

# Direct Primary Care In Louisiana

A White Paper for Louisiana Lawmakers and Healthcare Stakeholders  
In Support of Senate Bill 516

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## Foreword

The State of Washington is generally considered a “healthy” state. In a side-by-side comparison to Louisiana in factors such as obesity, smoking, diabetes and more, America’s Health Rankings® ranks Washington State #14; Louisiana #48.

Even Washington, however, has its state healthcare challenges, including a primary care physician shortage.

In Washington, a privatized medical practice model, Direct Primary Care (DPC), has emerged to help meet individuals’ and employees’ primary care needs. Direct Primary Care is a medical practice model of paying for primary care outside of insurance. Individuals or businesses pay for unlimited access to care for a flat monthly fee. Hallmarks of DPC are its patient-centered and preventive medicine approaches to healthcare.

Since passage of Washington’s DPC law, DPC practices have expanded into 11 counties. As of 2012, there were 29 practices, and the number continues to rise.

Seattle-based DPC provider Qlinace has attracted several big-name investors including Amazon’s Jeff Bezos and Dell founder Michael Dell. Venture capitalists elsewhere have also been attracted to DPC. Billionaire Tony Hsieh, CEO of Zappos, recently invested in Iora Health to bring an innovative DPC practice to his urban renewal project in downtown Las Vegas. Other large DPC providers such as Medlioni, Paladina and others are expanding, some nationally.

The “little guys” are getting involved too. Individual doctor-entrepreneurs, eager to return to the concept of old-fashioned patient-centered healthcare, are creating direct primary care practices across the U.S.

Direct Primary Care is explicitly a medical practice model and not insurance. Even so, a few lawmakers in other state have mislabeled the flat-fee payment model as “risk” and its patient fee agreement as an “insurance premium.” This white paper seeks to clarify the DPC concept, distinguish it from insurance products, increase awareness of the model and describe DPC’s overall win-win.

Passage of Senate Bill 516 recognizing DPC as a medical practice model would facilitate unencumbered expansion of new DPC practices in the State. SB516 will also provide a welcoming business environment that could bring new healthcare investments and resources into Louisiana. We ask your support in passing the bill.

Thank you for taking time to review this information. I look forward to answering your questions and meeting with lawmakers and healthcare stakeholders to discuss this topic.

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# Direct Primary Care in Louisiana

## A White Paper for Louisiana Lawmakers and Healthcare Stakeholders

### In Support of Senate Bill 516

#### Introduction

Primary care is the foundation of a state's healthcare system. When primary care needs are met, individuals experience fewer costly emergency room visits, diagnostic tests, specialist visits, hospitalizations and surgeries.

The State of Louisiana has an opportunity to officially recognize a new privatized medical practice model, Direct Primary Care, in which a doctor and his/her patient do business directly with each other without an insurance company functioning as a third party. Several states such as Washington, California and Utah have already codified legislation. Several other states are also leading the way to enable growth of this innovative resource.

The Direct Primary Care (DPC) model emphasizes a strong doctor-patient relationship, convenience, accessibility and affordability with the purpose of keeping people healthy and reducing costs. DPC is the only non-insurance offering provided for by the Patient Protection and Affordable Care Act (ACA).

This document seeks to educate Louisiana legislators and healthcare stakeholders about direct primary care and to garner legislative support for Senate Bill 516. Passage of SB516 will create an inviting business environment for creation of more DPC medical practices statewide and bring new healthcare investments and resources into Louisiana.

#### Three Important Issues Facing Individuals and Employers in Louisiana

In Louisiana, incidences of serious medical issues such as cardiovascular disease<sup>1</sup>, obesity<sup>2</sup> and diabetes<sup>3</sup> are problematic and costly in terms of human suffering and dollars. In many cases, individuals are unable to work and financially contribute to their families or society. Many individuals—including those with healthcare insurance—delay seeking preventive medical care or early diagnoses of serious health conditions when early interventions are most effective.

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<sup>1</sup> Heart disease and stroke are the leading causes of death in Louisiana, killing more than 13,000 people each year. Louisiana has the **5th** highest mortality rate for heart disease and the seventh highest mortality rate for stroke in the U.S. *Defining the Burden of Heart Disease and Stroke in Louisiana*, 2008, Louisiana DHH.

<sup>2</sup> Louisiana is ranked **5th** highest in the country in obesity. (2010 Trust for America's Health Report). 64.9% of Louisiana adults are overweight or obese (2009 CDC BRFSS).

<sup>3</sup> Approximately **10%** of Louisiana residents have been diagnosed with diabetes by a physician (BRFSS 2010). In 2006, the total cost of diabetes to Louisiana was approximately \$2,431,000,000, Louisiana DHH.

Concurrently many small- to medium-sized businesses, the backbone of the Louisiana economy, struggle to afford healthcare benefits for employees, which are important tools to attract and keep the best job candidates. Even ahead of ACA employer mandates, many employers are feeling the economic squeeze of higher renewal rates. For some businesses, economic growth and even commercial viability are threatened.

At the same time, the State of Louisiana and the nation face a physician shortage that is expected to exacerbate in the next few years. The number of family practice doctors—the ones who typically diagnose and manage the kinds of diseases that are most problematic for the State—are in short supply.

### What Is Direct Primary Care and How Can It Help Mitigate Those Issues?

Primary care is the patient’s entry into the healthcare system and the medical “home” for ongoing, personalized care. Primary care is provided by personal physicians—family physicians, general internists and general pediatricians—who are responsible for the entire health of an individual or family. Working closely with these generalist physicians are nurse practitioners and physician assistants.<sup>4</sup>

Dozens of studies show that a strong primary care sector is associated with lower health care costs and improved quality.<sup>5</sup>



Hallmarks of Direct Primary Care are its patient-centered and preventive medicine approaches to healthcare.

Direct Primary Care (DPC) is medical practice model for paying for primary care outside of insurance. The individual or business/organization paying for healthcare pays a flat monthly fee.

Hallmarks of DPC are its patient-centered and preventive medicine approaches to healthcare.

DPC, or a “direct primary care medical home,” is sometimes referred to as retainer-based medicine, direct-pay medicine, subscription-based medicine or a capitated payment model system. (The AMA describes capitated as a payment systems based on a payment per person, rather than a payment per service provided.<sup>6</sup>)

<sup>4</sup> J.C. Martin *et al.*, “The Future of Family Medicine: A Collaborative Project of the Family Medicine Community,” *Annals of Family Medicine* 2, no. 1 Supp. (2004).

<sup>5</sup> “Primary Care: Can It Solve Employers’ Health Care Dilemma?” by Martin J. Sepulveda, Thomas Bodenheimer and Paul Grundy: 10.1377/hlthaff.27.1.151 *Health Affairs*, January 2008, Vol. 27 No. 1 151-158.

<sup>6</sup> “Capitation,” American Medical Association, <http://www.ama-assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/private-payer-reform/state-based-payment-reform/evaluating-payment-options/capitation.page>, Accessed March 18, 2014.

## Is the Direct Primary Care Practice Model New?

DPC is not a new concept. Iterations of DPC have been around for several years. Before that, a similar practice model—concierge or boutique medicine—was mainly utilized by affluent patients who could afford “on demand” access to their physicians.

DPC is a variant of concierge medicine. Distinguished by its low cost, DPC has been called “concierge care for the masses.”

*Direct Primary Care has been called “concierge care for the masses.”*

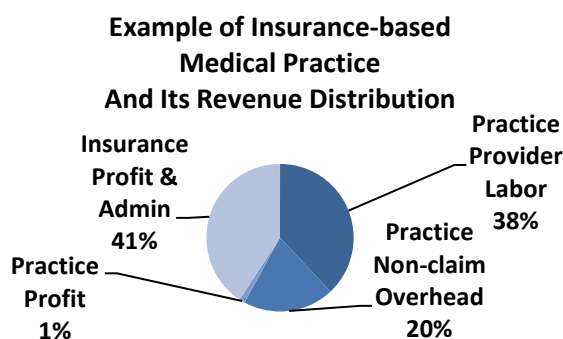
## Overview of the Direct Primary Care Practice Model

Direct Primary Care combines healthcare value with wellness, disease prevention and management, affordability and an old-fashioned relationship with one’s family physician.

DPC usually involves the following key features:

- Patients or employers pay their primary care medical providers an annual or monthly fixed fee with no (or nominal) per-visit charges.
- No insurance filing or reimbursement is involved (except for hybrid practices that might allow for insurance and/or Medicare).
- Doctors are usually salaried.
- DPC medical practices do not exclude any individuals or groups from flat-fee access.
- There are no restrictions on pre-existing conditions.
- Patients have easy access to their primary care doctor, especially for acute illnesses.

With insurance-paid primary care, where the cost of each and every part of medical care is billed to a third party payer, *reimbursement costs consume more than 40 cents of each dollar.*<sup>7</sup>



<sup>7</sup> “A Better Way—Direct Primary Care,” Direct Primary Care Journal. [www.dpc.org](http://www.dpc.org).

DPC eliminates third-party payments; that, in turn, removes the administrative time and expense required by the insurance reimbursement system. With DPC, there is no insurance paperwork, no billing approvals, no deductibles and no co-pays.

Eliminating insurance from primary care makes those 40 cents available for actual health care - more time with each patient, more extensive office hours, more on-site services and diagnostics, and more patient-provider support technology.<sup>8</sup>

In a DPC model, primary care providers are not compelled to compress high numbers of patients through their practices to generate enough revenue to meet overhead expenses. DPC physicians—with their smaller patient panels and incentives to deliver high quality and value—can take time to know their individual patients.



Direct Primary Care restores the doctor-patient relationship.

Erika Bliss, MD, FAAFP, chief executive officer of Qliance, a Seattle-area company that was an early pioneer of the direct primary care movement, explains that the direct-pay model changes the way physicians think by making them accountable to their patients directly. “It frees you up to think about wholistic care and encourages you to treat them better with nothing getting in the way,” she says. “You are not just cranking through enough visits to pay your bills.”<sup>9</sup>

In the current system, which only allows patients short visits with their doctors, comprehensive preventive care and care coordination—two keys to optimum care—cannot be adequately performed with patients with chronic illnesses.

Dr. Stephen Schimpff, one of the world’s foremost experts on healthcare, says it is the absence of time – time to listen, time to prevent, time to coordinate and time to think – that is critical.

In his highly-acclaimed book, *The Future of Health-Care Delivery: Why It Must Change and How It Will Affect You*, Dr. Schimpff gives an example of the importance of care coordination. He tells the story of Henry, a chronically ill patient who was taking 23 different prescription drugs; some once, some twice and some three times per day along with one by shot monthly. Henry was not certain why many of them had been prescribed and stated that despite taking them he did not feel well. After one primary care doctor *had* time and took time to coordinate Henry’s overall care, his medication was reduced to seven prescriptions and his health and quality of life greatly improved. Henry also reported he was saving “a great deal” of money.”<sup>10</sup>

<sup>8</sup> Direct Primary Care Journal online, [www.dpcare.org](http://www.dpcare.org)

<sup>9</sup> “Sorting through the new reimbursement models,” by Beth Thomas Hertz, *Medical Economics*, September 25, 2013.

<sup>10</sup> *The Future of Health-Care Delivery: Why It Must Change and How It Will Affect You*, by Dr. Stephen Schimpff, M.D., Potomac Books, 2012, pp 99-100.

DPC practices are structured to optimize value for patients and put patients first (rather than the vendors and insurance companies), and they do so transparently.



DPC practices are structured to optimize value for patients and put patients first.

Healthcare writer Brian Klepper provides an illustration of the approach in his *Medscape* article “A Better Way to Manage Care and Cost”<sup>11</sup>:

*“Most [DPC practices] operate outside fee-for-service reimbursement. So rather than having an incentive to deliver more products and services, making a margin on each one, they are paid to manage the care and cost processes. This means they have no incentive to deliver unnecessary care (or deny necessary care). Instead, they are rewarded if they implement mechanisms that ensure the appropriateness of care throughout the care continuum.*”

In a DPC model, physicians are empowered to practice medicine in ways not permitted by the time constraints of traditional medical practices, and they themselves are energized by the opportunities. A doctor in California who converted to a flat-fee practice echoed the sentiment of many doctors who are also considering the same:

*“I’m going back to my first love—primary care—and care for the sickest diabetes or cardiology or rheumatology patients, do fabulous work with them, keep them out of the hospital 60%-70% of the time, and do wonderful preventive care.”<sup>12</sup>*

The following metrics point out the principal differences between a traditional fee-for-service and a DPC medical practice structure:

	<b>Traditional Fee-for-Service Insurance Reimbursement Model</b>	<b>Direct Primary Care Flat-Fee Model</b>
Patients Per Day Seen Per Physician (National Average)	25-35	12-15
Patient Panel Size Per Physician (Typical)	2000-3000	600-800
Amount of Time Patient Usually Spends With Healthcare Provider	7-10 minutes	30-60 minutes

<sup>11</sup> “A Better Way to Manage Care and Cost,” by Brian Klepper, *Medscape*, October 10, 2013.

<sup>12</sup> “Concierge Practices Even for Doctors Who Don’t Like the Idea,” *Medscape*, quote by Thomas W. LaGrelus, M.D., a family physician and geriatrician in Torrence, CA.



See Appendix A for a list of typical services provided in DPC, and optional add-on services included in some practices.

### Direct Primary Care Gets High Marks in Patient Satisfaction

There is a high percentage of satisfaction among DPC patients. In the State of Washington, the Insurance Commissioner is tasked with annually reporting to the Legislature on direct primary health care practices including participation trends, complaints, etc. The commissioner's 2012 report accounted for 29 DPC practices treating 12,629 patients (7 clinics did not report their patient numbers). The report stated that the agency's hotline has received NO formal or informal complaints regarding any of the direct patient practices in 2012.

### Direct Primary Care Fees

Fees for DPC membership or subscriptions are set by individual medical practices. Fees can vary by age, family group or other criteria, but they usually range from \$50 to \$200+ per single adult.

"It's not just for the rich and famous anymore," Mark Hawkins, president of physician staffing firm Merritt Hawkins, said of [direct pay] medicine and direct primary care practices. "If you can afford a gym membership, you can afford this kind of care."<sup>13</sup>

"If you can afford a gym membership, you can afford [Direct Primary Care]"  
--Mark Hawkins, President  
Merritt Hawkins  
*Leading Physician Search and Consulting Firm*

DPC practices are affected by free-market principles, which could lower local and national pricing with volume.

### How Direct Primary Care Works Within the ACA

A DPC may operate a medical practice outside of the ACA on the same basis as any other provider of medical care.

DPC may also operate within the ACA. A clause specifically recognizing the DPC Medical Home was included in the ACA. It allows DPC providers to operate in state-based insurance exchanges beginning in 2014<sup>14</sup>

<sup>13</sup> "1 In 10 Doctor Practices Flee Medicare To Concierge Medicine" by Bruce Japsen, *Forbes* online, Jan. 30, 2013.

<sup>14</sup> Senate Language – H.R. 3590EAS – SEC. 10104 (3). On P. 2068 TREATMENT OF QUALIFIED DIRECT PRIMARY CARE MEDICAL HOME PLANS The Secretary of Health and Human Services shall permit a qualified health plan to provide coverage through a qualified direct primary care medical home plan that meets criteria established by the Secretary, so long as the qualified health plan meets all requirements that are otherwise applicable and the services covered by the medical home plan are coordinated with the entity offering the qualified health plan.

DPC is the only non-insurance offering to be authorized in the insurance exchanges. Within ACA, DPC practices are not considered insurers and are only authorized to offer primary care services to their direct practice patients and not comprehensive health care. Therefore under ACA, DPCs alone are not “qualified health plans” (QHP) eligible for sale through the state healthcare exchange. However the law specifies that a QHP may provide coverage *through* a qualified DPC medical home plan. Thus, a direct care practice may contract with a carrier to provide the primary care services included in the carrier’s qualified health plans that cover unpredictable and expensive services outside the scope of primary care [these plans are referred to as wrap-around plans].<sup>15</sup>

Wrap-around plans provide for healthcare services outside the purview of primary care including emergency and specialty care, surgery, hospitalizations, specialty medical testing and other essential health benefits.

The recognition of direct primary care in the ACA has prompted some insurance companies to design wrap-around plans to pair with DPC practices. Because the plans do not need to cover routine care, a patient will save money on premium costs.

Louisiana is among the 26 states that left all responsibility for its health insurance marketplace to the federal government.

### **Do Direct Primary Care Providers Take Traditional Insurance and Medicare?**

Although “pure” DPC practices do not accept insurance or Medicare reimbursements, some hybrid models may choose to do so. (Future federal legislation could bring DPC to those enrolled in both Medicare and Medicaid, allowing access for those most in need.)

The American Academy of Family Physicians has outlined a framework for physicians entering into or converting their practices into DPCs. If a hybrid DPC practice chooses to participate in an insurance plan or Medicare, practice providers are required to make clear to patients what medical services and procedures are covered by the insurance carrier contract. DPC practices may choose to see Medicare beneficiaries as long as the practice’s retainer fee does not cover services already covered under Medicare. DPC retainer contracts must not conflict with Medicare’s regulation of [direct pay-style] care delivery.



The guidelines also state it is up to DPC practice owners and administrators to determine how much support the practice will provide to patients in managing claims.<sup>16</sup>

<sup>15</sup>“How Will Direct Primary Care Work With Health Reform?” Direct Primary Care Journal online, [www.dpcare.org](http://www.dpcare.org)

<sup>16</sup> Direct Primary Care: An Alternative Practice Model to the Fee-For-Service Framework, American Academy of Family Physicians, [http://www.aafp.org/dam/AAFP/documents/practice\\_management/payment/DirectPrimaryCare.pdf](http://www.aafp.org/dam/AAFP/documents/practice_management/payment/DirectPrimaryCare.pdf) , Accessed March 16, 2014.

The American Medical Association has also established ethical and practice guidelines for retainer-based practices.<sup>17</sup>

### Handling Medical Needs Beyond the Purview of Primary Care

DPC physicians usually have a comprehensive network of specialists and healthcare providers for referral of patients whose medical needs fall outside of those typically handled in a primary care setting.

DPC doctors typically coordinate care with those providers, to help ensure patients receive appropriate follow-up care.

### DPC: A Value Option for Many Individuals

In a 2012 poll, Gallup researchers found that 30% of U.S. adults say that they, or a family member, have put off medical treatment in the past year because of costs. According to Gallup, one possible [explanation]...is **the increase in the number of high-deductible plans.**<sup>18</sup> When care is delayed, patients can be sicker. Delays, then, may raise overall costs.<sup>19</sup>



With DPC, financial costs to families can drop by hundreds or even thousands annually.

A recent Market Watch article underscores the dilemma. The writer poses the logical question: *If the ACA already requires individuals to buy health insurance, why would they choose DPC, too?* The apparent rationale: Cost and convenience. Most people will never reach their deductibles, and DPC saves out-of-pocket costs and facilitates their access to primary care providers.<sup>20</sup>

A recent study suggests it is also a matter of quality of life. Students at North Carolina State University who studied the practice of Dr. Brian Forrest, an early adopter of the DPC model, found that his patients with normal insurance spent 12% less out-of-pocket at his practice than by going to a “regular” doctor, and his practice kept them healthier.<sup>21</sup>

Many patients experience even greater healthcare costs savings. According to the *Direct Primary Care Journal*, the combined cost of the primary care provider monthly fee and a

<sup>17</sup> American Medical Association, Opinion 8.055 - Retainer Practices, [www.ama.org](http://www.ama.org)

<sup>18</sup> “Costs Still Keep 30% of Americans from Getting Treatment,” by Alyssa Brown, Gallup online, December 9, 2013.

<sup>19</sup> “Higher Copayments and Deductibles Delay Medical Care, A Common Problem for Americans,” by Martin Sipkoff, Managed Care Online, January 2010.

<sup>20</sup> “Is Obamacare driving doctors to refuse insurance?” by Jen Wieczner, Market Watch online, November 12, 2013.

<sup>21</sup> Ibid.

lower-premium insurance plan is significantly lower than paying for soup-to-nuts health insurance that covers even basic primary care needs. This is important when more than three-quarters of America's uninsured are working families. The annual income from a full-time, minimum wage job is only a few hundred dollars more than the cost of an average family insurance plan. With direct primary care, supported by a low-premium "wrap-around" insurance plan that covers everything primary care facilities do not, cost to families can drop by as much as 50%, saving hundreds or even thousands annually.<sup>22</sup>

### **DPC: A Cost-Effective Option for Many Employers**

The ACA was predicted to assist and affect small business in several ways.<sup>23</sup> Beginning in 2014, small businesses (companies with fewer than 50 employees) were to be allowed to participate in Small Business Health Options programs (SHOP) even though they were not required by the ACA to do so. The combined risk purchasing pools were intended to lower the costs of insurance. Very small businesses might qualify for healthcare tax credits.

However the Department of Health and Human Services announced a delay until sometime in November. The setback applies to small business owners in the 34 states that are letting the federal government run part or all of their insurance marketplaces, including Louisiana.

Additionally all the anticipated cost savings might not realized. According to a recent federal actuarial report, 65% of small businesses will see their health-insurance premiums *increase* under part of the ACA. The report concluded that about 65% of small businesses, or plans covering 11 million people would be affected; about 35% of employers would see plan [costs] decrease.<sup>24</sup>

Most small businesses have already seen medical insurance premiums rise dramatically. Ninety-six percent of small businesses say their premiums have increased in the past five years, with the average monthly insurance cost soaring from \$590 per employee in 2009 to \$1,121 in 2014, the National Small Business Association found in a recent survey of its members.<sup>25</sup>

In testimony to members of a House Subcommittee in Washington, NSBA President Todd McCracken expressed his members' worries: "The survey confirmed what has been widely

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<sup>22</sup> Direct Primary Care Journal online, [www.dpcare.org](http://www.dpcare.org).

<sup>23</sup> Note: Small employers, those with 50 or fewer full-time workers as defined for ACA purposes, are not required to provide healthcare coverage or fill out any forms. However many employers *do* provide healthcare benefits in order to attract and keep the best employees.

<sup>24</sup> "Rising Premiums May Hit Small Firms," by Jennifer Corbett Dooren, *The Wall Street Journal* online version, February 24, 2014. Accessed March 19, 2014.

<sup>25</sup> "Obama administration: Health law's new rules will increase costs for most small businesses," by J.D. Harrison, *The Washington Post*, February 25, 2014.

reported about health care costs for our smallest companies, they are rising steeply, and entrepreneurs are deeply concerned about what the future might hold.”<sup>26</sup>

Reportedly medium-sized employers, those with 50-99 workers, have now been given until 2016 to provide insurance or risk a federal penalty for not complying.<sup>27</sup> Larger employers’ mandate requirements have also temporarily changed.

*Employers and union groups across the country are realizing the benefits of containing costs and strengthening employee wellness and productivity through DPC practices.*

Confusion about the employer mandate and uncertainties about the cost of providing healthcare benefits have caused many businesses to investigate the DPC concept, which has already demonstrated its ability to contain costs, strengthen workforce wellness, increase productivity, and reduce absenteeism and presenteeism (attending work while sick).

Researchers who explored the correlations among primary care, employee productivity and healthcare cost management offered three reasons employers should consider a primary care model (*Sepulveda, Bodenheimer and Grundy*<sup>28</sup>):

1. [The] evidence shows, primary care has the potential to contain health care costs, particularly by reducing ambulatory care–sensitive (ACS) hospital admissions, emergency department (ED) visits, and inappropriate specialty consultations.
2. Prompt access to a well-functioning primary care “home” can improve employees’ satisfaction with care, thereby reducing employers’ need to handle employees’ health care–related complaints.
3. Primary care is the site of most care for chronic conditions and has the potential to produce better patient outcomes and reduce the absenteeism and low productivity associated with chronic disease.

Consider these examples of large, mid-size and smaller employers who have implemented the primary care medical home concept:

**The IBM Experience.** In a revolutionary study using the patient-centered primary care medical home concept—a practice model that shares many characteristics of DPC—IBM discovered a simple yet effective formula: More primary care access led to a healthier population which, in turn, led to less money spent. Paul Grundy MD, IBM’s Corporation’s Global Director of Healthcare Transformation, stated the following about the project:

<sup>26</sup> “NSBA President Testifies on Affordable Care Act,” <http://www.nsba.biz/?p=7644> March 12, 2014, Accessed March 17, 2014.

<sup>27</sup> “White House Delays Health Insurance Mandate For Medium-Sized Employers Until 2016,” by Juliet Eilperin and Amy Goldstein, *The Washington Post* online version, February 10, 2014. Accessed March 19, 2014.

<sup>28</sup> “Primary Care: Can It Solve Employers’ Health Care Dilemma?” by Martin J. Sepulveda, Thomas Bodenheimer and Paul Grundy: 10.1377/hlthaff.27.1.151 *Health Affairs*, January 2008, Vol. 27 No. 1 151-158.

*“In this model patients have superb access to care and we’re talking about profound patient engagement. In North Carolina, where we’ve been doing this for about seven years, there is a 42% decrease in hospitalizations for asthmatics and when you look under the covers it’s about patient engagement... This is what we want to buy, this what we’re going to buy: We want care that is comprehensive, that’s integrated, that’s coordinated, and that’s accessible...”*

**The Valero Energy Corporation Experience.** In San Antonio, Valero Energy Corporation has an on-site direct primary care-style clinic for employees. In 2012, the Valero clinic logged more than 10,000 office visits by 2,000 employees. For Valero, the average cost to the company per clinic visit is \$120 to \$130—compared to \$150 to \$200 per office visit by other health care providers, says Ruth Piña, vice-president of Valero’s Human Resources. She estimates Valero saves an average of nearly 25 percent in health care costs with the clinic — a return of two times the company’s investment.<sup>29</sup>

The company has added clinics at refineries in Corpus Christi, Port Arthur, Texas City and has plans to roll out one in St. Charles, La.<sup>30</sup>

**The Salt Lake County Experience.** In Utah, DPC provider PrimeCare Direct partnered with the Salt Lake County government to operate a DPC-type clinic for county employees. The onsite clinic “incorporated all the attributes of the DPC medical home model to provide accessible, coordinated, evidence-based medical care that focused as much on well care as much as sick care.” As a result, the practice stated that it reduced the county’s overall health care costs by at least 15%.<sup>31</sup>

Even with a combination of direct primary care membership and lower-cost “wrap-around” insurance policies, employers opting for this combined option have routinely saved 20 to 35 percent on comprehensive health care benefits over what they currently spend, while employees’ payments (including premium cost-sharing, deductibles, co-payments and co-insurance) drop significantly.<sup>32</sup>

*Employers opting for DPC plus lower-cost wrap-around insurance policies have routinely saved 20-35% on comprehensive health benefits.*  
--Direct Primary Care Journal

With DPC, businesses can better manage the cost of employee healthcare while keeping their workforces “well.”

<sup>29</sup> “Health By Design: Reducing costs, increasing workforce wellness,” by Jenny Halpin, San Antonio Business Journal online version, June 28, 2013.

<sup>30</sup> Ibid.

<sup>31</sup> White Paper: *An Analysis of the Efficacy of Cost Containment Modalities Adopted by PrimeCare Direct*, Theodore F. Linn and Michael Jennings, M.D., February 2013.

<sup>32</sup> Direct Primary Care Journal online, [www.dpcare.org](http://www.dpcare.org).

## DPC, Employer-Provided Health Plans and Federal Law

A DPC may operate a medical practice outside of the ACA on the same basis as any other provider of medical care. Paired with a qualified wrap-around insurance plan, DPC is ACA compliant.

Legal firm McDonald Hopkins is seemingly optimistic that a favorable regulatory climate is on the way for other DPC-related matters. The following statement was noted in the firm's e-newsletter in a 2014 article on direct primary care: "Though it's not explicitly slated in the ACA, and HHS regulations are not available, it seems likely that the IRS will treat DPC-modeled employer health plans—including the monthly membership fees paid by employers—the same way as other employer-provided health plans."<sup>33</sup>

The Direct Primary Care Coalition and a large number of DPC providers and healthcare stakeholders are working with members of Congress to change the Health Savings Account (HSA) regulations so that individuals can pay DPC fees out of their HSAs. We understand that federal legislation has received bipartisan support in Congress.

In 2011, bipartisan federal legislation was introduced by Rep. Bill Cassidy (R) and then Rep. Jay Inslee (D-WA) to bring DPC to people enrolled in both Medicare and Medicaid, which would improve access and quality for those most in need while reducing costs. The bill would create a demonstration program at the Centers for Medicare and Medicaid Services. It indicated growing federal recognition of the importance of the direct primary care model.

## DPC's Potential to Mitigate the Loss of Primary Care Physicians

Many states including Louisiana are facing a physician shortage. Primary care physicians, the gateway providers for most patients into the healthcare system, are in high demand.

At the same time, some physicians are leaving practice due to burdensome administrative demands, treadmill-like requirements of seeing 25-35 patients a day, increased regulations, reduced reimbursements and the potential of financial risks associated with patients who do not pay their ACA insurance premiums.

New data from a national survey of nearly 14,000 physicians conducted by physician staffing firm Merritt Hawkins for The Physicians Foundation, analyzing 2012 practice patterns, found that 9.6 percent of "practice owners" were planning to convert to [direct pay-style] practices in the next one to three years. The movement is across all medical disciplines with 6.8 percent of all physicians planning to stop taking insurance in favor of direct-pay.<sup>34</sup>

*Almost 10 percent of practice owners are planning to switch to [direct pay]- style medicine in 1-3 years; almost 7% of all physicians plan to stop taking insurance in favor of direct-pay.*

<sup>33</sup> "The Direct Primary Care Home Plan," *Alert* (e-news online), McDonald Hopkins's Attorneys at Law, January 16, 2014, <https://www.mcdonaldhopkins.com>.

<sup>34</sup> "1 In 10 Doctor Practices Flee Medicare to Concierge Medicine," by Bruce Japsen, *Forbes.com*, January 20, 2013.

Many physicians who have or are considering leaving practice find an opportunity to re-start their careers by entering direct primary care medicine.

Doctors tend to like direct primary care because it relieves them of the administrative burden of dealing with insurance, accelerates the cash cycle of their business, and allows them to focus more purely on delivering great patient care.<sup>35</sup>

There is also anecdotal evidence that suggests a growing number of medical school graduates, who would otherwise avoid primary care in favor of higher-salaried specialty fields (to repay huge educational debts and for other reasons) are now choosing primary care due to the emerging popularity of DPC.

In an online blog, a fourth-year medical student expressed his enthusiasm for “discovering” a medical practice model (DPC) that will allow him to fulfill his dreams about becoming a doctor. He wrote, “Direct primary care makes me incredibly optimistic about the future.”<sup>36</sup>

The *Direct Primary Care Journal* states that DPC could help curb the exodus of doctors from the primary care workforce.

### **Direct Primary Care – Health *Care*, Not Health Insurance**

DPC is explicitly non-insurance and does not satisfy the risks characteristics of an insurance product. Direct Primary Care providers do not practice insurance; they do not recommend or sell insurance plans, indemnify risks or share the cost of plans purchased. DPC fees and services are entirely transparent, and fee agreements do not constitute premiums requiring underwriting.

When DPC providers consult or work with insurance companies or employers, those relationships are governed under existing insurance law and federal regulations.

**DPC is explicitly non-insurance.**

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<sup>35</sup> “Disrupting the Traditional Primary Care Business Model- Direct Primary Care,” by Ben Wanamaker, Clayton Christensen Institute, October 31, 2013.

<sup>36</sup> “Why Medical Students Should Be Excited about Direct Primary Care,” by Brian Lanier, Primary Care Progress online blog, Posted January 2, 2014. PCP is a non-profit network of healthcare educators, trainees and healthcare providers. [www.primarycareprogress.org](http://www.primarycareprogress.org).



## **DPC is Another Tool for the Healthcare Solutions Toolbox**

Healthcare quality, value and access are complex issues that require a variety of “tools” to alleviate and resolve. Privatized Direct Primary Care practices will complement the State’s responses to three of its key challenges. DPC services will:

- ✓ Improve the healthcare services of many citizens
- ✓ Provide economic relief for many financially-strapped employers
- ✓ Help mitigate the primary care physician shortage in Louisiana

## **Seven Important Reasons to Support Senate Bill 516**

Legislative support of Senate Bill 516 would result in a number of important benefits for the Louisiana residents and employers.

Passage of SB516 would:

1. Help employers source affordable employee healthcare benefits and provide cost-effective employee wellness programs.
2. Improve healthcare and quality of life for many Louisiana residents.
3. Alleviate the family practice shortage in Louisiana.
4. Encourage rapid expansion of new DPC practices statewide and benefit from the economic impacts of those practices.
5. Fast-track creation of more approved wrap-around insurance products to coordinate with DPC.
6. Align with anticipated federal legislation and HHS rulings.
7. Keep pace with other forward-looking states that have enacted similar DPC legislation.

## **Conclusion and Appeal for Positive Legislative Action**

The challenges the State faces today—how to deliver more preventive medicine, how to drive greater quality and value into our healthcare system, how to attract primary care providers, and how to support businesses that provide employees with healthcare benefits—requires that lawmakers and stakeholders consider innovative solutions such as Direct Primary Care.

We strongly recommend passage of SB516.

For a copy of the bill and to track its progress, go to <http://legiscan.com/LA/research/SB516/2014>

## APPENDIX A

### Direct Primary Care Services

The following services are typically offered in a DPC practice:

- Half hour- to hour-long office visits with annual physical exams
- No limits for pre-existing conditions
- No deductible or copayment (or nominal copayment) to minimize barriers to usage
- Same day or next day appointments for acute illness
- Affordable, predictable monthly fees
- Routine primary and preventive care (many practices include vaccinations, some lab tests, and some women's health service; some practices provide on-site procedures such as suturing, casting and splinting)
- Management of chronic diseases such as diabetes, hypertension and obesity
- Coordination of any needed specialist and/or hospital care
- One-on-one counseling for patients with chronic diseases and/or behaviors that lead to health issues such as smoking, obesity, etc.
- Many offer extended hours; some are open seven days per week,
- Most offer telemedicine services including phone and email consultations
- Many offer patient portals through their practice websites
- Many offer 24-hour phone access to a physician for urgent after-hours issues.

Depending on a DPC provider's size and scope of service, additional add-on services may be offered as part of the flat fee, at a discounted rate or for fee-for-service:

- On-site X-ray, laboratory and "first-fill" prescription medicine dispensary for many commonly prescribed medications
- Nutritional counseling, cooking classes
- Smoking cessation classes, wellness workshops
- Yoga
- Ultrasonography
- Physical therapy
- Sports and school fitness testing
- Group counseling for patients with chronic diseases and/or behaviors that lead to health issues