



On Retainer: Direct Primary Care Practices Bypass Insurance

Introduction

Direct primary care (DPC) is an emerging model for delivering medical care that has gained some attention in California and nationally in recent years. Sometimes referred to as “retainer practices,” DPC practices generally do not accept health insurance, instead signing up patients in exchange for a recurring monthly fee — usually \$50 to \$80 — for a defined set of services.

This issue brief describes the landscape of DPC practices, which collectively have more than a half million people on their rolls.¹ It explores the opportunities and challenges for the DPC model, especially in light of the Affordable Care Act (ACA), and legislation in some states providing for the retainer practice model.

Because the field is too young for a detailed national study of its effectiveness in delivering cost-efficient quality care, this report relies on research on some of the early notable players. More than a dozen DPC organizations were included in the research, which involved interviews with payers, purchasers, and consumers. The DPC providers profiled were selected because they have significant market presence and/or major corporate/venture capital backing and they represent a geographic distribution nationally.

For the purposes of this report, DPC is defined as retainer practices that usually charge less than \$100 per month per patient. The research excludes what are known as “concierge” practices, which charge higher fees and target more affluent patients.

History and Current Landscape

As recently as the 1950s and '60s, it was normal for patients to have a direct paying relationship with their physician. As the scope of health insurance expanded from primarily catastrophic coverage to payment for most facets of health care, the direct relationship between patient and primary care physician dwindled. One of the founders of the DPC movement, Dr. Garrison Bliss, said the change had a negative impact on patients, and also diminished the professional role of physicians:

“To a very real extent, when patients do not pay or control the payment to their physicians, their power and influence in health care declines. In the current fee-for-service health care insurance environment funded by employers and governments, physicians are paid for diagnosis and treatment codes.”

In what has been primarily a grassroots movement, other physicians in at least 24 states have sought to reinstate direct payment through DPC practices. DPC practices with national aspirations like Iora Health, MedLion, Paladina Health, Qliance, and White Glove Health have brought greater visibility to this approach to health care delivery. Supporters of this approach believe that DPC will have a role in helping solve the growing problems of diminishing access to primary care as well as its increasing cost.

A significant recent development in the DPC market was the entrance of the publicly traded dialysis company DaVita in January 2012, which bought ModernMed, a health care services firm that provides direct primary care in 12 states through employer-based, on-site clinics and private physician practices. DaVita also bought HealthCare Partners, the country's largest operator of medical groups and physician networks, for over \$4 billion. The DPC/onsite company is the foundation of DaVita's new division, Paladina Health. Some of the HealthCare Partners practices could eventually transition to a DPC model, according to company officials. DaVita has jumpstarted Paladina by enrolling DaVita's largest concentration of employees in Tacoma, Washington, with over 1,000 employees and dependents.

In another potentially significant development, Paladina is offering their self-insured employer customers a guarantee that overall health care costs will be lowered while maintaining or improving health outcomes. Paladina indicated that it has reduced costs for its current clients by 30%, in sharp contrast to persistent health care inflation elsewhere.

How DPC Differs from Insurance-Based Practices

In describing their value, DPC leaders point to the efficiencies gained from reducing administrative burdens related to insurance, as well as to reducing downstream costs, including emergency department visits, hospitalizations, surgeries, and specialist visits. While typical primary care practices receive less than 5% of the total health care dollar, DPC practices generally charge double this, arguing that by increasing primary care spending to about 10% of total health care costs, they can reduce downstream spending by more than this increment. DPC practices, they maintain, focus on keeping patients out of the expensive parts of the health care system, such as specialist offices, emergency departments, and hospitals. Iora, Paladina, and Qliance

have each published outcomes studies claiming a 20% to 30% or more reduction in overall health care costs.

Due to smaller patient panels than insurance-based practices, DPC practitioners say they spend more time with patients discussing the trade-offs of particular screenings, treatments, and procedures. DPC practitioners frequently advertise their "unrushed 30-minute appointments." They describe the extra time as pivotal to reducing costs and improving outcomes.

DPC coverage is not comprehensive, and these types of practices often recommend that members obtain a high-deductible wraparound policy to cover emergencies and catastrophic events. Some efforts are underway to combine changes in plan design with the DPC purchasing methodology. To date, two insurance carriers have tailored offerings to DPC-based patients — Cigna and Associated Mutual. Cigna has paired its "Level Pay" program targeting self-insured employers with 50 to 250 employees and is offering this only to Qliance customers so far.

Associated Mutual has stated it is offering a wraparound policy but hasn't announced details yet. Physician Care Direct is working with DPC practices and networks, as well as multiple carriers, to facilitate wider adoption of the DPC model. They expect the combined cost of the DPC wraparound policy and DPC fees to be less than a standard health insurance plan.²

Table 1 shows five large DPC providers, along with their key accounts, number of patients, fee structures, and unique attributes.

Table 1. Five Large Direct Primary Care Practices

	KEY ACCOUNTS	# OF PATIENTS	FEE STRUCTURE	KEY ATTRIBUTES
Iora Health	Dartmouth, Culinary Health Fund, Freelancers Insurance Company	2,400+	\$80/month, average (based on risk-adjusted acuity)	<ul style="list-style-type: none"> Primarily near-site clinics for union-based organizations, insurers, and self-insured employers
MedLion	Declined to answer	3,000+	\$59/month	<ul style="list-style-type: none"> Transitioning fee-for-service practices to DPC — supports hybrid insurance/direct practices Operates in CA, NV, WA Creation of onsite or near-site clinics for large employers or municipalities
Paladina Health	DaVita employees plus 20+ undisclosed employers	8,000+	\$69 to \$109/month plus varied levels of performance-based pay	<ul style="list-style-type: none"> Acquired ModernMed 24/7 access to patient’s personal physician’s cell phone Transparency tool Referral management Puts fees at risk based on achieving cost savings, patient satisfaction, and clinical outcome targets
Qliance	United Food & Commercial Workers, Expedia	7,200	\$65/month, average	<ul style="list-style-type: none"> Most comprehensive list of services covered in monthly fee
White Glove Health	Highgate Hotels, Beryl Companies, Ivie & Associates	40,000 via self-insured employers; 450,000 via health plans	Up to \$35/month plus \$35/visit fee	<ul style="list-style-type: none"> House/office calls and remote care delivered by nurse practitioners overseen by doctors

Note: All monthly fees are per member, per month, unless otherwise noted.

Scope of Practice

Table 2 provides a list of services included in the scope of DPC practices (see page 4). Without a financial incentive to rapidly refer care to specialists, the scope of DPC care is generally broader than that of a typical primary care practice. For example, some DPC practices provide x-rays and EKGs that would typically be referred outside by an insurance-based primary care practice. While some of the listed services are outside the scope of the membership fee, they are generally offered at an additional cost.

Based on interviews conducted with DPC practitioners and their patients, a high percentage of DPC consumers are either uninsured or have high-deductible plans.

They often seek guidance from DPC practitioners on keeping their non-primary care costs low. In many cases,

according to interviewees, DPC providers refer patients to specialists who will offer significant savings off of the more generally available price in exchange for immediate payment and avoidance of the costs of billing and collections. Nextera, a direct primary care practice located in Firestone, Colorado, has arranged \$300 CT scans, \$425 MRI scans, and other steeply discounted prices. It is common for DPC practices — which often serve people who are uninsured or have high deductibles — to seek out organizations that give them a discounted case price. This is particularly common for imaging due to over-capacity. Paladina offers a mobile price-transparency app using Healthcare Blue Book data to inform their members of pricing.

Table 2. Services and Pricing of Selected Direct Primary Care Practices

	Annual exam	Phone and email access	Basic x-rays	EKGs	Pregnancy tests	Spirometry	Blood draws	Flu shots	Consultations and coaching (1)	Chronic disease management (2)	Specialist and hospital coordination	Urgent care (3)	Lab tests (4)	Casts	Braces (5)	Skin tag and wart removal	Vaccines	Membership Costs
AtlasMD Concierge Family Practice	✓	✓	\$\$	✓	✓	✓	✓	\$\$	✓	✓	✓	✓	\$\$	\$\$	\$\$	✓		\$10 to \$100/month depending on age (e.g., age 20–44: \$50/month; age 45–64: \$75/month)
Iora Health	✓	✓		✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		\$60 to \$80/month depending on patient complexity
MedLion	✓	✓	\$\$	✓	\$\$	✓	✓	✓	\$\$	✓	✓	\$\$	\$\$	\$\$	\$\$	\$\$	\$\$	\$59/month plus \$10/visit Vaccines, labs, etc., offered at cost
NeuCare Family Medicine	\$\$	✓		\$	\$	\$	\$	\$\$	\$\$	\$\$	✓	\$\$	\$\$	\$\$	\$	\$\$	\$\$	\$10 or \$20/month (family: \$50/month) Clinic and virtual visits: \$20 per 15 minutes Transparent pricing on labs, etc.
Nextera Healthcare	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	\$\$	\$\$	✓	\$\$	\$99/month
Paladina Health	Declined to respond																\$69 to \$109/month plus varied levels of performance-based pay	
Palmetto Proactive Healthcare	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	\$\$	\$\$		\$60/month
Qliance Medical Management Inc.	✓	✓	✓	✓	✓	✓	✓	\$\$	✓	✓	✓	✓	✓	✓	✓	✓	✓	\$54 to \$94/month depending on age Vaccines free for children in Washington, at cost for adults
Total Access Physicians, PSC	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	\$75/month (couple: \$120, family: \$150)
WhiteGlove Health	Declined to respond																\$35/month plus \$35/visit	

(1) Consultations and personalized coaching for weight loss, smoking cessation, and stress management.

(2) Chronic disease management for hypertension, diabetes, hyperlipidemia, heart disease, asthma, arthritis, osteoporosis, and many other conditions with referrals out to specialists when necessary.

(3) Same-day or next-day care for urgent medical issues including x-rays, sprains, strains, fractures, cuts requiring stitches, acute illnesses, and more.

(4) Laboratory tests including blood glucose (fingerstick), hemoglobin/hematocrit, HIV screening test, INR (blood coagulation measurement), mononucleosis test, pregnancy test, stool blood test (FOBT), strep throat test, urinalysis.

(5) Ankle braces, forearm splint, finger splint, thumb spica splint, cast bootsurgical shoe, walker boot (short and long), wrist brace.

Note: All monthly fees are per member, per month, unless otherwise noted.

Market Forces and the Future of DPC

There are current market forces that support the growth of the DPC model, as well as factors that may inhibit its success. The following are factors likely to encourage growth:

- **Health reform act.** A DPC clause was written into the Affordable Care Act (ACA) allowing retainer practices to be included in the proposed insurance exchanges, with the caveat that these practices be paired with a wraparound insurance policy covering services outside of primary care. It is the only non-insurance offering to be authorized in the insurance exchanges slated to begin in 2014; however, there is no requirement that DPCs be included. See Appendix for more information.
- **Patient centeredness.** DPC's focus on closely coordinated primary care, affordability, and eliminating unnecessary referrals fits well with the goals of national and state health policy, as well as with patient interest; DPC is positioned to benefit from renewed focus on primary care led by large employers in support of patient-centered medical homes.³
- **Uninsured.** After full implementation of the ACA, ineligible individuals (including undocumented immigrants) are a continuing source of customers for DPC.
- **Capital funding.** Significant venture capital funding for disruptive care/payment models coupled with corporate backing such as DaVita's Paladina division as well as a large Blue Shield company (Cambia Health) investing in DPC pioneer Qliance.
- **The Health Benefit Exchange.** Health plans may see a market opportunity through the Exchange by coupling DPC with a high-deductible wraparound policy that promises to deliver a lower price than conventional insurance products. Cigna and Associated Mutual are early adopters of this strategy.

In general, DPC offering is not a high priority for health plans.

- **Clinic convenience.** Some DPC providers use onsite and/or near-site clinics. The onsite model can be attractive for some large employers because it offers greater access and convenience for employees. Near-site clinics can be situated near a set of organizations where employees are covered. One major DPC provider uses this model to serve union members situated in geographic clusters.

However, a number of market forces may potentially inhibit the growth of DPC:

- **Low awareness.** To date, buyers of health care and primary care physicians know little about the DPC model.
- **Status quo.** The health care industry is historically slow to adopt new care or payment models unless mandated.
- **Resistance from competition.** Reducing referrals to specialists and hospitals may threaten those providers, provoking resistance.
- **Resistance from insurers.** Some insurance carriers may perceive a disintermediation threat and seek to get regulatory relief.
- **Primary care squeeze.** Due to unfavorable economics of primary care, many practices are selling out to larger health systems, eliminating the DPC option.
- **Inadequate scale.** Most DPC practices are very small; as yet there is not enough scale to service larger national employers.

AUTHORS

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ENDNOTES

1. Membership figures are an aggregate of self-reported figures from the DPC practices.
2. There remains a high degree of ambiguity in the pricing of “standard” plans as well.
3. According to the National Committee for Quality Assurance (NCQA), a patient-centered medical home (PCMH) is an innovative program for improving primary care. In a set of standards that describe clear and specific criteria, the program gives practices information about organizing care around patients, working in teams, and coordinating and tracking care over time. The NCQA patient-centered medical home standards strengthen and add to the issues addressed by NCQA’s original program. The patient-centered medical home is a health care setting that facilitates partnerships between individual patients, their personal physicians, and when appropriate, the patient’s family. Care is facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it, in a culturally and linguistically appropriate manner.

Appendix: Regulatory Backdrop for Direct Primary Care

The ACA authorizes HHS to permit qualified health plans (QHPs) to provide coverage through a qualified “direct primary care medical home” (direct PCMH) plan provided such coverage meets certain criteria (as developed by the Secretary of HHS) and that the QHP, meeting all other applicable requirements, ensures coordination of such services with the entity offering the QHP.

With respect to implementing guidance, this provision was addressed in 2012 in CMS Exchange/QHP final regulation, in which CMS codified the treatment of direct PCMHs. The provision authorizes QHP issuers to provide coverage through a direct PCMH that meets the standards established by HHS, provided that the QHP meets all standards otherwise applicable. CMS in its final rule addressed comments raised during the proposed rule-making process relative to what those standards might look like, noting in the final rule that direct PCMHs need not be accredited in order to participate in QHP networks. However, CMS “encourage[d] QHP issuers to consider the accreditation, licensure, or performance of all network providers.”

CMS opted in the final rule not to set firm requirements or thresholds that would necessitate that QHP issuers contract with a specified number or percentage of direct PCMHs. Thus, CMS in its final rule, does not direct that Exchanges create incentives for contracting with direct PCMHs; instead CMS “encourage[s] Exchanges to promote, and QHP issuers to explore innovative models of delivery along the care spectrum.” Thus, there does appear to be an opportunity for Exchanges and QHP issuers alike to promote and include such models, but per the final guidance on this provision, there is no obligation to do so.