



# The New England Journal of Medicine

## LUXURY PRIMARY CARE — MARKET INNOVATION OR THREAT TO ACCESS?

New England Journal of Medicine,  
April 11, 2002,  
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Primary care practitioners in several states have recently decided to restructure their practices in a way that enables them to see a much smaller number of patients and to spend more time with the ones they do see. Patients enrolled in these practices, referred to as "luxury primary care," pay an annual fee to the practice. In return for this annual fee, they can expect certain amenities that are not currently part of primary care, such as access to their physicians 24 hours a day, 7 days a week, using cell phones or prompt paging devices.<sup>1</sup> When they see their primary care physicians, they can expect up to an hour-long visit. The primary care provider is no longer under pressure to see as many patients as possible each day, because the up-front fee paid by the patient changes the financial structure of the practice. Physicians can even accompany their patients on visits to specialists or to the hospital.

Many physicians are enthusiastic about this new approach because it allows them to take more time in providing care for individual patients. Many patients who dislike the rapid pace and tight schedules that have become characteristic of primary care in the United States are also attracted to this model.<sup>2</sup>

However, some physicians have criticized this approach to primary care, pointing out that only the wealthy can afford such amenities and that physicians should not be catering to wealthy patients. They also claim that these practices are unethical, because patients who cannot afford to pay the annual fee are not allowed into the practice, and long-standing ties with such patients may be severed, disrupting the continuity of care.<sup>3</sup> Some policy analysts wonder whether insurance rules will permit physicians to collect annual fees while they are being reimbursed by insurers for office visits and procedures.<sup>1</sup> In this article, I examine the features of luxury primary care practices and also discuss the legal and ethical issues that arise with such practices.

### Market Innovation

The great debate in health policy over the past two decades has been the proper role of the market in medical care.<sup>4,5</sup> Traditionally, there was no

firmly established set of market incentives in medical care. Such incentives were crowded out by professional values and a peculiar set of financial relationships among patients, insurers, and physicians.<sup>6</sup> However, the federal government and many states have introduced market-based reforms in an effort to control costs.

Luxury primary care is an excellent example of a market innovation that serves the interests of both consumers (patients) and suppliers (physicians). The consumers in this case are patients who wish to pay extra for certain amenities that are currently unavailable in primary care. A primary care practice requires a substantial flow of patients in order to be financially viable.<sup>7</sup> Given the relatively low level of reimbursement for a standard office visit and the diminishing amount of money available for the provision of ancillary testing and services, most primary care providers are expected to handle 4000 or more visits per year. With approximately 240 workdays in a given year, primary care providers must therefore see approximately 20 patients a day. In a standard practice, the time allotted for each visit is 15 minutes for an established patient and 25 minutes for a new patient. Surveys of patients and doctors suggest that they are very unhappy with the amount of time allotted for visits,<sup>8,9</sup> even though empirical research suggests that the time has remained relatively constant over the past decade.<sup>10</sup>

The majority of American citizens have health insurance supplied by their employers, and a substantial minority may have some additional dollars to commit to health care. Thus, there may be a market for practices in which physicians spend more time with patients in return for an annual fee, especially if the fee is only a supplemental payment, with the rest of the costs of health care covered by the patient's health insurance.

Most luxury primary care practices fit this model, although the details vary. The patient usually pays a set fee for entry into the practice.<sup>1</sup> The fee ranges from \$1,000 to \$20,000 annually but in most cases is at the lower end of the range. The Dare Center in Seattle, for example, charges an annual fee of \$3,000.<sup>11</sup> Each physician provides care for 200 to 300 patients (as compared with approximately 1200 to 1600 patients in many standard primary care practices). The resulting gross revenue per physician is approximately \$600,000 and is greater than that in a highly efficient primary care practice with the requisite 4000 visits per year. Insurance reimbursements are therefore merely supplementary dollars rather than the lifeblood of the luxury primary care practice.

With substantial revenues from the annual fees that patients pay, physicians in luxury primary care practices can see fewer patients per day and have time for other activities, such as accompanying patients on visits to specialists. Since the average patient visits a primary care physician two to five times per year, a physician providing care for 200 to 300 patients would have a total of 1500 or fewer visits. In another model, the annual fee is much lower, and the physicians see a larger number of patients. For example, MDVIP of Boca Raton, Florida, charges \$1,500 annually. MDVIP emphasizes preventive care through regular physical examinations and wellness planning, as well as on-line health information.

Many providers will find this approach to primary care practice attractive. Almost all primary care physicians dislike the need to see patients at a rapid pace all day long in order to ensure the financial viability of the practice. They generally do not understand why reimbursement patterns cannot be changed so that such a high volume of visits is not required.<sup>12</sup>

The luxury style of practice may well represent a return to what many providers consider the old days, when physicians had ample time to spend with patients and could really undertake the ethical responsibility to put the patient's welfare above everything else. In addition, the small errors that can occur with rapid-fire primary care may be reduced with luxury primary care, resulting in better care for patients.<sup>13</sup> Certainly, from a professional viewpoint, this new approach promises a much richer and more satisfying practice. Thus, at first blush, luxury primary care appears to be the kind of market innovation that both physicians and patients would welcome.

Although the proponents of luxury primary care acknowledge that not all patients can afford to pay for such care, they argue that there are luxuries unavailable to many people in all sectors of our economy. The analogy to education is especially telling. Many children are educated in public schools, but a substantial minority of children attend private schools that cost much more per year than a luxury primary care practice would. Neither the administrators of such schools nor the parents of the children who attend them have qualms about the fact that not all parents can afford to give their children a private education. Moreover, the teachers enjoy the same professional rewards as teachers in public schools. Like private education, luxury primary care is simply a response to a market need.

### **The Expectations of Insurers**

As noted above, one of the assumptions of luxury primary care is that patients retain their health insurance. Although health insurance is not critical to the operation of the luxury primary care practice, since patients pay an additional premium, reimbursements from insurers for visits reduce the amount that the practice must charge for the luxury premium. More important, health insurance is still relied on to cover the costs of hospitalization, specialty care, and other sorts of care that patients may need. In effect, patients leave the luxury practice whenever they are hospitalized or receive care from a specialist.

Traditionally, insurance arrangements have not entailed an expectation that the insurance payment alone would be sufficient to cover the cost of care provided to the patient. Almost every form of health insurance has a set of copayments or deductibles for which the patient is liable.<sup>14</sup> In addition, some services are not covered. Insurers essentially treat uncovered services, such as cosmetic plastic surgery, as luxury items. Therefore, one might expect that traditional insurance plans would easily accommodate luxury primary care.

However, the situation is not that simple. There are certain insurance arrangements in which the expectation is that the payment provided by the insurer is sufficient to cover the cost of the care. These arrangements prohibit so-called balance billing (the practice of billing the patient for the portion of the physician's fee that is not covered by the insurance payment).<sup>15</sup> Balance billing used to be quite prevalent but has become less so in the past two decades.<sup>15</sup>

Medicare in particular has been hostile to balance billing. At one time, balance billing of Medicare beneficiaries was the norm, and physicians could bill patients for the portion of fees Medicare did not cover. To counteract this practice, Medicare has gradually introduced penalties for physicians who do not accept the Medicare reimbursement as full payment, and today most physicians are not allowed to bill patients for the balance.<sup>16</sup>

Medicare has pursued this policy for a number of reasons. First, Medicare wants to keep health care costs for its beneficiaries under control. In addition, Medicare has strived to create what it believes to be an adequate payment system, a perception that would be undermined if balance billing were allowed.

In many states, commercial insurers and Medicaid programs have followed Medicare's lead. For example, in Massachusetts, the state-regulated Blue

Cross program successfully lobbied for a ban on balance billing.<sup>17</sup> The legislature also imposed balance-billing bans for Medicaid. Many commercial insurers include a prohibition of balance billing in their terms of participation for individual physicians. Thus, providers are often not able to obtain their usual and customary fees by charging patients the balance for a service once the insurer has paid its share.

It follows that some insurers might balk at the luxury tax for primary care, for several reasons. First, they may think it is unfair for a patient who pays an insurance premium to be charged an additional premium, even if it is the patient's choice to do so. More likely, insurers may fear that patients who join luxury practices will expect not only highly personal care but also luxurious care in terms of diagnostic and therapeutic procedures. In addition, typical arrangements for ensuring that primary care providers act as gatekeepers, such as capitation mechanisms and the withholding of fees, will probably not be very effective if the primary care provider's main source of income is the luxury premium. Insurers are therefore concerned that luxury primary care will result in high rates of use of specialty services, with the patients in these practices essentially having a free ride on other patients' premiums.

Insurers are definitely studying luxury primary care but have not yet decided how to proceed. None of those I contacted wanted to be on the record. The Center for Medicare and Medicaid Services is simply watching the development of these practices, in effect giving physicians at least a yellow light, if not a green light, to proceed.<sup>1</sup> An executive of a managed-care company expressed doubt that his company would contract with luxury care providers, since the annual fee that they charge patients would be viewed as an access fee, which is prohibited.

### **Ethical Issues**

From the standpoint of market choice and product innovation, it may seem surprising that there are professional or ethical questions about luxury primary care. Physicians providing such care can make a reasonable argument that they are able to provide their patients with the time and effort that every patient should receive.

Nevertheless, there are ethical issues. The first concerns the transition to a luxury practice. Most physicians who are interested in providing luxury primary care are going to make the leap once they know that there is adequate demand for it in their own practice. That means that most

practitioners will be making the move from a fully staffed, traditional primary care practice to the new practice. To do so, they must rid themselves of patients who do not wish or cannot afford to pay the luxury tax. Opponents of luxury care argue that these patients will be abandoned and that their care will suffer.

Medical ethics prohibits physicians from abandoning sick patients. This prohibition is supported by the common law, which allows patients, within the context of an established relationship with a physician, to sue the physician for inappropriately refusing to provide further care.<sup>18</sup> But both medical ethics and the common law allow physicians to terminate their relationships with patients. If a patient is receiving treatment for an acute disorder, the physician must continue to provide care.<sup>19</sup> In the case of a patient with an acute problem that has been managed, however, or a patient who is relatively healthy, the relationship can be terminated by finding another physician to provide care for the patient. Therefore, as long as practitioners who make the transition to luxury care do so carefully, by winnowing down their practice and providing patients with referrals to other physicians, there should be no serious ethical or legal impediments.<sup>20</sup> MDVIP, for example, assists doctors with the transition by setting up a call center for patients.

Apart from the prohibition of abandonment, traditional medical ethics is rather poorly equipped to address issues related to luxury primary care. Ethical standards in medicine have focused on the physician's commitment to individual patients and have not addressed broader financial and political issues.<sup>4</sup> Slowly, however, views on these issues have evolved, and over the past 15 years, many have argued that resources and limits on resources have to play an important part in medical ethics.<sup>21,22</sup> Energized by debates on managed care, most ethicists now agree that the financial structure of health care is an important subject for ethical consideration.<sup>23</sup> Access to health care, in particular, is a salient ethical issue.<sup>24</sup>

Opponents of luxury primary care argue that its effect on access is the main problem. If almost all primary care physicians charged luxury fees before providing care for patients, then access to health care would certainly be affected. Luxury primary care would have a regressive effect on the health care system, reducing access.

Advocates of luxury primary care counter that they are simply filling a small niche. They point out that at the premium level required for a true luxury practice, relatively few patients will be interested in paying for

such care and that it thus does not pose a threat to health care access in general.

Since professional ethics is a matter of reasoning on the basis of principles, there is something suspect about this argument. It suggests that in the current situation — that is, with relatively little demand for luxury primary care — the practice can be endorsed by professional ethics. However, if the demand were great and access were reduced, then the practice would be considered unethical. This means that the definition of ethical practice changes with the situation — in this case, the degree of access to health care. Such situational ethics flies in the face of standard professional principles.

Luxury primary care also undermines cross-subsidized care. For the past 50 years, the American health care system has been dependent on cross-subsidies from patients with good insurance coverage to those with poor coverage or none. For example, a hospital manages to cover the costs of providing care for uninsured patients because it receives payments that exceed the costs of providing care for some well-insured patients. Physicians do the same.

Indeed, such cross-subsidies can be used to justify practices that otherwise might raise serious ethical questions. For instance, some hospitals and doctors solicit wealthy patients from other countries who are willing to pay a premium for care and for deluxe hospital rooms. The key difference between this practice and luxury primary care is presumably that these hospitals and physicians also provide care to the uninsured. Physicians who provide luxury primary care have simply dropped out of the cross-subsidy system, although some have said that they will continue to provide care for some patients who cannot pay the annual fee. This may reduce the damage to a certain extent, but luxury primary care overall will remain a threat to access.

We still might ask whether luxury primary care is more out of line with our professional commitment than are other practices we tolerate. Physicians today choose the communities and the situations in which they are going to practice. Relatively few physicians practice in impoverished inner-city or rural areas; many do not accept patients with Medicaid or those without insurance. As a result, poor people and members of minority racial or ethnic groups generally have less access to health care than other Americans. We have not, as a profession, addressed these issues in a serious fashion. Since we have accepted broad inequities in access to health care in the past, it is difficult to argue that luxury practice should be prohibited.

In this light, the development of luxury primary care might be seen as a

crystallizing event. The medical community must be prepared to step forward with ideas and programs that ensure an equitable distribution of health care services. No matter how innovative and attractive luxury primary care is to some patients and physicians, it poses questions about equity. We should identify ways in which luxury primary care can be regulated by the medical profession (perhaps by mandatory cross-subsidies and careful monitoring of the prevalence of such care), while also addressing other threats to access. The questions that luxury primary care poses should remind us that as physicians we have a commitment to the equitable distribution of health care and therefore a duty to address market innovations that could leave some patients without access to care.

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I am indebted to Atul Gawande, Michelle Mello, David Studdert, David Fairchild, and George Thibault for their advice on earlier drafts of this article.

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