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TESTIMONY

BENEFITS OF DIRECT PRIMARY CARE IN IMPROVING QUALITY AND REDUCING COSTS OF HEALTHCARE

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Chair Noland, Vice Chairs Buttrey and Sullivan, and members of the committee:

My name is Darcy Bryan, and I am a senior affiliated scholar with the Mercatus Center at George Mason University and a practicing obstetrician gynecologist surgeon. My research encompasses the positive impact that innovative healthcare models and technology can have on healthcare access, quality, and affordability. Thank you for the opportunity to testify regarding SB 101 and its support of the opportunities for healthcare delivery through direct primary care (DPC). Today, I offer three takeaways:

1. The fee-for-service model makes it difficult for both patients and physicians to understand the costs of healthcare services and results in overuse, which increases healthcare costs. DPC is a practice and payment model where patients pay their physician or practice directly in the form of periodic payments for a defined set of primary care services that aim to address the majority of reasons for which a patient would see their doctor.
2. The high administrative costs and lost clinical productivity imposed on physicians by the fee-for-service model have contributed to physician burnout and reduced the availability of primary care providers
3. The DPC model offers an alternative that reduces healthcare costs while increasing the time that physicians spend with patients. DPC practices can reduce administrative financial overhead by approximately 40 percent.[1] SB 101 is an exciting innovation in that it expands the DPC model beyond primary care.

THE FEE-FOR-SERVICE MODEL AND PHYSICIAN SHORTAGES

The country has been struggling for years with limited access to primary care providers. Rural communities have been hit hardest. The situation has only worsened with the COVID pandemic, but it

1. Philip M. Eskew and Kathleen Klink, "Direct Primary Care: Practice Distribution and Costs across the Nation," *Journal of the American Board of Family Medicine* 28, no. 6 (2015): 793–801.

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has several causes, including retirement of the existing workforce and limited availability of residency training programs.

Traditionally, healthcare as a business has largely been funded by fee-for-service payments paid by insurers. This payment methodology has a twofold effect on incentives. First, the service-by-service billing makes it difficult for patients—and even providers—to understand the cost of care. Second, reliance on third-party payers diminishes the incentives for patients and providers to economize. The fee-for-service model has led to more utilization of clinic visits, procedures, and overall interventions, but the link between increased utilization and quality or improved outcomes is hazy at best. Volume, not quality, determines remuneration. Regulators have subsequently attempted to flatten the cost curve through ever-increasing layers of codes, bundles, and restrictive cost interventions.

Twenty to thirty percent of a physician's time is now consumed by regulatory compliance–related administrative work rather than direct patient care.[2] In turn, physicians are burning out and leaving medicine to relieve themselves of the disheartening administrative demands imposed by public and private insurance. The end result is not just higher healthcare costs, but a shortage of physicians.

HOW DPC CUTS COST AND IMPROVES QUALITY

DPC allows patients to receive the routine services they need (consultations, laboratory tests, preventive care, etc.) from a primary care doctor as frequently as they need against a monthly membership fee paid directly to the physician. No third parties are charged on a fee-for-service basis. The price of a single visit is lower than the periodic fee.[3]

In 2015, Colorado-based DigitalGlobe partnered with Colorado's first DPC provider, Nextera Healthcare, to facilitate a case study focused on reducing insurance costs for the company. DigitalGlobe enrolled 205 of its 971 Colorado-based employees into Nextera's DPC pilot program.[4] Over a seven-month period, DigitalGlobe employees saw a 25.4 percent drop in per-member per-month costs, compared to only a 4.1 percent reduction in costs among employees not participating in the DPC program.[5]

DPC clinics boast extended facetime with doctors, resulting in more comprehensive doctor-patient relationships and highlighting preventive care as a major aspect.[6] Evidence of this can be seen in the average length of a patient's visit: DPC physicians' visit times with patients average 30 to 60 minutes versus 12 to 15 minutes at a traditional primary care provider.[7] This is likely owing to a 40 percent reduction in administrative financial costs, as surveys show that almost half of traditional primary

2. Christopher Kerns and Dave Willis, "The Problem with U.S. Health Care Isn't a Shortage of Doctors," *Harvard Business Review*, March 16, 2020.
3. Eskew and Klink, "Direct Primary Care."
4. Nextera Healthcare, "Nextera Healthcare, DigitalGlobe Case Study Highlights Health Benefits, Cost Savings of Direct Primary Care. Double-Digit Reduction in Costs Leads to Company-Wide DPC Implementation for 2017," news release, February 5, 2019, https://nexterahealthcare.com/nextera-healthcare-digitalglobe-case-study-highlights-health-benefits-cost-savings-direct-primary-care-double-digit-reduction-costs-leads-company-wide-dpc-implementation-2017/.
5. Tamaan K. Osbourne-Roberts, Letter to Bill Lindsay, Colorado Commission on Affordable Healthcare, February 24, 2017, https://www.colorado.gov/pacific/sites/default/files/CAFP_DPC%20Recommendations%20to%20Cost%20Commission%20February%202017.pdf.
6. Ian Pelto, *Direct Primary Care: A New Way to Deliver Health Care* (Denver, CO: Colorado Health Institute, 2018).
7. Pelto, *Direct Primary Care*.

care doctors spend one-third of their day on data entry and one-half of a patient's visit inputting data into a computer.[8]

DPC, with its value-based healthcare delivery model, reduces the perverse incentives common in the fee-for-service reimbursement model. It addresses the inefficient use of physicians' time on administrative tasks, which is better utilized concentrating on patients' needs without the onerous burden of insurance-driven demands. DPC rewards providers for innovating, incentivizing them to achieve good outcomes while not dictating the means by which they do so, so long as it's cost effective and beneficial for patients.

However, physicians have expressed concern about adopting the DPC model. Pioneers of the model have faced aggressive state insurance commissioners who, deeming DPC an insurance product, threaten criminal prosecution for the unlawful sale of insurance.[9] Montana is one of the few states that has yet to authorize DPC in state law. Legally establishing that DPC does not constitute an insurance product ensures that DPC physicians are not burdened with the regulations and financial risk borne by insurance providers.

HOW MONTANA RESIDENTS WOULD BENEFIT FROM DPC

Montana residents—patients and physicians alike—stand to benefit from recognizing DPC as not an insurance product through passage of SB 101. It prohibits government programs and insurance companies from penalizing doctors solely because they offer DPC as an option to their patients. An additional benefit of the bill is that it allows all types of medical providers to use the direct care model, not just primary care providers. This is an exciting extension of an innovative model to specialty providers. From the perspective of physicians, the DPC model offers physicians a work-life balance that can hardly be found anywhere else in the medical world. Patients benefit as well: they receive the full attention of their doctor, have access to their doctor outside of work hours, and enjoy increased price transparency.[10]

8. Charlie Katebi, "Research & Commentary: Missouri Should Expand Direct Primary Access to Medicaid Patients," Heartland Institute, November 20, 2017.
9. Philip Eskew, "Direct Primary Care: A Legal and Regulatory Review of an Emerging Practice Model," Heartland Institute, January 1, 2015.
10. Philip Eskew, "In Defense of Direct Primary Care," *Family Practice Management* 23, no. 5 (2016): 12–14.