Crozet Annals of Medicine: Modern Medicine Delivered the Old-Fashioned Way

By **Dr. Robert C. Reiser** - June 3, 2016

By Guest Columnist Dr. Maura McLaughlin

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Dr. Reiser invited me to write a column about opening my own family medicine office in Crozet in a new model known as Direct Primary Care. He didn't know that he was part of my decision to make this change.

I first heard of Direct Primary Care (DPC) a year and a half ago, at a family medicine conference at Wintergreen. I sat spellbound as the speaker described a new way to provide primary care that achieved the holy grail of medical practice: decreased cost, improved quality, and increased patient satisfaction.

The foundational element of DPC is an enduring and trusting relationship between a patient and his or her doctor. In DPC, the system of unwanted fee-for-service incentives ("do more tests and procedures, bill higher charges") is replaced with a simple, flat monthly fee for a patient's primary care. In this model, medical insurance is used the way insurance is meant to be used—for unexpected, potentially financially catastrophic events. Just as we have auto insurance to cover us in case of a crash that totals our car, we need medical insurance to pay if our child breaks his leg or needs stitches near his eye (both of which have been required in my family in the past couple years). Just as we don't need our auto insurance to cover oil changes, we don't need insurance for primary care—routine, expected services that can be obtained very affordably if practices don't have the 40 percent insurance overhead (for every dollar that comes into an insurance-based practice, forty cents is spent paying the administrative costs of bringing in that dollar). Cut out the insurance middleman for primary care, and you can make primary care much more affordable, and also make medical insurance more affordable, since insurance will need to be used only rarely.

Listening to DPC being described that day was the only time I've been at a medical conference that I have ever wanted to stand up and cheer. Over the following

months, I made the decision to open my own DPC practice, a move that a small but rapidly growing number of doctors around the country are making.

How can paying a monthly fee for your primary care lower your costs? If you are a small business owner or employee, or if you have ever had to purchase insurance on your own, you understand how incredibly expensive it can be. Here is an example: a healthy couple in their early 60s is paying $1,100 a month (yes, a month!) for their insurance that has a $6000 deductible (meaning they pay the first $6,000 before the insurance company starts paying), which they have never met in ten years. Twenty-four percent of all Americans now have high-deductible plans where they are paying the first $1,300-$6,550 out of pocket. These plans can work great if you are a member of a DPC practice, but if you are obtaining care in the typical insurance-based system, they work . . . not so great.

In my last few years in insurance-based practice, I encountered more and more patients who were avoiding coming to the doctor because they were spending thousands of dollars a year on insurance that they then could not afford to actually use. Those that would come in would bear the high cost of an insurance-inflated price for both the visit and labs, a price that, ironically, the insurance company then "discounts" and does not actually pay itself. A 15-minute visit for a sore throat could cost $150. Basic labs could cost $100-$300 or more, each. For a patient with diabetes who is seen every three months, with basic blood work, these costs for a year could equal at least $600 for visits plus $1,030 for labs—again paid by the person with the high-deductible plan, not by the insurance company.

Most DPC practices keep their monthly rates less than $100 (ours are $15-$60, depending on age), and offer discounted lab pricing (most of our common labs are less than $10 each). So that patient with diabetes seen in our DPC practice would end up spending $720 for as many visits as she needed during the year plus $55 for labs—a cost savings of $855 or more per year.

For insurance plans that are not high-deductible, monthly premiums and co-pay amounts are increasing, sometimes to levels where the co-pay is higher than our monthly fee! In the current system, at least a quarter of Americans are left without

good, affordable options for health*care* (which is not the same thing as health insurance). Direct Primary Care has spread by a grassroots effort of family doctors across the country, tired of waiting for the system to fix itself, who have figured out a better way and are helping each other to make it a reality.

My first week in my new practice, a patient asked me if anything about it had surprised me. It was so early on that I didn't really know yet—but now, five months in, I can say that the thing that has surprised me most is how many people have sought out the practice who have traditional (not high-deductible) insurance, Medicare, and Medicaid. These people are paying $15-$60 a month to be my patients—why?

The short answer is that the current system isn't working for them. The individual reasons are varied, but the reason that DPC is different can be summed up in one word: time. In the DPC model, I have time to schedule longer visits, see patients with urgent concerns the same day, start appointments on time, look at the patient instead of the computer, answer the office phone myself, give my cell phone number to all patients, call patients to check on them, and make home visits. This is the kind of family doctor I always wanted to be.

Which brings me back to Dr. Reiser's unknowing involvement in my decision to switch to this model of practice. In April 2015, in the Crozet Gazette, he published a column titled A Letter to a Young Physician. I remember exactly where I was when I first read these words of his about being a doctor: "What we do, if we do it right, is sacred."

For me, the practice of medicine is a calling, and I realized I was no longer doing the work of my calling, but was instead doing the work of the insurance companies. The sacred space of the exam room had gotten so crowded with insurance restrictions, medical coders and billers, and computer scribes, that I could hardly see the patient any more. Now, when I sit down in the room with the patient and close the door behind us, the rest of the world falls away and all I am thinking about is how I can help the person in front of me. That's the way medicine is meant to be.