Formal Written Testimony of Chad Savage, M.D.
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Direct Contracting: A Prescription for Lower Health Care Costs

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Chairman, Ranking Member, and Distinguished Members of the Subcommittee:
Thank you for the opportunity to testify. I am Dr. Chad Savage, a board-certified internal medicine physician who has practiced medicine since 2003. In 2015, I founded YourChoice Direct Care in Brighton, Michigan, to provide comprehensive, patient-centered primary care free from traditional insurance bureaucracy.
As President of DPC Action, I advocate for direct contracting models that prioritize the doctor-patient relationship, lower costs, and improve outcomes.
My testimony focuses on how direct contracting—primarily Direct Primary Care (DPC) for primary care and extensions to hospitals, specialists, and surgical centers— addresses the severe challenges employers face with escalating healthcare costs, administrative burdens, and involvement in employees' personal medical decisions regarding their own health.
Direct contracting enables pre-tax implementation options that deliver first-dollar primary care coverage, enhance patient autonomy, and allow employers to refocus on their core business.

The Problem: Skyrocketing Costs, Employer Distraction, and Erosion of the Doctor-Patient Relationship

U.S. healthcare expenditures are on an unsustainable path. Estimates indicate national health spending exceeded $5.6 trillion in 2025, exceeding the GDP of Germany, the world's third-largest economy. Nearly half of Americans receive coverage through employer sponsored plans, placing a massive burden on businesses of all sizes.

This system distracts employers from their core business. The familiar quip that "General Motors is an insurance company that makes cars" reflects this reality: employers manage complex networks, prior authorizations, claims processing, compliance, drug-formularies and ERISA fiduciary responsibilities. These responsibilities are the reason for proliferating administrative middlemen in the employer-sponsored heath care chain

Employers do not benevolently absorb healthcare costs; these expenses are simply a growing share of total employee compensation, crowding out wages. Bureau of Labor Statistics data show benefits account for approximately 30% of total compensation in private industry (higher in the public sector), with healthcare as the dominant expense. The 2026 Milliman Medical Index (MMI) projects annual costs of $37,824 for a typical family of four under employer sponsored coverage. This has been driven largely by outpatient and pharmacy spending.

Employees ultimately bear these costs, either through suppressed wages as employers adjust their total compensation budgets, or through lost job opportunities as American companies struggle to compete. Worse, the traditional Insurance-Based Primary Care (IPC) model often leads to fragmented, rushed care (frequently 5—15 minute visits), contributing to worse health outcomes and higher long-term utilization. Though it is easy to get lost in the numbers reflecting this financial burden, higher healthcare costs, partly driven by worse outcomes and increased utilization, more importantly represent unnecessary human suffering attributable to insurance-based payment policies..

Direct Primary Care (DPC) — A Proven, Physician-Led Model

Direct Primary Care represents a grassroots physician movement reclaiming the profession through direct contracting. Physicians contract directly with patients or employers, bypassing insurance billing and administrative complexity. This reduces overhead by approximately 50%, allowing physicians to refocus their limited time and staff resources on care rather than paperwork.

Core DPC Features Include:

- Affordable monthly membership fees for comprehensive primary care without copayments for visits.
- Extended visits (30—60 minutes or more). Allows DPC physicians the time to practice up to the full extent of their license. Managing more complex problems than possible in the traditional IPC practice.
- Same- or next-day access, often with 24/7 availability. Compared to the US average wait-time of 23.5 days or more to see a traditional IPC physician.
- Many have at-cost, on-site generic pharmacies and direct lab services yielding 80—90% savings.

DPC pairs effectively with lower-cost catastrophic, indemnity or high-deductible insurance, delivering better overall value than traditional insurance plans alone.

Combined with a high-deductible plan, DPC provides a form of predictable, “first-dollar” primary care access (i.e. no point-of-care charge) for a fraction of the cost of expensive, low-deductible insurance “first-dollar” coverage. This lack of point-of-care expense removes the financial disincentive for seeking timely medical care. Meaning entry level workers accessing low-cost, high-deductible insurance combined with DPC (no point-of-care charge, same/next-day 30-60 minute visit) may have better care than the C-suite executives receiving costly insurance based care (point-of-care charge, ~24 day wait for visit, 5-15 minute visit).

Evidence of Impact:

The Society of Actuaries 2020 Report, “Direct Primary Care: Evaluating a New Model of Delivery and Financing” showed DPC patients experienced:

- Overall healthcare services demand: —12.64%
- Emergency department usage: —40.51%
- Inpatient hospital admissions: —19.90%

These reductions translate to fewer patients progressing to serious illness, lower hospitalizations, and improved lives, not merely cost shifts. Employers integrating DPC often report total medical spend reductions of 20—52%.

Addressing HDHP Limitations with DPC first-dollar coverage:
The fear of point-of-care charges common with High-Deductible Health Plans (HDHPs) can deter necessary timely care, potentially reducing appropriate utilization, and worsen health outcomes. DPC eliminates this disincentive for primary care services. Patients access their DPC physician without financial barriers, enabling early intervention. DPC physicians guide patients, treating in-office when appropriate or advising when specialist/deductible-level care is truly needed. Beyond directly treating patients, DPCs function as healthcare guides, assisting their patients in finding quality affordable options and navigating the complexity of the health system. Further, estimates suggest 75—80% of medical care can be managed in the primary care settings. DPC's extended visits allow these physicians to practice fully to the extent of their license, improving chronic disease management, prevention and reducing costly specialty referrals and other downstream costs.

DPC innovation:

With smaller patient panels, DPC has the potential to extend life. Studies have shown that higher per capita physician-to-population ratios are associated with lower mortality. However, this correlation rests on the false premise of equal access to those physicians. The true measure of success is the size of the physician's patient panel and the ease with which those patients can access their physician. On this metric, DPC excels with its much smaller patient panels (approximately 600 patients per DPC physician compared to 2,500 per traditional physician). These smaller panels give DPC patients the ready access to care that the per capita studies imply is lifesaving.

DPC allows for the rapid integration of newer technologies:

Unshackled from arcane billing codes, DPC practices can rapidly adopt new techniques and innovations as soon as they become available. By contrast, insurance-based (IPC) practices remain tethered to complex billing codes that dictate how care is delivered. For example, many IPC practices only began offering virtual or phone visits when the COVID-19 pandemic forced the issue, nearly 150 years after Alexander Graham Bell invented the telephone. While these practices struggled with billing code updates to implement this 'radical new' technology, DPC practices—unburdened by such requirements—had been delivering seamless telehealth since their inception, at no additional cost to patients. This is possible because DPC physicians' time is already compensated through the membership fee, whereas IPC practices had to wait for updated coding rules before they could bill for these services.

This flexibility dramatically broadens access to care, allowing patients to reach their physician from anywhere at any time. It also values the patient's time by eliminating the significant lost opportunity cost of travel and waiting (estimated at $52 billion in 2010) associated with in-office IPC visits.

Future advances will likely sharpen this contrast further. As medical AI grows more refined, its clinical decision support will expand the capabilities of primary care physicians (PCPs) and reduce unnecessary subspecialty referrals. Yet because AI demands real engagement and time, only DPC's time-rich practices are positioned to maximize its potential.

Extending Direct Contracting to Specialists, Hospitals, and Surgical Centers

The direct contracting principle scales beyond primary care. Large employers like Walmart have long partnered directly with renowned centers (e.g., Cleveland Clinic, Mayo Clinic) for procedures such as joint replacements, cardiac care, and transplants securing fixed pricing, quality guarantees, and transparency while steering employees to high-value providers.

Self-funded ERISA plans excel here, enabling bundled payments and Centers of Excellence models that reduce variability, complications, and middleman costs. These arrangements provide predictability for employers and better outcomes for employees.

Practical, Pre-Tax Options for Employers

Employers can implement DPC and direct contracting on a **pre-tax basis** using existing vehicles without running afoul of IRS rules:

- **ICHRA (Individual Coverage Health Reimbursement Arrangement)**: Employers provide tax-free dollars for employees to buy individual market coverage + DPC memberships. Offers budget predictability and choice; DPC fees are generally eligible expenses. Reported savings of 20–30%+ are common.
- **HRA / Excepted Benefit HRA (EBHRA) / QSEHRA**: Employer-funded reimbursements for DPC and qualified services. EBHRAs work especially well with on-site/near-site DPC. QSEHRAs suit smaller employers (<50 employees) with annual limits.
- **HSA-Compatible Options (Enhanced in 2026)**: Qualifying DPC arrangements allow HSA contributions and tax-free payment of DPC fees when paired with an HDHP.
- **FSA and Section 125 Cafeteria Plans**: Pre-tax employee contributions or employer funding for eligible DPC expenses.
- **ERISA Self-Funded Plans**: Maximum flexibility for direct contracts with providers, custom plan design, and fiduciary management.

These vehicles enable first-dollar primary care coverage through DPC while wrapping with more affordable insurance or health sharing options—often at substantially lower total cost than traditional rich group plans. They shift power to patients (as empowered consumers via HRAs/FSAs/HSAs), reduce employer entanglement in personal and private clinical decisions, and free businesses to focus on core operations.

Encouraging Patient Agency

When employees directly manage funds through HRAs, ICHRAs, FSAs, or HSAs, they become active participants in their own healthcare spending rather than passive recipients of insurer-directed care. Armed with real financial skin in the game, patients shop for value—comparing prices,

questioning necessity, and seeking the best balance of quality and cost for their individual needs. In this role, they also function as vigilant auditors of every transaction, scrutinizing bills and flagging irregularities. This consumer-driven dynamic exerts powerful downward pressure on prices across the marketplace while simultaneously helping to curb fraud, waste, and abuse that often thrive in opaque, third-party payment systems.

Economic Benefits

By constraining costs through direct contracting, employers can achieve significant savings while delivering high-quality care. These savings can then be reinvested into core business operations and used to fund higher wages—supercharging economic growth. The result is better care, lower overall costs, and shared prosperity for both employers and employees.

Obstacles to Adoption

Despite the availability of these tools, many employers remain hesitant to adopt these options, overwhelmed by complex regulations, implementation burdens, and the fear of inadvertently running afoul of the IRS.

Recommendations for Congress and Federal Agencies (IRS, DOL, HHS)

1. Develop and disseminate employer toolkits, model contract language, and pilot programs to simplify adoption of Direct Primary Care and consumer-driven health tools.
2. Assess and reform the incentive structures that encourage insurance agents and plan designers to favor legacy coverage products. Pursue legislative and regulatory measures to ensure employers receive equal consideration and support for innovative models such as DPC.

Conclusion

Direct contracting restores the doctor-patient relationship, delivers first-dollar primary care efficiently, reduces overall costs, and frees employers to focus on their core business. By equipping businesses with simple tools and clear

guidance, Congress can foster a cost-effective, patient-centered system that restores the doctor-patient relationship, lowers costs, and strengthens America's workforce and economy.

Thank you for the opportunity and I welcome questions.