

BY LAWRENCE FISHER

Could there be a low-cost, high-quality fix for much of what ails American health care – a fix that requires no new legislation and no additional taxes? Could such a fix also help stem the exodus of primary-care physicians from medical practices and restore the personal relationship between patients and doctors? And could it possibly originate in Seattle, the city that gave us grunge rock and entertains tourists by throwing fish?

The idea calls for a momentary suspension of disbelief. But a small Seattle medical practice called Qliance Medical Management has a novel business model that could have broad consequences for health care. Qliance is the leading practitioner and proponent of what it calls “direct primary care.” Patients pay a flat retainer fee that comes to about \$2 a day for a bevy of services including 24/7 access to primary-care physicians, same-day or next-day appointments, in-office X-rays and basic lab work. Visits are an unhurried 30 minutes, and prescriptions are filled by a low-cost pharmacy next door. No insurance, no intermediaries between doctor and patient.

Were the Qliance story limited to one small practice in the quirky Pacific Northwest, it could be dismissed as a one-off. But Qliance has already raised venture capital to expand across the country, and its name already rings bells with frustrated doctors from San Francisco to Fort Lauderdale. Other ventures with variations on direct payment for primary care

are also proliferating, reflecting patients’ hunger for more-personalized care and physicians’ desire to practice without third-party interference.

If health care reform stalls once again in Washington, retainer-based primary care could offer some welcome relief to those unsatisfied with the status quo. But if it doesn’t stall, a system that guaranteed health insurance to all, even as it reined in runaway costs, would still leave general practitioners caught in a vise between costs and expectations that is all too familiar to Medicare and Medicaid recipients. As long as primary care remains a poorly reimbursed numbers-driven treadmill, physicians will keep leaving – to become specialists, to open Botox salons, to manage super-high-end care for the rich and over-insured (see below). That’s where direct primary care could still fit in.

Perhaps the best way to think of it is as the third leg of a stool dubbed “consumer-driven health care” (CDHC) by proponents of market-based reforms in the Bush II administration. Under CDHC the government would have matched contributions to patient-

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funded, tax-exempt health savings accounts up to \$3,000 per year (\$5,950 per family) as well as provided high-deductible insurance for catastrophic illnesses like cancer and heart disease. But CDHC had no provision for primary care, which accounts for nearly three in four patient visits to physicians. Retainer-based medicine could have filled that gap.

Yet another way to think of direct primary care is as a mass-market variant of so-called “concierge medicine.” That concept, which also originated in Seattle, was mostly of interest to folks like that city’s best known citizen (Yup: Bill Gates). The first such practice, MD² International, offers unlimited same-day doctor appointments in a plush environment for just 50 patient families at \$25,000 a year.

At those prices, concierge medicine draws predictable charges of elitism. But it has gained a foothold in affluent areas, and enrollments have continued to rise despite the recession. Do the math, and the appeal to physicians is obvious. But most say they also like concierge medicine because it allows them to spend the time to give patients the best possible care. The Society for Innovative Medical Practice Design, a trade group, estimates there are 5,000 doctors in concierge practices across the United States out of an estimated 240,000 internal medicine physicians and related primary-care providers.

How can Qliance offer a similar level of service for less money than a daily latte? For starters, the math still works pretty well for 500 to 800 patients at \$800 a year, so the practice’s physicians can have both a comfortable income and a manageable workload. By contrast, in a typical clinic setting, doctors have patient panels of 2,500 to 3,000 – which is why your doctor gives you five minutes, a prescription and a nudge out the door.

But the real key to making direct primary

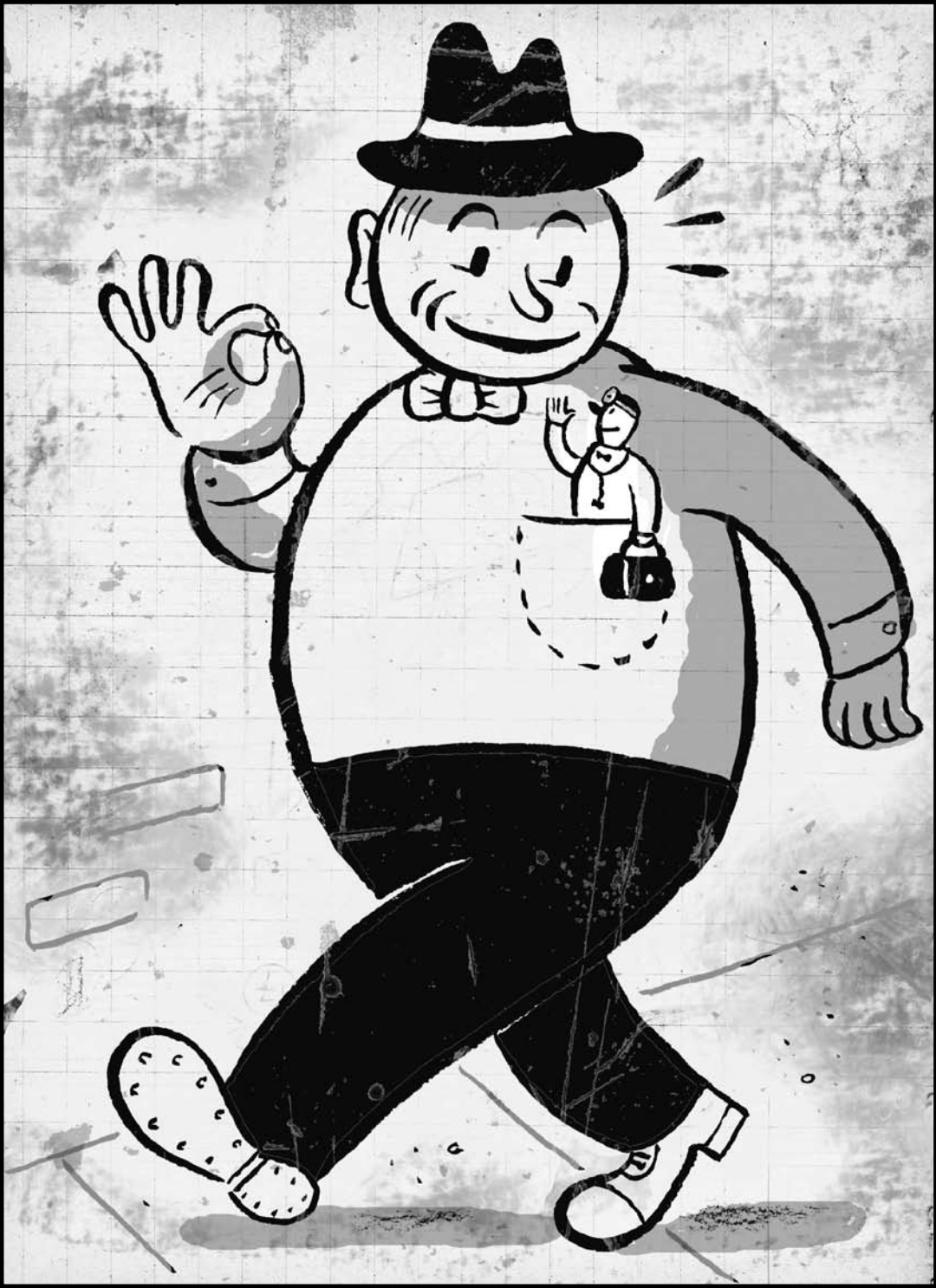
care a win-win proposition is the savings from cutting out the insurance intermediary. By eliminating the industry’s overhead and the small army of clerical employees needed to negotiate the thicket of fees, co-payments and compliance statutes that accompany insurers’ reimbursement schedules, Qliance and similar providers can spend more money on longer appointments with fewer patients, offering a standard of care that seemingly vanished about the time *Marcus Welby, MD* went into syndication.

“It’s hard to overestimate the inefficiency of the current system,” explains Dr. Garrison Bliss, Qliance’s co-founder and chief medical officer. “Of every \$1 spent on primary care, the insurance industry takes 40 cents. All of this cost and effort is being thrown at something that adds zero value to care. If we eliminate the middleman on primary care, we have done an enormous favor to everyone involved.”

Of course, the insurance industry views that 40 cents not as waste but as revenue, and in the aggregate it amounts to billions of dollars. Accordingly, the industry has fired a few warning shots across the bows of direct-care practices, lobbying for legislation that would categorize the physicians as insurers themselves and thereby subject them to state regulation. And if retainer-based medicine takes off in a big way, there is no doubt the insurers’ big guns will come out.

“If you cut out primary care and just sell catastrophic, the take of the insurance industry is going to go down,” says Regina Herzlinger, a professor at Harvard Business School, author of the book *Who Killed Health Care?* and a prominent advocate of consumer-driven health care. “They view it as a massive threat.”

Health care is rife with turf wars, and incumbents are adept at using the regulatory



MARC ROSENTHAL (ALL)

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system and public policy to protect their positions, Herzlinger adds. Thus, cardiac surgeons battled to keep garden-variety cardiologists out of the business of minimally invasive heart procedures, and primary-care physicians themselves lobbied against retail medical clinics – basic health clinics staffed by nurses, located inside chain pharmacies like CVS and Walgreens and big-box stores like Wal-Mart. Because insurance regulation is decentralized, retainer-based primary-care providers will have to fight the insurance industry state by state, she notes. “Part of their execution will be their ability to navigate these treacherous political and regulatory shoals.”

The other issue for retainer-based medicine is the law of unintended consequences. Critics say that luring physicians out of insurance-paid practices will reduce the number of doctors delivering the basics and put even more pressure on the quality of care received by those who can’t afford the retainers. That would lead to a two-tiered health system, they say, with one quality of service for the relatively affluent and another for the poor.

While the arithmetic is correct as far as it goes, this argument ignores the fact that primary-care physicians are already leaving traditional practices in droves and few medical school graduates are stepping up to replace them. A study in the July 2009 issue of *Annals of Internal Medicine* concluded that burnout is leading to a decline in primary-care physicians and, in turn, to lower-quality care. The study, which polled 422 doctors in the Midwest and New York City, found that large numbers of physicians were demoralized by a lack of control over their work, a chaotic work pace and time constraints on patient visits. More than 30 percent indicated they would leave the field within five years.

That meshes with other analyses: accord-

ing to the Association of Medical Colleges, by 2025 the country is likely to face a shortfall of more than 124,000 primary physicians. “They’re becoming foresters, fisherman... they’re taking themselves out one way or another,” says Dr. Richard N. Fogoros, a former clinical cardiologist and author of the book *Fixing American Healthcare*.

“Retainer-based medicine is of transcendent importance,” Fogoros argues. “To me, it is the only way primary-care physicians have of regaining their fundamental ethical precepts. When you’re working for a third-party payer, they have very powerful ways of coercing a primary-care doctor to put their interests ahead of the patient’s.”

Insurers can misalign incentives and raise costs in less-obvious ways, too. Because insurers pay so little for primary-care office visits and physicians are pressed to see so many patients a day, people with relatively easily treatable diseases are too often passed on to specialists. That doesn’t help the insurance industry; specialists are paid more and use more-sophisticated diagnostic technologies, like CT scans and MRIs, that add to the insurers’ costs. Nor is it typically in the interests of patients: with the inevitable delays in approving referrals, the patient’s illness often worsens – possibly resulting in a far more expensive emergency room visit or a hospital stay. And every step along the way generates another transaction between provider, payer and patient, with more paper to push and more people who must be paid to push it.

How did we get here? Dr. Bliss at Qliance points to the evolution of managed care and its reliance on the resource-based relative value scale, developed in the late 1980s by William Hsiao, an economist at the Harvard School of Public Health. That scale is used to set standard reimbursement rates for every medical procedure, from a simple office visit

to a coronary bypass operation.

“They wanted a system based on known variables,” Bliss explains. “Care by a primary-care physician was worth less than a specialist, tools that were expensive to make were reimbursed higher. What they did was drive health care to more expensive approaches that they would then pay more for. What happened in that evolution was that primary care got killed.”

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Insurance companies pay just \$10 to \$15 per visit to primary-care physicians, which is why such doctors feel compelled to see so many patients a day. “Because of their size and power, and because doctors can’t organize to negotiate rates, primary-care doctors simply began to shrivel on the vine,” Bliss says. “We didn’t know how valuable primary care was until it began to disappear.”

Qliance’s practice now has eight physicians (including Dr. Bliss) at a clinic in downtown Seattle and a second one that recently opened in suburban Kent, Wash. But the company has ambitious plans to expand throughout the Pacific Northwest, and ultimately across the United States. Towards that end, the company has raised \$7.5 million in venture capital in two rounds, led by Seattle-based Second Avenue Partners.

Nick Hanauer, Second Avenue’s managing partner, was the first non-family investor in Amazon.com, and he views Qliance as a similarly disruptive business model. “We see the Qliance direct primary-care model as an important transformational option to health care reform that is easily scalable for other

communities across the U.S.,” he says. “Their model reduces costs dramatically for individuals and businesses, while delivering exceptional care and access for patients.”

The only caveat is that someone has to pay for it, and Americans are not accustomed to paying directly for their health care. Most of the nation’s insureds get their coverage through their employers. Both employer and employee shares of the premiums are paid

with pretax dollars – a nifty advantage not available to clients in direct primary care.

Paying in advance for primary care, even just \$2 a day, thus requires a change of mindset. And patients still need to take out a catastrophic-care policy and keep cash in savings for charges that fall below such a policy’s deductible amount.

Dr. Chris Ewin, a Fort Worth, Tex., physician with a retainer-based practice (who is a former president of the Society for Innovative Medical Practice Design, the trade group) has been lobbying for a change in federal tax law that would allow patients to use pretax income to cover prepaid physicians’ fees. He charges from \$63 to \$158 per month, based on age.

Actually, one congressman did offer an amendment to the Patients’ Choice Act of 2009 (the Republican bill that responded to Democratic health care reform proposals), to include in the definition of medical care, “amounts paid by patients to their primary physician in advance for the right to receive medical services on an as-needed basis.” This would permit payment of retainer fees with

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existing health savings accounts, which are not taxed. The amendment, introduced by Rep. Paul Ryan of Wisconsin, would also eliminate the tax break that employers receive for providing health-insurance benefits to their workers, but would give an annual tax credit of \$2,300 to each individual and \$5,700 to each family that could be used to offset the cost of their insurance.

Given the political polarization in the House and Senate, however, little or nothing in that bill is likely to emerge in legislation. Indeed, the old-fashioned strategy of offering arguably better reforms as a means of advancing party interests has effectively been eclipsed by the partisan just-say-no approach to health care reform.

From their decidedly blue-state base, Qliance's founders have taken a two-edged approach to defending the turf on which they are trying to build. They have had some success in teaming up with insurance brokers to persuade Seattle employers to offer their service, coupled with a health savings account and a high-deductible policy for catastrophic care, as an alternative to traditional plans. But they're also making lots of trips to the other Washington.

"We've been very active on Capitol Hill and have met with people in the Obama administration," says Norman Wu, Qliance's president and chief executive officer. "We think it's critically important they don't squash this by mandating that everyone have insurance for primary care. It's really hard to break people out of that mind-set and the insurance companies want to keep it that way. This model is so efficient that you can actually deliver world-class care for not very much money at all."

MDVIP, a retainer-based group in Boca Raton, Fla., is trying a primary-care model

that is positioned not as an alternative to insurance, but as an adjunct. Its program, which is offered by over 300 affiliated physicians, focuses on prevention and early detection. For a fee of \$125 to \$150 a month, patients receive a host of services, ranging from an unusually thorough physical to a review of prescribed medications to screenings for a variety of diseases. But unlike most physicians in direct primary-care practice, MDVIP's doctors also coordinate with insurers and Medicare.

Still, at the core of the direct model is the decoupling of primary care from insurance, which proponents say is simply not structured to deal with frequent, predictable and affordable events like most visits to the doctor's office. They note that automobile insurance doesn't cover oil changes or new tires, and homeowners' insurance doesn't cover carpet cleaning or new paint. Why should health insurance cover routine checkups and flu shots? Making primary care subject to health insurance actually discourages patients from seeing their physicians early and often, they argue, which can lead to minor illnesses progressing to major illnesses.

"Primary care is not an insurable event, it's an ongoing relationship. And when you try to insure an uninsurable non-event, you destroy it," concludes Dr. Thomas LaGrelus, a physician in Torrance, Calif., who converted his practice to concierge medicine six years ago. "The average concierge fee across the country is \$1,500 a year, well within the affordability range for most Americans."

For all its potential, though, direct primary care remains a cottage industry, and its future impact depends on the ability of Qliance and other providers like it to scale their businesses, or for thousands of independent physicians to convert their current practices to variations on that theme. It is still very much a grass-roots phenomenon, dependent on the



initiative of entrepreneurs with an appetite for risk.

But disruptive technologies and business models always initially appear to be long shots. That is why established players ignore or dismiss them as irrelevant until it's too late.

Health care is ripe for disruption, argues Clayton M. Christensen of the Harvard Business School in *The Innovator's Prescription* (with Jerome Grossman and Jason Hwang). His disruptive models of choice, by the way, are retail clinics and prepaid integrated health systems, like Kaiser Permanente and the Mayo Clinic, which serve as both insurer and care provider.

Retail clinics are purely transactional, with no physician relationship offered or implied, while Kaiser Permanente is a comprehensive program that really does cover everything from sniffles to heart surgery. But direct primary care has one major element in common

with both: no insurance intermediary. In the big-picture perspective, what these programs all attempt is to unbundle health care from insurance, much the way Google and Craigslist have unbundled advertising from major media, iTunes has unbundled music distribution from the recording industry and designer outlets have unbundled brand name clothing from department stores. Unbundling is rough on incumbent aggregators, as any veteran newspaper reporter can tell you, but offers consumers more choices and lower costs.

Relegating health insurers to their core business of pooling and managing risk would force some painful restructuring on an industry accustomed to having its own way. But that is what disruptive innovations do. Returning control of the practice of medicine to physicians and nurses would be good for the health of all of us. **M**