

Dr. Josh Umbehr on the Concierge Medicine Revolution

INTERVIEWED BY ARI ARMSTRONG

Americans are rightly concerned about the rising costs of health care and the monstrosity known as ObamaCare. As patients are looking for better ways to manage their health care, doctors are seeking innovative ways to offer their services. One type of medical practice growing in the marketplace is “concierge medicine,” in which patients pay a doctor or group of doctors a set fee (usually paid annually or monthly) in exchange for a defined package of care.

Concierge medicine typically pertains to “family-practice” medicine for routine care—checkups, stitches, drug prescriptions, nutrition advice, and the like—as opposed to specialized care such as heart surgery or MRI scans. A typical concierge doctor sees far fewer patients than does a doctor in a typical office and is thus able to spend substantially more time with each patient. In a typical concierge practice, once a patient signs up for care, he may visit the doctor’s office regularly—in some practices, as often as he likes—and contact his doctor via telephone and email. Because patients pay doctors directly, many concierge doctors do not accept health insurance and thereby avoid the costs associated with its red tape and paperwork.

One particularly innovative concierge doctor is Josh Umbehr, who charges a relatively low monthly fee in exchange for unlimited access to his office. He calls his type of practice “direct medicine” or “direct primary care.”

Umbehr graduated from the University of Kansas School of Medicine and completed his family-medicine residency at Wesley Medical Center. After becoming a certified family physician, he opened AtlasMD in Wichita, Kansas. On his Web page, Umbehr writes, “AtlasMD represents my ideal medical practice wherein I am able to shrug off the burdens and restrictions of government and insurance regulation so that I may focus solely on my patients and their needs.”

Recently Dr. Umbehr joined me to discuss concierge medicine in general and his approach in particular. The interview was conducted orally and retains the character of an informal discussion.

—ARI ARMSTRONG

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Ari Armstrong: Thank you for joining me. I know readers of *The Objective Standard* will find great value in your thoughts on and approach to concierge medicine. How do you describe concierge medicine, and what are its advantages?

Josh Umbehr: For routine health care, insurance creates more problems than it solves. Concierge medicine removes the insurance middleman, making way for a far more efficient and mutually beneficial health-care practice. Doctors can focus exclusively on providing their patients with excellent medicine, and patients can deal directly with their doctors.

Health care today is expensive and inefficient because of red tape, so he who cuts the most red tape wins. And I think that's what we've done.

There are several variations on the concierge medicine theme, so I'll speak specifically about my particular model, which I think is best.

My model uses a membership plan with set monthly fees, rather than charging fees for office visits. It's akin to the way a gym membership works. For a typical gym membership, we pay a monthly fee, not a separate price for each service. I don't need another reason to not exercise. If it's \$5 to go to the gym, and I have to carry a bag of quarters to the treadmill, and lifting weights costs extra, that's not efficient, and it's not user-friendly. The same holds true in family medicine.

Part of the value of this model is that it accounts for the fact that the need for health-care services is unpredictable. People don't know how much they'll need, but when they need it, they want it, and when they want it, they want it right now, and they don't want to worry about cost. An industry in which consumers—in this case, patients—can't predict what they'll use, how much it'll cost, and how the cost will affect their lifestyle is not a consumer-friendly industry.

The membership model of concierge medicine allows us to keep the cost per person low while maximizing the availability and quality of the services. By eliminating the third-party payer—insurance—when it comes to routine care, we get ourselves back to a model more consistent with the actual, marketplace purpose of insurance and the way it works in every other area where it applies: car insurance, homeowner's insurance, life insurance. All these things insure primarily catastrophic events. You don't have car insurance for gasoline, oil changes, tires, etcetera; why have health insurance for family-medicine primary care?

What our style of concierge medicine does is make primary care family medicine affordable. I think the false logic has always been that "medicine is just always expensive." What we've been able to show is that medicine can be affordable.

The affordability comes from eliminating the red tape; standardizing revenue with a membership model; using wholesale cost for medications, lab tests, and

supplies; and reducing the number of employees needed to run a practice. Once you do this, health care becomes incredibly affordable.

In a standard model, a doctor would have seven to ten employees per physician—largely to process the insurance claims. With our model, we're able to reach an efficiency that allows us to have one staff member—one registered nurse—per three physicians. So right there we're able to pass along enormous savings to the patient.

And if we save the patient money, we're saving the insurance company money—which means the insurance company can lower its customers' premiums. How? When patients use our services, their insurance no longer has to pay for routine office visits or for most drugs and tests. And, because we help patients stay healthier, insurance companies have fewer catastrophic health problems to deal with down the road.

Concierge medicine is a win-win-win-win model. Employers who sign up for a group plan are able to get their employees better care for less money; insurers are able to insure a healthier group of people with less risk and thus higher profit margins based on lower premiums; doctors are able to make more money while seeing fewer patients and providing better care; and patients are able to get a more predictable product at a better value and a lower cost.

This is something we're not used to seeing in health care because we're used to the business of medicine run through the filter of health insurance. And when it's run through health insurance, enormous costs are built into it. With concierge medicine, we're getting back to a logical business model for how to deliver family medicine, which is 90 percent of what most people use in a given year.

AA: That's a fascinating approach, but I wonder if the membership model is essential to the sort of medicine you're discussing. Would it make sense for a doctor to accept cash payments per office visit, whether or not he also charged a monthly fee?

I assume that some patients have greater needs and cost more than others. A twenty-five-year-old in good health may only need to see a doctor once a year for a mere checkup. But a sixty-year-old might need to visit a doctor several times a year, get extra tests, and deal with a variety of maladies.

Thinking about my own situation, I'd probably rather pay a lower monthly fee but then pay out-of-pocket for extra visits I might need. How does concierge medicine deal with this kind of preference?

JU: With insurance, the co-pay was designed to get you to spend your dollars responsibly, and therefore the insurance company's dollars. You will spend twenty-five

of your own dollars more responsibly than you'll spend a hundred dollars of the insurance company's money, so the co-pay model gets you to limit the amount of care you'll seek in a given period.

But if you're limiting the amount of care you'll seek because of financial concerns, almost by definition you're shorting yourself of care you might really need. If you're diabetic and you have to pay \$25 every time you come in, you might find yourself asking, "Is it worth the \$25 for me now?"—rather than maintaining the optimal course of long-term diabetic control. A per-visit cost encourages patients to make a difficult decision based on cost. When you remove the per-visit cost, you enable him to maximize the care he receives. When you maximize the care, you maximize the potential for good outcomes, saving him even more money downstream. A diabetic can come to me every day for a week or until the condition is truly under control, with no additional cost to the patient.

I also prefer routine costs in other fields. I don't want to talk to my lawyer or my accountant if it's going to cost me \$50 a pop. But I might make a decision that isn't as wise as it could be and that may cost me thousands because I didn't want to spend \$50 to talk with my attorney to clarify something. I think the same is true with health care. When you level the payments, just like a gym membership, you remove that obstacle. You have no idea how much the people are going to use it, but if you maximize their opportunity to use it, you maximize your potential value to them and the benefit of their unlimited access to care. I think this best serves the patient's long-term health goals.

AA: You have a different idea about the value of per-visit prices than does health policy analyst John Goodman. Goodman's idea (as I understand it) is that, when people don't pay anything out of pocket per visit, they're less careful about the health care they receive. For example, with no per-visit payment, a person could get a health checkup once a month at great expense to the doctor but no expense to the patient. Or someone could go to the doctor for a runny nose or a tiny splinter or the like. How do you avoid such visits under the concierge model?

JU: For starters, we are able to treat people in nontraditional ways. Under today's typical insurance model, a doctor can only get reimbursed for care he provides in the office. You *have* to come to the office to be seen. When people have the opportunity to email, call, or text their doctor for the simple stuff, it's not worth their time to come to the doctor to find out they have the sniffles. And other conditions are easily managed in nontraditional ways.

Because I've already been compensated for my time, I'm more than happy to treat you in these nontraditional ways. You can stay at work, continue to be productive, and continue with your life without necessarily coming to the office. With our approach, we reach that triple aim that is so coveted: better care, more often, for less money.

With fee-per-service, you're just never going to do that. Again, analogous to the gym membership, if people had to pay every time they went to exercise, that'd be a barrier to them exercising, a barrier to them becoming healthier. Our model minimizes barriers. It's about working smarter.

For the typical medical practice, the classic analogy is the scene in *I Love Lucy*, when Lucy is standing at the conveyer belt, wrapping chocolates. The faster it goes, the fewer she can wrap, and the more chocolates fall on the floor. Currently, in the insurance-based model, that's what we do. We speed up the conveyer belt. We try to say that we'll see forty, fifty, sixty-plus patients a day, but in reality more patients just fall on the floor (so to speak). We're actually less efficient because we're spending seven minutes with some patients several times in a given month—something that costs the patient \$20 per visit, in addition to the cost of leaving work, spending time checking in, and so on. It's an incredibly inefficient system.

In my practice, I can spend thirty to sixty minutes with a patient at the time the patient needs me or wants my input. I'm going to figure out what is going on, we're going to get them the care, we're going to answer the patient's questions in depth, and we're going to be able to move forward.

With patients who have complex problems, a doctor in the traditional setting ends up spending seven minutes with each patient, then writing referrals or ordering more lab tests that don't make sense, because the doctor doesn't have thirty minutes to get to the bottom of a patient's problems. The patient ends up spending hundreds of dollars in blood work, medicine, and referrals—all to little effect—just because the doctor couldn't take the time to talk to the patient and figure out what was really going on.

The 80/20 rule here is that, roughly 80 percent of the time, 20 percent of the people are going to be your high-demand users. That's okay, though. Just like at an all-you-can-eat buffet, or just like with a gym membership, some people may use it a lot, but the heavy users don't break the bank; they don't change the economics of the model. Sure, some people eat too much at an all-you-can-eat buffet, and some people go every day to the gym, but the majority of people use a moderate amount of resources, and that allows the model to work.

We have an amazing ability to price the model such that it provides value to the healthier people. As an example of the advantages, we can offer wholesale medications and wholesale labs and save patients up to 95 percent. A patient can easily see savings that exceed his \$50 per month fee.

We provide a simple and predictable pricing schedule that is very comforting to the consumer and that can save people money overall. For example, recently we saved an uninsured woman roughly \$75 per month on her medications. Her membership was \$50 a month. We offered her all the medicine she needed, plus unlimited access to a doctor, and she has \$25 back in her pocket every month.

That's the kind of transformative change that can reverse the direction we're headed in health care. You don't need insurance for primary care; you don't need insurance for medicines, at least for the most part; you don't need insurance for labs.

Whereas a standard office might charge upwards of \$70 for a blood test, we get it for \$1.87—and that's the price our patients pay. Why would you ever pay insurance for that? That would be like paying insurance for windshield wipers or gasoline. Such things are affordable. You just buy them when you need them. That's not properly an insurable product or an insurable risk.

Our patients have unlimited access, so why would they go to an emergency room for something they can get treated with us? They already have a doctor who will provide them with care when they need it.

I can very cost-efficiently manage the care of six hundred people. So why do most doctors continue to work in a broken system? In large part, they just haven't seen the value. For the longest time, they haven't believed that primary care could be affordable.

When we tell doctors that we are able to run a three-physician practice with one nurse as support, often they don't even believe it. We've been accused of lying about our cost of labs because most doctors believe these tests are expensive. A test for cholesterol costs \$3; thyroid, \$3; various other tests, \$6. Often others charge \$50 or more per test.

Here is a good example of the benefits of changing the way we pay for primary health care. We took a local company with fifty employees, and we decreased the cost of their health insurance by 45 percent in the first year. During the company's first twelve months with us, the employees filed zero claims against their health insurance. That's phenomenal—practically unheard of for a group of fifty people. That means the insurance company made 100 percent profit off of those premiums. That's just fantastic. How? Our patients aren't going to the emergency room when

they don't need to. We're spending next to nothing on medicines because we get wholesale costs, so many pills are a penny a pill.

Our model could potentially save trillions in health costs nationwide. Health care is a \$2.8 trillion industry. I believe we can potentially take out more than \$1 trillion of that cost. I know that sounds extreme. But, again, if you take a model with family doctors, unlimited visits without co-pays, and wholesale pricing on medications and lab tests, dramatic savings are possible.

Don't underestimate the savings possible by dramatically reducing trips to the emergency room, urgent care clinics, and specialists. Plenty of evidence shows that the busy family doctor who sees patients for an average of seven minutes per visit is sending many patients unnecessarily to specialists. For example, a doctor probably can't get a patient's blood pressure under control in only seven minutes, which is as much time as insurance will cover. So the doctor may end up referring the patient to a cardiologist who charges much more.

In today's typical office, doctors are so busy that they cannot adequately address the needs of their patients, and the result is costlier care overall.

Our goal, which I believe we've achieved, is to offer better care for less money.

AA: What is your pricing for membership and for drugs and tests?

JU: Our membership is based on a flat rate, variable only by age for direct sign-ups. Our corporate rate is \$50 for all adults over 20. Our direct sign-up rates are \$10 for children ages 0 to 19; \$50 for adults ages 20 to 44; \$75 for adults ages 45 to 64; and \$100 for adults ages 65 and older. Everything is included except medicines and labs—things that we have a definitive cost in providing.

For medicines and labs, we're able to function as our own pharmacy according to state laws—and forty-four states allow that—so we're able to order medications from the same wholesalers that a pharmacy does. Because we're profitable on memberships, we don't need to make any profit off of medicines or labs.

Believe me, I'm a "hurrah, profit" kind of guy. At the same time, if our business model is to save you as much money as we can, any additional fee we add on—with co-pays for procedures, with extra costs for medicines or labs—is undermining our larger goal.

If you as a patient contact my office, I want to show you as quickly as possible how your membership for \$50 saves you (say) \$75, giving you \$25 back in your pocket. So the only extra fees, in addition to the membership, are for your medicines and labs.

If you tried to offer unlimited labs at zero cost, patients would have a perverse incentive to get more labs than they need. I, as a physician who is paying for those labs, would have a perverse incentive to limit your opportunity to get those labs—and there would be a crack in the patient-doctor relationship. We don't want that.

The same is true with medicines. I want my patients to know that, no, I don't profit off of your medicines. If I'm prescribing you medicine, it's because you need it, and if you're getting it from my office, it's the best price you can get it anywhere. You don't have to worry about that. So when I can show on your invoice that, although the retail cost of this medicine was \$85, our cost was \$5, and your membership is \$50—that every month you're saving money—why would you ever leave this membership? It's the most effective thing you can do. So our pricing policies are really about proving the value of our services.

AA: I'm in Denver, by the way, so if you expand into Denver, please let me know.

JU: We hope to expand dramatically. Recently we launched a new website, and within ten days of launching it we were on CNN, Rush Limbaugh, Breitbart.com, the *Drudge Report*, Hannity, Neil Cavuto, Huckabee—just to name a few outlets—and we saw this huge outpouring of patients and doctors saying, “I never knew it could work like this. Is there a doctor or are there patients in my area who are interested?”

We set up *IWantDirectCare.com*. This offers a simple way for patients and doctors to put their pin on a map and say, “I'm interested in this kind of model and in connecting with others interested in it.”

I fear that, unless we come up with good alternatives, family medicine—the type of medicine that I love—is dying on the vine. The cost and hassle of health insurance is driving good doctors out of practice. So we really have to show that our model is viable for doctors, patients, employers, and insurers.

AA: Obviously you can't provide every possible health service. So what kinds of things do you tend to refer to specialists, and what happens then? When you refer somebody to a specialist, are you still involved in the process and, if so, how so?

JU: To the degree that we can, we decrease the need for specialist referrals. If it sounds like a patient does need a specialist, we always try to ensure that our patients get high-quality care that is affordable and convenient.

Often we are able to negotiate prices with specialists. Take MRIs, for example. We used to be able to get an MRI for \$500 at an imaging center. We talked with an orthopedic group, and they said, “Hey, we can do better than that; we'll give it to you for \$400.” And the normal cash price? Two thousand dollars.

We had a young woman working in a retail store who had an injury to her knee, and she needed an MRI. Eventually she needed surgery as well, which itself cost around \$2,000. So, by saving her \$1,600 on the cost of the MRI, we saved her most of the cost of the surgery. Another way of looking at it is we saved her nearly three years' worth of membership with us. In this case, a lower-wage employee of a retail store got concierge health care, because it is the most efficient \$50 she can spend. For her, the value is very objective. And I think that's true for all of our patients.

AA: I assume that at least some of your patients, when they have expensive referrals, do access some kind of standard health insurance. When is insurance necessary?

JU: Serious car wrecks, cancers, heart attacks, appendectomies, and emergency room visits typically require insurance. Those are the types of catastrophic events insurance is for.

It is worth noting, however, that the cash price for treating appendicitis in a free-market system can actually be pretty reasonable. And our discounted price is 75 percent off for an orthopedic surgeon to do a "scope" of the knee. Normally \$6,000 or \$7,000, we've negotiated a price of \$2,000.

When someone has a \$2,500 or \$5,000 deductible, that makes many types of procedures a cash-for-service type of transaction. The patient is still on the hook for the first several thousand dollars, but if we can negotiate substantial savings, then, even when insurance doesn't cover the bill, the patient can get a hell of a deal.

If a patient doesn't make a claim, he's not affecting his insurance down the road, so whenever possible we negotiate prices for discounts from the specialists. And when you need an MRI because you were in a car accident, then that's okay, that's what insurance is for.

Does a catastrophic event happen often? By definition, no. But, for example, my daughter has Down syndrome. We didn't expect that when she was born. Thankfully, we bought insurance ahead of time, so when she spent weeks in the ICU, she was covered.

To take an example from another field, we buy insurance to protect against hail damage to our roof. We have homeowner's insurance, so when hail damage comes, it's unpredictable, but it gets fixed.

The key is to make health insurance affordable. How do you do that? You teach the insurance companies how to back out of covering so much. They don't need to know about sprained knees and everything else that a family doctor can treat. The paperwork, the red tape, the administrative cost for all-inclusive insurance is an expensive hassle that's not adding value.

We're actually changing an industry, we're changing how doctors practice medicine, we're changing the pharmaceutical industry. We have patients now getting medicine from their doctor. We're starting to change the industry of insurance, because we're showing companies that they can actually be more profitable at a lower premium if they don't insure routine family medicine—as long as their customers are working with us or with some other provider of direct primary care. Once patients can access their doctors and get the medicines they need, they can maximize their health—which decreases the likelihood that they will file a claim with their insurance company.

Consider an example. There is a type of software that can help track the skin changes on your back or your chest. I'm pretty good at dermatology; I can run my hand over your back to see if I can detect anything cancerous. Or, more effectively, I can load this software onto my iPhone and take a picture of your back, and the software automatically zooms in on every mole, grades it, tracks it, and compares it to the next scan I take of your back. This allows me to provide much more detailed information to a dermatologist if you do need to see one. That software is around \$3,000. A visit to the dermatologist can easily cost \$500. An insurance company might conclude it can buy the doctor the \$3,000 software, reduce the costs of dermatology visits, and reduce the risk of future claims.

That's the kind of free-market solution we can expect to see when we cut the red tape and insurance isn't paying for every routine office visit, the way it often does today.

AA: In a TOS blog post about medical tourism, Howard Roerig explains that a lot of people are traveling abroad for a variety of treatments ranging from knee surgery to dental work. What are your thoughts on medical tourism?

JU: I think we should pursue medical tourism within the states. The primary reason that medical care outside of the states is cheap is because those hospitals don't have the red tape. They don't have as many insurance costs or regulations.

The Surgical Center of Oklahoma (SurgeryCenterOK.com) has a very "Atlas Shrugged" model, similar to ours. For every surgery they do, the center lists the cash price online. You can use that price to seek a competitive bid from a local doctor.

By taking only cash, the Oklahoma center eliminates the need for extra staff to bill insurance. So why go to Mexico to get your family care through medical tourism, when can you get great care in the states from a doctor who has significantly cut his overhead expenses?

Our care is relatively inexpensive. Why travel when you can get high-quality care at very affordable prices?

AA: How did you get into concierge medicine as a doctor?

JU: As I was growing up, my dad was a trash man. He's a lawyer now. (I still tell people he's a trash man because that's less embarrassing for me—but I tease.) He was a system buckler. He had a First Amendment case go all the way to the U.S. Supreme Court, and he won it—and it became one of the top four cases of First Amendment law in its area. After he sold his trash business, we went to undergraduate school together. I went to med school; he went to law school. And, like my father, I had developed the MO of questioning everything.

Going through undergraduate school and working with doctors and med school and residency, I realized that the system was a disaster. No one knew what anything cost, and you had to be an expert in insurance coding to ever get paid.

I worked for a plastic surgeon as an undergraduate, and he made less money as a private physician than he did as a resident, all because he didn't know how to deal with the complexities of insurance.

Insurance companies would deny his claims, and he didn't know how to handle that. Being a technically good surgeon was not enough. He had to know how to play the insurance game. It didn't matter how good a surgeon someone was—or how bad. As long as he could play the insurance game, he could get paid. And, I thought, that's not for me. That doesn't make sense. Why should I hire seven to ten employees per doctor to bill an insurance company when I could just bill the patient?

Beyond that, I reject the idea that the insurance companies or the government has any respectable role in my exam room, telling me how to care for patients. Depending on which insurance plan you have, you can either have a certain medicine or not. And it's just a complete game—often an insurance company will not explicitly say it won't pay for a certain drug or procedure, but it knows I often don't have time to fight through the paperwork to get paid.

As we developed our practice, we built our own software, which we'll offer for sale soon to other doctors. For the vast majority of doctors who take insurance, the software is almost all about helping doctors bill insurance, not helping them care for patients. Most doctors hate their software. We think we can do better.

It goes back to Ayn Rand's comment: It's not who's going to let me; it's who's going to stop me. I'm going to do the best thing for my patient no matter what—come hell or high water. We don't have to ask, “Will the government let us treat

our patients?” It doesn’t matter. If my patient wants a certain treatment, and if that results in better health care for the patient, then I’m going to pursue it. My attitude was from the beginning and is, we’re going to take care of our patients first.

AA: When my wife and I opened our health-savings account and started spending our own money on health care, I noticed that I immediately had more control over the care I was receiving, and a correspondingly better attitude. If I didn’t like what I was hearing from a doctor, I would just walk out the door and find somebody more reasonable. Have you seen this sort of shift in attitude among your own patients or other people opting for concierge care?

JU: I think when people are in charge of their health care-dollars, they’re absolutely more cost-conscious and value-conscious. Here’s a good example: There’s a name-brand arthritis medicine that costs \$940 at the pharmacy. The generic version costs \$120 at the pharmacy. Our wholesale price is \$11 a month. When an insurance company says you can’t have the name brand, you may feel cheated. But when the dollars are yours, you’ll likely say, “Please give me the \$11 medicine,” realizing that you’re much better off capturing the savings.

AA: It seems clear to me that your patients—and generally patients of concierge doctors—are doing very well. But the fact is that doctors who are seeing patients for seven minutes are able to see a lot more patients in the day than you are. So what will happen if more and more doctors turn to concierge medicine and see many fewer patients in a day?

JU: That’s an excellent question that I’m going to rephrase slightly. Will this model worsen the current physician shortage? Because depending on the statistics, we’re looking at a shortage of several hundred thousand doctors in coming years.

Is the physician shortage my fault? Is it the fault of direct primary care or concierge care? Not at all. In fact, I’m going to reverse that claim and say that concierge medicine or direct primary care is the only viable solution to the physician shortage.

The current system is what is driving doctors out of practice. Blaming concierge medicine or direct primary care for a physician shortage is like blaming a victim of crime. It’s not the victim’s fault. What is driving doctors out of practice is today’s insurance-based model for primary care, which results in high costs, enormous hassle, and lower incomes for doctors. The cause of the shortage of doctors is the declining appeal of practicing medicine.

Either many doctors are going to leave and thus take care of no one, or they’re going to convert to direct care and take care of fewer patients very well. And

doctors who take great care of their patients keep them healthier for less money. When I work in the ER, much of what I see is family medicine practiced after hours—and that’s the most expensive real estate in health care.

Think of the perverse incentives today. In a typical setting, if I treat you over the phone after hours, for free, then you’ll want to get care over the phone rather than come into the office and pay a co-pay. So most doctors will not treat patients over the phone. Our model totally changes that dynamic.

As more doctors embrace this model, will there be a short-term market correction? Possibly, and that’s unfortunate. But this is the only viable model that will draw medical students and residents into the field of primary care.

The primary-care model offers hope to doctors who want to run their own family-medicine clinics. Otherwise, family medicine is dying on the vine—no one wants to do it when they can make more money and get more respect as a cardiologist or other specialist.

Could my model worsen the physician shortage short term? Possibly. Is it the best option we have for fixing the physician shortage in the long term? Absolutely.

AA: You’re going in the direction of people spending their money on health services with their doctors and spending less money on health insurance. ObamaCare, which will be implemented over the coming years, aims to move in the opposite direction; it wants us to have everything covered through insurance. How is that clash going to be resolved?

JU: ObamaCare is barreling down upon us, and it’s going to be expensive. It promises expensive insurance that covers most everything.

I firmly believe that direct care is the only viable model even under ObamaCare’s mandate that people buy government-approved insurance. As the Massachusetts insurance laws illustrated, we can require insurance to cover everything, but then no one can afford the insurance. So even under the ObamaCare mandate, the most viable option for affordable insurance and care is catastrophic insurance and a direct primary care model like AtlasMD.

Many people may find it in their financial interests to absorb the ObamaCare penalties, get less-expensive, non-approved insurance, and sign up for an AtlasMD-style practice. Just because ObamaCare is coming down doesn’t mean you have to have ObamaCare-approved insurance.

We do not have to be victims of ObamaCare. Much like gun owners gave Obama the “gun seller of the year” award, I firmly believe that he’ll inadvertently

sell our model. As ObamaCare complicates health care and makes it more expensive, people will have to look for simpler, affordable options.

You can have all the insurance you want, but if you don't have access to a doctor, you don't have health care. ObamaCare is driving physicians out of practice. We're going to lose up to a third of our family-medicine workforce because of all the hassles and red tape of insurance. You want to see the system crumble? That's how it could crumble. Not because more doctors are seeing fewer patients, but because more doctors are seeing no patients.

AA: Do you have any other general advice for people as they try to navigate the health system?

JU: For doctors or for patients?

AA: I was thinking of patients, but if you have any advice for doctors who might be reading this, that would be useful too.

JU: Take patients first. There are more of them, they're more desperate, they need a solution, and they're less averse to trying a new model.

My advice to patients: The most power they have is as a consumer. When they demand that their physicians provide a value to them, they get a much better product. If the practice of direct or concierge care grows, it will be because of a groundswell of support from patients going to their doctors and saying, "I want this model." Only then will physicians say, "Okay, I can comfortably leave the status quo of insurance-based practice and convert to this model."

My advice to doctors: Patients want this. They want better care for less money. They want better value. They want more time with their doctors. They want quality and convenience and accessibility and all the things that we're not offering to them right now. They want their doctors to answer the phone. They want their doctors to supply their medicine. They want their doctors to sit down and spend half an hour or an hour with them and not worry about what insurance is going to pay for or not pay for.

Our goal with our practice is to maximize the value, minimize the cost. That's horse sense, that's common sense. So this is much easier than doctors realize. This is a very basic business model where you provide a high value at a low cost to your patients. This isn't rocket surgery!

Each doctor needs only a few hundred patients for this to be sustainable—and about six hundred to make it nicely profitable. I just hired a new doctor. He was making \$135,000 a year; he's going to make \$200,000 with me. He had no idea that he could see fewer patients, make more money, and provide a better value.

Bringing the consumer back into medicine is vital. Doctors should be proud to earn a living. Often doctors worry about dirtying their hands with money. Medical school portrays profit as bad. So doctors have this idea that good business and good medicine can't coexist. Nonsense.

You profit by taking care of your patients. So really I'm not chasing profit directly. But the best medicine I can provide for my patients, ultimately, is profitable.

AA: This has been very informative, Josh. Thank you for your time, and best success with your health-care revolution.

JU: Thank you, Ari—it's been my pleasure.

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