

Self-pay Discussion Paper

Self-pay Defined

Self-pay is the basis upon which the healthcare financing system began. Patients paid physicians a fee-for-service. In its purest sense, the self-pay model includes only the physician and patient in the exchange of compensation for medical care provided. Over the years as healthcare financing arrangements have changed, entities paying a fee-for-service includes all payors-public and private. Recently, the healthcare industry has referred to physician practices that do not accept health insurance as “cash-only” practices. To better define practices in which patients are paying physicians directly for rendered services, the more appropriate term “self-pay” will be utilized.

Self-pay Demand

Why is a self-pay practice appealing? Because it vastly reduces the traditional overhead expenses by not having to bill and abide by contractual requirements of third party payors. Further, collection rates may be higher with fewer bad debt expenses. Yet, legal and ethical issues should be considered.

Legal Issues

It is prudent prior to assessing patients a fee for medical services to know the legal issues that may arise. Fees-for-services should be the same across the board, but offering discounts to privately-insured or uninsured patients who pay in full at the time of service would be permissible.

Publicly-Insured Patients

Physicians who wish to move to a pure self-pay practice and still take Medicare patients must privately contract with such patients. If still accepting Medicare, it is advisable to follow the Medicare fee schedule as to avoid causing any red flags to be raised. To still see Medicare patients and opt out of the Medicare program, there are certain procedures to follow. In summary, one needs to: (1) notify your patients, colleagues and others; (2) file an initial affidavit with Medicare and a new affidavit every two years to maintain opt-out status; (3) privately contract with the Medicare patients under physician's care; (4) and initiate appropriate office procedures (i.e. how to identify Medicare patients and ensure that they are notified of the opt-out status).¹

The rules related to treating Medicaid patients on a self-pay basis will vary from state to state. It is advisable to contact the state Medicaid agency for their terms on charging patients directly.²

Privately-Insured Patients

Physicians in a pure self-pay practice may want to continue to see patients with private insurance who are willing to pay cash and submit their own claims. Before charging privately insured patients on a cash basis, the physician should determine that there are no contractual or legal restrictions on doing so. This will necessitate a review of existing contracts and state insurance regulations. Certain states protect enrollees in particular private insurance plans from being billed for any sums beyond what the insurance company pays, except for co-pays and deductibles. (See Connecticut Code § 381.193(c) and § 20-7f9b (2004)).

Surcharges

Due to the high cost of malpractice insurance and inability to adequately impact a raise in reimbursement amounts, some physicians have turned to their patients to minimize the financial impact of the malpractice premiums. Publicly-funded health insurance regulations prohibit patient

surcharges. The AMA supports the ability of a physician to institute a “liability surcharge” where not prohibited by contract, state or federal law or regulation, but urges physicians to seek legal counsel in doing so.³ Its guidelines state that patients should not be obligated, but only asked to pay a surcharge as malpractice coverage is not a service provided to patients. All communications should be clear that the patient’s decision whether or not to pay a liability surcharge will have no effect on the physician-patient relationship or quality of care. However, exorbitant malpractice premiums can negatively impact patient’s access to care, as physicians may stop practicing medicine in certain states or close the practice, e.g. obstetricians. Lack of access to medical care in itself, could affect the timeliness of appropriate care as patients may have transportation issues that prevents the patient from receiving recommended care.

Ethical Issues

Opponents of a completely self-pay practice model would argue that it violates the professional principle of ensuring equal access for all. Individuals with insurance may not be able to afford seeing a physician who does not participate with their health plan due to the added financial responsibilities. Thus, the self-pay practice is limiting its level of patients’ access to care based on one’s financial means. Even so, the AMA holds that self-pay practice models are consistent with pluralism in the delivery and financing of healthcare.⁴ There are already millions of Americans who cannot afford private health insurance and have Medicaid coverage. Others self-insure due to their financial resources being such that they can pay out-of-pocket for their medical expenses.

There may be concern if a physician living in a community where s/he was the only physician in a reasonable geographic area decided to transition to a self-pay practice. This could disrupt patient access to care as well as the patient’s continuity of care.

Change Preparation

One must first determine whether or not the local market can support this type of practice design. If the preponderance of employees that work for the local major employer cannot afford to pay out-of-pocket for medical care, success in a self-pay practice may be challenging. In this scenario, the demand for paying out-of-network expenses is virtually non-existent, leaving little opportunity to compete with traditional practice designs. On the other hand, in a market where insureds have adequate out-of-network coverage, a high number of self-insured individuals, or a considerable number of insureds with disposal income, a self-pay model makes sense. It may be that as a greater number of consumers enroll in the high-deductible health plans and become transitioned to paying the first dollar out-of-pocket for non-preventive services, self-pay models may enjoy some growth.

If moving to a self-pay practice, knowing how many patients have a benefit plan that has out-of-network benefits will be helpful, as they may be more likely to pay a nominal fee over and above what they would be reimbursed by their health plan.

Questions to ask before transitioning to a full or partial self-pay practice:

- Can the local market support a full self-pay practice?
- What number of existing patients in the practice will be willing to transition with the practice?
- What services do I plan to offer?
- For what services will there be a charge?
- What is a market-based appropriate cash only ?
- Will lab tests be a part of the practice?

- If yes, is there a lab that will provide equipment and supplies for diagnostic testing and send a courier daily?
- For patients that will not continue their physician-patient relationship, what is the plan to transition them to another physician?
- Will hospital visits be an optional service?
 - If not, who should be recommended for hospital visits?
- If transitioning to a self-pay practice, is an advanced notice contractually required by health plans and Medicare?
- During the transition, what financial outlay will be required to stay solvent?
 - Will another source of income be necessary?
- What overhead is vital to the practice?
- How many active patients will be necessary to meet overhead expenses?
- What, if any, assistance in filing a claim will be adopted?
- Will payment be required at the time of service?

Implementation Steps

If it appears the market can bear a self-pay practice, it is important to have a long-term transition plan. In the beginning, it may be necessary to work part time for another practice or urgent care center to maintain one's financial stability during the full transition period. The goal is to minimize practice overhead so that the volume of visits necessary better fits the goal of spending more time with patients, working fewer hours, and making a decent living.

Determine your charges

Establishing a fee schedule is challenging. Several options are available and shared in AAFP's "On Your Own, Starting a Medical Practice From the Ground Up" publication: (1) use a professional consultant (see www.aafp.org/fpassist); (2) review the AAFP's survey results for office and hospital visit fees; and (3) use a percentage of Medicare's resource-based relative value scale (RBRVS).⁵ Another option could be to perform your own market research and contact the internists, urgent care centers, and other specialists to determine the prevailing market rates upon which fees can be based.⁶ As long as there is no communication that involved discussing and setting rates, there would not be an issue with collusion. Note, annual inflationary rate increases should be considered in order to stay current with the market rates. Alternatively, it may make sense to develop an hourly charge, like attorneys, with a minimum of a 15 minute charge.

Communication

Inform the current patient panel by mailing them a letter explaining the planned practice change with an effective date. Describe the concept of a self-pay practice and patients' financial obligations, clarify the physician-patient relationship and your willingness to assist patients who want to transition to another family physician, and direct patients to contact the practice with any questions.

Parting Thoughts

Some physicians have found the self-pay model a way to regain meaning in and control over their practices, as well as to reestablish a physician-patient relationship in which there is time to care. Another option to consider in not accepting health insurance is to combine a self-pay model with a retainer practice. This hybrid practice would allow patients who could not afford a monthly retainer fee, to still receive care in their personal medical home and only pay for the medical care provided. For more information on retainer fees, see the discussion paper on retainer practices.

¹ Kent J. Moore, How to Opt Out of Medicare, Journal of Family Practice Management, Nov/Dec 2003, <http://www.aafp.org/fpm/20031100/15howt.html>.

² Leigh Ann Backer, Should You Charge Your Patients for "Free" Services?, Family Practice Management, July/Aug 2004, <http://www.aafp.org/fpm/20040700/43shou.html>.

³ Surcharges, AMA Resolution 213, A-04, <http://www.ama-assn.org/ama1/pub/upload/mm/465/bot20i04.rtf>

⁴ Retainer Practices, AMA Resolution 6 (2001) <http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja128.pdf>.

⁵ Julie Henry, RN, MPA and James Bare, MHCA, On your own, Starting a Medical Practice From the Ground Up, American Academy of Family Physicians, <https://secure.aafp.org/catalog/viewItem.do?itemId=2316&productId=611&categoryId=11>.

⁶ James R. Dykes, MD, Making Time to Listen, Family Practice Management, Sep 2004, <http://www.aafp.org/fpm/20040900/45maki.html>.