Direct Primary Care—An Innovative Solution to Alleviate the Decline of Primary Care Physicians

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Primary care physicians are the foundation of our health system; they are the initial point of contact for patients seeking medical care, they are the first line of defense against common medical conditions, and they act as a gatekeeper when more specialized services are required.

Primary care physicians also are a dying breed. The United States has a low proportion of primary care and family physicians compared to medical specialists. Only one in three physicians practice primary care and one in six medical graduates choose primary care.[1] This year, the Association of American Medical Colleges requisitioned a study that ultimately projected a shortfall of between 12,500 and 31,100 primary care physicians by 2025.[2]

The national primary care physician exodus is rooted in financial concerns and administrative headaches. Medicare and commercial payers reimburse medical specialist services at much higher rates than primary care services. Primary care physicians also are routinely frustrated by the administrative overhead costs of running a practice. Hospitals and hospital-owned physician practices have traditionally benefitted from their ability to bill for "facility fees," which are intended to cover overhead costs. Freestanding physician offices, however, are left to cover overhead costs on their own, often spending 60% or higher of all revenue on overhead, much of which is dedicated toward simply getting paid for medical services provided. Billing for medical services requires navigating complex billing codes, submitting pre-authorization requests and medical necessity documentation, participating in quality assurance programs, haggling with carriers over reimbursement rates, and engaging in other time-consuming administrative activities. Hospitals and health systems are increasingly acquiring primary care physician practices, resulting in increased cost to patients (due to the practice's newfound ability to charge a facility fee) and diminished practitioner independence. Even hospital-based physician practices may see a decrease in overhead reimbursement as "facility fees" are increasingly subjected to national scrutiny.

New heightened regulatory requirements will only increase the need for back-end office support, potentially exacerbating the primary care shortage. As of October 1, all health care providers were required to implement International Classification of Diseases (ICD)-10 to file claims with Medicare, Medicaid, and commercial insurers. The new code set includes five times more codes than its predecessor, allowing providers to be more precise in classifying and requesting reimbursement for various conditions (implemented just in time for Thanksgiving, ICD-10 includes specific codes for being pecked by a turkey or being crushed, pushed, or stepped on by aggressive Black Friday shoppers).[3] The added complexities, however, increase billing time and effort, thereby detracting from the time physicians can spend with their patients. Similar concerns loom with the Centers for Medicare & Medicaid Services' (CMS') release of the final Stage 3 Meaningful Use (Stage 3) regulations on October 16, 2015.[4] The regulations provide financial incentives to eligible health care providers for "meaningful use" of certified electronic health record technology. Although Stage 3 is not mandatory until 2018, providers are apprehensive about the administrative effort required to achieve compliance.[5]

While the supply of primary care continues to diminish, demand for primary care services is growing, causing a considerable strain on our health system. Primary care visits account for 55% of the 1 billion physician office visits per year.[6] The Affordable Care Act (ACA), which was intended to increase access to health care, in part, through an employer mandate to provide health insurance and an individual mandate to purchase health insurance, triggered a net gain of 16.9 million more insured Americans.[7] Considering the wait time for the typical primary care appointment, it quickly becomes apparent that innovation is needed to alleviate the "bottlenecking" of primary care services.

One attempt at such innovation is Direct Primary Care (DPC), a physician practice model in which the practice does not accept insurance. Instead of contracting with insurance companies, the practice contracts directly with its patients so that the patients pay a monthly "retainer" fee for unlimited primary care services, in addition to a smaller fee per office visit. DPC providers also may make available additional basic ancillary services (i.e., lab services or limited radiologic testing) free of charge. A 2015 study of 141 DPC practices with 273 locations spanning 39 states reported that the average monthly cost to DPC patients is $93.26.[8]

The obvious benefit to DPC providers is the elimination of complex billing for services, resulting in significantly less administrative effort and cost. DPC practices claim to reduce overhead by more than 40%.[9] Patients also benefit from the model—with a steady stream of revenue and more time available to provide actual medical care, DPC practitioners often reduce their patient population by 50%, but offer more personalized and comprehensive health care (longer office visits and same-day appointments). Additionally, DPC eliminates any incentive for overutilization, which is inherent in any fee-for-service payment model.

The major downside to DPC is that the retainer fee only entitles the patients to primary care services. When a patient requires a referral for non-covered specialized medical services, however, the practice often refers care to specialists who offer relatively low out-of-pocket charges. In other words, the patients may benefit from the provider negotiating on their behalf. DPC patients often couple DPC coverage with a high-deductible "wrap-around" policy, which would kick-in to cover non-primary care services or catastrophic events. In fact, the ACA included regulations that explicitly permit DPC providers to participate in the mandated state insurance exchanges through a qualified health plan.[10]

DPC, though not yet a household concept, is gaining momentum. According to a Government Accountability Office report, there were 146 DPC providers nationwide in 2005.[11] The number grew to 4,400 in 2012.[12] A study last year projected that 10% of all primary care providers would switch to a DPC model within the next three years.[13] Health care attorneys that represent family practices should be prepared to discuss a number of legal and practical considerations when (not if) a client inquires.

One major legal consideration is whether a DPC provider is deemed to be "insuring" patients, and thus subject to insurance industry regulations. Primary care physicians are not able to meet insurance requirements, such as establishing and maintaining reserves, so a determination that DPC falls outside the scope of insurance regulation is critical. ACA commentary in the *Federal Register* indicates that DPC is not insurance, but this has not exonerated DPC providers from scrutiny by state insurance departments.[14] For example, a *New York Times* article in 2010 details the experience of one DPC provider, AMG Medical Group (AMG), which was subjected to insurance department interference. Initially, AMG charged patients $79 per month, but the Insurance Department deemed this to be the unauthorized provision of insurance. The Department determined that the practice's profit margin was too low to provide coverage in certain unexpected situations (i.e., 500 patients presenting to the practice with the flu) —akin to a determination that an insurance company failed to establish adequate reserves. The article reports that a compromise was reached whereby the practice agreed to increase its "reserves" by charging an additional $33 fee per sick visit.[15]

The following 13 states have enacted "DPC as insurance" regulations to define appropriate parameters for practice (with varying levels of detail and potential success): Arizona, Idaho, Kansas, Louisiana, Michigan, Mississippi, Missouri, Oklahoma, Oregon, Texas, Utah, Washington, and West Virginia.[16] Washington's DPC legislation is widely considered precedential—it not only exempts DPC providers from insurance regulation, but also provides a detailed definition of DPC, regulates the payment of monthly retainer fees, prohibits discrimination based solely on a prospective patient's health status, requires DPC providers to submit annual statements to the insurance commissioner, and requires contracts for DPC services to include a disclaimer that DPC does not provide comprehensive health insurance coverage.[17] On the other side of the DPC legislation spectrum, Arizona Revised Statutes § 20-123 simply purport to exempt DPC from insurance regulations, but the caveat that DPC providers are exempt only "if the plan does not assume financial risk" threatens to render the exemption irrelevant.

Unfortunately, insurance companies have been hesitant to couple with DPC providers on state health insurance exchanges. Doing so requires developing a new product offering resulting in less revenue to the company (high deductible plans come at lower premiums than comprehensive health insurance, which is the current standard). Anticipating this concern, several commentators recommended that the U.S. Department of Health and Human Services (HHS) offer incentives for insurance companies to contract with DPC providers or mandate that a certain percentage of issuers be required to contract with DPC providers, but HHS ultimately declined to pursue either measure.[18]

Insurance companies also may be deterred from partnering with DPC providers on the exchanges due to uncertainty surrounding the qualifications DPC providers must meet for such participation. HHS' regulations permit qualified health plans to provide coverage on the exchanges through a DPC provider "that meets criteria established by HHS." During the public comment period, HHS solicited input on what DPC criteria it should establish.[19] Several commentators recommended that DPC providers be accredited or comply with existing industry standards such as the Joint Principles of the Patient-Centered Medical Home developed by the Patient Centered Primary Care Collaborative. HHS ultimately responded by declining to mandate accreditation or compliance with any existing industry standards, writing instead that it intended "to encourage, rather than limit, innovative care models."[20] By declining to provide concrete standards, HHS may have stunted the evolution of DPC, instead of advancing innovation.

The Internal Revenue Code (IRC), which was drafted prior to, and without consideration for, DPC, also limits the effectiveness of the ACA's attempt to assimilate DPC providers into the state insurance exchanges. Section 223(c) of the IRC restricts the availability of Health Savings Accounts (HSAs) to "eligible" individuals. Individuals are eligible only if they are covered by a high deductible health plan and not covered under any other health plan that provides coverage for any benefit that is covered under the high deductible plan. The Internal Revenue Service has not clarified whether it deems DPC to be a prohibited second health plan, which would prohibit HSA holders from pairing with DPC providers. Moreover, HSA accounts may only be used to pay for "qualified medical expenses" defined in Section 213(d) of the IRC, which does not currently include payments for DPC. Senator Bill Cassidy, MD (R-LA) has introduced the Primary Care Enhancement Act of 2015, which would revise the IRC to clarify that: (1) HSA holders are not prohibited from having a relationship with a DPC provider; and (2) payments to a DPC provider are "qualified medical expenses." This legislation would facilitate DPC expansion by establishing HSA holders as potential DPC consumers.

Finally, as a practical matter, it is difficult for established physician practices to completely disentangle themselves from insurance carriers. Large networks of providers have significant leverage when negotiating contracts with managed care companies, but small family practices have almost none. Physician practices often are stuck with contract terms that favor the managed care company, including adhesive termination provisions. DPC providers also will need to decide whether or not to opt out of Medicare. Medicare's balance billing prohibition precludes providers from charging patients for a covered service (i.e., a monthly retainer fee) and subsequently billing Medicare for the same. DPC providers have three options in this regard: (1) they can opt out of Medicare and Medicaid completely (if it is financially feasible to lose all government health care program reimbursement); (2) they can have the retainer fee only cover services not otherwise covered by Medicare or Medicaid (if the patient sees the value in such additional coverage provided by the retainer fee); or (3) they can continue participating in Medicare (which would limit the benefits of adopting the DPC model because some billing efforts would still be required). The Medicare Access and CHIP Reauthorization Act of 2015 made opting out of Medicare easier by repealing the requirement of having to renew opt-out status every two years. Opting out also provides the added benefit of decreasing exposure under the Stark Law and Anti-Kickback Statute. Notably, the Primary Care Enhancement Act of 2015, discussed above, would establish DPC as an alternative payment model for Medicare. Specifically, it would establish a Medicare demonstration program under which CMS would pay a qualified DPC provider a periodic fee for furnishing DPC services to a Medicare Part B beneficiary.

Barriers remain to widespread proliferation of the DPC model, but with careful planning and a sufficient patient base, it could make running a family practice more finan-

cially rewarding and increase the job satisfaction of family physicians. If DPC experiences sustained success, it would have the potential to reverse the trend of the declining availability of family physicians and would result in more comprehensive and personalized health care services than our current fee-for-service model allows.

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9 *Id*.

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15 Kaminer, Ariel. *A Health Care Plan So Cheap, They Made Him Raise the Price*. The New York Times, March 19, 2010.

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17 Wash. Rev. Code § 48.150.

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19 76 Fed. Reg. 41866, 41900.

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