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I. Introduction

I am a 51-year-old board certified internist, presently practicing as an MDVIP affiliated physician in Boca Raton, Florida. I affiliated with MDVIP in order to provide my patients with comprehensive preventive care services that unfortunately can no longer be offered in a traditional primary care setting. This decision was prompted by the inability of the current healthcare environment to accommodate the necessary emphasis on wellness and prevention that I believe is essential for comprehensive preventive care. Instead, current practice, because of time constraints, focuses predominantly on acute care. I am honored to be able to discuss my career, and my decision to provide my patients with the attention to prevention and early detection that they have requested and deserve.

II. My Background

Choosing a career was a simple choice, inasmuch as I'd always aspired to be a doctor, even from the age of six. I attended Albert Einstein College of Medicine in New York, where I was elected to membership in Alpha Omega Alpha, the national medical honor society. Following graduation, I completed my training at New York University-Bellevue Hospital Center, where I served as chief resident in medicine and was responsible for the continuing medical education of the medical staff. My experience as

intern and resident was fulfilling, enlightening, and, because of the nature of medicine, with its unforeseen outcomes and complications, humbling. I believed that my intensive training, at one of the country's biggest and busiest urban medical centers, prepared me to be a consummate physician. I was trained to be academically proficient, empathetic and socially conscious. My Bellevue experience was unique. I cared for Park Avenue matrons and addicted single mothers, suburban entrepreneurs and the homeless. At the conclusion of my residency, I believed I was ready for the real world.

Following training, I stayed on as a junior faculty member at New York University School of Medicine. My position combined teaching with practice, an arrangement I considered optimal. Practicing in an academic environment allowed me to stay current and to apply what I learned to my practice.

About eight years into practice, in 1992, I encountered a situation that was new to me. A patient called and asked if I was on the panel of the insurance company that her employer was switching to. Until then, a patient's insurance carrier had never been a concern. If the patient had Medicare, I accepted assignment. When the patient was younger, insurance typically paid eighty percent of my fee, and the patient paid the balance. If the patient didn't have insurance, we made other arrangements. I now discovered that whether a patient saw me was no longer dependent on his preference, or trust in my skill, but rather on whether I was on his plan. At first, I considered this an isolated phenomenon, but it soon became clear that, unless I too joined the panels, my practice was at risk of becoming financially unsustainable.

Coincident with these changes, academia also began to change. The practicing faculty began to feel more pressured by declining reimbursement. With less time

available, it became increasingly difficult to volunteer uncompensated hours for teaching. Formerly, the attending staff had very generously donated their time.

Bowing to legislative constraints, residents in New York State changed from an every third to an every fourth night schedule. In addition, residents were no longer on call all night. They went home at midnight, without regard to whether a patient was stable or decompensating. This was implemented to mitigate the effects of stress and sleep deprivation. An unintended consequence of this change was the adoption of a more time clock oriented approach to healthcare. An intern no longer went home when his or her work was done. They went home when the “shift” was over. Faculty members were criticized for being “overly academic,” and teaching rounds were sometimes perceived as keeping staff from getting their work done. Moreover, the spectrum of pathology previously seen at Bellevue had narrowed. In the years prior to the advent of highly active antiretroviral therapy, most admissions were due to HIV related disease, and the residents became less interested in an atmosphere that was increasingly oriented toward less time with patients. The gratification from teaching is understandably diminished in such a setting.

At that time, South Florida had a reputation as possessing a burgeoning population and an inadequate number of rigorously trained physicians. Some of my New York patients, who wintered in Florida, suggested that I would do well there. I made the move.

Perhaps it was naive to think that the changes in medicine wouldn't become universal. What I had not anticipated was the rapidity with which managed care, particularly in the realm of Medicare HMO's, would take hold. Because of the generous

pharmacy benefit which was then offered, these plans held great attraction for patients. Of course, the reimbursement was lower than traditional fee for service Medicare but doctors had no choice. The alternative Medicare HMO model, called “capitation”, i.e. accepting a fixed payment per patient per month, held the potential to be very remunerative. Whatever was not spent on the patient accrued to the doctor. However, such an arrangement was never acceptable to myself and my partners because of the obvious inherent conflict of interest. The doctor is incentivized to order as few tests, and as little medication, as possible in order to improve his or her bottom line. Such an arrangement was not suitable to us. Moreover, the approach to care emphasized treatment of acute problems with diminished emphasis on prevention. Quantitatively, the time for preventive care was simply not there.

Concomitant with declining reimbursement, overhead continued to increase. Healthcare costs for employees rose. Malpractice insurance skyrocketed, especially in crisis states such as Florida. We attempted to cut staff but untenable delays occurred. We became more and more constrained in our efforts to be *proactive* with regard to healthcare, and were far more *reactive*. It was apparent that there was only one way a practice could promote prevention and still maintain its financial viability: by seeing more patients! But the reasoning was circular. More patients meant less time, so how could a physician implement prevention? A solution would necessitate *more* time, not less.

III. My Decision to Fundamentally Re-orient My Practice to Emphasize Preventive Care

The need for primary care is growing. Changing demographics, characterized by growth of the elderly as a percentage of the population, is not a problem confined to Social Security planning and Medicare budgeting. As the population ages, the number of primary care providers must expand accordingly. However, what is happening economically to practitioners of internal medicine is not lost on today's medical students. Average debt upon graduation is currently \$110,000. I've spoken to a student who has incurred \$175,000 of debt. Respected teachers, who were once role models, now advise students to consider seriously dermatology or the more lucrative surgical subspecialties. Each year the national residency-matching program documents a decline in applications for internal medicine and family practice programs. The American College of Physicians has been forced to launch an initiative program to try to attract students to primary care. I have been present at gatherings of internists where the question has been posed, "Who would encourage their child to go into internal medicine?" Not a hand goes up. Doctors are concerned that their children will not be able to attain the professional gratification that makes practicing medicine a joyful pursuit.

Declining reimbursement and more elderly patients equals more visits. But, is that a viable or sustainable model? The Annals of Internal Medicine has pointed out that as newer technologies are developed, physicians are less and less able to find the time to incorporate these changes into their practice. ("General Internal Medicine at the Crossroads of Prosperity and Despair: Caring for Patients with Chronic Diseases in an

Aging Society,” *Ann Intern Med* 2001; 134: 997-1000). Whereas before, a patient with congestive heart failure may have been treated with just diuretics and digoxin, now one must consider ACE inhibitors, beta-blockers and aldosterone antagonists. How many additional visits will this entail? Where does one find the time for them? Patient education is, and should be, time consuming. The days of the paternalistic physician, who freely prescribes without offering an explanation, are long gone. Suppose a diabetic patient is well controlled. Her blood tests document that the standard of care is being met. But a newer insulin might work just as well and may be given only once per day instead of three times. It might not be an advantage medically, but it will improve the patient’s lifestyle tremendously. Of course, the patient will need to come in frequently during the transition. It is horrific that a physician must even consider such matters.

Last June, the *New England Journal of Medicine* documented that only 55% of recommended preventive care is administered, and only 52% of recommended screening is performed. It has been estimated that if a doctor, with a typical patient load of 2500 patients, complied with the recommendations of the U.S. Preventive Services Task Force, he would spend 7.4 hours a day on prevention. Only a tiny fraction of the day could then be devoted to acute care.

The above scenario describes what my day had become. I was on a treadmill, running at an ever-accelerating pace, desperately trying to do the best for patients with a limited resource, i.e. time. I was essentially putting out the fires of acute problems and was frustrated by my inability to place appropriate emphasis on prevention and wellness. I was disappointed professionally and missed the gratification that had always been inherent in physician-patient interaction. Patients, too, were becoming increasingly

unhappy. While they were sympathetic to the time constraints I labored under, they read about, and wanted, more preventive care. Patient dissatisfaction was particularly irksome and frightening, since studies have demonstrated that malpractice is often not the product of malfeasance, but, rather, is due to poor communication between doctors and patients. Yet, how can that dynamic be altered when numerous surveys report that patients routinely feel that they are not getting enough face time with their physician?

In early 2001, it became apparent that I was no longer the physician I had trained to be. I was always frenetic. I treated heart disease while desperately trying to devote attention to nutrition and exercise. I treated emphysema but lacked the time to consistently call each patient regularly and encourage him or her not to smoke. Sometimes that's what it takes - direct engagement rather than technologically based intervention.

What was I looking for? A way to make prevention the foundation of my practice rather than an often ignored recommendation. A practice style that would allow me to dwell on exercise and nutrition, weight loss, smoking cessation and curtailment of alcohol use. A method to provide patients with electronic tools that would guarantee timely transfer of clinical data between providers. Planners have been talking for years about the need for a dramatic change in the delivery of primary care, but I knew of no feasible solution. Similarly, in regard to technology, smart cards, containing digitized patient data, had been regularly touted. I'd yet to see one. As a profession, we were awash in well-intentioned ideas, but lacking in the ability to implement meaningful change. I was ready to abandon clinical medicine. It was a most propitious confluence of

events that MDVIP came on the scene just as I was on the verge of leaving clinical medicine.

In a typical practice of 2,500 patients, if one worked 50 weeks a year and planned on performing a comprehensive preventive exam of even an hour in length for each patient, then 50 hours a week would be devoted to annual physical exams. Of course, that leaves no time whatsoever for acute care. In contrast, if a practice is limited to 600 patients, such as in my current practice, then 12 hours a week, or even 18 hours, can be devoted to annual preventive exams, with adequate time still available for routine and urgent care.

Hence my decision to join MDVIP, a program focused on an annual preventive care physical examination and related wellness planning, individually tailored to a patient's needs. This includes detailed analysis of medical and family history, nutritional, psychological and fitness screenings, EKG's, and comprehensive lab and imaging studies. In order to offset the decline in revenue associated with the far smaller practice size, patients pay an annual fee to receive these preventive care services. MDVIP provides me, and other physicians located in eight states, with the operational, technological, and administrative support required to effectively establish a preventive care based practice.

What does it mean to patients who are members of a practice limited to 600 patients? It means they know that when I talk about diet and exercise I really mean it. I will urge them repeatedly, and be able to assist them throughout the year, to be more compliant with proactive preventive care initiatives. It means they will travel with a pocket CD which contains a comprehensive summary of their history, physical exam,

medications, allergies, EKG tracing, x-ray findings and digitized images. I could offer you many anecdotes, but here's just one. A patient had her CD with her when she was hospitalized in Beijing, and it made an incalculable difference in her care. Her physician called me from Beijing, late at night, to discuss the information on her CD, which was essential to his treatment decisions. With a practice limited to 600 patients, I was able to recall details even when at home, and without access to the chart, and actively participate and assist in the care of my patient in another part of the world. How could I ever commit to memory the details of 2,500 patients, or have the ability to offer this level of involvement consistently to each of 2,500 patients? Logistically, it could not be possible.

My patients are thrilled. I've rediscovered the intimacy that traditionally had been part of the doctor patient relationship. Soon after starting my new practice, I realized that patients would share with me stories that they had never told me before. For instance, one woman tearfully related that she had never told me that she had been an abused wife and was seriously injured. I asked her why she had never shared that with me. As similar stories have surfaced, I have come to realize that the reason I now knew was because of the changing dynamic of our relationship. I have become a friend, a confidant—a real doctor, just like Sinclair Lewis' Dr. Arrowsmith. It is gratifying beyond description.

The emphasis on prevention mandates that the practice be kept small. Otherwise, there wouldn't be enough time to perform a comprehensive exam and implement wellness plans for each patient. The *de facto* benefit of being a patient in a smaller practice is that the ambiance of the office is less harried; the tenor of the office staff is calmer. Patients exhibit relaxed body language. Calls are returned promptly. Patients reach me by e-mail. No phone tag. Again, these are *de facto* benefits of being in a smaller

practice. They are simply reflections of how I run my practice. When a patient calls and tells my assistant that his oncologist hasn't gotten back to him about his CAT scan results and he is nervous, we assuage the concern by obtaining the results, even though we haven't ordered the test. When a patient asks me to tell her a little about her *sister's* rare illness (and her sister is not a patient!), I am able to oblige. When I reassure my patients, when I address their fears, I'm being a doctor again. Would a busy physician taking care of 2500 to 3000 patients reasonably be able to research a matter totally devoid of any relevance to their patient's care? Despite the best of intentions, it would be very difficult.

I've frequently been asked how an MDVIP practice is received by the specialists I work with. Actually, specialists enjoy seeing my patients. Quite often, a patient will appear for a consultation without the reason for the consultation being clearly documented. This can be frustrating to the specialist who asks the patient, "why are you here?", and gets a blank look in response. In contrast, before my patient sees the consultant all pertinent records, x-rays, labs, etc., will have already been faxed. Furthermore, the software tracking that MDVIP has provided advises me that the patient has seen a specialist and prompts me to speak with the specialist regarding the visit. If a patient comes in and advises me that they had an appointment with a consultant that was arranged through other auspices, my office makes sure to get a record of the visit. Since elderly patients will often see several consultants, the only way to prevent potentially harmful drug interactions is to make a determined effort to keep abreast of any medication changes instituted by a physician other than myself.

MDVIP has assisted me in establishing benchmarks for preventive services. Our patient satisfaction scores are extraordinary, and the membership renewal rate exceeds

95%. Not surprisingly, our hospital admission rates are unusually low. Because our practice is small, a patient with swelling of the ankles or shortness of breath is invariably seen the same day. The patient is therefore treated when his or her congestive heart failure is incipient, and presentation to the emergency room in the middle of the night is avoided.

Our attentiveness to an old fashioned style of care, with emphasis on prevention, results in significant savings to insurance providers. I listen to patients -- literally. Much has been written about the increasing reliance of practitioners on technology, to the exclusion of a careful physical exam. My utilization is lower because I rely less on expensive imaging studies and more on careful scrutiny of physical findings. I *listen* to the heart and lungs carefully, as I was taught in medical school. I'm judicious with my use of tests. Sometimes, careful auscultation with a stethoscope obviates the need for an expensive echocardiogram.

My relationship with my patients is special. I am their "doctor". I am not a provider chosen from an insurance company roster. My patients trust me. Many physicians typically must order an excessive number of tests to protect themselves from the threat of malpractice. Because of the time I now have for preventive care, and the trust engendered, I am not subject to that fear. My patients and I recognize that whatever the outcome, I gave them my best.

Who are my patients? The demographic makeup of my current practice very closely mirrors that of my former practice. My patients range in age from 18 to 101, and come from all socioeconomic backgrounds, including patients on fixed incomes, and those whose incomes qualify them as upper middle class. Those patients who *chose* not

to avail themselves of the benefits of the MDVIP prevention program remained in my former practice and a new internist joined the group to take my place and *insure continuity of care for all such patients*. I use the word “chose” advisedly. For the vast majority of patients, joining my new practice was a matter of choice. The financial foundation for this dramatically smaller practice setting is largely based upon an annual fee of \$1,500. Such an amount is certainly significant. However, \$125 per month to maintain one’s health is certainly no less important than a cell phone and cable bill, which cost more.

Nonetheless, for those patients for whom it was not a choice, for those who truly could not afford the membership fee, the fee was waived. Those patients are full members and reap the benefits of the prevention program. Absolutely no distinction is made between the paying and the “scholarship” patients.

IV. The Role of Preventive Care Based Programs Such as MDVIP

In order to fully understand my practice, it is essential to recognize that the preventive services I provide to patients are not covered by Medicare or by commercial insurance. Perhaps the most striking, and least understood, aspect of the Medicare program, from the perspective of patients, is that Medicare is designed to cover only a portion of the healthcare expenses of seniors. Indeed, annual preventive care physical examinations are specifically excluded from coverage under Medicare.¹ Similarly, these services are beyond the scope of care that is covered under commercial insurance. Accordingly, patients who desire such services must obtain them using personal funds.

¹ The recent Medicare Modernization Act of 2003 established a limited one-time preventive care examination available only during the first six months of Medicare eligibility

Clearly, I am not suggesting that my practice is an option for all patients, as there cannot be a single healthcare alternative for all segments of society. I firmly believe, however, that my practice offers a compelling and viable choice for many patients who seek services that are not available in traditional primary care practices.

The national media has described my MDVIP practice, and other efforts by physicians who incorporate annual fees in their practices, as “retainer” or “concierge” based medicine. Although initially the subject of some controversy, this approach, when properly implemented, is now acknowledged by both the Federal government and the American Medical Association as an appropriate and innovative option for patients.

Charges in excess of the Medicare fee schedule for covered services are, of course, contrary to law. However, in a May 1, 2002 letter to Rep. Henry Waxman, Secretary of Health and Human Services Tommy Thompson specifically confirmed that as long as a charge, such as the fee associated with my practice, is solely for non-covered services, such fee is consistent with Medicare law. The HHS Office of the Inspector General recently reaffirmed this determination in an alert dated March 31, 2004. As stated in the OIG Alert, “Medicare participating providers can charge Medicare beneficiaries extra for items that are not covered by Medicare.”

The American Medical Association has considered retainer medicine and supports such practices. In its Report of the Council on Medical Services issued in June 2002, the AMA found that

“ . . . retainer practices *are consistent with long standing AMA policy* in support of pluralism in the delivery and financing of health care. . . The success of retainer practices in the market *is the best evidence that these practices fill a market need*. There are several factors that explain the successful proliferation

of this model to date . . . first, these practices fill otherwise unmet market demand . . . second, retainer practices may lead to market driven improvement in quality . . . third, the practices have great appeal to physicians and their patients. ***Instead of spending a few minutes with each patient, physicians are at liberty to spend as much time as needed with each patient, which may result in higher patient satisfaction, higher physician satisfaction, and better outcomes for the patient. (emphasis added)***²

The suggestion that such practices will deny access to care is misplaced. As found by the AMA, retainer practices are:

“a growing but small-scale market phenomenon that seem to have sparked a disproportionate share of media attention . . . The phenomenon of retainer medicine is inherently self-limiting. The more physicians charge for their services, the smaller the demand for their services . . . ***These economic realities limit any potential for widespread adoption of retainer practice and any potential growth in retainer practice to adversely impact patient access to care. . . The Council currently finds no evidence that special retainer agreements adversely impact the quality of patients’ care or the access of any group of patients to care. (emphasis added)***”

Although there is no factual basis to suggest that MDVIP, or similar programs, would diminish availability of physicians, MDVIP nonetheless requires all affiliated physicians to provide for continuity of care for ***all*** patients that elect not to become MDVIP members. This is done to insure that patient care is not interrupted when a patient chooses to not remain with a physician who begins an MDVIP affiliated practice, and this policy formed the basis for the establishment of my practice.

MDVIP provides a niche service. It meets the needs of patients who desire these services but would not otherwise receive them because they are not covered by insurance, and therefore are not provided. In parallel fashion, it meets the needs of those physicians who seek to employ a methodology that emphasizes prevention and wellness. The sentiment has been expressed that patients should not be allowed to receive these services

² The AMA Council on Ethical and Judicial Affairs also determined in June 2003 that “retainer” practices are consistent with ethical guidelines and recommended policies to ensure appropriate transition to, and operation of, such practices.

at a time when tens of millions are uninsured. However, that notion is flawed because the presence or absence of preventive services has no discernible impact on the plight of the uninsured. Those who may believe that physicians should not run MDVIP affiliated practices assume that, were I not doing what I am presently doing, I would still be on the treadmill, seeing 30 patients a day. That assumption is incorrect. As I related earlier, I was on the verge of leaving clinical medicine and would have done so if not for MDVIP. In fact, many fine physicians, frustrated and overburdened by a system that does not place the physician-patient relationship at the forefront, have left the profession, and, sadly, their skills are being wasted. In any case, even if I were still in my old practice, would that ameliorate the plight of the uninsured? From a purely logical standpoint, causality cannot be inferred.

It appears that the quality of care that I am able to provide may be enhanced as well, as suggested by the AMA position statement of June 2002. Preliminary analysis, using a modified HEDIS survey of MDVIP affiliated practices located in Florida, yielded results that far exceeded national averages.³ These same practices were also surveyed to

³ In 1990 the National Committee for Quality Assurance (NCQA) was founded. NCQA is a private not-for-profit organization that measures the quality performance of over 90% of all health plans. NCQA developed a series of measurements known as HEDIS, the Health Plan Employer Data Information Set. HEDIS is a tool that uses more than 60 different measures to evaluate the care and service performed by health plans. HEDIS makes it possible for consumers and employers to compare the performance of health care plans on an "apples-to-apples" basis, something not previously possible. The HEDIS criteria include the evaluation of preventive measures, such as the percentage of female patients receiving mammograms. It also includes treatment data, such as the successful management of high blood pressure and elevated cholesterol. These are just some of the treatment aspects evaluated by HEDIS. Although MDVIP practices are not health plans, the use of HEDIS data allowed for a preliminary assessment of the care provided to MDVIP patients. The MDVIP physicians surveyed had superlative HEDIS scores, which cumulatively approached an average of 90% compliance against a sample of HEDIS criteria. While each individual HEDIS evaluation has its own numerical score, the range of national compliance generally runs from 40% on the low side to 77% or 80% as a high score on some measures. Most health plans achieve compliance in the 60% to 70% range when all HEDIS scores are averaged. These numbers have real life significance. For example, raising the compliance numbers for blood pressure treatment from 40% to 68% could potentially save an estimated 28,000 lives in a population of 100,000.

determine the average number of patients admitted to hospitals throughout the year. This is not only of importance in regard to patient health, but also in the context of the dramatic expense associated with hospitalization. Significantly, the results showed approximately 30% fewer hospitalizations relative to national averages compiled by Milliman and Robertson, a leading national actuarial consulting firm. This applied across all age ranges, even though MDVIP participation is skewed to an older patient base. Admittedly, these results are preliminary since they are derived from a small number of practices and in one locale. It is noteworthy, however, that the locale is an area known to have one of the highest hospitalization rates in the nation. Early analysis nonetheless suggests that the scope of care that can be delivered in an MDVIP affiliated practice such as mine can result in enhanced patient outcomes.

V. Conclusion

I was quite idealistic when I started practicing medicine. The bond of trust that I had with my patients was of paramount importance to me. For a while I loved being a doctor. Then, the dynamic began to change and gradually eroded. My “customer,” if you will, was no longer the patient. It was the insurance company. The patient paid the insurance company, and the insurance company, in turn, paid me. There was no transaction utility between the patient and me. Now, with great appreciation for the fortunate position I find myself in, I can proudly say I’m a doctor again. I treat people, not clients. I am their healer, their friend, their confidant. This is how it was when I was a child in the early 60’s. For myself and my patients, the clock has been turned back, and the practice environment of yore has been restored. Doctors are now in a position to

incorporate into their practices the newest recommendations regarding prevention. It's a win for patients, a win for doctors and a win for insurers who save money. What could be better?