A PUBLICATION FOR THE
DPC COMMUNITY
FROM MY DPC STORY

THE TOOLKIT

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2025

THE OPEN ENROLLMENT ISSUE

HOW TO PREPARE YOUR CLINIC
FOR OPEN ENROLLMENT.
TEMPLATES TO USE IN YOUR CLINIC!

DR. EMILY HOLT TALKS DPC IN NEW ORLEANS

THE BIG BEAUTIFUL BILL HAS PASSED...NOW WHAT?

HOW DPC DOCTORS FIND INSURANCE FOR THEMSELVES

WHERE HUMANITY MEETS DESIGN

PATIENT RESOURCES
AND MUCH MORE!

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IT'S OPEN ENROLLMENT TIME!

Maryal Concepcion, MD FAAFP

Helping you be prepared for the season ahead!

Every fall, coverage resets while life keeps moving. Formularies shuffle. Networks tighten. Employers re-bid benefits. Medicare mails plan-change letters. And by January 1, your patients want one thing: confidence that nothing important fell through the cracks.

Open Enrollment is when calm, relationship-based primary care **shines**. A few clear conversations now prevent a month of pharmacy surprises later. For Medicare patients, that starts with the Annual Notice of Change and the Oct 15–Dec 7 window to switch drug or Advantage plans (with a Jan 1–Mar 31 "do-over" for those already in MA). For Marketplace shoppers, most states open **Nov 1–Jan 15**.

Employers tend to renew in Q4, often with last-minute decisions that affect your panel overnight.

This issue leans into the practical: simple language for complex choices, lightweight checklists, and patient-ready handouts. Use them to align meds with formularies, steer referrals inside networks, and remind patients what DPC covers—and what insurance still handles—so expectations stay clean.

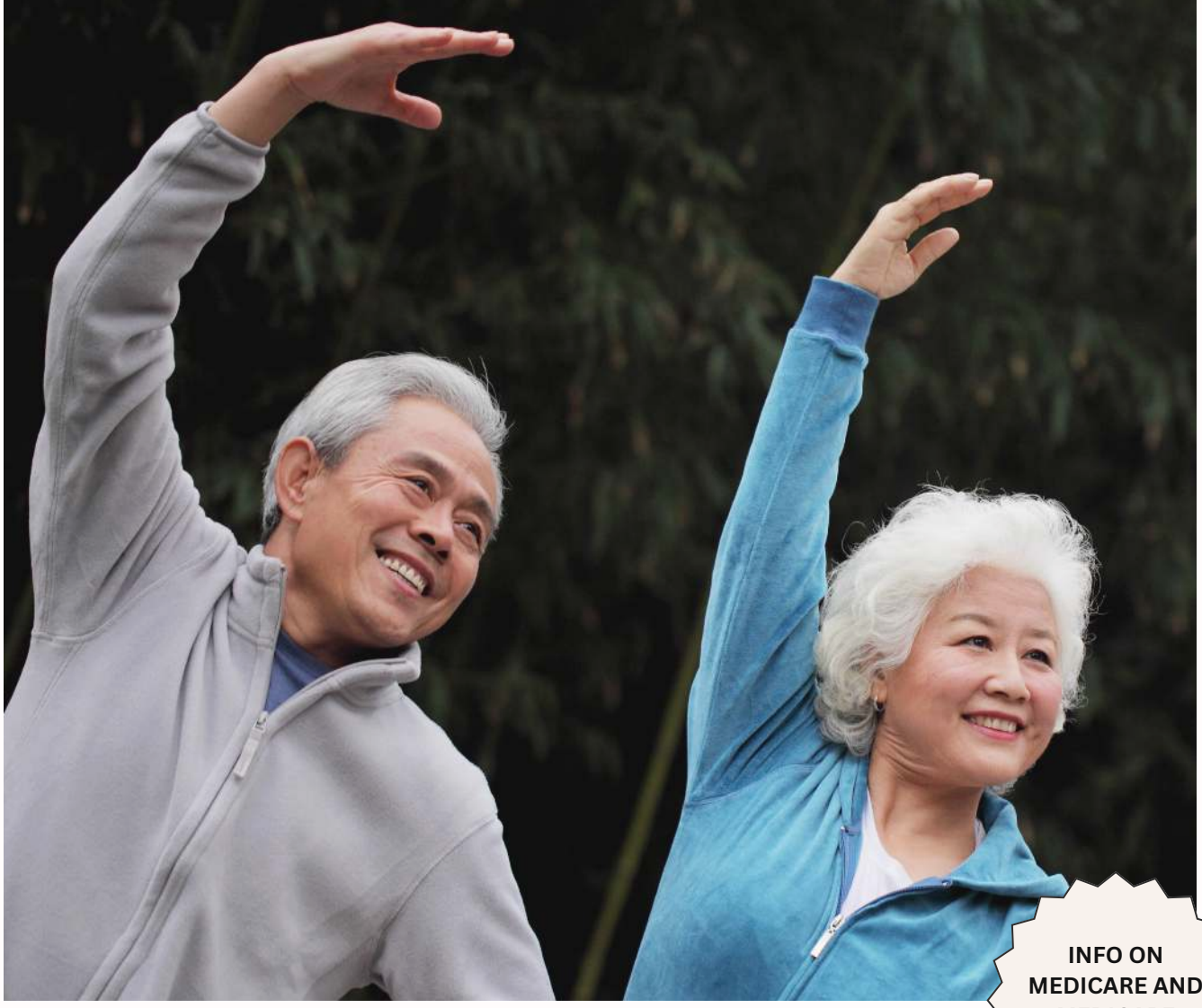
The goal here isn't to turn you into an insurance broker. It's to help you keep care steady while plans, prices, and policies change in the background.

In this edition:
You'll find resources to prepare your DPC for the open enrollment season!

- A talk track to triage patients with active prescriptions during open enrollment.
- An article on how DPC works with Medicare.
- A ready-to-use open enrollment messaging kit for your clinic.
- An open enrollment tracker to keep everything organized.
- A set of social media caption templates.
- A white-labeled option you can download and personalize for your own practice.

Here's to a smooth Open Enrollment and a quieter January!

~Maryal, Host and Creator of My DPC Story



INFO ON MEDICARE AND MEDICARE ADVANTAGE

How To

PREPARE YOUR DPC FOR JANUARY 1, 2026

PREPARE NOW

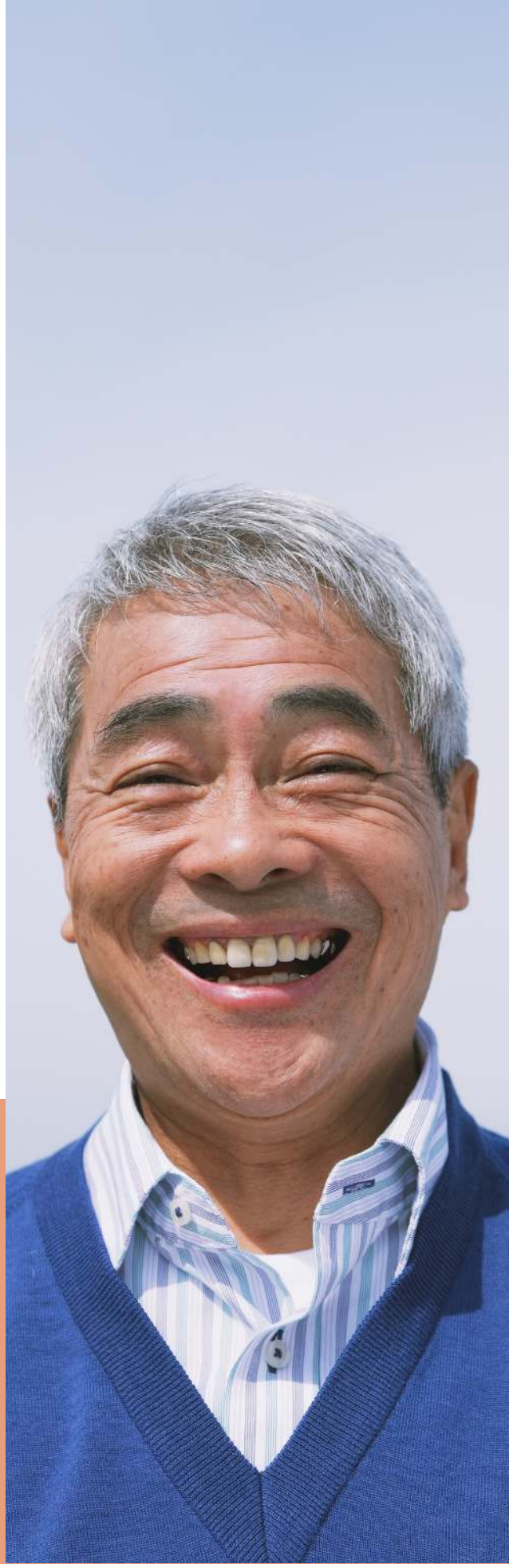
Picture this: it's late October. Your front desk has three voicemails that all sound the same—
"My plan changed… Do I need a new card?"
"My neighbor switched to Advantage—should I?"
"Why did the pharmacy charge me more this month?"
Open enrollment (Oct 15–Dec 7) is when your Medicare patients shop, switch, or stay put. What they really want is someone they trust to help them make sense of it—and that's you. Here's a simple, DPC-friendly way to get your clinic ready and keep January 1 smooth.

Put the real windows on your wall calendar

- Fall Open Enrollment (Oct 15–Dec 7): Patients can change Medicare Advantage (MA) and Part D drug plans for the new year.
- MA Open Enrollment (Jan 1–Mar 31): Anyone already in an MA plan gets a one-time "do-over" (switch MA plans or go back to Original Medicare and add Part D).
- Annual Notice Of Change (ANOC) letters (late Sept): Plans mail their Annual Notice of Change. That letter is gold—formularies, costs, pharmacies, all in one place.
    - ANOC DEFINED: This document is sent to Medicare Advantage and Part D (prescription drug) plan members each fall by their plan provider to inform them of changes to their plan's coverage, costs, and benefits that will become effective the following January.

TRY THIS 30-SECOND SCRIPT:

"Bring your ANOC letter and your med list to your next visit—or snap photos and upload them to the portal. We'll help you sanity-check your plan."



Give them the fast, plain-English drug update

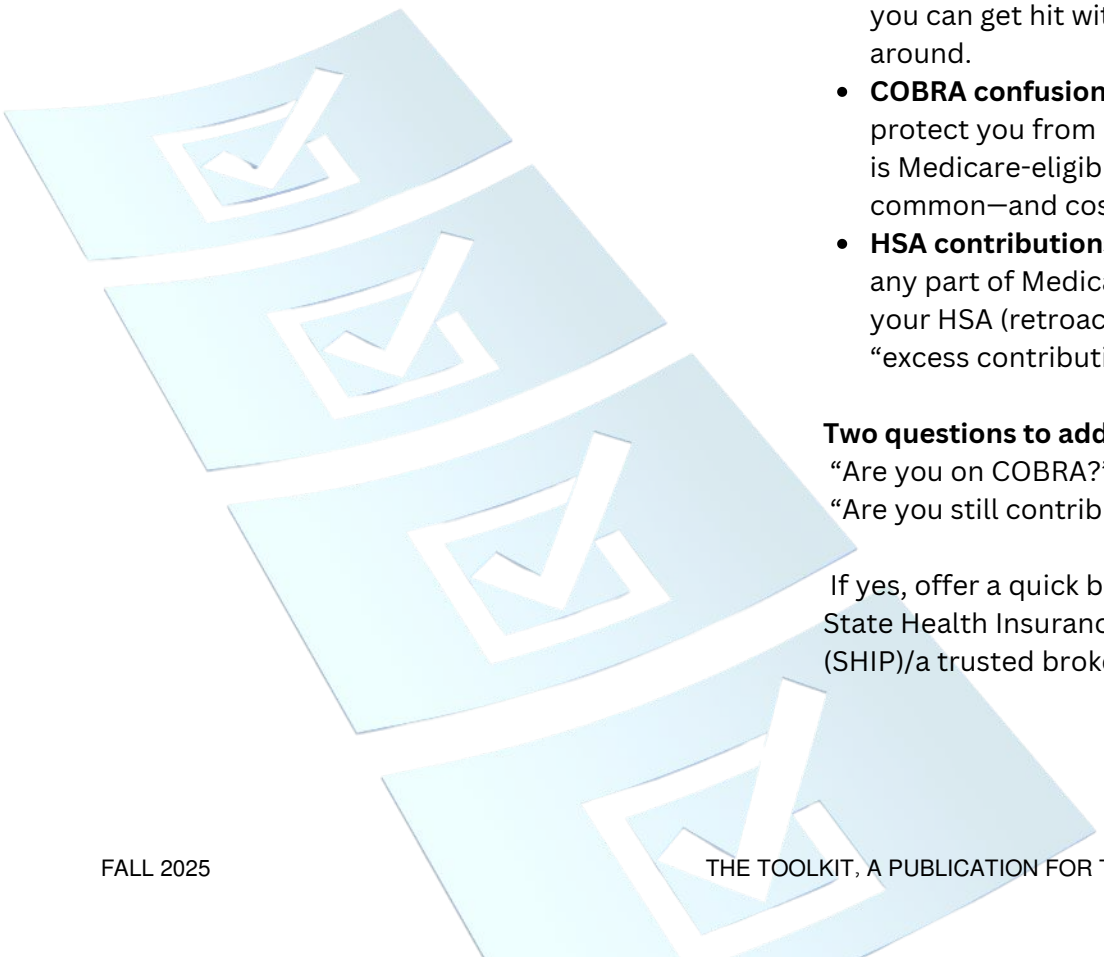
When patients ask, “Which is better—Original Medicare or Medicare Advantage?” try this framing:

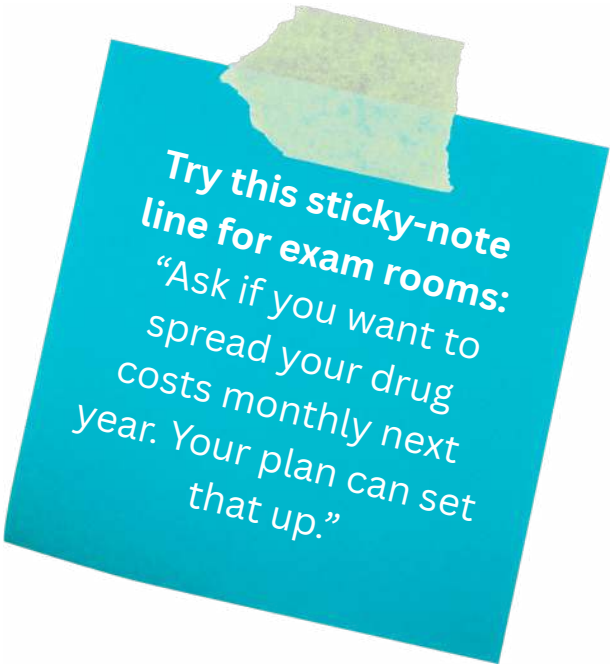
Original Medicare (+/- Medigap):
“Biggest provider freedom, fewer prior auth headaches. If you add a Medigap plan, it can cap your costs. You’ll pay more in premiums but get predictability.”

Medicare Advantage:
“Often lower premiums and extra perks (vision/dental/gym), but expect networks and prior auths. There’s a yearly in-plan out-of-pocket max, which some folks like.”

Reassurance that matters:

For those who have opted out of Medicare, here is a piece of reassurance that can work to put your patient’s mind at ease: “Either way, you can ***still*** keep me as your DPC doctor. Your membership is a private contract. Medicare still covers hospital care, specialists, imaging, vaccines, and outside labs.”





Guard them from the classic gotchas

A little prevention here saves your patients real money.

- **Late enrollment penalties:** Delay Part B or Part D without the right kind of coverage and you can get hit with penalties that stick around.
- **COBRA confusion:** COBRA usually doesn’t protect you from Part B penalties. If someone is Medicare-eligible, waiting on COBRA is a common—and costly—mistake.
- **HSA contributions:** As soon as you enroll in any part of Medicare, stop contributing to your HSA (retroactive enrollments can create “excess contributions”).

Two questions to add to your 64–68 intake:
“Are you on COBRA?”
“Are you still contributing to an HSA?”

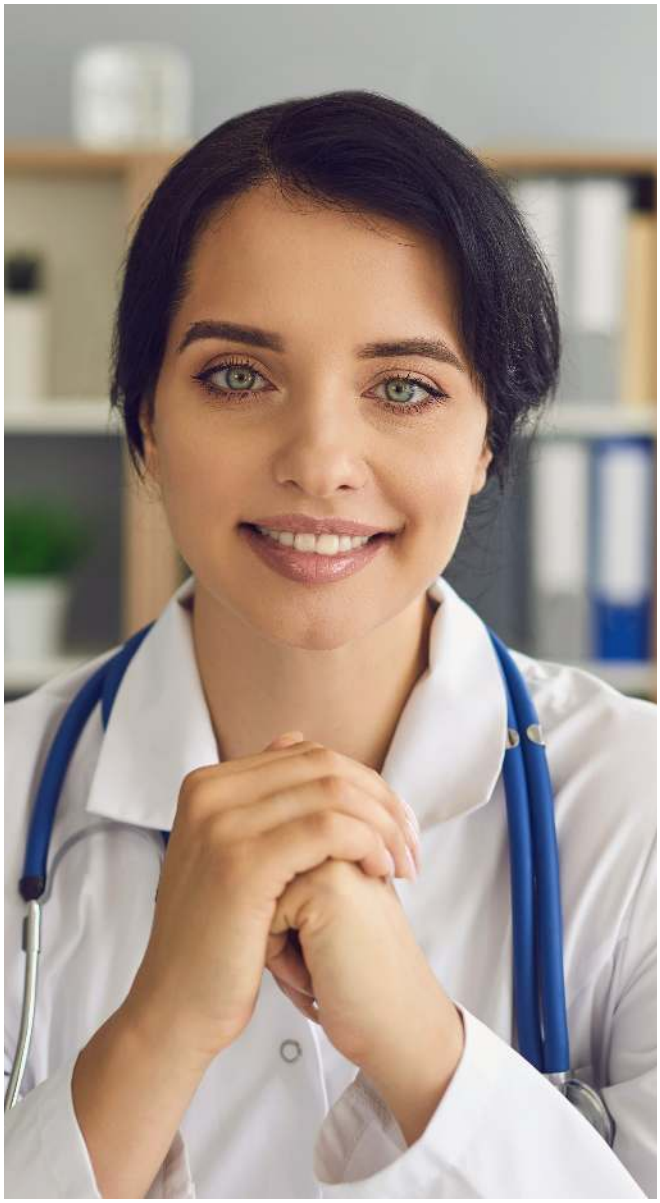
If yes, offer a quick benefits check or refer to State Health Insurance Assistance Program (SHIP)/a trusted broker.

Make Medicare + DPC crystal clear

This is where confusion turns into complaints if you're not proactive.

- Membership fees: Medicare doesn't cover DPC/concierge fees. Period.
- If you're opted out: You privately contract with Medicare beneficiaries and don't bill Medicare for those services. Keep your opt-out paperwork current and use the private contract consistently.
- Referrals and tests: Patients keep using Medicare (or MA) for outside services—specialists, imaging, vaccines, durable medical equipment, etc.

One-paragraph explainer for your welcome packet/website:
"Your DPC membership covers unlimited primary care with me. It's a private agreement and isn't billed to Medicare. You'll still use Medicare or your Medicare Advantage plan for hospital care, specialists, imaging, vaccines, and outside labs. We'll help coordinate all of it."



Point members to the right tools (so you don't become tech support)

- Medicare Plan Finder: Great for comparing MA and Part D plans based on their meds and pharmacies.
- SHIP counselors: Free, unbiased, local Medicare help for the deep-dive questions.

Tip: Have a one-pager at checkout or have this copy on your website: ***"How to use Plan Finder in 5 minutes"*** and add your local SHIP phone and website.

A 30-minute plan for your team to prep for the year!

In September

- Send a portal message: “Upload your ANOC + med list.”
- Open a few weekly 15-minute “coverage check” slots (tele or in-person).

Oct 15–Dec 7

- Prioritize patients on multiple meds, insulin, biologics, or specialty drugs.
- Ask if they want to spread drug costs monthly next year.

January–March

- For MA enrollees, schedule a quick “Is your plan working for you?” touchpoint. If not, they can use MA Open Enrollment (one switch allowed).

Year-round

- Keep your Medicare + DPC explainer visible.
- Refresh opt-out paperwork and private contracts if applicable.
- Keep a short list of trusted brokers and your local SHIP.

COPY-AND-PASTE MINI SCRIPTS

Phone/portal opener:

- “Open Enrollment runs Oct 15–Dec 7. Upload your ANOC letter and medication list so we can make sure your plan still fits.”

In-visit explainer:

- “Original Medicare gives the most freedom; Advantage can have lower premiums but more rules. Either way, you keep me as your DPC doc.”

Pharmacy pain reliever:

“If the register total surprises you in January, call us. Sometimes it’s a pharmacy or plan setting we can fix in five minutes.”

BOTTOM LINE

You don't need to be an insurance guru to be invaluable during open enrollment. A few timely prompts, a couple of good tools, and clear DPC-plus-Medicare messaging will carry most of your panel through January 1 without drama.

That's the DPC advantage: calm, relationship-based guidance when life (and coverage) gets complicated.

Want ready-to-hand answers? Share our **Medicare & Medicare Advantage Resource PDF** with patients and keep a staff copy at the front desk.

Find Additional Resources in our Open Enrollment Survival Kit:

- Open Enrollment Talk Track
- Patient One-Pager: "How DPC Works with Medicare" (print + portal)
- Email/SMS Template Pack
- Open Enrollment Tracker (Google Sheet)
- Social Media Templates (Canva)

GET YOUR COPY TODAY HERE

The Wait Is Finally Over

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My DPC Story
Open Enrollment Survival Kit

mydpcstory.com/openenrollment

SCAN ME

DPC at the Crossroads

Why the Time to Act Is Now

The Direct Primary Care (DPC) movement has achieved a watershed moment. With the passage of HR 1 (see section 71308)—within the so-called "Big Beautiful Bill" or "BBB"—Congress has officially amended the IRS tax code to allow Health Savings Account (HSA) dollars to be used for DPC services. It's a policy breakthrough that has been over a decade in the making, led by a bipartisan coalition of lawmakers and advocates, including policy expert and head of the DPC Coalition, Jay Keese.

This development is not the conclusion of the story—it is a strategic opening. The onus now falls on physicians, policymakers, and grassroots advocates to ensure that the regulations solidify DPC's role in a more patient-centered future.

The Policy Shift: Understanding HR 1 and the "BBB"

For years, the IRS classified DPC as a "second health plan," making patients ineligible to fund an HSA if they had a DPC agreement. The new law changes that. Beginning in tax year 2026, patients with high-deductible health plans can use pre-tax dollars from their HSA accounts to pay for DPC memberships, provided those fees remain under $150 per month and $300 for a family (indexed annually for inflation).

This change empowers:

- Employers to offer DPC as part of a benefits package.
- Patients on ACA exchange plans (bronze/silver) to access consistent primary care.
- More than 61 million Americans with HSAs to seek affordable, personalized care.

Why It Took So Long: A Policy Labyrinth

Jay Keese, head of the DPC Coalition, recounted the legislative journey at the 2025 DPC Summit. The IRS's interpretation dated back to the 2003 Medicare Modernization Act, which never anticipated the DPC model. While the Affordable Care Act and 34 state laws eventually recognized DPC as a non-insurance medical service, the IRS remained the last holdout. HR 1 corrects this misalignment. Senator Bill Cassidy, a physician himself and US Senator for Louisiana, spoke on the passing of HR 1 at the Summit which was held in New Orleans this past July. Senator Cassidy has been advocating for this fix since 2013. His leadership was instrumental in ensuring the provision's survival through multiple rounds of negotiations and fiscal scoring hurdles.

But Now What? Regulation, State Law, and Vigilance

With federal law changed, attention turns to the IRS, which must implement specific guidelines. Several questions remain unresolved:

- What qualifies as a "primary care service" under the $150 cap?
- Can labs or medications be bundled into DPC memberships?
- How will employer contributions and reporting work?

These regulatory details matter deeply. Jay Keese and coalition partners are already working with stakeholders like the American Bankers Association and large employer groups to ensure favorable interpretations. Yet federal recognition is only part of the equation. Only 34 states currently have laws affirming that DPC is not insurance. In the remaining 16, ambiguity or opposition persists. Advocacy at the state level is now urgent.

A Bipartisan Win in a Polarized Era

One of the most remarkable aspects of this policy victory is its bipartisan nature. From Senator Cassidy (R-LA) to former Representative Earl Blumenauer (D-OR), the DPC provision in HR 1 reflects rare cross-aisle consensus. As Keese noted, this is not about politics; it's about restoring value to primary care and giving patients more control over their health choices.

Medicare and Medicaid: The Next Frontiers

Keese outlined emerging advocacy efforts targeting Medicare and Medicaid. Currently, DPC physicians who opt out of Medicare cannot participate in any form of reimbursement. Efforts are underway to explore mechanisms similar to the SNAP program, where patients could use preloaded funds on qualified healthcare expenses, including DPC. In Medicaid, new work requirements tied to HR 1 offer an opportunity to integrate DPC into employer-provided benefits, especially for populations transitioning off Medicaid rolls.

What Physicians Must Do Now

This is not the time for passivity. The DPC movement must now consolidate its gains and prepare for the next battles. Physicians are urged to:

- Join the many DPC physicians and DPC Supporters of the DPC Coalition (dpcare.org)
- Participate in IRS comment periods and state-level legislative efforts
- Educate local employers, patients, and policymakers on what DPC offers
- Avoid bundling labs and medications into membership fees until regulations clarify

The "BBB" represents a milestone, but it is not the finish line. The law opens possibilities, but the shape of DPC's future will be determined by how we engage from here. With leadership from advocates like Jay Keese and policymakers like Senator Bill Cassidy, the foundation is laid.

Now it's up to us—as physicians, advocates, and innovators—to build on it, protect it, and ensure that DPC remains a force for meaningful, patient-first care. **The moment is now. Let's lead.**

Have questions? Join us for a LIVE WEBINAR about DPC, HSA and the future of healthcare policy. Join the DPC Coalition 11/6 1:30pm PST/4:30pm EST. Contact us to register at dpcare.org!

DR. EMILY HOLT: RESTORING THE SOUL OF MEDICINE, ONE PATIENT AT A TIME

It was a humid New Orleans morning in October when Dr. Emily Holt opened the doors of Poppy Direct Care, a practice built not just on medicine, but on relationship and humanity. For many, that phrase might sound like rhetoric. For Holt, it's a mission carved out of hardship, resilience, and radical hope.

As physicians watching the healthcare landscape bend under new bills, funding cuts, and systemic change, Holt's model offers both a compass and a question: What if we could return medicine to what matters most—people?

FROM EMT TO HEALER OF HEARTS

Dr. Emily Holt's journey isn't linear—but it is deeply rooted in service. Before medical school, she served as a full-time emergency medical technician in New Orleans, choosing the night shift where at least once nightly she might face gunshot wounds. Those adrenaline moments, the immediacy of life and loss, were formative. Then came Hurricane Katrina — an inflection point. Stranded with patients in the Superdome, with six feet of water rising, communication cut, resources scarce, Holt triaged, comforted, and was witness.

"IT MADE ME REALIZE HOW IMPORTANT RELATIONSHIPS WERE WITH THE PEOPLE I CARED FOR AND HOW MUCH I WANTED TO KNOW WHAT HAD HAPPENED TO THEM ... I WANT TO LIVE MY LIFE WITH THEM ALONGSIDE THEM." ~DR. EMILY HOLT

From that crucible, she turned toward primary care—not as a retreat, but as a deliberate choice. Emergency medicine had taught her urgency; primary care allowed her to tend to the ongoing pulse of life.

A CAREER WOVEN WITH PURPOSE AND STRUGGLE

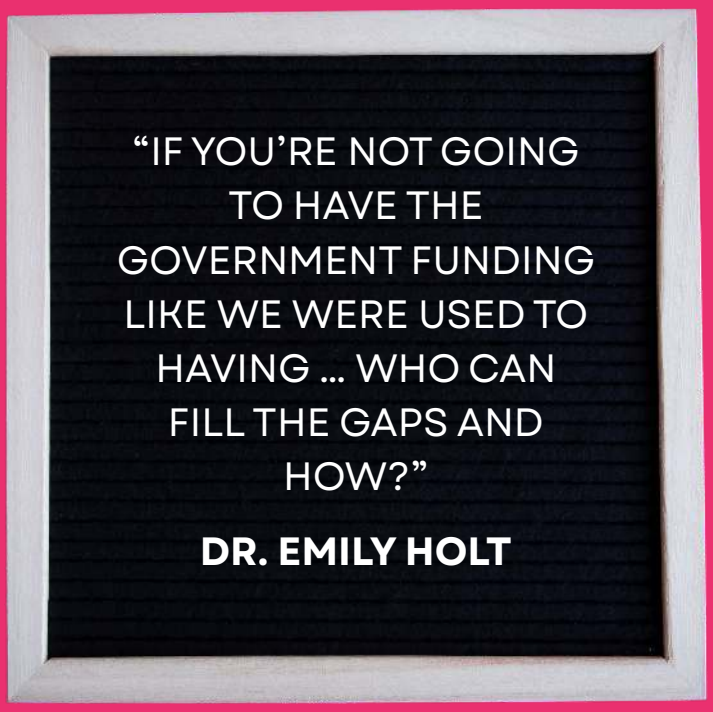
After residency in New York (Tulane undergrad + MPH at Tulane, then Virginia College of Osteopathic Medicine, followed by family medicine training at Columbia-New York Presbyterian) Holt returned to New Orleans to work at an FQHC. She loved the patients, but the system strained her. Twenty-plus patients a day, waking at 4 a.m. to finish charts, having to pick which medications a family could afford—these were the sacrifices. When her third child arrived, the fragility of that pace became unsustainable.

A period at Tulane's campus health center followed, where her patient population shifted: more young adults, more opportunity to educate, more ability to build trust. But still, Holt felt the tension of institutional constraints. Then, **Poppy Direct Care was born**: a practice where the weight of insurance, coding, bureaucracy, and funder constraints give way to time, trust, and spoken humanity.

WHAT IS POPPY DIRECT CARE?

Holt's practice is rooted in the Direct Primary Care (DPC) model.

- Patients pay a predictable monthly membership fee—not insurance—with uncapped access for primary, urgent, and reproductive health needs. (LGBTQ+ Healthcare Directory)
- Visits last 30-60 minutes, so there is time to dive deep—no rushed 10- or 15-minute "insurance-dictated" slot. (Poppy Direct Care)
- Communication is flexible: text, email, phone, telehealth, or in-person. (Poppy Direct Care)
- There is emphasis on inclusivity—a safe, shame-free space. Sexual and reproductive health, gender-affirming care, eating disorder work, being trauma-informed, etc., are part of the care. (LGBTQ+ Healthcare Directory)
- Cost transparency, discounted labs & pharmaceuticals. (Poppy Direct Care)



TURNING SYSTEMIC PRESSURE INTO INNOVATION

With sweeping policy changes (the so-called "big beautiful bill" and others), Holt is feeling loudly what many in DPC know: for many patients, access to care is being threatened—not just by lack of insurance, but by restrictive politics, shrinking funding, and shifting eligibility.

In her community: workers making $16/hr told they don't qualify for Medicaid, forced into marketplace plans with premiums they can't afford. Clinics worried about losing funds that sustained them, about not being able to serve people without insurance or documentation. Gender-affirming care under threat. FQHCs are fearful. Holt is not waiting for the perfect policy environment; she's building around it. One strategy: she's become an affiliate with Byja Clinic, a nonprofit DPC lead by Dr. Byron Jasper. Through that affiliation, she gains access to programs like publicly-funded rapid point-of-care testing for HIV, syphilis, Hepatitis C, and 340B pricing for pharmaceuticals. Through Byja, donations and pharmacy savings can help offset the cost of membership for patients who can't afford full fees.

LESSONS FOR DPC PHYSICIANS: WHAT WE CAN LEARN FROM DR. EMILY HOLT

As changes in healthcare intensify—more patients without insurance, more clinics under financial pressure, more inequality—there are practices from Holt's journey that other DPC physicians might adopt, adapt, or be inspired by:

Mission Clarity Anchors Everything

- Holt's early experience in EMS, her empathy from Katrina, her years in FQHC—all give her a moral backbone. A well-defined mission (e.g., "restore the doctor-patient relationship," "inclusive, shame-free care") helps guide hard choices: who to serve, what services to offer, how to structure pricing.

Flexible Affiliation & Collaboration Are Key

- You don't have to go it alone. Affiliating with a nonprofit that already has infrastructure (e.g. for lab or pharmacy pricing, for grant access) can allow economies of scale, better cost leverage, ability to serve lower-income persons. Holt's tie to Baija Clinic is one example.

Diverse Revenue / Funding Strategies to Protect Access

- Membership fees are core—but so are sliding scales, scholarships, nonprofits donations, benefactors. Recognizing that not every patient can pay full rate. Incorporating models like "Robin Hood" cross-subsidization within a membership base is one way to balance mission and sustainability.

Communication & Accessibility Are Non-negotiables

- Same-day or next-day appointments, flexible modes of communication, long visit times—these might feel luxuries but in fact are deeply efficient in patient satisfaction, in avoiding downstream costs (ER visits, complications), and in physician satisfaction.

Advocacy Is Practice-Level Medicine

- Holt is not only treating patients—she's at the table: with coalitions, legislative advocacy, working with the DPC community in Louisiana. DPC physicians can't assume policy is someone else's job. Knowing the bills, showing up to local/state meetings, being visible helps protect access for patients and the viability of the model.

Self-Care & Sustainability Matter

- Holt underscores that burnout risk was real—seeing 22-26 patients/day, sleepless hours, overwhelmed charting. **Choosing** a model that allows fewer patients, more depth per patient, time for family, rest—this isn't indulgence. It's essential to maintain quality of care long term.

What's Next—or What Must Shift

Holt acknowledges she can't fill every gap. She's scared. But she's hopeful. The work ahead involves building stronger DPC coalitions, clarifying regulatory and financial space for care outside insurance, pushing for policy that supports rather than hinders inclusive care.

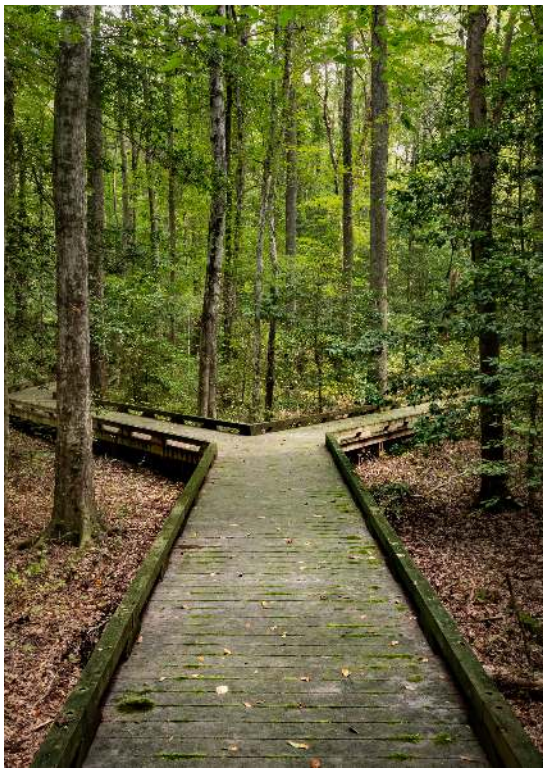
For physicians interested in DPC, this moment is both perilous and pregnant with possibility. The policy winds won't always favor us—but patients still need us. And when we show up with clarity, compassion, and courage, models like Poppy Direct Care shine through the storm.

Why Dr. Emily Holt Matters for Our Moment

Medicine in 2025 is not a rehearsal. The pressure points are public: access, equity, cost, and trust. For doctors committed to primary care, Dr. Holt's story is a template, a map, a fire. Her practice is not perfect—not yet widely profitable—but it is deeply real. For physicians in DPC, or considering it, there is in her work both a call and a permission: to care with intention, to invest in relationships, and to build models that prioritize humanity over bureaucratic ease.

THE MY DPC STORY substack

HEAR THE INTERVIEW WITH DR. HOLT SOON ON OUR SUBSTACK!



DPC AND MEDICARE: THE FORK IN THE ROAD

Maryal Concepcion, MD

The Direct Primary Care (DPC) movement thrives on freedom—freedom from third-party interference, freedom to prioritize patient relationships, and freedom to design sustainable, high-value care models. But when it comes to Medicare, that freedom requires a conscious choice: to opt in or opt out.

With the passage of the "Big Beautiful Bill" (HR 1), which opens the door for Health Savings Accounts (HSAs) to fund DPC memberships, DPC physicians are entering a new era of legitimacy.

Yet one crucial question remains: How should we handle Medicare? The answer depends on your clinic's mission, your patient mix, and your appetite for regulatory risk.

Understanding the Medicare Dilemma

Medicare was never built for the DPC model. Its fee-for-service (FFS) framework rewards volume, not value, and defines nearly every aspect of "covered care." This rigidity clashes with the DPC philosophy of personalized access and predictable pricing.

For DPC physicians, there are two main paths:

1. Stay "opted in" (participating or non-participating) — continue billing Medicare for covered services and exclude Medicare beneficiaries from DPC memberships, or
2. Opt out — sign formal private contracts with Medicare patients for covered services, freeing your practice from Medicare billing rules entirely.

Each path has its own risks, rewards, and implications for patient relationships.

Why Some Physicians Choose to Opt Out

Opting out is the cleanest legal way to serve Medicare patients directly within a DPC model. It allows you to:

- Provide care under private contract. Both physician and patient agree that no claims will be submitted to Medicare for covered services.
- Simplify compliance. Once opted out, you no longer have to track whether a service is "covered" or "non-covered." You can sleep at night without fearing an audit gone wrong.
- Retain clinical autonomy. You decide what care to provide and how much time to spend—not Medicare.
- Maintain continuity of care. You can still order labs, imaging, and prescriptions for Medicare patients, as long as your NPI remains active in PECOS.

Since the Medicare Access and CHIP Reauthorization Act of 2015, opt-outs are automatically renewed every two years—a welcome simplification for DPC physicians. Once you've filed your opt-out affidavit, your status persists until you actively revoke it.

For many, the decision to opt out follows months (or years) of patient demand. Practices often maintain a waitlist of Medicare patients eager to join once the physician completes the process.

The Case for Staying "Opted In"

For others, particularly those early in practice or dependent on hospital or locum work, opting out can close doors. Remaining "opted in" allows you to:

- Maintain flexibility for employment or side work. You can moonlight or take shifts in systems requiring Medicare participation.
- Serve a mixed patient panel. You can see younger DPC patients privately while billing Medicare for older adults in a traditional setting.
- Avoid administrative hurdles. The opt-out process requires contracts, affidavits, and strict adherence to private contracting rules.

However, if you choose to remain in Medicare but want to collect membership fees, the terrain becomes treacherous. You must only charge for non-covered services, and these must be clearly defined. Mislabeling even one covered service could trigger penalties under the Office of Inspector General (OIG) fraud statutes.

As the scope of "covered services" continues to expand—especially with new chronic care management and remote monitoring codes—maintaining a "non-covered services" model becomes a moving target.

Why "Playing Both Sides" Is Dangerous

Some concierge practices attempt a hybrid approach: billing Medicare for covered services while charging a separate membership fee for "non-covered" amenities. But as the OIG warned in a 2004 fraud alert, this approach can backfire if any of those amenities overlap with covered services. The lesson is clear: don't gamble with semantics.

If your goal is to serve Medicare patients within DPC's flat-fee model, opt out fully. If you plan to continue billing Medicare, avoid charging membership fees that could be construed as payment for covered care.

Medicare Advantage: The Gray Zone

A growing number of patients are enrolled in Medicare Advantage (MA) plans, and many DPC physicians wonder if these plans can reimburse for DPC services. Technically, no—once you've opted out, you and your patient have promised not to submit claims to Medicare.

However, some MA plans may choose to reimburse patients directly for out-of-network or "non-covered" services. The key is transparency: patients can submit your invoice and opt-out agreement, but reimbursement is not guaranteed.

Steps to Opt Out (the Right Way)

1. File an opt-out affidavit with every Medicare carrier in your jurisdiction (see aapsonline.org for templates).
2. Execute private contracts with each Medicare patient, separate from your standard DPC membership agreement.
3. Notify your patients and document your effective date (typically 30 days after filing).
4. Mark your two-year renewal window if you ever wish to rejoin Medicare.
5. Confirm your status via the CMS Opt-Out Database.

These steps formalize your independence and protect both you and your patients legally.

The Advocacy Horizon: Integrating DPC Into Federal Programs

As Jay Keese and the DPC Coalition have noted, the next policy frontier lens is, in part, Medicare and Medicaid inclusion. With HSA recognition now secured under HR 1, advocates are exploring models—similar to SNAP or HSA preloaded funds—that could allow Medicare beneficiaries to direct funds toward DPC memberships.

If successful, this would let physicians **remain opted out of the Medicare FFS bureaucracy while still enabling patients to use public dollars for their DPC care**—a potential game-changer for seniors seeking affordable, relationship-based primary care.

The Takeaway: Freedom Requires Clarity

Opting out of Medicare is not an act of rebellion; it's a strategic alignment with your mission. If your DPC model is built on transparency, access, and autonomy, opting out may be the cleanest way to protect both your values and your license. But if your practice depends on hybrid work, institutional affiliations, or a significant Medicare patient base, opting in—at least temporarily—can buy you flexibility while the policy landscape continues to evolve.

Whatever you choose, make it intentional, informed, and well-documented.

In this new era of DPC legitimacy, the goal isn't just to survive regulatory complexity—it's to shape the future of care itself.

Have questions about Medicare and DPC?

Join the DPC Coalition's upcoming webinar, "DPC, Medicare, and the Next Frontier in Healthcare Policy," on **November 6 at 1:30 PM PST / 4:30 PM EST.**

Register now at dpcare.org.

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Hosted by FlexMedStaff and My DPC Story

Dr. Holly Shen, OBGYN
Physician Co-Lead FlexMedStaff

Nearly 20 years ago, as an OBGYN resident, I could never have imagined the shape my professional life would take. To be fair, the healthcare landscape itself is nearly unrecognizable. What remains constant, however, is my deep commitment to caring for pregnant and gynecologic patients.

Like many of us, I spent the first seven years of my career working relentlessly—on the proverbial hamster wheel, giving my all for systems that rarely gave back. Over time, the slow but persistent advance of corporate medicine and private equity drained the passion that had once fueled me. I came to realize that the secret to a sustainable and fulfilling career in medicine is staying closely aligned with your own sense of purpose—and being willing to adapt.

Truthfully, it's not the patients or the medicine that have changed. It's the system, and how Physicians are too often treated as interchangeable cogs in a machine. No one is coming to save us - it's time to save ourselves. For me, that meant saving grace was stepping into life as an independent physician contractor. Working as a critical access locums OBGYN, I rediscovered professional autonomy, flexibility, negotiating power, financial opportunity, and—most importantly—joy in patient care. I now have the freedom to give my full commitment to my patients while on shift, and to my family when I'm home. That balance is invaluable. As the healthcare system continues to shift, Physicians remain its most essential asset. Yet we are seeing more and more colleagues leave medicine altogether, burned out and disillusioned. Now is the time to pivot. The challenge? Most of us are never taught how. That's why those of us who have found success through innovation feel a deep responsibility to share what we've learned. That's why Dr. Aaron Morganstein, (orthopaedics) myself and other committed Physicians built **FlexMedStaff**—the first and only educational platform by Physicians, for Physicians, created to empower independent career paths in medicine. We are building a knowledge base to help Physicians break free from outdated models and explore innovative, sustainable work options. Our offerings extend across beginner to advanced topics in locums and agency "how-to", barriers to leaving employment, contract negotiation, tax strategies and more. Every aspect of becoming a successful independent Physician contractor is covered. In alignment with our mission, we've partnered with **My DPC Story**, a leader in the Direct Primary Care movement. This collaboration reflects our shared commitment to advancing Physician-led, patient-centered care while creating meaningful professional freedom.

We invite you to join us this October for the first ever RiseUp Physician Summit—a groundbreaking virtual event bringing together visionary Physicians from across the country. This is a space to learn, connect, and be inspired by others who are redefining how medicine is practiced and experienced.

It's time to reclaim your purpose, rediscover your passion, and reshape the future of medicine—*on your terms*.

https://flexmedstaff.com/rise-up-physician-summit/

Health Shares and the Self-Employed: Exploring Alternatives During Open Enrollment

As open enrollment season unfolds, many families and self-employed professionals — including Direct Primary Care (DPC) physicians — are weighing their healthcare options. With insurance premiums continuing to rise, health share plans have become a growing topic of interest. These member-based programs, often faith- or community-driven, pool monthly contributions to cover one another's medical expenses. But how do they really work, and who might benefit most?

What Health Shares Are — and What They're Not

Health share plans (or healthcare sharing ministries) are not insurance. Instead of paying premiums to an insurance company, members contribute a monthly "share" that's distributed to help pay other members' eligible medical bills. Popular examples include Liberty HealthShare, Medi-Share, Samaritan Ministries, Zion HealthShare, and Sedera.

While these plans often cost significantly less than traditional health insurance, they operate outside the Affordable Care Act (ACA). That means they don't have to cover essential health benefits, accept pre-existing conditions, or guarantee payment. Participation typically involves lifestyle or belief statements — for example, maintaining tobacco-free living or faith-based community standards.

While these plans often cost significantly less than traditional health insurance, they operate outside the Affordable Care Act

Recent Developments and Regulation
Recent scrutiny, such as the Sedera settlement, highlights both the promise and pitfalls of the health share model. Sedera, a non-profit administrative vendor, settled with regulators over concerns about transparency and marketing practices. The outcome emphasized the need for clear communication, transparent guidelines, and member education.

Meanwhile, newer organizations like Zion HealthShare have adopted more modern, non-denominational frameworks and clear member guidelines outlining what's eligible for sharing, waiting periods, and cost-sharing limits. Zion, for instance, separates "Initial Unshareable Amounts" (the member's portion before costs can be shared) from other fees, helping members understand their potential out-of-pocket exposure.

The DPC Connection: A Natural Fit
For many Direct Primary Care physicians and patients, health shares complement the DPC model beautifully. DPC covers routine and preventive care directly with your doctor for a flat monthly rate, while a health share plan can step in for unexpected, high-cost events — surgery, hospitalization, or trauma care. This combination helps individuals bypass insurance bureaucracy while still having a financial safety net for larger expenses.

When a Health Share Makes Sense — and When It Doesn't
Health shares can work well for:

- Healthy, self-employed individuals who want catastrophic coverage without the high cost of insurance.
- Families comfortable with community-based cost sharing and transparent guidelines.
- DPC patients who already have routine care covered and need protection for emergencies.

However, those with chronic conditions, ongoing medication needs, or who prefer the security of federally regulated coverage may be better served by a Marketplace plan.

How to Shop the Marketplace if You're Self-Employed

If you're self-employed — whether a DPC physician, consultant, or independent contractor — you can enroll in individual coverage through the Health Insurance Marketplace®. You'll estimate your net self-employment income to see if you qualify for premium tax credits or cost-sharing reductions. Plans range from high-deductible, low-premium "catastrophic" coverage to comprehensive plans with lower out-of-pocket costs.

You can also check eligibility for Medicaid or CHIP based on income and household size. For self-employed clinicians, this is a smart way to secure ACA-compliant coverage while maintaining control of your healthcare delivery model.

The Takeaway

Health share plans can be a useful bridge between affordability and autonomy — especially for DPC practices and patients seeking flexibility outside the traditional insurance system. But because they lack ACA protections, it's essential to read the fine print, understand exclusions, and verify the organization's transparency.

Whether you choose a Marketplace plan, a health share, or a DPC-plus-share hybrid, the goal is the same: maintaining access to care without sacrificing financial peace of mind.

Zion HealthShare + DPC Affordable Care That Works Together

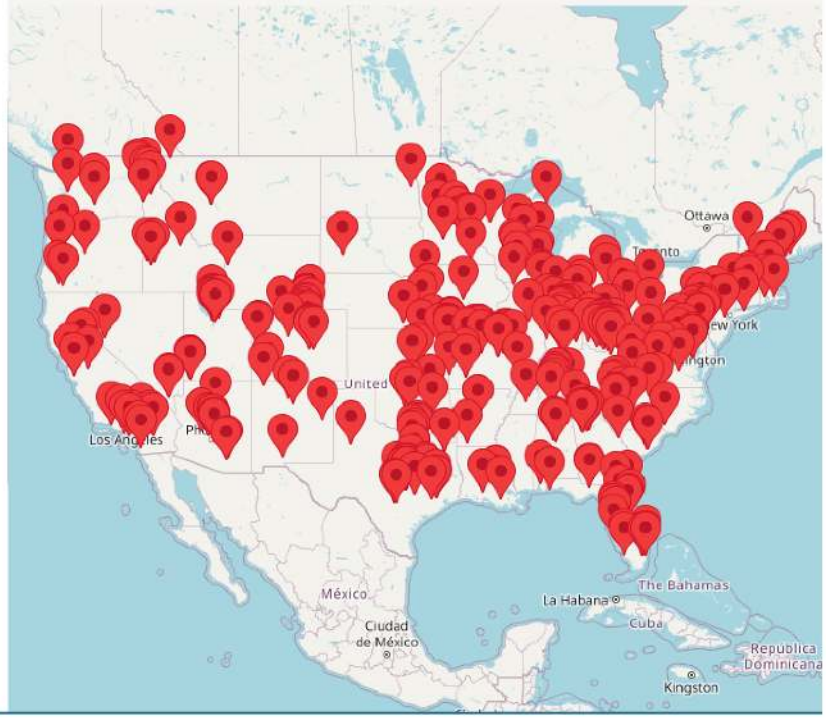
EXPANDING WHAT YOUR PRACTICE CAN DO FOR PATIENTS

Direct Primary Care has already transformed how patients access healthcare. You provide affordable, relationship based care without the interference of insurance. At Zion HealthShare, we share your commitment to patient centered healthcare and we step in where your care ends.

Our nonprofit health sharing community helps with larger, unexpected medical expenses such as hospital stays, surgeries, and emergencies. When paired with your practice, patients can rely on you for everyday care while turning to Zion HealthShare for major medical needs. Together, this creates a complete and cost effective solution that keeps patients engaged with you while protecting them from high healthcare costs.

We want to help your practice thrive. DPC practices can be listed on our national DPC map so Zion HealthShare members can find and join your practice. We also provide brochures and posters you can use in your office to introduce Zion HealthShare to patients who need support beyond routine care. By working together, we can strengthen independent practices and give patients peace of mind at a fraction of the cost of traditional insurance.

*To be added to our DPC map call **(888) 920-9466** option 5 or email **affiliate@zionhealthshare.org.***



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DPC DOCTORS ANSWER:

What do you do for health insurance?

My family has health insurance through the small business that my husband owns. He pays a small fortune for this insurance though, so we are always eager to learn better ways to give his employees and their families access to great medical care.

DR. JACLYN HARRIS OF DESERT DPC

We need to talk. I practice what I preach, have a plan set up for my own family, and (full disclosure) have a husband who is an expert who has helped guide other direct care docs to find the health coverage solutions for both their families and their practices.

DR. GRACE TORRES-HODGES OF TORRES HODGES PODIATRY

I'm very fortunate that my husband works for our state university and so we have very good health insurance through him.

Before I left my urgent care practice, I was able to transfer over other benefits like my 401k and life insurance into a private benefit fund, so I was able to make a clean break with my salaried practice.

DR. JO ANN BELTRE OF WANDERCARE PEDIATRICS

My spouse has insurance for us through his company, USAA. But we still do DPC. When I was solo, we paid for a subscription to other DPC in the area, but now that I have partners my family sees them.

DR. JENNA SILAKOSKI OF NORTH IDAHO DPC

HUMANITY MEETS DESIGN:
A DIALOGUE ON THE FUTURE OF DIRECT-PAY MEDICINE

KALLI ORTEGA, BENEFITS ADVISOR OF MISSION-ALIGNED HEALTHCARE AT MELEOS GROUP

THE FALSE PREMISE OF A "BROKEN SYSTEM"

For decades, healthcare has been described as "broken." But what if the truth is more uncomfortable? *The system isn't broken—it's operating exactly as designed.* The issue isn't mechanical failure; it's diagnostic failure. We've been treating symptoms without identifying the root cause—or even clarifying what we're optimizing for.

Each legislative patch, compliance fix, and billing reform was a well-intentioned attempt to repair dysfunction. Yet these cumulative fixes have created a system that now perfectly serves bureaucracy while exhausting the humans within it. If we are to reclaim the humanity of healthcare, we must do more than repair. We must redesign.

Direct Primary Care (DPC) and the broader direct-pay movement represent that redesign in motion. They are not rebellion; they are recovery—an intentional act of restoring medicine around relationships, not transactions.

THE HUMAN COST OF DESIGN BLINDNESS

The fee-for-service model didn't just distort care delivery; it rewired identity. Physicians became productivity units. Patients became line items. In speaking about this shift with Dr. Maryal Concepcion, she once said to me:: "I became a doctor to care for people, not to feed algorithms.

Technology can serve, but it cannot substitute for the human relationship that defines healing." This has stuck with me.

This isn't an argument against technology—it's a call to realign it. When we automate dysfunction, we multiply harm at scale. The work of DPC and direct-pay specialists is to restore the relational architecture of medicine—where care is personal, trust is earned, and outcomes reflect human flourishing.

FROM COMMODITIZATION TO CONNECTION

As DPC gains traction, it faces a new challenge: becoming commoditized by the very market it sought to liberate itself from. Aggregators, venture-backed

> ***Kalli Ortega***
>
> *If we are to reclaim the humanity of healthcare, we must do more than repair. We must redesign.*

networks, and employer plan integrations can unintentionally turn physicians into interchangeable vendors.

I feel that trust is the new currency,. And it's earned through excellence, clarity, and continuity of care.

The antidote to commoditization is not scale—*it's differentiation rooted in identity*. DPC physicians must document who they truly serve: employers, individuals, or both. Your trust position must be visible in your materials, your words, and your contracts. If you don't define that position, the market will define it for you.

CONCIERGE NAVIGATION: THE MISSING METRIC

Healthcare's greatest cost isn't always financial—it's cognitive. The average patient spends hours navigating phone trees, redundant paperwork, and fragmented systems. Every minute of confusion is a minute of disengagement.

There's a difference between navigation, concierge, and concierge navigation. Most navigation solutions outsource the human part. DPC was built to own it.

Concierge navigation means proactively guiding patients through every care step—closing referral loops, ensuring records flow, confirming follow-ups, and shielding them from bureaucratic friction. For employers, this translates to something measurable: restored productivity and emotional bandwidth.

Track how long it takes to close referral loops. Measure hours patients spend coordinating care. Each metric is both a business KPI and a humanity indicator. The return on that investment is trust and engagement—the most undervalued ROI in healthcare.

Follow one patient's referral journey from start to finish. Document every friction point. How many could you eliminate tomorrow with one hire or better alignment? That exercise alone could redefine your value to both patients and employers.

Kalli Ortega

...deliver something that can't be bought or automated: stability that feels human.

CONTINUITY IS CREDIBILITY

Continuity is the cornerstone of trust. Yet many DPC practices unintentionally undermine it by operating as single points of failure. For employers, that's risk. For individuals, that's instability.

Employers don't expect perfection—they expect reliability and results. Individuals expect excellence. But excellence loses its meaning if it comes at the expense of trust, communication, or continuity.

Excellence isn't intensity—it's consistency paired with care. It's knowing that if something happens to you, your patients won't be left stranded. It's ensuring the relationships you build endure through transitions of care and employment alike.
Employers aren't afraid of small—they're afraid of *fragile*. A simple continuity plan—a trusted backup clinician, transparent coverage protocol, or written transition policy—can convert independence into credibility.

When you pair continuity with concierge navigation, you deliver something that can't be bought or automated: *stability that feels human.*

CULTURAL CALIBRATION: DESIGN THAT RESPECTS CONTEXT

What works in one geography or industry may not work in another. The Rosen Hotels model thrives in Orlando, and Ashtabula's near-site clinic transformed a rural healthcare desert—but both would fail in a dense urban setting where privacy concerns run deep.

Healthcare design must respect the culture it serves. Privacy isn't just technical—it's psychological. Before you design anything, map the trust boundaries of your population. What feels safe to them? What signals surveillance? A therapist embedded within an employer clinic may look efficient on paper—but to an employee who doesn't want to be seen walking in, it's a barrier, not a benefit.

Map the psychological trust boundaries of your target population. What feels safe to them? What signals intrusion? Design accordingly.

REDEFINING VALUE FOR EMPLOYERS AND CLINICIANS

Employers seek reliability and results. Clinicians seek autonomy and sustainability. The bridge between them isn't price—it's alignment. Tust positioning and continuity planning are your differentiators. These demonstrate reliability without corporate overhead, and humanity without inefficiency. When employers see that you solve for both engagement and outcomes, they stop comparing you to a PPO network—they start seeing you as infrastructure. One strategy to try is to craft a one-page visual comparing your direct-pay model's outcomes (time saved, navigation friction removed, continuity preserved) to the traditional plan experience. Show it, don't just explain it.

DESIGNING THE FUTURE: HUMANITY AS THE LOAD-BEARING WALL

The future of medicine isn't less human—it's more intentionally designed. Technology will accelerate it. Data will validate it. But only human beings can anchor it.

DPC and direct-pay specialists aren't rebelling against healthcare—they're re-architecting it from first principles. They're asking what we should have asked decades ago: What are we optimizing for? The answer, finally, is trust, continuity, and care.

Redesign isn't rebellion—it's recovery. Humanity isn't an inefficiency; it's the load-bearing wall of any system that hopes to endure.

Audit your continuity and trust statements—are they visible, documented, and embodied? Track your navigation metrics—time saved, loops closed, patients retained. Calibrate your model to your community's cultural and psychological realities. Partner only where philosophical alignment is clear - where others are designing for integrity, not expedience.

The future of medicine will belong to those who design for it—and design with humanity as their foundation.

Connect with Kalli Ortega on LinkedIn.

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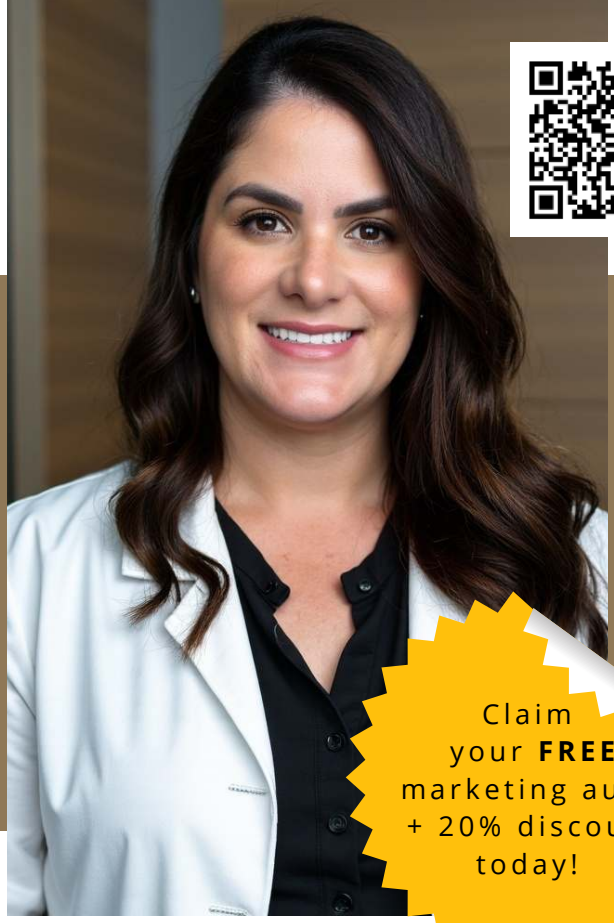

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The My DPC Story Open Enrollment Survival Kit was created for physicians who live and breathe DPC — to help you navigate the chaos with clarity, connection, and calm.

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- Plug-and-play email + text templates
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Built from real-life practice experience at Big Trees MD (Dr. Maryal Concepcion's practice), tested in the trenches, and designed to save you hours.

This is your season to stand out, educate, and grow — while everyone else scrambles.

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Advocating for our patients.

Lessons from Christy Snodgrass, RN and Patient Advocate

When **Christy Snodgrass, RN** began her career as an oncology nurse, she thought her mission was simple: provide compassionate care for patients facing devastating diagnoses. But what struck her most was not only the suffering caused by cancer itself, but the crippling financial toxicity that followed. Patients she treated often left the hospital only to organize fundraisers so they could afford their next round of chemotherapy. "I'll never forget watching a young woman with cancer stumble into her own barbecue fundraiser," Snodgrass recalls. "She was pale, immunocompromised, wearing a mask, but she was cooking food just to raise enough money to keep living."

That moment—and countless others like it—drove Snodgrass to shift her focus. She began investigating why care cost so much and why nonprofit hospitals could not explain their own charges. What she discovered was a system built on complexity and confusion, where patients had little chance of survival financially, even if their medical treatment succeeded.

Today, Snodgrass is not only a leading patient advocate, but also a Direct Primary Care (DPC) patient herself. Through her platform **HealthcareReformed.org**, she provides resources to help patients—including those in DPC practices—navigate the rest of the healthcare system.

While DPC solves many problems, such as access to a trusted physician and transparent primary care pricing, it doesn't always eliminate costs for hospital care, labs, imaging, or prescriptions. That's where her Patient Resources library comes in.

Why Resources Matter for DPC Patients

Direct Primary Care is a growing model that eliminates insurance middlemen from primary care. Patients pay a monthly membership fee and, in return, get unlimited access to their doctor, extended visits, transparent procedures, and direct communication.

But DPC patients still interact with the traditional system for:

- Specialty care (oncology, cardiology, surgery)
- Hospitalizations and emergency care
- Labs, imaging, and prescriptions outside of the clinic
- Unexpected bills when insurers or hospitals overcharge

Snodgrass recognized that many patients—herself included—needed practical tools to avoid being overwhelmed by these extra costs. Her Patient Resources page curates trustworthy organizations, discount programs, and advocacy templates that anyone can use.

Medical Debt Relief and Advocacy

One of the most powerful tools she highlights is Dollar For, a nonprofit that helps patients apply for—and enforce—hospital financial assistance programs. Many hospitals, especially nonprofits, are legally required to offer charity care or discounted billing based on income. Yet few patients know these programs exist, and hospitals rarely advertise them.

- Even with DPC memberships, hospitalizations and surgeries can generate overwhelming bills. Dollar For guides patients through applications, appeals, and negotiations, often erasing thousands of dollars in debt.

Other advocacy tools on her site include bill negotiation services and appeal templates, giving patients a way to challenge errors or unfair charges. By empowering individuals to push back, Snodgrass creates accountability for hospitals and insurers alike.

Prescription Savings

Medications are another area where DPC patients face high costs—especially when pharmacies and insurers inflate prices. HealthcareReformed.org lists programs such as:

- GoodRx and Cost Plus Drugs, which provide transparent, cash-based prescription pricing.
- Manufacturer assistance programs for patients who qualify.
- Direct-to-consumer pharmacies that bypass insurance and offer wholesale rates.
- Many DPC clinics dispense common medications at wholesale prices. But for drugs not stocked in-house, these programs prevent patients from overpaying at the pharmacy counter.

Imaging and Labs

Snodgrass also curates resources for low-cost labs and imaging centers, including independent radiology providers and direct-pay lab services. Patients can compare prices and often pay a fraction of hospital rates. While DPC memberships cover primary care labs like strep or flu tests, more complex labs (lipid panels, hormone testing, MRIs, CT scans) are usually referred out. Knowing where to find cash-based or discounted rates makes care more affordable and predictable.

Snodgrass recognized that many patients—herself included—needed practical tools to avoid being overwhelmed by these extra costs. Her Patient Resources page curates trustworthy organizations, discount programs, and advocacy templates that anyone can use.

Understanding Insurance When You Still Need It

Even though many DPC patients pair their membership with high-deductible health plans (HDHPs) or catastrophic coverage, most don't fully understand how their insurance works. Snodgrass provides education guides on terms like deductible, copay, coinsurance, and balance billing.

- Understanding the basics of insurance helps patients avoid paying bills they don't owe, identify mistakes on their Explanation of Benefits (EOBs), and use insurance strategically for the big expenses DPC doesn't cover.

Upcoming Policy Changes: A Win for DPC Patients

Snodgrass also tracks legislative changes that impact DPC. Starting January 1, 2026, federal rules will allow DPC membership fees to count as qualified medical expenses. That means patients will be able to pay their DPC fees with Health Savings Accounts (HSAs) and apply them toward deductibles and out-of-pocket maximums.

- This is a major step toward making DPC accessible to more patients, especially those with employer-sponsored high-deductible plans.

Building a Smarter Patient Community

What makes Christy Snodgrass unique is that she isn't just an advocate speaking from the outside—she's living this system as a DPC patient herself. She knows the relief that comes from having a physician who works directly for you, but she also knows the frustration of navigating everything else.

Her mission is to arm patients with knowledge and tools so they can survive and thrive within the system while also advocating for bigger reforms. Whether it's eliminating a $10,000 hospital bill through charity care, saving hundreds on a prescription refill, or choosing an affordable imaging center, these resources deliver immediate relief while fueling long-term accountability.

Direct Primary Care is helping rebuild the foundation of patient-centered medicine. But as Christy Snodgrass reminds us, patients still need support in the rest of the system. Through HealthcareReformed.org, she provides that support: practical, trusted resources that save money, reduce stress, and hold institutions accountable.

For DPC patients, her work is not just inspirational—***it's essential.***

Christy Smith, RN joined by Dr. Garrison Bliss, the "Father of the DPC Movement", and Dave Chase of Health Rosetta

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