Pricing Patients Out of Primary Care

Primary care has long been known to be an effective tool for improving population health outcomes (1). However, the number of Americans receiving their care from primary care providers (PCPs) has been decreasing. Ganguli and colleagues (2) explore this issue by reporting PCP visit trends between 2008 and 2016 among members aged 18 to 64 years of a large, national, commercial insurer that covers millions of Americans yearly (2).

Rates of PCP-billed visits decreased by 24% from 2008 to 2016, and the proportion of adults with no PCP visit increased from 38% to almost half. Specialist visit rates remained essentially unchanged, whereas visits to alternative settings, predominantly urgent care centers, sharply increased. All subgroups had a double-digit decline in PCP visits; the largest declines were among young adults, persons without chronic conditions, and those living in low-income areas. The authors found decreases in problem-based PCP visits and PCP visits for low-acuity conditions (such as conjunctivitis) and an increase—though of a much smaller magnitude—in preventive visits to PCPs. Over the same period, mean out-of-pocket costs paid by these members increased by almost a third for problem-based visits, and a greater share of all PCP visits were subject to a deductible. Member costs for preventive PCP visits declined by three fourths. The strength of this study lies in the large number of observations through repeated cross-sectional analyses of deidentified claims and the ability to observe rate trends over time. The use of annual cross sections, though, precludes any assessment of longitudinal effect.

What are we to make of these findings? Administrative claims provide limited insight into questions about access. Although we can observe how individuals use or do not use services, claims provide no information about the reasons for or consequences of delayed or forgone care. The authors propose 3 explanations for decreasing PCP visits: replacement of low-acuity visits by self-care or electronic communication, the convenience of alternative care settings, and care avoidance due to increased cost sharing. A record number of Americans (>90%) have health insurance coverage, and it would be reasonable to assume that having insurance would increase use of primary care services (3). Insurance coverage, however, does not guarantee access. The challenges faced by those with public health insurance coverage have been well documented, but even those with commercial coverage face barriers related to geography; transportation; scheduling; and, increasingly, cost. An annual national survey of employees with employer-sponsored health insurance found that the average employee share of premium for single coverage increased from $882 to $1325 between 2008 and 2016, while the proportion of employees in high-deductible plans grew from 17% to almost half (4). More employers required coinsurance for physician visits, and the average deductible increased, which resulted in growth of out-of-pocket maximums from $2466 to $4099. Employees are paying more for less coverage at a time when income and wages have been relatively flat. Americans purchasing insurance on the individual market can face even higher costs and less generous coverage.

Both public and private health insurers have been trying different strategies to bend the cost curve, and private insurers have focused heavily on encouraging consumers to be cost-conscious through first-dollar cost sharing. The push to use price sensitivity to give patients more "skin in the game" and decrease unnecessary health care use is exemplified by the growth in high-deductible plans, where families face high out-of-pocket costs for nonpreventive services. Studies have consistently shown that cost matters. Perhaps less well appreciated is the fact that when patients face cost barriers, they are just as likely to decrease use of medically necessary care as medically unnecessary care. Many studies since the seminal RAND Health Insurance Experiment have shown that higher cost sharing leads to less health care use but unfortunately reduces use of care "recommended" by physicians as well as "non-recommended" care (5).

Effective primary care builds on 4 attributes: first-contact access for each need; longitudinal, person-focused care; comprehensive care for most health needs; and coordination when care is sought elsewhere (6). Studies have shown that health is better in areas with more PCPs, that patients who receive care from PCPs are healthier, and that the 4 attributes of primary care are associated with better health (6). First-contact care requires an adequate supply of PCPs conveniently available even with short notice. Long-term person-focused, comprehensive, and coordinated care require team-based care models and electronic records with interoperability. Patient cost sharing and high-deductible health insurance plans do not promote the development of any of this infrastructure. Instead, they create a disincentive to use the very services that have been shown to improve health outcomes through prevention, early management, and coordination. Even young adults would benefit from better primary care, given the overall prevalence of prediabetes of 1 in 4 and good evidence that type 2 diabetes can be prevented or delayed (7). Add the burden of behavioral health concerns and substance use among both younger and older adults, and the lack of access to comprehensive care seems penny wise and pound foolish (8).

The infrastructure necessary to ensure access to effective primary care is not in place, and that is where more energy should be focused. Ganguli and colleagues (2) have shown the health care choices being made by 1 large group of Americans given their available options. The steady decline in PCP visit rates across age, health status, and income may be the unintended consequence

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of using cost sharing to reduce unnecessary care in an uncoordinated health care system.

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