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Medical Home NEWS

Top Three Obstacles to Better Primary Care

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Fee-for-service is the wrong business model for primary care. Why? Because it bases payment too much on activities that are measurable, when the role calls for excellence in areas that are very difficult to measure. For example, if you have been diagnosed with Stage 4 ovarian cancer, what is it worth to discuss options, likely outcomes, and get advice from your personal physician who you have known for years, whom you like, and who you know cares about you and your family? It's tough to put an exact price on that, but it is worth far more than what Medicare reimburses for an office visit.

So if fee-for-service is wrong, then what is the right business model? The job of a primary care physician calls for an ongoing relationship, ideally with an ongoing health "accountability partner" component, a chronic care management component, and an acute care advisory component, all wrapped up in a strong, mutually beneficial relationship. The right model for that kind of ongoing, long-term relationship is a subscription-based business model.

And please don't take my word for it. Clayton Christensen, often referred to as the father of disruptive innovation, calls for it in his book *The Innovator's Prescription*. Qliance, backed by Amazon.com founder Jeff Bezos, is already doing it in Seattle. There are other examples of it around the country, too -- check out MedLion out of Las Vegas for one. An industry term has even developed for it: Direct Primary Care.

What's Direct Primary Care? There are different flavors, but the bottom line is that it's kind of like concierge medicine for the masses. Doctors who practice it generally don't take insurance, and the patients or their employers pay an ongoing, monthly fee for the kind of primary care doctor relationship most people say is what they want. Sound expensive? Qliance charges between $54 and $94 per month, depending on the patient's age.

So we have experts saying we need this new business model for primary care. We have some practices already doing it. We have visionaries like Bezos backing it financially. Three obstacles remain that keep it from spreading as rapidly as it should.

Obstacle 1: The Expectation Primary Care should be paid by Insurance. Having insurance companies pay for primary care doesn't work. How do we know? We've tried it and failed.

When it comes to primary care, patients want an involved, comprehensive relationship with their doctor. They want someone they trust implicitly. If they end up with a chronic ailment, they want their doctor involved and helping them sort out what to do. When tough decisions need to be made in acute settings, they want to be able to rely on their doctor for advice. Not the specialist that they met five minutes ago. They want the doctor who has known them for years.

Insurance has a hard time figuring out how to reimburse for that. Insurance reimbursement emphasizes measurable activities, in part simply because they are easier to measure. It's too hard to measure the value of "Long, caring conversations around Stage 4 ovarian cancer options with a patient who the doctor has built a relationship with over thirty years."

As health care consumers, we are more than capable enough to put a value on having that kind of relationship with our primary care doctor. We are closer to the problem than the insurance company or Medicare, and we can be better judges of whether the primary care doctor is doing a good job.

The problem is that, historically, we've thought everything should just be "paid for" by insurance. We're disappointed that insurance reimburses for office visits, not for relationships. Bottom line: if we want a relationship with our doctor, we need to expect to pay for it.

Obstacle 2: "No Other Payment" Clauses in Insurer-Provider Contracts. Say you agreed with the first part of this article and decided you wanted to pay your primary care doctor differently and more for the kind relationship you want. You might go to your doctor and say "Hey doc, instead of you only getting paid x by the insurance company when I have an office visit, I'd like to pay you $60 per month whether I see you or not because I'd like to have an ongoing relationship with you and I'm willing to pay for that." As things stand today, your doctor would have to say "I'm sorry, I can't do that as long as you have your health insurance because of my contract with your insurance company."

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This is because of the "No Other Payment" clauses in insurer-provider contracts. These clauses provide that the doctor cannot charge the patient any amount other than the price (reimbursement rate) that was negotiated in the insurer-provider contract.

Why? To explain this, it helps to start by understanding that there are three types of "prices" in health care:

1. Retail price: What the provider publishes as its "retail" price.
2. Insurer-negotiated rate: The rate the provider has negotiated with the insurer that all members have to pay.
3. Cash-paying patient price: What the provider is actually willing to take if the patient is paying cash.

Many patients are already "on the hook" to pay cash out-of-pocket for their health care needs up to their deductible. As things currently stand, when they go to the doctor, they pay the insurer-negotiated rate. It has surprised many to find out that this insurer-negotiated rate is higher than the provider's cash-paying patient price.

This issue has been widely covered in the media, including an excellent recent article by Chad Terhune in the *Los Angeles Times*. When pressed, providers say that they are not allowed to charge insured patients the lower cash-paying patient price because of the contracts they have with insurers. The providers explain that those contracts force them to charge these patients the higher insurer-negotiated rate. But what it the patient wants to pay more, or pay differently, as in a subscription based model? Same issue applies. The doctors can't do it because of these "No Other Payment" clauses.

Legal experts say that states could forbid insurers from putting these clauses in their provider contracts. In other words, states could stop insurers from forbidding providers from charging prices to covered patients that are lower or different than the insurer-negotiated rate. Passing such a law would open the door to giving doctors more flexibility to experiment with different business models for delivering care. This would be particularly true for primary care, where the subscription-based business model has already started to flourish. Without this sort of change, doctors who want to implement a new, better business model have to end their carrier contracts completely. That is hard. By forbidding these clauses, doctors could make an easier transition to a different business model than fee-for-service.

Obstacle 3: Doctors feeling like they also have to be entrepreneurs. Almost 70 percent of doctors work in small, private businesses. In fact, nearly half work in businesses that have less than five physicians. These doctors are not only doctors, but they are the entrepreneurs running a small business, which can be an unhappy combination.

Why is that? It's partly because an excellent service provider does not equal an excellent business operator. In fact, a service provider and a business operator are two very different roles. Adding "business operator" activities to a doctor's slate takes away time that could be devoted to better patient care. This is due to all of the non-patient care activities to which the doctor has to devote time:

1. Marketing
2. Sales
3. Customer service
4. Recruiting, managing, firing employees
5. Negotiating contracts with health insurance companies
6. Accounting, payroll

Again, these activities are all *in addition* to doing things that are required to be a great doctor. Running a business takes a lot of time doctors could be devoting to patients. If doctors had that time back, we'd have better primary care.

The Good News: This Change Is Inevitable. Winston Churchill is often credited as having said "You can always count on Americans to do the right thing…after they've tried everything else." This shift toward a subscription-based business model for primary care is inevitable. We've tried everything else, and the cost of healthcare continues increasing at a rate other sectors of the economy will not put up with for much longer.

Instead, employers in other sectors of the economy will begin taking the issue of their employee's health and health care decision-making much more seriously. They, along with individuals and families, will reject fee-for-service as a viable model for primary care. Their demand for another solution will help to flourish those primary care providers who move to a subscription-based model.

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