

CONCIERGE MEDICAL PRACTICES WITHIN THE REGULATED MEDICINE ENVIRONMENT: ARE THEY ETHICAL, WORKABLE, LEGAL?

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I. Introduction

According to Webster's Dictionary, the French word *concierge*, derived from the Latin *conserves*, or fellow slave, is defined as: doorkeeper, custodian, head porter. The implied image to prospective patients when used in the context of the nascent national phenomenon of exclusive priority medical care for a prepaid premium would appear to be that of a ready and willing caretaker who is always available to the patient fortunate enough to be in the program. The reciprocal connotation regarding the provider, then, is evidently that of a highly skilled "Johnny on the spot" or handmaiden. The unavoidable question then becomes why a well-qualified physician would willingly choose to put him or herself in such a role. What would transform the honorable call to serve many pressing needs of one's fellow man into a sycophantic subservience to the few who can afford instant and, perhaps often times, superfluous attention?

Answering this question will help explain the genesis of this emerging trend, commonly known as Boutique Medicine, Cadillac Care, Platinum Practice, and other specific elitist sounding names, such as that of one of the largest current concierge franchises, MDVIP. After a brief background, this article will explore this interesting psychosocial question of how economic forces have influenced individual physician choices, and address the more important overarching issues of whether society should sanction, pay to support, or even tolerate such private contracts. Finally, the article defines and predicts the application of the law and controlling regulations relevant to these controversial enterprises.

A. What is a Concierge Medical Practice?

Concierge care is a relatively new concept in health care delivery that is generally offered by Family Medicine practitioners or Internists providing out-patient primary care who also sell special services for an additional annual fee. By significantly decreasing his or her

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panel of patients from typically 3,000 per provider to 300 or 600 patients, the concierge physician is able to guarantee such services as: priority, same day, extended appointments; 24-hour pager, e-mail, or cell phone access to the physician; house calls or other care outside the office, including accompanying patients on visits to specialists; elegant waiting rooms and spa-like amenities; free and more thorough physical exams; and preventive care, wellness, weight loss, and nutrition counseling. The fees charged vary from \$1,500 to \$13,500 per person per year.¹ The more expensive plans accept no insurance and are, therefore, the province of the truly wealthy members of society. These rare plans raise legal issues regarding insurance regulations, but involve no governmental health care regulatory questions, *per se*, and will not be discussed in this article.

The more common concierge practice does accept reimbursement from private health insurance and Medicare. In fact, the annual concierge fee is not intended to pay for specific medical service such as labs, x-rays, medicines or other services covered by the patient's primary payer. This article discusses in the next sections how the concierge concept under these circumstances correlates with the Medicare rules and what the goals should be of the federally subsidized health care system regarding concierge care as it exists.

B. What Motivates Physicians to Chauffeur the Cadillac?

Unfortunately, the morale of many physicians today is low. Ask almost any practitioner and he or she will recount a litany of hassles encountered on a daily basis, including Medicare or other insurance paperwork, diminished reimbursements, restrictions imposed by managed care, lack of time for patients, and encroachment on their personal time. Gone are the days when a physician was the master of his or her own practice, an independent, self-employed entrepreneur. Physicians feel increasingly squeezed by administrative burdens and rising overhead costs, such as increasing malpractice insurance premiums, at the very time physician reimbursements are being reduced and are often delayed. To compensate and support their incomes, physicians have typically resorted to treating an ever increasing number of patients, leading to an upward spiral of burgeoning frustrations.

Concierge care has come along just at the time many physicians are crying uncle, and, rather than throwing in the towel, are electing to change the rules of the game and shift to a kinder, gentler arena. The profound allure of a concierge practice is that it offers the marvelously counterintuitive double incentive of a less hectic pace, although perhaps less predictable and, for nearly all primary care providers, a pronounced increase in their incomes. What could be better: less patients, more money? As a concrete example, consider that the average primary care provider makes \$153,000 per year and sees 112 patients per week.² If that same provider develops an MDVIP³ franchise practice, he receives \$1,000 of the patient's \$1,500 enrollment fee – the remainder going to the parent company – in addition to the normal reimbursements earned performing medical procedures or treating patients. The math is quite astounding when one considers that an MDVIP provider with a panel of 600 patients typically sees 30 patients per week.⁴ The major downside, evidently, is that any one of those patients may request to be seen when the provider is teeing up on the fourth hole or brushing his teeth at bedtime, yet the physician remains obligated under the concierge arrangement to respond to that unwelcome call.

C. In a Free Market Society, Why is Concierge Care Controversial?

Since the inception of Boutique Medicine, newspaper editorial pages, medical journals, letters to editors, and the blogosphere have included numerous arguments both for and against concierge practices. Addressing the debate on what it prefers to refer to in non-elitist terms as “retainer practices,” the American Medical Association (AMA) perhaps best encapsulates the issues in a one page report of its Council on Ethical and Judicial Affairs (CEJA). This official AMA policy statement serves well as an outline to follow to address the relevant principles and list of concerns enumerated by the CEJA.⁵

The AMA generally supports physicians' entrepreneurial right to freely contract for the medical care they provide with some significant caveats. The CEJA maintains that providing special services and amenities to patients who pay additional fees is “consistent with pluralism in the delivery and financing of health care.”⁶ The abstract concept of pluralism in our capitalist economic environment is apparently the CEJA's sole ethical justification for permitting such exclusivity because, after making this contention in the first two sentences of the report, the rest of the document lays out the ethical and practical conundrums and potential medical-legal landmines encountered by living with such a free market

principle in a country with limited medical resources.

Looking to the broader ethical and philosophical considerations is necessary because, as a strict matter of statutory interpretation, what at first glance seems to be rigidly controlling law has been rendered malleable in the hands of the current federal government. The Medicare statute requires physicians to submit claims for all procedures performed on Medicare patients, even if the physicians do not accept assignment.⁷ Medicare also prohibits physicians who accept assignment of a patient's claim from charging more than the Medicare fee schedule amount. Those physicians who do not accept assignment are prohibited from charging more than 115 percent of the fee schedule amount.⁸ In 2002, five Democratic members of the House of Representatives challenged the legality of the Florida-based MDVIP's practices under the statute.⁹ They also introduced legislation to prohibit doctors from charging Medicare beneficiaries membership fees or any incidental fees, or to require them to purchase non-covered items or services as a condition of receiving covered services. This legislation has gone nowhere in the Republican-controlled Congress. In a letter responding to their complaints, then Secretary of Health and Human Services (HHS), Tommy Thompson, determined that, as long as the concierge fees charged by MDVIP were for non-covered services, such fees would not violate the Medicare rules and added that HHS would continue to carefully monitor such practices.¹⁰ What that monitoring process is exactly looking for has not been elucidated. Besides the statute, which is evidently open to interpretation, and beyond this predictable general philosophical disagreement across the Congressional aisle lie the five following dilemmas addressed by the CEJA that frame the arguments on both sides.

First, in laying out the policy of how physicians could “opt out” of traditional Medicare or insurance reimbursable health care delivery, the CEJA document stresses honesty and fair dealing in contracting by stating that patients must also be able to opt out of a retainer contract without undue inconveniences or financial penalties. This is a mutually libertarian principle on its face: physicians are able to decide who they see based on who can afford the services they choose to offer, and patients can decide to get on board or leave as they please. However, it is not without irony when one considers that once a physician has pared his practice down to a small number of patients, should a significant number of them decide to get off the boat midstream, the physician could be left up the proverbial creek with too few paddles supporting his practice. This situation is not dissimilar to the reverse consequences of a significant number of physicians opting out of Medicare,

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effectively leaving patients high and dry without a boat to navigate the turbulent health care waters.

This first provision goes to the heart of the gamble physicians take when they restrict the pool of patients they can recruit. The CEJA document specifically cautions that a patient's health insurance should not be jeopardized by the arrangement. The potential compromise of a patient's health insurance coverage is a real concern because some plans prohibit charges beyond what is covered. It is a violation of some state licensing boards and insurance laws to hold managed care enrollees responsible for any additional charges for covered services.¹¹ The net effect of this need to rely on and preserve each patient's underlying health insurance may be that the requirements for entry into boutique plans are further elevated beyond the reach of the average citizen. Effectively, only those with the most robust, and presumably most expensive insurance policies, or those whose jobs already provide excellent health insurance, would qualify; otherwise, both physician and patient are put at risk. Analogously, not only would one have to be able to afford the dues to the country club, but the security of one's source of income would have to meet muster, as well.

Second, the CEJA emphasizes that "it is important that a retainer contract not be promoted as a promise for more or better diagnostic and therapeutic services Physicians who engage in mixed practices . . . must be particularly diligent to offer the same standard [of care] to both categories of patients."¹² Concierge physicians are cognizant of this admonition and attempt to walk the line between promising to provide equivalent levels of care to all their patients while reassuring their wealthier clients that they are getting their money's worth. A representative testimonial of a concierge provider proclaims: "We don't claim to be practicing better medicine, but the fact that we can spend more time with our patients means they're going to get better care."¹³ Below, the inherent inequities that are likely to occur in a two-tiered practice despite the rhetoric otherwise are discussed.

Third, the CEJA firmly states it is imperative that physicians do not abandon their patients.¹⁴ Avoiding a claim of patient abandonment is one issue that warrants more than the soft ethical guidelines proposed in the document because well-defined caselaw creates a significant legal risk for a physician who takes no steps to find subsequent care for patients who leave his or her practice. Such charges can be expected when, for example, 2,500 patients are forced to find a new doctor; however, in practice, reducing a practitioner's patient load is done by well-known procedures any time a physician leaves town or moves to a smaller practice.

Most physicians transitioning to a concierge practice obtain the necessary legal help to comply with these requirements. Nevertheless, care must be taken to avoid the perception or reality that the sickest patients are not offered the same opportunities to stay on, or that only those with the best insurance policies are kept in the new practice. From a policy perspective, the practice of "creaming off the top" only the healthiest and wealthiest patients should not be tolerated by concierge franchises or the community, whether or not there are specific laws against such a practice. If for no other reason than creating harmony among colleagues, the remaining non-concierge physicians in the community should not be expected to absorb only the least fortunate patients who are dumped in their laps.

Fourth, after reiterating the maxim that physicians must be honest in their billing practices, the CEJA states: "[i]t is desirable that retainer contracts separate clearly special services and amenities from reimbursable medical services."¹⁵ Separating covered services from the extras is more than merely desirable; it is the legal *sine qua non* on which a concierge medical practice depends if it hopes to include Medicare patients in its clientele. In 2002, then HHS Secretary Tommy Thompson declared that, as long as the concierge fees charged by MDVIP were for non-covered services, such fees would not violate the Medicare limiting charge rules prohibiting fees above and beyond the physician fee schedule amount.¹⁶ But the boundary between "special services and amenities" and "reimbursable medical services" remains unclear, apparently enough so that the CEJA statement continues: "[i]n the absence of such clarification, identification of reimbursable services should be determined on a case-by-case basis."¹⁷ This invites the questions – determined by whom, when, and by what criteria? In most cases, crossing the boundary between an amenity and a covered service is clear enough that it does not require fine line analysis.

Like so many legal questions, the issue comes down to one of defining and categorizing terms; this has not occurred in any formal statute or regulation regarding concierge care. The central question involves the actual verses and semantic differences between a retainer fee, an access fee, and a charge for a non-covered service. The \$1,500 to \$13,500 paid annually to a physician in a concierge practice logically has to be considered one of the three. A retainer is a concept more familiar to the legal profession than the practice of medicine, its use in the latter context being more of a nebulous descriptor, rather than a legal term with attendant references or history. An additional access fee is clearly prohibited under Medicare rules that limit charges and prohibit balance billing, accounting for the complete shunning of

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the term by any proponents of boutique medicine.¹⁸ Therefore, classifying their surplus fees as charges for non-covered services provides the current categorical haven which allows concierge practices to exist.

However, as used, the term “non-covered service” is also an ill-defined concept that serves as a shape-shifting accounting black box. A physician’s cell phone number, a plush monogrammed waiting gown, and an escort to an appointment with a specialist are clearly not covered services, but if a patient never utilizes any of them over the course of the year, can the patient be required to pay for them up front simply because they must in order to have any access at all to their doctor? This payment for an open-ended contingency would then not fit the definition of a charge for an actual non-covered service, but rather, could be considered nothing other than a payment for the privilege of access. Hence the AMA’s preferred term, “retainer fee,” is entirely appropriate if interpreted as an access fee, and cannot masquerade as a charge for an uncovered service. The legal catch-all case-by-case analysis proposed by the CEJA could only be applied after the fact to determine if indeed the extra amenities actually provided throughout the year amounted to sufficient services to reasonably justify the charge. Any excess beyond the fair market value of services rendered would have to be accounted for. Strict adherence to the HHS Secretary’s guidance would then require the concierge practice to refund the balance of the retainer not used for the unneeded non-covered services. This is neither happening nor envisioned.

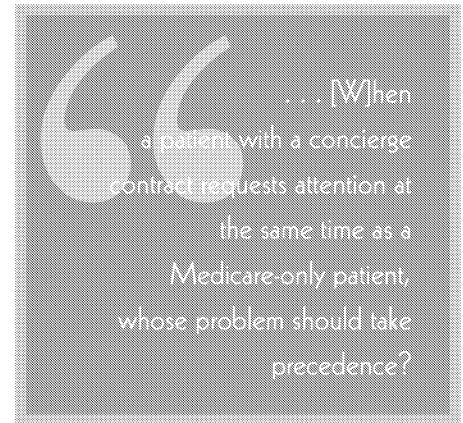
To counter this conclusion, concierge franchises must argue that the services they provide to all their clients, such as a more thorough annual physical exam and nutrition and lifestyle counseling, justify the entire retainer charge. If that is the case, the concierge practices should say so. But they do not itemize only these specific services as such in a bill and completely discount the value of the remainder of the variably utilized services they market. The fee is for a package of potential services and, as it stands, a healthy client’s single visit for an annual exam effectively costs significantly more on a pro-rated basis than that of the needier client who makes use of the myriad of other benefits available under the flat fee. If the uniformly provided services truly justify the entire retainer fee, the practice then would be providing every other non-covered service as a free courtesy. It would be disingenuous at best to maintain such a contention.

Importantly, a \$1,000 physical exam and \$500 worth of “eat right and exercise more” would not stand up to the laugh test. But if the boutiques agree that the fee is for the whole package as advertised, the only other interpretation of the untapped, upfront cost paid by the healthy client is that it serves as insurance – and that involves a whole other kettle of regulatory fish that concierge practices do not operate under today nor likely contemplate abiding. Therefore, under this analysis, the AMA’s stated desire for separation of charges is not being fulfilled and may well be unworkable. The current hybrid boutique practices that accept both Medicare and private paying patients such as MDVIP would be hard-pressed to pass a closely scrutinized investigation because not fulfilling the CEJA’s desire to separate charges is in reality not complying with a legal requirement. Interestingly, Tommy Thompson, the former Secretary of HHS who did not see it this way when he gave his blessing to the concierge concept in 2002, is now employed by MDVIP.

The fifth and final “ethical concern that warrants careful attention” raised by the concierge concept addressed by the CEJA is the long-accepted notion that “physicians have a professional obligation to provide care to those in need, regardless of ability to pay, particularly to those in need of urgent care.”¹⁹ The first evidence that this may be

an endangered, if not forsaken, ideal in the modern era, where the terms “provider” and “consumer” have replaced “physician” and “patient,” is that at the drafting of the CEJA statement, the AMA proponents of boutique medicine argued that the word “urgent” in this document should be limited to “emergency.”²⁰ Their concerns must be rooted in the practical reality of operating as a concierge practice where it would seem to be difficult for the doctor to take time or go out of the way to provide any type of charity care when he or she is obligated to remain immediately available around the clock to a personal panel of patients. A concierge provider presumably could set aside a block of vacation time to do charity work, but holding up his or her end of each of the 300 to 600 contracts with patients would significantly inhibit integrating any “pro bono” work into the day-to-day routine, as is the custom of most traditional practitioners.

The unstated parallel consideration is that it would be similarly problematic to operate a mixed practice that includes non-enrolled patients in addition to patients entitled to the concierge treatment. This mixing remains a common practice and often occurs at least temporarily as a physician transitions from an old practice to the new model. In such a practice, how is it determined which of these patients gets the provider’s “urgent” attention? Traditionally, such triage decisions are based on the severity of the problem coupled with the time sensitivity of the indicated intervention. In a homogenous patient population where everyone begins with equal rights, i.e. they have all either paid a retainer fee, or they all have not, when simultaneous calls go into the doctor for an acute problem no one has a legitimate gripe when the doctor employs such a medical decision analysis. However, when a patient with a concierge contract requests attention at the same time as a Medicare-only patient, whose problem should take precedence? Arguably, the medical triage principle should still apply. But if that is the case, what is the concierge patient paying for? We are back to that \$1,000 physical exam and \$500 worth of counseling. On the other hand, if the concierge patient with a lesser problem takes precedence, is it ethically justifiable to make the otherwise entitled but worse off patient wait? The obvious but difficult to implement answer is that the choice should only swing the premium paying patient’s way when his problem is clearly more urgent, or so similar as to be a toss-up. In the final analysis with respect to prioritizing urgent care, the fee entitles the payer to jump a rung in the triage ladder only in the instance of a coincidental tie in the level of urgency. In actuality, these head-to-head conflicts would seldom occur so bluntly, but are illustrative of the more subtle inequities that must be dealt with by patients and managed by providers in a two-tiered practice.



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For instance, consider the Medicare-only patient, Mrs. Jones, with out of control diabetes and all its sequelae, who dutifully waits until her regularly scheduled brief appointment on Monday morning with Dr. Hilton, who was delayed that morning making a house call with Mr. Rich, who had a cold. Dr. Hilton is running behind schedule and knows that the MDVIP franchise audits his practice to ensure he maintains the strict timeliness standards they require, and he knows that the next patient after Mrs. Jones, Mr. Trump with the itchy scalp, is a demanding concierge customer who threatens to lodge a formal complaints when his contractual promises are not fully met, including the sixty-minute visit to discuss Rogaine. Could these monetarily driven superimposed conditions on Dr. Hilton apply undue extraneous pressures to cause him to invert the priorities that the traditional egalitarian medical ethic would demand in such circumstances? The unavoidable conclusion makes the fair management of a mixed practice a questionable proposition.

It is not too far a reach to extend this same concern about the functioning of a single medical practice to the community. Thus far, concierge practices are cropping up primarily in the affluent areas of big cities. Should they spread to the small towns or less well served areas of cities, the consequences could exacerbate the pervasive problems of medical access. It is not hard to imagine a small community where some providers cull their practices by 80 percent to establish concierge practices and effectively dump thousands of less well-off patients on the remaining already strapped providers. The AMA recognizes this potential harm to society if concierge practices were to become widespread, but the CEJA stopped short of proscribing the spread, stating only that “if no other physicians are available to care for non-retainer patients in the local community, the physician *may* be ethically obligated to continue caring for such patients.”²¹ Again, this begs some questions, such as: Who monitors the fair distribution of health care resources? Who does the epidemiologic assessment when providers want to make the switch? Who enforces these vague ethical obligations? Thus far, no answers have been forthcoming from Congress or HHS. It appears that market forces, political lobbying, and the philosophical leanings of the administration interpreting the rules will determine the answers to these questions in addition to the numerous others raised by this new medical phenomenon.

II. Conclusion

Boutique medicine remains a very small portion of the health care industry, but despite these far reaching ethical and public policy concerns, the number of concierge practices is growing. The personal attractions for those

who can afford it are undeniable. In that dichotomous small town scenario where overbooked harried providers toil alongside relaxed physicians standing by ready to roll out the red carpet for the select few, who would not want to have his or her elderly parents enrolled in the concierge practice? The retainer fee could readily be considered worth the peace of mind gained by knowing they would not get lost in the overburdened medical bureaucracy. Is that peace of mind the uncovered medical service that justifies the fee? If so, does that mean the vast majority of the population who cannot afford the fee are not entitled to the security of knowing the health care system is up to the task of taking care of them? If there is to be a two-tiered system, who is responsible for assuring the viability of the system sans surcharges?

Many liken using medical boutiques to the guilt-free convenience of flying first class. This analogy makes intuitive sense if the shared destination of all passengers is good health care, since everyone on board the plane gets to the same destination. However, in the big picture view that acknowledges limited medical resources, the analogy must be extended to encompass the reality that if enough jumbo seats are put in enough airliners, some people will be left standing on the ground. Certainly, there is no right to fly, and taking the bus or walking are always alternatives. But unlike the mere inconvenience of a delayed travel arrival, a delayed medical diagnosis and compromised treatment are potentially so much more consequential as to make the analogy break down.

When the air traffic controllers went on strike in the 1980s, President Ronald Reagan stepped in to ensure all citizens had continued access to air travel. At this stage in the development of the boutique medicine trend it is a stretch to compare the impact of the small number of doctors leaving traditional practices to a complete industry strike. But if enough doctors elect to opt out of Medicare, at what point should the federal government consider stepping in to ensure adequate access to medical care for its citizens? Or if enough Medicare patients are required to pay thousands of dollars simply to have access to a provider, who decides when that bill is too steep? I would argue that given the 48 million uninsured patients who are effectively denied the opportunity to become customers, the point for additional government support for the underserved is already at hand. Even the AMA, through the CEJA, has acknowledged that there is a potential volume of physician converts that would not be ethically sustainable.²²

If a new administration should decide that line has been crossed in the dwindling physician supply, physicians are not federal employees, and any intervention to address

the problem would have to take a form different than the President's Executive Order in the airline instance. To curb the trend, it is currently within the realm of the regulatory function of HHS to interpret the existing statutes in such a way as to limit the propagation of concierge practices. Simply requiring itemized billing, much like most cosmetic plastic surgery practices, would effectively change the enterprise into a fee for service arrangement. Any fee charged not accounted for as reasonably going toward an uncovered service would properly be interpreted as balance billing and be disallowed. Simply put, calling a lump sum payment a retainer would not obviate the fact that some Medicare patients' identical physical exams are costing more than other's. If a concierge practice persisted in collecting unredeemed charges, appropriate sanctions or exclusion would be called for. Concierge practices containing Medicare patients paying the retainer would then properly be tightly audited.

Alternatively, they could elect to be totally segregated from any federally subsidized plans. Such a practice could contain Medicare patients only if none of them were paying any access fees. Such a mixed practice would be rife with all the conflicting ethical and contractual obligations raised above and make life hard for the conscientious physician trying to do the right thing for all his patients. To continue to operate under the current paradigm where the access fee is up front, not subject to scrutiny, and the provider can comfortably promise similar access and treatment to all his patients would effectively limit the existence of medical boutiques to the truly exclusive neighborhoods where enough patients not dependent on any federal assistance could fully populate a practice. Concierge physicians would undoubtedly love to have such a practice, but the number of such pure, Medicare-free panels of patients would be quite limited as, I believe, it should.

When debating how government should act in shaping a proposed outcome, it is important to realize that the economic reasoning regarding the correct public policy relevant to the distribution of health care resources does not fit neatly into traditional philosophical camps. To further exploit my airline analogy, it is true that in the widening economic divide between the "haves" and the "have-nots," the coach passengers may envy the first class passengers, but those at the back of the plane generally do not and should not begrudge those up front their privilege. The American way is to work toward the day when flying supplants the bus to when flying first class makes cramped seats a thing of the past. Every hard working capitalist wants that legroom and a martini to be waiting for them when they finally arrive. However, the hardships imposed by inadequate health care on an individual's road to prosperity are

fundamentally more difficult to overcome than any economic or social hurdle encountered on one's path. In other economic respects it can be legitimately argued that it is not the government's job to clear all the obstacles or lift every burden. But the government should recognize that the vaunted entrepreneurial spirit cannot take flight without a healthy body to sustain it. If the downtrodden are indeed expected to pick themselves up by their bootstraps, they must first have a modicum of health and strength with which to attempt it. Unlike economic success, people cannot will themselves to good health. It is different. Ill people without resources need help and all people without resources will one day become ill. A poor person with an idea, ambition and willingness to work hard and take risks may or may not need a government loan or other such boost to succeed. But when that person needs health care, all of his efforts will be for naught if what is available is inadequate to allow him to remain a productive member of society.

Toward that end, the proverbial leg up medical assistance provides cannot be granted to as many people as need it if a broad based health care infrastructure is not available. Therefore, the four-star treatment concierge plans offer should not be subsidized by the government in the form of continued Medicare or Medicaid payments to retainer practices if those practices charge more than 115 percent of the fee schedule amount allowed by law. In most cases the retainer fee amounts to a surcharge above and beyond the allowable charges and is tantamount to smoke and mirrors to circumvent the Medicare rules. Enforcing the Medicare restrictions would be consistent with a government policy that protects Medicare recipients from coercive billing practices, and ultimately helps ensure the larger society has greater access to medical care.

1 See R.M. Portman, *Concierge Care: Back to the Future of Medicine?*, 15:5 ABA HEALTH LAWYER (August 2003).

2 See Wayne Guglielmo, *How To Set Up a Concierge Practice*, MEDICAL ECONOMICS, Aug. 22, 2003, available at <http://www.medicaleconomics.com/memag/article/articleDetail.jsp?id=112475> (last visited Feb. 24, 2008) (citing the American Academy of Family Physicians 2003 Physician Survey).

3 See MDVIP Concierge Medical Care Group, <http://www.mdvip.com/NewCorpWebSite/index.aspx> (last visited Feb. 24, 2008).

4 See *id.*

5 See Report of the Council on Ethical and Judicial Affairs: Retainer Practices, CEJA Report 3-A-03 available at www.ama-assn.org/goceja (last visited Feb. 24, 2007).

6 See Monique Johnson, *A Different Approach to Health Care: "Boutique" Medical Practices Attempt to Strengthen the Doctor-Patient Relationship- and Local Residents are Opening Up their Wallets*, THE ALMANAC, June 8, 2005, available at <http://www.almanacnews.com/>

- morgue/2005/2005_06_08.health1.shtml (last visited Feb. 24, 2007).
- 7 42 U.S.C. § 1395w-4(g)(4).
- 8 42 U.S.C. § 1395w-4(g)(2).
- 9 See Letter from Representatives Henry Waxman (D-CA), Sherrod Brown (D-OH), Pete Stark (D-CA), Benjamin Cardin (D-MD), and Senator Richard Durbin (D-IL) to Tommy Thompson and Janet Rehnquist (Mar. 4, 2002); see also M. Hawryluk, *Boutique Medicine May Run Afoul of Medicare Rules*, American Medical News, April 8, 2002.
- 10 See Letter from Secretary Tommy Thompson to Rep. Henry Waxman (D-CA) (May 1, 2002).
- 11 See, e.g. MAHHLMI MA-CLE 5-1, Massachusetts Continuing Legal Education, Inc. PHYSICIANS, 2004.
- 12 See CEJA *supra* note 5.
- 13 See Guglielmo, *supra* note 2.
- 14 See CEJA, *supra* note 5.
- 15 See *id.*
- 16 See Letter, *supra* note 10.
- 17 See CEJA, *supra* note 5.
- 18 42 U.S.C. § 1395w-4(g)(2).
- 19 See CEJA, *supra* note 5.
- 20 *AMA Delegates Adopt Ethical Guidelines for Retainer Practices*, AMA News Release, June 17, 2003 available at <http://www.ama-assn.org/ama/pub/article/1616-7783.html> (last visited Feb. 24, 2007).
- 21 See CEJA, *supra* note 5 (emphasis added).
- 22 See CEJA, *supra* note 5.

