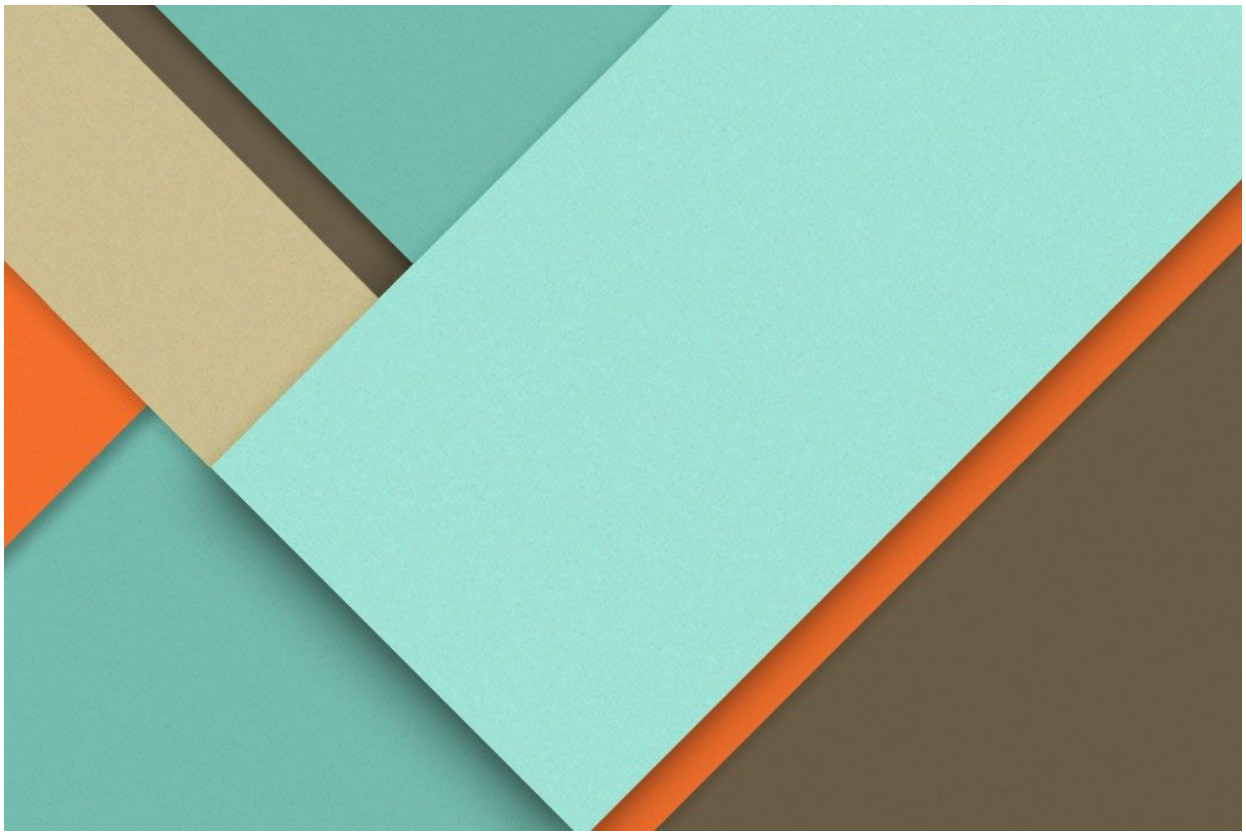

Direct Primary Care and its Impact on Healthcare Costs and Patient Experience

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Abstract

Healthcare costs continue to rise at over two times the rate of inflation[1], while high deductibles[2] have raised out-of-pocket costs and created friction to accessing preventive care. In parallel, a disjointed health care system steers patients up the value chain to often unnecessary specialty care or in-patient procedures.

Direct Primary Care (DPC), in which a patient has unlimited access to a primary care physician for a fixed monthly price, while modest in market share, is growing rapidly. The model is designed to align incentives between provider and patient, emphasize preventative care, allocate more time to treat patients, offer same or next-day appointments, and lower costs for payers. Estimates put the number of practices at 1,200[3], covering some 500,000 patients.

This paper finds that DPC delivers average net claims savings of 2-6% for self-funded employer groups while improving quality and convenience. In addition, we find that DPC is likely satisfying an unmet need for healthcare and improving access to care for patients.

Introduction

Direct Primary Care is a membership-based model that allows providers to directly contract with payers. By contracting directly, providers bypass insurance, reduce paperwork and the pressure of capturing billable events, which allows them to focus on providing a better patient experience.

In a direct arrangement, for the cost of the monthly membership, providers can offer unlimited and after hours in-person and virtual care, at cost generic drugs[4], access to discounted labs, steerage to lower cost imaging, and multiple points-of-engagement with physician teams. Monthly fees typically range from $50-$100[5] per member with discounts

[1] https://fred.stlouisfed.org/series/CPIMEDSL
[2] The average single deductible is $1,655 for employees with a deductible according to the 2019 Kaiser Family Foundation Employer Benefits Survey
[3] https://www.dpcare.org/
[4] An analysis of the top 20 generic medications from a 3,000 DPC lives showed 60-70% savings over the second cheapest GoodRx price.
[5] https://mapper.dpcfrontier.com/

for children and families, and many have some variable pricing depending on age (though it's more consistently priced when offered directly to employers). When offered alongside a menu of one or more other plans, typically a bolt on to a high deductible plan, 30-50% of eligibles enroll in DPC, growing over time[6].

Traditional vs. Direct Primary Care

	Traditional Primary Care	Direct Primary Care
Total Patients per Doctor	2-3,000+	<1,000
Patients Per Day	25-35	6-10
Average Appointment Wait	29 days	Same day
Average Waiting Room Time	25 minutes	5 minutes
Average Wait Time in Exam Room	16 minutes	<5 minutes
Average Time Spent with Doctor	8-12 minutes	30-60 minutes
Average Copay per Office Visit	$25	$0
Average Copay per Virtual Visit	$20-$40	$0

Some may ask how sustainable a model is with fewer billable events and lower total costs. The reduction in paperwork, electronic medical record (EMR) time savings of 40%+[7], more efficient virtual and telephonic care, less time on billing staff, improved patient panels through positive selection, no pressure to keep care in a closed healthcare system, and uniform reimbursement schedules (gone are the $23 office visit reimbursements under CA Medicaid[8]) fuel DPC's success, stability, and flywheel. Happier doctors and happier patients are a powerful combination. Client retention of over 96%[9] shows patients and employers voting with their wallets.

Survey Summary

In December 2019, Olavi Group conducted a survey to collect data, perceptions, challenges, and questions from many in the DPC community. Close to 90 people responded, primarily brokers, researchers, and doctors. Respondents showed their collective wisdom, with answers closing matching the actual per member use of office visits, labs, prescriptions, and the connection between age-gender and utilization of healthcare services. The survey also revealed gaps and exposed wants:

[6] Results vary but implementations we've seen typically fall in this range.
[7] https://www.sec.gov/Archives/edgar/data/1404123/000119312520001429/d806726ds1.htm
[8] CA Medicaid pays $22.90 for a level 1 office visit, code 99201.
https://files.medi-cal.ca.gov/pubsdoco/rates/rates_information.asp?num=22&first=94799&last=99600
[9] HealthDirectly

70% wanted unbiased industry utilization and claims savings

70% would like client facing reporting on DPC use and savings

50% requested data on area hospital cost/quality to better steer care

<50% wanted research, information on bulk discounts, and other DPC related studies

Data, perceptions, and questions from the survey respondents led to further research where we highlight three angles of DPC's impact on cost and quality.

Analysis Overview

Taking a unique approach to assess the credibility of a DPC model as a cost management strategy, we present DPC utilization data, expectations, and high level claims from three quantitative angles:

1) **DPC patient engagement and utilization data** from 4,000 DPC patients show utilization, virtual engagement, and generic prescription drug delivery patterns, delivering a net savings after membership fees and a much better patient experience.

2) **High level claims data from** 9 public and private sector groups, representing 19,000 lives, before and after the transition to direct primary care show claims savings, net of all DPC fees, relative to market trend.

3) **Public disclosures from OneMedical**, a tech-first concierge model, and its recent S-1 filing on use, reporting claims savings, and customer satisfaction across its 390,000 patients.

Patient Engagement and Utilization

For patients, the Direct Primary Care model compares favorably to the traditional fee-for-service setting. Patients can expect zero copays, same or next day in-person appointments, and virtual care access. Yet, despite these compelling differentiators, questions remain on whether patients are fully utilizing their Direct Primary Care membership.

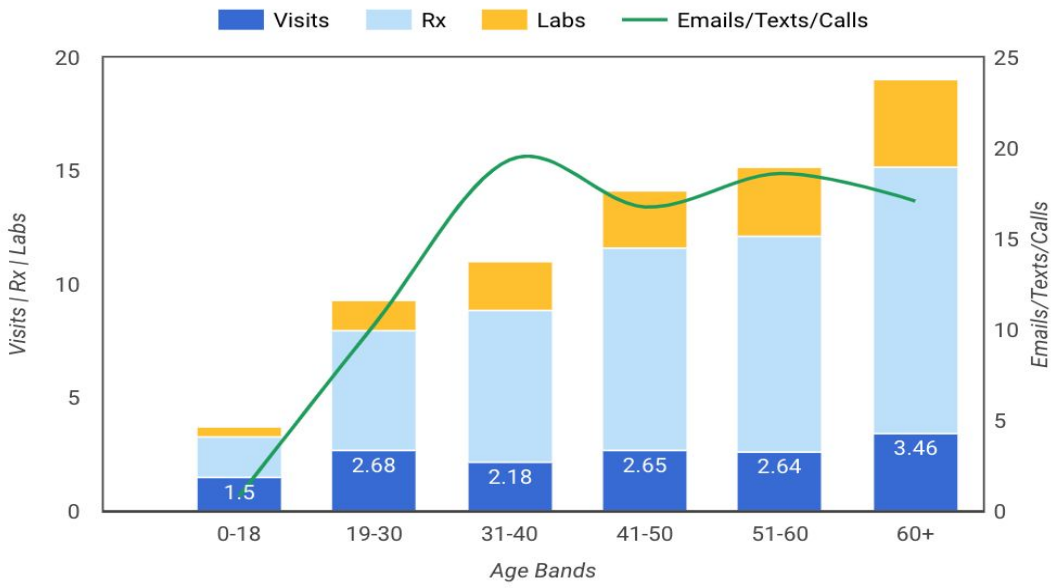
We collected and analyzed patient-level DPC utilization data across approximately 4,000 patients in multiple practices in the midwest and northeast. Our goal was to get a sense of utilization, how use varies with tenure, age, and the sources of savings by categories. To do this we compared the two groups to typical commercial claims data[10] on use and costs. All use data is per tenured year.

Average Metrics	Typical Commercial Group	Midwest DPC	Northeast DPC
Patients	n/a	3,200	700
Age	35-45	37	43
Primary Care Visits	1.5	2.4	2.4
Generic Prescriptions	7-8	7	3.9
Labs	4-5	2.1	1
Emails/Texts/Calls	n/a	21	32

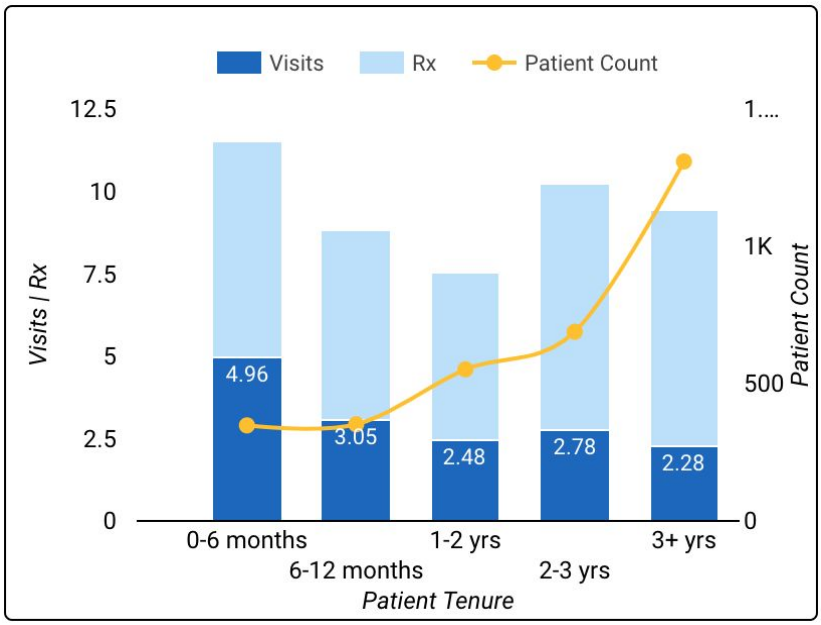
Patient data show a full replacement of primary care visits with an additional added visit vs. typical utilization in a fee-for-service model. Generic prescriptions are dispensed at cost and alternative forms of engagement via emails, texts, calls, and video calls are high, at over 20 per member per year, showing an impressive scope and variety of care access points.

DPC engagement and use varies considerably by age, indicating that utilization reflects the expected health profile of patients as opposed to overuse of a model that removes financial barriers to care. It also reveals that patients of all ages use their membership to access both in-person and virtual care.

[10] 2018 CMS Gold continuance table.

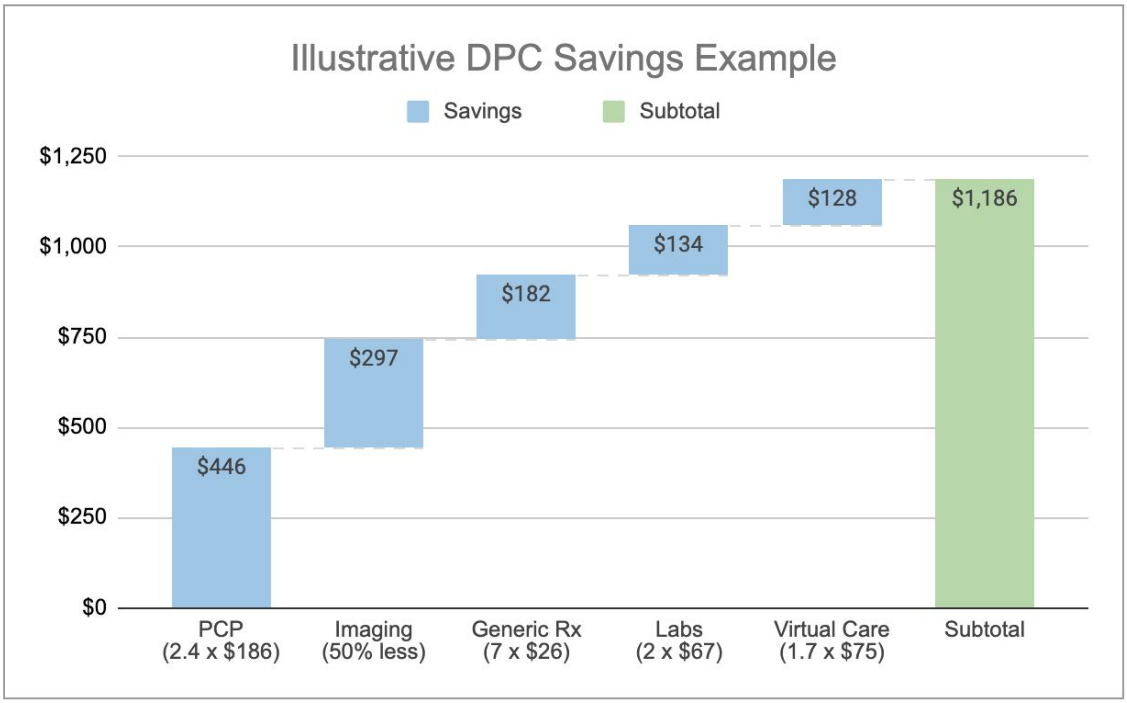


Annualized utilization reveals a likely unmet demand for healthcare. In the first year of membership utilization spikes, notably in the first 6-month period. This is consistent with the removal of financial and logistical barriers to care and speaks to the friction in the fee-for-service system and costs of kicking the healthcare can down the road. As a risk sharing model, DPC offers unlimited care at a fixed monthly price, allowing employers to release pent-up demand without increasing the cost of DPC membership.



Savings Potential

An analysis of utilization data reveals immediate savings from avoided office visits, at-cost generic prescriptions, imaging, virtual care, and labs. The below savings figure of $1,186 compares favorably to the $600-$800 annual DPC membership, a net reduction of almost $400 on the high end: while leaving out potential savings from reductions in ER visits, reduced hospitalizations, and other steerage.



Assumes allowed office visit charge of $186/visit[11]; imaging reduction of 50% through steerage; Rx savings of $26/script, or 70% based on an analysis of the top 20 generic drugs dispensed from DPC vs. the second lowest GoodRx price; labs in-house at $67; Per visit fees based on 2018 CMS continuance tables for the commercially insured and from DPC and consumerhealthcareratings.com; virtual care visits (calls or video) average 1.7 per patient per year and savings at $75 per visit[12].

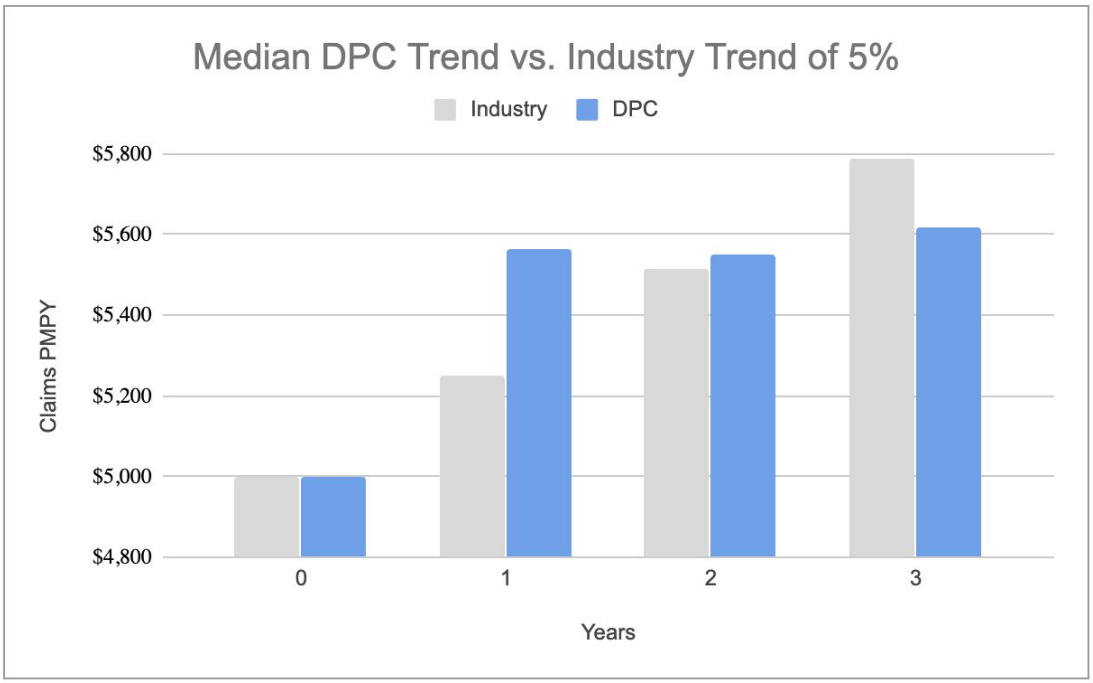
[11] https://consumerhealthratings.com/healthcare_category/doctors-charges-physician-prices-average-cost-anesthesia/

[12] Teladoc's 2019 annual report shows total all-in cost per televisit of $130 (subscription fees being 85% of total)

Claims Savings

Analysis of high-level aggregate claims data for 19,000 DPC lives across nine private and public sector groups, compares all claims one year prior to DPC and three years post. Adjustments were made to year-over-year plan design changes and include all member fees. All groups are DPC-only and the median start year was 2013.

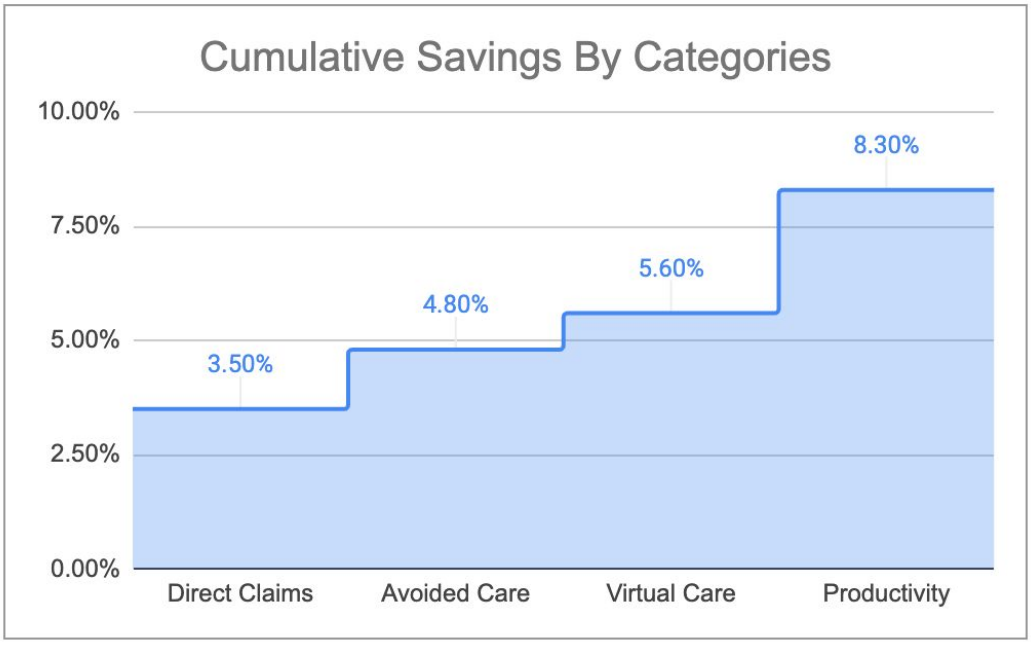
Overall claims initially jump above industry trend in year 1 as more people engage with their doctor and receive care that might have been put off or delayed due to financial and logistical barriers. This mirrors the utilization data indicating an initial spike in consumption. After year 1, claims fall to a negative to flat trend divergence that leads to a 4% net claims savings (+/- 2%). Below is a summary in total healthcare claims before and up to three years after DPC implementation based on the median year-over-year trend in the total claims.



‘Soft’ Savings: OneMedical Example

There is little doubt that improved access to in-person and virtual care and an improved patient-doctor relationship has tangible benefits for patients and employers beyond direct cost savings. Though not Direct Primary Care, the OneMedical model presents some similarities to DPC, notably the unlimited telemedicine, short wait times, high satisfaction and renewal rates, and an annual membership fee.

The OneMedical S-1 filing lists a customer case study of a professional services company with 20,000 employees and the reported savings to both claims and productivity. The study compared an age- and geography-adjusted cohort to non-OneMedical members, comparing measured savings associated with claims, avoided use, virtual care, and time and increased productivity. This amounts to 4.8% in total direct savings, and 8.3% in total savings.



Conclusion

DPC is a value-based approach that reduces friction at the fundamental point of access. A program that can pay for itself, with savings as shown in utilization, claims, and disclosures from similar patient-centric providers[13]. An objectively better patient experience, as evidenced by high NPS scores[14] and high retention, points to success. As more doctors make the jump, the model looks poised for continued growth.

The analysis in this paper supports meaningful savings combining avoided primary care claims, reduction in overall claims, and improved productivity. In conjunction with other smart interventions, DPC can be an integral piece of wider cost management and benefit planning strategies.

The next frontier of value for Direct Primary Care will include greater steerage on downstream care, better avoidance of ER and urgent care visits, and integration with other directly purchased bundled services.

With most Americans receiving their care via their employer, national models that can adapt to employer needs, share and consolidate utilization and claims reporting, and scale enrollment and education for employees will allow Direct Primary Care to grow beyond its current foothold. In the end, restoring the doctor-patient relationship is a laudable goal and a bright spot in the US healthcare system.

[13] As expected, there have been no randomized controlled trials with DPC, so there is potential for selection bias. However, from the a public sector group in NC that has 50/50 DPC to non-, the two groups have similar average ages and PCP visit utilization per member.
[14] OneMedical S-1 filing

About the Authors

Joseph Andelin is the founder of Olavi Group, a healthcare consulting and research firm that offers data analytics, reporting consulting, and unique data sets for the next generation of healthcare challenges. Clients include healthcare startups, brokers, employers, and a China-based healthcare software firm.

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