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The Failing Experiment Of Primary Care As A For-Profit Enterprise

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If you thought for-profit conglomerates were going to save primary care, maybe it is time to think again.

National primary care scorecards <https://www.milbank.org/focus-areas/primary-care-transformation/health-of-us-primary-care-scorecard/> document the increasingly imperiled state of primary care in the US, the result of decades of underinvestment. Calls for bold policy reforms to increase primary care payment and investment in practice infrastructure have failed to reverse the decline. The nation's spending on primary care as a percentage of total health care expenditures has continued to decrease and more primary care physicians are exiting patient care.

years have seen a slew of acquisitions of primary care practices <https://www.nytimes.com/2023/05/08/health/primary-care-doctors-consolidation.html> by large, investor-owned corporations <https://www.nejm.org/doi/full/10.1056/NEJMp2212841> . Private equity, which once shunned primary care in preference for more lucrative specialty practices, is also now accelerating the purchase of primary care practices <https://acrobat.adobe.com/link/review?uri=urn:aaid:scds:US:a1c57741-c7ee-3a21-bb10-26eed42b4584> . What are we to make of this new-found enthusiasm among investors and large corporations for primary care? Are they enlightened saviors of primary care, appreciating the need to invest capital in primary care to achieve a high-value health system? Or are they mainly eyeing primary care as an opportunity for extractive financial gains? In this article, we discuss the rapid waxing and, of late, waning of corporate investment in primary care, arguing that recent events are quickly dispelling hopes of these interests rescuing primary care.

Interpreting The Expansion Of Corporate Investment Into Primary Care

Walgreen's acquisition of VillageMD <https://www.fiercehealthcare.com/retail/walgreens-takes-6b-hit-q2-villagemd-investment> in 2021 marked a watershed for corporate investment in primary care. A flurry of multibillion dollar acquisitions soon followed, with Walgreens next acquiring Summit Health <https://www.fiercehealthcare.com/providers/walgreens-villagemd-inks-9b-deal-buy-summit-health-expand-healthcare-footprint> , Amazon purchasing One Medical <https://www.healthcaredive.com/news/amazon-closes-39b-buy-of-one-medical/643245/> (which had previously acquired Iora Health <https://www.fiercehealthcare.com/practices/one-medical-to-acquire-iora-health-2-1b-all-stock-deal>), and CVS purchasing Oak Street Health <https://www.healthcaredive.com/news/cvs-closes-oak-street-health-buy/649177/> and Carbon Health <https://www.beckershospitalreview.com/healthcare-information-technology/cvs-healths-vc-arm-invests-100m-in-carbon-health.html> . Walmart launched its own venture into operating primary care clinics <https://www.reuters.com/business/healthcare-pharmaceuticals/walmart-open-28-new-us-health-center-locations-2024-2023-03-02/> , while United Health's Optum subsidiary <https://hospitalogy.com/articles/2024-01-05/year-in-review-part-1-vertical-integration-dominates-payor-landscape/> steadily took a controlling interest in a growing number of primary care practices.

One interpretation of this phenomenon was that these corporations saw what other business interests failed to perceive—that despite current payment models disadvantaging primary care, the long game for creating high-value health care requires strong primary care. Investments in primary care would eventually pay off as the foundation of corporate-run integrated health care systems. That the early wave of acquisitions included many practices celebrated as innovators <https://catalyst.nejm.org/doi/pdf/10.1056/CAT.22.0032> only added to this notion. One Medical was highly regarded for its patient-centered and accessible care. Oak Street and Iora were admired for comprehensive, coordinated care for high-need Medicare beneficiaries. Carbon exemplified a virtual-first model of primary care emphasizing telehealth.

None of these innovative organizations appeared to be breaking even <https://www.washingtonpost.com/technology/2024/02/28/amazon-health-one-medical/> on the basis of clinical revenues. All relied on angel investors or other sources for start-up capital; some, like Oak Street and One Medical, had gone public. Perhaps the new corporate owners understood the need for ongoing investment to achieve high-performing primary care, or had the business acumen to operate efficient, high-quality primary care. Sponsorship of primary care clinics by giant retailers such as Walmart and the pharmacy behemoths was also viewed as potentially a virtuous direction for primary care, collocating services in convenient locations close to where people live and shop.

Corporate Exploiters

The alternative view was suspicious of the growing capture of health care delivery by investor-owned corporations and private equity. Adherents of this view pointed to evidence that such capture was driving up health care costs without improving quality <https://journals.sagepub.com/doi/10.1177/0020731420966976> (see here <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2795946> as well)—and in the case of private equity, in some instances it was harming quality <https://jamanetwork.com/journals/jama/fullarticle/2813379> . Rather than corporate and PE investors having genuine interest in strengthening primary care in service to patients, critics suggested they were interested in opportunities for primary care to serve short-term, extractive capitalist interests <https://www.economicliberties.us/our-work/medicare-advantage-and-vertical-consolidation-in-health-care/> . These opportunities include:

Entities such as Optum, Walgreens, and CVS are all part of (or affiliated with) corporations that include the nation's biggest for-profit health insurers. Insurers like United Health have far greater revenues from Medicare Advantage than from commercial lines of insurance. Medicare Advantage is highly profitable, with MedPAC <https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch12_MedPAC_Report_To_Congress_SEC.pdf> estimating that Medicare Advantage plans have manipulated risk adjustment scoring and patient selection to generate $83 billion in additional payments in 2024 relative to what traditional Medicare would pay for the care of similar patients.

If Medicare is the cash cow for these insurers, primary care is what brings the cow to the barn. Enrollment of Medicare beneficiaries in managed care depends on having primary care physicians to meet "network adequacy" requirements imposed by the Centers for Medicare and Medicaid Services.

Evading Limits On Medical Loss Ratio

The Affordable Care Act placed limits on what insurers could retain from premiums as overhead and profits, requiring a minimum proportion be spent on patient care (a metric that bears the insurance-company centric term "medical loss ratio"). One way for an insurance plan to evade this is to generously pay one of its subsidiaries delivering patient care—let's say for example, a primary care practice—and count this toward the medical loss expense. Profits from the subsidiary ultimately roll up to the parent corporate entity and its investors.

Loss Leader to Boost Retail Sales

Corporate retailers might tolerate primary care running in the red if it generated more green for retail sales by drawing customers into retail stores with collocated primary care clinics. For pharmacies, this includes sales of medications. This also applies to a huge online retailer like Amazon, which is developing its own online platform for pharmaceutical products.

Bricks And Mortar Savings

Purely (or mostly) virtual care primary care practices avoid the capital cost of clinical facilities, potentially making them a more financially solvent model. Detractors of the purely virtual model argue that companies put a veneer of convenient access on a model

savvy client population.

Corporate Retrenchment

The spring of 2024 brought a burst of headlines about corporations scaling back their primary care endeavors. Walgreen's will shut more than 160 primary care clinics <https://www.aha.org/aha-center-health-innovation-market-scan/2024-04-09-walgreens-shutters-160-villagemd-clinics-after-6-billion-loss#:~:text=Walgreens%20paid%20more%20than%20%245,locations%20inside%20its%20existing%20stores.> after posting a multi-billion dollar loss; Amazon is laying off One Medical employees <https://www.healthcaredive.com/news/amazon-one-medical-office-closures-layoffs/707082/> ; CVS, which bought Oak Street, is expanding primary care for seniors, but closing some of its minute clinics <https://www.wsj.com/articles/SB12366407439567732 9> ; and Walmart is closing all 51 of its health care centers across five states <https://www.reuters.com/business/healthcare-pharmaceuticals/walmart-close-51-us-health-centers-2024-04-30/#:~:text=Walmart%20(WMT.,sustainable%20business%20model%20to%20continue.> .

Closure of primary care practices linked with retail stores indicates to us a rethinking of the profitability of that strategy. Staff layoffs at One Medical may portend a reluctance to support a care model that cannot break even much less turn a profit under current primary care payment rates. Amazon is rethinking its standalone telehealth product <https://mhealthintelligence.com/news/amazon-combines-virtual-care-clinic-with-one-medical> and integrating it with its OneMedical clinics. With bipartisan sentiment <https://www.nytimes.com/2024/05/19/briefing/centrism-washington-neopopulism.html> growing in Congress to scrutinize Medicare Advantage plan profits and monopolistic behavior, we suspect that impending reforms of that program will push corporations and investors to reconsider the business case for investing in comprehensive, resource-intensive primary care.

In its press release <https://corporate.walmart.com/news/2024/04/30/walmart-health-is-closing> , Walmart stated, "This is a difficult decision, and like others, [we find that] the challenging reimbursement environment and escalating operating costs create a lack of profitability that make the care business unsustainable for us at this time." This is hardly the first time that large corporations have displayed overconfidence in being able to "fix" primary care. In 2018, fanfare accompanied the announcement by Amazon,

venture to revolutionize primary care. The life span of that venture <https://www.nytimes.com/2021/01/04/business/haven-amazon-berkshire-hathaway-jpmorgan.html> was three years.

The Way Forward

When Walmart, the corporation ranked number one on the Fortune 500 list, cannot achieve a successful business model for primary care, it reveals the root problems of thoroughly inadequate payment for primary care and underestimation of the work of primary care. Corporate and private equity investors—seeking extractive short-term financial returns and not committed to long-term investment—destabilize an already fragile primary care sector. Rapid start-ups and closures of primary care practices add turbulence to forces already buffeting communities dealing with declining access to primary care. The failing experiment of corporate, investor-owned primary care highlights the need for bold public policy to address primary care payment, infrastructure, and corporate ownership.

Payment

Existing payment policies woefully undervalue primary care. Several states have set, or are in the process of setting, targets to increase primary care investment. California, for example, has an ambitious goal of increasing primary care spending <https://stateofreform.com/california/2024/06/california-health-officials-discuss-10-year-plan-for-primary-care-spending/> to 15 percent of total state health expenditures, with current spending estimated to be about 6 percent. To achieve a tipping point, state initiatives must include most, if not all, payers. The Centers for Medicare and Medicaid Services should use its authority, through state waivers and the Innovation Center, to partner with states interested in implementing all-payer programs for primary care; these partnerships would commit private and public health plans to unified payment methods and rates for primary care to achieve higher-spending goals at scale. The longstanding Medicare waiver for an all-payer hospital payment program in Maryland is a precedent for this approach.

Infrastructure Investment

An alternative to corporate shareholders and private equity as a source of capital investment in primary care is needed—in essence, an American Recovery Act <https://www.gao.gov/blog/2019/02/21/the-legacy-of-the-recovery-act> to shore up

training and recruitment of interprofessional teams, practice facilitation, and related infrastructure needs. Precedents exist in federal grants to community and rural health centers and the Agency for Healthcare Research and Quality's primary care extension programs <https://jamanetwork.com/journals/jama/article-abstract/2819779> .

Federal and state governments should substantially increase appropriations for infrastructure programs and expand funding eligibility to physician-owned practices that meet strict eligibility criteria, such as participation in Medicaid and limits on profits for physician owners. These programs could include tax-credits or forgivable loans in addition to outright grants. Workforce is the most critical component of the primary care infrastructure. Federal and state governments already invest billions of dollars annually in graduate medical education and other training programs; greater accountability is needed to ensure that more of these funds are invested in primary care workforce development.

Regulating Corporate And Private Equity Ownership

The health care marketplace is an uneven playing field for smaller, physician-owned medical practices, which are disadvantaged by the consolidated economic power of large health systems and investor-backed enterprises. The recent decision of the Federal Trade Commission <https://www.ftc.gov/news-events/news/press-releases/2024/04/ftc-announces-rule-banning-noncompetes> to ban non-compete clauses in employment contracts is a positive step that will, for example, give physicians more control over employment options when a corporate employer closes primary care practices (assuming the rule survives legal challenges). Corporate Practice of Medicine laws that exist in many states must be tightened to rein-in maneuvers used by corporate and private equity interests to evade the intent of those laws, such as having a titular physician owner for a practice management company controlled by a larger corporate entity. State and federal policymakers and regulators should also consider more far-reaching measures <https://thehill.com/opinion/healthcare/4633316-unitedhealth-group-change-cyberattack-glass-steagall-act-healthcare-too-big-to-fail/> such as prohibiting for-profit insurance plans and their subsidiaries from owning physician practices. Several states are deliberating measures to curtail private equity <https://www.wsj.com/articles/state-private-equity-healthcare-takeovers-cb43f70b> ownership of medical practices.

In its 2021 report, Implementing High-Quality Primary Care <https://nap.nationalacademies.org/resource/25983/Highlights_High-Quality%20Primary%20Care-4.23.21_final.pdf> , the National Academies of Sciences, Engineering, and Medicine asserted that primary care is a common good. The economist Mariana Mazzucato recently articulated a conceptual framework <https://www.tandfonline.com/doi/full/10.1080/17487870.2023.2280969> positing that both market and state actors have roles to play in shaping and achieving collective goals for the common good, and explaining how extractive financialization of markets can undermine collective endeavors. Recent events make us pessimistic that for-profit corporate and private equity actors in the US can play a constructive role in advancing primary care as a common good. Much more assertive public policy is required to move the nation on a collective path to primary care for all <https://www.annfammed.org/content/21/2/180> .

Authors' Note

All three authors currently serve on the NASEM Standing Committee on Primary Care. The opinions expressed in this article are those of the authors and do not imply endorsement by, or official positions of, the NASEM Standing Committee on Primary Care or the authors' institutions. Dr. Grumbach is also a gubernatorial appointee to the California Health Workforce Training and Education Council, and the opinions expressed in this article do not represent official policies of that state advisory council.

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