

# Freedom: My Experience in Starting an Insurance-Free Practice

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The greatest benefit of an insurance-free practice is just that—being free.

More than three years ago, I left emergency medicine to start an insurance-free practice. I'd studied the feasibility of starting a part-time clinic primarily for the uninsured.

Of course, I wouldn't refuse anyone else willing to *Pay At The Moment Of Service*, so I chose the acronym PATMOS as the clinic name. By avoiding all contracts with third party payers, I could avoid the crushing costs of settling relatively small claims, and thus provide more affordable primary medical care to all point-of-care payers.

From my experience as an ER physician, I knew the people the charts classified as "self-pays." In a small community such as ours, I had purchased goods and services from many of them. They were my neighbors, and for the most part they were hardworking trade people and small business owners, too poor for \$10 co-pay insurance, and earning too much income to qualify for Medicaid. Like John the Apostle banished to Patmos Island, they were political exiles within the healthcare system.

Most doctors refused to see them. With practices set up for insurance, the uninsured tend to disrupt patient flow. Many cannot pay for tests and procedures sometimes needed to exclude potentially litigable misdiagnoses. The uninsured simply take too much time, with too much risk in exchange for uncertain payment.

No wonder physicians turn these patients away and refer them to the ER. But as we all know, the ER is not the appropriate place for these patients. Charges are higher, work-ups more extensive, and few physicians are willing to see them in follow-up.

Self-pay patients, I learned, are neither destitute nor derelict. I felt certain that these farmers, carpenters, plumbers, beauticians, housecleaners, and small business owners and their employees would appreciate and value medical care at fair and honest prices. They didn't have the time to wait at government clinics, and did not like the quality of care they received there. They urged me to start a practice, and promised that they would come see me if I did.

This turned me around. I thought that maybe over time, this clinic might replace my income from the ER, and I could then jettison from my medical practice the increasingly wasteful and dehumanizing bureaucracies.

Because of the charitable nature of the clinic, I had considered making it a non-profit to take advantage of tax breaks and to raise money for my own salary. After several discussions with my attorney, I was inclined to decide against it. He pointed out that dealing with a board would probably be about as frustrating as every other bureaucracy I had encountered since my residency. In addition, even though I would be the one building the patient base, the board could dismiss me whenever it wished, and the years I would have invested might well end in futility and bitterness.

I reasoned that since the sick and injured we will always have with us, it was more prudent in the long run to depend on them for my income, rather than on fickle donors and ever-changing tax laws. The long-term risks did not appear to be worth the short-term financial security a non-profit might offer.

Non-profit status became an academic issue quickly, since my plans to make the clinic full-time were realized sooner than I had expected. For various reasons, the president of the hospital had my ER contract terminated abruptly. I no longer had time to start a practice and raise money too. Had I pursued the non-profit option, the idea of this clinic might still be in committee.

I had to make a decision. Either get ER work at another hospital, or start the clinic full time. I decided on the latter, and the clinic was up and running within two weeks of my dismissal.

More preparation time might have saved me substantial expense from misadventures, since I not only had to start a practice from scratch and see patients, but I also had to learn on the fly how to run a small business. Yet had I not been kicked out of the nest, the clinic might still be a vague longing. Fortunately, I had already made a list of all equipment and medicines I was using in the ER.

PATMOS is in a village of 16,000, in a county of 60,000, in a state where only 10 percent of the population is without medical insurance—one of the smallest such percentages in the nation. Twenty-five percent have Medicaid. These percentages are definitely not in our favor.

In addition, there is a government-run clinic in town, two others within 15 miles, and a charity clinic in a town 25 miles away. To my knowledge, no large company in our community has adopted a consumer-driven medical plan, such as a health reimbursement account (HRA) or health savings account (HSA), that motivates employees to find low-cost medical care. I compete daily against \$10 to \$20 co-pays, and regularly have to disabuse patients of the notion that timely, quality medical care costs practically nothing.

Given a market so stacked against us, how have we been able to survive these last three years? The answer of course, as any other successful small business will tell you, is by providing value and service at fair and honest prices.

I realized quickly that I had to let my core clientele—the uninsured and people with high deductibles—know about the cost breaks of a clinic not taking insurance. Although it ran counter to my own feelings of professionalism, I broke with convention—though within the bylaws of the Tennessee Medical Board—and made my fees public in newspaper ads and flyers. Visits for poison ivy and sports physicals cost \$25; for sore throats, coughs, and sinus infections, \$35; and for simple cuts, \$95. I thought this represented timely, high-quality medical care from the type of physician who seems rare today—one who actually enjoys practicing medicine. And we gladly take MasterCard!

We have worked out discounts with various other facilities in the area so that a CBC and lipid panel cost the patient \$20; a complete chemistry and TSH are \$25; a chest X-ray with an interpretation is \$70; and an MRI with an interpretation is about \$500. Costs to the patient here are about 60 percent of those at other physicians' offices, 40 percent of the local urgent care, and 10 to 20 percent of the local ERs.

Not wishing to turn Medicare beneficiaries away from my clinic if they wished to pay me at the time of service, I was forced to opt out of Medicare, effectively preventing me from working in any ER to supplement my income, the logical consequence of an illogical regulation.

The biggest mistake I made was starting out with grander visions than this town was ready to support. I employed an ER nurse and paramedics, providing a mini-ER for the uninsured. Once I even helped resolve a case of mild diabetic ketoacidosis (the bicarbonate level was 17) in a 12-year-old, using intravenous fluids and an insulin drip over eight hours. His mother recoiled at the thought of taking him to one of the local ERs.

I took care of some serious infections with several days of intravenous antibiotics, leaving a heparin lock in patients and bringing them back repeatedly. On occasion I cooled off an episode of unstable angina with a nitroglycerin drip, intravenous beta-blockers, and Lovenox, and had the patients admitted directly to the coronary care unit at a tertiary care hospital equipped with a cardiac catheterization laboratory 25 miles away, bypassing its ER and the ones here in town.

There were many such professionally satisfying cases when the practice operated as an "EmergiClinic." However, this also forced me to hire expensive staff and made me rely on an office manager who, although having every appearance of sharing the clinic's vision, was embezzling practically from day one!

The financial realities, the lack of a compatible partner willing to opt out of Medicare, and the need to reconstruct the books to provide accurate records for the Internal Revenue Service forced me to scale back our operation.

Today I have one full-time employee and one part-time, about 1.3 full-time equivalents. The clinic is open 35 hours a week, 29 hours walk-in and six hours of scheduled appointments. We have nearly 5,000 patient charts with, at last count, about 51 percent uninsured, 38 percent commercially insured, 8 percent Medicaid recipients, and 3 percent Medicare.

One physician who contemplated quitting medicine was quoted in a story in *Time* magazine last summer, "The Doctor Is Out," as saying, "Our income is completely controlled by the government, but we have no control on our expenses." In contrast, I rely on appreciative neighbors for my income, and by avoiding third-party payment contracts I have a handle on costs.

My overhead is about one-third that of the typical family practice and requires about three employees fewer. In absolute dollar terms, the savings produced by our clinic over other clinics that offer similar services—but accept insurance—is about \$200,000 per year, more than 40 percent of the typical family physician's gross income.

My break-even volume is about 1.2 patients per hour. My average volume over the last six months has been about three patients per hour, which makes my net income before taxes a little less than what I was making at the local ER. At four patients per hour, I would be earning about 50 percent more than I did at the ER.

As I said, the greatest benefit of an insurance-free practice is the freedom: I have freedom to take care of patients in the way I would want to be taken care of, rather than the way an insurance bureaucrat wants me to. Freedom to refuse care to the disruptive and unappreciative. Freedom from increasingly wasteful, capricious, and dehumanizing bureaucracies. Freedom from betraying the confidence of my patients from unannounced audits of my charts by insurance companies. Freedom from arbitrary documentation requirements. Freedom to set my own schedule and hire my own staff.

I'm now free to reconnect with the pure, spiritual purpose for which I entered medicine: to see to the medical care of people who in turn value and appreciate my knowledge and skills.

I have made many mistakes. I have few regrets. I have learned that it is easier to change the course of a moving wheel than to move a stationary one, and I am convinced that if I'm not making at least some mistakes, I'm probably not making progress either.

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