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WHERE OBAMACARE LEAVES QUESTIONS, DIRECT PRIMARY CARE MAY OFFER ANSWERS

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ABSTRACT

With its passage in 2010, the Affordable Care Act (ACA) set out to remake American health care, but in many respects the ACA didn't change the health care paradigm at all; it simply doubled-down on a broken, decades-old status quo that placed health "coverage" as a national priority above both limiting health care costs and enhancing health care access. After establishing the problem with maintaining an insurance-centered care mindset, this paper explores a promising medical practice model, direct primary care (DPC), which could deliver on the cost and access promises broken by the ACA.

INTRODUCTION

What is a direct primary care arrangement? DPC arrangements are agreements between a patient and doctor that generally cut insurance companies out of the primary care equation. Usually in return for a monthly fee or similar retainer,¹ a DPC physician agrees to limit the number of patients she sees while guaranteeing greater patient access.² Rather than work through an insurance middleman, patients negotiate fees with the doctor directly, reducing overhead and simplifying the process by which care is delivered.

ADVANCING LIBERTY WITH RESPONSIBILITY
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Over the last half-century, policymakers have built an artificial seller's market in health care, and as one might expect, sellers of health care have done quite well in that system.



In important ways, DPC agreements return prices and price signals to the health care space. As doctor and Cato Institute adjunct scholar Jeffrey Singer observed in 2013, “The third party payment system is the principal force behind health care price inflation,”³ and that is because in the absence of clear prices, consumers demanding health care have to rely on the suppliers to determine the value of those services. Over the last half-century, policymakers have built an artificial seller’s market in health care, and as one might expect, sellers of health care have done quite well in that system.

Unfortunately, the ACA did not fundamentally change this equation, inflating costs and, similarly, explicitly and implicitly making care less available. However, evidence suggests that a combination of “wraparound” insurance-augmented DPC care packages not only is less expensive than comprehensive insurance arrangements, but can actually result

in improved health outcomes as well.

This mix of superior cost and access distinguishes DPC arrangements from more common care frameworks, which render and reimburse for care in the context of insurance. DPC’s advantages are most pronounced when compared to the dominant, third-party payer health care models, both before and after the ACA became law.

COST AND ACCESS: BEFORE AND AFTER THE AFFORDABLE CARE ACT

It’s been a rough half-decade for millions of American patients. In 2010, Congress passed and President Barack Obama signed the Patient Protection and Affordable Care Act (ACA), an historic and wide-reaching shuffling of the U.S. health care system that, for good and bad, ushered in a new era of American medicine. For President Obama and his allies, it was a bruising political battle, but the ACA’s supporters

were outwardly confident that the law they had enacted would bring comprehensive, positive change to the American health care system, largely by making health insurance more widely available.

“This law will cut costs and make coverage more affordable for families and small businesses,” President Obama told reporters in June 2010,⁴ two months after signing the ACA into law. “It’s reform that brings—that begins to bring down our government’s long-term structural deficit. It’s reform that finally extends the opportunity to purchase coverage to the millions who currently don’t have it—and includes tough new consumer protections to guarantee greater stability, security and control for the millions who do have health insurance.”

Few at the time would have disputed that the American health care was in need of significant reform.⁵

One major problem was the growth in the cost of health care and health coverage, both to purchasers in the private market and to the government through Medicaid. A study by the Kaiser Family Foundation found that the average annual premium for a single person in an employer-sponsored health plan—the most common care arrangement in the United States⁶—actually doubled between 2000 and 2010, from a cost of just over \$2400 annually to a price tag of over \$5000 each year.⁷

Comparable family plans mirrored this cost acceleration. Over the same ten-year period, the average premiums for employer-sponsored

family plans jumped from around \$6400 to over \$13,000. Overall government spending on the country’s Medicaid program rose at a similar clip. In 2000, combined state and federal spending on Medicaid programs totaled just over \$200 billion annually; by 2010, Medicaid spending had exceeded \$400 billion.⁸

Another major problem was that as the cost of health coverage rose, substantive access to care narrowed—especially for government-sponsored segments of the insurance market. According to the Center for Studying Health System Change, in 2008 only about 42% of primary care physicians (PCPs) were accepting new Medicaid patients, compared to just over 84% for privately-insured patients.⁹ This disparity in service was driven by a combination of low Medicaid reimbursement rates as well as other earnings-related trends that were already driving doctors away from PCP practices, including the administrative hassle government medical programs brought to physicians’ practices.¹⁰ Under the ACA, reimbursement rates for Medicaid patients rose in 2013 and 2014, boosting doctor acceptance of new Medicaid enrollees into the upper 60% range nationally;¹¹ however, as reimbursement rates fall back to their historical levels, it is likely that doctor interest in taking new Medicaid patients will recede as well.¹²

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COSTS FOR COVERAGE CONTINUE TO RISE

Prices are signals. They express knowledge about the scarcity of a good or service, and they help establish consensus values for purchasers and sellers alike so that buyers can use their money efficiently and sellers can be properly compensated for their labors. An iPhone produced in 2015 that costs just \$100 may be broken or a fake; an iPhone that costs \$10,000 is almost certainly overpriced.

As rational buyers of cellular phones, many of us have a good set of reference prices to draw on when we decide whether to buy an iPhone. Indeed, a fair price for a new iPhone is probably somewhere between \$500 and \$1000. Many, if not most, Americans know this. But while other qualitative measures, like patient comfort and trust, distinguish health care from iPhones and affect how we evaluate the value of healthcare we receive, it is nonetheless true that the general pricing knowledge we've come to expect in consumer electronics, and should expect in health care, is often

unavailable. This is attributable in no small part to the fact that Americans largely rely on a third party—whether a private insurer or the government—to do our healthcare shopping on our behalf.

The ACA did not meaningfully change this payment paradigm, and consequently, the magnitude of the cost problem in the private market was largely unchanged after the insurance exchange provisions of the ACA came into effect two years ago. A report issued by the Deloitte Center for Health Solutions projected in 2014 that insurers in the ACA's insurance exchanges would have to deal with the "10 percent problem," representing the double-digit annual rate increases Deloitte projected would be needed at least through 2017 for insurers to reach profitability.¹³ Deloitte's forecast has been confirmed in subsequent rate revisions by insurers. In June 2015, HealthPocket, a company that aggregates insurance price data for consumers, reported that proposed ACA insurance rate increases for 2016 would reach 12% on average, with the highest rate increases exceeding 20%.¹⁴



While the increased cost of employer-sponsored plans has not accelerated at the same rate as the cost of plans in the exchange, employees' shares of the cost of care in employer-sponsored plans are still on the rise. From 2009 to 2014, the Kaiser Family Foundation found that the average deductible for employer-sponsored plans had risen by nearly 50%, from \$826 to \$1217 annually. Moreover, the average premium for employer-sponsored family health plans rose by three percent in 2014—lower than the double-digit increases of the late 1990s and early 2000s, but still higher than the general inflation rate of 2%.¹⁵⁻¹⁷

Medicaid spending growth also continues to outpace inflation.¹⁸ In 2010, combined state and federal spending on the Medicaid program topped \$400 billion. In 2015, Medicaid spending exceeded \$500 billion.¹⁹ This growth is consistent with the HHS's most recent actuarial report for the Medicaid program, which suggests Medicaid spending will continue to grow at a whopping 7% pace at least through 2022. By that time, federal and state Medicaid spending will approach \$900 billion—a nearly two-fold increase over 2010 spending and a four-fold increase over Medicaid spending in 2000.

Taken together, spending on health coverage in both the private market and in Medicaid is headed in precisely the wrong direction, despite the ACA. In both private plans and in the government program that sponsors coverage for tens of millions of needy Americans, spending consistently outpaces inflation. Rather than bend the cost curve down, the ACA may in

fact be cementing in place an upward spending curve that will cost patients dearly, through their own plans and through their taxes, in the years ahead.

ACCESS TO CARE IS DECLINING FOR MILLIONS OF AMERICANS

Even as insurance coverage has expanded under the ACA, substantive barriers to quality medical care remain in place. And these barriers are often linked to the cost of care itself. In an elegantly headlined February 2015 report titled, “Insured, but not covered,” Elisabeth Rosenthal of the New York Times recounted some of the horror stories that patients have experienced after the passage of the ACA.²⁰ Rosenthal's most important takeaway is this:

The Affordable Care Act has ushered in an era of complex new health insurance products featuring legions of out-of-pocket coinsurance fees, high deductibles and narrow provider networks. Though commercial insurers had already begun to shift toward such policies, the health care law gave them added legitimacy and has vastly accelerated the trend, experts say.

In other words, to ensure health insurance remained profitable and plans remained cheap enough for consumers to afford, the costs imposed by the ACA and by a largely unpriced third-party payer system had to be shifted to patients—either explicitly through expanded cost-sharing, or implicitly through significant care network limitations.

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It's a story that's being repeated again and again across the country. From the Times:

Ms. Pineman, who is self-employed, accepted that she'd have to pay higher premiums for a plan with a narrower provider network and no out-of-network coverage. She accepted that she'd have to pay out of pocket to see her primary care physician, who didn't participate. She even accepted having co-pays of nearly \$1,800 to have a cast put on her ankle in an emergency room after she broke it while playing tennis.

But her frustration bubbled over when she tried to arrange a follow-up visit with an orthopedist in her Empire Blue Cross/Blue Shield network: The nearest doctor available who treated ankle problems was in Stamford, Conn. When she called to protest, her insurer said that Stamford was 14 miles from her home and 15 was considered a reasonable travel distance. "It was ridiculous—didn't they notice it was in another state?" said Ms. Pineman, 46, who was on crutches.

She instead paid \$350 to see a nearby orthopedist and bought a boot on Amazon as he suggested. She has since forked over hundreds of dollars more for a physical therapist that insurance didn't cover, even though that provider was in-network.²¹

Paradoxically, by forcing insurers to cover more services for everyone, many beneficiaries are being covered less for the medical needs that they

actually have to confront.²² The impact of limited resources on access needs is perhaps most obvious in the post-ACA Medicaid program.

One way that access issues affect Medicaid patients is in the limited availability of primary care physicians, or PCPs, thanks in part to low reimbursement rates from the government. Medicaid reimbursement rates generally have been below the rate provided both through Medicare and the market rates of private insurance. With limited time, physicians behave like other rational actors: with an eye, generally, to maximizing their own benefit. Because Medicaid patients are comparatively unprofitable, better-paying patients receive a higher priority and, in the aggregate, have wider access to care than those in the lower-paying government program

This low-payer paradigm was briefly interrupted during the past two years. For 2013 and 2014, Medicaid was, thanks to the ACA, reimbursed at Medicare rates, temporarily stoking physician participation in the program. Those rate boosts ended this year,²³ but it should be noted that this exception proves the access-to-care rule here. To widen the network of physicians accepting Medicaid, Medicaid had to bend its cost curve up by paying physicians more. To reduce costs, Medicaid care networks will likely narrow. And the beat goes on.

That isn't to say doctors did not want enhanced Medicaid payments to continue, despite the negative fiscal implications.²⁴ From a December 2014 edition of the Times:

Dr. George J. Petruncio, a family physician in Turnersville, N.J., described the cuts as a “bait and switch” move. “The government attempted to entice physicians into Medicaid with higher rates, then lowers reimbursement once the doctors are involved,” he said.

But Nicole Brossoie, a spokeswoman for the New Jersey Department of Human Services, which runs the state’s Medicaid program, said the increase was not meant to be permanent. “The enhanced rates will not be extended in New Jersey,” Ms. Brossoie said. “It was always understood to be temporary.”

If history is any indication, as go Medicaid reimbursement rates, so too will go PCP participation in the program. That means there will be fresh limits to the availability of care for some of America’s most vulnerable patients—limits that will be especially acute as enrollment in the program rockets upward in the years ahead.

Fewer doctors, lower rates, and more patients is a recipe for health care disaster, but it appears that’s where the Medicaid program is headed at the moment.

Another way narrow care networks in Medicaid reveal themselves is in the emergency room. One of the most highly touted selling points of the ACA was that emergency room use would drop as more people found insurance and, presumably, non-emergency care.²⁵ The claim is plausible enough; if a formerly uninsured person has access to health care that could fix minor maladies (like a cold) or even head

off a catastrophic health event (like a heart attack) with some prevention, it’s reasonable to think expensive emergency room utilization would fall.

But it isn’t true.²⁶ Evidence out of Oregon suggests that rather than reduce emergency room use, enrollment in Medicaid may at best have no effect in reducing unnecessary ER visits.

Perhaps most startling is recent news from a survey of emergency room doctors, taken this year by the American College of Emergency Physicians, suggesting that the expansion of Medicaid has actually increased—not decreased or kept flat—emergency room usage. As explained by Dr. Howard Mell of the ACEP in the Wall Street Journal, “Visits are going up despite the ACA, and in a lot of cases because of it.”²⁷

ACEP’s 2015 report was not the product of a once-off survey, either. In 2014,²⁸ one-third of emergency departments reported seeing more Medicaid patients; in 2015,²⁹ over half reported an increase.³⁰ Dr. Michael Gerardi, the president of ACEP, put the problem succinctly in the organization’s 2015 press release:³¹

America has severe primary care physician shortages, and many physicians will not accept Medicaid patients because Medicaid pays so inadequately,” said Dr. Gerardi. “Just because people have health insurance does not mean they have access to timely medical care.

These results should have come as no surprise to policymakers. In Massachusetts, state-instituted

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reforms in the 2000s, similar to those instituted by the ACA, were associated with increases, not decreases, in emergency room use.³² Although Massachusetts has by far the highest per capita supply of PCPs in the country,³³ it still saw a “consistent increase in the use of the [emergency departments] across the state.”

And although the number of PCPs accepting Medicaid patients has wavered nationally over the last few decades, the number of Medicaid patients has not. In 2000, 34.5 million people were enrolled in Medicaid. In 2010, in the midst of a deep recession, over 54 million were enrolled in the program. By 2014, 65 million had joined.³⁴ And as of April 2015, over 71 million Americans were enrolled in Medicaid, an all-time high.³⁵

It may be comforting to believe that enrollment in an ACA health insurance plan or in the Medicaid program itself brings with it guaranteed access to care. For millions of Americans, that simply hasn’t been the experience. For the lucky ones, limited access to care networks results in inconvenience and, sometimes, more out-of-pocket spending. For the unlucky ones, however, the consequences of miserable care networks can lead to much worse, tragic, and yet altogether avoidable health outcomes.³⁶ Americans can do better.

A TROUBLING CONTRADICTION

Taken together, this reality—that increased spending on coverage has not led to consistent access to care—is

a central concern for all of us. The law is called the “Affordable Care Act,” and yet for millions of Americans subject to this leviathan legislation, it has not reliably delivered services that are affordable, or care that is accessible. That’s a big problem.

There is no single silver bullet that will solve the ACA’s multifaceted problems. Certainly there are many separate and substantive reforms that policymakers can undertake to make health care in this country better.³⁷ However, there is at least one health care option that can be pursued right now by patients and policy innovators that not only addresses some of the unresolved cost and access concerns of the ACA, but could be used by beneficiaries in both private and government-sponsored health care plans. That option: direct primary care arrangements.

THE IMPORTANCE OF PRIMARY CARE

Depending on your generation, your picture of a PCP could vary. For Baby Boomers, mild mannered television doctor Marcus Welby, M.D., out making house calls may be the archetype; for Generation Xers, a professionally progressive doctor of the type seen on *Private Practice* may capture the PCP vocation best. But whatever the cultural reference point, what Americans generally expect out of their primary care arrangements is a personal and reassuring touch.

In fact, a great deal of research suggests that other than the patient herself, perhaps the next most important player in patient health outcomes is the PCP. In a highly



cited paper published in the *Annals of Family Medicine* in 2003, researchers found that while specialists are instrumental in treating individual diseases, “single-disease management does not appear promising as a strategy to care for patients.”³⁸ Rather,

[t]he high salience of comorbidity³⁹ makes it unlikely that management of a patient visit by visit, with each visit focused primarily on 1 condition, can provide effective care from the vantage of the patient, even in, patients with bona fide common conditions. In the case of common conditions, the large proportion of visits to generalist physicians rather than to disease-oriented specialists and the frequency of such visits for both the specific condition and for comorbid conditions suggest a major role for primary care physicians, operating in a patient (“case”) management mode, with a strong imperative for appropriate consultation with specialists.

Perhaps less glamorous and often less well-compensated than other medical specialists, PCPs are nonetheless instrumental in promoting and maintaining the good health of the patients they see. Rather than a gateway to a specialist, PCPs are more like an intersection through which care can be coordinated and tailored to the holistic needs of the patient.

The problem, often, is whether a PCP is available to patients. Traditional primary care practices often require larger patient panels to be successful—on average, over 2000 patients per provider⁴⁰—in no small part because the transactional costs of insurance billing and reimbursement are so high that those expenses have to be made up in patient volume.⁴¹ Research suggests that more patients often mean less time spent with patients (per visit and in the aggregate) and potentially worse health outcomes.^{42 43}

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Dr. Philip Eskew, a researcher and proponent of DPC arrangements. “Eighty percent of the diagnosis is in the history, and when a physician cannot spend the time to obtain a good history, his hands are tied.”

Unsurprisingly, there is fresh interest from doctors in alternate primary care practice arrangements. DPC is among the most prominent, and among the most promising.

DIRECT PRIMARY CARE ARRANGEMENTS

Even among doctors, the definition of what constitutes a DPC provider remains a topic of discussion, but DPC practices, generally speaking, charge a set fee to patients, limit patient panels to maximize time per patient, and tend not to bill third parties, like insurers, on a fee-for-service basis. These traits of DPC are in fact related to one another. By cutting out the frequent participation of an insurer, DPC doctors are able to reduce administrative costs by a third or more.^{44 45} In theory and practice, those lower overall costs then allow doctors to take smaller patient panels and charge a stable fee to guarantee access to the doctor.

What would make DPC arrangements attractive to patients in the post-Obamacare world?

For one, nationwide mandatory health insurance does not guarantee access to primary care doctors. That is fundamentally what DPC arrangements provide: agreements between a patient and her doctor in which the patient pays a fee for services to be rendered over a period of time,

and the doctor agrees to limit the number of his or her patients to ensure robust patient access to primary care.

For another, direct primary care may be coming en vogue because DPC is (arguably) promoted by the ACA itself. Paired with “wraparound insurance coverage”—insurance policies meant to cover catastrophic events and other required health benefits that are not traditionally part of a primary care relationship—DPC arrangements can actually be part of a qualified health plan as defined by the ACA and HHS.⁴⁶

The benefits to patients of this “augmented DPC” provision are three-fold. First, it is possible⁴⁷ for DPC subscribers to contract with doctors for reliable health care access as part of a larger insurance plan.⁴⁸ Second, there is evidence to suggest that the cost of combined DPC and augmented insurance arrangements “is lower than the cost of a comprehensive insurance plan by itself,” according to the Heritage Foundation.⁴⁹ “If the number of practices continues to increase and compete directly for consumers, prices will likely decline further.” Third, augmented DPC may provide better care to patients than traditional comprehensive insurance plans,⁵⁰ leading to better health outcomes and ultimately better quality of life for patients.

The other benefits specific to doctors are also substantial. A new DPC practice can “make it” with a panel of as few as 400 patients, although a practice can range from 1200 to 2400 patients or more.⁵¹ Being able to have fewer patients facilitates more diligent diagnosis, better coordination

of care, fewer mistakes, and better patient outcomes and satisfaction. The time and expense of collecting from insurance companies is reduced because third parties have largely been removed from the payment process. And aside from the professional benefits, DPC practitioners report more personal time, as well—contributing to their own satisfaction and helping to prevent burnout and exit from the PCP field.^{52 53}

There are other versions of direct care arrangements as well, although they don't necessarily fit neatly under the DPC umbrella. Perhaps the best-known of these is “concierge care.” Although the terms DPC and concierge care are often used interchangeably, concierge care doctors tend to maintain considerably smaller panels of patients, charge higher monthly fees and, importantly, typically bill patients' insurance companies for services.⁵⁴ Along with not billing insurers, DPC arrangements generally have larger

patient panels and charge monthly subscription fees between \$50 and \$150,⁵⁵ with a median monthly fee of \$80.⁵⁶

Beyond the legal distinctions that differentiate concierge and DPC physicians, DPC proponents are often quick to put daylight between themselves and concierge practices because of the popular cultural misconceptions that persist about what DPC and concierge practices look like. The words “concierge care” can conjure images of private doctors catering to the rich, much like the fictional (albeit affable) Dr. Hank Lawson in the television show “Royal Pains”; the term can connote a certain level of inaccessibility for people of middle class means. In contrast, DPCs operate more like a traditional PCP practice: fewer house calls, certainly, but more accessible for regular people than many other PCP practices, including concierge care practices.

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Direct primary care certainly isn't without reasonable critique. Among them:

- A practice model that facilitates smaller patient panels, if widely adopted, could mean worse access to the patients not in those DPC panels.
- Guaranteeing access to doctors under a DPC model may facilitate overuse of those physicians, undermining the doctor's availability to other DPC patients and weighing on the doctor's own satisfaction with her practice.
- Because DPC doctors can comfortably limit the size of their patient panels, they may take the cream of a patient pool—that is, take healthier and wealthier patients and leaving unhealthy and poorer patients to other doctors to take.

Time will tell to what extent these objections will bear themselves

out; at present, limited adoption of DPC practice models also provides limited data from which to draw conclusions one way or another on these points. But the critiques are not without responses. First, while DPC patient panels can be smaller, they do not have to be.⁵⁷ With lower administrative, reimbursement, and collection burdens on a doctor's time, patient panel sizes similar to those of a traditional setting are possible and not uncommon. Second, anecdotal observations from DPC practitioners suggests that while patient overuse in a care arrangement is a concern in theory, in practice such instances are nonetheless manageable. Third, the question of taking only healthy and financially comfortable patients is a practical and ethical concern being grappled with in DPC circles today, especially for those practices moving from traditional to DPC practices. However, many DPC practices already have a mix of patients of varied health and economic circumstances. Because the price of a DPC PCP can often be

the equivalent to that of a monthly cell phone bill,⁵⁸ such services are not just reserved to the wealthy; indeed, these services are usually priced to appeal to the pocketbooks of most Americans.

Is DPC a perfect policy solution? Probably not, but it does seem to be a step in the right direction. And like any policy space, the landscape that makes DPC practices attractive today could always change. Government red tape and overregulation will always exist as a potential threat to such arrangements, as they do with traditional primary care practices. That said, it appears that the weight of legislation is moving in the favor of DPC practices.

DIRECT PRIMARY CARE DEVELOPMENTS AT THE STATE LEVEL

Because most states have not established their own ACA insurance exchanges, the definition of a qualifying DPC wraparound insurance plan is dependent on federal action. Mystifyingly, those regulators have declined to offer such a definition to date. But while movement at the federal level toward facilitating DPC arrangements is stuck in limbo, movement at the state level has often been brisk.

One major concern among DPC physicians is that given the nature of their care model, state regulatory bodies will start treating them as something they're not—insurers. While DPC contracts usually make clear that the provider is not also an insurer, the comprehensive nature of the practices could provide an ambitious regulator with an excuse to step in and

inappropriately regulate DPC practices. Fortunately, elected representatives appear to be getting ahead of the bureaucracy. For instance, this year in the great state of Missouri, the general assembly passed HB 769, which clearly defined DPC agreements as non-insurance arrangements.⁵⁹ On July 2, 2015, Governor Jay Nixon signed the bill into law.⁶⁰ This means that going forward, the state's Department of Insurance cannot treat DPC physicians as insurers subject to its regulatory regime.

The passage of HB 769 could not have come at a better time. At least nine DPC groups currently operate in Missouri, with another seven located in a neighboring state but within an hour of a Missouri resident.^{61 62} Missouri joins at least twelve other states, including the bordering states of Kansas and Oklahoma, that have passed similar laws protecting DPC doctors, and ultimately DPC patients.

Several states have begun to pursue DPC-enhanced state medical programs. Some, including Maine, have added DPC practices to their lists of eligible providers.⁶³ In New Jersey, upwards of 60,000 public employees would be eligible to join the state's proposed Direct Primary Care Medical Home Pilot Program, introduced this year.⁶⁴

Of all the states that have DPC practices, however, the state that has pushed the ball the farthest is Washington, where DPC arrangements have been exploding for a number of years. While Federal regulators have dragged their feet in defining what DPC wraparound insurance must look like in federal exchanges, Washington's regulators cleared the way for

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wraparound insurance in its exchange earlier in 2015,⁶⁵ the first of its kind in the country. Perhaps unsurprisingly, today about 10% of DPC clinics nationwide are located in Washington. While this is progress, the wide adoption of DPC arrangements will continue to face regulatory headwinds until ACA-compliant wraparound coverage is widely offered.

RECOMMENDATIONS

Today, improvements in cost and access to care facilitated by DPC arrangements are progressing at different speeds. In the industry, DPC practices appear to be gaining in popularity among practitioners;⁶⁶ it may be only a matter of time before DPC practices are not only available in most states, but to most patients as well.

Legislatively, some progress has been at the state level in support of DPC. In 2014, only eight states had enacted rules that defined DPC practices as engaged in the practice of care, rather than insurance. As of this publication in 2015, that number had risen to thirteen. Before, no states had wraparound insurance plans available in their exchanges. Now, there is one in Washington—a modest start, but a start nonetheless. As Daniel McCorry of the Heritage Foundation noted last year in his excellent paper on DPC, to the extent state law unnecessarily restricts DPC practices, those laws should be reformed to instead facilitate their growth.⁶⁷

But the real obstruction to more expansive progress with DPC has been the federal government. McCorry's summary of needed federal reforms

from 2014 unfortunately could, and should, in large part be reiterated in 2015. As they should for all manner of health purchases, health savings accounts should be liberated from the narrow buying restrictions that have rendered HSAs particularly difficult to use since the enactment of the ACA, and that should include unfettered spending on DPC. Federal regulators should finally define what wraparound coverage must cover so that DPC arrangements can be joined to them, to the benefit of patients, doctors, and the health care marketplace more generally. Moreover, federal impediments to the broader adoption of DPC practices should be drawn down, particularly in Medicare and Medicaid.

I would add one more legislative recommendation to the mix. States should waive re-licensing requirements for physicians practicing DPC medicine in good standing in any state. For a state like Missouri, which borders eight states, the pool of DPC doctors that could be available to state residents would grow considerably.

Moreover, the Academy should conduct additional peer-reviewed research into the advantages and disadvantages of DPC practices for patients, doctors and to taxpayers, especially now that the expansion of the practice model will provide more data for analysis.

DPC arrangements may help doctors and patients to improve the cost, quality, and availability of care in this country. Policymakers should seriously consider DPC's fiscal and policy implications, and particularly its opportunities, in the current legal and regulatory environment.

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NOTES

1. American Academy of Family Physicians. "Direct Primary Care." Available at: <http://www.aafp.org/practice-management/payment/dpc.html>. Accessed September 21, 2015. There is some variation in how direct care practices are defined, and one variation includes direct surgical care like that seen at the Surgery Center of Oklahoma (<http://www.surgerycenterok.com>). My primary focus in this paper will, appropriately, be primary care, but the services provided by SCO are an important component and extension of the direct care debate, since direct surgical care deals with some of the same cost and care access issues engaged by DPC practices.

2. Zickafoose JS, Clark SJ, Sakshaug JW, et al. "Readiness of Primary Care Practices for Medical Home Certification." *Pediatrics* 131, no. 3 (2013). 473–482.

3. Singer, Jeffrey A. "Health Care's Third-Party Spending Trap." Available at: <http://www.cato.org/publications/commentary/health-cares-third-party-spending-trap>. Accessed September 21, 2015.

4. Office of the Press Secretary—The White House. "Remarks by the President on the Affordable Care Act and the New Patients' Bill of Rights."

June 23, 2010. Available at: <https://www.whitehouse.gov/the-press-office/remarks-president-affordable-care-act-and-new-patients-bill-rights>. Accessed September 21, 2015.

5. The list of American health care problems, pre- and post-ACA, is long. Too long, in fact. The focus of this paper is limited to issues relating to cost and access problems both because the problems are so prominent and because DPC arrangements address both concerns.

6. Kaiser Family Foundation. "Health Insurance Coverage of the Total Population." Available at: <http://kff.org/other/state-indicator/total-population/>. Accessed September 22, 2015.

7. Kaiser Family Foundation. "Employer Health Benefits 2014." Available at: <http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report>. Accessed September 22, 2015.

8. United States Department of Health & Human Services. "2011 Actuarial Report on the Financial Outlook for Medicaid." Available at: <http://medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/medicaid-actuarial-report-2011.pdf>. Accessed September 22, 2015.

9. Center for Studying Health System Change. "State Variation in Primary Care Physician Supply: Implications for Health Reform Medicaid Expansions." March 2011. Available at: <http://www.hschange.com/CONTENT/1192/>. Accessed September 22, 2015.

10. It should also be noted that PCP practices also have, in general, fallen out of favor with both new and long-practicing doctors. Between 1996 and 2003, the number of new doctors entering family medicine dropped nearly in half, with much of this decline, and subsequent declines, attributable to the availability of better-compensated medical specialties. In other words, with primary care patients, particularly those on Medicaid, less financially rewarding for doctors than patients in specialty fields, many doctors either left the PCP field, limited their patient load to more profitable patients, or declined to enter the primary care field entirely after leaving medical school. See “The U.S. Primary Care Physician Workforce: Persistently Declining Interest in Primary Care Medical Specialties.” October 15, 2003 Available at: <http://www.aafp.org/aafp/2003/1015/p1484.html>. Accessed September 22, 2015.

11. The Advisory Board Company. “The States Where Doctors Are Least Likely to Accept New Medicaid Patients.” April 6, 2015. Available at: <https://www.advisory.com/daily-briefing/2015/04/06/docs-medicaid-patients>. Accessed September 22, 2015.

12. The enhanced Medicaid rates created a bubble; the concern is over the impact on Medicaid patients as the rates fall and access deflates.

13. Deloitte Center for Health Solutions. “The 10 percent problem: Future health insurance marketplace premium increases likely to reach double digits.” Available at: <http://www2.deloitte.com/content/>

dam/Deloitte/us/Documents/life-sciences-health-care/us-chs-ten-percent-120114.pdf. Accessed September 22, 2014.

14. Novelty, Thomas; Washington Free Beacon. “Obamacare Rates Jump an Average 12 Percent for 2016.” June 11, 2015. Available at: <http://freebeacon.com/issues/obamacare-rates-jump-an-average-12-percent-for-2016/>. Accessed September 22, 2014.

15. Kaiser Family Foundation. “Employer -Sponsored Health Premiums Rise 3 Percent in 2014.” September 10, 2014. Available at: <http://kff.org/health-costs/press-release/employer-sponsored-family-health-premiums-rise-3-percent-in-2014/>. Accessed September 22, 2015.

16. It should be noted that a dollar spent on benefits could be a dollar not spent on wages, so shifts from benefits to cash compensation are not necessarily a negative development. But as the tide for health benefits rises, there is no guarantee that any increases in wages will keep up with the costs of coverage. Since 1999, premiums for employer-sponsored plans have risen 212%, but employee earnings have grown only 54%. With the cost of employer-sponsored insurance expected to rise in the decade ahead, enhanced employee cost-sharing in the forms of heftier deductibles, premiums and copays—likely without commensurate increases in cash compensation—will increasingly become a fact of life for these workers. See Shapiro, Jordan. “Workers Increasingly Shoulder the Cost of Employer-Sponsored

Health Insurance.” St. Louis Post-Dispatch, September 14, 2014. Available at: http://www.stltoday.com/news/special-reports/mohealth/workers-increasingly-shoulder-cost-of-employer-sponsored-health-insurance/article_390faaf6-3aa4-5c7d-a1cd-6e9959af8287.html. Accessed September 22, 2015.

17. Tax-advantaged employer-provided care has been a rite of passage in American employment dating back to World War II, but as costs have accelerated in recent years, employer-provided health insurance has dipped precipitously. While constituting a plurality of the health coverage market, it appears that the days of employer-provided coverage as the undisputed, dominant player in the field may be ending.

18. As part of the ACA, states were required to expand their Medicaid programs to meet the law’s expanded eligibility requirements or else risk losing all of their existing Medicaid funding. After the Supreme Court determined in *National Federation of Independent Business (NFIB) v. Sebelius* (2012) that this provision was unconstitutionally coercive, states effectively had the choice of whether to expand their Medicaid programs or not. This created a quirk both in math and in rhetoric. Because initial Congressional Budget Office estimates assumed all states, plus the federal government, would be forced spend more money on Medicaid coverage for newly eligible enrollees, subsequent CBO figures for the cost of the Medicaid expansion after NFIB were billions of dollars “cheaper” than when the first expansion projections were released. For some, this subsequent,

downward revision of expanded Medicaid costs was vindication that the expansion was effective at getting health care costs down nationwide; in reality, these post-NFIB revisions appropriately reflect the fact that nearly half the states have declined to participate in the program. Despite this massive change in the program, a close look at actuarial reports in 2011 and 2013 by HHS reveals that the ultimate impact of the expansion on aggregate Medicaid spending is limited. In 2011, HHS projected Medicaid spending would approach \$900 billion in 2020; in 2013, that threshold was instead approached in 2022. See also: Ishmael, Patrick and Josh Archambault, “Altering the Deal: HHS Goes to the Dark Side with Medicaid Waiver Threats.” *Forbes*. June 23, 2015. Available at: <http://www.forbes.com/sites/theapothecary/2015/06/23/altering-the-deal-hhs-goes-to-the-dark-side-with-medicaid-waiver-threats/2/>. Accessed September 22, 2015.

19. United States Government Accountability Office. “High Risk: Medicaid Program.” Available at: http://www.gao.gov/highrisk/medicaid_program/why_did_study. Accessed September 22, 2015.

20. Rosenthal, Elisabeth. “Insured, but Not Covered.” *The New York Times*. February 7, 2015. Available at: <http://www.nytimes.com/2015/02/08/sunday-review/insured-but-not-covered.html?smid=tw-share&r=0>. Accessed September 22, 2015.

21. The question of whether insurers should be able to limit care networks is separate and apart from the reasons insurers would impose with

gusto such limitations in a post-ACA world. The idea of in-network providers—generally chosen based on a combination of cost, quality and the price the insurer could charge for the service—has been around for decades now, so it isn't the practice of insurer-organized provider networks that is remarkable here. "Network" care arrangements are not perfect, but they are neither unprecedented nor necessarily uncalled-for.

22. Entire studies have been written on the provisions of the ACA that have driven up the cost of care and led to especially narrow care networks. The impact of guaranteed issue and community rating provisions in the ACA, which have a disproportionately negative effect on the young and the healthy, cannot be understated here, and the use of "young invincibles" by the ACA to subsidize the coverage of other beneficiaries has all sorts of negative repercussions, both economically and also ethically. But for our purposes, the observation that government-imposed burdens raise the cost of care and force uncomfortable decisions that negatively impact care, is sufficient for the time being.

23. Zuckerman, Stephen, Laura Skopec, Kristen McCormack; Urban Institute. "Reversing the Medicaid Fee Bump: How Much Could Medicaid Physician Fees for Primary Care Fall in 2015?" December 10, 2014. Available at: <http://www.urban.org/research/publication/reversing-medicaid-fee-bump-how-much-could-medicaid-physician-fees-primary-care-fall-2015>. Accessed September 22, 2014.

24. Pear, Robert. "As Medicaid Rolls Swell, Cuts in Payments to Doctors

Threaten Access to Care." The New York Times. December 27, 2014. Available at: <http://www.nytimes.com/2014/12/28/us/obamacare-medicaid-fee-increases-expiring.html>. Accessed September 22, 2015.

25. Cannon, Michael. "Oregon Study Exposes Another ObamaCare Falsehood: Rather Than Reduce Unnecessary ER Use, Medicaid Increases It." Forbes. January 2, 2014. Available at: <http://www.forbes.com/sites/michaelcannon/2014/01/02/oregon-study-exposes-another-obamacare-falsehood-rather-than-reduce-unnecessary-er-use-medicaid-increases-it/>. Accessed September 22, 2014.

26. See Taubman, Sarah L, Heidi L. Allen, Bill J. Wright, et al. "Medicaid Increases Emergency-Department use: Evidence from Oregon's Health Insurance Experiment." Science. 343, no. 6168 (2014). 263–268. Available at: <http://www.sciencemag.org/content/343/6168/263.abstract>. Accessed September 22, 2015. The Oregon Health Insurance Experiment, or OHIE, has provided a wealth of knowledge on the effect of government-sponsored health coverage on beneficiary well-being and behavior. Although beyond the scope of this paper, the OHIE's findings on health outcomes of Medicaid in Oregon is worth the time of anyone interested in taking a deeper dive into the subject of Medicaid expansion under the ACA. The subjects in the OHIE had randomized access to expanded Medicaid coverage. Such studies are considered the gold standard in assessing the effect of a social policy.

27. Armour, Stephanie. "U.S. Emergency Room Visits Keep Climbing." *The Wall Street Journal*. May 4, 2015. Available at: <http://www.wsj.com/articles/u-s-emergency-room-visits-keep-climbing-1430712061>. Accessed September 22, 2014.
28. American College of Emergency Physicians. "ER Visits Up Since Implementation of Affordable Care Act." May 21, 2014. Available at: <http://newsroom.acep.org/2014-05-21-ER-Visits-Up-Since-Implementation-of-Affordable-Care-Act>. Accessed September 22, 2014.
29. American College of Emergency Physicians. "ER Visits Continue to Rise Since Implementation of Affordable Care Act." May 4, 2015. Available at: <http://newsroom.acep.org/2015-05-04-ER-Visits-Continue-to-Rise-Since-Implementation-of-Affordable-Care-Act>. Accessed September 22, 2015.
30. The results of ACEP's 2014 emergency room survey are helpful in demonstrating a pattern that tests the general hypothesis that more insurance coverage—whether private or government sponsored—means more primary care and, presumably, less emergency care utilization. In 2014, emergency room doctors who responded to ACEP's survey were "already seeing a rise in emergency visits since January 1 when expanded coverage under the Affordable Care Act (ACA) began to take effect." By 2015, the number of respondents reporting a similar rise in ER usage had jumped to three-quarters. Each survey received roughly 2000 responses.
31. American College of Emergency Physicians. "ER Visits Continue to Rise Since Implementation of Affordable Care Act." May 4, 2015. Available at: <http://newsroom.acep.org/2015-05-04-ER-Visits-Continue-to-Rise-Since-Implementation-of-Affordable-Care-Act>. Accessed September 22, 2015.
32. Smulowitz PB, O'Malley J, Yang X, Landon BE. "Increased Use of the Emergency Department After Health Care Reform in Massachusetts." *Annals of Emergency Medicine* 64, no. 2 (2014) 107–115. Available at: www.ncbi.nlm.nih.gov/pubmed/24656759. Accessed September 22, 2014.
33. United Health Foundation. "America's Health Rankings: Primary Care Physicians—United States." Available at: <http://www.americashealthrankings.org/all/PCP>. Accessed September 22, 2014.
34. Statista. "Total Medicaid Enrollment from 1966 to 2015." Available at: <http://www.statista.com/statistics/245347/total-medicaid-enrollment-since-1966/>. Accessed September 22, 2015.
35. Kaiser Family Foundation. "Total Monthly Medicaid and CHIP Enrollment." June 2015. <http://kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/>. Accessed September 22, 2015.
36. "Tragic Results When Dental Care Is Out of Reach." <http://www.pbs.org/wgbh/pages/frontline/health-science-technology/dollars-and-dentists/tragic-results-when-dental-care-is-out-of-reach/>. Accessed September 22, 2015.

37. Admittedly, I am partial to my own menu of comprehensive reforms, published in 2014 (Ishmael, Patrick. "Move Missouri's Medicaid Program Forward, Not Backward." (<http://www.showmeinstitute.org/publications/report/health-care/1116-move-missouris-medicaid-program-forward-not-backward.html>).

However, a short list of recommended health care reform reading should include: Klein, Philip, *Overcoming Obamacare: Three Approaches to Reversing the Government Takeover of Health Care*. Washington, DC: Washington Examiner, 2015; Tanner, Michael, Michael Cannon. *Replacing Obamacare: The Cato Institute on Health Care Reform*. (ebook: <http://www.amazon.com/dp/B008OX36LK>); and Graboyes, Robert. *Fortress and Frontier in American Health Care*. (ebook: <http://www.amazon.com/dp/B011PQJO22>).

38. Starfield B, Lemke KW, Bernhardt T, et al. Comorbidity: Implications for the Importance of Primary Care in "Case" Management. *Annals of Family Medicine* 1, no. 1 (2003), 8–14. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1466556/>. Accessed September 22, 2015.

39. Defined in the *New Oxford American Dictionary* (3rd ed) as "the simultaneous presence of two chronic diseases or conditions in a patient."

40. Alexander, G. Caleb, Jacob Kurlander, Matthew K. Wynia. "Physicians in retainer ("concierge") practice. A national survey of physician, patient, and practice characteristics." *Journal of General*

Internal Medicine, 20, no. 12 (2005), 1079–1083.

41. "Top 10 Challenges Facing Physicians in 2014." Available at: <http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/affordable-care-act/top-10-challenges-facing-physicians-2014?page=full>. Accessed September 22, 2014.

42. Dugdale, David C., Ronald Epstein, and Steven Z. Pantilat. "Time and the Patient–Physician Relationship." *Journal of General Internal Medicine* 14, Suppl 1 (1999), S34–S40.

43. Grol R, Mokkink H, Smits A, et al. "Work satisfaction of general practitioners and the quality of patient care." *Family Practice* 2, no. 3 (1985), 128–135.

44. Institute of Medicine (US) Roundtable on Evidence-Based Medicine. Yong PL, Saunders RS, Olsen LA, editors. *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary*. Washington (DC): National Academies Press (US); 2010. 4, Excess Administrative Costs. Available from: <http://www.ncbi.nlm.nih.gov/books/NBK53942/>.

45. Forrest, Brian R. "DPC 101: A Blueprint for a Thriving Practice." Direct Primary Care Summit. 2015. Available at: <http://www.dpcsummit.org/dam/AAFP/documents/events/dpc/DPC101Blueprints.pdf>. Accessed September 22, 2015.

46. McCorry, Daniel; Heritage Foundation. "Direct Primary

Care: An Innovative Alternative to Conventional Health Insurance.”

August 6, 2014. Available at:

<http://www.heritage.org/research/reports/2014/08/direct-primary-care-an-innovative-alternative-to-conventional-health-insurance>.

Accessed September 22, 2015.

47. The Heritage Foundation discusses the obstacles that remain due to the Administration’s slow movement in defining the rules for such wraparound coverage. This doesn’t change what the text of the law provides, but it could delay patients nationwide from enjoying the benefits of the law. Washington State, which established its own exchange, has promulgated rules for qualified coverage in a wraparound plan for its state, so it may be a matter of time before the federal government catches up.

48. The Direct Primary Care Coalition sums up one of the biggest exceptions, dealing with health savings accounts: “Section 223(c) of the Internal Revenue Code (IRC) prohibits individuals with high deductible health plans (HDHPs) paired with HSAs from having a second health plan. Although the ACA regulations correctly define DPC as a primary care service and not a health insurance plan, current IRS policy treats DPC monthly fee arrangements just like another health plan. Under the current IRS interpretation, individuals with HSAs are effectively barred from having a relationship with a DPC plan, and employers who cover their employees in HDHPs paired with HSAs may not offer DPC as a health benefit. Furthermore, since payments to physicians practicing under the DPC model are not considered a

“qualified medical expense,” under Sec. 213(d) of the IRC, employees cannot use their HSA funds to pay their DPC physicians” (see www.dpcare.org/#!specialties/ctnu).

49. McCorry, Daniel; Heritage Foundation. “Direct Primary Care: An Innovative Alternative to Conventional Health Insurance.” August 6, 2014. Available at: <http://www.heritage.org/research/reports/2014/08/direct-primary-care-an-innovative-alternative-to-conventional-health-insurance>. Accessed September 22, 2015.

50. Klemes, Andrea, Ralph E. Seligmann, Lawrence Allen, et al.; “Personalized Preventive Care Leads to Significant Reductions in Hospital Utilization.” American Journal of Managed Care. Epub December 18, 2012. Available at: <http://www.ajmc.com/journals/issue/2012/2012-12-vol18-n12/personalized-preventive-care-leads-to-significant-reductions-in-hospital-utilization/P-1>. Accessed September 22, 2015.

51. Gans, Brian; Primary Care Progress. “Seeing Family Medicine in a New Light.” Available at: <http://www.primarycareprogress.org/blogs/16/325>. Accessed September 22, 2015.

52. Forrest, Brian R. “DPC 101: A Blueprint for a Thriving Practice.” Direct Primary Care Summit. 2015. Available at: <http://www.dpcsummit.org/dam/AAFP/documents/events/dpc/DPC101Blueprints.pdf>. Accessed September 22, 2015.

53. The physician’s interest in more profitable practices dovetails nicely with the public’s interest in a greater supply of primary care doctors. If the effective

profit realized by primary care doctors rises, chances are better that current PCPs will remain in the field and new physicians will join it. Because DPC arrangements can help boost such doctors' profit for their practices by reducing overhead, the public could also benefit by having a higher supply of primary care physicians, which not only would help facilitate patient access but may also help keep the market equilibrium price lower for primary care consumers over the long haul.

54. The relationship between insurers and concierge care physicians complicates the analysis of whether they could enjoy the wraparound insurance advantages of the ACA.

55. California HealthCare Foundation. "On Retainer: Direct Primary Care Practices Bypass Insurance." April 2013. Available at: <http://www.chcf.org/-/media/MEDIA%20LIBRARY%20Files/PDF/O/PDF%20OnRetainerDirectPrimaryCare.pdf>. Accessed September 22, 2015.

56. Keese, Jay; Direct Primary Care Coalition. "Direct Primary Care: Legislative and Regulatory Update." April 2015. Available at: http://media.wix.com/ugd/677d54_bb1366d5e4e54dafb43abf2e3c3731cd.pdf. Accessed September 22, 2015.

57. American Academy of Family Physicians. "Direct Primary Care: An Alternative Practice Model to the Fee-For-Service Framework. Available at: http://www.aafp.org/dam/AAFP/documents/practice_management/payment/DirectPrimaryCare.pdf. Accessed September 22, 2015.

58. Forrest, Brian R. "DPC 101: A Blueprint for a Thriving Practice." Direct Primary Care Summit. 2015. Available at: <http://www.dpcsummit.org/dam/AAFP/documents/events/dpc/DPC101Blueprints.pdf>. Accessed September 22, 2015.

59. Ishmael, Patrick; Show-Me Institute. "Passed: Direct Care Bill Moves On to the Governor." Available at: <http://showmeinstitute.org/blog/health-care/passed-direct-care-bill-moves-governor>. Accessed September 22, 2015. <<http://www.showmedaily.org/2015/05/passed-direct-care-bill-moves-governor.html>>.

60. Missouri House Bill 769 (2015). Available at: <http://www.house.mo.gov/billssummary.aspx?bill=HB769&year=2015&code=R>. Accessed September 22, 2015.

61. Eskew, Philip; DPC Frontier. "Defining Direct Primary Care." Available at: <http://www.dpcfrontier.com/defined>. Accessed September 22, 2015.

62. To be counted in this figure, practitioners had to meet a three-part test outlined by DPC Frontier, a website run by DPC practitioner and researcher Philip Eskew. "For the practice to qualify as a direct primary care practice the practice must: (1) charge a periodic fee; (2) not bill any third parties on a fee for service basis; and (3) any per-visit charge must be less than the monthly equivalent of the period fee." (<http://www.dpcfrontier.com/defined>.)

63. McCarthy, James. "Primary-care Practices across Maine Take a New Approach to Help Patients

and Reduce Costs.” Primary Care Journal. May 15, 2014. Available at: <http://directprimarycarejournal.com/2014/05/15/primary-care-practices-across-maine-take-a-new-approach-to-help-patients-and-reduce-costs/>. Accessed September 22, 2015.

64. Sweeney, Stephen. “Opinion: Patient-centered Health Care Can Provide Public Employees Better Care at Lower Cost.” Times of Trenton Guest Opinion Column. March 7, 2015. Available at: http://www.nj.com/opinion/index.ssf/2015/03/opinion_patient-centered_health_care_can_provide_p.html. Accessed September 22, 2015.

65. Englehard, Carolyn L. “Is Direct Primary Care Part of the Solution or Part of the Problem?” The Hill (website). October 13, 2004. Available at: <http://thehill.com/blogs/pundits-blog/healthcare/220527-is-direct-primary-care-part-of-the-solution-or-part-of-the>. Accessed September 22, 2015.

66. “Hear That Rumble? It’s Called Direct Primary Care.” MedCity News. N.p., 18 Apr. 2014. Web. 30 June 2015. <<http://medcitynews.com/2014/04/hear-that-rumble-its-called-direct-primary-care-and-its-gaining-momentum/>>.

67. “Direct Primary Care: An Innovative Alternative to Conventional Health Insurance.” The Heritage Foundation.

