

Direct Primary Care: Update and Road Map for Patient-Centered Reforms

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KEY TAKEAWAYS

For too many Americans, health care is overpriced and dysfunctional. Direct primary care could lower costs while improving quality and patient access.

This innovative DPC arrangement lets doctors contract directly with patients, eliminating bureaucracy and regulations that often drive up costs.

Direct primary care strengthens the doctor-patient relationship, but many federal and state obstacles prevent widespread DPC use, obliging lawmakers to act.

As policymakers embark on a renewed debate about future reforms, there are a couple key lessons from the years following the passage of the Affordable Care Act (commonly known as Obamacare). Most importantly, *coverage is not health care*. Simply having an insurance card does not guarantee access to care.¹ Too often, an insurance card is a barrier to care. Almost equally important, there are too many middlemen and regulations on the supply side of the health care delivery system that are driving up costs, increasing health care complexity, causing health care provider burnout, and driving consolidation of independent medical practices.²

Primary Care Physicians (PCP) are first line providers of health care. Primary care can reduce the need for other spending on health care by providing quality, accessible continuity of care.³ However,

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under most forms of health care payment in the U.S. (which typically involve a third party, such as an insurer or government program, that pays the doctor on a “fee-for-service” basis), primary care physicians have witnessed erosion of the doctor–patient relationship, experienced intrusion of less-informed third parties into decision-making, and been burdened by complex payment systems that divert time and attention from medical care.⁴

Innovative American physicians have developed a new option: direct primary care (DPC). DPC circumvents the complexity, cost, and coercion of the traditional third-party payer system by contracting directly between doctors and patients in a Netflix-like membership model of care that can cost less than a cell phone subscription.⁵ This payment model’s resiliency was highlighted during the pandemic, as these practices entered well-positioned with stable revenue streams due to flexible membership models of care and flexible care delivery tools such as telehealth.⁶

Policymakers should enable doctors to continue to build on the initial successes of the direct primary care model by removing legislative and regulatory obstacles at the state and federal level that continue to be a headwind slowing broader uptake of the model.

Direct Primary Care Explained

DPC practices use an alternative payment model in which individuals contract with their physicians to obtain a defined set of health care services for a predictable fixed subscription fee. These fees average between \$40 to \$85 per person per month and vary depending on age.⁷

Generally, DPC contracts between a health care provider and a patient contain three core features. The health care provider agrees to provide primary care services to the patient:

1. Without billing a third party on a fee-for-service basis;
2. In exchange for a monthly subscription fee; and
3. On condition that any per-visit charge must be less than the subscription fee.⁸

This flat fee allows DPC physicians to provide their “members” medical office visits, in-office procedures, tests, and telehealth⁹ that can fit neatly within many family budgets. By this definition, today there are between

1,300¹⁰ and 2,000¹¹ DPC practices in the United States—approximately 1 percent of actively practicing primary care physicians.¹²

Where not hampered by regulatory impediments, DPC practices provide ancillary products and services—such as medications, imaging, and laboratory tests—to their patients *at cost*. These practices are able to dispense medication¹³ directly to their patients and perform laboratory¹⁴ testing at substantial discounts. Many also collaborate with imaging¹⁵ and surgical centers¹⁶ to offer patients considerable discounts on those services in a price-transparent manner. By doing so, DPC further drives down the cost of care, and patients know costs in advance.

The Results. Most DPC practices have fewer than 1,000 patients compared to conventional practices, which can have several thousand patients per physician. By having a more manageable number of patients and by eliminating the administrative burden of interacting with an insurance company for every aspect of routine care, DPCs are able to offer same-day accessibility and extended office visits.

These timely and in-depth visits are key features that allow for reduced emergency room visits, hospitalizations, urgent care referrals, specialist consultations, and unnecessary testing—the downstream cost-drivers in health care.¹⁷ This approach to payment and practice management allows most routine medical services to be provided at an affordable, predictable price without fear of surprise medical bills.

Pre-Existing Conditions. Also, DPC practices do not exclude patients for “pre-existing conditions”—an insurance term, not a medical term. DPC practices typically age-stratify their pricing. Therefore, a 64-year-old healthy patient may pay more than a 24-year-old, but will still pay the same as a 64-year-old with diabetes and heart disease.¹⁸ DPC practices serve all socio-economic, racial, and geographic groups. DPC physicians are currently providing high-quality, affordable care in inner-city Detroit,¹⁹ wealthy Boston suburbs,²⁰ and rural Texas,²¹ expanding access in all 50 states.

DPC injects market forces into the American health care economy with price transparency and makes routine health care costs predictable and affordable. It allows insurance to hedge against catastrophic loss. When combined with less expensive coverage options, DPC may substantially reduce family and individual’s annual aggregate health care spending.²² For example: A family of four can save, on average, \$17,280 per year by combining Samaritan Health Ministries with DPC, compared to an ACA marketplace Gold Plan alone.²³

By reducing the involvement of third-party insurance in routine care, direct-to-consumer fixed-fee primary care allows affordable access to the

basic level of care that every American needs, while also eliminating some of the problems seen in third-party coverage. For example, it resolves the most common “surprise” medical bills that are caused by complex insurance billing and coding rules that can leave people fearful of accessing the health care system. It also eliminates much of the medical bureaucracy for primary care and can therefore reduce physician burnout²⁴—thereby extending the career of a primary care physician, effectively increasing supply.

Society of Actuaries Study. Although many DPC patients become members on their own initiative, some employers (both private businesses and municipal governments) have contracted with DPC practices to offer DPC membership as an option in their employer-sponsored health plans. The Society of Actuaries recently published the results of a two-year study examining the experience of one such employer plan with about 2,000 covered lives (workers and their dependents)—roughly half of whom had chosen the DPC option and roughly half who chose only the employer-sponsored plan.

The authors adjusted the claims data used in their study for differences between the two groups in age, sex, and health status to ensure that comparisons were valid. They found that DCP was associated with reduced Emergency Department utilization by 40 percent, which they said was consistent with the explanation “that the DPC model leads to reductions in emergency department usage due to the enhanced PCP access provided to DPC members.”²⁵

DeSoto Memorial Hospital. One recent case study showed how an innovative health plan design built upon a DPC backbone helped a Florida rural hospital’s self-funded employee health plan reduce ER visits, specialty referrals, and spending on its employees being treated at other hospitals. The results were that DeSoto Memorial Hospital achieved a 54 percent reduction in health plan spending (a \$1.2 million savings), while eliminating co-payments and deductibles, reducing employees’ out-of-pocket costs at the point of care by 30 percent, and lowering employee premiums by 20 percent. These savings were achieved in a population that has the second-lowest median family income in the state of Florida, making the impact from reducing the cost of care delivery even more significant.²⁶

Savings were achieved by empowering doctors to provide care, while eliminating patient’s financial and bureaucratic barriers to care. This approach stands in contrast to one that inserts hurdles to care for both physicians and patients, as typical of the current third-party payer system of care.

Built-In Flexibility. Because DPC practices do not rely on insurance company payments, they have more flexibility to innovate in real time to provide the immediate and unique needs of their community, situation,

and patient population. This built-in flexibility proved critical during the 2020 COVID-19 pandemic, while nimble DPC practices were able to adapt quickly to the changing needs of their patients.

For example, these authors' own DPC practices shifted to video, telephone, e-mail, parking lots, and drive-up visits. House calls were made to patients with a high risk of contracting COVID-19 in order to protect them from any potential exposure from traveling to our offices, as well as point-of-care rapid testing for patients at their places of work. This flexibility allowed practices to adapt to the rapidly changing situation—and provided timely care needed for patients and the community.

Next-Step Recommendations

With so much potential for disruption of entrenched special interests, DPC has faced many challenges from government policymakers, including over-exuberant attempts at regulation and misclassification, which have caused unnecessary headwinds. By removing the policy hindrances outlined below, direct primary care practices could better serve current patients, while also paving the way for a true patient-centered American health care system.

The executive branch should:

Finalize a Rule to Clarify That DPC's Fixed Fee for the Promise of Care Constitutes Payment for Medical Care, Not for Health Insurance. The Treasury Department should explicitly recognize DPC as payment for the “diagnosis, cure, mitigation, treatment and prevention of disease” under subsection 213(d)(1)(A) of the Internal Revenue Code,²⁷ thus clarifying that it does not constitute payment for “insurance” under subsection 213(d)(1)(D).²⁸ This clarification would ensure that patients could use tax-advantaged funds in their health savings accounts (HSAs),²⁹ flexible spending accounts (FSAs),³⁰ or Medicare Medical Savings accounts (MSAs)³¹ to pay for DPC.

On June 24, 2018, President Donald Trump signed an Executive Order³² directing the Secretary of Treasury to resolve this issue. A proposed rule was published by the Treasury Department on June 10, 2020, but has not yet been finalized.³³

Make Clear That DPC Is Also Not “Insurance” or a Second “Health Plan” in the Context of Health Savings Accounts Rules. Health savings accounts are accounts that allows individuals and families to save tax-free for health expenses and receive tax-free employer contributions toward their care. Patients with an HSA are only allowed *one* health plan, and it

must be a high-deductible plan. The plan also cannot provide first-dollar coverage before the deductible, with limited exemptions.³⁴ The Treasury Department should clarify in its regulations implementing section 223 of the Internal Revenue Code that payments for DPC services do not constitute payments for a health plan, insurance, or arrangement, which would resolve any confusion about whether DPC patients are allowed to continue to fund their HSAs.

Preserve Access to Affordable Health Coverage Options. Patients were given relief from the individual mandate penalty under the Tax Cuts and Jobs Act of 2017,³⁵ and additional relief when the Trump Administration expanded access to cost-effective alternative coverage options such as short-term limited duration insurance,³⁶ indemnity plans,³⁷ and newer health care sharing ministries.³⁸

Prior to this, patients were penalized for not being able to afford expensive Obamacare coverage. Moreover, they often could only find plans with such high deductibles that they could not afford the care they needed. While DPC practices offer access to more routine care at affordable prices, patients also need more affordable coverage options than the expensive ACA plans for the “what ifs” of unplanned medical expenses.³⁹ The executive branch should maintain access to these affordable alternative options to cover unplanned expenses.

Create a Pilot Program in Medicare for DPC. The Centers for Medicare and Medicaid Services should use existing authority to create a DPC pilot program within the Medicare program using existing MSAs, the HSA-style option for seniors enrolled in Medicare. Under current law, Medicare providers are restricted from entering into such private payment arrangements with Medicare patients. This pilot program would establish a time-limited model to test the viability of permitting seniors to use their MSAs to fund a DPC subscription and to evaluate the benefits such arrangements have on the quality of care seniors receive.

Congress should:

Codify That DPC Arrangements Are *Not* a Health Plan. The IRS has previously opined that direct primary care might be deemed a “health plan,” even if not “health insurance.”⁴⁰ Congress should amend section 223 of the Internal Revenue Code to clarify that, with regard to health savings accounts and their interactions with health insurance coverage, payments for DPC services do not constitute payments for “health insurance or a health plan.”

Congress should also amend section 213(d) of the code to more broadly apply the same clarification that DPC payment arrangements are *not* a form

of insurance. These changes would permanently allow for direct primary care to be funded with money in patient accounts that allow them to pay for health care tax-free, such as HSAs, MSAs, and FSAs.⁴¹

Decouple HSAs from High-Deductible Coverage. Congress should pass legislation decoupling Health Savings Accounts from the requirement they be paired with a very specific type of high-deductible health plan.⁴² This change would allow for significant innovation in the kinds of affordable wrap-around coverage options that can be paired with a health savings account, while also opening opportunities for lifelong investment toward future health care expenses.⁴³

Permit DPC Physicians Greater Flexibility to Participate in Medicare Than Is Permitted Under Current Law. Medicare participating providers are not allowed to accept payment directly from Medicare recipients for covered services.⁴⁴ Accordingly, physicians are currently forced to opt out of Medicare in order to adopt the DPC model. That not only limits the ability of direct primary care practices to serve Medicare patients, but also reduces access to primary care for Medicare beneficiaries.

Congress should allow DPC practices to contract directly with Medicare recipients without needing to opt out of Medicare.⁴⁵ This will prevent direct primary care physicians from having to choose between innovation or participation.

States should:

Ensure That DPC Physicians Can Refer Patients for Specialist Care. In some cases, an insurer may refuse to recognize a patient referral from an out-of-network primary care physician (such as a DPC physician)—even when the referral is to an in-network provider (such as an in-network cardiologist or an in-network imaging center). There is no principled reason why the contractual status of the referring physician should affect the ability of patients to utilize their insurance product to cover the charges of an “in-network” provider.

Indeed, the network status of the referring primary care physician is completely immaterial to any insurer determination of the appropriateness of a particular referred service for a particular patient. In cases where insurers engage in the restrictive practice of disallowing referrals to specialists from non-network primary care providers, such as DPC physicians, states may need to consider taking action to address such anti-competitive insurer practices.⁴⁶

Clarify That DPC Is *Not* Insurance. Twenty-nine states⁴⁷ have passed laws clarifying that DPC is not insurance. The remaining states should pass similar laws.

Ensure Patients Have Access to Affordable Catastrophic Coverage Options. Eleven states have laws prohibiting short-term limited duration (STLD) plans.⁴⁸ When patients use DPC for routine and predictable care, STLD plans can offer affordable protection against incurring large, unexpected medical expenses. Some argue these short-term plans should be banned,⁴⁹ as they offer insufficient coverage for those with pre-existing conditions. However, this is irrelevant for patients who use DPC because any chronic “pre-existing condition” is treated and managed by DPC instead of through the insurance plan.

Repeal State Individual Mandates to Purchase Health Insurance. Despite the elimination of the federal individual mandate, five states⁵⁰ and the District of Columbia have enacted their own individual mandates.⁵¹ DPC is not insurance and does not satisfy most requirements to avoid penalties—even if this is the only arrangement desired by the consumer.

Give DPC Physicians Broader Dispensing Authority. Many direct primary care practices dispense generic medications directly to the consumer, avoiding the often-steep retail markup. Forty-five states and Washington, DC, allow direct physician dispensing of prescription medications. Five states⁵² restrict physicians from dispensing the medications that they legally prescribe, and the doctor-dispensing ban is currently in litigation in Texas.⁵³ States should lift these restrictions.

Make DPC Compatible with Obamacare-Compliant Qualified Health Plans (QHPs). Within federal rules, states define what insurance qualifies as a QHP under the Affordable Care Act. States should take steps to make sure that there are QHPs that are compatible with a direct primary care arrangement.

By taking advantage of Section 1301(a)3 of the Affordable Care Act,⁵⁴ states can allow insurers to sell QHPs that provide “wrap-around” coverage to individuals who obtain their primary care through a DPC arrangement—in the same way that insurers sell high-deductible plans that qualify as “wrap-around” coverage for an individual with an HSA. This action would expand the number of coverage options and types of arrangements available in their state.

Expand Access to DPC for State Employees. States and municipalities should pursue arrangements that allow their employees to access direct primary care, either through HSAs, health reimbursement arrangements, FSAs, or a customized “wrap-around” plan offering.⁵⁵ In addition to the DeSoto Memorial Hospital case study above, Anderson County in South Carolina and Union County in North Carolina are examples of counties that have experienced significant cost-savings, improved access, and quality by adding DPC for their employees.⁵⁶

Conclusion

The American health care system is overpriced, impersonal, and dysfunctional. Direct primary care offers a consumer-driven approach to correct many problems. DPC is now pandemic-tested, and the care model has proven its staying power. DPC improves patient access, raises quality, and lowers costs,⁵⁷ as well as increasing physician satisfaction and improving doctor–patient relationships.

Legislative and regulatory relief could remove barriers to growth and better allow direct primary care to help transform American health care to a patient-centered delivery model.⁵⁸

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