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Battle for Primary Care: Emerging Changes in the Primary Care Delivery Environment

Primary care--the gateway to the entire health care delivery network—is undergoing radical change as new primary care arrangements may challenge the historical supremacy of hospital or physician owned primary care practices and urgent care clinics.

The Affordable Care Act (ACA) created 5 categories of health insurance plans options for consumers: Bronze, Silver, Gold, and Platinum, plus a high deductible "catastrophic" plan option for emergency, safety net-type coverage for large, unforeseen health care expenses for individuals under the age of 30 or with low incomes. The expansion of Medicaid coverage in Michigan adds to the strain on the existing system in terms of access. With tens of millions of formerly uninsured individuals looking for primary care providers, there is a "gloves off, bare knuckles" fight between industry giants to re-define and claim the new primary care delivery environment. The twin drivers of easy access and controlling out-of-pocket spending may be expected to fuel consumer demand for new low cost, easy access primary care providers.

New entrants into the market?

Big box retailers and chain pharmacies have been and are likely to continue moving into the primary care space. In mid-January, 2014, Caremark CVS threw down the gauntlet and announced its intention to challenge traditional primary care providers and fill the primary care space with in-store, low cost, easy access primary care medical clinics. Certain state laws may slow this process, but if past history is an indication, these restraints may be removed in the future in states where they may currently be an obstacle. In addition, federally qualified health clinics (FQHCs) are on steroids in their expansion into traditional primary care space in low income and medically underserved areas, while enjoying enhanced reimbursement for their extensive menu of primacy care and support services.

How do traditional providers respond?

Hospital and physician owned primary care practices and urgent care clinics—especially non-profit owned—will have a very hard time competing with these new for-profit, lost cost, easy access providers. Access to capital will be necessary to compete with the for profit entities. Hospitals and physician groups have once again entered into the primary care space. High fixed costs and low (or no) profit margin hospital or physician owned primary care practices depend on revenue. Even with pay-for-performance and EMR incentive payments enhancing the revenue side, revenue challenges remain dependent on a balance of volume-capacity mix, payor mix, fee for service payments, provider productivity, relationship management, coding and documentation, revenue stream management and service mix. Hospital and physician owned primary care practices will be hard pressed to compete with low cost, high access, profit-based providers.

Changes in consumer behavior

Consumer demand will also force a change in the current status quo of hospital or physician dominated primary care networks. Once the euphoria of having some form of coverage and access to the primary care system wears off, consumers of all stripes will focus on their personal financial consequences of their coverage choices as they deal with the out-of-pocket costs they must pay under their plan of choice in the form of deductibles, co-payments or co-insurance

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fees. Individuals with high deductible catastrophic coverage or with Bronze Plan coverage, and individuals with chronic conditions or who experience a severe health event, are likely to incur high deductibles and co-pays before they hit the applicable ACA caps on annual out-of-pocket costs. Individuals with high deductible catastrophic coverage will be responsible for most primary care services out-of-pocket. Some low income or young consumers may be expected to be move toward low cost, high access providers for the type of “nuts and bolts” care that can be mass produced and delivered at low cost by big box retail and chain pharmacy in-store clinics. Also, inviting traffic into the chain stores may improve the sales per square foot and likely the margins currently enjoyed by these chains. Instead of providers historically cherry picking patients by limiting access to low paying patients, low paying patients may be expected to turn the tables and cherry pick primary care providers based on how much they can limit their out-of-pocket costs. Big box and chain pharmacy providers already have extensive experience in operating high-volume businesses that offers cost-saving opportunities in the form of economies of scale. Cost conscious patients may place a higher priority on out-of-pocket cost and quick access over a traditional physician/patient relationship. Further, these aggressive new providers already have a point of access for patients: retail pharmacies or durable medical equipment outlets.

The role of other non-physician providers

One of the most interesting aspects of the changing primary care delivery environment involves the leveraging of physicians through the use of allied health professionals, such as physicians’ assistants, clinical nurse practitioners, nurses, medical assistants and others to deliver primary care pursuant to protocols. Telemedicine and technology, such as interactive stations in stores that feature mobile and social components to engage patients and promote better health, wearable monitors, smart sensors, medical health apps, cloud based EHRs and other digital health technologies, all expand options to attract, engage and retain patients to low cost, high volume, repetitive, standardized and low risk services.

3 major trends

Three important factors bear special note. First, unlike in Europe and other parts of the world, the scope of practice of pharmacy is greatly restricted in the United States. Despite opposition from the physician and hospital trade associations, state boards of pharmacy and pharmacist trade associations, along with big box and chain pharmacy special interest groups will challenge the status quo that currently limits pharmacy practice. In some countries, pharmacists may diagnose, prescribe and treat a wide variety of primary care concerns. Given the stable of pharmacists in the United States and their extensive education and training requirements, they are “low lying fruit” as a solution to the need for more primary care providers. As they already operate within pharmacies, large and small, they are already in place, at a necessary provider/supplier point of service, to meet expanded needs of patients for primary care services, beyond filling prescriptions and providing flu shots.

Second, transparency in health care pricing is accelerating. When health care consumers know what services cost, they can be more discriminating in their health care purchases. State and federal governments and consumer groups have significant policy interests in price transparency. Entrepreneurs have a financial interest in meeting the demand for tools to deliver transparency. Most motivated of all in the quest for transparency are consumers who incur personal, out-of-pocket costs that vary by ACA Plan and provider. In particular, Internet-based businesses are offering consumers options to comparison shop for providers and prices and obtain reliable quotes on services and alternatives that best meet their needs and budgets. Like the Kelly Blue Book for car values, these businesses offer price advisory reports that benchmark information for consumers. This is of special interests to those who pay a large share of their costs out-of-pocket.
The Internet offers “Priceline-like” online medical auction sites that let consumers post the procedures they need and physicians can bid on price, credentials, terms and conditions.

Third, both insurers and primary care providers are looking to offer plans and services that fill the gap left by ACA Plans, Medicaid or employer sponsored plans. Insurers can offer non-ACA compliant plans that provide supplemental health

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coverage to fill in gaps in ACA compliant plans, Medicaid or employer plans with health savings accounts (HSAs). For example, insurers offering ACA compliant high deductible, catastrophic plans can also offer non-ACA compliant supplemental plans analogous to Medigap, which provide fewer benefits but at less cost. These policies can cover out-of-pocket copays and deductibles under the ACA Plans, employer plans or Medicaid. If the combination of the ACA compliant high deductible plan, for example, and a non-compliant supplemental plan meet certain ACA requirements, the separate, but interlocking twin plans can be offered on the state and federal health exchanges.

Primary care providers will need to further expand their services. A form of pre-paid concierge medicine, called "direct primary care" is being offered by an increasing number of physician groups throughout the United States. In exchange for a membership fee, a patient's membership gives them unlimited access to primary care services for routine, everyday care, such as checkups, vaccinations, sprains, minor cuts, flu and cold care and other services necessary for preventative and low impact health maintenance.

The membership fee is not insurance because all of the services must be provided with the primary care group and cannot be outsourced to any other separate legal entity, such as a diagnostic imaging facility. Depending how the membership fee is structured, it can be high for "all-you-can-eat" services that are included within the membership fee or low to merely guarantee prompt access to the primary care group, with a reduced fee schedules for "a la carte" services depending on the actual services needed. It is marketed as an attractive option to supplement high deductible catastrophic policies, without the need for a Medigap-like supplemental insurance product. Advantages to the direct primary care practice are a non-insurance or risk of bad debt revenue stream, elimination of the need to bill insurers, and control over their patient volumes and populations.

A changing picture

The primary care provider playing field will likely continue to undergo significant changes. Informed consumers will be presented with new options for their primary care services. These new options are going to challenge previously conceived notions about how primary care should be provided. Chain drug stores used to promote their photo departments to help drive traffic to their stores. Now, the pictures taken might be of something more important – your health.

If you have questions regarding the primary care changes, or other health care law matters generally, please contact the authors of this client alert, your regular Butzel Long attorney or any member of Butzel Long's Health Care Industry Group.

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