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Charlotte Huff

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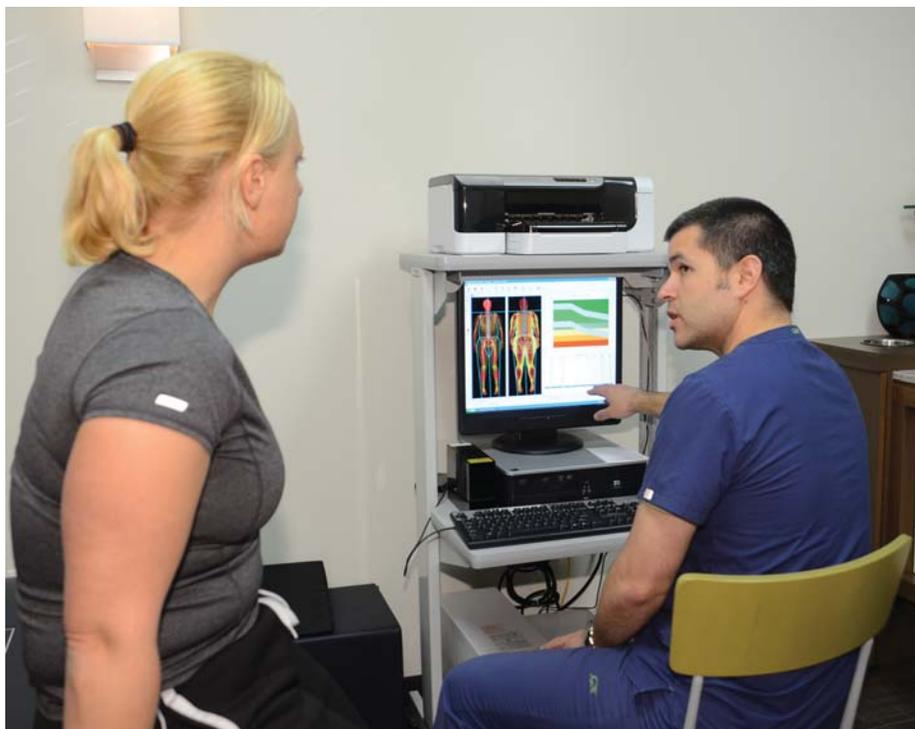
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ENTRY POINT



Direct care: Doug Nunamaker, a physician with Atlas Medical, a direct primary care practice in Wichita, Kansas, discusses weight management, body mass index, and health issues with a patient, Jeanette Reeder. Atlas charges a monthly membership fee and does not bill insurers for the care it provides. Each physician in the practice sees about 500 patients—far fewer than most traditional practices.

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Direct Primary Care: Concierge Care For The Masses

Direct primary care represents a new model for providers eager to spend more time with fewer patients and bypass insurance headaches.

BY CHARLOTTE HUFF

Steven Manning had been working at a hospital-owned practice for about two years and had been growing increasingly disenchanted with the level of care he could provide to 25–30 patients a day, many with mul-

tiple medical problems. “On those days I would walk out and sort of have this gut feeling that I’d missed something,” says Manning, a family physician in rural eastern North Carolina. “I often couldn’t pinpoint what that was. And I didn’t like that.”

Working on medical charts in his Williamston, North Carolina, office late one night in 2013, Manning suddenly recalled a presentation that another family physician had made to his residency program a few years earlier about a new style of practice called direct primary care. Within a year, Manning had opened the doors of his own direct primary care clinic, AccessMedicine.

Sometimes dubbed “concierge care for the masses” by proponents, direct primary care refers to an emerging style of physician practice that’s driven in part by the frustration of patients and doctors alike about treatment time constraints. But the approach has met with skepticism in some quarters, with concerns that it could aggravate the shortage of primary care doctors and lead to a two-tier health system.

For a monthly fee, generally \$25 to \$85,¹ patients can get all of their primary care covered—from an annual physical to treatment for various maladies and screening tests—with little or nothing more out of pocket. Neither the doctor nor the patient bills an insurer. However, direct primary care practices encourage patients to carry some kind of coverage for big-ticket items such as surgeries and cancer treatment.

Scarcely a decade old, the model appears to be gaining traction, particularly in the past few years. Data about the number of direct primary care practices and their overall cost-effectiveness remain limited. Nonetheless, the approach has attracted some prominent backers, including the American Academy of Family Physicians (AAFP).² By mid-2015 laws had been changed in at least thirteen states to enable the approach—which looks a lot like insurance to patients but is not—to be used outside the oversight of state insurance regulators.³ Federal legislation called the Primary Care Enhancement Act has been introduced that would further reduce some of the obstacles that enthusiasts say limits the expansion of these practices, such as allowing patients with health savings accounts to use those funds to pay the monthly fees.⁴

By not billing insurers, doctors say that they're able to sharply reduce staff and other overhead costs, which allows them to still earn a living while treating a smaller panel of patients—generally 600–800 versus at least 2,000 patients for a traditional practice, according to the AAFP.⁵ Thus, doctors can step off the “hamster wheel” of packing an increasing number of appointments into the same number of hours to offset lower reimbursement rates.

The feeling of going through a turnstile in many doctors' offices is not lost on patients like Bill Benjamin, who signed up for Manning's practice earlier this year. “All of the other doctors—it's sort of like a cattle call, where they try to get as many people through so they can charge them,” says Benjamin, a fifty-two-year-old who has diabetes.

With the increasing proliferation of high-deductible plans, proponents argue that the time might be right for this fee-based approach. Patients with higher deductibles are paying more out of pocket, and they're searching for more value for their buck. Nearly one-fourth of US workers are covered by a high-deductible plan with some type of savings option, such as a health savings account, according to data from the 2015 Kaiser Family Foundation/Health Research and Educational Trust Employer Health Benefits Survey.⁶ High-deductible plans also are being sold on the Affordable Care Act (ACA) health insurance exchanges.

However, the launching of direct primary care practices presents challenges not only for those doctors attempting to switch to the new approach, but potentially also for the US health system if the approach attracts a substantial number of adherents. **To be successful, doctors like Manning first have to convince patients that the treatment benefits are significant enough to justify the monthly fees, which sometimes are on top of insurance premiums.**

Michael Gusmano, a research scholar at the Hastings Center, also worries about the potential impact on the physician workforce. Given that direct primary care practices treat fewer patients than the long-standing traditional model, the approach could worsen doctor shortages in years to come, he says. Meanwhile, patients might get caught

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short financially if their medical problems exceed the basics of primary care. “I'd want to know exactly if people understand what they are signing up for and how limited are the range of services that fall into this,” Gusmano says.

Practicing Directly

Direct primary care comes in various flavors, but broadly speaking the term refers to practices that don't bill insurers for a range of primary care services—anything from the annual physical and treatment for pneumonia or a skin rash to ongoing care for diabetes. In return, the patient pays a fee, typically every month. Depending upon the practice's approach, the patient may pay an additional small fee for each office visit and for lab tests or a specific service such as a home visit. Benjamin says that he pays \$40 monthly and \$20 for each visit. In return, he typically spends forty-five minutes with Manning as they strive to improve his blood sugar control, compared to the ten minutes Benjamin usually spent with his previous doctor.

Just 2 percent of physicians report practicing in a direct primary care setting, but another 7 percent are assessing whether to make the switch, according to a 2014 physician practice survey by the AAFP.⁷ A 2015 survey reported even higher levels of interest, finding that 10 percent of doctors were either working in direct primary care or planning to transition to it, with an additional 43 percent contemplating such a move.⁸

Mike Stevenson was practicing family medicine at top speed at a large Missouri practice, seeing 45–55 patients a day in appointments that frequently ran no longer than 5–7 minutes. One patient called them “peek-a-boo appointments,” he says. Worn out and haunted by the thought that he might miss a serious medical problem, he left the

practice and started working in an emergency department while he figured out what to do next. Soon afterward, the first Direct Primary Care Summit was held in 2013 in nearby St. Louis, and Stevenson's wife decided to check it out as they brainstormed about what path he should pursue next. “She came back and said, ‘I've got your problem figured out,’” he says.

The following year Stevenson opened his direct primary care practice in Poplar Bluff, Missouri, one that he's still building. Roughly one-third of his patients who pay the monthly fees lack insurance, he says, but at least he knows that “they've got good basic sound primary care.”

Still, how does this fee-based treatment model compare with concierge services, which also charge some type of retainer? **One key difference is that concierge practices will frequently bill a patient's insurer, while direct care practices don't deal with insurers at all, public or private, says Brian Forrest, a family physician in Apex, North Carolina, who in 2002 launched one of the first direct primary care practices.**

Another difference, according to Forrest, is that fees for direct primary care practices are lower than those for concierge practices. Typically fees for direct primary care are less than \$100 a month, Forrest says, and concierge practices, in addition to billing insurance, charge more than that—sometimes significantly more. His practice fees start at \$45 monthly, he says.

As a result, direct primary care practices serve a more socioeconomically diverse patient population, according to Forrest. “If you were to go into a direct primary care practice, you would commonly see uninsured patients and potentially even indigent homeless patients in the waiting room,” he says. “You're never going to see those people in a concierge medical practice waiting room.”

In late 2013, the same year that the first Direct Primary Care Summit was held, Forrest gave a presentation to the AAFP's board. He recalls a few hours of “getting grilled” by members who were initially skeptical that the approach differed much from concierge care. Wanda Filer, the current AAFP president, attended that meeting and until then

had known little about the model. She remembers being fascinated. “Both from a patient care and a cost-efficiency model, it looked really solid,” she says.

By scaling back the number of patients doctors are responsible for, Filer says, direct primary care has the potential to stave off burnout, reduce early retirement, and inspire more medical students to pursue primary care by making “family medicine sexy again.”

The AAFP has become a prominent advocate of direct primary care, even publicly supporting the Primary Care Enhancement Act.^{2,4}

Direct primary care has been adopted not only by small independent practices such as Forrest’s and Manning’s, but also by larger practices and companies with more national aspirations such as Iora Health, MedLion, and Qliance, according to an issue brief by the California HealthCare Foundation.⁹ Whereas small practices tend to get the bulk of their fees from patients, the larger groups are more likely to contract with employers and unions, who then pick up the employee tab for the monthly fees, Forrest says.

Qliance started in 2007¹⁰ and now reaches 25,000 patients through five primary clinics in the Seattle, Washington, area. It generally contracts directly with employers such as Expedia, Brown & Haley, and Glacier Fish Company, according to Erika Bliss, Qliance’s president and chief executive officer.

Convincing individuals to pay separately for primary care on top of their insurance premiums—no matter how comprehensive the care—is a “hard sell,” Bliss says. As a result, Qliance contracts primarily with employers and unions. She argues that the approach increases treatment accountability: “If any employee complains to the company, then it puts hundreds of thousands of people at risk for us.”

Patient Implications

Given the recent advent of direct primary care, data on the scope of its market remain limited, according to Michael Tetreault, editor of the *Direct Primary Care Journal*. The publication conducted an online survey earlier this year that provides a snapshot of the demographic characteristics of participants based on responses from 147 self-identified direct

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primary care practices. The survey found that 83 percent of direct primary care physicians specialize in family medicine or internal medicine, patients are typically Gen Xers or millennials and have an annual household income of less than \$95,000, and two-thirds of the practices have monthly fees ranging from \$25 to \$85.¹

Although not as high as the fees of concierge practices, those monthly costs are “not incidental,” says Robert Berenson, a fellow at the Urban Institute, in Washington, D.C. “Fifty dollars a month is a lot of money for a lot of people, when they are already either paying for insurance or it’s being taken out of their wages,” he says. But some patients can afford that amount if they prioritize, counters Forrest, pointing out that a carton of cigarettes costs roughly \$50 in North Carolina.

Berenson, a general internist, expresses sympathy for primary care doctors who want to dial back the hectic pace of practice. But, he says, the solution is to work within the current system to better compensate primary care doctors for the work they’re already doing, instead of having doctors jettison insurance entirely.

Shedding ties to insurance, though, allows doctors to personalize care without reimbursement constraints, says Bruce Jung, a physician who opened a direct primary care practice last year in Corbin, Kentucky. Sometimes a simple phone call or text exchange with the doctor is all the patient needs, and an office visit is unnecessary. Yet under traditional fee-for-service, “you don’t get paid unless they walk in the doggone door,” Jung says.

The website of Jung’s practice, called the Doc Shoppe, has a per service price list adjacent to one that highlights what the monthly membership encompasses.¹¹ By offering the option of per service charges, Jung says that he hopes

to convince patients of the value of becoming a monthly paying member—particularly those people with high-deductible plans who are already paying for basic services out of pocket anyway. Jung’s plan is to build a practice of 600 patients who pay the \$50 monthly fee; he reports that he’s roughly halfway there.

But will direct primary care practices be more cost-effective in treating patients than the traditional fee-for-service approach? The relevant data still come largely from providers. In an analysis released in early 2015, Qliance reported that its patients’ health care costs were nearly 20 percent lower than the costs of people being treated elsewhere. The company attributed the lower costs largely to reduced hospitalizations and specialist visits.¹²

One potential risk, though, is that by charging a flat monthly fee regardless of the primary care provided, the direct primary care model could encourage specialist referrals by some doctors, Berenson notes. “The incentive—and I’m not saying all docs will follow this incentive—is to take the money and not see the patient,” he says.

Primary care doctors say that there are a lot of conditions that they can treat within a direct primary care practice and, with the additional time they have to devote to each patient, they can assist people who require specialty care. Stevenson describes one situation in which a patient had a foot fracture and needed to see a podiatrist. With the help of his medical assistant, Stevenson worked out a more affordable rate with a local podiatrist than the patient would have been charged otherwise, he says.

Jung says that he negotiated with a local orthopedic surgeon to read straightforward x-rays for \$40 to \$100—lower than the \$600 minimum that he was quoted by a nearby hospital. Jung also located a site in Lexington, Kentucky, where patients pay far less for magnetic resonance imaging (MRI) than if they got the image locally. “I tell my patients, ‘Look, I can save you \$3,000 on an MRI if you want to go to Lexington.’” Despite the three-hour round trip, most people opt to invest the time and gas, Jung says.

Ripple Effects?

A provision in the ACA allows direct primary care practices to be marketed in the exchanges, as long as they are packaged with an insurance policy that will cover other medical costs, including catastrophic care.¹³ The Qliance direct primary care practice is sold on Washington State's health exchange.¹⁴

Washington is one of at least thirteen states to have passed laws stipulating that direct primary care is not a form of insurance and thus not subject to state insurance regulations, according to the Direct Primary Care Coalition, an advocacy group. In August Sen. Bill Cassidy (R-LA) and Sen. Maria Cantwell (D-WA) introduced the Primary Care Enhancement Act,⁴ which includes language similar to that in most of the re-

cent state laws stipulating that direct primary care is not a form of insurance.

For doctors already in practice, moving to a direct primary care model can require a financial and emotional leap of faith, says Filer of the AAFP. It requires "some willingness to accept significant financial risk" by leaving insurance reimbursement behind. Moreover, many patients will be unable or unwilling to follow the doctors, which is another problem. "It's tough. We don't typically walk away from patients," she says.

Although such dramatic change can be daunting, the promise of a less hurried and more therapeutic relationship with one's patients is tempting enough for some physicians to go all out for the new approach.

Before Manning opened his direct pri-

mary care practice last year, he mailed letters to his panel of 3,000 patients explaining the concept and inviting them to an informational meeting, one that also featured Forrest—who offered the perspective of a physician already engaged in a direct primary care practice. Between 300 and 400 of Manning's patients attended, he estimates, and about 200 signed a list expressing some interest. Today, Manning is treating at least 100 of the original 3,000 at his new practice, which now has roughly 400 patients. His goal: to treat 800 to 1,000 people in this new model of care. ■

Charlotte Huff (charlotte@charlottehuff.com) is a health and business journalist based in Fort Worth, Texas.

NOTES

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