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Direct Primary Care: Good for What Ails Us

By Gayle Brekke

Some DPC providers are … successfully delivering primary care to employees of all-sized employers, resulting in savings of 15 to 30 percent on employee health benefit costs.

Direct primary care (DPC) is a newer primary care practice model that early evidence indicates holds promise for improving some of our most daunting problems in health care today—problems such as poor care coordination, chronic conditions that are not well-controlled, over-utilization of high-intensity settings like emergency departments, unaffordable insurance premiums, health care spending growing at a faster pace than the economy as a whole, and high levels of frustration and dissatisfaction among patients and doctors.

DIRECT PRIMARY CARE—WHAT IT IS AND HOW IT WORKS

DPC is a newer incarnation of concierge medicine or retainer medicine in which patients pay a modest monthly membership fee in exchange for unlimited primary care. There are many practice models emerging; I will use the term "direct primary care" to refer to those practices that do not take insurance. Hybrid models are also common; these are practices that use a traditional insurance-based model for some patients and a DPC model for others. Sometimes a hybrid model is used to transition from an existing traditional practice to a DPC practice over time.

The median monthly DPC fee for an adult is about $70[1] and the *DPC Journal* reports that 68 percent of fees are between $25 and $85 per month.[2] Monthly per child fees are modest, often $10 to $20 per child with a cap on the total monthly fee for a family. Rates are independent of pre-existing conditions and health status. There are typically no copays, deductibles or coinsurance for most or all services provided by the physician. Care management and care coordination are included. Patients receive 24/7 access to the physician for office visits, emails and phone calls, and many DPC providers include technology visits such as texts, as well as visits at other locations as needed. DPC practices typically promise same-day or next-day appointments of 30 to 60 minutes. As an example of enhanced access, consider the following story. DPC physician Dr. Josh Umbehr of AtlasMD in Wichita, Kansas, tells of a patient who cut himself carving the family's Thanksgiving turkey. The man wasn't sure whether he needed stitches so he texted Dr. Josh a picture of his hand. Sure enough, he needed stitches. The patient met Dr. Josh at the DPC clinic. Dr. Josh sewed him up for no charge and got a piece of pumpkin pie for his trouble. One thing that's interesting about this story is that it's typical of the sorts of interactions we see in other areas of our lives but atypical of the interactions we see in health care. For one thing, this is a customer-centered transaction. With no third party in the middle, patient and doctor are free to interact in a way that works well for both parties. And in the process, money and time were saved by avoiding a trip to the emergency department.

DPC patients receive many preventive and primary care services at no additional charge beyond the monthly membership fee; common low-cost ancillary services and supplies are provided at no additional charge. This often includes routine office testing such as electrocardiograms, some medications, on-site lab testing and various procedures as well as digital x-rays. Higher-cost items such as prescription medications and durable medical equipment are often provided at cost or for a small mark-up above cost.[3] In addition, many DPC providers partner with local imaging centers and labs to provide high-quality services at a reduced price if the patient pays cash at the time of service. For example, Dr. Brian Forrest of Access Healthcare has obtained prostate cancer tests for $5 from the same lab that would charge a Medicare patient at least $175; $80 for mammograms instead of $350; and colonoscopies for $400 when the going rate is $2,000.[4]

Another cost-saving measure that many DPC providers offer (subject to state regulations) is to dispense prescription medications to their patients at wholesale cost. About a dozen states allow this without restriction. It is not unusual for DPC providers to shop around for lower-cost pharmacies so that their patients get even more bang for their health care dollar. With insurance removed from the relationship, the focus is on the service, convenience and value that the DPC provider can offer his or her customer patients.

DPC is an effective way to deliver primary care for almost every segment of the population. Some DPC providers are expanding beyond the individual market and are successfully delivering primary care to employees of all-sized employers, resulting in savings of 15 to 30 percent on employee health

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benefit costs.[5,6,7] Employers pay the DPC membership fees as an employee benefit.

DPC providers are also embracing Medicare and Medicaid populations. For example, the large DPC practice Qliance recently enrolled 15,000 patients via a Medicaid managed care contract, where Medicaid simply pays the membership fee on behalf of the patients as part of a shared savings program. Dr. Garrison Bliss of Qliance estimates that Washington state will save between 15 and 20 percent on these beneficiaries, compared to what traditional Medicaid would have spent.[8] Another 5,000 patients recently signed up with Qliance via the Washington state health insurance exchange.[9] Iora Health, a DPC practice that contracts with unions and employers, a year ago launched clinics in Washington and Arizona catering to Medicare Advantage patients, and they're setting up similar clinics in Colorado and Masssachusetts.[10] Qliance and Iora Health are just two examples of innovative DPC practices that are expanding and finding new ways to serve all sorts of patients, including those with Medicare or Medicaid.

The Affordable Care Act (ACA) allows DPC to count as ACA-compliant insurance as long as it is bundled with a "wrap-around" catastrophic medical policy. Many patients use DPC in conjunction with a high-deductible health plan, and insurance carriers are starting to develop catastrophic plans specifically designed to complement DPC. At this time, membership fees paid to DPC practices are not recognized by the IRS as health savings account (HSA) expenses, and thus they are not counted as tax deductions the way that other health expenses are. Legislative efforts are underway to change this. In addition, efforts are underway to clarify at the state level that DPC practices are engaged in the practice of care, rather than insurance. In states where such legislation has been passed, the state's department of insurance cannot treat DPC physicians as insurers subject to its regulatory scheme. As of July 2015, 13 states have DPC laws on the books.[11]

OUTCOMES AND SAVINGS

While the typical primary care physician practicing in a traditional insurance-based way maintains a patient panel of around 2,000 to 2,500 or more, the typical established DPC physician's panel is about 600 patients. The significantly smaller panel size allows the DPC provider to be more available to her patients and to provide more comprehensive and coordinated care, which translates to improved outcomes for the patient and reduced spending for the system as a whole. A *British Medical Journal* study of Qliance found that DPC patients experienced significantly better outcomes than similar patients who received primary care in the traditional way.[12] Qliance DPC patients experienced

- 35 percent fewer hospitalizations
- 65 percent fewer emergency department visits
- 66 percent fewer specialist visits
- 82 percent fewer surgeries

Savings can be considerable. In a study of results of MD Value in Prevention, the decrease in preventable hospital use (admissions and re-admissions) alone saved $2,551 per patient, which is more than the cost of the DPC membership fee.[13] The savings on hospital use were achieved through 56 percent fewer non-elective admissions and 49 percent fewer avoidable admissions compared with similar patients who received primary care the traditional way. DPC patients were readmitted 91 to 97 percent less frequently for acute myocardial infarction, congestive heart failure and pneumonia.

An assessment of Qliance patient experiences placed Qliance in the 95th percentile in overall patient satisfaction, well above the 90th percentile national average.[14] Since patients pay month to month, DPC physicians know that they must provide value to patients or they will leave.

WHAT ABOUT THE PHYSICIANS?

In addition to the significant positive impacts that it has on patient outcomes and spending, DPC also can dramatically improve the experience of physicians. Administrative burden is causing significant stress and burnout for physicians in the United States in general, and for primary care physicians and internists in particular. In a 2011 survey, 87 percent of physicians named the leading cause of work-related stress and burnout as paperwork and administration, with 63 percent indicating that stress is increasing.[15] Internists and general/family practitioners spend an average of more than nine hours per week on administrative tasks according to the 2008 Health Tracking Physician Survey; this represents a 23 percent increase in the administrative portion of the physician's work week since 1995.[16] Physicians who spend more time on administration are markedly less satisfied with their careers. In a 2014 survey, 68 percent of family physicians and 73 percent of general internists reported that they would not choose the same specialty if they could start their careers anew.[17]

In the case of primary care physicians practicing in the traditional way, a significant cause of stress and career dissatisfaction is that they have so little time to spend with patients. Some doctors report that they have as little as five to eight minutes to spend with each patient. Their panel sizes are so large because reimbursements continue to decline and administrative requirements continue to increase. The only lever they have to keep their revenues up and keep their business model sustainable is to see more patients each day. They don't have time for extended conversations with patients to effectively manage chronic conditions, medications and lifestyle factors; they don't get reimbursed for extended conversations. Adding to the burden is the worry over the financial sustainability of the practice due to the number of administrative staff that is needed to handle paperwork and other tasks required for reimbursement from insurance companies and Medicare. DPC practices claim to reduce overhead by more than 40 percent by eliminating administrative staff resources associated with third-party billing, resulting in lower price points for patients.[18]

It's too soon to tell what the impact of DPC will be on the shortage of primary care physicians. On the one hand, DPC physicians serve roughly one-fourth to one-third as many patients as traditionally practicing primary care physicians serve. On its face, this seems to suggest that DPC will exacerbate physician shortages. But on the other hand, as DPC is a much more satisfying way to practice medicine, frustrated physicians are switching to DPC rather than retiring early or leaving the profession altogether. And as DPC continues to grow, more medical students will hear about it and perhaps some who otherwise would have chosen a different specialty will decide to go into primary care.

THE ROLE OF INSURANCE

If one of the key factors contributing to the success of DPC is that DPC practices don't take insurance, what then is the proper role of insurance in the health care system? In general, insurance is an important financial tool without which individuals and businesses would have a great deal of difficulty surviving. How many of us could take on the risk of our house burning down if homeowners insurance or a similar mechanism were not available? A miniscule number of us, I'm sure. Insurance works well for insurable events, very large risks that are unpredictable and very unlikely to befall a given individual. None of these characteristics apply to primary care, and so I believe it's wise to question whether the insurance mechanism should be employed to pay for primary care. Primary care is inexpensive and predictable. Just as it doesn't make sense to pay for oil changes with auto insurance or lawn mowing with homeowners insurance, it doesn't make sense to pay for primary care with medical insurance. The most efficient way to pay for something that everyone ought to be using is directly. Paying for primary care with insurance inflates the price without getting commensurate value in return. If the price of an oil change is $40, you would not pay $55 so that a third party can process the claim for you rather than just paying the $40 directly yourself. Specialty care and hospitalization should continue to be covered by insurance, as these are expenses that everyone would prefer to avoid. By using the insurance mechanism for only those events that are insurable, we stand to save a great deal of money and bend the cost curve. While more research needs to be done in this area, consider that patients can realize savings of 35 percent or more for comprehensive care when DPC is combined with low-cost catastrophic "wraparound" insurance.[19,20,21] If early DPC results are indicative of future claim savings due to lower utilization of specialists, hospitals and emergency departments, then we can expect these lower claims costs to be reflected in the "wraparound" insurance premiums.

CONCLUSIONS

Early results of DPC indicate that it promotes care coordination, improves quality and outcomes, and reduces spending. By working closely with the patient in a relationship characterized by trust and access, the DPC physician is often able to identify concerns early and prevent or reduce the severity of subsequent problems. Unlimited availability prevents urgent care visits, emergency department visits, and hospital admissions and re-admissions. Patients get better health for a lower cost. In addition, DPC seems to be a more satisfying way to provide primary care, for both the patient and the physician. As more medical students choose primary care and as physicians switch to DPC instead of leaving the profession or retiring early due to frustration and burnout, we may slow the current trajectory of primary care physician shortages.

DPC is good medicine for what is ailing in our health care system. ■

Gayle Brekke is an actuary practicing in Kansas City, Missouri. She can be reached at *gayle.brekke@hotmail.com.*

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