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PRACTICE FORUM

Employee response to employer-sponsored direct primary care

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Abstract
Health benefits represent employers' fastest growing operating expense. Efforts from human resources to control healthcare spending through restrictive plan design changes and corporate wellness programs may not achieve employer health and financial goals and may negatively impact employee outcomes. Employers are increasingly contracting directly with providers in order to access quality medical care and to control spending. The purpose of this practice-focused paper is to provide survey data collected from 10 employers as part of the quality improvement activities of a direct primary care (DPC) program. Overall, survey responses of employees engaged with DPC had higher patient satisfaction, group health plan rating, perceived organizational support, and job satisfaction than survey responses of those registered into the program but not yet engaged with a DPC physician. Implementation considerations and DPC characteristics are provided.

About 159 million people in the US receive coverage through an employer-sponsored group health plan (Kaiser Family Foundation, 2022), which is over half of the nonelderly population in the US Employer healthcare benefits impact employee recruitment, retention (Greenwald & Fronstin, 2018), productivity (Chen et al., 2015), and commitment to the organization (Weathington & Jones, 2006). In a recent survey by the Society for Human Resources Management (SHRM; Miller, 2015), 60% of employees reported that their healthcare plan is a very important contributor to job satisfaction. The challenge for human resources (HR) is healthcare costs represent employers' fastest growing operating expense (SHRM, 2019). Employer premium increases consistently outpace inflation with the average premium for family coverage in 2022 being 20% higher than the average premium for family coverage in 2017 and 43% higher than 2012 (Kaiser Family Foundation, 2022). HR has the critical role of balancing corporate financial requirements and employee healthcare expectations.

Employer group health plan structure

A number of health plan structure modifications over the years have decreased employer spending but are also tied to employee dissatisfaction. In the 1970s and 1980s, health maintenance organizations (HMOs) gained market share. HMOs are designed to properly align provider incentives and manage patient care through a primary care provider (PCP), the gatekeeper to all other medical services. Although HMOs have lower employer premiums than traditional plans, they have fallen short of HR expectations. They are an unpopular choice because some employees believe that they limit care and restrict treatment options (Morrison & Luft, 1990), and they

account for only 12% of the US group insurance enrolled population (Kaiser Family Foundation, 2022). In the early 2000s, high-deductible health plans (HDHPs) with a savings account option were touted as the next big health plan innovation and promised both healthcare spending control and employee healthcare empowerment. Although HDHPs save employers 10–25% on healthcare spending (Kaiser Family Foundation, 2022), there is less employee satisfaction with these plans as compared to traditional lower deductible copay plans (MacDonald, 2014). In addition, certain HDHPs may be inappropriate for employees with health conditions (Bindman et al., 2016), older employees (McDevitt et al., 2014), employees with lower salaries (Jordan & Cotter, 2016), and children (Shenkin et al., 2014), and those employees end up delaying or discontinuing needed medical care under this type of plan. In terms of market share of enrollment, HDHPs have leveled off at about 28% for the past 5 years (Kaiser Family Foundation, 2022).

Corporate wellness

Workplace wellness programs are an adjunct to group health plans and are marketed as controlling spending through the promotion of employee health. Corporate wellness is an $8 billion industry in the US and continues to grow. Eighty-eight percent of midsize/large employers offer worksite wellness, up from 70% in 2008 (Kaiser Family Foundation, 2022). Wellness programs include biometric screenings, coaching, health risk assessments, and incentive-based health goals.

There is wide support and a large body of observational research in favor of corporate wellness. However, the positive impact of corporate wellness has been questioned due to methodological weaknesses such as lack of statistical control for health status, lack of adequate control groups (Caloyeras, 2018), regression to the mean (Linden, 2007), and selection bias (Song & Baicker, 2019). Two recent randomized controlled trials through the University of Chicago (Jones et al., 2019) and the Harvard Medical School (Song & Baicker, 2019) found no significant effects of structured wellness programs on medical expenditure, health status, or employment outcomes such as absenteeism and job performance. Although corporate wellness continues to grow, causal evidence of their impact on employer healthcare spending and employee health is scarce (Song & Baicker, 2021).

There is also growing concern about the employee engagement impact and compliance issues of wellness programs. Stringent programs that require participation in order to gain eligibility to the company health plan, base employee premiums on healthy biometric levels such as weight, cholesterol, and blood pressure, and compel health screenings that include family medical history have become more common. However, recent employee lawsuits claim that these types of programs are coercive and violate the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act (Miller, 2022). In addition, critics of corporate wellness programs claim that they shift costs onto low-income employees, unfairly burden those with chronic conditions, and most benefit already-healthy employees (Jones et al., 2019).

Direct primary care

Employers offer primary care-centric models such as direct primary care (DPC) to increase patient access to care, improve the quality of medical services, increase patient satisfaction, attract and retain employees, and control spending (Watts & Comaszewicz, 2020). In contrast to plan restrictions and wellness program participation, the central strategy of DPC is to control costs through enhancements to the PCP–patient relationship. Currently, 33% of large U.S. employers, up from 20% in 2010, and 16% of midsize companies offer a DPC/general medical clinic (National Association of Worksite Health Centers, 2022). In addition, an increasing number of employers are taking advantage of the 1,600 DPC practices across the U.S. Primary care-focused models are

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associated with lower spending by reducing inpatient and outpatient services, less emergency department use (Friedberg et al., 2010), improving the quality of healthcare services (Ellner & Phillips, 2017), improving coordination of care and care management (Budgen & Cantiello, 2019), avoidance of the high administrative costs in the traditional healthcare system (Tseng et al., 2018), and mitigating high increases in healthcare facility charges (see Cooper et al., 2019, for research on price increases for the privately insured population).

The Center for Medicare and Medicaid Innovation (CMMI) differentiates DPC from traditional care noting that DPC (a) provides enhanced access to physicians, (b) reduces administrative costs, and (c) emphasizes the central role of patient choice and empowerment (Centers for Medicare and Medicaid Services, 2018). The hallmarks of DPC are:

- Emphasis on prevention and patient-centered care
- Offering primary care appointments with no employee out-of-pocket cost
- Emphasis on primary care as first point of contact
- Maintaining continuity of care and comprehensive care
- Incorporating wellness, mental health, and chronic care model interventions
- Coordination of external care, including hospital and specialist services.

DPC employee outcomes

Eisenberger et al. (2016) outline the HR tactics that impact employee outcomes such as job satisfaction (JS) through their effects on perceived organizational support (POS). Specifically, discretionary and flexible individualized benefits, such as DPC, may convey the organization's positive valuation of employees, which in turn increases employee POS. As part of ongoing quality improvement activities, we surveyed employees of 10 employers utilizing the same DPC service on healthcare satisfaction as well as POS, health plan benefit satisfaction, and JS. Health plan satisfaction, POS, and JS were included in order to monitor and adjust DPC and employer plan attributes based on employee feedback. The employee surveys were voluntary and anonymous. Initial surveys were sent after enrollment in the DPC program but before the initial DPC physician visit. Follow-up surveys were sent on an annual basis after that. Survey data presented here include the initial survey and second-year survey responses. There are a total of 634 employee responses. There are 510 responses from employees registered into the DPC program but prior to their initial DPC medical visit. There are 133 responses from employees who are engaged with a DPC physician.

The following survey items were used.

- Patient Satisfaction Questionnaire (PSQ-18; Marshall & Hayes, 1994). The PSQ-18 is a shortened form of the 51-item PSQ-III and has been used in various settings including outpatient care. The PSQ-18 provides a global satisfaction score of medical care along with the subdomains of technical quality, interpersonal manner, communication, financial aspects of care, time spent with physician, and accessibility of care. In certain cases, items were removed at employer request due to survey length.
- Perceived organizational support measured by three items from Eisenberger's Scale of Perceived Organizational Support (Eisenberger et al., 2002).
- Job satisfaction was surveyed using the single item: *Overall, I am satisfied with my job.*
- Employer health plan satisfaction was surveyed using the single item: *Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?*
- View of employer was surveyed using the single item: *Has satisfaction with your employer and health plan improved after participating with your direct primary care doctor?*

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View of employer and group health plan

Survey responses indicate that DPC and onsite services have a positive impact on the employees' view of both the health plan and employer. After enrolling in the DPC program, but before their first physician visit, 64% of employees stated that satisfaction with their company and health plan improved because their employer offered this service. After at least one visit to the DPC provider, 91% stated that satisfaction improved. Prior to seeing the DPC physician, 71% were satisfied their health plan. After seeing the DPC physician, 92% were satisfied with their health plan.

Patient satisfaction

Our aim was to gain insight on how the DPC program impacts the general experience of healthcare under the employer group health plan rather than satisfaction with a specific medical encounter. For this reason, surveys were not administered as part of or following a physician visit. In addition, survey items were included that would not pertain to each medical visit. The survey item, "I have easy access to the medical specialists that I need" is a good example of this. Although individual encounters may not include specialist care or referral, we wanted to elicit employee perceptions about accessing specialists within the DPC model as compared to their experience prior to DPC participation.

Mean survey responses after participation in DPC services were higher for all patient satisfaction domains (i.e., financial aspects of care, access to specialists, time spent with provider, satisfaction with medical care, and convenient access to care). Prior to seeing a DPC physician, 74% of employees reported overall healthcare satisfaction. After engaging with a DPC physician, 93% of employees reported overall healthcare satisfaction.

In terms of subdomain score changes over time, the financial aspects of care and time with physician were markedly higher after engaging with a DPC physician. Healthcare affordability is strongly related to health plan satisfaction (America's Health Insurance Plans, 2018). In fact, when employees are dissatisfied with their health plan, 82% reported high cost as one of the main reasons. Prior to DPC participation, 38% of employees worried that medical care would set them back financially. After DPC participation, this number dropped to 16%. Because more time with the physician is a hallmark of DPC, it is not surprising that survey results reflected this. Prior to DPC, 72% were satisfied with the time that they spend with the physician and after at least one visit with their DPC physician, almost 90% were satisfied.

Perceived organizational support and job satisfaction

POS and JS scores were strong both before and after DPC involvement. However, after DPC physician engagement, there were gains in both areas. Prior to a DPC visit, 85% of employees reported higher levels of POS, which increased to 90% after engaging with the DPC physician. Similarly, 90% of employees reported higher JS prior to their DPC visit, which increased to 93% after.

Concluding thoughts and implementation considerations

In today's challenging market of attracting and retaining employees, the HR impact of any benefit change becomes critical. Certain healthcare spending control measures such as plan design restrictions and coercive wellness programs may be counter to an organization's employee engagement goals. In contrast, DPC enhances employee healthcare and is consistent with Eisenberger et al. (2016) suggested HR tactics for enhancing POS. Employee survey responses within this quality improvement project allowed us to measure and respond to employee perceptions of the program. Second-year quality improvement survey responses from DPC-

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participating employees demonstrates higher patient satisfaction, health plan satisfaction, and an enhanced view of their employer.

Due to the recent growth and wide range of DPC models, I-O practitioners interested in this approach will find a number of options available including onsite, nearsite, multi-employer shared, occupational only or general medical, hospital-based or independent, and provider credential preference (e.g., physician, nurse practitioner etc.). The DPC service referenced here has the following characteristics:

- Both onsite and nearsite offered
- Physician based
- Patient–physician relationship emphasized
- Independent (not health system owned)
- Employee has choice of PCP from large physician panel
- 24/7 access to PCP (supported by virtual, remote messaging)
- Nurse triage
- Same day appointments
- No employee out of pocket copays for physician visits
- Unlimited physician visits
- No employee out-of-pocket copays for common lab work
- All medical care coordinated through the DPC.

HR departments that choose DPC have access to a new realm of data and process. In traditional healthcare, HR evaluates and chooses the insurance company and/or network but has no input on individual providers. With DPC, HR may have a role in recruiting, selecting, and managing their company healthcare provider(s) and analyzing big data related to employee satisfaction, medical expenditure, and health plan optimization. As more employers contract directly for healthcare services, I-O psychology is uniquely suited to evaluate and guide this emerging employee benefits solution.

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