MILLIMAN WHITE PAPER

Direct Primary Care: A unique healthcare solution for employers

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Background

Employers are on the frontlines in the battle against rising healthcare costs. Nearly 157 million Americans receive their healthcare coverage through an employer,[1] and of those, over 60%[2] are in self-funded plans, where the employer is at risk for all claims expenses, including fluctuations from year to year. Because self-funded employers bear the direct cost of claims—and reap any savings from improving the cost and quality of healthcare—many employers actively implement strategies intended to reduce the cost of healthcare coverage for their employees. The list of cost containment solutions is long and heavy on buzzwords: reference-based pricing, narrow networks, centers of excellence, second medical opinions, transparency tools, and medical tourism to name a few. Among the many possible strategies an employer could use to improve care and lower cost is a focus on primary care. Although much has been published on the topic of primary care, the Patient-Centered Primary Care Collaborative, in its report "Investing in Primary Care: A State-Level Analysis,"[3] succinctly stated its opinion: "Consistent and growing evidence shows that primary care-oriented systems achieve better health outcomes, more health equity, and lower costs."

Primary care is often a patient's entry point to the healthcare system. How often a patient accesses primary care, and the quality of that care, can have a significant impact on downstream costs and patient health outcomes.[4,5] Primary care physicians (PCPs) diagnose and treat illnesses, refer patients to specialists, prescribe medications, and recommend diagnostic tests, just to name a few responsibilities. Unlike specialists, who tend to focus on specific body systems and related diseases, PCPs routinely triage a variety of cases involving multiple body systems and overlapping symptoms. Moreover, PCPs also often serve their patients in other more interpersonal roles, such as educator and trusted advisor, care coordinator, and a guide and advocate to help navigate our complex healthcare system. Optimally, a longitudinal and direct patient-physician relationship should characterize primary care.

Among the various primary care delivery models that exist, a new model is gaining traction among self-funded employers: Direct Primary Care (DPC). This model provides primary care services outside of a major medical insurance benefit and is not administered by a third party. Rather, DPC packages and distributes primary care services in the form of clinic memberships directly to employers and consumers, often by the PCPs themselves.[6] This feature, along with what DPC advocates claim are the advantages inherent within the DPC model, is capturing the attention of more and more self-funded employers.

Direct Primary Care differs from traditional models in both delivery and financing of primary care. There is no one definition of what constitutes a DPC practice or a DPC solution; however, many DPC offerings share common key features in one form or another:

- **Recurring fee:** Employers pay a DPC physician a monthly fee for clinic access for their employees. The majority of DPC practice revenues typically come from these fees, generally ranging from $40 to $85 per person per month.[7] By contrast, traditional primary care practices bill third-party payers on a fee-for-service basis.
- **Payer contracting:** DPC practices typically do not contract with insurers, government payers, or third-party administrators (TPAs). DPC practices generally only contract directly with patients or with employers. Traditional practices, by contrast, typically contract with payers, bill them for services provided, and accept the negotiated fees.

[1] Kaiser Family Foundation. Employer Health Benefits: 2020 Annual Survey. Retrieved March 31, 2021, from http://files.kff.org/attachment/Report-Employer-Health-Benefits-2020-Annual-Survey.pdf.

[2] Kaiser Family Foundation (September 25, 2019). 2019 Employer Health Benefits Survey. Retrieved March 31, 2021, from https://www.kff.org/report-section/ehbs-2019-section-10-plan-funding/.

[3] Patient-Centered Primary Care Collaborative (July 2019). Investing in Primary Care: A State-Level Analysis, p. 4. Retrieved March 31, 2021, from https://www.pcpcc.org/sites/default/files/resources/pcmh_evidence_es_2019.pdf.

[4] Macinko, J., Starfield, B., & Shi, L. (2007). Quantifying the health benefits of primary care physician supply in the United States. International Journal of Health Services; 37(1):111-126.

[5] Reschovsky, J.D., Ghosh, A., Stewart, K., & Chollet, D. (March 2012). Paying More for Primary Care: Can It Help Bend the Medicare Cost Curve? The Commonwealth Fund. Retrieved March 31, 2021, from https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2012_mar_1585_reschovsky_paying_more_for_primary_care_finalv2.pdf.

[6] In addition to individual physicians, there are also companies that specialize in providing direct primary care to employers.

[7] Busch, F. Grzeskowiak, D., & Huth, E. (May 2020). Direct Primary Care: Evaluating a New Model of Delivery and Financing, p. 88. Society of Actuaries. Retrieved March 31, 2021, from https://www.soa.org/globalassets/assets/files/resources/research-report/2020/direct-primary-care-eval-model.pdf.

- **Smaller patient panels:** DPC practices have fewer patients per physician than traditional primary care practices, typically fewer than 1,000 and most often around 200 to 600.[8]
- **Expanded patient access:** Due primarily to smaller patient panels, members of a DPC practice have increased access to their PCP. Relative to traditional practices, this improved access manifests itself in longer-duration office visits, same-day or next-day appointments, texts or phone-based provider contact, and occasionally PCP home visits.
- **Longer office visits:** The typical length of an office visit for a traditional primary care practice is around 13 to 16 minutes, a significant portion of which is typically not "face time" as coding and electronic health record (EHR) documentation pressures keep physicians behind a computer screen. By contrast, for DPC practices, office visits average around 40 minutes, but can vary based on the patient's need.[9]
- **Reduced patient cost sharing:** Most DPC practices do not charge any cost sharing for services covered under the DPC membership fee. Services covered under the fee without cost sharing are similar to what is covered under a major medical policy for primary care office visits. By contrast, under most employer's major medical coverage, there are member copays for each office visit. Proponents of DPC contend that removing the patient's cost-sharing burden improves care, as financial barriers are often the cause of patients missing important follow-up visits.

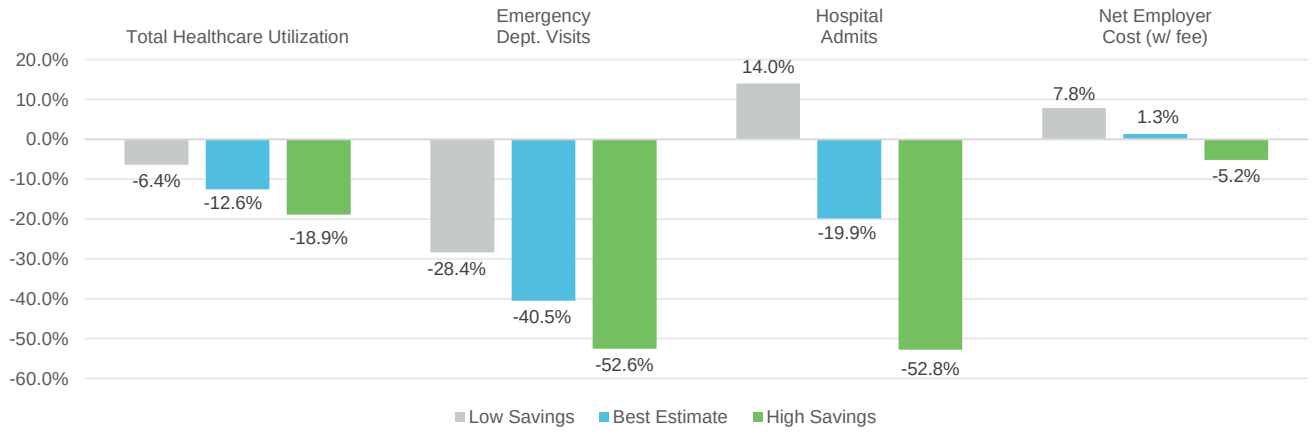
The DPC financing and delivery model provides an alternative to traditional fee-for-service-based primary care models, and proponents of the DPC model claim that it improves the patient-doctor relationship, reduces the fragmentation of patient care, and improves both personal and professional satisfaction for physicians. Moreover, DPC proponents also argue that this alternative primary care arrangement generates system-wide reductions in healthcare utilization including emergency department visits, hospitalization rates, and other unnecessary and avoidable services, leading to broad-based healthcare cost savings.

Claims and evidence about DPC

In 2020, the Society of Actuaries commissioned Milliman to develop a study characterizing the DPC model and evaluating certain claims made about its effectiveness. Our study, in part, sought to provide an actuarial perspective on such claims by evaluating actual outcomes for a midsized employer that implemented a DPC point solution in its self-funded medical benefit. Under the medical benefit, covered employees and dependents could enroll in a traditional preferred provider organization (PPO)-style plan option or they could enroll in an option that included a DPC membership along with a deductible waiver for all medical services.

We compared utilization and cost outcomes for about 900 members enrolled in DPC to the same outcomes for about 1,100 members not enrolled in DPC during a two-year period. We risk-adjusted the results to control for differences in health status between the DPC and PPO cohorts. Figure 1 presents key results from our analysis. Given the underlying variability in the data, we applied a confidence interval methodology around our best estimates. In Figure 1 we refer to the low- and high-ends of our confidence interval as the "low savings" and "high savings" scenarios, respectively.

FIGURE 1: ESTIMATED IMPACT OF DPC ENROLLMENT ON KPIS* FOR CASE STUDY EMPLOYER



[8] Ibid., p. 90.

[9] Busch, F. Grzeskowiak, D., & Huth, E. (May 2020). Direct Primary Care: Evaluating a New Model of Delivery and Financing, p. 88. Society of Actuaries. Retrieved March 31, 2021, from https://www.soa.org/globalassets/assets/files/resources/research-report/2020/direct-primary-care-eval-model.pdf.

* Key performance indicators

For the employer in this case study, enrollment in the DPC option was associated with statistically significant reductions in total healthcare utilization (-12.6%) and emergency department visits (-40.5%), a non-statistically significant reduction in hospital admits (-19.9%), and a non-statistically significant increase in net employer costs after accounting for the DPC membership fee and deductible waiver (+1.3%). Thus, even though members enrolled in the DPC option used less healthcare services, the employer's net cost for these members was actually higher than for PPO members due to the employer covering the DPC membership fee and reducing cost sharing under the DPC option. While these results come from just one employer, they have implications for all employers considering a DPC point solution.

1. **Enrollment in DPC can result in using less downstream healthcare services**

   After accounting for differences in health status between DPC and PPO members, we observed lower utilization of healthcare services for those enrolled in the DPC option, driven primarily by reductions in utilization rates for certain facility services including emergency department services. This result was consistent with claims made by proponents of DPC; namely that the model's enhanced patient access and continuous primary care resulted in reduced need for downstream healthcare services relative to traditional primary care.

2. **The design and cost of a DPC offering matters**

   While we estimate that patients enrolled in this employer's DPC option used fewer healthcare services, our best estimate is that the employer's net costs for patients enrolled in the DPC option were 1.3% higher than if the patients had been enrolled in the traditional PPO option. However, there were additional employer costs associated with the DPC option—covering the DPC membership fee on behalf of the member and waiving the medical deductible for all services (not just primary care).

   Two key tenets of the DPC model are increased provider payments per patient for primary care and reduced patient out-of-pocket costs. Both increase net costs for self-funded employers or other payers. Whether or not a self-funded employer can introduce a DPC option on a cost-neutral basis—or achieve savings—will depend on the:

   - Volume of services covered under the DPC arrangement
   - Engagement rate among covered employees and dependents with the DPC solution
   - Effectiveness of the DPC solution in reducing the use of downstream healthcare services
   - Cost of the DPC membership fee
   - Any other benefit changes packaged with the DPC offering for employees (i.e., non-primary care cost sharing or contribution rate incentives)

3. **Controlling for patient selection in evaluating DPC outcomes is imperative**

   For the group that we analyzed, DPC patients were expected to have lower overall healthcare costs than PPO patients due to differences in age, gender, and health status (i.e., mix and severity of medical conditions). We expect that other employers offering DPC as an option will see similar selection patterns. It is imperative to control for patient selection when assessing DPC outcomes; otherwise, differences in cost due to underlying patient differences may be erroneously assigned as differences caused by DPC.

Key considerations for employers

How do employers consider the learnings from this study of the DPC model and leverage them to design optimized health benefit programs for their employees? Key to whatever impact this strategy can have on a self-funded employer's total cost of care, population health, and employee satisfaction is how well engaged the participants are in the model itself and how well aligned the offering and DPC partner are with the employer's total rewards objectives.

DEFINE THE PROGRAM OBJECTIVES.

As with all point solutions, employers considering a DPC offering should set clear goals and objectives for the program and monitor key performance indicators over time. While much of the buzz around DPC relates to potential cost savings, DPC is a financing and delivery model aimed at the Quadruple Aim of:

1. Higher-quality care
2. Improved patient experience
3. Improved provider experience
4. Lower cost of care

Employers will want to consider their total rewards strategy in the context of these four standards. For example, if an employer's primary objectives relate to aims 1 and 2, then implementing DPC on an employer cost-neutral basis—or even with a small cost increase—may be acceptable, provided it improves access to, and quality of, care provided while also reducing participant out-of-pocket costs. In this scenario, a DPC vendor with a high-touch DPC offering that may have higher membership fees may be more philosophically aligned with the employer's objectives. However, if the primary objective relates to aim 4, then a lower-fee DPC offering may be more appealing and likely to meet the employer's goals.

CLINIC PLACEMENT

Any DPC solution will involve considering where clinics are currently located or where to place any new physical provider clinic(s) relative to where employees live and work. There is a spectrum of DPC vendor offerings relating to clinic location—from on-site to near-site to off-site to virtual. With sufficient employee volume, DPC vendors may give employers a say in where to locate physical clinics. Our work with DPC vendors suggests there is a distance beyond which participants will not travel for primary care regardless of the incentives to do so (e.g., such as 25 miles).

Consequently, in building out a DPC offering, employers should consider how many clinics are required to achieve their desired DPC engagement (use of the DPC clinic) for the bulk of their target population(s). Employers should take time to fully understand exactly where their employees live and work—and use this to inform the assessment of any DPC vendor with existing clinics or, if the vendor is willing, where new clinics will be built. With few exceptions, it is unlikely that any DPC vendor's established clinic network will perfectly align with a population's footprint. If targeting particular areas, it is well worth the effort to fully understand where the opportunity is greatest in terms of driving better outcomes from the DPC approach. Claims utilization patterns, prevalence of chronic conditions among employees, average healthcare costs in the region, and existing access to primary care are just a few of the factors that can inform decisions in this regard.

BENEFIT DESIGN

As referenced earlier, employee engagement is a critical component to achieving desired outcomes from any DPC offering. Employers typically implement DPC solutions to increase access to care, improve the quality of care, reduce participant out-of-pocket costs, and/or achieve total cost of care savings; how many participants utilize the DPC solution is directly correlated to the ability of successfully meeting these objectives. When designing a DPC program, employers should consider plan design features such as lower copays or tiered networks to incentivize the eligible participant to access care at the DPC clinic. If establishing a DPC network solution within a typical PPO or point-of-service (POS) plan design, as one plan choice among other medical options, employee plan contributions should reflect the advantages of selecting that DPC-focused approach.

OPERATIONAL EFFECTIVENESS

Although employers typically contract directly with DPC vendors and pay DPC membership fees in lieu of fee-for-service claims submitted to their carriers or TPAs, many self-funded employers do seek some interaction between their carriers or TPAs and the DPC vendor. For example, many employers have DPC vendors submit "ghost" or "zero dollar" claims to their carriers or TPAs for data reporting purposes. Other employers require their TPAs to help steer members to the DPC provider for primary care services by including the DPC provider in provider directory resources given to members. Employers should ensure that the claims administrator (national carrier, TPA, or regional health plan) is willing to incorporate DPC information and data to the extent desired. There may be contractual considerations for the employer's TPA in terms of its own provider network that may get in the way of a smooth integration.

FINANCIAL RESULTS

How will an employer know whether its DPC model has been financially successful? As with most solutions, it is not effective unless it can be measured; data is key. It is not only important to define an approach for measuring outcomes, but it is also important to understand how the DPC vendor will be measuring the results of its efforts. What will be the key performance indicators to monitor, and how will the vendor be held accountable for these results? It is imperative that the employer understand how often the vendor will be reporting utilization, and its method of calculating any program savings. These measurement and accountability parameters should be established before entering into a formal agreement with the DPC vendor.

In summary, Direct Primary Care is growing and becoming a viable option for more and more employers. But like all employee benefits, some homework ahead of time can help set up the program for success.

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