from a $50 annual ‘access fee’ to retainer fees of between $900 and $20,000 per patient per year”). Id. Interestingly, in the Affordable Care Act, the Congress has seemingly approved of a mild version of concierge care called by some observers as “direct pay,” in which members of a practice pay a moderate monthly membership fee. See, e.g., Kaiser Health News, Some medical practices move to monthly membership fees for patients, available at: http://www.calpatientcare.org/post/some-medical-practices-move-monthly-membership-fees-patients (featuring the Qliance primary care practice in Seattle, Washington that charges its patients $65 per month for unlimited visits with the practice’s providers. See also, AFFORDABLE CARE ACT §10104(a)(3) (“The Secretary of Health and Human Services shall permit a qualified health plan to provide coverage through a qualified direct primary care medical home plan that meets criteria established by the Secretary, so long as the qualified health plan meets all requirements that are otherwise applicable and the services covered by the medical home plan are coordinated with the entity offering the qualified health plan”).

53 This, of course, is dependent upon how one considers access to and provision of care. If one considers stories of, for example, a radiology practice in New York City that has two entrances and two waiting rooms, one for concierge patients and the other for “regular” patients, it is easy to determine that some provision of concierge medicine is unseemly. See Bill Dedman, Clinic with two doors, a symbol of two-tier care, available at: http://www.msnbc.msn.com/id/33863680/ (November 23, 2009). The American Medical Association has addressed the access the problem by requiring concierge physicians to help their patients who cannot pay the
cash-only doctor, the concierge doctor must balance declining third-party reimbursement that in many cases does not cover the cost of treatment along with payers’ onerous technical requirements. The concierge doctor’s twist is the annual fee. The fee covers the cost of decreased revenue from fewer patients, and it provides patients with extra amenities not normally found in a primary care doctor’s practice.\(^{54}\) The concierge doctor stands to reap a windfall of a practice-related revenue stream that he could not hope to make as a “regular” insurance-receiving doctor or even as a cash-only doctor.\(^{55}\)


\(^{54}\) See 2003 CEJA REPORT at 1; see also, GAO REPORT at 3 (describing typical amenities as same day appointments and preventive services not typically covered by insurance). But see, AFFORDABLE CARE ACT §§1001, 4103, and 4104 (describing preventive health services that must be provided to patients as of [January 1, 2011] without any patient cost-sharing, including deductibles or coinsurance).

\(^{55}\) See Adam Graham-Silverman, *Two-Tiered Medical Care for the Haves and Have-Nots*, THE FISCAL TIMES, available at: [http://www.thefiscaltimes.com/Issues/Health-Care/2010/05/18/Two-Tiered-Medical-Care-for-Haves-and-Have-Nots.aspx](http://www.thefiscaltimes.com/Issues/Health-Care/2010/05/18/Two-Tiered-Medical-Care-for-Haves-and-Have-Nots.aspx) (May 18, 2010) (noting that some concierge physicians charge between $10,000 to $20,000 per year per patient). Physicians who charge that much in an access fee could only have 100 patients and make significant income apart from fee-for-service encounters.

\(^{56}\) See, e.g., Lee Bowman, Scripps Howard News Service, *Does: 'Cash-only' practices take different styles*, available at: [http://www.scrippsnews.com/node/42604](http://www.scrippsnews.com/node/42604) (April 20, 2009) (profiling Dr. Brenda Arnett, who has a total of 450 patients in her cash only primary care practice). When a physician transitions to a cash only practice, issues of patient abandonment are potentially implicated, since many patients will need to find another doctor who will accept their insurance plan. It is incumbent upon the new cash only physician to act ethically with respect to these departing patients. See, e.g., American Medical Association, CODE OF MEDICAL ETHICS, Opinion 8.115, *Termination of the Physician-Patient Relationship* (June 1996), available at: [http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8115.page?](http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8115.page?)
any one day than a standard insurance-taking doctor.\textsuperscript{57} On either horn of the perceived dilemma, the cash only doctor could reasonably substitute a higher per-service fee for the large amount of gross revenue the insurance-taking doctor earns in her practice by treating many patients during a service period.

While some cash only doctors might charge more for their services once they disengage from insurance, no data support a generalized conclusion about cash only doctors’ prices. It is likelier that a cash only doctor’s charges are less than or the same as their charges to insurance companies, while they are actually paid more by their patients than insurance companies to insurance-taking doctors.\textsuperscript{58}

Although not enough data are present to make generalized conclusions, at least two provisional conclusions are in order. First, cash only physicians set their charges according to the demands of the marketplace, and any physician who prices her services “too high” might very well price herself out of the cash only market. Second, and perhaps more importantly, both cash only doctors and their patients self-select. That is, a cash only physician is drawn to an insurance-free practice because of the great freedom that such a way of working out her profession gives her. She is free of the omnipresent specter of insurance in all its guises, and therefore she is liberated to practice medicine according to her truest, most authentic values. Importantly, she is not bound to the values of the insurance companies that before were not only her contractual counterparties but also the

\textsuperscript{57} See Bowman, Docs: ‘Cash-only’ practices take different styles, supra note __. (in which Dr. Arnett registers her discomfort at having to see an average of 18-20 patients per day for no more than 15-20 minutes per appointment).

\textsuperscript{58} See Perry, A health plan that covers it all – cash, supra note __. See also, Mecia, Cash For Doctors, supra note __ (noting the sharp uptick in income for Dr. Brian Forrest of North Carolina viz. other primary care physicians).
“real” purchasers of healthcare services from her. Further, the patient also self-selects. The patient is willing, in some cases, to pay more for the multivalent benefits that he receives from the cash only doctor. For example, the patient has greater access to the physician. Because the doctor may not have a patient roster of thousands, but merely hundreds, it is easier for the patient to get an appointment with the doctor. Additionally, the doctor is able to devote more time to the patient’s health concerns should the patient want that extra attention. In all patient encounters, whether brief or long, the doctor can be more attentive to the patient because her mind is not divided and focused on fulfilling an insurer’s mandates for securing reimbursement.

This Article will explore cash-only reimbursement as a reemerging phenomenon in healthcare reimbursement. Part II will examine the deepening crisis in primary care medicine that is encouraging many internists and family medicine doctors to forego third-party payers in exchange for cash-only patients. Beginning in medical school, general medicine is derided as unworthy by the vast majority of medical students. Once they enter practice, generalists are besieged by the inequitable RBRVS formula, the iniquitous committee in charge of maintaining it, and the indecipherable mechanism that tamps down overall Medicare payments to physicians. And perhaps more than any other specialist, the primary care doctor is cornered by the administrative burdens mandated by managed care. Part III will investigate cash-only reimbursement qua trend. This section will survey the typical cash-only practice and the decisions that moves doctors to jettison insurance. This

59 See Weiss, Is Cash-Based Medicine the Next Big Thing?, supra note __ (noting the precipitous reduction in patients once Dr. Rick Baxley transitioned his practice to cash only).

60 See Institute of Medicine, EMPLOYMENT AND HEALTH: A CONNECTION AT RISK 51-55 (1993) (tracing the development of employer-provided health insurance from cash payment).
Part will also address the main objection of critics of cash-only doctors. If the insurance-denying trend continues, access to primary care physicians will be compromised. Further, in light of the Affordable Care Act’s individual mandate, thirty million previously uninsured Americans will be insured and presumably will seek far more care in a system that already does not have enough generalists to care for them. This mandate has set up a perfect storm of access - more patients and fewer doctors who want to treat them given the paltry state of public and private reimbursement. The likely result of the individual mandate is an acceleration of generalists fleeing to cash-only practices. Part IV briefly concludes the Article.

II. The Crisis in Primary Care

A. Portrait of the Modern Primary Care Doctor

Primary care, roughly bounded by general internal medicine, family medicine, and pediatrics, is in the crosshairs of the many forces besieging it. Popular culture has long since dumped the avuncular Marcus Welby for the sexy, hip surgeons of “Miami Medical.” Medical students no longer see primary care as a noble outlet for their training.

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61 See Letter from Douglas W. Elmendorf (Director, Congressional Budget Office) to Hon. Nancy Pelosi, available at: http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf (March 20, 2010) (noting that CBO and the congressional Joint Committee on Taxation anticipate that 32 million previously uninsured Americans will obtain health insurance by 2019). Broadened coverage could have deleterious effects could have deleterious access effects. See Kevin Sack, In Massachusetts, Universal Care Strains Coverage, N.Y. TIMES (April 5, 2008) available at: http://www.nytimes.com/2008/04/05/us/05doctors.html (highlighting the strain in primary care delivery in Massachusetts after it adopted a coverage scheme upon which the Affordable Care Act was based).

62 See Sarah E. Brotherton, et. al., U.S. Graduate Medical Education, 2004-2005: Trends in Primary Care Specialties, 294 J. AM. MED. ASSN. 1075 (September 7, 2005) (describing the primary care specialties surveyed as: family medicine, internal medicine, pediatrics, combined internal medicine/pediatrics, and obstetrics and gynecology).

Instead, they covet technically challenging specialties or sub-specialties, like the so-called “ROAD” specialties (radiology, ophthalmology, anesthesiology, and dermatology) that do not require intense patient care obligations with the attendant unpredictable hours and onerous call schedules. Primary care is viewed by these young students as passé – day after day of patients with sore throats, flu, and twisted ankles – without the exceptional per service reimbursement that their specialist colleagues receive.

Primary care has received such a bad rap among medical students that a recent study maintains that only 2% of entering students think they will choose a general internal medicine residence (and not go on and subspecialize) upon graduation from medical school. Ironically, medical students choose internal medicine residencies in far greater proportions than family medicine residencies. After finishing the three years or four years of the internal medicine residency, the young doctor can go on to a sub-specialty fellowship. And, of course, after completing the fellowship, the doctor can anticipate earning roughly 20 to 35% more than her general internist colleagues, as a measure of

64 See Karen E. Hauer, et. al., Factors Associated With Medical Students’ Career Choices Regarding Internal Medicine, 300 J. AM. MED. ASSN. 1157, 1158 (September 10, 2008) (reporting that medical students prefer internal medicine subspecialties, surgical specialties, and pediatrics as the top three groupings of available career choices); see also, Pauline Chen, Primary Care’s Image Problem, N.Y. TIMES (November 12, 2009), available at: http://www.nytimes.com/2009/11/12/health/12chen.html?_r=1 (describing the “ROAD” specialties popular among medical students and how the author was skeptical when a top-performing peer chose a primary care specialty for residency).

65 See generally, id.

66 See Hauer, et. al., supra note __ at 1157 (noting that of the 23.2% of graduating medical students surveyed who wanted a career in internal medicine, which includes subspecialties, only 2% wanted to stay with general internal medicine) [Check on this: NEJM has slightly different numbers – Okie – Innovation in Primary Care (November 27, 2008)] .

67 See id. at 1158 (noting that only 4.9% of medical students surveyed wanted to select a family medicine residence, while 11% wanted to choose pediatrics, and 4.2% wanted to choose obstetrics/gynecology. The relatively high percentage of students choosing pediatrics did not give an indication of how many would be staying with general pediatrics and not going on to a sub-specialty).
starting compensation. Nevertheless, relatively few young physicians choose to go into
general internal medicine, even though internal medicine is widely hailed as one of the most
challenging specialties in medicine. The doctor must treat the whole person (instead of a
particular organ or region of the body), and he must do so when the patient is at her sickest.
And because the internist is often the first set of eyes over the adult medical problem, the
good internist must have an exquisite power of clinical reasoning and judgment, in order to
marshal disparate clues into a coherent diagnosis and prognosis.

1. Educational Debt and Salary Disparities

At least two factors animate the medical student’s decision to forsake general
medicine for more lucrative specialties. First, students are more concerned about debt than
ever before. Many students enter medical school with outstanding debt from undergraduate
education. Four years of medical school promises to add another $125,000-$200,000 of
educational debt. Thus, students graduating from good, yet not even elite, colleges and

68 See 2009 AMGA (American Medical Group Association) Medical Group Compensation and Financial
Survey [hereinafter 2009 AMGA Report], available at:
http://www.cejkasearch.com/compensation/amga_physician_compensation_survey.htm (comparing the
starting compensation for general internal medicine of $146,251 to allergy/immunology of $180,000 yields an
approximate 19% gap, and comparing the general internal medicine compensation to critical care medicine
($225,000) yields an approximate 35% gap).

69 See Eric B. Larson, General Internal Medicine at the Crossroads of Prosperity and Dispair: Caring for
Patients with Chronic Diseases in an Aging Society, 134 ANNALS INT. MED. 999 (“The greatest opportunitie
for general internal medicine relate to its strength as an integrating, cognitive specialty”).

70 See generally, JOY HIGGS AND MARK JONES, EDs., CLINICAL REASONING IN THE HEALTH PROFESSIONS, 2d.

Medical Student Section Task Force on Medical Student Debt, available at: http://www.ama-
allopathic medical students entered medical school with debt from college/university); but see, American
Association of Medical Colleges 2009 Graduate Questionnaire, available at:
medical students surveyed in 2009 no longer owed any outstanding undergraduate debt).
medical schools, could accumulate several hundred thousand dollars of debt before they see one patient in private practice.\textsuperscript{73} It is no wonder that students want to grab the “golden goose” while they can.\textsuperscript{74} Interestingly, though, debt accumulation follows medical students after they graduate from medical school. Many new doctors must take out a bank loan in order to purchase ownership interests in their private practices.\textsuperscript{75} Regardless of their business situation, other doctors purchase a home upon entering or finishing residency.\textsuperscript{76} It is therefore not uncommon for a freshly-minted doctor to have several hundred thousand dollars of debt before they start making good money.

Whether ego-driven or compelled by the need to service the debt that will help them keep up with their peers, medical students are driven to the higher paying specialties. Though the average compensation for a generalist, anywhere from $125,000 - $200,000, would put the doctor within the top 20\% of income,\textsuperscript{77} many specialists, however, start at

\textsuperscript{72} See id. at 42 (noting that in 2009, of all medical students surveyed, total medical school indebtedness was $143,870).

\textsuperscript{73} See id. (noting that in 2009, 25\% of medical students surveyed had $200,000 or more of total student debt).

\textsuperscript{74} But see id. at ___ [noting that over 50\% of medical students surveyed claim not to be affected by their debt loads].

\textsuperscript{75} See American College of Physicians, Partner Buy-Ins, available at: \texttt{http://www.acponline.org/residents_fellows/career_counseling/partner_buy.pdf} (noting that doctors can have the opportunity to purchase ownership in their medical practice immediately upon entering the practice or after a few years of employment).

\textsuperscript{76} See SunTrust Mortgage, Mortgages for Special Needs: Doctor Loan Program, available at: \texttt{http://suntrustmortgageproducts.com/special.asp#Doctor-Loan-Program} (describing 100\% loans with no private mortgage insurance required for loans of up to $1.5 million for physicians who have completed their residency program within the past ten years and loans of up to $417,000 for doctors still in residency or fellowship); see also, Doctor Loan USA, available at: \texttt{http://www.doctorloanusa.com/} (describing 100\% loan programs with no private mortgage insurance or origination fees charged).

\textsuperscript{77} See 2009 AMGA Report, supra note ___ (noting that in 2009, family medicine physicians average starting compensation was $144,990, while general internal medicine physicians average starting compensation was $146,251. Median compensation for family medicine practitioners was $197,655, while median compensation for internists was $205,441); see also, U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, Table HINC-05. Percent Distribution of Households, by Selected Characteristics Within Income Quintile and Top 5 Percent in 2006, available at:
$200,000 and can make many times more than that.\textsuperscript{78} And the internist who makes
$200,000 is in the top quartile for all earners within his specialty, which means that he
works hard for his compensation – long hours and dozens of patients seen each workday.\textsuperscript{79}

In medicine, like many other professions, money is power. The American
medical student who chooses a specialty perceives himself to be more powerful, and thus a
better, more worthy physician because his talents are more highly valued. There develops a
form of pity between medical students who choose specialties and their generalist-
identifying peers. This pity looks upon the soon-to-be generalist with a benevolent disgust
because it is thought he cannot or will not match for a specialty residency.\textsuperscript{80}

2. \textit{Intellectual Complexity}

\begin{itemize}
\item \url{http://pubdb3.census.gov/macro/032007/hhinc/new05_000.htm} (noting that the lower limit for household income in the top fifth of all household income was $97,030 and for the top 5% was $174,000 in 2006).
\item \textsuperscript{78} See 2009 AMGA Report, supra note ___, (noting the following starting average compensation amounts for the following selected specialties: anesthesiology - $325,000, cardiology - $292,000, dermatology - $238,000, and orthopedic surgery - $370,000. The median salary for orthopedic surgery is $476,083, neurosurgery is $548,186, and spine surgery is $641,728).
\item \textsuperscript{79} See Harold C. Cox, \textit{The Hospitalist Model: Perspectives of the Patient, the Internist, and Internal Medicine}, 130 ANN. INT. MED. 368 (February 16, 1999) (reporting that “anecdotal anecdotal reports indicate that 20 to 30 patients per work day is the norm for internists in areas where managed care is well established”); see also, Richard J. Baron, \textit{What’s Keeping Us So Busy In Primary Care? A Snapshot From One Practice}, 362 N. ENG. J. MED. 1633 (April 29, 2010) [hereinafter \textit{What’s Keeping Us So Busy In Primary Care?}]. Dr. Baron accounted for the following average activities per physician, per day:
\begin{verbatim}
Visit 18.1
Telephone Call (Involved in) 23.7
Prescription Refill (Written) 12.1
E-mail Message (Written) 16.8
Laboratory Report (Reviewed) 19.5
Imaging Report (Reviewed) 11.1
Consultation Report (Reviewed) 13.9
\end{verbatim}
\textit{Id.}
\item \textsuperscript{80} See, e.g., \textit{Primary Care’s Image Problem}, supra note ___ (where Dr. Pauline Chen, the article’s author, noted about herself and her medical school peers, “some of my classmates were incredulous. In their minds, primary care was a backup, something to do if one failed to get into subspecialty training”).
\end{itemize}
Second, medical students are unimpressed with the types of patients seen by generalists. The simple and the routine dominate most generalists’ (especially family practitioners’) days. Sore throats, sprained ankles, routine physicals, and counseling recalcitrant diabetics and hypertensives, and the like, fill most of their schedules.\(^{81}\) The contemporary student wants an intense, intellectually complex practice, yet one he can leave behind at 7 P.M. For many medical students, this means becoming proceduralists – specialists (or sub-specialists) who perform office-based or hospital procedures upon patients.\(^{82}\) This can take the form of the anesthesiologist who inserts breathing tubes in the operating room or the dermatologist who does simple lesion removal in his office.

The need for intellectual complexity by the specialist is shared by the generalist. But the generalist typically handles more problems in a typical encounter than does the specialist. The generalist devotes less than twenty minutes to patients with typical presenting symptoms.\(^{83}\) This contributes to a practice environment in which patients are rushed through encounters with their providers.\(^{84}\) When coupled with a payment system skewed heavily toward his specialist colleagues, it is surprising that more doctors have not

\(^{81}\) See generally, id.

\(^{82}\) See id. (discussing the “ROAD” specialties).

\(^{83}\) Studies vary significantly regarding the length of time that physicians spend with their patients. See, e.g., David Mechanic, et. al., Are Patients’ Office Visits With Physicians Getting Shorter?, 344 N. ENG. J. MED. 201 (January 18, 2001) (stating that in 1998, an office visit for a “non pre-paid” patient with a complaint of hypertension was 17.2 minutes and a “prepaid” patient with the same diagnosis was 16.5 minutes); see also, Ming Tae-Seale, et.al., Time Allocation in Primary Care Office Visits, 42 HEALTH SERV. RES. 1879 (October 2007) (reporting of a study in which the median office visit time was 15.7 minutes and the median number of medical complaints discussed was six) and Andrew Gottschalk and Susan A. Flocke, Time Spent in Face-to-Face Patient Care and Work Outside the Examination Room, 3 ANN. FAM. MED. 488 (November/December 2005) (noting that the 2003 NAMCS study found an average of 18.7 minutes for each family medicine/general medicine visit). [Cite original source]

\(^{84}\) See id. (concluding that for the major presenting problem, patients, in all sample groups, spoke for a median time of 2.0 minutes while the doctor spoke for 2.3 minutes. For minor presenting problems, patients spoke for a median time of 0.5 minutes and the doctor spoke for 0.4 minutes).
left the medical practice altogether. However, the proceduralist too must guard against the mental fatigue and discontent that comes with routinization of procedures they do on a daily basis. The proceduralist can take comfort, though, in that his procedures are “commoditized” so that he can sell as many of them as he desires during a workday, while his generalist colleague must sell his time on a deeply discounted basis.

C. RBRVS – Legalized Monopoly Domination by Specialists

By 1980, Medicare was having a strong growth spurt. Millions of patients were treated, but costs were practically unrestrained. Congress was determined to corral those costs else Medicare spending overwhelm the rest of the national budget. Stark realization of the country’s dire situation met with the political determination to arrest the fiscal brinkmanship. Thus, for physician reimbursement, the Resource Based Relative Value Scale was born.

Congress originally based its physician reimbursement system, like its original system of hospital reimbursement upon what the provider (physician) actually charged, limited by the usual charge for the same service in the community. Predictably, prices for physician reimbursement increased rapidly when they were left to little but the doctor’s and his peers’ own imagination. Thus, in 1989, Congress created RBRVS to equitably parcel

85 MARILYN MOON, MEDICARE: A POLICY PRIMER 58 (2006) (claiming that “by 1980, Medicare was the second largest federal domestic program and the fastest growing one”).

86 For example, the Inpatient Hospital Prospective Payment System (“IPPS”) was enacted in 1983 and is credited for reining in the Medicare rate of growth. See Jason S. Lee, et. al., Market Watch – Medicare Policy: Does Cost Shifting Matter?, HEALTH AFF. Web Exclusive W3-481 (October 8, 2003), available at: http://content.healthaffairs.org/content/early/2003/10/08/hlthaff.w3.480.full.pdf. [cite authors’ source?]

87 OMNIBUS BUDGET RECONCILIATION ACT OF 1989 §6102.

88 For an interesting perspective on the creation of the original Medicare payment mechanisms, see Robert M. Ball, What Medicare’s Architects Had In Mind, 14 HEALTH AFF. 69 (Winter 1995).
out physician compensation based upon medical interventions’ difficulty and the time needed to complete, among other factors.

Medicare Part B reimbursement is not open-ended. A large, yet discreet amount of money is set as a spending target every year.\textsuperscript{90} Through the Sustainable Growth Rate (“SGR”), Congress has created an algorithm by which every Medicare-enrolled physician’s compensation is (theoretically) corralled, and thus, (theoretically) all enrolled physicians share in the pain presaged upon SGR-mandated cuts.\textsuperscript{91} Were it this easy and egalitarian. In fact, with RBRVS and SGR, Congress unwittingly created a Hobbesian war of “all against all” in which primary care doctors annually must battle their specialist colleagues for diminishing pieces of the Medicare pie. And that is why the annual allocation of “relative value units” by CMS is such a contentious and emotionally-driven process. But it was not always that way. RBRVS was originally constructed to benefit primary care physicians.

The charge-based system greatly advantaged specialists, who could charge high premiums for their expert knowledge. So, in order equalize reimbursement between the two camps, Congress allowed for the formula to function show that it benefitted primary care.\textsuperscript{92} This


\textsuperscript{90} See 42 U.S.C. §1395w-4(d)(3) (establishing the Sustainable Growth Rate).

\textsuperscript{91} SGR works by cutting the RBRVS “conversion factor” in Year 2 if the targeted amount of Part B physician spending is exceeded (as defined by the SGR formula) in Year 1. See id.; see also, John Mayer, The American Health Care System and the Role of the Medical Profession in Solving Its Problems, 84 ANN. THORAC. SURG. 1432 (2007) (for a concise description of the interplay between SGR and RBRVS).

\textsuperscript{92} See John K. Inglehart, The American Health Care System – Medicare, 340 N. ENG. J. MED. __ [page number not apparent – on Lexis printout] (noting that primary care reimbursement increased by 36.1% from 1991-1997 and decreased by 9.3% and 18.1% for cardiologists and ophthalmologists, respectively during that same time period).
did not last, though. Eventually, the number of seats on the unit-setting committee, the Relative Value Unit Update Committee, expanded to 29 with 23 of the seats going to specialist medical societies.\(^{93}\) Unsurprisingly, with the specialists in control, they receive more of the Medicare pie than their generalist colleagues.

A large, yet understated and inchoate problem with RBRVS is that it is formula-based system.\(^{94}\) On the one hand, that the system is driven by a formula should make it predictable and workable by all physicians. However, because a key component of the formula – the number of units to assign to particular service - is privately controlled by the Relative Update Committee, and the RUC’s recommendations are almost always adopted \textit{in toto} by CMS, primary care physicians feel disenfranchised and abused by it.\(^{95}\) The RUC and CMS have therefore truly become the “public private cartel” lamented in a recent popular article.\(^{96}\)

The formulaic nature of reimbursement extends beyond the mere claim form and Current Procedure Terminology ("CPT") codes that populate it. When the doctor’s pay is tied, in large part, to a formula that drives his compensation, he tends to build his practice and work life around the norms and strictures of that formula. For example, most primary care physicians spend a significant amount of time conducting office visits that are later billed as “evaluation and management” codes, heralded as part of the RBRVS reforms.\(^{97}\)


\(^{94}\) \textit{See infra}, note ___.

\(^{95}\) \textit{See} Sanghavi, \textit{The Fix Is In, supra} note ___.

\(^{96}\) \textit{See id.}
Their name belies their use. These codes define the clinical assessments and on-going medical management of both new and established patients. These are the codes that get to the heart of “cognitive-based” medicine, in which the doctor must induce a diagnosis and prognosis based on different, and sometimes unrelated and incongruent clues. These codes are the core of a generalist’s practice. Most patients that a generalist sees in a typical workday do not have to have something done to them. Rather, they must be examined and listened to in order to determine what is wrong with them. These are the patients with hypertension, or Type II diabetes, or acid reflux disease who must be seen (if ever so briefly), have their medications checked and re-prescribed, and briefly counseled about the steps to take to suppress their chronic diseases. Otherwise, these are the patients who have pressing enough acute conditions that require some attention by the doctor. Because these codes are defined according to the time spent with the patient, the severity of the patient’s condition when he sees the physician, and the amount and complexity of decision-making.

97 Marshall W. Raffel, et al., THE U.S. HEALTH SYSTEM: ORIGINS AND FUNCTIONS, 5th ed. 44 (2002) (noting that E&M codes were introduced through RBRVS; however, “clear regulations governing their use were not found until 2000”). [Note: drill down exactly when they were first introduced.]


From the perspective of practice, primary care can be defined by its several clinical tasks: (a) medical diagnosis and treatment, (b) psychological diagnosis and treatment, (c) personal support of patients of all backgrounds in all stages of illness, (d) communication of information about prevention, diagnosis, treatment, and prognosis, and (e) prevention and care of chronic disease and disability through risk assessment, health education, early disease detection, preventive treatment, and behavioral change. These tasks are a clinical or operational definition of the work of primary care practitioners.

making that goes into the management of the patient’s condition, the physician has a fairly
good indication of the amount of time he must spend with each patient. In other words,
patient symptoms coupled with the contours of the evaluation and management code give
shape to a typical physician’s workday.

The evaluation and management code thus transforms the generalist’s practice
from one in which he develops deep, lasting, and trust-based relationships with his patients
to one in which he sells CPT code 99201 (defining a 10 minute office visit) to the insurance
companies (including in this case, Medicare) and spends his time gathering requirements to
justify his billing of the code. In this sense, the generalist is no better (or worse) than his
specialist colleague because he does not sell health or the authority-based dictum to improve
health. Rather, he sells something – in this case, the generalist’s time in pre-defined
blocks.

Ironically, in a strong sense, the cash-based doctor does the very same thing. The
cash doctor sells his time, often in pre-set increments. The key difference, though,
between the Medicare-enrolled doctor and the cash doctor is that the patient of the cash
doctor herself internalizes the value that the doctor will spend with her. And in that sense,
the consumer-valued cash office visit is a paradigmatic example of a market transaction –

101 See Medicare Learning Network, Evaluation & Management Services Guide 5, 6 (July 2009), available at:
E&M codes).

102 See id. at 4 (summarizing the requirements for the code as: “problem focused history, problem focused
examination, and straightforward medical decision making”). [Need to find more on this.]

103 For an incisive discussion of E/M coding and RVUs in the primary care context, see generally, Thomas
Bodenheimer, et. al., The Primary Care-Specialty Income Gap: Why It Matters, 146 ANN. INT. MED. 301
(February 20, 2007).

104 See, e.g., Mecia, Cash For Doctors, supra note ___ (describing a cash-only physician who starts a stopwatch
at the beginning of an office visit and charges $2 per minute).
the consumer knows the price of the service, as freely determined by the seller, ahead of its actual delivery and accedes to the service.\footnote{See id. (noting Dr. Brian Forrest’s posted price list). While not all cash-only doctors post price lists, a sizeable number of those whose practice profiles are readily available do post such price lists. Of course, the patient cannot know, \textit{ex ante}, the full price of the encounter if the doctor orders laboratory or imaging studies, shots, or other interventions as part of the encounter.}

Though the exterior contours of the cash encounter are upon traditional, arms-length terms, the patient’s illness places her in a supplicant position \textit{viz.} the physician. Though she willingly accedes to the doctor’s announced charge, she does so, first and foremost, because she needs relief from her injury or illness. Neither she nor any rational patient would pay the doctor $30 to $100 or more simply out of her charitable impulses.\footnote{This implicates the swath of ideas surrounding moral hazard in healthcare. While insured people might be incentivized to use healthcare resources more than absolutely needed because they are not bearing the full brunt of the charges (including the so-called “worried well,” this does not necessarily hold true for poorer people without access to insurance. These people might instead simply go without needed healthcare. Thus, like for everyone who is a patient of a cash only doctor, the economically disadvantaged patient truly does “count the cost” of the doctor-patient encounter, in that the patient must decide to go to the cash only doctor or use his money for some other purpose. For a contemporary criticism of moral hazard theory in healthcare, see Malcolm Gladwell, \textit{The Moral Hazard Myth}, THE NEW YORKER (August 29, 2005) (recounting anecdotes of severely ill economically disadvantaged people who simply go without healthcare because they cannot afford health insurance or the cash price of the needed care). For a classic iteration of moral hazard theory, see Mark V. Pauly, \textit{The Economics of Moral Hazard: Comment}, 58 THE AM. ECON. REV. 531 (June 1968).}

She will submit herself to the indignity of leaving her home in her ill state only because the doctor offers the prospect of wellness. Thus, while she has \textit{motivations} for willingly acceding to the charge: namely convenience (in terms of patient queues and waiting) increased time with and affinity for the doctor, that she chooses to do so is a rational decision, all things considered.

Cash medicine can be a thorny thicket to navigate for certain patient populations. For example, some elements of the chronically diseased population are vulnerable to not receiving all of the treatment that will maintain health by seeing cash only doctors.\footnote{See id. (noting Dr. Brian Forrest’s posted price list). While not all cash-only doctors post price lists, a sizeable number of those whose practice profiles are readily available do post such price lists. Of course, the patient cannot know, \textit{ex ante}, the full price of the encounter if the doctor orders laboratory or imaging studies, shots, or other interventions as part of the encounter.} These
are the patients who need consistent encounters with patients (in addition to multiple prescription medicines and other healthcare items and services). Unfortunately, outside of the implementation of the individual mandate (or price controls upon cash only doctors, or mandated free care), not much can be done – from a financial perspective - to assist the poor, chronically diseased population. They can, of course, find a provider who will further discount his fees past the normal cash medicine price points.

Critics have urged that some forms of cash based medicine privilege wealthy patients who are able to plan, save, and able to look after their health so that they are not so consistently needy, and does not benefit the poor and some racial minorities, who are likelier to have problems that would quickly drain whatever resources these patients have. However, that some patients might be financially disenfranchised by seeing a cash only doctor obscures one of the real purposes behind cash medicine. Doctors need an alternative to insurance-based medicine, particularly in light of the passage of the Affordable Care Act, else they make good on their threats to leave the practice of medicine altogether. If

[107] [Check Health Affairs article – Paez, Zhao, and Hwang – January 2009; and check Health Affairs article – Pizer, Frakt, and Iezzoni – November 2009; and check Health Affairs article – Hwang, Weller, Irey, Anderson – November 2001; and check Health Affairs article – Hoffmann & Schwartz – September 2008]. See also, Amal N. Trevedi, Hussein Moloo, and Vincent Mor, Increased Ambulatory Care and Hospitalizations Among the Elderly, 362 N. ENG. J. MED. 320, 325-327 (January 28, 2010) (observing that increases in ambulatory copayments among certain parts of the Medicare population resulted in higher rates of hospitalizations).

[108] [Insertion]


[110] See infra, note __.

[111] See THE PHYSICIAN’S FOUNDATION, Nation’s Frontline Physicians Unhappy With Health Care Reform Measures, supra note __. As has been discussed throughout this Article, doctors have not, as of yet, left the practice of medicine en masse. It is too early to tell whether a wide-scale defection by doctors will ever materialize. However, it is important to note two points: (1) the level of disaffection among doctors with health care reform was massive, and (2) the Affordable Care Act is just beginning to be implemented.
accurate, then this criticism of cash based medicine is blunted. The problems of attracting young physicians into primary care medicine would be amplified manifold times if experienced physicians left the practice entirely. It is better, for example, that one-third of the cash only doctor’s former patients has ready access to their doctor and receives the care they need than none of the patients have access once the doctor leaves medicine to do something else with his life.\footnote{See Harold C. Sox, Leaving (Internal) Medicine, 144 ANN. INT. MED. 57, 58 (January 3, 2006).}

On the other hand, RBRVS has been likened to a Ricardian or even Marxian example of valuation, where the values of the units of production are aggregated, and the resulting sum is the price paid to the producer.\footnote{See, e.g., American Society of Dermatology, Medicare’s Flawed Economic Basis (April 1995), available at: http://www.asd.org/gmarxc.html (claiming that RBRVS is The Concept of the RBRVS is that of the Marxist Labor Theory of Value, i.e. that the value of the service depends only upon the cost of production. This idea has been thoroughly discredited (for example, in its related form of "comparable worth").

Even if, [sic] this theory were correct (it is wrong to the point of absurdity), the RBRVS is flawed in practice because it cannot accurately calculate the cost of production. The tables of costs are derived from subjective evaluations by a small panel, data (such as apartment rents) that may be completely inapplicable, and arbitrary extrapolations. The tables disregard variations in cost due to location, type of practice, individual abilities and training of the practitioner, individual complexity of the patient's case, and uncontrollable fluctuations in the marketplace for goods and services. Even if the data could be vastly improved, the tables of values would still give an erroneous price in every single individual instance because they are based on broad averages.

code. Under this paradigm, the inputs of the finished commodity are more important than the ultimate appraisal of the commodity’s value by the producer or the consumer. The import of this standard of value is that a select economic oligarchy has the power to centrally set prices. This has not gone unnoticed by the generalists; they perennially make accusations of self-dealing and economic freeze-outs against the specialists who control the RUC. 

It is this difference, of the locally-oriented setting of prices between doctor and patient over against a stock version of price-fixing (though shielded by government intermingling) that expresses the frustration of doctors and the reasons some gravitate to cash-only practices. The doctors who contract with Medicare are told what to charge for a good or service, and have no latitude to do no other. And to compound the insult, CMS plots, and values, and adds together units of production that do not approximate the real cost of providing the service. The insurance system – of paperwork completion and filing, follow-up on tardy reimbursement, and reluctance by the insurer in paying the claim – has

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114 See Physician Fee Schedule – Overview, available at: https://www.cms.gov/PhysicianFeeSched/01_Overview.asp#TopOfPage (2010) (identifying the RBRVS formulas as:

2010 Non-Facility Pricing Amount = [(Work RVU * Work GPCI) + (Transitioned Non-Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor (CF);

and

2010 Facility Pricing Amount = [(Work RVU * Work GPCI) + (Transitioned Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * CF

The conversion factor for CY 2010 is $36.0846.

Id.

115 See The Primary Care-Specialty Income Gap: Why It Matters, supra note ___ at 303.

116 See Medicare’s Flawed Economic Basis, supra note ___.

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caused the typical doctor to build a back-office apparatus that makes it nearly impossible for the external valuation by Medicare to approximate (much less exceed so that the doctor makes a profit) the true cost of producing the service.\footnote{117}

Interestingly, since Congress passed the Benefits Improvement Protection Act and Medicare Modernization Act in 2000 and 2005, respectively, Medicare progressively has become better at claims administration and payment. Medicare’s carriers (claims administrators for Part B claims) are required to pay all “clean claims” within thirty days of submission.\footnote{118} Thus, from the physician’s perspective, the Medicare claims submission process is relatively quick and simple. That does not necessarily mean that the claims preparation process is any less onerous for electronic claims compared with their paper cousins. Those doctors who play the insurance “game” of increased staff employment, scurrilous documentation and proof requirements, and inconvenient and seemingly incessant protestations to the insurer to get a treatment approved certainly do make respectable incomes. However, the doctors who eschew the insurance game make up for lost income in patient satisfaction, professional fulfillment, and an enhanced work-life balance.

\footnote{117 See Martin Bergman, \textit{Physicians Drop Health Insurers}, PHYSICIANS NEWS DIGEST (March 2003), available at: http://www.physiciansnews.com/cover/303.html (in which the author quoted medical practice consultant Ralph Biddle about the cost of keeping up with insurance requirements):

‘Physicians today feel like they’re spending 100 percent of their time seeing patients and they’re exhausted when they finish the day,’ said Ralph Biddle, president of Philadelphia-based Medical Program Development Inc., a Philadelphia consulting firm that helps physicians determine if they can downsize and rearrange the payer mix of their practices.

‘They’re getting 50 to 60 percent of their value back from the payers. And now comes the kicker, they pay 30 percent of that for a staff of billing people to collect the money from the payers. There isn’t a business in this country that would do that,’ said Biddle.

\textit{Id.}

\footnote{118 See \textit{MEDICARE, MEDICAID, AND SCHIP BENEFIT IMPROVEMENT PROTECTION ACT OF 2000 (BIPA) §521 and MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003 (MMA) §§931-940.}}
D. Sustainable Growth Rate

If RBRVS accentuates the class stratification between generalists and specialists, the device invented by Congress to tamp overall Medicare physician spending unites doctors of all stripes in their disdain of Medicare reimbursement. The Sustainable Growth Rate (“SGR”) is a legislative concoction, first introduced in the Balanced Budget Act of 1997 designed to tie the growth of Medicare physician spending to the rate of the overall economy’s (GDP) growth.\footnote{119 BALANCED BUDGET ACT OF 1997 (P.L. 105-33) §§4501-4507}

The effect of SGR was to annually hang a sword of Damocles over physician reimbursement.\footnote{120 See Gene M. Ransom, III, Will Congress Stop Medicare Cuts Again ?, BALTIMORE SUN (March 30, 2010), available at: http://articles.baltimoresun.com/2010-03-30/news/bal-op.medchi30mar30_1_sgr-medicare-payments-medicare-reimbursement (one of many outlets comparing the impending SGR cuts to the sword of Damocles).} The formula inevitably projects a cut to the Physician Fee Schedule.\footnote{121 See Jim Hahn, Congressional Research Service, Medicare Payment Updates and the Sustainable Growth Rate, available at: http://assets.opencrs.com/rpts/R40907_20091106.pdf 1 (November 6, 2009).} As if on cue, Congress has postponed annual cuts.\footnote{122 See id.} Unfortunately, though for physicians, postponement did not mean extinguishment. Annual cuts began to aggregate until the unthinkable became not only thinkable but plausible. On June 1, 2010, the SGR was set to take effect with an unfathomable 21% cut to the Fee Schedule.\footnote{123 See HEALTH AFFAIRS, Robert Wood Johnson Foundation, Policy Brief: Paying Physicians for Medicare Services 1, available at: http://www.healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_18.pdf (June 25, 2010).} As was its custom, Congress delayed implementation until it could delay no more. On June 1, 2010, the SGR was implemented. CMS actually disbursed checks and electronic transfers representing the 21% cut. It was only after Congress could see SGR actually implemented did it break its
legislative inertia to fix a new, yet again temporary, patch to the cut. June 25, 2010 saw
President Obama sign a bill entitled Preservation of Access to Care for Medicare
Beneficiaries and Pension Relief Act of 2010 that postpones the implementation of SGR
once more, but only for six months.124

The anger regarding the implementation of SGR reached a fever pitch in the
summer of 2010. Doctors from across the country, led by the American Medical
Association and the Texas Medical Association, signed petitions, ranted, and otherwise
decried the draconian cuts they foresaw with the implementation of SGR.125 Doctors boldly
predicted that they would drop out of the Medicare program if the cuts materialized.126
Some doctors ginned up the courage and actually did drop out. The summer of 2010 saw a
spate of Medicare voluntary deactivations and disenrollments not seen in recent years.127

The popular press picked up on these stories of discontent.128 The events of 2010
seemed to trigger something within these experienced physicians to the point where they

124 PRESERVATION OF ACCESS TO CARE FOR MEDICARE BENEFICIARIES AND PENSION RELIEF ACT OF 2010, 29
U.S.C. §1001 (2010). And there has been a subsequent “doc fix” since June. See MEDICARE AND MEDICAID

125 See, e.g., Stop the Medicare Meltdown, A Petition of the Texas Medical Association, available at:
http://www.ipetitions.com/petition/meltdown/ (“Doctors want to take care of Medicare patients. Congress is
forcing doctors to limit the number of Medicare patients we see or to quit taking Medicare patients
altogether”); see also, MEDPAGE TODAY, AMA Ad Takes SGR Message to Patients, available at:
http://www.medpagetoday.com/PracticeManagement/Reimbursement/20460 (June 3, 2010) (describing an
advertisement developed by the American Medical Association excoriating Congress for not passing a fix to
SGR).

126 Medicare Meltdown: Today’s Reality (July 7, 2010), available at:
http://www.texmed.org.Template.aspx?id=3728 (predicting that 42% of Texas physicians would drop out of
the Medicare program if the full 21% cut were implemented and another 37% would consider limiting the
number of Medicare patients they saw).

127 See, e.g., Chris Silva, Brief Medicare Pay Fix May Mean Showdown in Lame Duck Congress, AM. MED.
that 120 physicians have dropped out of Medicare since January 2010).
refused to continue to tolerate otherwise intolerable conditions. No doctor who publicly commented upon the impending doom of SGR was happy with, or even neutral about, the proposed cuts to their Medicare reimbursement.\(^{129}\) Many physicians who complained about the possibility of SGR’s implementation did so after already acknowledging the woeful general state of Part B reimbursement. That is, they bemoaned the fact that Medicare already reimbursed them at a level that did not adequately cover their production costs.\(^{130}\)

If RBRVS accentuates the cleft between generalists and specialists, SGR unites doctors of all specialties in disdain of Medicare payment policy. General surgeons joined with neurosurgeons, who joined with the cardiologists and family practitioners to decry the impending implementation of SGR. While some doctors may be “more equal than others,” they shared a common ground of disdain for a system that did not pay them, indeed could not pay them, what they thought they deserved.

**E. Barriers to Practicing Medicine**

Reimbursement disparities strike at the heart of physicians’ willingness to forsake the modern insurance regime. But, there are other, less prominent reasons why physicians are willing to opt out and give up upon relatively stable sources of funding. Previously, it was asserted that RBRVS and third party insurance gave birth to a sub-system of paperwork and regulatory compliance that was frustrating for physicians. Overlaying the dissatisfaction with the unseen insurance bureaucracy is a more pressing concern – all of the


\(^{129}\) See Chris Silva, *Medicare Pay: SGR Fatigue*, AM. MED. NEWS (May 3, 2010), available at: [http://www.ama-assn.org/amednews/2010/05/03/gvsa0503.htm](http://www.ama-assn.org/amednews/2010/05/03/gvsa0503.htm) (recalling the stories of several experienced doctors of different specialties whose practice revenues would have been severely affected by the implementation of SGR).

\(^{130}\) See generally, id.
work that the physician does outside of the examination room (and much of the work that they do inside the exam room) is not compensable. Imagine a lawyer only able to bill forty-five minutes out of every working hour. That lawyer (and his firm) would not be pleased with the results. Likewise, physicians are not happy with the inordinate amount of “unfunded mandates” pushed down upon them by insurers that leave uncompensated significant portions of the physician’s workday. Second, though not immediately pressing in the treatment encounter or yet in day-to-day practice, there is a great amount of foment and concern regarding the Affordable Care Act. Whether right or wrong, physicians who prize their autonomy perceive that the Affordable Care Act is an elaborate power aggrandizement orchestrated by Congress and the Obama Administration. Finally, the physician, particularly the primary care physician is disconcerted with the sorry state of chronic disease care in America today. Especially, there is a rift between patients with “lifestyle” chronic diseases, namely Type II diabetes and hypertension who do not attempt to remedy their own condition and the doctors who treat them. These doctors are discouraged and upset that their ministrations do not break through to their recalcitrant patients.

1. Non-Compensable Work

Healthcare delivery is one notorious field in which regulatory and contractual compliance carries administrative burdens that the delivery mechanisms (e.g., physicians) only reluctantly bear. Private managed care companies, in particular, prop up insidious techniques to make treatment delivery harder, and thus ration treatment that is perceived as needed by the physician and frustrate the physician’s autonomy. Two particular compliance mechanisms highlight the barriers to treatment. The first is the preauthorization. While
there is wisdom in checking an indiscreet physician’s predilection to order any test imaginable, especially if the physician has a stake in the testing apparatus, frustration sets in when doctors must supplicate before untrained clerks. A sense of reluctance, anger, and even dread sets in when the doctor must call for a preauthorization and then must soldier on in the managed care plan’s appeals process.

Second is the inordinate amount of work that the physician has to do that is not direct, face-to-face encounter time with the patient. This includes charting, care coordination, taking notes, writing prescriptions, and other non-compensable care. One study estimated that the average physician spends only 55% of his day performing face-to-face clinical tasks. But high administrative burdens are not endemic to only doctors. Lawyers, especially the ones who work in big firms with substantial billable hour requirements, must work half-again as hard as the typical American worker in order to meet productivity benchmarks. Both professions need to attend to non-compensable administrative tasks in roughly the same proportions of time. The administrative tasks distract from the main function of both types of professionals – to deploy their knowledge in piecemeal fashion on direct client work. The lawyer may only bill his client for work that directly relates to the client’s legal matter, even though this “direct” work may not be the classical legal products – a memo, a brief, or a contract. E-mails and telephone calls may

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131 See Ian Morrison, The Future of Physicians’ Time, 132 ANN. INT. MED. 80 (calling the incessant need for insurance authorizations, among other things, the ‘hamster model’).


133 See Time Spent in Face-to-Face Patient Care and Work Outside the Examination Room, supra note ____ at 490.

134 See Dennis Curtis and Judith Resnik, Review: Teaching Billing: Metrics of Value in Law Firms and Law Schools, STANFORD L. REV. 1409, 1411 (June 2002) quoting WILLIAM G. ROSS, THE HONEST HOUR: THE ETHICS OF TIME-BASED BILLING BY LAWYERS 171 (1996) (“To generate two thousand billable hours, attorneys typically need to work ten hours a day, six days a week.”)
properly be billed to the client’s account. However for doctors, only the direct patient encounter, or things done to the patient outside of a direct physician encounter, like shots, blood or imaging tests, is billable. That the physician himself has to bring his skills to bear outside of the patient’s presence, for things like documenting requirements mandated by CPT codes, interpreting test results, etc., only shows the stark inefficiencies of the insurance coding and reimbursement system.

Not all non-compensable work vanishes when doctors transition to a cash only model. There will still have to be care coordination with specialists, hospitals, and other facilities. Prescriptions still will have to be written or called in to pharmacies. However, physician interactions with insurers will be eliminated. Thus, it will never be the case that a cash only doctor will spend, for example, ten hours out of ten hour workday seeing patients. However, the time that is spent outside the heart of practicing medicine – in paperwork, telephone conversations, and the like, is reduced to those tasks most closely related to the patient’s care. The result is that the doctor can recast his professional vision into one with an authentic patient orientation. Once the transition is made, the cash only doctor will work for the patient and not the insurer, who once paid the bills and therefore corralled the doctor’s instincts and judgment.

From a larger perspective, two main potential criticisms of the cash only movement (and derivatively, the physicians who participate in it) are apparent. First, cash only medicine will cut off access for patients who do not have the extra disposable income to see their newly-minted cash only doctor. That is, the doctor’s transition to a cash only practice would affect those patients who could not afford a $50 or $100 or $150 office visit,
but could afford occasional $20 to $30 copayments.\textsuperscript{135} This, however, seems to be unavailing. The patient who cannot see a cash only doctor must merely shift his attention to a doctor who accepts insurance. If the patient does not have health insurance (before the 2014 individual mandate), then he is in the very same position regardless of the type of physician he has – cash only or insurance taking. If this patient has to spend time, information gathering, and other resources to find another insurance taking doctor for his care is not unusual. During the height of managed care, patients were frequently dislocated from their providers in their (former) networks and had to choose new ones.\textsuperscript{136} Further, the reverse is true as well - insurance-taking doctors drop particular insurance plans from time to time, forcing patient-enrollees to find a new physician.

Second, and more importantly from a systemic perspective, is the risk that cash only medicine could track the abuses of the unvarnished fee-for-service system that occasioned RBRVS, the Medicare Physician Fee Schedule, and the Sustainable Growth Rate. This, however, is an insidious form of the slippery slope argument and therefore unlikely to happen. Fee-for-service became abusive because there was no governor upon

\textsuperscript{135} See \textit{New National Health Benefits 2010 Data: Office Visit Copays Show Variance By Industry}, BusinessWire, available at: \url{http://www.businesswire.com/news/home/20100624005706/en/National-Health-Benefits-2010-Data-Office-Visit} (June 24, 2010) (summarizing a study by the human resources consultancy HighRoad that showed that more than half of the insured consumers in the transportation and finance industries, significantly more than one-half paid in office copayments of $25 or more. Of wholesale, services, and manufacturing employees, significantly more than one-half of insured consumers paid $20 or less for in office copayments. Cost of cash only medicine encounters would be problematic for the patient to the extent that the patient could not routinely meet his healthcare needs. The cost of healthcare that has become burdensome to the point that extreme indebtedness for healthcare bills is a leading cause of bankruptcy filings in America. \textit{See generally}, Melissa B. Jacoby, \textit{The Debtor-Patient: The Search for Non Debt Alternatives}, 69 \textit{BROOK. L. REV.} 453 (2004) and Melissa B. Jacoby, \textit{The Debtor-Patient Revisited}, 51 \textit{ST. LOUIS U. L.J.} 307 (2007). While theoretically an accumulation of unpaid bills at a cash only doctor could be the source of significant medical debt, it also seems likely that few cash only doctors would ‘float’ the indigent patient until he could pay off his debt, for such ‘floating’ obviates one of the main purposes of cash only medicine – that of closing the books on each patient encounter whenever the patient leaves the physician’s office.

\textsuperscript{136} See Mark Schlesinger, Benjamin Druss, and Tracey Thomas, \textit{No Exit? The Effect of Health Status on Dissatisfaction and Disenrollment from Health Plans}, \textit{34 HEALTH SERV R SCH} 547, 549 (June 1999) (“Finding a new plan may disrupt existing relationships with providers and requires that the enrollee learn the administrative protocols of the new plan...”).
the doctors’ charges within insurance systems, whether public or private.\footnote{137} For example, with respect to Medicare, Congress’ regulatory architecture allowed doctors to maximize their individual self-interests at the expense of the public purse. Fee-for-service has continued to be abusive to the public fisc because, in part, doctors have shifted their unfettered discretion to diagnose and manage patients’ conditions upon the ever present concept of medical necessity – if the diagnostic or therapeutic modality is needed (in the doctor’s opinion) to competently manage the patient’s condition, then it is ordered, oftentimes without appreciable results inuring to the patient’s health.\footnote{138}

Cash-based medicine, on the other hand, avoids some, but not all of the problems associated with third party fee-for-service reimbursement. It is important to note that no system, whether third party or cash only, can eliminate unscrupulous doctors whose main motivation is to gouge their patients. If a cash doctor wanted to recklessly run up a $500 bill upon the patient with x-rays, laboratory tests, etc. without any sound basis for those orders, the patient would be faced with the stark choice of acceding to the doctor’s orders or walking out.\footnote{139} Perhaps the doctor can blithely get away with disrespect of his patient’s


\footnote{138} See American Medical Association, Council on Ethical and Judicial Affairs, CEJA Report 1 – I97, \textit{Financial Incentives and the Practice of Medicine}, available at: http://www.ama-assn.org/ama1/pub/upload/mm/code-medical-ethics/8054a.pdf 1(1997) (“…paying physicians on a fee-for-service basis provides an inducement to provide more services. On the other hand, paying physicians a portion of whatever balance remains in a pool of funds used first to cover referral services strongly encourages physicians to reduce utilization”); see also generally, MARC A. RODWIN, MONEY, MARKETS & MORALS: PHYSICIANS’ CONFLICTS OF INTEREST (1993).

\footnote{139} The patient might complain about an inordinately high bill, if the patient is motivated and confidant enough to interact with her doctor about her care. However, not all patients voice their feelings or disagreements with their physicians’ choice of care or therapies. \textit{See generally,} Wendy Levinson, et. al., \textit{Not All Patients Want to Participate in Decision Making}, 20 J. Gen. Int. Med. 531 (noting that preferences for patient involvement in medical decision making varied significantly according to factors such as race and age).
pocketbook (not to mention the patient’s time) once. However, when the patient’s own money is on the line, she will seemingly want to know about the need for and efficacy of a “fishing expedition” for the second and subsequent visits. In its most economically efficient form, a cash system will force the patient to completely internalize the costs of the physician encounter, thus prompting the patient to be more value conscious in her health care purchasing decision.\textsuperscript{140} If the patient starts to think that the value of her healthcare dollar is diminishing, she can switch to another cash only doctor or to an insurance-taking doctor.

It is unlikely, though, that cash only medicine would ever have the chance to make the same type of system-wide impact as did fee-for-service and its attendant abuses. If there is not a mass exodus from physician contracting with third party payers, cash medicine will likely always be a minority reimbursement mechanism within American healthcare. If the Affordable Care Act’s individual mandate survives court challenges, many Americans will find it difficult to allocate a significant amount of monthly income to purchasing health insurance and retaining a reserve to pay for the cash only doctor for whom they have a particular affinity.\textsuperscript{141} Thus, after implementation of the Affordable Care Act, cash medicine’s likeliest trajectory is that it will carve out a marginally larger position

\textsuperscript{140} Of course, the patient may bring very real inefficiencies to the doctor-patient relationship such as the inability to finance ongoing care. See M. Gregg Bloche, \textit{Consumer-Directed Health Care and the Disadvantaged}, 26 \text{HEALTH AFF.} 1315, 13\textsuperscript{ _1}, and 13\textsuperscript{ _2} (arguing from the RAND Health Insurance Experiment that higher cost sharing has led to poorer outcomes for chronic diseases such as hypertension and also that lower incomes associated with racial and ethnic minorities leads to decreased out-of-pocket purchasing power). [NOTE: get PDF.]

\textsuperscript{141} See Florida, \textit{ex. rel.} Bondi \textit{v.} Department of Health and Human Services, 2011 WL 285683 (January 31, 2011) (granting summary judgment to Florida and other Plaintiffs in declaring the individual mandated unconstitutional under the Commerce and Necessary and Proper Clauses) and Virginia \textit{ex. rel.} Cucinelli \textit{v.} Sebelius, 728 F.Supp.2d 768 (December 13, 2010) (holding that the Affordable Care Act is unconstitutional under the Commerce Clause and is an impermissible tax). \textit{But see}, Thomas More Law Center, et. al. \textit{v.} Obama, et. al., 720 F. Supp. 2d 882 (October 7, 2010) (holding, \textit{inter alia}, that the Affordable Care Act does not violate the Commerce Clause, nor is it an impermissible tax) and Liberty University \textit{v.} Geithner, 2010 WL 4860299 (November 30, 2010) (holding, \textit{inter alia}, that the Affordable Care Act does not violate the Commerce Clause).
than it has now, while it will remain a distinct minority position. It is difficult to imagine a world in which a majority of family medicine physicians or general internists suddenly and completely drop all insurance plans. Most physicians are simply too addicted to the cash flow (as attenuated and untimely as it may be) to completely turn off the spigot of insurance reimbursement.

As it stands now, the polarizing antipodes of the individual mandate and Americans’ precarious economic positions will make cash medicine an attractive alternative for the relatively well-to-do or the desperate that might live outside the strictures of the individual mandate. The affluent patient could use the cash only doctor much like a concierge doctor, trading cash for access that other patients practically cannot have. Critics have argued that forms of private access (of which cash medicine is a type) have the effect of dividing the health care market between the “haves” and the “have nots,” with the haves enjoying superior treatment because of their wealth. Further, critics also lambaste doctors who opt out of insurance participation as facilitating stratifications within the delivery system, essentially privatizing part of the delivery system for those who can pay for it. The argument seems to be that physicians have a professional obligation to take both private and public forms of insurance. To do otherwise would be to blatantly disfavor the vast majority of the patient population who cannot afford to self-finance their healthcare.

142 According to one group of researchers, 12.4% of all American physicians do not contract with any managed care plan. This figure, however, does not account for those physicians who might not contract with a private managed care plan but still contract with Medicare and/or a state Medicaid program. See Ellyn R. Boukas, Allwyn Cassil, and Ann S. O’Malley, A Snapshot of U.S. Physicians: Key Findings from the 2008 Health Tracking Study Physician Survey, Center for Studying Health System Change Data Brief No. 35 (September 2009), available at: http://www.hschange.com/CONTENT/1078/. [Get page # from PDF.]

143 See PASQUALE, supra note __, at 63-66 (featuring “queue jumping” as one of the unattractive features of concierge medicine.)
Cash medicine represents a rational choice of treatment for the doctors and patients who participate in it. The benefits that accrue to cash purchasers of medical care - shorter queues, more time with physicians, and greater satisfaction with care – could accrue to anyone who chooses to purchase their healthcare entirely with cash. From the demand side, the true barrier to entry for cash treatment is the willingness to divert disposable income from other rational uses into healthcare. Even before the 2014 implementation date of the individual mandate, those lower income patients who might be “forced” to see a cash only doctor because they do not have ready access to insurance, still accrue all the benefits as do their wealthier fellows who self-insure with cash doctors despite having medical insurance.\textsuperscript{144}

2. Foment About Health Reform

A slow, but steady refrain – almost like the beat of war drums - grew in volume and intensity in the run-up to last March’s passage of the Affordable Care Act. On the one hand, doctors who supported the Administration’s plan lent their vocal support to the President in photo opportunities, letters to the editor, and other prominent displays of support.\textsuperscript{145} Contrarily, doctors who opposed the Affordable Care Act (or even the concept of health system delivery reform) mobilized their factions with furious calls to their Congressmen and Senators, equally biting letters and articles, and threats – threats to quit


the system – whether the payment system or medicine altogether, if the reform bill passed.\footnote{See Gauthem Nagesh, Arizona Doctor says ObamaCare will force him to close up shop, THE DAILY CALLER (April 14, 2010), available at: \url{http://dailycaller.com/2010/04/14/arizona-doctor-says-obamacare-will-force-him-to-close-shop/#ixzz0ur3b1BQv} (“If you voted for Obamacare, be aware these doors will close before it goes into effect.” The note is signed Joseph M. Scherzer M.D. and includes the following addendum: “****Unless Congress or the Courts repeal the BILL”); see also, David Whelan, Doctors Versus The AMA, FORBES (August 17, 2009), available at: \url{http://www.forbes.com/2009/08/17/obamacare-doctors-ama-business-healthcare-obamacare.html} (arguing that the AMA’s support for health care reform would alienate its physician membership).}

Physician-supporters of health care reform mobilized on arguments related to patient access to healthcare. They saw in the Act’s individual mandate coupled with avenues for securing coverage, a way through which they could fulfill their call as doctors – to treat all of the sick as dignified agents deserving of health.\footnote{See AMA votes to continue to support health system reform, available at: \url{http://www.ama-assn.org/ama/pub/health-system-reform/resources/resources-archives/ama-continues-hsr-commitment.shtml} (November 9, 2009).} Detractors, while not necessarily disagreeing with the ultimate ends as articulated by reform supporters, nevertheless prized personal professional goals over service goals.\footnote{See Reed Miller, U.S. healthcare reform bills inspire fear and hope among cardiologists, available at: \url{http://www.theheart.org/article/1039423.do} (January 15, 2010) (discussing cardiologists’ trepidation at perceived government control over their treatment choices).} In short, detractors saw in reform a large, though inchoate, possibility that their autonomy would be compromised. Apart from a potential crush of new patients, there appears to be no lurking tentacle of direct government oversight or specter of public takeover of physicians’ practices.\footnote{But see, infra note ___ (describing bills introduced in the Massachusetts legislature that would require Massachusetts physicians to contract with a state-sponsored plan).} What is feared by opponents of health reform is what cannot be presently known, namely whether this, the largest accretion on the health system since the advent of Medicare is a final resting point for system reform, or whether it is a harbinger for (in their
view) something more controlling and sinister – a single payer system.\textsuperscript{150} With single payer, so say the detractors, the government bureaucracy will prevail and will be omnicompetent in determining health care outcomes.\textsuperscript{151} This great sensitivity to single-payer likely stems from backlash at bureaucratic controls in the first place. That is, the doctor (or patient) who bristles at managed care utilization management methods, but otherwise has some control over care choices, would blanche at one boss who “calls all the shots” or is feared to do so.

In any event, government challenge to physician autonomy in the statute is indirect and does not necessarily implicate the physician’s choices or decisions made in the exam room. The statute curtails the fora through which the doctor may ply his trade, and stealthily channels his choices so that his economic well-being is top of mind; nevertheless, there is no mandate in the Affordable Care Act that surgeries or throat swabs or flexible sigmoidoscopies, be done a certain way.

3. The Chronically-Diseased Patient

The generalist devotes a significant part of his day to treating patients with one or more chronic diseases.\textsuperscript{152} Upon diagnosis of a lifestyle chronic disease, the typical course is to prescribe prescription drugs and significant lifestyle changes, with a particular focus on

\textsuperscript{150} See Sally Pipes, Mass. health meltdown is your future, N.Y. POST (May 25, 2010), available at: http://www.nypost.com/p/news/opinion/opedcolumnists/mass_health_meltdown_is_your_future_qA65Dx77kp pzP5IHJN23pN.


\textsuperscript{152} See Tara Parker-Pope, Post to Well Blog, Treating Illness is One Thing, What About a Patient With Many, NEW YORK TIMES (March 30, 2009), available at: http://www.nytimes.com/2009/03/31/health/31sick.html (claiming that 68% of Medicare beneficiaries have five or more chronic diseases).
diet overhaul and weight loss. Post-diagnosis begins the delicate dance of compliance between patient and doctor. It is extraordinarily hard for the lifestyle chronic-diseased to adhere to their doctors’ care plans. It could be stubborn recalcitrance, or lack of education, or shame, or “counseling” from the doctor that was nothing more than quick, though stern admonition from the doctor to “lose some weight”. Researchers have documented that it could be any of these or any of a host of other reasons that prevent the diseased patient from optimizing his health, per the prescriptions of the doctor. Nevertheless, month after month, appointment after appointment, in walks the diabetic to the doctor’s office, with blood sugars haywire, or blood pressure elevated.

This non-compliance contributes to no end of frustration for the doctor. One can only imagine the helplessness and dissatisfaction experienced by the generalist when he sees that his patient, though loved and cared for, cares himself nothing for the doctor’s ministrations, and by extension, himself. It is therefore unsurprising that generalists, in recounting their reasons for professional burnout, cite patient non-compliance as a key factor in their professional disappointments.

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155 I have argued elsewhere that, due to projected exponential growth in the Medicare program that left unchecked will imperil the nation at large, chronically diseased beneficiaries who do not follow their doctors’ care plans (after an initial acclimation period), should have their subsidized care ended. See Jeffrey B. Hammond, The Responsible Patient: The Senior’s Obligation to Conserve Medical Resources, 12 MARQUETTE ELDER’S ADV. 123 (2010).

156 See generally, Donna H. Kern and Arch G. Mainous, Disease Management for Family Practitioners and General Internists: Opportunism or Planned Care?, 33 CLIN. RES. METH. 623-625 (2010).
Generalists who transition to cash-only or cash-majority practices have two large advantages over peers who stay in insurance dominated practices. First, enhanced patient interaction (in the form of increased or "right sized" appointment times) can improve the "feedback loop" between doctor and patient. Although reason dictates that the patient who is motivated enough to pay $50 to $150 entirely out of her own pocket for an office visit so the doctor can monitor her Type II diabetes, for instance, is likely motivated enough to adhere to the doctor’s regimen of strict diets and weight control, this is not always the case.  

There are many reasons why a chronically-diseased patient might not adhere to her doctor’s care plan, including defiance/self-sabotage, lack of financial resources or access to the tools/methods of compliance, or lack of education about the requirements of adherence, among many others. Adherence deficiencies need to be met with a multi-pronged strategy of cooperation between providers and patients. These strategies take time, in the form of increased appointment times, more focused attention from the doctor to the patient, and vice versa, and longitudinal respect for compliance with the strictures of a rigorous disease management plan. Cash only medicine can be beneficial for the patient because the medium through which cash medicine is practiced - longer visits, more focused attention from the doctor, and a more authentic relationship between doctor and patient - creates the foundation for lasting disease management and patient compliance. It is ironic that cash medicine has

157 In the world of insurance reimbursement, however, increases in copayments does not necessarily correlate with better outcomes (e.g., adherence to provider instructions). In fact, evidence suggests the opposite is true. See, Rachel L. Elliott, et. al., Strategies for Coping in a Complex World: Adherence Behavior in Older Adults with Chronic Diseases, 22 J. GEN. INT. MED. 809 (concluding that changes in medication copayments can have an effect upon medication adherence); see also, Matthew L. Maciejewski, et. al., Increasing Copayments and Adherence to Diabetes, Hypertension, and Hyperlipidemic Medications, AM. J. MAN. CARE e23-e25, available at: http://www.ajmc.com/media/pdf/AJMC_2010janMaciejWEB_e20to34.pdf (suggesting increase in medication copayments increased immediate adherence but decreased it in the lasting compliance).

158 See, e.g., Barbara Kocurek, Promoting Medication Adherence in Older Adults...And the Rest of Us, 22 DIABETES SPECTRUM 81 (reporting medication compliance rates of about one-half for the chronically-diseased population) [Note: Find and cite their internal sources.]
one deleterious effect upon regime compliance (because of increased costs borne by the patient), yet at the same time, it solves for problems occasioned by insurance-dominated forms of payment (shuttling patients in treatment rooms, quick physician visits, impersonal, cold connections with patients) that do not help long term compliance. The patient who willingly internalizes the unpalatable from cash medicine (e.g., bearing the entire cost of the physician encounter) is the same patient who stands to gain the most from it (special access and increased physician rapport). Thus, for the patient whose time with the doctor is financially dear to her, and who actually pays the money to see the doctor, can leverage those costly office visits into better health.159

It is true that corralling chronic disease is a more significant challenge for lower income patients. For patients in such a position, cash only medicine could be a stumbling block to managing their diabetes or hypertension, for example. Cash only medicine would do nothing for these patients, apart from its ability to provide an alternative delivery mechanism, should they choose to use their available resources for their health care. However, the cash only doctor would be such a stumbling block only if he were the sole available access point for the chronically diseased in a particular geographic area. If there was an insurance-based physician in the vicinity of the chronically diseased patient, then if the patient had the insurance contracted by the physician, then the patient would have an obvious access point. The patient’s problem is, of course, when the cash only doctor is the only provider in the patient’s immediate vicinity.

159 But see, Song Chen, et. al., Medication Adherence and Enrollment in a Consumer-Driven Health Plan, 16 AM. J. MAN. CARE e-46-e48 (finding negative correlation between medication adherence and patients enrolled in a consumer-directed health plan, who must pay cash for their healthcare until the deductible is met). [Note: get 2008 article in Health Affairs by Greene, et.al., with countervailing conclusions to Chen’s article.]
Because there is not a central price control mechanism for healthcare, cash only doctors are completely free to charge what they want for their services. Some, and perhaps most, chronically diseased patients will be priced out of the cash only market. This is because (1) they cannot pay the sometimes high per service charge, and/or (2) they cannot bear multiple encounters, and thus multiple service charges, demanded of chronically diseased patients. However, that some chronically diseased patients are disenfranchised from care is ultimately not the entire concern of the cash only doctor. A doctor has never had to accept any particular insurance plan as a condition of professional licensure, professional ethics, or board certification. Rather, doctors have always been free to contract with whomever and whatever insurance company they please. While there is a general professional ethical obligation for a doctor to take care of patients who cannot pay, there is a concomitant recognition that the doctor does not have to devote his entire practice to ministering to the destitute. Instead, the duty is for the doctor to take his fair share of indigent patients who have no means of paying in full.  

Ironically, the cash only doctor is

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160 Cash only medicine is not uniformly expensive for patients. In fact, one physician estimates that three-quarters of all patients could self-finance their care for one year for the cost of one month’s insurance premium. See Val Jones, *Cash Only Physician Practices Could Save You A Bundle*, BETTERHEALTH (March 26, 2009), available at: http://www.getbetterhealth.com/cash-only-physician-practices-could-save-you-a-bundle/2009.03.26 (arguing that 75% of Americans need to see the doctor 3.5 times in year, costing a total of $300, a typical price for a family health insurance premium).


162 See id. at 7. The AMA went on to say that:

Each physician has an obligation to share in providing care to the indigent. The measure of what constitutes an appropriate contribution may vary with circumstance such as community characteristics, geographic location, the nature of the physician's practice and specialty, and other conditions. All physicians should work to ensure that the needs of the poor in their communities are met. Caring for the poor should become a normal part of the physician's overall service to patients.
better able to shoulder his fair share of indigent care. Because the cash only doctor does not have an elaborate array of coders, billers, file clerks, and computer technicians to pay and manage, he is better equipped to handle the hiccup in cash flow by treating the occasional indigent patient.

The problem of haphazard access for the poor chronically diseased patient is not one that can be regulated out of existence. For as long as Medicare and state Medicaid programs offer physicians compensation that does not meet their production costs, doctors will continue to search for payment alternatives.\textsuperscript{163} Physicians are particularly upset at shrinking payment rates coupled with: (1) incipient practice channeling mechanisms (e.g., RBRVS-driven CPT coding) and (2) new and overt regulations.\textsuperscript{164} This is an especially pernicious feeling among physicians, the professionals who prize work autonomy a great deal among all professionals.\textsuperscript{165} And that is why a cash only practice is so elegantly simple for the physician. He can reclaim is professional independence at the same time that he eliminates many of the perceived barriers that prevent him from practicing authentic medicine.

While the purpose of this article is not to offer wholesale solutions to the problems that trigger doctors’ moves to cash only practices, it is important to emphasize that the solution is not to mandate that any physician be required to contract with any particular insurance plan. Rather, the solution is for existing payers to increase market-based solutions for physician treatment patterns. For example, in the chronic disease management context,

\textsuperscript{163} See supra note ___.

\textsuperscript{164} See supra note ___.

\textsuperscript{165} See Jeffrey J. Stoddard, et. al., \textit{Managed Care, Professional Autonomy, and Income}, 16 J. GEN. INT. MED. 675, 676 (2001).
existing insurance programs should be modified so that physicians’ compensation increases with the number of “quality” interventions ordered for chronically-diseased patients. That is, a doctor’s compensation should not track the stark number of tests, interventions, office visits, etc., he orders, but rather should progress when he orders, according to best practices and other consensus standards, interventions that can improve the patient’s health.166

Second, both the cash-only doctor and her patient are advantaged by avoiding, in large part, the eight to fifteen minute office visits that plague a generalist’s workday. Because the cash-only doctor sees a fraction of the number of patients in a typical day as does his insurance colleague, he has the ability to schedule longer appointments in which she can provide the type of trust-based counseling that he wants to provide and that chronically-diseased patients are receptive to hearing.167 Patients feel judged when their physicians disapprovingly admonition them to start an exercise program or lose thirty pounds.168 Contrarily, patients feel welcomed and more like the doctor’s “partner” in the treatment enterprise when there is time enough to discuss the patient’s own treatment goals, and the doctor and patient can negotiate upon mutually satisfying goals and outcomes.169

Though a subtle shift in treatment delivery, the chance to lengthen the treatment session afforded by the cash-only practice, implicates and strengthens both parties’ independence and well-being: the doctor is able to say to the patient what he truly desires without the

166 See supra, note ___.


168 See generally, Karen A. Luftey and William J. Wishner, Beyond “Compliance” is “Adherence”: Improving the Prospect of Diabetes Care, 22 DIABETES CARE 636 (detailing the reasons for non-compliance among diabetics).

169 See Funnell and Anderson, supra note ___.
grinding pressure to shuttle the patient out the door so he can meet the next one, and the patient is afforded the space and time to tell the doctor, in a safe environment, the hopes, fears, and challenges faced during treatment.

To the extent that longer treatment sessions might lead to increased compliance with medication regimens, nutrition schedules, and exercise plans, the cash-only doctor will have a broader and valuable effect on the larger pressures facing America’s health care system. Though the Affordable Care Act includes many measures to combat the geometrically-rising costs of chronic disease care, unfortunately for policymakers, “bending the cost curve” is not entirely within their control.170 For, notwithstanding incentives and disincentives offered to the chronically-diseased population, patient autonomy is the final driver in regimen compliance. And regimen compliance determines in significant part whether the ambulatory chronically diseased patient will develop complications and comorbidities that imperil the health care system at large.171

III. The Cash-Only Doctor

A. Generally

The triggers that prompt doctors to disenroll from insurance plans altogether closely track the general flash points of dissatisfaction for primary care physicians: woeful Medicare reimbursement provided in a payment system that is oriented toward their failure and taxing insurance compliance standards that seem to multiply burdens for the physician

170 See, e.g., AFFORDABLE CARE ACT §1301(b)(1)(I) (regarding chronic disease care management), §2705 (procurement of health insurance by persons with chronic diseases), and §4108 (programs for healthy living among the chronically diseased population in state Medicaid programs).

and which occasion the hiring of staff to meet the payers oppressive demands.\textsuperscript{172} In a very real sense, the doctor who transitions to a cash-only practice does so seeking the nostalgic, halcyon days of medicine. Then the doctor’s compensation was not overwhelming, but what the physician lost in remuneration, he gained in respect and prestige from the community.\textsuperscript{173}

Similarly, it is not at all certain that the contemporary cash-only doctor will exceed the compensation she made as a contractor of insurance companies; however, what she might lose in remuneration she has the potential to gain in deeper, more authentic, trust-filled relationships with her patients.\textsuperscript{174} Some doctors who are now cash-only claim the transition off of insurance has allowed them to practice medicine again authentically; that is, they have a deeper connection with the ideals of medical practice with which they entered medical school (and that many entering medical students still have and are still derided for when they choose primary care over more lucrative specialties).\textsuperscript{175}

The cash-only doctor is a pioneer of sorts. While most physicians are enrolled in one or more managed care plans, about one in eight doctors forsake all forms of third party funding.\textsuperscript{176} Most doctors who try foregoing managed care reimbursement have been practicing for up to twenty years or more.\textsuperscript{177} The typical cash-only doctor has a sizeable advantage over the younger upstarts, though. The doctor in practice for twenty years has a well-developed patient roster of several hundred to several thousand. This doctor can ride

\textsuperscript{172} See Yee, Doc’s cash only billing bucks the insurance morass, supra note ___.

\textsuperscript{173} See id.

\textsuperscript{174} See id.


\textsuperscript{176} See supra, note ___.

\textsuperscript{177} See id. at 3.
out the sometimes precipitous decline in patient allegiance because he knows that the patient volume he receives from the “faithful remnant” will allow his practice to survive.\textsuperscript{178}

Though it is not certain that the new cash-only doctor will maintain her insurance-funded level of compensation, some doctors even exceed their prior income.\textsuperscript{179} Doctors have found new efficiencies and streamlined processes once disengaged from managed care. They have been able to economize in staffing because they no longer need a cadre of specially trained clerks to meet the idiosyncratic minutiae of individual payers. Further, the cash-only doctor wrests the initiative away from a centralized bureaucracy that tells him what his time is worth and instead installs it in himself, where he and his patients set the market for his services. The doctor then can find peace, knowing that, while demand may be dependent upon many factors, he has the two ultimate drivers of demand solely within in his own control: the price for his services and the perceived quality with which he provides those services.

B. Access

Though cash-only doctors, unlike their “concierge” or “retainer” cousins have yet to receive much pointed criticism for forsaking third-party payment, it is easy to anticipate the main negative evaluation of their break with the reimbursement system. Critics can rightly charge that these physicians, who are on the front lines of American healthcare, are forsaking the mantel of healer to the masses in favor of a professional life of ease and

\textsuperscript{178} See id.

\textsuperscript{179} See, e.g., supra note ___ (discussing Dr. Brian Forrest’s net revenue far in excess of typical family practitioner net revenue).
personal satisfaction. The cash-only doctor, so the critic might say, is trading the inevitable vicissitudes of primary care (including spotty payment and a frenzied workplace) in exchange for self-selecting patients and the security of immediate cash flow.

While it would be blithe to argue the desirability of cash-only physicians solely from an economic standpoint, the claim has intuitive and sustaining merit. And the economic argument is as facile as introductory microeconomics – supply is countered and corralled by demand of the good or service. In this case, the supply of doctors who eschew any type of managed care agreement seems to at least be holding steady. At the same time, these practices are maintained, but not overwhelmed as of yet, by the patients who can handle the burden-shifting of insurance administration and who value more attentive doctors.

There is a grander policy-oriented reason why cash-only doctors should be tolerated and encouraged. These physicians provide a release to the highly pressurized world of primary care. It is hard to overestimate the genuine angst and anger experienced by generalists at their working conditions. Though it may only siphon off a relative dearth of the total physician population, the possibility of opting out of the established payment system serves as a valve that prevents the entire primary care system from exploding. If there weren’t the possibility of moving to a cash-only model, the possibility of

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180 See, e.g., FITZHUGH MULLAN, BIG DOCTORING IN AMERICA: PROFILES IN PRIMARY CARE MEDICINE 1-16 (2002).

181 See Center for Studying Health System Change, supra note ___ (reporting that the 12.6% of American physicians did not have any type of managed care contract, but that that number includes those physicians who accept, among other forms of payment, fee for service Medicare. This survey from the Center for Studying Health System Change contains the best data available, to this author’s knowledge, of those physicians included within the cash-only movement).

182 See generally, Mark Linzer, MD, et. al., Working Conditions in Primary Care: Physician Reactions and Care Quality, 151 ANN. INT. MED. 34, 35 (July 7, 2009).
leaving the practice of medicine entirely would look more and more attractive to these physicians. 183

While it is true that primary care physicians treat a wider swath of the population as gatekeepers of the sick, it is not true that generalists necessarily are the selfless, wholly unconcerned with money, Osler-ian idealists they are made out to be. Rather, many as small businessmen and women must meet payroll, cover expenses, and try and eke out a profit like every other business owner. 184 They are not immune to the challenge of trying to stay afloat in a desperate economy. In short, every primary care physician who is not independently wealthy must manage the dissonance caused by his own personal and professional aims (e.g., his autonomy interests) and the interests of his patients, including the patients who cannot pay with cash, up front, for his services.

The serendipitous byproduct of taking on a cash-only practice seems to be the real possibility that the doctor can realize more net income from his work activities than he did as an insurance contractor. 185 This is despite reduced gross revenue from slashed patient rosters. The doctor no longer has the apparatus of coders and plan liaisons he formerly had to employ just to keep up in the insurance game. 186 Now he outsources all of those concerns

183 See generally, id. at 34 (noting generally that “…adverse work conditions were strongly associated with intent to leave the practice…”).

184 See generally, Robert W. Katz, The Physician’s Survival Guide to the Business of Medicine (1994) (discussing, inter alia, the accounting and financial statement rudiments with which a doctor must be familiar in order to maintain a healthy business).

185 See, e.g., Morgan Lewis, Jr., How to Run a Cash-Only Practice and Thrive, Modern Medicine (January 22, 2010), available at: http://www.modernmedicine.com/modernmedicine/Modern+Medicine+Now/How-to-run-a-cash-only-practice-and-thrive/ArticleStandard/Article/detail/652945 (profiling Dr. Brian Forrest, whose net pre-tax income varies between $270,000 and $495,000 without working past 5 P.M. and not seeing more than 16 patients in a day).

upon the patient herself. The insured patient of the cash only doctor must fill out forms and be her own intermediary with the insurance company. This burden-shifting can, but does not necessarily, lead to decreased prices for the patient. A cash only doctor’s charges are as idiosyncratic as the doctor himself. Indeed, for doctors to coordinate on prices would be a felony. No two doctors’ charges are exactly alike, and no conclusions can be drawn from the relative dearth of information about prices.

At the same time the doctor is incentivized to deliver high quality care in line with both scientific evidence and the patient’s relational concerns, the patient is incented to “right size” the care she requests because she bears all of the cost. However, whether cash only patients actually receive all of the healthcare they need is an entirely different proposition. Though cash only medicine is the ideal setting to test the merits of moral hazard theory; and indeed, one might expect moral hazard cannot come into play in the patient-cash-only physician relationship because there is no insurer available to shield the patient from an intervention’s true cost, it is true that some patients forego needed care simply because they cannot purchase it – even with cash.\(^{187}\) This is so even though the tendency to engage in morally hazardous behavior is just as strong in primary care as it is in specialty care.\(^{188}\)

However, because both the patient and the physician must be sensitive to price in the cash-only relationship, the doctor is incented to function as the patient’s agent and pre-

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negotiate cash prices for laboratory tests, imaging studies, and other specialty services.\textsuperscript{189} Interestingly, specialists seem to relish immediate cash in hand as much as their generalist colleague, because they appear to be eager to discount their own prices.\textsuperscript{190}

Critics could also observe that cash-only physicians comprise a fringe movement in the health care delivery system and never will dominate the mainstream. This potential criticism, however, is less sure. There has not yet been a mass exodus from Medicare or private insurance within the past few years; however, foment for such an exodus is lurking just below the surface.\textsuperscript{191} If popular polling is to be believed, a sizeable minority of all Medicare-contracted physicians were willing to disenroll from Medicare upon the passage of the Affordable Care Act. Another sizeable minority of physicians were willing to give up practicing medicine altogether.\textsuperscript{192} To date, the exodus \textit{en masse} has not materialized; however, the implementation of the statute has just begun. Of course, should SGR ever be fully implemented, the likelihood of doctors fleeing to the exits of the Medicare program increases.

\textsuperscript{189} See \textit{Cash for Doctors}, supra note __. The author notes that Dr. Brian Forrest is able to negotiate very favorable deals for specialists and ancillary health services:

He’s negotiated deals with a lab company to reduce his patients’ costs for tests. The lab loves being paid on the spot for services rendered and allows Forrest to charge his patients $30, for example, for a prostate-cancer screening test that the company bills to an insurer at $184. “For specialists, cash in the hand is better than a bigger amount charged to insurance,” he says. He’s found other doctors happy to join in, such as a cardiologist who’s willing to give discounts of 80 to 90 percent to his patients if he’s paid cash up front.

\textit{Id.}

\textsuperscript{190} See \textit{id.}

\textsuperscript{191} [Insertion]

\textsuperscript{192} See \textit{The Medicus Firm Physician Survey}, supra note ___ (placing the number at 46\% of the primary care physicians surveyed expressed a desire to leave the practice of medicine if the Affordable Care Act passed).
The most probing question, though, is whether current and future cash-only doctors should be tolerated. That is, should the phenomenon be allowed at all considering that access remains a pressing problem for primary care generally and the Medicare population specifically? Should there be a requirement that all eligible doctors must contract with Medicare and the main managed care plans in the doctor’s area? Indeed, the most compelling argument for a physician’s initial enrollment as a Medicare contractor is the program’s subsidization of that doctor’s training. Medicare indirectly subsidizes post-graduate training to the tune of $8.8 billion for all residents nationwide. A persuasive case in equity can be made for a period of “payback” service to the program equivalent to the number of years the doctor was floated by Medicare. But, the inherent power of the

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193 The focus of this Article has been physicians who solely and completely take cash, and only cash, for their services. A significant structural problem with concierge physicians who concurrently contract with Medicare, other government payers, and private payers is that those doctors arguably violate significant contractual and legal restrictions regarding billing. Many of those same contractual and legal prohibitions and restrictions would affect physicians who contract with insurance, whether public or private, yet give discounts for patients who pay in full with cash. Sandra Carnahan and Frank Pasquale provide thorough overviews of the legal and contractual hurdles faced by concierge physicians. See 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 (2006) and Pasquale, The Three Faces of Retainer Care: Crafting a Tailored Regulatory Response, supra note ___.


   In 2007, Medicare provided $8.8 billion to teaching hospitals in support of their GME programs and related patient-care activities. Private insurers do support GME implicitly through the higher payments they negotiate with teaching hospitals on behalf of the inpatients they cover. Although one report estimated that private insurers contributed $7.2 billion in support of GME in 2006, it is almost impossible to calculate such a number because the portion of these higher prices that defrays the costs of advanced training is neither separately negotiated nor specifically identified. Regardless, private insurers have strongly opposed any public policy that would mandate that they pay a portion of GME expenses.

   Id. at ___ (internal citations omitted).

195 But if the (admittedly unscientific) numbers are to be believed, doctors value their independence more than the prospect of the perception of having to work for the government. A substantial number of primary care doctors surveyed in a December 2009 poll stated that they would probably give up their private practices if the Affordable Care Act passed. See The Medicus Firm Physician Survey: Health Reform May Lead to Significant
subsidization argument is also its undoing. Medicare’s indirect benefit to students is necessarily time-bounded, by the length of the resident’s training program. Equity would also dictate that any requirement or dictate to participate as a contractor in the Medicare program would necessarily be limited to that same number of years. With an explicit limit ceiling on required participation, physicians would likely drop out of the program in greater numbers, knowing they had fulfilled the strictures of the law.

Absent a single-provider system in which all American doctors are functional employees of a unified government plan, proscribing the practice of accepting only cash smacks of strong arm techniques usually not seen in government relations with the medical profession. It has not happened yet. There has been no move to mandate acceptance of Medicare or any particular private plan, though doctors are ready if such a move takes place. However, doctors are particularly apprehensive that the federal government will model a mandate according to the template of a bill currently stuck in the Massachusetts legislature. If passed, the bill would require all doctors in the Commonwealth to accept payment at levels only slightly above Medicare rates for services provided to beneficiaries

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Medicare has two different types of post-graduate funding, “direct graduate medical education” (GME) payments and “indirect medical education” (IME) payments. GME is an express stipend made to teaching hospitals based upon a fixed amount and the number of residents working in the hospital. IME is meant to cover the costs a teaching hospital incurs in training residents in the form of increased test volume and other items that are normally covered by the hospital’s PPS payment. See 42 U.S.C. §§1395ww(h) (for GME) and 1395ww(d)(5)(B) (for IME) [double-check]; see also, CCH 2010 MASTER MEDICARE GUIDE ¶¶ 8.17 and 8.18 (for explanations of GME and IME payments).

If the program were mandatory, though, theoretically there would be replacement physicians for every physician whose service obligation expired - that is, if the number of replacement physicians kept up with the number of physicians dropping out of the program.

See Massachusetts Senate Bill 2170, Docket No. 2188 (introduced July 23, 2009) (requiring, if passed in present form, that Massachusetts doctors accept, as a condition of being licensed in the Commonwealth, rates at 110% of Medicare rates for insurance plans endorsed as “Affordable Health Plans,” pursuant to Massachusetts law) and Massachusetts House Bill H4452 (introduced January 28, 2010) (substantially the same as the Senate bill).
of Massachusetts’ “Affordable Health Plans.” There would be no opting out or refusal, as any recalcitrance would be grounds for revocation of the doctor’s license.199

IV. Conclusion

At this time more than any other in recent memory, American medicine is at a crossroads. The way we shield the entire population against the vicissitudes of illness is set to fundamentally change. Yet, the way we value and pay our doctors, especially the frontline generalists, will adjust, but it remains to be seen whether that adjustment will accrue to the generalists’ good or ill. The recent revival of the cash-only payment movement is a move by primary care doctors to take back some of the professional self-management they feel is lost in the rigid mandates of managed care. Perhaps the lasting benefit of the cash-only doctor movement is the independence experienced by the doctors who choose that way of practice. In the cash-only practice the doctor revels in his freedom to practice medicine how he wants to and for a price that he perceives his patients are willing to pay. And in that freedom, the cash-only doctor experiences true professional satisfaction.

199 See id.