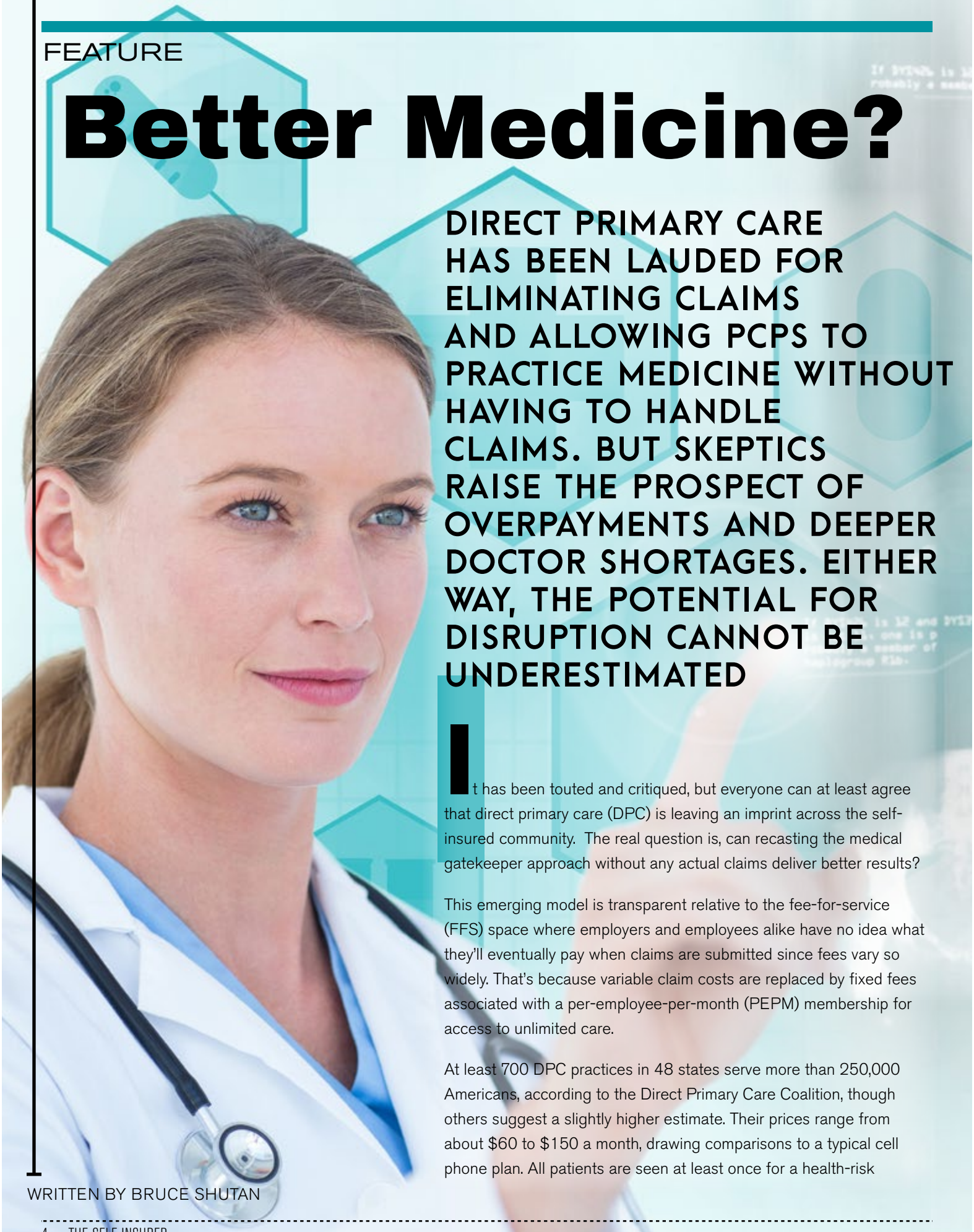
FEATURE

Better Medicine?



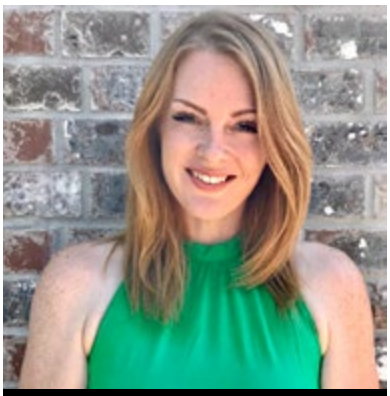
DIRECT PRIMARY CARE HAS BEEN LAUDED FOR ELIMINATING CLAIMS AND ALLOWING PCPS TO PRACTICE MEDICINE WITHOUT HAVING TO HANDLE CLAIMS. BUT SKEPTICS RAISE THE PROSPECT OF OVERPAYMENTS AND DEEPER DOCTOR SHORTAGES. EITHER WAY, THE POTENTIAL FOR DISRUPTION CANNOT BE UNDERESTIMATED

It has been touted and critiqued, but everyone can at least agree that direct primary care (DPC) is leaving an imprint across the self-insured community. The real question is, can recasting the medical gatekeeper approach without any actual claims deliver better results?

This emerging model is transparent relative to the fee-for-service (FFS) space where employers and employees alike have no idea what they'll eventually pay when claims are submitted since fees vary so widely. That's because variable claim costs are replaced by fixed fees associated with a per-employee-per-month (PEPM) membership for access to unlimited care.

At least 700 DPC practices in 48 states serve more than 250,000 Americans, according to the Direct Primary Care Coalition, though others suggest a slightly higher estimate. Their prices range from about $60 to $150 a month, drawing comparisons to a typical cell phone plan. All patients are seen at least once for a health-risk

WRITTEN BY BRUCE SHUTAN


Emma Passé

assessment, while sicker members can go as often as needed. The flat-rate pricing model is also seen as a talent-management tool in tight labor markets amid mounting consumer confusion and frustration over their health care.

Proponents suggest that a subscription approach is superior to FFS. A key selling point is no wait times or rushing patients out the door, as well as an ability to leverage telehealth services and identify behavioral health concerns before they turn into costly claims.

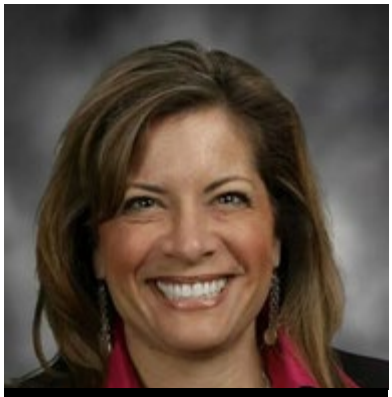
By investing in DPC, they say self-insured employers could reap huge dividends in terms of fewer surgeries, urgent care and ER visits, as well as eliminating overused health care services. They note that primary care physicians (PCPs) are positioned to handle up to 80% of all care needs under this nascent model, which also offers stop-loss carrier underwriters greater visibility of claims that can translate into 10% to 15% lower rates for employer customers.

"DPC doctors spend so much less time dealing with medical records and submission of claims that they spend so much more time practicing medicine," explains Emma Passé, an account executive for EBMS, a TPA.

However, critics argue that DPC could exacerbate an already chronic shortage of PCPs and spike rates in the individual insurance market by luring away healthy patients. Another concern is that people overpaying for their health care if they're charged a membership fee and also incur claim costs. In addition, the DPC movement has experienced recent setbacks. Two leading industry players, Seattle-based Qliance and Las Vegas-based Turntable Health, shuttered in 2017.

Since not all DPC practices are the same, producing contracting standards or industry benchmarks is complicated by varying clinical services and pricing structures. However, there are several baselines to consider. For example, providers must be properly licensed and insured and offer set hours for accessibility by patients, says Dan Thompson, founder and CEO of the Clinical Wellness Network.

Mindful of these wild inconsistencies, all DPC practices in his network offer the same list of services with less than 2% variation. Doing so "translates better into something that's actually sellable to an employer," he explains.

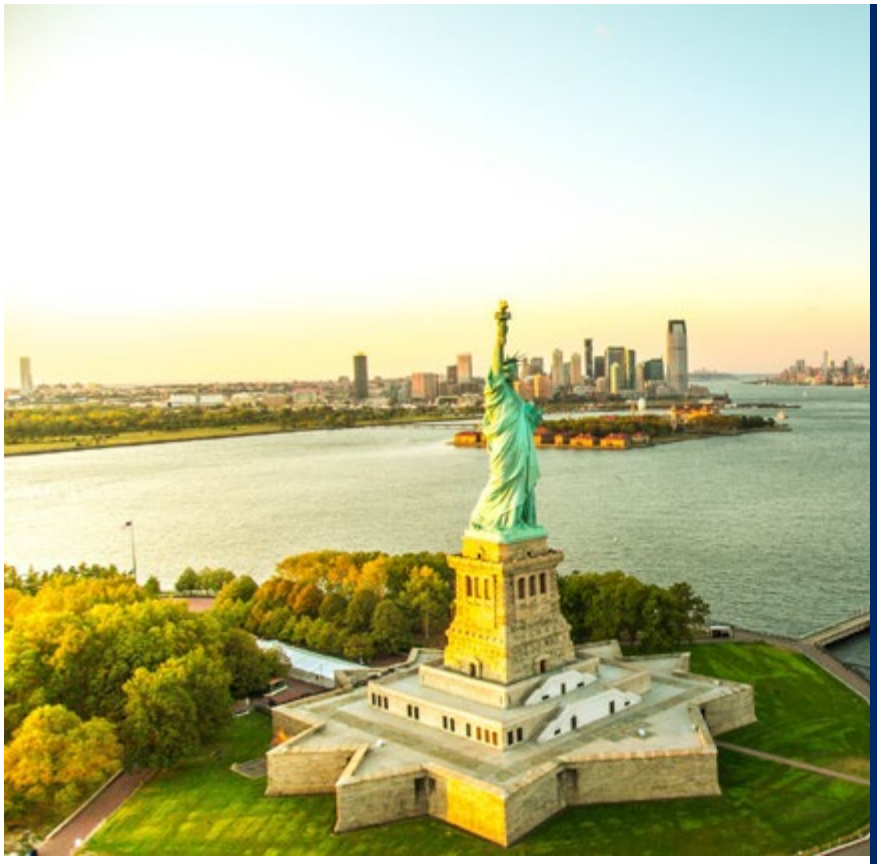

Christine Vago

COURTING FRUSTRATED PHYSICIANS

Stark marketplace realities are driving the re-imagination of primary care. Look no further than health care costs rising to unsustainable levels alongside high physician burnout. Both have set the stage for the DPC movement, notes Christine Vago, SVP for OneBeacon Health. "Satisfaction in the health care system for both patients and physicians has declined as quickly as costs have increased," she says.

But physician buy-in is critical to the success of DPC entities. That means convincing risk-averse PCPs that their compensation for services rendered will be fair and reasonable. In addition to receiving a fixed rate for managing patients, it also could help if these practices are able to incorporate incentives based on management of the total cost of care for employee populations, according to Glenn McLellan, president of McLellan Consulting Services. That will make "the DPC entity more interested in integrating with the remainder of the plan," he says.

Although a DPC plan member himself, as well as a supporter of the concept, he's unconvinced that it's a meaningful strategy for payers and describes it as an island unto itself. More of his clients are dabbling in onsite clinics and patient-centered medical homes than DPC. Also, he cautions that nearly all of the model's metrics reporting is focused on patient satisfaction when it needs to include quality considerations such as improved outcomes.



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DPC can be traced back to the late 1990s when it began as a costly white-glove service known as concierge medicine until about the middle 2000s at which time lower price points were introduced, according to Alex Lickerman, M.D., founder and CEO of a DPC practice called ImagineMD.

While acknowledging that abruptly replacing FFS with a DPC model would exacerbate the nation's PCP shortage, Lickerman argues that it would be temporary and there's an even bigger problem lurking within the status quo. Medical school students who are saddled with six-figure student loan debt realize they can't make money in primary care and the lifestyle is disastrous, he explains. "If we don't do something to make primary care look really attractive to new doctors, the shortage is going to be even worse," he adds.


Adam Russo

HOW TO STRUCTURE PRACTICES

Perhaps no one realizes the power of DPC better than new SIIA Chairman Adam Russo, Esq., CEO of the Phia Group, LLC, who began offering the model to his own employees two years ago. The results have been eye opening. "We've seen a 20% drop in overall expense as it relates to direct primary care," he reports.

With 70 of 200 employees now choosing a self-insured DPC plan option whose PEPM price tag Phia pays, rave reviews have spread across the office about unfettered access to a personal doctor. "We use it as a huge selling point for recruiting in a tight labor market and to show employees our appreciation for them," Russo says.

DPC will enjoy tremendous staying power only "if it stays true to its roots," he cautions. Translation: 24/7 in-person or digital access to a PCP who understands each patient's health plan design and their employer. Other requirements include a commitment to flat monthly rates without an FFS option, reasonably priced clinical services and the highest possible quality of care. While some DPC doctors still want to accept patients with traditional health insurance coverage lest they lose those customers, Russo believes it sullies the model.

Unlike McLellan's critical assessment, he believes DPC combines the best of an onsite clinic, urgent care facility and telemedicine with personalized attention from a primary care doctor. But it shouldn't be confused with its concierge medicine roots, which he says involves both a flat access fee and additional doctor bill.

DPC certainly could give traditional medicine a run for its money as long as it's properly structured and explained. For example, Passé has a large account in South Carolina that will waive out-of-pocket costs for employees on referrals to specialists and labs outside the company's embedded DPC practice. But any information associated with those visits must be funneled back to the referring DPC doctor for follow-up care. Another client in Denver layers reference-based pricing onto its DPC to manage catastrophic claims associated with specialist care, surgery and inpatient care, which other observes support.

But for all its promise, DPC is still a fringe movement. Fewer than a dozen of several hundred EBMS clients, for example, have implemented this model. Passé says part of the problem is that TPAs, brokers and consultants just aren't embracing it enough and, therefore, aren't in a position to recommend the appropriate vendors.

A stand-alone DPC model is difficult to sustain because many employers can obtain direct primary care from an onsite clinic or local community clinic, Passé believes. It's also worth noting some practices that are skittish about the financial viability of this new model feature both a monthly membership and FFS.

IMPACT ON TPAS AND BROKERS

While DPC may be simpler and more palatable for self-insured employers and their employees, it's more challenging to administer. With no claims to process, TPAs need access to a DPC practice's medical records in order to make financial projections for self-insured customers for the following year. "Most TPAs are very accustomed to just processing claims from the retail environment, and they do it so well and efficiently," Passé says. "DPC is much more of a partnership agreement." It also forces TPAs to engage in a more consultative approach.

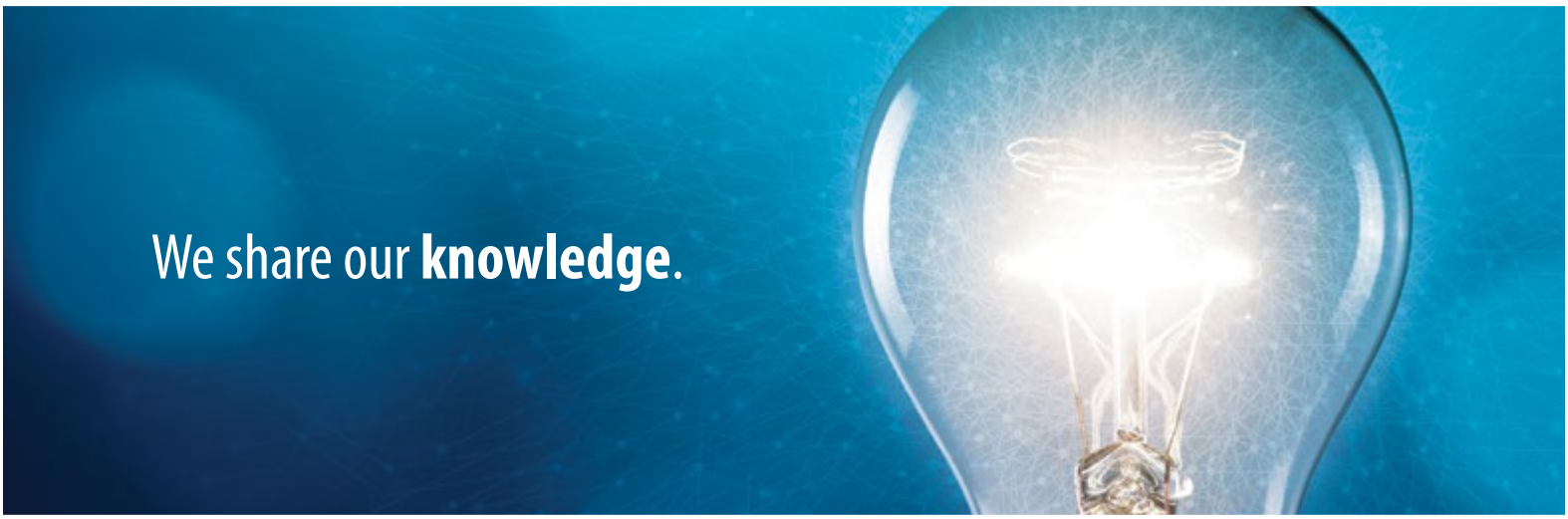
By both improving benefits and lowering costs, Vago believes brokers, consultants and vendors that promote DPC to their self-insured customers will be better able to retain business and close new sales. "Including the DPC physician in client renewal meetings is a priceless resource when determining benefits and setting strategic plans," she says.

Supported by a legion of 8,500 health insurance brokers, agents and advisers, the Clinical Wellness Network is in the process of scaling DPC to an employer setting across 25 states that have granted the arrangement statutory approval and is eyeing at least 10 other states. Thompson says 97.5% of DPC's focus is on individuals vs. group health plans.

There are several key considerations when selecting a DPC solution, according to Vago. They include examining the background and credentials of physicians leading the DPC clinic, as well as determining if after-hour access is confined to staffers vs. doctors. She says it's also helpful to spell out what services are included with the monthly membership fee, and integrating DPC physicians with utilization and care management, referrals, the employee assistance program and pharmacy solutions.

As medical gatekeepers, PCPs are no doubt in a powerful position to address untreated behavioral health problems by digging deeper into their patients' state of mind. Significant results could follow. "I have uncovered an epidemic of stress, anxiety and depression in highly functional people who, for whatever reason, don't see a therapist or psychiatrist," Lickerman reports.

DPC also can become a tremendous lifeline for some people. Thompson is reminded of a woman with leukemia whose $8,000-plus out-of-pocket max on a traditional health insurance plan seriously eroded her $25,000 yearly income. "Participating in DPC meant that she could get her wellness, Pap, imaging and blood work and seeing the doctor regularly," he says, noting how it helped cure colds and flues. "She actually cried when we did the open enrollment."



There's no simple way to overcome the rising claims trend in today's market. But we know that incorporating smart practices into our business model is helping us to gain more control of the situation. We're making informed decisions based on data analytics and industry knowledge; using the insight of in-house experts to create thoughtful solutions; and choosing our cost containment partners wisely as we work to protect our clients' financial well-being.

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DPC practices typically have low overhead and feature just one or two physicians, as well as a receptionist and/or medical assistant who serve no more than 600 patients at any time averaging about 10 daily visits, noted a physician blog in 2017.

Some nurse practitioners who also recognize a need to change with the times are embracing their own version of this approach. Nice Healthcare in Minnesota, for example, charges a PEPM fee of just $25 to $35 for video or home visits, as well as in-home lab work and x-rays, 30 free medications and unlimited wellness coaching.

With immediate access to primary care under the DPC model, Lickerman is relieved that he and his fellow physicians aren't under any time constraints with patients and, as a result, are able to help reduce ER visits, specialty referrals, inpatient admissions, MRIs and other unnecessary care.

LEVERAGED SAVINGS VEHICLES

The federal government is poised to play an important role in helping spread DPC. With a new Congress now in session, observers say a key legislative change could help raise the model's profile. The U.S. House of Representatives passed HR 6199 in 2018, which recognizes that DPC is not health insurance, and therefore, would allow working Americans to use flexible spending accounts (FSAs) and health savings accounts (HSAs) toward DPC memberships. It still needs to clear the Senate before arriving on the president's desk for his signature. At least 24 states have already followed suit.

Employers currently are able to earmark health reimbursement accounts (HRAs) toward DPC expenses. One example is Union County, N.C., which deducted HRA funds for government workers who chose a DPC option over traditional health insurance.

Once employees have the ability to use FSAs and HSAs to pay for DPCs, Russo believes the concept will catch fire. He's confident that federal legislation will pass, noting the potential for bipartisan support. ■

Bruce Shutan is a Los Angeles freelance writer who has closely covered the employee benefits industry for more than 30 years.