States Should Expand Direct Primary Care to Address Primary Care Shortage

Problem

One of the lesser-known factors driving skyrocketing health care costs throughout the country is the lack of primary care physicians. Indeed, many states are experiencing a severe shortage of primary care physicians. According to a 2018 report from United Health Group, 13 percent of American patients live in a county with a shortage of primary care physicians.

This shortage is exacerbated by the fact that many new physicians choose to practice specialty medicine instead of primary care. Although there are many reasons for this shift, the high costs and logistical challenges inherent in primary care medicine are major contributing factors. According to the American Journal of Medicine, the percentage of American primary care physicians decreased from 50 percent in 1961 to 33 percent in 2015. The United Health study also found that only 288,000 out of 869,000 physicians conduct primary care services.

Unfortunately, this problem is likely to become worse before it becomes better. The United Health Group study estimates that by 2030 there will only be 306,000 primary care providers in the nation. Additionally, by 2032, the number of Americans over the age of 65 will increase by 48 percent, according to the U.S. Census Bureau. This, along with several other factors, will magnify the need for primary care doctors.

Policy Solution

Direct primary care (DPC), also known as “retainer medicine,” could revitalize the U.S. primary health care system. Under a DPC agreement, patients pay a monthly membership fee, typically between $50 and $80. As part of the membership, patients can receive more appointments than they do under a traditional health insurance plan. Some DPC agreements even include same-day appointments and house calls.

The DPC model removes the layers of regulation and bureaucracy created by the traditional insurance system and allows physicians to interact more with their patients instead of wasting time filling out mountains of paperwork. Routine tests and procedures are also included in most DPC plans. Moreover, lower membership fees are often charged for programs that do not provide these additional services.

The main barrier blocking expansion of DPC is government interference in the health care market. Several states now define direct primary care providers as “risk bearing entities” when providing care in exchange for a monthly fee. This puts DPC doctors under the same regulatory and licensing system as insurers. The first reform states ought to consider is a new law that would clarify DPC does not constitute insurance. Currently, only 25 states have a direct primary care law in place.

Sample Legislation:

Direct Primary Care Coalition Model Bill

Georgia Senate Bill 15

Wisconsin Assembly Bill 26

Georgia Senate Bill 18

Minnesota Senate File 277

Other reforms states should consider are laws that would codify what is defined as DPC. This will bring clarity for new providers, and an exemption from certificate of need laws, which could accelerate the ability of DPC providers to grow or expand.

Sample Legislation:

Kansas House Bill 2225

Tennessee House Bill 2323

One model state legislators can follow is Nebraska’s DPC pilot program for state employees. The Cornhusker State’s pilot program offers two DPC plans: a high-deductible option and a low-deductible alternative. Furthermore, the program includes several wellness incentives.
States Should Expand Direct Primary Care to Address Primary Care Shortage

Sample Legislation:

Nebraska Legislative Bill 1119

Another DPC reform gaining steam in the states is incorporating DPC into Medicaid. In December, Missouri state Rep. Steve Helms (R-Jefferson City) introduced draft legislation that would launch a pilot program that would allow Medicaid enrollees in certain Missouri counties to contract with physicians who practice DPC. Under the proposed bill, HB 1416, physicians in the selected counties would be paid $70 per month to care for Medicaid patients.

In 2016, Michigan considered a pilot proposal that would integrate a DPC program into the state’s expensive Medicaid system to help reduce costs and improve care. Under the pilot project, 2,400 Medicaid recipients would be enrolled in the state’s Direct Primary Care Services (DPCS).

Sample Legislation:

Missouri House Bill 233

Oklahoma House Bill 386

Minnesota House File 718

Indiana Senate Bill 470

Virginia House Bill 2456

Tennessee House Bill 894

Policy Message

Point 1: By 2030, demand for primary care is expected to increase by 38 percent for patients over 65, and by 55 percent for those over 75. Across all age groups, demand is expected to increase by 8 percent.

Point 2: Current primary care doctors face myriad regulations and a convoluted reimbursement system, which can drain up to 60 percent of a typical primary care practice’s revenue.

Point 3: A study in the American Journal of Managed Care found patients receiving DPC are 52 percent less likely to enter a hospital than those in traditional private practices.

Point 4: According to the Direct Primary Care Frontier, the number of DPC practices has increased from only a few in the early 2000s to nearly 900 as of August 2018.

Point 5: Under a DPC model, medical practice overhead can be reduced by as much as 40 percent, according to the Docs4Patient Care Foundation.

Point 6: According to a recent report from the Centers for Medicare and Medicaid Services, Medicaid expenditures are expected to rise at an average annual rate of 5.7 percent from 2017 to 2027, a rate that far exceeds annual U.S. gross domestic product growth.

* * * For more information, contact The Heartland Institute at 312/377-4000 or by e-mail at governmentrelations@heartland.org. Or you can visit our website at www.heartland.org.