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Health Plan Rorschach Test: Direct Primary Care

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Despite its inclusion in Obamacare, Direct Primary Care (DPC, aka Concierge Medicine for the Masses), it's surprising how few health insurance executives know about DPC. DPC is a model of paying for primary care outside of insurance. The individual or organization paying for healthcare pays a monthly fee (like a gym membership) for all primary care needs. Generally, DPC providers say they can address 80 or more of the top 100 most common diagnoses.

Once I explain DPC to insurance executives, I have found it's an excellent Rorschach test reflecting whether that executive's organization is playing to win or is back on their heels regarding the wrenching changes that are reshaping healthcare from the DIY Health Reform movement as well as the effects of Obamacare. For example, rapid growth of self-insuring by corporations is a trend pre-dating Obamacare but many expect it to accelerate as self-insuring gives companies down to 20 employees more flexibility than Obamacare rules allow.

Forward-looking health plans view DPC as part of a broader strategy to reinvent themselves. For example, the parent company of a large Blue Shield recently invested in the pioneer of DPC, Qliance. Conversely, health plans that are back on their heels simply look at it as a way they will get disintermediated. This DPC Rorschach test will presage how that health plan will fare in the coming years. For example, some will discount it as only applicable for a certain segment of the population such as the "worried well" yet I've found the exact opposite. For example, the Grameen Foundation (famous for its Nobel Prize-winning founder known for microfinance) has brought it to low-income populations in New York that the Financial Times (http://www.ft.com/intl/cms/s/0/4676ce4c-c498-11e2-9ac0-00144feab7de.html#axzz2Y5Ri7Mqs) reported on — see Nobel Prize Winner Sets Sights on Fixing U.S. Healthcare (http://www.forbes.com/sites/davechase/2013/07/09/nobel-prize-winner-sets-sights-on-fixing-u-s-healthcare/) for more. In Washington state, DPC is now being used with Medicaid populations and in the health insurance exchanges (driving tremendous growth for DPC pioneer, Qliance).

the fourth blot of the Rorschach inkblot test (Photo credit: Wikipedia)

Over the years, the California Health Care Foundation (CHCF) has commissioned many excellent reports (http://www.chcf.org/search?type=chcf&se=1&contenttype=publications&sdate=all) outlining trends affecting healthcare. Just as they wrote about retail clinics several years ago as they began to emerge, they wanted a similar analysis done for DPC. The CHCF asked me as I've studied DPC perhaps more than anyone other than those operating DPC businesses. Many ask why I have OCD on DPC. My answer is twofold.

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1. There is a lot to learn from organizations demonstrating the Triple Aim (http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx) (lower costs, improved outcomes, better consumer experience). I've yet to see any model that more consistently delivers on the Triple Aim than DPC.
2. When you found a tech startup, you make a bet on how the future will unfold so that you can get there before your competition. Our bet a few years ago when we began has now become obvious — healthcare will become more patient-centric, accountable and coordinated. In other words, virtually the opposite of the "do more, bill more" model that is bankrupting our country. My belief is DPC is a microcosm of the future healthcare system so I've been studying it and working with DPC providers the last few years. Naturally, DPC providers have a fundamentally different set of requirements than traditional players so it is helpful in shaping our decisions. *See The Marcus Welby/Steve Jobs Solution to the Medicaid-driven State & County Budget Crisis (http://www.forbes.com/sites/davechase/2012/03/11/the-marcus-welbysteve-jobs-solution-to-the-medicaid-driven-state-county-budget-crisis/) for what I wrote earlier.*

The CHCF published the DPC report (http://www.chcf.org/publications/2013/04/retainer-direct-primary-care) I wrote in April. It is a good summary of what I have learned. CHCF papers have a neutral, objective tone which is appropriate for their role. However, I have formed opinions about DPC so I'm publishing here my raw perspective on DPC starting with an introduction. Please see the introduction and history of DPC below.

[Contact me via LinkedIn (www.linkedin.com/in/chasedave) if you'd like a copy of the full seminal study on the Direct Primary Care model]

Introduction

This paper provides the landscape of an emerging practice model called Direct Primary Care (DPC) sometimes referred to as "concierge medicine for the masses". There are over a half million people in DPC practices. With DPC legislation passed in some states and inclusion in the Affordable Care Act (ACA), the implications, successes and obstacles to DPC growth are explored. The field is too young for detailed national studies so some of the early notable players were studied. Over a dozen DPC organizations were studied as well as interviewed payers, purchasers and consumers to gain their perspective on the DPC model. In state regulatory and legislative language these practices are sometimes referred to as "retainer practices, " and are defined as those that charge a recurring monthly fee in exchange for a set of services.

Direct Primary Care is defined as retainer practices that charge less than $100 per month per patient. Most charge in the $50-80 per month range. Of note, we are not including in this definition practices that continue to bill insurance companies for their services but charge in addition a monthly fee to patients. While these practices are able to provide additional time and resources to their patients, they are still largely driven by the current fee-for-service business model, and subject to its limitations.

History

Just a few decades ago, it was the norm to have a direct paying relationship with one's physician, whether it was cash or bartering some product or service. As health insurance expanded from primarily catastrophic coverage to payment for all facets of healthcare, the direct relationship between patient and provider deteriorated. One of the founders of the Direct Primary Care movement, Dr. Garrison Bliss, articulated the changes in healthcare payment and their effect as follows:

> *"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.*

Bliss goes on to say that the result of these changes has led to a decline in the perceived value of primary care, a massive dependence on medical technology and a focus on higher cost procedures over effective, results-oriented health care.

Brian Klepper, PhD, and David C. Kibbe, MD, MBA outline the roots of valuing specialist care at the expense of primary care in a piece about the playing field being extremely tilted towards specialists in this Kaiser Health News piece (http://www.kaiserhealthnews.org/Columns/2011/January/012111kepplerkibbe.aspx). Part of the transition back to patient-driven care began with the first concierge practice, opened in Seattle in 1996 by Howard Maron and Scott Hall. It was called MD2 ("MD squared") and charged $1,000 per member per month. Shortly thereafter in 1997, also in Seattle, Garrison Bliss and Mitch Karton converted Seattle Medical Associates from a fee-for-service insurance Internal Medicine practice to a maximum $65 per monthly fee Direct Primary Care practice. This is currently a three- physician practice that remains highly

successful and popular. Dr. Bliss later went on to establish Qliance Medical Group of Washington PC, the first scalable Direct Primary Care practice designed for the mass market.

Bliss and Karton determined that a panel size of 800 for their combined practice would be the break-even point. 1600 would be a full practice. (i.e., 2 MDs with 800 patients each). Bliss and Karton designed their DPC practice with the following design principles that persist to this day:

- Work for our patients directly – know who's the boss (the patient).
- Give the providers and the patients time to do the job right. Keep the panel sizes low and expectations high.
- Be open when patients need you to be open (12-hr days, weekends) and/or accessible electronically.
- Don't charge insurance co-pays or deductibles.
- Don't pay providers to do anything but the right thing for our patients – no incentives to "do stuff" as the fee-for-service model has encouraged.
- Build an electronic medical record that does medicine, not insurance billing.
- Monthly fees go to care, not an "insurance bureaucracy tax".
- Frequently ancillaries are either free or at cost such as lab tests and prescriptions.

Within a year of Seattle Medical Associates converting its practice to Direct Primary Care, yet another innovative practice in Seattle – SimpleCare – was created by Vern Cherewatenko, M.D. and David MacDonald, D.O. Dr. Cherewatenko describes what led them to switch their model:

> We both had excellent business staff and business-wise ran a very tight ship. Our combined practice billings totaled over $10 million, not a tiny operation by any means. With a combined annual practice billing of $10 million we calculated that we were losing approximately $7 per patient or $80,000 per month.

They realized they couldn't make it up in volume. With 2 clinics, 55 providers and 75,000 patients, they needed 6 clerks just to deal with copying of records from patients transferring in and out of various managed care plans. They analyzed their average patient charges and they described it as follows:

- Their charge for a 10-minute patient visit was $79.
- The insurance companies typically reimbursed $43
- Costs of collection were anywhere from $5-20 depending on the staff time, billing system, etc. (All doctors know they are discounted, but most doctors overlook what it costs to *collect* the $43).
- Therefore, the actual fee reimbursement for a $79 charge was $23.
- With a single, all-inclusive exam room overhead at $30 (the national average), they discovered they were losing about $7 on each of the 75,000 patients they were seeing annually.

This analysis caused them to rethink what they had taken for granted.

> "We knew we could not cut our overhead any further– we had been doing that for the past 2 years (cheaper copy paper, less fancy patient info, less nurses, less receptionists, no more "pantry stocking," and so on). We were running as lean as we could, practically on bare bones."

Extent of Direct Primary Care

Although DPC practices are currently evolving primarily as a grassroots movement and most of these practices make little effort to obtain national recognition, they have been identified in at least 24 states and are burgeoning in several regions including California, Florida, Washington State and Texas. With the advent of scalable versions of DPC practices with national aspirations like Iora Health, MedLion, Paladina Health, Qliance, and White Glove Health, it is this author's opinion that the DPC movement will grow rapidly in the coming decade, particularly if the US health care system fails to find other solutions to the problems of declining primary care, high cost, accessibility and poor performance.

Note that some of the DPC providers profiled in this paper also offer additional primary care options such as near-site and on-site clinics. The care delivery model is essentially the same, however they offer their services only to a limited number of employers.

Cottage DPC Industry Emerges

After the first DPC practices formed in Seattle, an array of entrepreneurs followed the model pioneered by Dr. Garrison Bliss or simply came up with a model on their own, unaware that others had begun to develop similar practices. Some of the notable pioneers include Drs. Vic Wood of Primary Care One in West Virginia, Brian Forrest of Access Healthcare in North Carolina, and Samir Qamar of MedLion in California. In addition, venture-backed White Glove Health in Texas developed a model with Nurse Practitioners making house calls.

By sheer numbers, White Glove Health is the most successful DPC organization, with over 500,000 members. The others all have fewer than 5,000 patients thus far. Not all DPC practices have had quick success. For instance, Symbeo based out of New Jersey raised and then burned through capital before it became economically sustainable.

The entrance of the highly successful dialysis company, DaVita, is one of the biggest recent developments in DPC. They bought a DPC/onsite clinic company ModernMed, a healthcare service firm providing direct primary care in 12 states through employer-based, on-site clinics and private physician practices. Later, they bought Healthcare Partners, the country's largest operator of medical groups and physician networks, for over $4B. The DPC/onsite company is the foundation of DaVita's new division, Paladina Health. Some of the Healthcare Partners practices could transition to a DPC model. DaVita has jumpstarted Paladina by enrolling DaVita's largest concentration of employees in Tacoma, Washington with over 1,000 employees and their dependents.

Even more recently, Qliance has received a major infusion of capital from Cambia Health (parent company of a regional Blue Shield). This is one of the best signs that health plans are beginning to wake up to the DPC opportunity. Qliance's previous investors have been founders of some of the most successful technology companies of the last 20 years – Amazon, aQuantive, Dell and Expedia.

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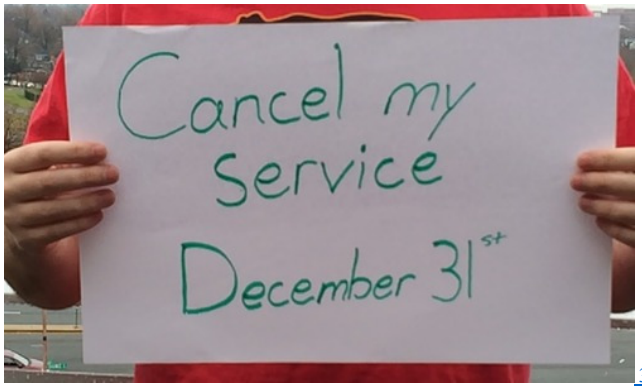
- 1. 

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