# With Direct Primary Care, It's Just Doctor and Patient

## Patients pay a monthly fee for a range of basic services, eliminating the insurance middleman

Melinda Beck  Updated Feb. 27, 2017 12:46 p.m. ET

Linnea Meyer, a physician in Boston, says the direct-pay model frees her to focus on patient care. Photo: Shiho Fukada for The Wall Street Journal

*By*
*Melinda Beck*

There's no waiting room at Linnea Meyer's tiny primary-care practice in downtown Boston. That's because there's rarely a wait to see her. She has

only 50 patients to date and often interacts with them by text, phone or email. There's no office staff because Dr. Meyer doesn't charge for visits or file insurance claims. Patients pay her a monthly fee—$25 to $125, depending on age—which covers all the primary care they need.

"Getting that third-party payer out of the room frees me up to focus on patient care," says Dr. Meyer, who hopes to expand her year-old practice to 200 patients and is relying on savings until then. "This kind of practice is why I went into medicine, and that feels so good."

Dr. Meyer is part of a small but growing cadre of doctors practicing "direct primary care," which bypasses insurance and charges patients a monthly membership fee that covers everything from office visits to basic lab tests.

It's similar to "concierge medicine" but less costly: The average monthly fee for direct primary care is $25 to $85, according to the Direct Primary Care Journal, a trade publication. That compares with $100 or more a month for concierge practices—which often charge patients, or their insurers, for individual visits as well. Concierge practices, which can run as high as $25,000 a year, often target affluent baby boomers in high-cost urban areas and may include services such as personalized wellness plans and advanced testing.

Direct-primary-care practices run the gamut from small, independent offices like Dr. Meyer's to multistate networks, with many variations. Some work with employers and insurers, offering unlimited primary care as part of employee-benefit plans. Boston-based Iora Health works with Medicare Advantage plans in Colorado, Arizona and Washington state. Qliance, with six offices in the Seattle area, is working with Medicaid there and is an option on the state health-insurance exchange.

**To some, a win-win**

Although less than 2% of the nation's 900,000 licensed physicians are

involved in direct primary care to date, proponents say the model could grow as Republicans encourage more free-market alternatives to insurance-based, fee-for-service medicine.

Tom Price, the new Health and Human Services secretary, introduced legislation while he was in Congress that called for replacing the Affordable Care Act with tax-credit-funded health savings accounts. Currently, Internal Revenue Service rules prohibit using HSA funds to pay direct-care membership fees, but bills to lift that prohibition have been introduced in both the House and Senate.

The American Academy of Family Physicians supports direct-pay primary care, too. With the new practice model, “you’re not on the hamster wheel of getting paid based on the volume you do,” says John Meigs, the group’s president. “Patient satisfaction goes up. Physician satisfaction goes up. Quality goes up and costs go down because you don’t have to prove it to Uncle Sam or an insurance company.”

Doctors in such practices say the steady income from membership fees frees them from having to pack patients into 10-minute visits to make ends meet. They can take more time with those who need it and handle many issues via text or email, which are rarely reimbursed in traditional fee-for-service medicine.

“I’ve cared for eight patients today and it’s only 11 a.m.,” says Terry Ann Scriven, a direct-primary-care doctor in Cape Elizabeth, Maine. “But I haven’t seen any of them in the office because they didn’t need to be seen.”

Dropping out of insurance networks and opting out of Medicare also frees doctors from haggling with claims adjusters, filing quality reports and meeting standards for electronic medical records, which helps keep overhead low.

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## Membership Medicine

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While physician practices that charge membership fees vary considerably, here's how typical direct primary care and concierge medicine compare, according to online polls with doctors who run them

| | DIRECT PRIMARY CARE | CONCIERGE |
|---|---|---|
| **Number of practices** | 500 to 600 | 5,000 to 5,500 |
| **Typical monthly fees** | $25 to $85 | $101 to $225 and up |
| **What's included** | All office visits; 24/7 support; often basic lab tests, vaccinations, scans and generic drugs | Annual physical; 24/7 support; wellness plan and counseling; often advanced testing and screening |
| **Per-visit charges** | None | Many also bill insurance or Medicare for individual visits and services |
| **Patients seen in office per day** | 6 to 10 | 6 to 10 |

| | | |
|---|---|---|
| **Typical visit length** | 30 to 60 minutes; some 15 to 30 minutes | 30 to 60 minutes; some 60 to 90 minutes |
| **Typical patients** | Ages 29 to 59; incomes below $93,000 | Over age 59; incomes over $93,000 |

Sources: Direct Primary Care Journal; Concierge Medicine Today

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"People ask me how I can do this for $60 a month," says David Cunningham, who left a large medical group to open a two-doctor direct-care practice in Mansfield, Mass., last year. They think it should cost more, he adds, but "that's only because we have this bloated way of paying for it." In his old practice, he says, more than 60 cents of every dollar went to administrative costs.

Patients in direct-primary-care practices still need insurance to cover hospitalizations and other costly services (as well as meet the Affordable Care Act's requirement). But with their primary-care needs covered, they can choose high-deductible plans with lower premiums. "You're essentially buying insurance against using your insurance," says Jay Keese, executive director of the Direct Primary Care Coalition, a trade group.

While some people balk at paying for both a membership and insurance, others say it is still a good deal. Josh Maibor of North Attleborough, Mass., says the $60 a month that he and his wife each pay Dr. Cunningham for unlimited care "is less than we'd pay in copays for a single visit." Plus, Mr. Maibor says, "it's like having a doctor in the family. I texted him on Christmas Eve, and he got back to me in 10 minutes."

Proponents say the direct-primary-care model may work particularly well for

patients with complex medical conditions who need careful monitoring and help coordinating multiple specialists.

Judy Cozine of North Attleborough, Mass., age 68, says she and her husband, who both have Type II diabetes, visit Dr. Cunningham's partner, Wendy Cohen, every few months to have their blood sugar and blood pressure checked. Their two daughters, a son-in-law and all four grandchildren are patients of Dr. Cohen's, as well. "I can talk to her about anything and know that there's no clock ticking," says Mrs. Cozine. "None of us would go back to another model of practice again."

While concierge practices tend to attract affluent patients, direct-primary-care doctors say their practices are highly diverse. "I have heroin addicts and multimillionaires in my office," says Chris Ewin, a direct-primary-care physician in Fort Worth, Texas.

**Doctor shortage**

To date, there are few academic studies assessing whether direct primary care actually cuts costs and improves patient health. But practices that work with insurers and employers are starting to generate data.

Qliance says its patients had 27% fewer ER visits, 60% fewer hospital days and cost their employers 20% less on average than similar non-Qliance patients in the area.

Iora Health says 83% of the patients in its practices with high blood pressure have it under control; the national average is 63%.

R-Health, a Philadelphia-based group, says it can save self-funded employers 15% on their total costs, and has high rates of cancer and cholesterol screenings, medication adherence and blood-sugar control. R-Health has teamed up with Aetna and Horizon Blue Cross Blue Shield of New Jersey to offer unlimited primary care at four of its practices to New Jersey state

employees. It hopes to enroll as many as 60,000 of the 800,000 eligible workers in the first two years. “We need to hire a lot of doctors,” says Mason Reiner, R-Health’s CEO.

And therein lies a big challenge: Scaling up the model significantly could exacerbate the shortage of primary-care doctors. Most physicians in direct-care practices treat fewer than 600 patients, compared with more than 2,000 for doctors in a typical primary-care practice. “We’d need three times as many physicians as we have now,” says internist Robert Berenson, a fellow at the Urban Institute and former head of managed-care contracting for Medicare.

Another problem, health-care experts say, is that payers may balk at even modest monthly fees if the services go unused, as Qliance found working with Medicaid in Washington state.

About 25,000 people who qualified for the state’s Medicaid expansion were assigned to Qliance for their primary care in 2014. But only about 25% of them came to get care in the first year. With the state demanding that insurers it worked with refund some of the premium fees retroactively, the Medicaid plan renegotiated the contract the following year, leaving Qliance with a sharp decline in revenue after it had opened two new clinics to handle the patient influx.

With return on investment looking more distant, company officials bought out their private investors—including Amazon’s Jeff Bezos and entrepreneur Michael Dell—last March and introduced an additional tier, offering unlimited virtual urgent care via telemedicine visits and other services for $10 per month.

Qliance CEO Erika Bliss says she believes direct primary care could deliver better care for many more Americans. “If the market started to ask for this and was willing to pay, say, $50-$100 per person a month, instead of $15 or sometimes less with Medicaid or $30 with commercial insurance, primary-care doctors would switch to this in a heartbeat,” she says.

And then there's the risk that primary-care practices might have an economic incentive to fill their practices with young, healthy patients who rarely see them and avoid older, sicker patients or stint on their care, as some HMOs were accused of doing in the 1990s.

"Where is the quality control?" asks Dr. Berenson. Working with insurers and Medicare Advantage plans does provide oversight, he says, but it also involves the kind of paperwork and oversight many doctors join direct primary care to avoid.

Proponents say patients can provide their own quality control—by leaving any practice that doesn't give them good care. So far, satisfaction rates run high. "Patients love it, and I love it," says Dr. Meyer in Boston. While she hopes to add more patients to her practice, she's disinclined to advertise. "I think I'd be overrun," she says.

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**Corrections & Amplifications**

R-Health, a Philadelphia-based physicians group, has joined with Aetna and Horizon Blue Cross Blue Shield of New Jersey to offer direct primary care as an option to New Jersey state employees. An earlier version of this article incorrectly said R-Health had teamed up with Humana instead of Horizon. (Feb. 27, 2017)

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