
Restoring the Doctor-Patient Relationship

How Entrepreneurship Is Revolutionizing Health Care in Maine

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I. Executive Summary

As Maine's broken health care system continues to offer excessive prices and poor outcomes to dissatisfied patients, lawmakers and consumers alike would do well to consider a promising health care innovation that is rapidly gaining supporters nationwide: direct primary care.

Direct primary care (DPC) is an innovative medical practice model in which physicians charge patients a regular fee to provide routine health care services including screening, assessment, diagnosis, and treatment. As a result, insurance companies and government payers are entirely cut out of the primary care equation, simplifying the doctor-patient relationship and cutting administrative costs.

Six DPC practices operate in Maine, and all have opened since 2013. This report analyzes the current DPC landscape in Maine, evaluates how DPC is benefiting patients, highlights some of the challenges DPC practices face, and offers policy recommendations to promote this type of practice in the future.

The findings of this study reveal that direct primary care in Maine:

- Is reducing preventable hospitalizations and emergency services by providing better preventive care and chronic disease management.
- Reduces patients' out-of-pocket expenses.
- May help to mitigate the primary care physician shortage.
- Is burdened by unnecessary government regulations.

Recommendations include:

At the federal level:

- Loosen restrictions on health savings accounts.
- Define Affordable Care Act-compliant wraparound health insurance.

At the state level:

- Explicitly exempt DPC practices from insurance regulation.

II. Introduction

In the face of systemic dissatisfaction with our health care system, rising costs, and poor medical outcomes, a growing number of physicians and patients are transitioning to direct primary care (DPC), an innovative health care delivery model hailed as the “best kept secret in the health care industry”¹ and “one of the most intriguing experiments in [medicine].”² The model abandons third-party insurance payments and emphasizes coordinated, comprehensive, and personalized care. In DPC, a simple flat monthly fee is charged for comprehensive coverage of all primary care services. This empowers the doctor-patient relationship and enables DPC providers to focus on providing outstanding medical care instead of spending time with administration and billing.

The DPC model provides unrestricted access to unhurried primary care. Patients go to their DPC physician for all routine and preventive services like checkups,



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urgent care, and chronic care management. High-deductible insurance is typically paired with DPC to cover hospitalization and expensive specialty care.

Though the idea of direct doctor-patient financial arrangements may seem radical in light of the insurance-based system prevalent today, the DPC model was the conventional payment mechanism for much of our history. Before the rapid growth of employer-based health insurance coverage in the 1940s, Americans paid directly for virtually all of their medical needs. As insurance-based health care emerged, the underlying financing mechanisms and cost structures became opaque, leaving patients unable to determine the true cost of their health care and enabling insurance companies and medical providers to exploit this lack of transparency. Exorbitant health insurance premiums and deductibles are now the norm, with patients shouldering an ever-increasing share of the cost of their health care. Direct primary care, by simplifying the payment arrangement, promotes cost transparency and empowers patients to have a more active role in controlling their health care spending.

During the last five years, direct primary care has experienced a nation-wide surge in popularity. In 2005, only 146 DPC practices existed in the United States. By 2012, that number had grown to 4,400, with hundreds of physicians continuing to transition to the model every year.³ A 2015 study identified DPC practices in 39 states.⁴ In Maine, six DPC practices have opened since 2013, serving roughly 1,300 patients.

Direct primary care is helping to resolve many of the underlying problems created by convoluted third-party payment arrangements by eliminating administrative burdens, reducing insurance-related paperwork, and refocusing physicians’ efforts on patient care. It

has the potential to provide better health outcomes for patients, create a more fulfilling work environment for physicians, and reduce overall health care spending while bringing high-quality primary care within reach of low-income individuals.

III. Better Health Outcomes

Primary care serves as the cornerstone of a strong health care system.⁵ Considerable evidence suggests that, next to the patient, the most important player in patient health outcomes is the primary care physician.⁶ Primary care providers can help patients avoid illness and identify problems early, particularly if they have the time to build strong, trusting relationships with their patients. In order to foster clear, frank communication and a personalized approach to health, providers must be accessible and significant time must be devoted to in-depth office visits. Both scholarly research and anecdotal evidence point to the fact that strong doctor-patient relationships—the key to effective primary care and disease prevention—cannot be built during infrequent ten-minute consultations.

With patient panels typically ranging from 200 to 600 people, DPC physicians can devote more time to each patient.

The DPC model, with its emphasis on close collaboration between doctor and patient to monitor existing illnesses, coordinate treatments, and quickly address emerging issues, differs from a traditional primary care practice

that is often forced to concentrate on reactive, superficial care to alleviate symptoms and acute health problems. In the United States' current primary care model, physicians must each juggle the needs of about 2,500 patients, resulting in office visits—lasting from 10 to 15 minutes—too brief to provide detailed information or develop a long-term wellness plan. With patient panels typically ranging from 200 to 600 people, DPC physicians can devote more time to each patient.

DPC practices are exceptionally successful at managing chronic conditions like diabetes and heart disease that are responsible for 86 percent of all health care costs in the United States.⁷ For example, as a 2012 study noted, “better glycemic control in persons with diabetes can lead to reductions in health care costs and improved outcomes.”⁸ Another study found that family practices with a higher proportion of diabetic patients with moderate glycemic control had fewer emergency admissions for short-term complications of diabetes.⁹ Follow-up consultations with one's primary care physician after hospitalization for chronic obstructive pulmonary disease also lead to substantially lower re-admission rates.¹⁰

Several recent studies have scrutinized the health outcomes of direct primary care practices. A 2012 study found that urgent and avoidable hospital admissions were lower among DPC

members compared to nonmembers. Overall, DPC patients were 62 percent less likely to be hospitalized than members of the control group in 2010. The study’s authors concluded: “We believe that the [DPC] personalized preventive care model of smaller practices allows the physician to take a more proactive, rather than reactive approach...This increased physician interaction has resulted in lower hospital utilization and ultimately lower healthcare costs.”¹¹

IV. Patient Savings

Primary care physicians can treat about 90 percent of medical conditions in a venue that is fundamentally lower-cost and less stressful for patients than a hospital. By providing unrestricted access to primary care through longer appointments, extended hours, and phone and electronic communications with patients, DPC can substantially reduce patients’ out-of-pocket medical expenses by taking care of health needs promptly and avoiding costly downstream care.

When given enough time, primary care physicians can help patients navigate the rest of the medical system. They can assist patients in deciding what treatment they need, choose the best providers, avoid overpaying, and recover after acute care.

Direct primary care, by relying on a flat fee, encourages doctors to provide *better* health care rather than *more* health care. A DPC physician who provides unnecessary and excessive treatments doesn’t benefit additional revenue—to the contrary, the extra costs come out of his bottom line.

Several studies have tried to quantify the financial benefits of DPCs personalized approach. Data collected from thousands of DPC patients from 2013 to 2014

indicated average annual savings

of \$679 per person compared to similar individuals with commercial insurance; researchers attributed the drop in health care spending to sharp declines in hospitalizations, emergency room visits, and specialist services.¹²

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But better health outcomes and lower hospital and specialist utilization are not the only sources of patient savings. Since DPC practices reject third-party insurance, much of the billing and administrative infrastructure typical of a traditional primary care office is avoided. Non-clinical staff is kept to a minimum, cutting payroll costs. While the average primary care practice has 2.05 administrative staff members for every doctor,¹³ no DPC physicians in Maine reported having more than one full-time equivalent administrative

employee, and 40 percent of DPC practices only employed a part-time administrator. A recent report noted, “The administrative efficiencies gained by abandoning third-party fee-for-service overhead are often cited as one of the chief reasons that DPC is offered at a minimal cost to the patient.”¹⁴

A study published in 2014 argued that if the DPC model were adopted nation-wide, overall health care costs could be reduced by as much as 30 percent.¹⁵ That would translate to roughly \$3.3 billion in savings in Maine—about \$2,500 per capita. Independent scholars have offered more modest estimates, but have still found that DPC practices lead to a 12.3 percent net drop in the total cost of care, even after taking into account the costs of DPC membership.

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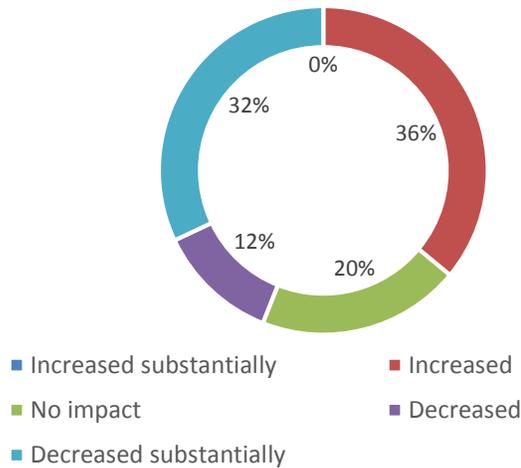
Since DPC does not cover hospitalization, radiological services, and specialist visits, patients typically purchase high-deductible health insurance to protect against catastrophic expenses. In Maine, an informal

survey of DPC patients suggests that 80 percent have some kind of health insurance; most obtain comprehensive coverage through their employer, though some have high-deductible (catastrophic) plans; additionally, nearly 20 percent of DPC patients are on Medicare.¹⁶

A 2010 report by Qliance—a network of direct primary care providers mainly in Washington State—described DPC’s ability to reduce costs for consumers:

When [direct] primary care at Qliance is bundled with a low-premium, wraparound insurance plan to cover nonprimary health care, patients can realize savings of 35 percent or more for comprehensive care, depending on what level of deductible they choose. For example, the annual premium for a plan with a \$1,000 deductible and 30 percent coinsurance for a nonsmoking, fifty-three-year-old male...is \$10,068. Including the \$1,000 deductible, the patient will pay \$11,068 before the insurance plan pays anything, except for a periodic exam costing up to \$200. As a Qliance member, the same patient can purchase a \$2,500 deductible plan...with comparable benefits except for the periodic exam (included in Qliance). The insurance premium costs \$5,532. When the \$828 annual cost of Qliance is added, the patient pays \$6,360 before the insurance deductible, or a 37 percent savings compared with the lower-deductible plan.¹⁷

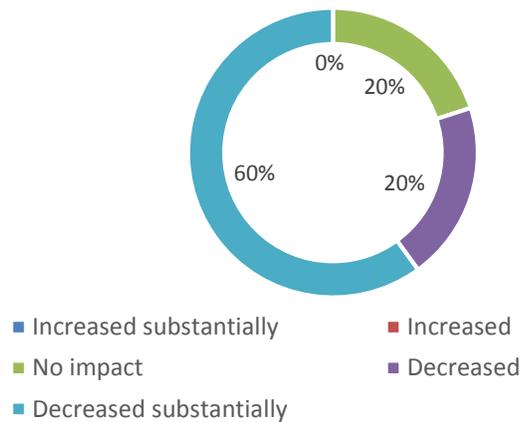
Graph 1: How has DPC impacted your health care spending?



To better understand the unique circumstances of DPC patients in Maine, we conducted a small, unscientific survey of 25 DPC patients. Thirty-two percent of respondents reported that their health care spending “decreased substantially” thanks to DPC. An additional 12 percent of patients said that their health care costs had “decreased” (see Graph 1 for details).

Our survey of DPC physicians in Maine revealed similar results. The majority—60 percent—said that they believed DPC substantially reduced their patients’ health care expenses, compared to a traditional primary care arrangement, while an additional 20 percent responded that their patients experience a modest decline in health care costs as a result of DPC (see Graph 2). When asked what factors contribute to cost reductions, a DPC physician in Maine responded: “Finding many of [my patients] lower cost medications, tests and procedures. A few of them save quite a bit by seeing or calling me after hours instead of the [emergency room].” According to another physician, “The way our practice model reduces our patients’ overall expenditures is multifactorial. An acute visit costs our patients nothing extra, but may save an ER visit that would have cost several hundreds, or more likely thousands of dollars...I often save my patients a lot of time and money by avoiding expensive visits with specialists. We also save them money by providing generic medications at our cost and lab studies that must be sent to outside facilities at prices often less than 10 percent of what they would have paid at a hospital lab.”

Graph 2: What impact does DPC have on your patients’ health care spending?



Consider the following examples.

Example 1: Single person

A 30-year-old woman lives in Rockland, earns \$40,000 per year, and gets insurance through her employer. Let's assume she pays \$1,176 per year for health insurance through her employer (the average in Maine, according to the Kaiser Family Foundation).¹⁸ Her deductible is \$3,000.

If she chose to purchase a DPC membership on top of her employer-sponsored health insurance, she would likely see a decline in her out-of-pocket costs. The closest DPC practice to her domicile is Megunticook Family Medicine, located in Rockport and owned by Dr. Brian Pierce. The cost is \$35/month; some tests and procedures, as well as office visits (beyond an annual physical examination), have small additional charges. The total annual cost of DPC would likely be between \$420 and \$500, depending on how much medical care she requires; this is roughly equivalent to the cost of three office visits through her insurance or a visit to the emergency room.

Example 2: Family

Next, consider a family of four living in Bangor. Both parents work low-wage jobs that don't offer employer-sponsored insurance; the children are on MaineCare. The family earns \$30,000. Because of the family's low income, neither parent qualifies for premium tax credits through the Obamacare exchange. Nor do they qualify for MaineCare, since their income narrowly exceeds the eligibility threshold. Even the children, despite their MaineCare



For a low-income family unable to afford health insurance, DPC can be an accessible, affordable way to receive medical care.

coverage, have difficulty getting the primary care services they need. Appointments for the flu take weeks to schedule, and follow-up visits for mild injuries are delayed and postponed.

Without government assistance, comprehensive health insurance coverage is realistically out of reach of this family. A basic plan with a deductible of \$5,000 would cost approximately \$10,320 annually, more than one-third of this family's gross income. More robust coverage, with a deductible of \$1,000, would cost more than \$18,000 per year. For this family, DPC offers an affordable, accessible solution. The Osteopathic Center for Family Medicine located in Hampden, owned by Dr. Jack Forbush, offers family DPC services for \$1,750 per year. All family members—including the children enrolled in MaineCare—would have access to the practice. While this solution leaves the parents vulnerable to large financial liabilities in the event of a catastrophic injury, it is by far the best option of those currently available.

V. Greater Patient Satisfaction

Patients are deeply dissatisfied with the way we deliver and finance health care in the United States. A 2014 survey found that 82 percent of Americans would give our health insurance system a grade of C or below.¹⁹ As administrative tasks consume an ever-increasing portion of a physician's day and the amount of time devoted to patient care declines, patients lack the personal attention they need to discuss health concerns and evaluate treatment options.

Patients who subscribe to a DPC practice report significantly higher satisfaction rates than those who receive care from a traditional practice. A 2015 study on the satisfaction of DPC members reported that 90 percent of DPC patients were satisfied with their ability to contact their physician during business hours, compared to just 53 percent of conventional patients. More than 96 percent of DPC members were happy with their relationship with their physician, compared to only 58 percent of traditional patients.²⁰ An informal survey we conducted suggests that DPC patients in Maine are exceptionally happy with their care. All of the respondents indicated that they were satisfied with DPC, and the vast majority responded that they were "very satisfied."²¹



Ninety-six percent of DPC patients are satisfied, compared to just 58 percent of patients at conventional practices.

VI. Addressing Maine's Primary Care Crisis

An increasingly concerning trend in health care, and one that DPC could help to reverse, is the shortage of primary care physicians. According to the Association of American Medical Colleges, demand for primary care physicians by 2025 will exceed supply by as many as 31,100 doctors nationwide. "The physician shortage will persist under every likely scenario, including increased use of advanced practice nurses (APRNs); greater use of alternate settings such as retail clinics; delayed physician retirement; rapid changes in payment and delivery (e.g., ACOs, bundled payments); and other modeled scenarios."²² Many health policy experts warn that the shrinking supply of primary care physicians is the single biggest challenge the United States' health care system faces in the coming years.

The current environment of heavy regulation, extensive administrative responsibilities, and narrow flexibility is discouraging medical students from specializing in primary care. Around the country, physicians are becoming more like assembly-line workers, constrained by myriad rules and regulations. Policies designed to increase efficiency, maximize productivity, and boost profits have limited physicians' opportunities to care for patients directly. In-depth conversations with patients and personal relationship-building are

disappearing in primary care as doctors spend less and less time with their patients. In 2013, the average primary care visit was about 18 minutes nationally,²³ with many physicians even scheduling patients at 15-minute intervals.²⁴

As a result, many physicians are also dissatisfied with the current state of health care. A recent report designed to help physicians select a state in which to practice ranked Maine 33rd in the country.²⁵ Another source ranked Maine 42th.²⁶ Doctors are increasingly tempted to retire early or pursue another profession. A survey conducted in 2012 found that 90 percent of doctors believe the medical industry is on the “wrong track” and 83 percent are thinking of quitting. The vast majority blamed excessive government involvement for the problems the health care system faces. A 2014 survey found that 46 percent of physicians give the Affordable Care Act (“Obamacare”) a D or F grade, and 81 percent describe themselves as overextended or at full capacity.²⁷ Research suggests that nearly half of physicians are experiencing burnout, a proportion far higher than in the rest of the labor force.²⁸

Physician shortages are commonplace in Maine and are likely to grow more acute absent a dramatic shift in physicians’ incentives to stay in practice.

Physician shortages are commonplace in Maine, and are likely to grow more severe as thousands of previously uninsured Mainers obtain insurance through the Affordable Care Act.²⁹ In 2010, there were only 45.7 primary care physicians (PCPs) per 100,000 residents of Washington County, about half the national average. Similar shortages exist in Oxford, Sagadahoc, and Somerset counties.³⁰ Statewide, Maine had nearly 30 percent fewer PCPs than the national average. A recent study found that Maine will need 120 additional PCPs by 2030 merely to maintain the status quo, much less begin to address the unmet need for primary care.³¹ As of April 2014, Maine contained 67 federally-designated Primary Care Health Professional Shortage Areas.³² The lack of primary care providers reduces access to important medical care. In 2014, nearly 11 percent of adults in Maine reported not seeing a doctor in the past 12 months,³³ while more than 12 percent lacked a personal physician.³⁴

Concerns have been raised regarding the possibility that DPC might exacerbate existing shortages instead of providing a solution. While traditional PCPs commonly have 1,500 to 2,000 patients, DPC doctors typically have about 400 patients or fewer. With each doctor caring for fewer patients, it would seem that the amount of unmet care would increase if large numbers of physicians transitioned to the DPC model. Although little empirical evidence is available to adjudicate this question, it should be noted that the DPC model has a proven track record of enhancing physician satisfaction and attracting doctors who are fed-up with the traditional insurance approach to primary care. If additional physicians—and

students—gravitate to primary care as a result of DPC, they could offset the reduction in supply caused by smaller patient panels per physician. As a 2010 study noted, “The direct primary care model has the potential to reignite excitement among those considering a primary care career.”³⁵

We asked DPC physicians in Maine to respond to concerns that widespread adoption of the DPC model could undermine health care access by downsizing patient panels. One doctor opined, “I think it will do the opposite because doctors who would otherwise avoid primary care, quit, go into administration or education, or change careers, now have an option to practice on their own terms, for a comparable salary to other specialties. I think it will attract

Adopting a simple payment mechanism that excludes insurance companies eliminates one of healthcare providers’ most unpleasant and time-consuming tasks: insurance claims processing.

more primary care doctors whereas the current model is driving them away (myself included).” Another added: “I completely disagree. DCPs [sic] offer excellent access to patients who would, otherwise, not be able to obtain medical care.”

In addition, by adopting a simple payment mechanism that excludes insurance companies and government payers, the DPC model eliminates one of health care providers’ most unpleasant and time-consuming tasks: insurance claims processing. In many cases, insurance processing and other collection costs can consume in excess of 30 percent of a practice’s revenue. The monthly DPC payments provide a predictable cash flow to providers, allowing them to focus on caring for their patients.

There are already promising signs that dissatisfied primary care physicians might decide to continue practicing medicine through the DPC model. In 2015, a survey of nearly 700 primary care physicians across the United States indicated that 46 percent are considering transitioning to a direct primary care model within the next three years.³⁶ A 2014 survey found that 14.8 percent of primary care physicians intend to switch to a cash-based model.³⁷

VII. Direct Primary Care in Maine

Since 2013, six DPC practices have opened in Maine (see Map 1). Interviews and surveys of several DPC physicians in Maine revealed that their motivations for selecting DPC were typically rooted in dissatisfaction with the impersonal, administratively-focused environment of many conventional primary care practices. Some expressed concern that excessive paperwork was encroaching on their time with patients, while others noted that flexible scheduling was an attractive feature of DPC. All respondents indicated they were “very satisfied” with DPC and would recommend the model to other physicians.

According to a survey of DPC patients in Maine, the median age is 59; the mean is 56. On average, patients drove 30 minutes to visit their DPC physician, with several respondents indicating one-way driving times of more than one hour.

Membership costs, services offered, and payment schemes vary among DPC practices in Maine. Some charge different rates depending on the patient’s age, while others have a standard fee. Most DPC practices in Maine reported that 25-50 percent of their patients were low-income, an indication that DPC services are increasing health care access for people who might otherwise rely on expensive emergency services or put off essential medical care.

DPC practices charge different rates depending on their geographic location, size, demographics of the patients they serve, and the breadth of services provided.

As a whole, Maine’s DPC practices currently offer some of the lowest prices in the country. According to recent survey of DPC practices across the country, the median monthly cost per patient is \$75, not including small additional charges or per-visit fees.³⁸ In Maine, monthly membership costs range from \$25 to slightly more than \$100, depending on the patient’s age and payment plan. For a 40-year-old patient willing to pay the full annual cost upfront, the average monthly price is \$58; the median is \$46.

Map 1: DPC Practices in Maine

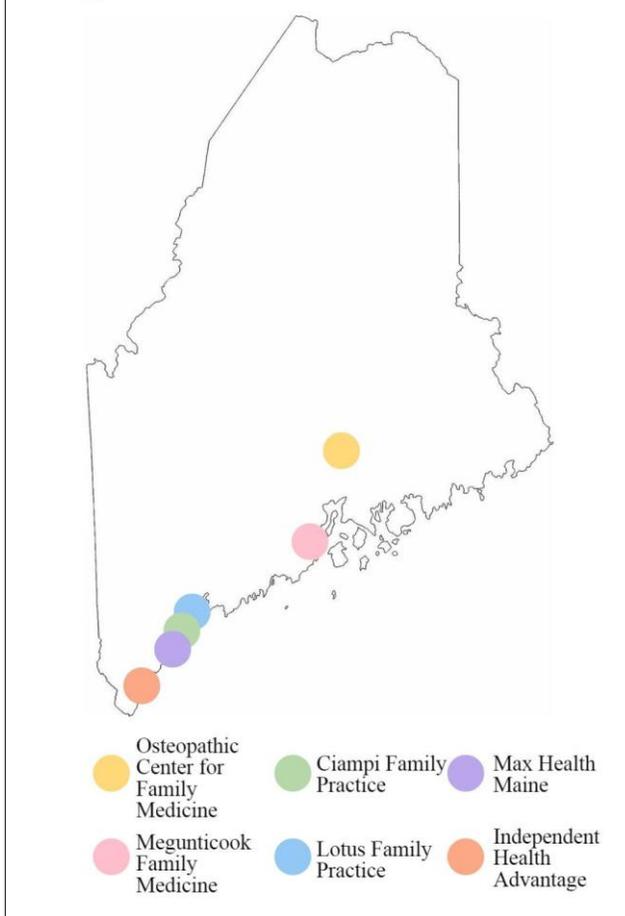


Table 1 provides cost estimates for DPC practices in Maine. Though efforts were made to provide accurate figures, some eligibility and pricing discrepancies between practices makes direct comparison difficult. Readers are encouraged to visit the practices' websites to learn about specific policies and payment options.

Table 1: Annual Cost of DPC Membership in Maine

DPC Practice	Annual cost (individual) ¹	Annual cost (family) ^{1,2}	Additional charges
Ciampi Family Practice (South Portland)	\$550	\$1,540	Lab tests and generic medications are discounted. Home visits are available for an extra fee per visit.
Lotus Family Practice (Falmouth)	Adult: \$720 Child: \$240	\$1,920	Lab tests and medications are offered wholesale, without markup.
Osteopathic Center for Family Medicine (Hampden)	\$1,250	\$1,750	Lab tests and medications are offered wholesale, without markup. One-time enrollment fee of \$99, office visit co-pay of \$35.
Megunticook Family Medicine (Rockport)	<22 year-olds: \$300 22-64 year-olds: \$420 >64 year-olds: \$600	\$1,440	A few tests and procedures have small additional fees. One-time enrollment fee equal to one month's membership. House calls are \$60.
Max Health Maine (Cape Elizabeth)	1-29 year-olds: \$420 30-44 year-olds: \$552 45-64 year-olds: \$708 >64 year-olds: \$504 ³	\$1,740	In-office lab tests and vaccinations are available at a small cost.
Independent Health Advantage	\$1,800 ⁴	\$4,400	Services, including testing and vaccinations, are available for an additional fee.

¹ Annual costs assume that the full charge is made in a single payment. If a monthly or biannual payment plan is preferred, annual costs sometimes increase slightly.

² Family prices assume a typical two-parent, two-child household.

³ Special rates apply for Medicare patients.

⁴ This practice offers several membership options for different prices. The \$1,800 plan is the most similar to what other DPC practices offer.

In addition to competitive pricing, several DPC physicians in Maine provide additional services beyond office consultations and physical examinations. Some practices offer yoga and meditation classes, prenatal and midwifery services, or breathing therapy.

VIII. Challenges to Direct Primary Care in Maine

While DPC in Maine is a growing movement, it continues to face several public policy obstacles. Direct primary care physicians in Maine operate with regulatory uncertainty and the possibility that the Bureau of Insurance may begin imposing rules and restrictions on their business. If considered health insurers under Maine law, DPC practices would face difficult—and possibility prohibitive—obligations, such as maintaining a minimum of \$1 million of capital reserves,³⁹ submitting annual detailed financial reports to the superintendent of the Bureau of Insurance,⁴⁰ and undergoing a “comprehensive” examination by state regulators at least once every five years.⁴¹

Exempting DPC practices from the insurance code “removes regulatory uncertainty for health care providers.

In order to protect DPC practices from burdensome regulation, 14 states have adopted laws explicitly exempting DPC from insurance regulations; six more states are considering similar legislation. According to nonpartisan researchers at the Florida legislature, exempting DPC practices from the insurance code “removes regulatory uncertainty for health care providers by stating that the direct primary care agreement is not insurance and as a result not regulated by the [Bureau of Insurance]. Additional primary care providers may elect to pursue a direct primary care model and establish direct primary care practices which may increase access to affordable primary care services.”⁴² The Heritage Foundation agrees: “The lack of clear state policy causes uncertainty and hesitation for physicians looking to form direct primary care practices.”⁴³

Another challenge DPC faces in Maine is the lack of “wraparound” health insurance plans specifically designed to cover services and procedures—such as specialist visits and hospitalization—beyond the scope of a DPC practice. Since the Affordable Care Act—which acknowledged that DPC, combined with wraparound insurance coverage meant to cover catastrophic events and other health benefits outside the scope of a primary care practice, constituted a qualified health plan—was passed, federal regulators have failed to delineate what precisely constitutes a wraparound insurance plan, leaving patients with little choice but to enroll in a comprehensive health plan (which technically includes primary care services) and purchase DPC on top of that. The redundant cost to the consumer is a deterring burden, which could easily be eliminated through federal action.⁴⁴

Insurance carriers are reluctant to create wraparound plans—which would only cover medical expenses not provided by DPC—without a large customer base. A DPC physician in Maine contacted one of the state’s largest insurers to inquire about the possibility of developing such a wraparound plan, but was told that at least 10,000 patients would need to

be prepared to purchase such a plan in order to make it worthwhile. As the number of people interested in DPC increases in the face of a dysfunctional insurance-based system, the market for additional DPC practices will expand. With it, some insurers may develop inexpensive wraparound health insurance coverage, as has been done in other states. Group-based DPC practices like Qliance may also begin to flourish, creating a robust and geographically-dispersed DPC system in Maine.

Another challenge the direct primary care industry faces in Maine is a lack of public awareness. All of Maine's DPC physicians who completed our survey reported that they were interested in significantly expanding their patient panels. National polls suggest that the vast majority of patients—and a large proportion of health care workers—have never heard of direct primary care, and certainly have not conducted the research necessary to understand

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how it works and determine whether adopting the model is the right decision. There are encouraging signs, however. Over the last few years, as several Maine physicians transitioned to DPC, several state and local media

organizations published articles introducing the concept to a broad audience. Several DPC physicians in Maine also host regular open houses to engage curious members of the public and harness social media advertising to attract clients. Currently, all of Maine's DPC practices are clustered—with the exception of the Osteopathic Center for Family Medicine located in Hampden—in southern or coastal Maine. As a result, a significant number of Mainers do not have access to DPC services within reasonable driving distance. This may be partially due, as one former Maine physician has stated, to the lack of a sufficiently large patient population in northern and eastern regions to support a DPC practice.⁴⁵

Finally, federal restrictions on the use of Health Savings Accounts (HSAs) are preventing many DPC patients in Maine from using their accounts to pay their DPC membership fees. The Internal Revenue Code states that an HSA must be coupled with high-deductible insurance, and that individuals with an HSA paired with a high-deductible plan may not have a second health plan. Since, at the federal level, DPC is considered a form of insurance, patients are prohibited from using their HSA funds to finance DPC. Congress could easily rectify this issue by passing a bill specifying that DPC is not to be treated as insurance for the purposes of tax regulation.⁴⁶

IX. Recommendations and Conclusion

Policymakers at the state and federal level should enact the following reforms to make it easier for DPC practices to thrive by providing more regulatory certainty to physicians, expanding options for consumers, and reducing out-of-pocket costs.

At the federal level:

- Congress should pass legislation authorizing the use of HSAs for DPC expenses.
- Federal regulators at DHHS should provide detailed information regarding the requirements of wraparound insurance needed to make DPC eligible for sale on the health insurance exchanges.

At the state level:

- Lawmakers in Augusta should join a growing number of states in passing legislation explicitly stating the DPC is not insurance, and that physicians in such practices are not subject to insurance regulations.

For too long, Maine's health care system has failed to deliver cost-effective, accessible primary care services. Direct primary care promises to revolutionize health care by empowering patients and emphasizing affordability, access, and prevention. Many other states have embraced the DPC model and created hospitable regulatory environments for such practices to thrive. It is time for Maine to do the same.

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