Attachment # 1

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BACKGROUNDER

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Direct Primary Care: An Innovative Alternative to Conventional Health Insurance

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Abstract

Insurance-based primary care has grown increasingly complex, inefficient, and restrictive, driving frustrated physicians and patients to seek alternatives. Direct primary care is a rapidly growing form of health care that not only alleviates such frustrations, but also goes above and beyond to offer increased access and improved care at an affordable cost. State and federal policymakers can improve access to direct primary care by removing prohibitive laws and enacting laws that encourage this innovative model to flourish. As restrictions are lifted and awareness expands, direct primary care will likely continue to proliferate as a valuable and viable component of the health care system.

With new concerns over the effects of the Affordable Care Act (ACA)[1] on access to care and continued frustration with third-party reimbursement, innovative care models such as direct primary care may help to provide a satisfying alternative for doctors and patients. Doctors paid directly rather than through the patients' insurance premiums typically provide patients with same-day visits for as long as an hour and offer managed, coordinated, personalized care. Direct primary care—also known as "retainer medicine" or "concierge medicine"[2]—has grown rapidly in recent years. There are roughly 4,400 direct primary care physicians nationwide,[3] up from 756 in 2010 and a mere 146 in 2005.[4]

Direct primary care could resolve many of the underlying problems facing doctors and patients in government and private-sector third-party payment arrangements. It has the potential to provide better health care for patients, create a positive work environment for physicians, and reduce the growing economic burdens on doc-

Key Points

- Direct primary care is financed by direct payment, outside of insurance, usually in the form of a monthly fee. In return, patients have ready access to physicians who deliver continuous, comprehensive, and personalized primary care.
- Direct primary care resolves the growing frustrations with the current health care system, particularly problems with third-party payment, paperwork, and government bureaucracy, experienced both by patients and by their physicians.
- Preliminary data show excellent outcomes for patients enrolled in direct primary care and a reduction in health care costs.
- Policymakers should create a legal and regulatory environment that is less restrictive toward direct primary care.
- If policymakers will encourage change, innovation, and competition instead of just reacting to the increasingly dysfunctional status quo, the possibilities are endless.

This paper, in its entirety, can be found at **http://report.heritage.org/bg2939**

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narrow networks,[7] and frustrations and failures that doctors and patients have experienced with third-party reimbursement.

Before the rapid growth of employer-based health insurance coverage in the 1940s, Americans paid directly with cash for virtually all of their health care. With the rise of third-party health insurance after World War II, cash payment for medical services declined sharply. Doctors, hospitals, and other medical professionals increasingly were reimbursed through third-party insurance, which often provided "first dollar" coverage. Superficially, this seemed to be efficient, quick, and easy, but it had the unintended consequence of making health care financing largely opaque. This hid the true cost of services, leaving patients with the false impression that their employers paid for their medical expenses, except for the occasional co-pay, deductible, or coinsurance.

Over time, the third-party payment systems in both private health insurance and public programs, such as Medicare and Medicaid, have become increasingly complex and costly, less transparent, and more economically inefficient.

This major transition in American health care financing during the 1940s left physicians to seek reimbursement from patients' insurance companies. Over time, the third-party payment systems in both private health insurance and public programs, such as Medicare and Medicaid, have become increasingly complex and costly, less transparent, and more economically inefficient.

In light of these mounting complexities and inefficiencies, increasingly dissatisfied doctors and patients are looking for innovative ways to deliver and receive primary care. Direct primary care has become a viable solution for many Americans.

Professional Decline. For many physicians, the traditional third-party payer model is becoming increasingly unattractive. A survey by the Physicians Foundation found that most doctors are profoundly dissatisfied and believe that their profession is in decline. Among the "very important" reasons that they give for the decline are too much regulation and paperwork (79.2 percent of physicians); loss of clinical autonomy (64.5 percent); lack of compensation for quality (58.6 percent); and erosion of physician–patient relationship (54.4 percent).[8]

In Medicare and Medicaid, these shortcomings are exacerbated by their outdated payment models, which routinely underpay physicians relative to the private sector while increasing regulatory and reporting requirements as a condition for continued participation. The Affordable Care Act has only increased these regulatory burdens.

For a typical physician, "half of each day can be consumed with clerical and administrative tasks, such as completing insurance claims forms, navigating complex coding requirements, and negotiating with insurance companies over prior approvals and payment rates."[9] The Direct Primary Care Coalition estimates that 40 percent of all primary care revenue goes to claims processing and profit for insurance companies.[10] A typical physician would need 7.4 hours per day to provide all of the preventive care as determined by the U.S. Preventive Services Task Force.[11] Such time commitment is unfeasible when physicians must spend several hours per day on clerical work. Declining reimbursements have prompted primary care providers to see more patients in an attempt to maintain stable income. This means that

7. Scott Gottlieb, "The President's Health Care Law Does Not Equal Health Care Access," testimony before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, June 12, 2014, http://www.aei.org/speech/health/scott-gottlieb-the-presidents-health-care-law-does-not-equal-health-care-access/ (accessed July 18, 2014).
8. The Physicians Foundation, "Practice Arrangements Among Young Physicians, and Their Views Regarding the Future of the U.S. Healthcare System," 2012, http://www.physiciansfoundation.org/uploads/default/Next_Generation_Physician_Survey.pdf (accessed July 21, 2014).
9. Robert Pearl, "Malcolm Gladwell: Tell People What It's Really Like to Be a Doctor," *Forbes*, March 13, 2014, http://www.forbes.com/sites/robertpearl/2014/03/13/malcolm-gladwell-tell-people-what-its-really-like-to-be-a-doctor/ (accessed June 4, 2014).
10. Zamosky, "Direct-Pay Medical Practices Could Diminish Payer Headaches."
11. Kimberly S. H. Yarnall et al., "Primary Care: Is There Enough Time for Prevention?" *American Journal of Public Health*, Vol. 93, No. 4 (April 2003), pp. 635–641.

focusing on specific prevention quality indicators[17] estimated that the costs of two preventive conditions ("uncontrolled diabetes without complications" and "short-term complications") for diabetes ranged between $2.3 billion and $2.8 billion annually. Medicare or Medicaid patients accounted for 49 percent of preventable hospital admissions in this study.[18]

While detailed quantitative analysis of the efficacy of direct primary care is scarce, the limited existing research generally supports the value of direct primary care practices. Researchers writing in the *American Journal of Managed Care* evaluated the cost-benefit for MD-Value in Prevention (MDVIP), a collective direct primary care group with practices in 43 states and the District of Columbia. For states in which sufficient patient information was available (New York, Florida, Virginia, Arizona, and Nevada), decreases in preventable hospital use resulted in $119.4 million in savings in 2010 alone. Almost all of those savings ($109.2 million) came from Medicare patients.[19] On a per-capita basis, these savings ($2,551 per patient) were greater than the payment for membership in the medical practices (generally $1,500–$1,800 per patient per year).[20]

The five-state study also showed positive health outcomes for these patients. In 2010 (the most recent year of the study), these patients experienced 56 percent fewer non-elective admissions, 49 percent fewer avoidable admissions, and 63 percent fewer non-avoidable admissions than patients of traditional practices. Additionally, members of MDVIP "were readmitted 97%, 95%, and 91% less frequently for acute myocardial infarction, congestive heart failure, and pneumonia, respectively."[21]

A *British Medical Journal* study of Qliance, another direct primary care group practice, also shows positive results. The study found that Qliance's patients experienced "35% fewer hospitalizations, 65% fewer emergency department visits, 66% fewer specialist visits, and 82% fewer surgeries than similar populations."[22]

Affordable direct primary care is more than just an option for the wealthy. In fact, two-thirds of direct primary care practices charge less than $135 per month,[23] and these lower-cost practices account for an increasing proportion of the market. For comparison, cable television is projected to cost an average of $123 per month in 2015.[24] Frequently, the sum of the membership fees and an augmented insurance plan—called a "wraparound" plan because it covers costly care beyond the scope of primary care—is *lower* than the cost of a comprehensive insurance plan by itself. If the number of practices continues to increase and compete directly for consumers, prices will likely decline further.

Additionally, under the ACA, individuals enrolled in a direct primary care medical home[25] are required only to have insurance that covers what is not covered in the direct primary care program. Section 10104 exempts patients who are enrolled in direct primary care from the individual insurance mandate for primary care services if they have supplementary

17. Prevention quality indicators "are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease." U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, "Prevention Quality Indicators Overview," http://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx (accessed July 21, 2014).
18. Sunny Kim, "Burden of Hospitalizations Primarily Due to Uncontrolled Diabetes," *Diabetes Care*, Vol. 30, No. 5 (May 2007), pp. 1281–1282, http://care.diabetesjournals.org/content/30/5/1281.full (accessed July 22, 2014).
19. Medicare patients comprised approximately 55 percent of the patients.
20. Andrea Klemes et al., "Personalized Preventive Care Leads to Significant Reductions in Hospital Utilization," *The American Journal of Managed Care*, Vol. 18, No. 12 (December 2012), pp. e453–e460, http://www.ajmc.com/publications/issue/2012/2012-12-vol18-n12/Personalized-Preventive-Care-Leads-to-Significant-Reductions-in-Hospital-Utilization (accessed July 22, 2014).
21. Ibid., p. e458.
22. Leigh Page, "The Rise and Further Rise of Concierge Medicine," *British Medical Journal*, October 28, 2013, p. 2, http://www.bmj.com/content/347/bmj.f6465 (accessed July 22, 2014).
23. Jen Wieczner, "Is Obamacare Driving Doctors to Refuse Insurance?" *The Wall Street Journal MarketWatch*, November 12, 2013, http://www.marketwatch.com/story/is-direct-primary-care-for-you-2013-11-12 (accessed July 31, 2014).
24. News release, "Average Monthly Pay-TV Subscription Bills May Top $200 by 2020," NBD Group, April 10, 2012, https://www.npd.com/wps/portal/npd/us/news/press-releases/pr_120410/ (accessed July 8, 2014).
25. Direct primary care practices that qualify as Patient-Centered Medical Homes under the criteria are set forth by the ACA.

care medical home enrollment must be coupled with a wraparound insurance plan that "meets all requirements that are otherwise applicable."[35] In essence, the Secretary of Health and Human Services is responsible for setting the criteria that determine which direct primary care plans qualify for the exchanges. However, the secretary has yet to establish the criteria, and HHS has given no indication of when that may happen.

Lack of HHS criteria also hinders insurance companies from creating qualified wraparound plans to put on the exchanges. If insurance companies are uncertain of the criteria for direct care practices, they cannot know which benefits to supply in the wraparound plans.

Currently, only a handful of insurance companies have attempted to embrace direct primary care. Cigna and Michigan Employee Benefits Service (MEBS) have created plans for employers who choose to offer wraparound plans in conjunction with direct primary care.[36] Keiser Group is creating plans that work in conjunction with services of MedLion, a direct primary care group.[37] Even with the rise of these plans, there is no clear timeline for when they might be available on the health care exchanges.

Health Savings Accounts. The second federal obstacle is the treatment of these arrangements under the provisions of the Internal Revenue Code that deal with health savings accounts (HSAs). The statute says that to be eligible for an HSA, an individual cannot be covered under a high-deductible health plan *and* another health plan "which provides coverage for any benefit which is covered under the high deductible health plan."[38]

In theory, this restriction could be addressed by combining a high-deductible health plan with coverage for primary care through a direct primary care practice. Even so, there would still be another issue. The statute also specifies that funds in an HSA may not be used to purchase insurance.[39] Consequently, Congress would still need to amend the statute either to exempt payments for direct primary care from this restriction or to specify that such payments do not constitute payments for insurance coverage. Given that Congress included language in the ACA providing for integration of direct primary care with insurance coverage offered through the exchanges, amending the tax code's HSA provisions in a similar fashion should not be controversial.

Recognizing these inconsistencies, Senator Maria Cantwell (D–WA), Senator Patty Murray (D–WA), and Representative Jim McDermott (D–WA) wrote a letter to IRS Commissioner John Koskinen asking for clarification of the tax code.[40]

Some Members of Congress have already attempted to address these discrepancies in the federal tax treatment of direct care payments. The Family and Retirement Health Investment Act of 2013 (S. 1031), sponsored by Senator Orrin Hatch (R–UT), would change the language of the Internal Revenue Code to specify that direct primary care is not to be treated as a health plan or insurance and that "periodic fees paid to a primary care physician" count as qualified medical care.[41] This bill has three cosponsors and has been referred to the Senate Committee on Finance. The House companion bill (H.R. 2194), sponsored by Representative Erik Paulson (R–MN), has been referred to the House Subcommittee on Regulatory Reform, Commercial and Antitrust Law.[42] If this bill became law, Americans would have greater financial incentives to enroll in a direct primary care practice.

It is perfectly reasonable that direct primary care fees should qualify as medical expenses payable through HSAs. The fact that they do not is simply

35. Ibid.
36. Chase, "Direct Primary Care," pp. 18–19.
37. Wieczner, "Is Obamacare Driving Doctors to Refuse Insurance?"
38. 26 U.S. Code § 223(c)(1)(A)(ii)(II).
39. 26 U.S. Code § 223(d)(2)(B).
40. Maria Cantwell, Patty Murray, and Jim McDermott, letter to John Koskinen, June 17, 2014, http://media.wix.com/ugd/677d54_4f0975c488f44d4bbef4bf15a4f7f69a.pdf (accessed July 8, 2014).
41. Family and Retirement Health Investment Act of 2013, S. 1031, 113th Cong., 1st Sess., §§ 116 and 203.
42. Family and Retirement Health Investment Act of 2013, H.R. 2194, 113th Cong., 2nd Sess. The bill has six cosponsors: Bill Cassidy (R-LA), Tom Latham (R-IA), Thomas E. Petri (R-WI), John Kline (R-MN), David T. Roe (R-TN), and Bill Posey (R-FL).

fund special accounts with debit cards for Medicaid patients, who could use those funds to pay the fees of a direct primary care provider chosen by the beneficiary. As noted, S. 1031 and H.R. 2194 would allow such a Medicaid option.

States pursuing such an approach could potentially reap significant Medicaid savings. The empirical evidence indicates that patients with direct primary care experience substantially lower admissions, fewer emergency room visits, and fewer hospitalizations. If Medicaid patients enjoyed similar experiences, the resulting savings would directly redound to taxpayers. In fact, if the per-capita savings were as substantial as those found in the MDVIP study ($2,551 per person), the savings to taxpayers could exceed the cost of a state Medicaid account program.[49]

Currently, 40 cents of every dollar of primary care spending goes to insurance company costs rather than to patient benefits.

Related Issues. Some object that direct primary care would create a two-tiered health care system in which those who cannot afford to pay direct care fees would be priced out of access to quality care.[50] There are several problems with this line of reasoning.

First, it fails to recognize that American health care already is a multitiered system and that the Affordable Care Act is not changing that fact. Indeed, the ACA will likely harden the existing tiers. For example, Medicaid patients already have much more difficulty finding a doctor than those enrolled in private insurance do, and when they find medical care, it is frequently of poorer quality than the care provided to patients in private coverage or Medicare.[51]

Furthermore, a single-tier program, even if it were desirable, would invariably mean that everyone would end up receiving worse, not better, care over time because it would stifle innovation. If innovative clinicians can provide a better option, they should be encouraged, even if it will not immediately be available to all. In a free market, competition will reduce the price of goods and services over time—sometimes rather quickly.

Second, patient cash payments are not necessarily made to physicians in addition to patient payments for an existing comprehensive plan. If a patient opted for a wraparound plan instead of a comprehensive plan, the patient could save money. Currently, 40 cents of every dollar of primary care spending goes to insurance company costs rather than to patient benefits.[52] Eliminating the spending on insurance for routine medical services, which passes through a complex claims processing system, and instead paying the doctor directly would not only cost less, but also empower the patient.

As Dr. Robert Fields, an award-winning direct primary care physician in Maryland, has stated, "Money is not purified by first passing through an insurance company."[53] As long as the amount of health care spending remains relatively constant or declines, no one is being priced out of health care by direct primary care.

Policymakers in particular should realize that physicians can offer more free care to those who need it most precisely because they have more free time and are spending less time coping with paperwork, claims processing, and the entire set of interactions with health insurance companies that doctors today must endure. Dr. Marcy Zwelling-Aamot, former president of the American Academy of Private Physicians, has noted that "10% of my patients do not pay me one

49. Klemes et al., "Personalized Preventive Care Leads to Significant Reductions in Hospital Utilization."
50. Sandra J. Carnahan, "Concierge Medicine: Legal and Ethical Issues," *The Journal of Law, Medicine & Ethics*, Vol. 35, No. 1 (Spring 2007), p. 211, and Michael Stillman, "Concierge Medicine: A 'Regular' Physician's Perspective," *Annals of Internal Medicine*, Vol. 152, No. 6 (March 16, 2010), pp. 391–392.
51. Kevin D. Dayaratna, "Studies Show: Medicaid Patients Have Worse Access and Outcomes Than the Privately Insured," Heritage Foundation *Backgrounder* No. 2740, November 9, 2012, pp. 3–4, http://www.heritage.org/research/reports/2012/11/studies-show-medicaid-patients-have-worse-access-and-outcomes-than-the-privately-insured.
52. Zamosky, "Direct-Pay Medical Practices Could Diminish Payer Headaches."
53. Robert P. Fields, "Further Perspectives on Concierge Medicine," *Annals of Internal Medicine*, Vol. 153, No. 4 (August 17, 2010), p. 274.

many are seeking research or non-clinical jobs.[62] For example, dropoutclub.com is a new network devoted entirely to helping physicians procure jobs outside of health care. Smith calls this "a silent exodus."[63] Allowing physicians to practice direct primary care not only addresses the underlying problems facing primary care practice, but also can make primary care appealing once again to more and more physicians, residents, and medical students.

Under the current third-party payment systems, physicians are increasingly overburdened and must see too many patients in too little time. A more important problem is that doctors were never supposed to care for 3,000 patients in the first place. No moral imperative compels physicians to martyr themselves in service to a broken third-party payment system.

Dr. Floyd Russak, a direct primary care internist in Colorado, argues that practicing the current model of "inferior care" is morally wrong when quality care can be provided affordably.[64] Dr. David Albenberg, a family physician in South Carolina, agrees: "What's ethical about cutting corners and shortchanging patients in the name of efficiency and productivity?"[65] Additionally, Russak proposed that physician's assistants and nurse practitioners could treat younger, healthier individuals, leaving more experienced physicians to care for older, sicker patients. As a result, all patients could receive comprehensive, quality care at a reasonable cost.

What Policymakers Should Do

Direct primary care could resolve many of the underlying problems facing doctors and patients in government and private-sector third-party payment arrangements. It has the potential to provide better health care for patients, create a positive work environment for physicians, and reduce the growing economic burdens on doctors and patients caused by the prevailing trends in health policy, including implementation of the Affordable Care Act of 2010.

The question is not whether direct primary care should be allowed as part of the health system, but how to enable even more direct primary care practices to flourish. In this, policymakers can play a powerful role.

State Policy Recommendations

State legislators who want to see this innovative approach flourish should implement free-market policies so physicians can feel free to start a direct primary care practice without fear of its being outlawed or overregulated out of existence. Specifically, they should:

- **Review, rewrite, or repeal any state law, rule, or regulation that inhibits the growth of direct primary care practices.** For example, Maryland limits services in a given year to an annual physical exam, a follow-up visit, and a number of other visits. Such arbitrary restrictions should be removed.[66]

- **Address insurance regulation and licensure issues.** States that have not done so already should review, and amend as necessary, their laws governing insurance regulation and medical provider licensure so as to ensure that state laws do not create unnecessary impediments to the offering of direct primary care arrangements. In the vast majority of states, physicians remain uncertain about the potential legal complications they could face in operating a direct primary care practice. State lawmakers can easily end that uncertainty, thus enabling physicians to practice with relative confidence and freeing patients from anxiety about the security of their care.

Federal Policy Recommendations

Congress should also make reforms that clarify the status of direct primary care arrangements under the tax code and federal programs. Specifically, Congress should:

62. Drew Lindsay, "Concierge Medicine," *Washingtonian*, February 1, 2010, http://www.washingtonian.com/articles/health/concierge-medicine/ (accessed July 22, 2014).
63. O'Reilly, "Will a 'Silent Exodus' from Medicine Worsen Doctor Shortage?"
64. Floyd Russak, "Concierge Medicine: A Revolution in Primary Care," *The Advocate*, October/November 2012, http://www.ademedicalsociety.org/clubportal/images/clubimages/1532/ADEMS_Advocate_OctNov2012.pdf (accessed June 20, 2014).
65. Timothy W. Boden, "Concierge Medicine: Glitz and Glamour or Good Medicine?" *MGMA Connexion*, October 2011, p. 52.
66. Maryland Insurance Administration, "Report on 'Retainer' or 'Boutique' or 'Concierge' Medical Practices."

other specialists are also branching out into direct care models of practice.[73]

The possibilities are endless. Instead of paying higher and higher premiums and deductibles, patients could substitute a simple monthly payment. Doctors and other health care professionals could group together under the direct pay format. While insurance premiums could guarantee catastrophic protection, which is what insurance is meant to do, patients could receive a majority of their care, including specialty care, as part of a monthly fee. If policymakers will encourage change, innovation, and competition instead of just reacting to the increasingly dysfunctional status quo, the sky is the limit.

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73. Norbut, "Retainer Model Slowly Spreading to Specialties."