TEXAS PUBLIC POLICY FOUNDATION
RESEARCH
NOVEMBER 2020

Addressing the Primary Care Crisis by Expanding Access to Direct Primary Care

by David Balat
Policy Director, Right on Healthcare
John O'Shea, MD
Senior Fellow, Right on Healthcare

Key Points

- Primary care providers are essential to the nation's health. Their decisions determine patient outcomes as well as the efficiency of the healthcare system.
- Primary care is in a state of crisis characterized by physician burnout, outsized patient panels, increased administrative burden, reduced time spent with patients, low reimbursement, and a shrinking workforce.
- By reducing administrative burden and allowing primary care providers to spend more time with patients, Direct Primary Care (DPC) addresses many of the challenges facing primary care.
- In spite of the potential benefits and growing popularity of DPC and ongoing legislative efforts, barriers to wider adoption of the model remain.
- IRS definitions need to be updated to permit individuals who hold health savings accounts to access the benefits of DPC, and policymakers should include DPC as an option in public programs.

Abstract

Primary care providers are the vanguard of healthcare. The decisions they make influence patient outcomes and patient experience as well as the cost efficiency of the healthcare system. However, primary care is, by many accounts, in a state of crisis characterized by physician burnout, outsized patient panels, increased administrative burden, reduced time spent with patients, low reimbursement relative to other specialties, and a shrinking workforce in the face of an increasing demand for primary care services.

Direct Primary Care (DPC) is an alternative to the traditional fee-for-service method of financing and delivering primary care that can address many of these challenges. Although the DPC practice model is still evolving and there is no single accepted definition of what constitutes a DPC practice, DPC physician practices generally include certain elements: they contract directly with patients, charging them a recurring—typically monthly—subscription fee to cover most or all primary-care-related services; they do not charge patients per-visit, out-of-pocket amounts greater than the monthly equivalent of the subscription fee; and they do not bill third parties on a fee-for-service basis for services provided. DPC practices have shown the potential to generate reductions in unnecessary healthcare utilization, including emergency department usage and hospitalizations. Commonsense policy approaches are needed to remove barriers to wider adoption of DPC, including to public programs like Medicaid.

The Essential Role of Primary Care

"Primary care" has been defined in various ways: according to the specialty of the provider, as a set of functions served by a usual source of care, and as an orientation of a health system to provide that care (Friedberg et al., 2010). In 1996, the Institute of Medicine (1996) defined primary care as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community" (p. 1)—a definition that characterizes primary care as the logical foundation of an effective healthcare system and essential to achieving value in healthcare.

Although the variability in definitions of primary care makes data collection challenging, there is good evidence that having a primary care doctor can result in better health outcomes at lower cost. A 2019 study published in the *Journal of the American Medical Association, Internal Medicine* (Levine et al., 2019)

continued

reported that receipt of regular primary care was associated with significantly more high-value care and a better healthcare experience, while individuals without a stable source of primary care missed substantial healthcare benefits, including high-value cancer screening, diagnostic and preventive testing, diabetes care, and counseling. According to a July 2020 article published in BMC Family Practice (Hostetter et al., 2020), one or more primary care visits per year is associated with an increased likelihood of specific evidence-based preventative care interventions, such as vaccination (127% increase), colonoscopy (122% increase), and mammography (75% increase) that improve longitudinal health outcomes and decrease future healthcare costs.

Current Primary Care Crisis

In spite of its essential function, primary care is often described as being in a state of crisis, characterized by physician burnout, large patient panels, increased administrative burden, reduced time spent with patients, low reimbursement relative to other specialties, and a shrinking workforce.

Burnout

Given their central role in the healthcare system, it is particularly concerning that primary care providers (PCPs) report some level of burnout at a higher rate than providers in many other specialties. The most commonly cited factors that lead to burnout among PCPs include increased administrative burden from charting, paperwork, and electronic health records (EHRs); too many hours at work; lack of autonomy; government regulations; and an emphasis on profits over patients (Kane, 2019). In a 2019 survey of U.S.-based physicians (InCrowd, 2019), 79% of PCPs reported experiencing burnout at some level.

Too Many Patients

Primary care panel sizes are a critical component of primary care practices. A panel size that is too large (or too small) has implications for patient access, physician workload, clinician/patient satisfaction, care comprehensiveness, and overall quality of care. Although 2,500 is often used as the "standard" primary care panel size, it has been estimated that a PCP would need to work 21.7 hours per day to adequately deliver recommended health services to a panel of 2,500 patients (Yarnall et al., 2009). According to the American Academy of Family Practice (AAFP) Practice Profile (White & Twiddy, 2017), in 2015 the average panel size among family physicians was 2,194.

There is evidence in the literature suggesting a correlation between panel size and some measures of the quality of care. For example, larger panel sizes have been associated with poor diabetes control (Angstman et al., 2016) and decreased rates of preventive services, including cancer screenings, as well as increased rates of admissions for ambulatory-care-sensitive conditions (Dahrouge et al., 2016). Across primary care specialties, physicians report that pressure to provide greater quantities of services effectively limits the time and attention they can spend with patients, detracting from the quality of care provided (Friedberg et al., 2013). PCPs with larger panel sizes are also less likely to discuss health promotion activities, such as smoking cessation, healthy eating, or increased physical activity with their patients (Hogg et al., 2009).

On the other hand, *in a traditional primary care model*, where reimbursement is tied to the number of services provided, a panel size that is too small can result in financial instability for the practice and reduce the likelihood that the practice could weather a financial downturn. During the COVID-19 pandemic, primary care visits dropped precipitously, and it has been estimated that, nationally, the primary care system could face aggregate losses of as much as $15 billion (Basu et al., 2020). However, DPC practices that had a steady source of revenue from recurring payments were better positioned to weather the storm, and many have reported that their finances were relatively unchanged by the decline in patient visits caused by the pandemic (Pifer, 2020).

Administrative Burden

All physicians, and PCPs in particular, spend an increasing amount of time and effort performing nonclinical administrative and regulatory tasks. A time and motion study of ambulatory care published in the *Annals of Internal Medicine* in 2016 (Sinsky et al., 2016) found that physicians spent 27.0% of their total time in the office on direct clinical face time with patients and 49.2% of their time on EHRs and desk work. Even when in the examination room with patients, physicians spent only 52.9% of the time on direct clinical face time and 37.0% on EHR and desk work. Physicians also reported 1 to 2 hours of "after-hours" work each night, devoted mostly to EHR tasks. A 2016 *Health Affairs* study (Casalino et al., 2016) estimated that an average size medical practice spends 785.2 hours ($40,069 per physician or $15.4 billion per year in the aggregate) reporting on quality measures that do little to help improve care or assist patients with treatment decisions. It has been estimated that PCPs spend 9.9% more time on nonclinical paperwork than providers in other specialties (Physicians Foundation, 2018).

Workforce Issues

An analysis of projected supply and demand by the Association of American Medical Colleges (AAMC) predicts a shortage by 2033 of between 21,400 and 55,200 primary care physicians. Based on an analysis of American Medical Association Physician Masterfile data, the 2020

AAMC estimates include a slightly lower number of physicians trained in primary care who subspecialized or became hospitalists. However, this is offset by an increase in the number of physicians planning to retire earlier than previously modeled, according to analyses based on AAMC 2019 National Sample Survey of Physicians data (Association of American Medical Colleges, 2020, p. 5). This increase in the rate of retirement is consistent with reports of the effects of high levels of burnout on workforce turnover in primary care (Willard-Grace et al., 2019). There is also concern that the number of medical graduates entering the primary care workforce will not adequately offset the increasing number of retirees. Although a record number of primary care positions were offered in the 2019 National Resident Matching Program ("the Match"), the percentage of primary care positions filled by fourth-year U.S. medical students was the lowest on record (Knight, 2019). The Match figures for 2020 show that,

> *of the 34,266 first-year positions offered in the Match, 17,135 were in the primary care specialties of family medicine, internal medicine, internal medicine—pediatrics, internal medicine—primary, pediatrics, and pediatrics—primary, a 7.4 percent increase over the number offered in 2019. Of those, 16,343 (95.4%) were filled and 7,369 (45.1%) were filled by U.S. MD seniors. (*National Resident Matching Program, 2020, "Primary Care Specialties" section*)*

Overview of DPC

DPC is a practice and payment model where patients contract with their physician or physician practice directly in the form of periodic payments for a defined set of primary care services. The DPC practice model is still evolving, and much like primary care in general, there is no consensus on what constitutes a DPC practice. However, the most commonly used definitions generally include the following elements (Busch et al., 2020, p. 5):

1. The practice charges patients a recurring—typically monthly—subscription fee to cover most or all primary care-related services.[1]
2. The practice does not charge patients per-visit, out-of-pocket amounts greater than the monthly equivalent of the subscription fee.[2]
3. The practice does not bill third parties on a fee-for-service (FFS) basis for services provided.

One way to broadly categorize the various iterations of the DPC delivery model is the division between "pure" and "hybrid" models. A pure DPC model includes only patients whose care is financed by the membership fees, while hybrid models include both member patients and patients in the traditional third-party payment system. DPC practices exhibit a range of iterations, from small and independent practices with varying levels of network affiliation to larger practices that employ physicians and grow by marketing themselves directly to large employers (Eskew & Klink, 2015).

A 2018 AAFP survey reported that 80% of DPC practices were pure DPC, while 14% of practices were hybrid DPC. Of the hybrid practices, 42% plan to operate the model "indefinitely." Approximately 35% of current DPC practices converted from a more traditional practice setting, including participating in Medicare (Quinn, 2018). As of November 2020, the DPC Frontier "Mapper" lists 1,350 DPC practices across 48 states and Washington, D.C., with the vast majority being pure DPC models (DPC Frontier, 2018).

According to a market survey done by Milliman, Inc. and published by the Society of Actuaries in May 2020, the majority of DPC practice revenues typically come from monthly or annual DPC subscription fees, and the average per-person monthly DPC fees reported in the analysis were "$40 for children and ranged from $65 to $85 for adults, depending on age. Most DPC practices do not charge a per-visit fee for services covered under their DPC memberships (89%)." Also according to the analysis, "DPC practices usually have fewer patients than traditional primary care practices, typically fewer than 1,000 and most often around 200 to 600" (Busch et al., 2020, pp. 7, 12). The 2018 AAFP survey found that 17% of DPC practices have achieved their full desired panel size of 600 patients (Quinn, 2018).

The DPC fee generally covers primary care services that may include preventive care, office visits for acute and chronic illnesses, home visits, lab tests, basic medication, care coordination, 24/7 access and follow-up visits—in person or via phone, email and telehealth. Care coordination may include navigating patients to lower-cost or discounted ancillary services, such as lab tests and imaging. The subscription fee does not cover specialists or emergencies, and it is recommended that patients also have a high deductible health plan/wraparound catastrophic policy.

1 DPC differs fundamentally from traditional capitation in that the patient, rather than an insurance company, is the payer. This direct patient-doctor link creates a system where doctors are incentivized to keep patients well without limiting patient care in order to comply with insurance company parameters—a problem seen with capitated models like the health maintenance organizations (HMOs) of the 1990s.

2 DPC differs from insurance since DPC providers do not assume risk for additional services that are not provided under the agreement. A patient can be charged additional ancillary fees for services such as labs, imaging, and minor procedures. Some practices charge a low subscription fee and an additional per-visit fee to discourage overuse of services. However, if the per-visit fee is higher than the monthly subscription fee, the practice functions more like a cash pay practice and may be subject to insurance regulations. For a more detailed discussion of the definition of DPC, see DPC Frontier, n.d.

How DPC Could Address the Current Crisis in Primary Care

DPC can address many of the issues at the heart of the current primary care crisis. Through the use of appropriately sized patient panels and a reduction in the nonclinical administrative burden, PCPs can provide more high-value primary care that will result in better outcomes, cost reductions, and enhanced patient and provider satisfaction.

More Patient Time and Enhanced Access Equals More Care

Excluding the time spent interacting with patients via telephone or electronic communications, the average amount of time physicians spend with the patient in a DPC practice is higher than in a traditional primary care practice. According to the 2017 Medscape Physician Compensation Report, most family physicians (70%) spend between 13 and 24 minutes with each patient and 21% spend 12 minutes or less (Medscape, 2017). Because of a heavy administrative burden (coding and documenting in EHRs), even a portion of this time is often not spent facing the patient (Eskew, 2016). By contrast, in DPC practices, office visits average about 35-40 minutes (Busch et al., 2020, p. 13; Eskew & Klink, 2015, p. 796). In addition to more time spent with patients in the office, many DPC practices include home visits ("house calls") and telehealth encounters in their covered services.

Cost Reduction

For a number of reasons, including the variety of DPC iterations, the small size of most practices, and the general desire of most DPC providers to reduce their administrative and reporting burden, there is currently a relative paucity of data on cost and quality outcomes in the literature. The existing literature does, however, suggest the potential for DPC to reduce unnecessary care and lower costs for patients, employers, and the healthcare system.

The 2020 Society of Actuaries report includes a case study that analyzed data from a single employer that offers a DPC benefit option and a traditional benefit option and compared cost outcomes during the same 2-year period[3] between 912 members enrolled in DPC and 1,074 members enrolled in the traditional option (Busch et al., 2020, pp. 27-35). The following are key results from the case study:

- DPC members had 19.90% lower claim costs for employers on an unadjusted basis and 12.64% lower claim costs on a risk-adjusted basis during the 2-year period.[4]
- DPC members had 36.39% lower ER usage on an unadjusted basis and 40.51% lower usage on a risk-adjusted basis than those in traditional plans.
- DPC members experienced a 53.6% reduction in ER claims cost on a risk-adjusted basis.
- DPC members experienced 25.54% lower hospital admissions on an unadjusted basis and a 19.90% lower rate on a risk-adjusted basis.

These findings support previous analyses that suggest that primary care models with smaller panel sizes and a higher frequency of encounters can lead to lower healthcare costs (Ghany et al., 2018).

Importantly, the reductions in healthcare costs are evident not just at the system level, but at the patient level as well. Most DPC practices do not charge any cost sharing for services covered under the DPC subscription fee. Since as many as roughly 3 in 10 Americans have delayed or forgone seeking medical treatment due to costs (Saad, 2018), removing financial barriers that are often the cause of patients forgoing care such as missing follow-up visits should lead to improved care and better health outcomes.

Patient Satisfaction

According to the Society of Actuaries market survey, on average, "DPC members are able to schedule an appointment with their DPC provider within one day, wait just four minutes in the DPC office for scheduled appointments to begin, and spend 38 minutes with the DPC clinician during visits" (Busch et al., 2020, pp. 5, 16). Most DPC members are able to access their personal EHRs through a patient portal (58%) and are also able to manage their enrollment through the DPC practice's website (58%). Practices in the survey indicated that they expect the DPC model of care to

- *Improve patient satisfaction with primary care experience (98%).*
- *Increase the extent to which patients rely on their PCPs to navigate the health system for nonprimary care services (81%).*
- *Lower patient out-of-pocket costs for primary care services, including the DPC membership fee (81%).*
- *Increase patient compliance with preventive care guidelines (68%). (p. 16)*

Provider satisfaction

In general, DPC providers report being very satisfied with their choice to practice in the DPC model with the primary

3 The average exposure period for selected members during the 2-year period of interest was 22.0 and 21.9 months for the DPC option and traditional option, respectively.

4 The risk-adjusted results account for differences in health status of patients. Unadjusted results do not account for these differences.

motivators for choosing to operate a DPC practice being "the 'potential to provide better primary care under a DPC model' (96%), 'too little time for FFS visits' (85%), and 'too much FFS paperwork to complete' (78%). Just 10% … indicated that the 'potential to earn more under DPC' was a primary motivator" (Busch et al., 2020, p. 14). Most respondents also "reported that each of the following has been better or much better under a DPC model of care:

- Overall (personal and professional) satisfaction (99%).
- Ability to practice medicine (98%).
- Quality of primary care provided (98%).
- Relationships with their primary care patients (97%).
- The amount of time spent on paperwork (88%).
- The amount of time spent at the office (73%)." Thirty-four percent "of respondents reported having better or much better earnings as a PCP under a DPC model of care (Busch et al., 2020, p. 15).

Workforce

One criticism of DPC from a public policy viewpoint is that wider adoption of the model will exacerbate the projected primary care physician shortage (Weisbart, 2016). Even proponents of DPC admit that this may be an effect of DPC adoption in the short term. However, they argue that with greater access to DPC and with more effective and efficient delivery and use of primary care, career satisfaction will increase, the number of specialty referrals will fall, and the disparity between primary care and specialty physician compensation could eventually shrink, incentivizing physicians to enter and remain in the primary care workforce (Eskew, 2016, p. 13).

Current Policy Efforts

An important barrier to wider adoption of DPC is the treatment of DPC service arrangements by the Internal Revenue Service (IRS) that makes individuals in these arrangements ineligible to contribute to a tax-favored Health Savings Account (HSA). Generally, to qualify for an HSA an individual must be covered under a high-deductible health plan (HDHP) and, with a few exceptions, have no additional health coverage. Under current law, the IRS Code considers an individual in a DPC arrangement ineligible to contribute to an HSA and considers DPC subscription fees as insurance and not as payment for medical services (IRS, 2019). There are ongoing efforts to address this issue at the state and federal levels, as well as to include access to DPC in public health programs.

State level

According to the Direct Primary Care Coalition, as of 2020, Direct Primary Care laws have been passed in 32 states with pending legislation in 12 states. In general, these laws define DPC as a medical service outside of state insurance regulation and offer varying levels of consumer protection (Direct Primary Care Coalition, 2020). In 2015, Texas became the 13th state to enact Direct Primary Care legislation when the Legislature passed and the governor signed House Bill 1945 "An Act Relating to the Provision of Direct Primary Care." (HB 1945, 2015). This legislation specifies that a Direct Primary Care service agreement is not health or accident insurance or coverage and is not subject to regulation by the Texas Department of Insurance. It provides additional protections by specifying that no state agency, health insurer, or health maintenance organization can prohibit, interfere with, or initiate a legal proceeding against a physician solely because the physician provided DPC, or against a person solely because the person paid a fee for DPC. However, as explained below, further efforts at the federal level are needed.

Bills have also been introduced in Indiana, Missouri, Minnesota, Oklahoma, Colorado, and Iowa that include provisions to expand DPC to Medicaid (Eskew, 2020). New Jersey (NJ Treasury, n.d.) and Nebraska (Nebraska Dept. of Administrative Services, n.d.) currently offer DPC as an option in their state employee plans, and Tennessee introduced a bill in the General Assembly in 2019 that, if passed, would have required the Department of Finance and Administration "to study the feasibility of adding direct primary care as a covered benefit under one or more of the basic health plans approved by the state insurance committee for eligible state employees" (HB 0894/SB 0696, 2019).

Federal Level

While language in passed or pending state legislation, as well as in the Affordable Care Act,[5] expressly states that DPC is not insurance, the IRS maintains the viewpoint that a contract with a DPC practice constitutes a second health plan, which makes an individual with such an arrangement ineligible to use or contribute to a health savings account (HSA). On June 24th, 2019, the president issued an "Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First" urging the secretary of the treasury to propose regulations that would potentially clarify that DPC expenses are qualified health expenses under 213(d) of the Internal Revenue Code (Executive Order No. 13,877, 2019).

5 The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, § 10104 contains a provision in Section 10104 stating that the Secretary of HHS "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." For a full discussion, see: https://www.law.cornell.edu/uscode/text/42/18021

On June 10, 2020, the Treasury Department and the IRS released proposed regulations stipulating that because they typically provide for primary care services such as physical examinations, vaccinations, urgent care, and laboratory testing, DPC arrangements generally count as health insurance that is not a high-deductible health plan (HDHP)[6] and that is not disregarded coverage[7] or preventive care. Since the proposed rule failed to address the key issue of redefining DPC as a medical service outside of health plan or insurance regulation, individuals covered by a DPC arrangement would continue to be precluded from contributing to an HSA (Department of Treasury, 2020).

Since at least 2014, a number of stakeholders have made efforts to provide input and urge the IRS to change their position on DPC.[8] The IRS has formally responded on at least two occasions but has given no indication that its position would change without legislative action.[9]

Over the past several years, a number of bills have been introduced at the federal level that include provisions that would allow patients and their employers to securely use DPC plans through HSAs by providing clarification that DPC subscription fees are a qualified medical expense under 213(d)[10] and are not health plan fees as defined by current law under 223(c). For example, S. 3112, the Personalized Care Act of 2019 (Personalized Care Act, 2019), sponsored by Sen. Ted Cruz and introduced in the Senate on December 19, 2019, and H.R. 5596, the Personalized Care Act of 2020 (Personalized Care Act, 2020), sponsored by Rep. Chip Roy (R-TX) and introduced in the House on January 14, 2020, would include these provisions for all DPC arrangements. Another bill introduced in the House by Rep. Roy, the Veterans Access to Direct Primary Care Act, would require "the Department of Veterans Affairs (VA) to implement a five-year pilot program to provide eligible veterans with the option to receive primary care services from a non-VA healthcare provider under a direct primary care service arrangement through the use of a veteran health savings account" (H.R.6259, 2020; Veteran Access to Direct Primary Care Act, 2020).

Policy Recommendations

Promote Choice, Competition, and Value by Removing Barriers to Wider Adoption of DPC

Although the Patient Protection and Affordable Care Act and legislation in a majority of states expressly affirm that DPC is not insurance, further action at the federal level is needed for patients to safely fund and use HSAs for DPC. IRS definitions need to be updated so that the tax code conforms with other relevant state and federal laws. In order to permit individuals that hold HSAs to access the benefits of Direct Primary Care, the Internal Revenue Code (IRC) needs to clarify that DPC does not constitute a health plan under IRC Section 223(c), and that periodic payments to DPC practices for primary care services are to be treated as qualified medical expenses under Sec.213 (d). Ideally, this should be done without unnecessary restrictions on the type of arrangement a patient and their doctor freely choose and that best suits the needs of the patient. Giving patients greater control of their healthcare resources and more choice over the care they receive will lead to greater competition based on the value of the care provided.

Expand DPC to the Medicaid Population

Medicaid accounts for a significant and growing portion of spending in most state budgets (Rosewicz et al., 2020). In the state of Texas, for example, spending on Article II (Health and Human Services), which administers Medicaid, represented more than 36% of the All-Funds[11] appropriations for the 2018-19 biennium. Medicaid is the costliest Article II program, receiving $61.8 billion in All Funds for the biennium, or 78% of the total Article II funding (Texas Comptroller, 2018, pp. 6-7). By minimizing the costs associated with unnecessary care in the Medicaid program, DPC could help considerably to alleviate the stress on state budgets and reduce taxpayer burden.

The emergency department (ED) is an inappropriate and expensive way to provide care for non-urgent medical conditions. Nationally, patients with Medicaid, CHIP, or "other state-based programs" as an expected source of payment accounted for 40.3% of emergency department visits in 2017, significantly more than the privately insured (31.2%), Medicare beneficiaries (18.5%), or the uninsured (8.0%) (National Center for Health Statistics, 2020, Table 6). Barriers to timely primary care have been associated with increases in ED utilization. Reported barriers include

6 According to the IRS, DPC is not considered an HDHP because it provides coverage for HDHP benefits before the minimum annual deductible has been met.

7 Section 223(c)(1)(B) of the Internal Revenue Code provides that, "in addition to coverage under an HDHP, an eligible individual may also have specifically enumerated coverage that is disregarded for purposes of the deductible" (IRS, 2004).

8 See, for example, Letter to IRS from Sens. Cantwell and Murray, and Rep. McDermott, June 17, 2014, Letter to the IRS from Sens. Cruz and Johnson, April 17, 2018, Letter to the IRS from Docs 4 Patient Care Foundation, January 4, 2019.

9 See, for example, Letter from John A. Koskinen to Sen. Murray, June 30, 2014, Letter from Drew Maloney to Sen. Cruz, May 15, 2018 ().

10 For the purposes of IRS Code 223(d), qualified medical expenses are amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body, for transportation to receive that care, and for certain long-term care expenses. See: 26 USC § 213(d)(1).

11 All Funds include General Revenue Funds, General Revenue dedicated funds, federal funds, and other funds.

(a) inability to contact the office; (b) inability to get an appointment soon enough; (c) excessive wait to see the doctor after arriving at the office; (d) inconvenient office hours; and (e) lack of transportation (Cheung et al., 2011). The Medicaid and CHIP Payment and Access Commission reported that, "despite the fact that nearly all Medicaid enrollees report having a usual place of care other than the ED, approximately one-third of adult and 13 percent of child enrollees have reported barriers to finding a doctor or delays in getting needed care" (Medicaid and CHIP Payment and Access Commission [MACPAC], 2014b; MACPAC, 2014a).

According to a Texas Department of State Health Services analysis of hospital emergency department data from 2018 (Texas Department of State Health Services, 2019), the most frequent payer source from all avoidable ED visits in Texas was Medicaid (29.2%), followed by uninsured or self-pay (27.2%), private insurance (27.1%), and Medicare (13.9%). In 2014, 31% ($n = 346{,}651$) of Texas Medicaid adult enrollees visited the ED at least once, and only 13% of those ED visits were considered "not preventable" or "unavoidable"(Delcher et al., 2017).

DPC has shown the potential to reduce unnecessary ED utilization substantially. The case study included in the 2020 Society of Actuaries analysis (Busch et al., 2020, pp. 27-35) reported a 40% reduction in ED visits and a 53.6% reduction in ED claims costs in the DPC group as compared with the group in traditional primary care. According to an analysis by United Health Group (2019), the average cost of treating common primary care treatable conditions at a hospital ED ($2,032) is 12 times higher than the cost ($167) in a physician's office. If even a portion of the inappropriate ED utilization can be reduced by including DPC as an option in Medicaid, it could have a positive fiscal impact on state budgets. The Society of Actuaries case study also showed the potential for DPC to reduce costs through a reduction in hospitalizations of 25.54% among DPC members (Busch et al., 2020, p. 32). In addition to cost reduction, DPC also has the potential to improve health outcomes in Medicaid through better coordinated care. Importantly, tracking downstream impact (for example, reductions in unnecessary ED utilization and hospitalizations) could be done in the Medicaid program without imposing a significant administrative burden on DPC practices.

Conclusion

Primary care providers play a central role in the health and well-being of Americans. The decisions they make influence health outcomes for their patients and have widespread downstream consequences that affect the cost efficiency of the healthcare system. However, due to a number of challenges, including physician burnout, over-sized patient panels, increased administrative burden, reduced time spent with patients, low reimbursement relative to other specialties, and a shrinking workforce in the face of increasing demand, primary care is commonly described as being in a state of crisis. DPC, where healthcare consumers contract with a physician or physician practice directly in the form of periodic payments for a defined set of primary care services, is an evolving practice and payment model that is increasingly favored by patients and providers. By reducing administrative burden and allowing PCPs to spend more time with patients, DPC addresses many of the challenges facing primary care, resulting in improved satisfaction for providers and better care for their patients. DPC has also shown the potential to reduce costs for patients as well as generate downstream savings for the healthcare system.

In spite of the potential benefits and growing popularity of DPC, barriers to wider adoption of the model remain, and there are ongoing efforts at the federal and state level to address these barriers. Although a majority of the states have passed or are considering legislation to define DPC as a medical service outside of state insurance regulation, IRS definitions need to be updated so that the tax code conforms with other relevant state and federal laws in order to permit individuals that hold HSAs to access the benefits of Direct Primary Care. In addition, policymakers should continue to pursue efforts to include DPC as an option in public programs, especially Medicaid, in order to improve health outcomes for beneficiaries and help reduce the strain on state budgets and taxpayers. ☆

Reference List

Angstman K. B., Horn J. L., Bernard M. E., Kresin, M. M., Klavetter, E. W., Maxson, J., Willis, F. B., Grover, M. L., Bryan, M. J., & Thacher, T. D. (2016). Family medicine panel size with care teams: Impact on quality. *Journal American Board of Family Medicine*, *29*(4), 444–451. https://www.jabfm.org/content/29/4/444.long

Association of American Medical Colleges. (2020). *The complexities of physician supply and demand: Projections from 2018 to 2033*. https://www.aamc.org/system/files/2020-06/stratcomm-aamc-physician-workforce-projections-june-2020.pdf

Basu, S., Phillips, R. S., Phillips, R., Peterson, L., & Landon, B. (2020). Primary care practice finances in the United States amid the COVID-19 pandemic, *Health Affairs*, *39*(9), 1605–1614. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00794

Busch, F., Grzeskowiak, D., Huth, E. (2020). *Direct primary care: Evaluating a new model of delivery and financing*. Society of Actuaries. https://www.soa.org/globalassets/assets/files/resources/research-report/2020/direct-primary-care-eval-model.pdf

Casalino, L., Gans, D., Weber, R., Cea, M., Tuchovsky, A., Bishop, T., Miranda, Y., Frankel, B., Ziehler, K., Wong, M., & Evenson, T. (2016). US physician practices spend more than $15.4 billion annually to report quality measures. *Health Affairs*, (3), 401–406. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.1258

Cheung P., Wiler J., & Ginde A. (2011). Changes in barriers to primary care and emergency department utilization. *Archives of Internal Medicine*, *171*(15), 1393–1400. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1106287

Dahrouge, S., Hogg, W., Younger,J., Muggah, E., Russell, G., & Glazier, R. (2016). Primary care physician panel size and quality of care: A population-based study in Ontario, Canada. *Annals of Family Medicine*, *14*(1), 26–33. https://doi.org/10.1370/afm.1864

Delcher, C., Yang, C., Ranka, S., Tyndall, J., Vogel, B., & Shenkman, E. (2017). Variation in outpatient emergency department utilization in Texas Medicaid: a state-level framework for finding "superutilizers." *International Journal of Emergency Medicine, 10*(31). https://intjem.biomedcentral.com/articles/10.1186/s12245-017-0157-4

Department of Treasury. (2020). Internal Revenue Service, 26 CFR Part 1. [REG-109755-19] RIN 1545-BP31. Certain Medical Care Arrangements. https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-12213.pdf

Direct Primary Care Coalition. (2020). *State Policy*: https://www.dpcare.org/state-level-progress-and-issues

DPC Frontier. (2018). *DPC Frontier Mapper*. https://mapper.dpcfrontier.com

Eskew P. (2016). In defense of direct primary care. *Family Practice Management*, *23*(5), 12–14. https://www.aafp.org/fpm/2016/0900/fpm20160900p12.pdf

Eskew, P. (2020). *2020 state legislative activity*. DPC Frontier. https://www.dpcfrontier.com/blog/2020/2/4/2020-state-legislative-activity

Eskew, P., & Klink, K. (2015). Direct primary care: Practice distribution and cost across the nation. *Journal of the American Board of Family Medicine*, *28*(6), 793–801. https://doi.org/10.3122/jabfm.2015.06.140337

Exec. Order No. 13,877, 84 FR. 30,849 (2019). https://www.whitehouse.gov/presidential-actions/executive-order-improving-price-quality-transparency-american-healthcare-put-patients-first/

Friedberg, M., Chen, P., Van Busum, K., Aunon, F., Pham, C., Caloyeras, J., Mattke, S., Pitchforth, E., Quigley, D., Brook, R., Crosson, F., & Tutty, M. (2013). *Factors affecting physician professional satisfaction and their implications for patient care, health systems, and health policy*. RAND Corporation. https://www.rand.org/pubs/research_reports/RR439.html

Friedberg, M., Hussey, P., & Schneider, E. (2010). Primary care: A critical review of the evidence on quality and costs of health care. *Health Affairs*, *29*(5), 766–772. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0025

Ghany, R., Tamariz, L., Chen, G., Dawkins, E., Ghany, A., Forbes, E., Tajiri, T., & Palacio, A. (2018). High-touch care leads to better outcomes and lower costs in a senior population. *American Journal of Managed Care*, *24*(9), e300–e304. https://www.ajmc.com/view/hightouch-care-leads-to-better-outcomes-and-lower-costs-in-a-senior-population

HB 1945. 84th Texas Legislature. Regular. (2015). https://capitol.texas.gov/tlodocs/84R/billtext/html/HB01945I.htm

HB 0894/SB 0696. Tennessee General Assembly. (2019). http://wapp.capitol.tn.gov/apps/BillInfo/default.aspx?BillNumber=HB0894&GA=111

Hogg W., Dahrouge S., Russell G., Tuna M., Geneau R., Muldoon L., Kristjansson E., & Johnston S. (2009). Health promotion activity in primary care: Performance of models and associated factors. *Open Medicine*, *3*(3), e165–73. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3090121/

Hostetter J., Schwarz N., Klug M., Wynne J., & Basson M. (2020). Primary care visits increase utilization of evidence-based preventative health measures. *BMC Family Practice*, *21*(1), 151. Published 2020 Jul 28. https://bmcfampract.biomedcentral.com/articles/10.1186/s12875-020-01216-8

H.R. 6259. 116th U.S. Congress. (2020). https://www.congress.gov/bill/116th-congress/house-bill/6259

InCrowd, (2019, August 6). *InCrowd study shows a 79% burnout level among PCPs, and 68% across all specialties, spotlighting a national problem* [Press release]. https://incrowdnow.com/press-release/incrowd-study-shows-a-79-burnout-level-among-pcps/

Institute of Medicine (U.S.) Committee on the Future of Primary Care, Donaldson, M. S., Yordy, K. D., Lohr, K. N., & Vanselow, N. A. (Eds.). (1996). *Primary care: America's health in a new era*. National Academies Press. https://www.nap.edu/catalog/5152/primary-care-americas-health-in-a-new-era

Internal Revenue Service. (2004). *Revenue ruling 2004-38*. https://www.irs.gov/pub/irs-drop/rr-04-38.pdf

Internal Revenue Service. (2019). *Publication 969: Health savings accounts and other tax-favored health plans*. https://www.irs.gov/publications/p969#en_US_2019_publink1000204039

Kane, L. (2019). *Medscape national physician burnout, depression & suicide report 2019*. Medscape.

Knight, V. (2019, July 3). *American medical students less likely to choose to become primary care doctors*. Kaiser Health News. https://khn.org/news/american-medical-students-less-likely-to-choose-to-become-primary-care-doctors/

Levine, D., Landon, B. E., & Linder J. (2019). Quality and experience of outpatient care in the United States for adults with or without primary care. *JAMA Internal Medicine*, *179*(3), 363–372. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2721037

Medicaid and CHIP Payment and Access Commission. (2014a). *MACStats: Medicaid and CHIP Program Statistics*. https://www.macpac.gov/wp-content/uploads/2015/03/March-2014-MACStats.pdf

Medicaid and CHIP Payment and Access Commission. (2014b). *Revisiting emergency department use in Medicaid*. https://www.researchgate.net/publication/267025692_MACFacts_Revisiting_Emergency_Department_Use_in_Medicaid

Medscape. (2017). *Medscape Family Physician Compensation Report 2017*.

National Center for Health Statistics. (2017). *National hospital ambulatory medical care survey*. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/data/nhamcs/web_tables/2017_ed_web_tables-508.pdf

National Resident Matching Program. (2020, March 20). *Thousands of medical students and graduates celebrate NRMP Match results* [Press release]. https://www.nrmp.org/2020-press-release-thousands-resident-physician-applicants-celebrate-nrmp-match-results/

Nebraska Department of Administrative Services. (n.d.). *Direct primary care*. https://das.nebraska.gov/Benefits/Active/healthplan-DPC.html

New Jersey Treasury, Division of Pensions and Benefits. (n.d.). *Direct primary care*. https://www.nj.gov/treasury/pensions/dpcmh.shtml

Personalized Care Act of 2019, S. 3112, 116th Congress (2019). https://www.congress.gov/bill/116th-congress/senate-bill/3112

Personalized Care Act of 2020, H.R. 5596, 116th Congress (2020). https://www.congress.gov/bill/116th-congress/house-bill/5596

Physicians Foundation. (2018). *2018 survey of America's physicians: Practice patterns and perspectives*. https://physiciansfoundation.org/wp-content/uploads/2018/09/physicians-survey-results-final-2018.pdf

Pifer, R. (2020, July 21). *Direct primary care backers hope COVID-19 entices docs to alternate payment model*. HealthCareDive. https://www.healthcaredive.com/news/direct-primary-care-backers-hope-covid-19-entices-docs-to-alternate-payment/581871/

Quinn, S. (2018, June 19). AAFP survey reveals DPC trends. *In the Trenches Blog*. American Academy of Family Practitioners. https://www.aafp.org/news/blogs/inthetrenches/entry/20180619ITT_DPC.html

Rosewicz, B., Theal, J., & Ascanio, K. (2020, January 9). *States collectively spend 17 percent of their revenue on Medicaid*. Pew Charitable Trusts. https://www.pewtrusts.org/en/research-and-analysis/articles/2020/01/09/states-collectively-spend-17-percent-of-their-revenue-on-medicaid

Saad, L. (2018, December 17). *Delaying care a healthcare strategy for three in 10 Americans*. Gallup. https://news.gallup.com/poll/245486/delaying-care-healthcare-strategy-three-americans.aspx

Sinsky C., Colligan L., Li L., Prgomet, M., Reynolds, S., Goeders, L., Westbrook, J., Tutty, M., & Blike, G. (2016). Allocation of physician time in ambulatory practice: A time and motion study in 4 specialties. *Annals of Internal Medicine*, *165*(11), 753–760. https://www.acpjournals.org/doi/10.7326/M16-0961

Texas Comptroller. (2018). *Budget drivers: The forces driving state spending*. Fiscal Notes. https://comptroller.texas.gov/economy/fiscal-notes/2018/november/docs/fn.pdf

Texas Department of State Health Services. (2019). *Hospital emergency department data Collection 2018*. https://www.dshs.texas.gov/legislative/2019-Reports/Hospital-Emergency-Department-Data-Collection-Report-2018.pdf

United Health Group. (2019). *The high cost of avoidable hospital emergency department visits*. https://www.unitedhealthgroup.com/newsroom/posts/2019-07-22-high-cost-emergency-department-visits.html

Veteran Access to Direct Primary Care Act, H.R. 6259, 116th Congress (2020). https://www.govtrack.us/congress/bills/116/hr6259

Weisbart, E. (2016). Is direct primary care the solution to our health care crisis? *Family Practice Management, 23*(5), 10-11. https://www.aafp.org/fpm/2016/0900/p10.html

White B., & Twiddy D. (2017). The state of family medicine. *Family Practice Management*, *24*(1), 26–33. https://www.aafp.org/fpm/2017/0100/p26.html

Willard-Grace R., Knox M., Huang B., Hammer H., Kivlahan C., & Grumbach K. (2019). Burnout and health care workforce turnover. *Annals of Family Medicine*, *17*(1),36–41. https://www.annfammed.org/content/17/1/36.long

Yarnall K., Østbye T., Krause K., Pollak K., Gradison M., & Michener J. (2009). Family physicians as team leaders: "Time" to share the care. *Preventive Chronic Dis*ease *6*(2). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2687865/

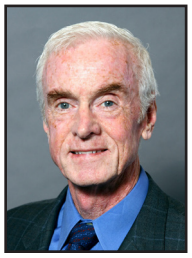
ABOUT THE AUTHORS

David Balat is the policy director of Right on Healthcare at the Foundation. He has broad experience across the healthcare spectrum with special expertise in healthcare finance. He is a former congressional candidate in Texas's 2nd Congressional District and a seasoned hospital executive with more than 20 years of healthcare industry leadership and executive management experience.

Balat has earned the privilege of being invited to testify before the U.S. House Committee on Oversight and Reform in Washington, D.C., and before various House committees in the Texas state Legislature. He is a published op-ed columnist in The Hill, Real Clear Politics, and other news outlets and an active speaker and commentator on matters of health policy. He speaks at national conferences and advises on healthcare policy to both state and federal lawmakers.

Balat often volunteers to help families navigate their bills and how to understand their benefits. He serves as a board member for a nonprofit focused on educating legislators and the community about important matters pertaining to healthcare freedom.

Balat is a first generation American and the first in his family to graduate from college. He received his B.S. from the University of Houston and joint master's degrees in business administration and hospital administration from the University of Houston – Clear Lake.



John O'Shea, MD, is senior fellow for Right on Healthcare at the Texas Public Policy Foundation. He is also a surgeon and independent researcher. From 2014-2019 O'Shea was a senior fellow in the Center for Health Policy Studies at the Heritage Foundation in Washington, D.C., where he worked on a number of health policy issues, including implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), healthcare payment and delivery reform, Medicare Advantage, VA healthcare, emergency medical care, and graduate medical education.

From 2013-2015, O'Shea was a visiting scholar in the Engelberg Center for Health Care Reform at the Brookings Institution, where he was clinical lead on a project with MITRE and CMMI to develop alternative payment models for specialty care. From 2011 to 2013, he served as senior health policy advisor to the U.S. House Committee on Energy and Commerce, where he helped draft the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) that replaced the Sustainable Growth Rate formula for reimbursing physician services in the Medicare program.

Before moving to DC in 2011, O'Shea was an assistant professor of surgery at the Albert Einstein College of Medicine in Bronx, NY. He completed his surgical training at New York Medical College in New York City and holds a master of public administration from the Harvard Kennedy School and master's degrees in history and sociology of science from the University of Pennsylvania.

O'Shea has published widely on health policy, clinical surgery, the history of surgery, and the history of health policy.

About Texas Public Policy Foundation

The Texas Public Policy Foundation is a 501(c)3 nonprofit, nonpartisan research institute. The Foundation promotes and defends liberty, personal responsibility, and free enterprise in Texas and the nation by educating and affecting policymakers and the Texas public policy debate with academically sound research and outreach.

Funded by thousands of individuals, foundations, and corporations, the Foundation does not accept government funds or contributions to influence the outcomes of its research.

The public is demanding a different direction for their government, and the Texas Public Policy Foundation is providing the ideas that enable policymakers to chart that new course.

Texas Public Policy Foundation

901 Congress Avenue | Austin, Texas 78701 | 512.472.2700 | www.TexasPolicy.com