



HEALTH CARE POLICY



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Get Ready for More Direct Primary Care Medical Homes: Opening the Door to Insurance-Free Primary Care in State-Run Exchanges

By GARRISON BLISS, M.D.

Many of us who followed the health care bills in Congress have wondered, “why all the focus on health insurance?” when insurance was only a small part of what was broken. Was it not the broader health care problem—especially skyrocketing costs—we really wanted to fix?

Fortunately, tucked into the health care bill President Obama signed into law is a relatively little-known provision that could lead to one of the most significant health care reforms in decades, reducing cost while simultaneously increasing access and quality.

Sec. 10104 of H.R. 3590, the Patient Protection and Affordable Care Act of 2010, states that the secretary of the Department of Health and Human Services “shall permit coverage in the exchange to be offered through a qualified direct primary care medical home plan.”

This provision enables Americans who shop in the insurance exchanges to elect an alternative to traditional insurance plans in which patients and/or employers pay a flat monthly fee directly to a primary care provider for all primary and preventive care, chronic disease man-

agement and care coordination throughout the entire health care system. Under the new law, a flat-fee direct primary care medical home (DPCMH) membership, which starts as low as \$49 per month and acts much like a gym membership, can be bundled with a new, lower-cost “wraparound” insurance plan that covers unpredictable and expensive services outside its scope, such as specialist care, hospital stays, or emergency room visits.

This single, short provision is one of the best-kept secrets of the new law. It not only will help ensure that health care will be available to people of modest means employed by small businesses and currently uninsured individuals with low incomes, but it also has the potential to completely change the way primary care—and insurance—is delivered and paid for. If implemented correctly, it could save taxpayers, individuals, and employers billions of dollars in unnecessary costs in the years ahead.

Direct Primary Care in Health Policy

As is often the case, during the early stages of health care reform discussion, lawmakers looked to the states for innovative ideas about how to make affordable health care coverage work. What caught their attention were DPCMH practices.

Direct primary care started in the state of Washington in the mid-1990s after a few doctors (including myself) decided we could improve our medical care and protect our sanity if we worked directly for our patients instead of insurance companies. By removing the payment middleman for inherently low-cost, routine care and focusing insurance on expensive, unpredictable care where it adds the most value, primary care doctors were freed to focus on unhurried, personalized care instead of claims processing. By freeing up time, we could

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more easily help patients avoid unnecessary specialist, hospital, and ER visits in the future, resulting in great systemwide cost savings.

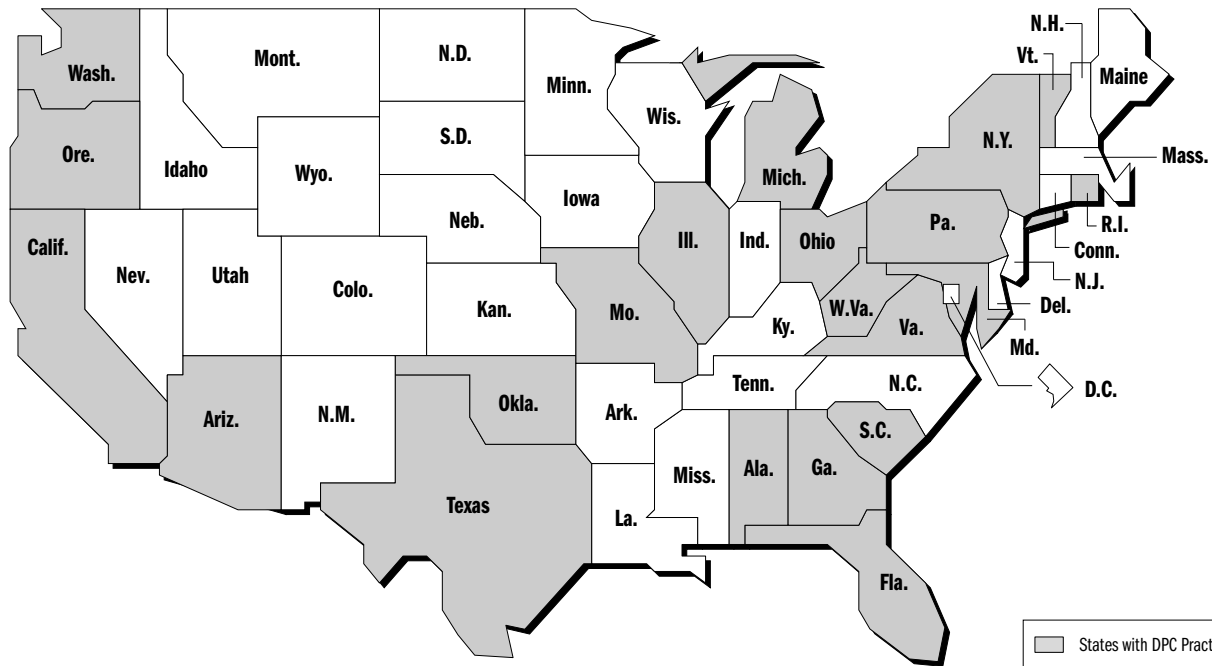
The lower overhead enabled many of us to run successful practices at surprisingly low rates. (For example, when I started in 1997, I accepted a maximum of \$65 per month in lieu of insurance.) The model caught on and in 2007, the Washington Legislature moved to foster the growth of DPCMHs and specifically designated that these direct primary care only practices are not insurance or HMOs and should not be regulated as such.¹

chronic diseases like diabetes, hypertension and obesity;

- On-site X-ray, laboratory, and “first-fill” prescription drug dispensary;
- Coordination of any needed specialist and hospital care; and/or
- Open seven days per week, often with extended hours, plus phone and e-mail consultations and round-the-clock phone access to a physician for urgent after-hours issues.

While some of these benefits resemble those offered

Known Direct Primary Care (DPC) Practices in the Continental U.S.



Source: Direct Primary Care Coalition

A BNA Graphic/hcr010g1

Today, similar DPCMHs can be found in at least 21 states (see map insert). Benefits of direct primary care membership vary by provider, but typically include many of the following:

- Unhurried 30- to 60-minute office visits;
- No limits for pre-existing conditions;
- No deductibles or copayments to minimize barriers to usage;
- Same- or next-day appointments for urgent care needs;
- Affordable, predictable monthly fees as low as \$49 (children as low as \$39);
- All routine primary and preventive care including vaccinations, many lab tests, women’s health services, on-site procedures (suturing, casting, splinting, colposcopies, etc.) and ongoing management of

by expensive concierge medicine practices, the DPCMHs are quite different. In most concierge practices, doctors charge a premium fee for easy and immediate access, yet still bill insurance for all visits and procedures. That’s great for patients who can afford it, but does little to help those without coverage or address the inefficiencies and inequities in the U.S. health care system.

While the Washington delegation to the U.S. Congress led by Sens. Maria Cantwell (D), Patty Murray (D) and Rep. Brian Baird (D) were initial champions of including the direct primary care model in the final federal health reform legislation due to their personal knowledge of the benefits, the model quickly garnered support from both sides of the aisle. Rep. Bill Cassidy (R-La.), a practicing gastroenterologist, is a proponent and recently wrote about direct primary care as a model for health care reform in an opinion piece in *Politico*, outlining 10 ideas for “How Dems Can Win Health Care Reform”:

“...#9 Direct Primary Care. Pioneered by Seattle-based Qliance, the direct primary care model gives pa-

¹ Revised Code of Washington, Title 48, Chapter 48.150, Direct patient-provider primary health care, <http://apps.leg.wa.gov/RCW/default.aspx?cite=48.150>.

tients access to comprehensive primary care for a monthly payment of \$39 – \$79. Physicians are rewarded for quality, not quantity, and patients are firmly in control.” (Feb. 10, 2010)

In the end, the House and Senate bills (H.R. 3962 and H.R. 3590) included language to allow these innovative flat-rate primary care plans to compete within all of the state health insurance exchanges created by the bills.

This is a significant step forward; however, there is still much work to do to make sure every American and employer has the choice to elect this type of plan in the exchanges that can be supplemented by a new type of wraparound insurance. It requires involvement from doctors, communities, states, businesses, unions, and insurance companies. And, it requires that we all think beyond the status quo.

Thinking Beyond the Traditional: Problems With Insuring Primary Care

When you think about it, insuring primary care makes little sense on a practical level. We don’t rely on auto insurance to cover routine maintenance services like oil changes, and worn tires. We use it to cover accidents... unexpected events... risk. Primary care is akin to routine auto care in this sense: Everyone is going to need it and it won’t bankrupt anyone. In fact, roughly 90 percent of the reasons patients see a doctor in a lifetime can be categorized as primary, preventive, or chronic care, which can be largely handled through a direct primary care medical home.

So why have we let health insurance become our primary care gatekeeper? It wasn’t always this way. When I left medical school to start my primary care internal medicine practice in 1980, primary care doctors were almost exclusively paid by their patients. Most patients paid their bill as they completed their office visit and the price was low enough that they could do so easily. Insurance was used as intended—to cover emergency and highly expensive circumstances. Most people had bare bones hospital coverage insurance, if they had any insurance at all. Primary care physicians made a good living and there were lots of us. Somewhere along the way, insurance has crept into all health care transactions, which has driven up costs and selectively hampered the most necessary and least expensive providers of medical care—the primary care internists, family practice physicians and pediatricians.

It is estimated that 40 percent of every health care dollar spent on primary care is spent on insurance reimbursement processes, including both the provider and the insurer. A recent study² determined that for every week a primary care provider works, 59.6 hours of provider and staff time are spent on claims processing. Doctors working in insurance-reimbursed facilities must see 25 to 35 patients per day to generate enough revenue to cover costs, shortening provider-patient face time to as little as seven minutes per appointment. This is hardly ample time to diagnose, much less treat patients.

By contrast, in a typical DPCMH that has eliminated insurance fee-for-service billing and third-party claims

processing, providers see 10 to 12 patients a day, with average visits ranging from 30 to 60 minutes.

Insurance reforms in the new law do not address the current systemwide inefficiencies in traditional insurance nor do the limited efforts to simplify administrative procedures with electronic claims adjudication. The direct primary care medical home provision does.

Redefining Insurance in the Insurance Exchange: Eliminate Redundancies

Under the DPCMH model, insurance is left to do what it does best; insure risk. This is a key reform in itself. With the new law, insurance companies are able to create new types of wraparound insurance plans that cover everything DPCMHs do not. This means that if a patient has a more serious condition that cannot be treated by their primary care physician, they will have insurance to cover hospital-based and more expensive specialty care.

These wraparound plans will eliminate redundancies that currently exist. Right now patients who join DPCMH practices are forced to buy primary care twice—once from their doctor and again from their insurer (even though they no longer need insurance coverage for primary care). These new wraparound insurance plans will extract the costs and paperwork associated with any duplicative routine care coverage, which can significantly reduce costs for patients, employers, physicians, and insurers. Over time, it is expected these wraparound plans will recognize the long-term impact DPCMH practices can have on the amount and cost of downstream care as patients stay healthier, longer. This should translate into more efficient health care and lower premiums over time.

Saving Money for Patients and Employers

Already today a DPCMH can save patients and employers 20 percent to 50 percent on their health care costs by bundling with a low-premium, off-the-shelf insurance plan.

In the current insurance-based system, a single non-smoking male in Seattle aged 53 with a \$1,000 deductible can expect to pay \$10,068 in premiums per year (\$839 per month), totaling \$11,068 before the insurance plan starts to pay out. By contrast, the same patient in the direct primary care model spends \$828 for an annual membership (\$69 per month). By supplementing the DPCMH plan with a \$2,500 deductible plan with a \$5,532 premium (\$462 per month), the combined cost of a DPCMH plan plus the lower insurance premium is \$6,360 annually. That is an individual savings of 37 percent for someone who doesn’t require much care beyond routine primary care, and is still 20 percent less for someone who becomes ill and must pay the entire \$2,500 deductible.

Once patients have the ability to choose a wraparound insurance plan that eliminates the primary and preventive care redundancies, and insurance companies recognize that DPCMHs reduce the cost of downstream care, it is expected these savings will grow.

Small and mid-sized businesses already are leveraging DPCMHs to deliver better health care for their employees while improving balance sheets. One example is Tri-Tec Manufacturing in Kent, Wash., with 40 employees. After several years of having health insurance premiums rise as much as 40 percent annually, last year Tri-Tec began offering employees the option of

² Lawrence P. Casalino et al, “What Does It Cost Physician Practices To Interact With Health Insurance Plans?” *Health Affairs* 28, no. 4 (2009): w533–w543 (published online May 14, 2009; 10.1377/hlthaff.28.4.w533).

low-cost, flat-fee primary care at a local DPCMH and switching to a lower-premium, high-deductible plan. To bridge the small gap between the direct primary care monthly fees and the insurance deductible, Tri-Tec management self-insured using an employer-funded HRA. While self-insuring carries some risk for any business, the majority of employees of any company will not utilize their entire deductible each year. This means even a small company can afford to self-insure below the deductible, especially since the DPCMH covers so much medical care without using those self-insured funds.

Rick Corday, the owner of Tri-Tec, estimates the company saved \$30,000 in 2009, and expects to save roughly 20 percent in annualized health care costs by shifting the majority of employees' health care needs to the local DPCMH.

As the movement expands, it is likely there will be even greater price and service competition based on the cost efficiencies of the underlying model that will benefit employers and small businesses shopping in the exchanges.

Restoring the Primary Care Profession as a Medical Home

Several studies have shown that the United States is facing a shortage of primary care physicians. Family medicine residencies filled by U.S. medical school graduates dropped by 46 percent from 1999 to 2009.³ There are a number of contributing factors, including the cumbersome insurance reimbursement process, that have diminished the appeal. After all, who wants to spend several years and hundreds of thousands of dollars in medical school only to face huge workloads, daily compromises in care delivery and low salaries relative to your classmates going into specialty care? It's simply not worth it and the residency decisions made by our medical school graduates prove that.

Doctors in most DPCMHs are on a salary that is commensurate with what doctors in primary care practices make, but with lower costs. Since primary care doctors rely on recurring fees—not codes and maximum reimbursement rates—it means they can spend more time with each patient.

These practices also put incentives in the right place. Doctors in insurance-based practices have incentives to mark as many codes as possible in order to get paid. In DPCMHs, doctors have incentives to keep patients healthy. Bonuses in DPCMHs, if used, can be tied to medical outcome and patient satisfaction rather than the volume measures typically used in insurance-based practices, since patient membership retention is the key to economic success in recurring revenue models like DPCMHs.

DPCMHs are designed to serve as a patient's medical home in which a doctor has a central and long-term relationship with the patient. Providers adopt many of the same "medical home" principles that have successfully improved health outcomes at innovative clinical settings such as Mayo, Cleveland Clinic, and Geisinger. Although patients still have insurance to cover hospital-

ization and specialty care, their need for these services is considerably less in this model, since the doctor gets paid to focus on primary prevention and is rewarded by keeping the patient healthy. Catching potentially complex and deadly conditions early leads to better health outcomes and drastically reduced health care costs over the long run. In the event specialty or emergency care is required, a DPCMH provider serves as the "home base" for such care, coordinating services among other specialists and facilities.

This coordination is also vital for chronic care. Professor Kenneth Thorpe, PhD., of the Emory University Center on Health Outcomes and Quality cites that fully one-third of the rise in Medicare spending over last 10 years is traced to five chronic conditions—diabetes, hypertension, lipids, mental disorders, and arthritis and fully 75 percent of overall spending is associated with chronically ill patients with these conditions. All of these conditions can be treated with substantial success by primary care doctors who have the time to make the right diagnosis and the resources to prescribe and regularly follow up with the patient on a treatment plan. If unaddressed or managed poorly, patients suffer health consequences and medical costs soar.

By working directly for their patients again, doctors have the right incentives to provide better care at reasonable prices. This enhances personal satisfaction and eventually could help restore primary care as a profession sought by graduating medical students.

The Path Ahead: Cooperation and Change

The new health care reform law has opened the door for new and more cost-effective ways of delivering health care, but the implementation will take some work. For this policy to succeed in delivering consumers and employers more choice, it will require the cooperation of federal and state policymakers, regulators, providers, insurance companies, labor unions, and employers.

One-third of states already have viable DPCMHs operating. To be truly effective and offer real alternatives for Americans—employed and unemployed—and businesses, DPCMH must be enabled and made available at the local level in all states. Some states like Washington specifically have addressed this growing model through state legislation⁴ while others are just beginning to evaluate the benefits and how best to address this solution within existing state health systems.

In the months and years ahead, primary care doctors need the flexibility to break away from insurance-based models and switch to flat-fee systems. Employers and unions must evaluate and consider these practices for their employees and members. Most importantly, insurance companies need to be involved every step of the way and develop innovative lower-cost wraparound plans as effective options for the insurance exchange. This is already in the works with major insurance companies in some states, but it must be expanded. Ultimately, everyone should have the ability to choose the right health care plan for their needs.

It likely will take years to sift the facts from the rhetoric to truly understand the new health reform law. If DPCMH practices receive the continued support they

³ American Academy of Family Physicians. Based on data from National Residency Matching Program. <http://www.aafp.org/online/en/home/residents/match/graph2.html>. Graph 2. (Accessed March 28, 2010).

⁴ Revised Code of Washington, Title 48, Chapter 48.150, Direct patient-provider primary health care, <http://apps.leg.wa.gov/RCW/default.aspx?cite=48.150>.

warrant at both the federal and state level, one thing will become more clear: this little-known provision will be one of the most important tools for achieving the promise of the reform law—significant cost reductions

(not just “bending the curve”), revitalized physician interest in primary care, and measurable improvements in health care quality and access for all Americans.