Remarks to the Wisconsin Legislative Council Study Committee on Direct Primary Care

August 29, 2018

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My goal today

- **How an economist thinks about DPC**
  - Focus on how different health care models affect *incentives*
- **A few thoughts on possible legislation and regulation**
- **A few thoughts on how to evaluate a DPC pilot for the state**

The Traditional Insurance Model

High-coverage
+
Fee for Service

Insurer HMOs

HDHPs

Capitation and Integration

Fully-integrated System Plans (Kaiser Permanente)

ACO

PCMH

Bundled Payment Programs

The Traditional Insurance Model

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How does DPC affect the Economics of Health Care?

- **This is *not* a cheaper way to get primary care.**
  - About 2x to 3x the cost per patient for primary care services
  - Better visits and access may be worth that cost for some

- **May be a way to lower costs for other types of care:**
  - Provide some services at lower cost than specialist (e.g., dermatology)
  - Avoid need for costly care through improved patient health
  - Partner with patients to avoid low-value services and high-cost providers.
  - Contract at wholesale rates for some services (e.g., labs, drugs, imaging)

- **Key questions:**
  1. Why DPC instead of integrated system?
  2. What incentives promote these savings by DPC?

Why DPC instead of integrated system?

- **Integrated systems can create low-volume, high-touch panels for PC**
  - Can empower to do more services and help patients navigate the system

- **Some potential challenges within an integrated system:**
  - Complex patients require more coordination than just PC can handle
  - Poor targeting in large system of patients who value extra PC most
  - Challenge to align incentives within the large organization fully
    - How to get PC to refer only to high-value services? Specialists unhappy.
  - Integration leads to concentration …

    …which leads to market power at system level …

    … which stifles some of the system incentives to hold down costs

What incentives promote DPC cost savings?

- **Patients need to care that DPC saves costs elsewhere**
  - Likely integrates better with HDHP than high-coverage plans
- **DPC needs to have information to help manage trade-offs**
  - Easier for certain services (labs, imaging)
  - Some systems a DPC refers to will have incentives to obfuscate
  - Challenge to help with different insurance networks and negotiated prices
- **"Mid-level" users may be the sweet spot for DPC savings**
  - High users may be too complicated for DPC to coordinate
- **Is benevolence only incentive for straight wholesale pricing?**

Some regulations that might improve DPC model

- **Consumer protection and clarity regulations for DPC**
  - Model works best if the DPC has to compete on its quality
  - Lock-in and consumer inertia may stifle those incentives over time
- **Prohibit DPC from profiting from non-subscription services**
  - Lock in wholesale pricing for labs, etc…
  - But does it limit DPC contracts for providers who are also part of systems?
- **Rules to prohibit or limit “non-compete clauses”**
  - DPC may be limited by PC docs locked into systems
- **Broader transparency regulations for providers & insurers**
  - DPC can help patients navigate system if they know their costs

DPC effects on insurance markets

- **May promote adoption of HDHP**
  - *Concern:* may mute insurer incentives to negotiate provider prices
    - Consider increased disclosure requirements for insurers/providers
    - Look at self-insured employer shared-savings models
- **Some healthy types may take risk and go uninsured past DPC**
  - Worsens insurance risk pool & exposes individuals to substantial risk
- **"Mid-level" users selecting DPCs may have consequences to others**
  - Unclear effect on costs for high vs. low coverage plans
  - May worsen risk pool for integrated system plans that attract high users
- **Watch for how insurers want to price adjust for DPC over time**
  - Discount for avoided primary care *but* also price discrimination

Thoughts on need for *evaluation* of DPC for the state

- **No good evidence to inform a “leap of faith” into DPC use for state**
  - DPC has not been systematically evaluated
  - Other evaluations of capitation, ACO, etc… show mixed effects:
    - Can work, but depends a lot on context and details of implementation
  - Wisconsin context likely unique (e.g., integrated system dominance)
- **Initial DPC movers will not be representative**
  - First DPC providers likely uniquely passionate and motivated
  - First DPC patient adopters likely uniquely engaged health care consumers and/or attached to those specific providers

Thoughts on *how* to evaluate DPC for state programs

- **Better aligned for state employees (esp. with HDHP) than Medicaid?**
- **Key decision: Evaluating mandatory or voluntary DPC?**
- **Randomization and "intention to treat"**
  - Randomize a subset of population into the appropriate treatment:
    - a) they *must* use DPC or b) they *can* use DPC
  - Compare outcomes for entire randomized group to entire control group
    - For voluntary DPC look at all those *offered* DPC, not just those who use it
- **Getting the right outcome measures**
  - Overall spending
  - How to measure health/quality: Surveys? Biometric markers? Compliance?
  - Think about longer-term evaluation

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