

## IMPROVING QUALITY AND REDUCING COSTS IN PRIMARY CARE

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Senate Committee on Health and Human Services

June 6, 2019

Dear Chair Testin, Vice Chair Kooyenga, and members of the Senate Committee on Health and Human Services:

My name is Darcy Bryan and I am an associate clinical professor at UC Riverside School of Medicine and an obstetrician gynecologist surgeon. I also conduct research on the impact of regulations on healthcare access, quality, and affordability. Thank you for the opportunity to testify regarding SB28 and the opportunities for healthcare delivery through direct primary care (DPC).

The country is in the midst of a primary care physician shortage, and the DPC model can serve to remedy this shortage. 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.<sup>1</sup>

This model allows physicians to take on a smaller panel size of patients (600–800 instead of the traditional primary care provider average of 2,300),<sup>2</sup> which, in turn, allows the doctor to spend more time with each patient. Patient visits average 30 to 60 minutes, compared to the 12 to 15 minutes observed for traditional primary care visits.<sup>3</sup> Consequently, administrative costs to the physician are 40 percent less than the industry average.<sup>4</sup>

However, many physicians are currently hesitant to open a DPC practice because of the threat of criminal prosecution for the unlawful sale of insurance.<sup>5</sup> As of March 2019, 23 states have already recognized this problem and enacted legislation establishing that DPC does not constitute an insurance product.<sup>6</sup> This ensures that DPC physicians are not burdened with the regulations and financial risk borne by insurance providers.

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<sup>1</sup> Philip M. Eskew and Kathleen Klink, “Direct Primary Care: Practice Distribution and Cost across the Nation,” *Journal of the American Board of Family Medicine* 28, no. 6 (2015): 793–801.

<sup>2</sup> Ian Pelto et al., *Direct Primary Care: A New Way to Deliver Health Care* (Denver, CO: Colorado Health Institute, 2018).

<sup>3</sup> Pelto et al., *Direct Primary Care*.

<sup>4</sup> Eskew and Klink, “Direct Primary Care.”

<sup>5</sup> Philip M. Eskew, *Direct Primary Care: A Legal and Regulatory Review of an Emerging Practice Model* (Arlington, Heights, IL: The Heartland Institute, 2015).

<sup>6</sup> DPC Frontier, DPC Frontier home page, accessed March 22, 2019, <https://www.dpcfrontier.com/states/>.

Wisconsin stands to gain from following suit and giving DPC the legal status it deserves. 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. The average physician spends over 10 hours a week handling administrative tasks, and 32 percent of physicians spend over 20 hours per week.<sup>7</sup> The DPC physicians, by contrast, are able to focus on the patient instead of spending half of each patient visit entering data.<sup>8</sup> Patients benefit as well: they receive the full attention of their doctor, have access to them outside of work hours, and enjoy increased price transparency.<sup>9</sup> Furthermore, important cost savings were observed as a result of scaling DPC. For example, savings of over \$1.4 million were achieved in Union County, North Carolina, as a result of individuals switching from their employers' consumer-directed health plans to DPC.<sup>10</sup> Clarifying the legal gray areas surrounding DPC can thus lead to lower overall healthcare costs without sacrificing quality of care provided to patients.

Sincerely,

Darcy Nikol Bryan, MD  
Associate Clinical Professor, UC Riverside School of Medicine

#### **ATTACHMENT**

Darcy Nikol Bryan, contribution to "Better Health for More People at Lower Cost, Year after Year" (Letter to Chairman Alexander) (Mercatus Center at George Mason University, Arlington, VA, February 28, 2019)

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<sup>7</sup> Tanya Albert Henry, "Do You Spend More Time on Administrative Tasks Than Your Peers?," *American Medical Association*, November 13, 2018.

<sup>8</sup> Charlie Katebi, "Research & Commentary: Missouri Should Expand Direct Primary Access to Medicaid Patients," *The Heartland Institute*, November 20, 2017.

<sup>9</sup> Philip M. Eskew, "In Defense of Direct Primary Care," *Family Practice Management* 23, no. 5 (2016): 12-14.

<sup>10</sup> Katherine Restrepo, "Direct Primary Care Helping North Carolina Public Sector Save Big on Health Care Claims: Part II," *Forbes*, July 19, 2016.

*From the Desk of Darcy Nikol Bryan*

February 28, 2019

Chairman Lamar Alexander  
United States Senate  
455 Dirksen Office Building  
Washington, DC 20510

Chairman Alexander,

Thank you for the opportunity to respond to your call for ideas on rising healthcare costs and to discuss direct primary care (DPC) with you. DPC is a practice and payment model where patients pay their physician or practice directly in the form of periodic payments, usually monthly or annually, for a defined set of primary care services that aim to address 90 percent of the reasons for which patients see a doctor.<sup>1</sup> A free-market solution, DPC lowers the costs of and access to primary care. It does so by eliminating fee-for-service payments and by encouraging more physicians to become primary care providers through a humane and flexible practice model rather than the crushing workload of volume-driven care and compliance with insurance administration demands. Given the variety of retainer practice models and the resulting legislative confusion, it is important to define DPC accurately. A DPC practice (1) charges a periodic fee for services (generally \$25 to \$85 per month),<sup>2</sup> (2) does not bill any third parties on a fee-for-service basis, and (3) assesses any per-visit charges at less than the monthly equivalent of the periodic fee.<sup>3</sup> Through this mechanism, DPC practices claim to reduce administrative overhead by approximately 40 percent.<sup>4</sup> Patients can join a DPC practice without regard to their insurance or socioeconomic status. Doctors may see a smaller volume of patients in clinic through use of telemedicine and secured email exchange, while targeting longer in-person appointments for patients with complex needs. As a supplement, patients are encouraged to enroll in a catastrophic health plan that meets federal medical insurance requirements.

DPC clinics boast extended facetime with doctors, resulting in more comprehensive doctor-patient relationships highlighting preventative care as a major aspect.<sup>5</sup> 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.<sup>6</sup> This is likely owing to a 40 percent reduction in administrative overhead, as surveys show that almost half of traditional primary care

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<sup>1</sup> Qliance, "New Primary Care Model Delivers 20 Percent Lower Overall Healthcare Costs, Increases Patient Satisfaction and Delivers Better Care," news release, January 15, 2015, <https://www.prnewswire.com/news-releases/new-primary-care-mode-l-delivers-20-percent-lower-overall-healthcare-costs-increases-patient-satisfaction-and-delivers-better-care-300021116.html>.

<sup>2</sup> Charlotte Huff, "Direct Primary Care: Concierge Care for the Masses," *Health Affairs* 34, no. 12 (2015): 2016-19.

<sup>3</sup> Phillip Eskew and Kathleen Klink, "Direct Primary Care: Practice Distribution and Cost across the Nation," *Journal of the American Board of Family Medicine* 28, no. 6 (2015): 793-801.

<sup>4</sup> Eskew and Klink, "Direct Primary Care."

<sup>5</sup> Ian Pelto, *Direct Primary Care: A New Way to Deliver Health Care* (Denver, CO: Colorado Health Institute, 2018).

<sup>6</sup> Pelto, *Direct Primary Care*.

doctors spend one-third of their day on data entry and one-half of a patient's visit inputting data into a computer.<sup>7</sup> Lengthening average visit times and strengthening doctor-patient relationships in DPC could also be explained by the smaller average patient panel size, or the number of patients a physician serves. DPC physicians typically have an average panel size of 600–800 patients, compared to an average panel size of 2,300 patients at traditional primary care providers.<sup>8</sup>

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.<sup>9</sup> 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 the employees not participating in the DPC program.<sup>10</sup> In 2017, the Colorado Academy of Family Physicians wrote a letter to the Colorado Commission of Affordable Healthcare to "initiate a Health First Colorado (Medicaid) DPC pilot program similar to the Qliance DPC program in the State of Washington."<sup>11</sup> The state of Michigan has applied to the Centers for Medicare & Medicaid Services for a waiver allowing a DPC pilot program for Medicaid enrollees.<sup>12</sup> Similar calls have been made for allowing Missouri Medicaid patients to have access to the DPC model.<sup>13</sup>

However, there is a real concern among physicians about adopting the DPC model. Pioneers of the model have faced aggressive state insurance commissioners who threaten criminal prosecution for the unlawful sale of insurance, deeming DPC an insurance product.<sup>14</sup> Per state commissioners' analysis, too much risk was being transferred from patient to physician for a fixed monthly fee, with the following concerns: What might happen should too many ill patients need to be seen at once by a DPC physician? What guarantees could be made that care would be delivered as promised?

The DPC movement has responded by advocating for state-level protective legislation clarifying that DPC is not an insurance product, along with other measures protecting the ability of physicians and patients to access this model. Currently a small number of states have laws protecting DPC practices against complex insurance regulations.<sup>15</sup> The Affordable Care Act (ACA) contains a provision stating that the US Department of Health and Human Services "shall permit a qualified health plan to provide coverage through a qualified direct primary care medical home plan that meets criteria established by the Secretary."<sup>16</sup> Additionally, the ACA allows for DPC

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<sup>7</sup> Charlie Katebi, "Research & Commentary: Missouri Should Expand Direct Primary Access to Medicaid Patients," The Heartland Institute, November 20, 2017.

<sup>8</sup> Ian Pelto, *Direct Primary Care*.

<sup>9</sup> 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/>.

<sup>10</sup> 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](https://www.colorado.gov/pacific/sites/default/files/CAFP_DPC%20Recommendations%20to%20Cost%20Commission%20February%202017.pdf).

<sup>11</sup> Osbourne-Roberts, Letter to Bill Lindsay.

<sup>12</sup> Michigan Department of Health & Human Services, *Implementation of the Direct Primary Care Pilot Program Quarterly Report 1*, January 19, 2018, [https://www.michigan.gov/documents/mdhhs/Section\\_14078\\_PA\\_158\\_of\\_2017\\_Quarterly\\_Rpt\\_1\\_614860\\_7.pdf](https://www.michigan.gov/documents/mdhhs/Section_14078_PA_158_of_2017_Quarterly_Rpt_1_614860_7.pdf).

<sup>13</sup> Katebi, "Research & Commentary."

<sup>14</sup> Philip Eskew, "Direct Primary Care: A Legal and Regulatory Review of an Emerging Practice Model," The Heartland Institute, January 1, 2015.

<sup>15</sup> Bill Kramer, "Direct Primary Care: The Future of Health Care?," *MultiState Insider*, April 1, 2015.

<sup>16</sup> Eskew, "Direct Primary Care."

practices to be marketed in state exchanges as long as they are combined with a “wrap around” insurance policy that will cover other medical costs such as catastrophic care.<sup>17</sup>

Sincerely,

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<sup>17</sup> Huff, “Direct Primary Care: Concierge Care for the Masses.”