# Direct Primary Care

*Paying for the relationship, not the visit*

By William Breen, DSc, FACHE · The Healthcare Fix · thehealthcarefix.com

If you have ever waited three weeks for a primary care appointment, then spent eleven minutes with a doctor who was watching the clock, you already understand why direct primary care is growing.

The idea is simple. Instead of billing insurance for each visit, a practice charges patients, or their employers, a flat monthly membership fee. In return, patients get unhurried visits, same-day or next-day access, and a physician they can actually reach. No prior authorization gauntlet. No coding for every conversation. Just the relationship.

## A model whose time may have come

Direct primary care has moved from experiment to movement. As of early 2026, there were more than 2,800 direct primary care practices, with locations in every state. Fees vary, but they tend to be modest, often well under $100 a month for adults, with higher rates for older patients.

This year, Washington gave it a push. Beginning January 1, 2026, direct primary care membership fees became a qualified expense for tax-free health savings account withdrawals, up to $150 a month for an individual and $300 for a family. The American Academy of Family Physicians was an early partner, seeing the model as one of the ways small, independent practices can survive alongside larger networks.

## What it gets right

I believe direct primary care gets three things right.

First, it pays for the relationship, not the visit. The average direct primary care practice cares for about 413 patients, far fewer than a typical primary care panel. That is what time with patients looks like.

Second, it puts the physician close to the patient again. The further you get from the visit, the less you can see the flaws in the system. Direct primary care removes almost everything that stands between the two people in the exam room.

Third, it gives engaged patients a reason to stay engaged. When access is easy and the cost is predictable, people call before a problem becomes an emergency. That is Return on Care in its simplest form.

It also offers something to the many Americans who are insured but not really covered. For a working family on a high-deductible plan, a predictable monthly fee can make primary care affordable when the deductible otherwise makes it untouchable.

## What the evidence actually says

I want to be careful here, because enthusiasm runs ahead of data. The most rigorous independent look so far, a 2020 Milliman study for the Society of Actuaries, compared about 900 patients in direct primary care with about 1,100 who were not, at one employer. After adjusting for health status, direct primary care members used fewer services, mainly fewer emergency room visits and other facility care.

But the employer's overall costs came out roughly even, an estimated 1.3 percent higher at the midpoint, because the plan also paid the membership fees and waived deductibles. And the authors cautioned that it was one practice and one employer. Healthier people may simply choose these practices.

So the honest answer is this: direct primary care appears to change how people use care. Whether it saves money depends on how it is designed.

## What leaders should watch for

Direct primary care is not a complete answer. It covers primary care, not hospitals or specialists, so patients still need insurance for the big things. Smaller panels mean more time per patient, but if many physicians move to them at once, a community short on doctors can lose total capacity. And without employer or public support, it can be hard to reach for low-income and Medicaid patients, who often need it most.

Those are not reasons to dismiss it. They are reasons to design it well.

## What to do Monday morning

For employers: ask whether a direct primary care option, paired with your health plan, could improve access for employees who are avoiding care because of their deductible. Measure emergency visits and employee use, not just premiums.

For health systems and physician groups: ask whether a membership-based primary care option belongs alongside your traditional practices. It may be the most attractive way to recruit and keep primary care physicians who are burning out under volume.

Then test it with my two questions. Does it serve the patient? Can it keep doing so?

If you are weighing direct primary care for your organization, I would welcome the conversation. My goal is to help you become your own best consultant.

When it seems crazy out there, and it sometimes is, remember that the patient is still a reliable true north. Direct primary care, at its best, is simply a way of paying for that.

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