Direct Pay Care: The Role of the Specialist

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Our discussion, in about an 30 minutes...

- **Why?** For specialists, for DPC physicians
- **Who?** Patients: insured, underinsured, uninsured
  Employers: initially the self-funded
- **How?** Go alone, maximize success together
- **What if?** Medicare regulation
  Commercial insurance issues
For many of the same reasons that primary care medicine has moved in this direction:

The third-party payor healthcare model is broken.

- Healthcare costs higher than necessary and rising
- Employees paying greater share of these rising costs
- Care becoming increasingly inaccessible for too many
- Model promotes billing above patient health
- Physicians buried in paperwork and administration
- Physician burn-out is rising
- Patient health declining
- And it’s not getting better...
Why?

For Specialists:
Less administrative costs
Less bureaucratic burden
Efficient: cash for service
Growing market to access
Make medicine joyful again

For DPC physicians:
Improve value proposition
Improve patient access
Greater potential to scale
Who? Insurance trends point to fertile ground

**Individuals:** Missionary selling
Uninsured
Underinsured
- 2017 Maximum OOP: $7150/$14,300
- “Sharing” Insurance Entities

**Employers:** Greater scale
Very small (3-9) and small firms (10-199)
- 38% of workforce
- 47%/56% offer health insurance

Increase cost sharing: HDHP increased from 4% to 29% over past 10 years

Largest increase in self-insured plans: 25–99 and 100–999 employees

Specialty care: Average in-network copayment $38; coinsurance 19%

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The Realities:
Most specialists are still well compensated
Different business model
● More acute care: less chronic management
● Must draw from large patient population
● In surgical specialties: high cost procedures
● Value Added Process more conducive to FFS
As a result, most specialists will follow hybrid path…initially

Two Paths:
Specialist alone:
Move into DPC
Direct contracting with self funded businesses

PCP and Specialist joint effort:
Need strong PCP foundation
  Consolidate DPC patient population if feasible
Create panel of specialists—DPC network
  Interact with self funded businesses
The Chargemaster

Must maintain single fee schedule

Everyone should be shown the same provider "price"

Can accept agreed upon discounts or negotiated rates

All payers (including self-pay patients) are allowed to negotiate with the provider a unique payment or discount for services.
Usual and Customary/Most Favored Nation Clause

It continues to be OIG’s position that, when calculating their “usual charges” for purposes of section 1128(b)(6)(A) of the Act, individuals and entities do not need to consider free or substantially reduced charges to (i) uninsured patients or (ii) underinsured patients who are self-pay patients for the items or services furnished.

OIG believes that section 1128(b)(6)(A) of the Act can be reasonably interpreted to allow providers to carve out discounts to these patients when calculating their “usual charges” to other customers.

Federal Register/ Vol. 72, No. 116, 33432/ Monday, June 18, 2007
What if? Medicare Fears

Medicare Beneficiary Right of Refusal

However, there is an exception to this rule where a beneficiary (or the beneficiary’s legal representative) refuses, of his/her own free will, to authorize the submission of a bill to Medicare. In such cases, a Medicare provider is not required to submit a claim to Medicare for the covered service and may accept an out of pocket payment for the service from the beneficiary. The limits on what the provider may collect from the beneficiary continue to apply.

Federal Register/ Vol. 78, No. 17, 5626-5630 / Friday, January 25, 2013 / Rules and Regulations

Medicare patients desiring to pay cash must agree:

- No compulsion to enter into a cash transaction
- Provider would otherwise bill Medicare
- Provider and/or patient will not submit a claim
- Agreement is not a “Private Contract” and provider may continue to bill Medicare for services
- Medicare allows cash discounts proportional to savings in claims processing
Most Favored Nation Clause

18 states have enacted a ban on MFN clauses in the healthcare context:


Pending in Pennsylvania and Missouri.

10 states also prohibit a plan from requiring a participating provider to disclose the rates a provider negotiates with any other plan:

Chargemaster Issue: same as in Medicare discussion
Avoidance of Claims Submission

Insurance Ignorance

HITECH-HIPAA Omnibus Rule, September 23, 2013: Right to Restrict Disclosure

A patient has the firm right to demand that a health care provider not disclose the patient’s protected health information (PHI) to the patient’s health plan.

The patient makes a Request to Restrict disclosure:

- Disclosure is to a health plan for payment or health care operations
- Disclosure is not required by law, and
- Patient (or someone on behalf of the patient) has paid for in full out of pocket

An individual may use an FSA or HSA to pay for the health care items or services that the individual wishes to have restricted from another plan.

Cost of service does not apply to deductible
I am not a lawyer, but I play one...

Not really—always ask your lawyer
Healthcare Delivery Model
Innovation and Disruption

Develop a new value network:

Evaluate the proper role of each stakeholder
Remove processes that add cost without corresponding benefit
Properly realign incentives of the market’s participant

Altering independent aspects without a global perspective will not lead to sustainable change and will not fully realize the true value proposition of disruption.

The healthcare ecosystem must be reconfigured under a unified vision to facilitate development of a more effective delivery model.
A physician-driven, patient-centric employer healthcare solution that lowers cost and improves care for employees.