Protecting the Private Practice of Medicine

Direct Primary Care: Kicking Insurance Out of the Exam Room

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The evolution of our healthcare system has forced primary care physicians, like many other specialties, to operate an insurance-centric business rather than practicing medicine. In order to sustain a practice, physicians must see 20-30 patients per day, making the average office visit only 15 minutes. Physician and patient satisfaction are decreasing while reimbursements rates continue to decline. In response to these conditions a new practice model called direct primary care is gaining national attention. Direct primary care practices are designed to provide physicians with the freedom to practice medicine, instead of managing insurance claims.

Recently our Vice President of Legal Affairs Greg Waddell traveled to Seattle, Washington, to interview the Co-Founder and Vice President of Medical Affairs of Qliance, Dr. Garrison Bliss. A primary care physician with more than 30 years of experience, Dr. Bliss founded his first direct primary care practice in 2007 after growing disillusioned with the current direction of healthcare. In addition to advocating for the national expansion of the direct primary care practice model, he has also served as the President of the Society for Innovative Medical Practice Design and the Direct Primary Care Coalition.

Direct primary care practices offer a membership-based approach to routine and preventive care. Patients pay a low monthly fee, typically $49 to $100, to their physician for all of their everyday health needs. Like a health club membership, this fee gives patients unrestricted access to visits and care, allowing them use of the services as much or as little as they want. "What distinguishes us from other practices is that we have eliminated the fee-for-service model of care," said Bliss. However, don't confuse direct primary care with other pre-paid models. "This is not a concierge model; this model has been applied from the wealthiest patients to the indigent and uninsured," he added.

A direct primary care practice provides routine healthcare, essential for the well-being and ongoing maintenance of a patient's health. This is where patients go for check-ups, vaccinations, or sprained ankles. If a patient has a chronic illness, their primary care physician is a partner in their management every step of the way. Direct primary care practices are operated under the principle that the physician-patient relationship is the main focus. Bliss emphasized that "we want (the patients) to have trust in us; we want them to believe that we work for them and not for a bunch of other interests."

He believes direct primary care's success is ultimately based on "a real doctor-patient relationship, reinforced by the economics, so that our customer is the patient. Our job is to get the care right, not the coding." Direct primary care practices do not take insurance; therefore, there is no need for billing approval, deductibles, or co-payments. With lower overhead and dramatically less paperwork, direct primary care providers are no longer forced to squeeze in an unmanageable number of patients and can instead take the time necessary with each patient to deliver high-quality, personalized care. By eliminating insurance burdens from

Dr. Garrison Bliss (left), co-founder and vice president of Medical Affairs of Qliance, a direct primary care practice in Seattle, talks with LSMS Vice President of Legal Affairs Greg Waddell (right).

direct primary care practices, physicians have more time to do what they were trained to do, practice medicine.

By cutting out the instability of an insurance dependent income stream, direct primary care practices allow physicians the financial security to focus on patient care. "Monthly fee based practices allow you to know what your income is this year. Now you can plan," said Bliss. The direct primary care model relies instead on the economic power of its patients to fund a practice dedicated to quality and affordable healthcare. Simply stated, it allows patients to directly contract with their primary care physician by removing health insurance from the primary care equation.

Patients in a direct primary care practice can purchase an insurance plan to cover emergencies and serious illnesses. Because this insurance policy doesn't need to cover routine care, many patients choose a less comprehensive plan with a higher deductible and lower premiums. For example in Washington, Bliss's practice has partnered with an insurance company to offer a complementary catastrophic plan to their patients. According to Bliss, the insurance company can make the plan affordable because, "when primary care is working well, the insurance company doesn't have to regulate the rest of the healthcare as much. There are no incentives to over-refer."

In the 18 states direct primary care has already been implemented, physicians report increased satisfaction and a renewed commitment to providing the kind of care that initially inspired them to dedicate their lives to medicine. In short, direct primary care facilities enable physicians to do what they were trained to do, treat patients.

In Louisiana, the Louisiana State Medical Society has introduced legislation, Senate Bill 516 authored by Senator Sherri Buffington and Representative Stuart Bishop, to make it possible to operate a direct primary care practice. Current law requires that any entity receiving any type of prepayment for medical services be licensed as an HMO or insurance company, which makes the practice model cost prohibitive. SB 516 amends the law to recognize that a direct primary care practice is a medical practice and not an insurance company. We believe this legislation will be signed into law, and we will be seeing direct Primary Care practice open statewide soon.

Bliss emphasized that, "The only people who will be unhappy with a future built on Direct Primary Care will be those who think that the present system works for the doctor and the patient. I'm still waiting to meet that person". As we have seen here in Louisiana, and Bliss has seen in Washington, we can't afford the alternative.

***This is the second installment in a new four-part series that will report on emerging trends and new practice models in medicine.*