The Direct Primary Care Subsidy Play Why Cuban’s HSA Idea Actually Make Sense (Even If Nobody Wants To Adm It)

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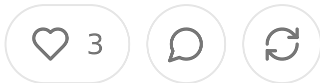

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ABSTRACT

Mark Cuban recently floated an unconventional approach to ACA premium sub redirect $100 per month into HSAs specifically earmarked for Direct Primary C subscriptions, with remaining subsidies applied to premiums as originally inten This proposal addresses a fundamental market failure where the existing subsid structure inadvertently incentivizes high-deductible plans that create access bar to primary care, the very services most likely to prevent expensive downstream utilization. The DPC model, which operates on a monthly subscription basis out traditional insurance structures, has demonstrated potential to improve access, administrative burden, and lower overall system costs through better preventive and care coordination. However, implementation faces significant challenges including DPC provider availability across markets, regulatory complexity arou HSA eligible expenses, political feasibility of subsidy restructuring, and the risk unintended market distortions. For health tech investors, this concept illuminat

several investment themes: the continued unbundling of primary care from trad insurance, the infrastructure needed to support alternative payment models at s the technology requirements for managing hybrid insurance-DPC arrangements the consumer engagement challenges inherent in changing healthcare purchasin behavior. While Cuban's specific proposal may never reach implementation, the underlying dynamics it addresses represent genuine market opportunities for companies building toward a post-fee-for-service primary care ecosystem.

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The Problem Cuban Is Actually Trying T Solve

Mark Cuban's LinkedIn posts tend to generate strong reactions in healthcare ci and his latest foray into ACA subsidy reform is no exception. The proposal itsel sounds simple enough: take $100 per month from the enhanced premium subsid currently supporting marketplace plans and redirect it into HSAs that can only used for Direct Primary Care monthly subscriptions, with the balance of subsid applied to premiums as originally intended. His logic follows that having DPC s

lower plan costs since better primary care access reduces expensive utilization, v
should allow premiums to be lowered rather than raised even with reduced subs
support.

The immediate reaction from most healthcare policy experts will be to poke hol
this idea, and there are plenty of holes to poke. But before we get into why this
probably cannot or will not happen, it is worth examining what actual problem
is identifying here, because the underlying issue is real even if his proposed solu
is politically implausible.

The current ACA subsidy structure creates a perverse set of incentives that mos
people do not think about very carefully. Enhanced subsidies, which were tempo
expanded under the American Rescue Plan Act and have been extended through
make marketplace coverage extremely affordable for lower and middle income
households. For many families earning between 200 and 400 percent of the fede
poverty level, the post-subsidy premium for a benchmark silver plan is quite low
often under $100 per month for an individual. These subsidies have dramaticall
increased marketplace enrollment and reduced the uninsured rate.

But here is the thing nobody wants to say out loud: affordable premiums do not
automatically translate to affordable healthcare access. Most marketplace plans,
silver plans, come with deductibles ranging from $3,000 to $8,000 or more. For
someone earning $35,000 per year, paying $75 per month for insurance feels
manageable, but facing a $4,500 deductible before most services are covered me
that insurance provides catastrophic protection but limited practical access to c
You are insured, but you are effectively uninsured for most of the services you m
actually need in a given year.

This is particularly problematic for primary care services. The whole theory of
managed care and value-based arrangements is that robust primary care acts as t
foundation of cost-effective healthcare delivery. Good primary care catches prob
early, manages chronic conditions proactively, coordinates care across specialist
helps patients navigate the system efficiently. Study after study shows that bette

primary care access correlates with lower total cost of care, better outcomes, anc higher patient satisfaction.

But if you are a marketplace enrollee with a $4,500 deductible and limited finan resources, you are not going to your primary care physician for that nagging cou to get your blood pressure checked or to discuss your prediabetes management. are rationing your healthcare utilization because you cannot afford the out-of-pc costs until you hit your deductible. And the irony is that by avoiding primary ca today, you are much more likely to end up in the emergency department or requ expensive specialist intervention later, which costs the system more money overa

The ACA tried to address this through first-dollar coverage requirements for preventive services, which is why annual wellness visits and certain screenings a covered without cost-sharing even before you hit your deductible. But the list of covered preventive services is limited, and it does not include the vast majority c primary care interactions that happen outside of structured preventive visits. If need your doctor to manage your acid reflux or evaluate your knee pain or adjust thyroid medication, that is subject to your deductible.

So we have engineered a system where subsidies make premiums affordable, but deductibles make care inaccessible, particularly for the primary care services mc likely to keep people healthy and costs down. This is the actual problem Cuban pointing at, even if he is doing so in his typical provocative style.

Why Direct Primary Care Works (When Works)

Direct Primary Care operates on a fundamentally different model than tradition for-service primary care. Instead of billing insurance for each visit, DPC practic charge patients a flat monthly subscription fee, typically ranging from $50 to $1 month depending on age and geographic market. In exchange for this subscripti patients get essentially unlimited access to their primary care physician, includi same-day or next-day appointments, extended visit times, direct communication

their physician via phone or text, and often some basic services like EKGs or sim procedures included in the monthly fee.

The economic model works because DPC physicians carry much smaller patient panels than traditional primary care practices. A typical fee-for-service primary doctor might have 2,000 to 3,000 patients on their panel, seeing 25 to 30 patient day in 15-minute appointment slots to generate enough billing volume to cover overhead and physician compensation. A DPC physician might carry only 600 to patients, allowing for longer appointments, better continuity, and more persona care while still generating comparable or better revenue through the subscriptic model.

For patients, the value proposition is clear: predictable monthly costs with no su bills for primary care, dramatically better access to their physician, and a care relationship that feels more like what healthcare should be rather than the rush transactional interactions that characterize most modern primary care. For phys DPC offers an escape from the administrative burden of insurance billing, bette work-life balance, more satisfying patient relationships, and often better compensation than employed primary care positions.

The evidence on DPC outcomes is mixed but generally positive. A 2020 study published in the Journal of the American Board of Family Medicine found that I practices had lower rates of emergency department utilization and specialist ref compared to traditional primary care. A separate analysis by Milliman in 2017 sl that DPC enrollment was associated with lower total medical costs driven prima by reduced hospital admissions and emergency visits. Patient satisfaction scores DPC practices consistently run in the 90th percentile or higher.

However, these studies come with important caveats. DPC patients tend to be healthier and more engaged than the general population, creating selection bias may explain some of the positive results. The practices studied were often early adopters with particularly committed physicians and patient populations. And t cost savings calculations often fail to account for the fact that patients are payin

the DPC subscription fee and traditional insurance premiums, making the true c
comparison more complex.

The real value of DPC may not be in directly reducing costs, but in creating the conditions for better care. When patients have unfettered access to their primar physician without worrying about cost-sharing, they use that access. They get problems addressed earlier. They build stronger therapeutic relationships. They receive better care coordination. The DPC physician, unburdened by insurance and carrying a smaller panel, can practice medicine the way they were trained ra than churning through patients on a assembly line.

For the ACA subsidy population specifically, DPC could theoretically solve the deductible access problem. If your marketplace plan has a $5,000 deductible but are paying $100 per month for DPC, you now have robust primary care access regardless of your deductible status. The DPC subscription is a known, budgeta expense that does not vary based on utilization. And if that DPC relationship ke you healthier and out of the emergency department, your high-deductible marketplace plan might actually be a reasonable arrangement since you are most protecting against catastrophic costs anyway.

This is what Cuban is gesturing toward. If we accept that primary care access is weak link in the current subsidy structure, and if DPC demonstrably improves primary care access for a predictable monthly fee, then redirecting some portion subsidies toward DPC subscriptions could be a rational policy intervention.

The HSA Mechanism and Its Constraint

Cuban specifically proposes using HSAs as the delivery mechanism for DPC sub which adds an interesting layer of complexity. Health Savings Accounts exist as a advantaged way to pay for qualified medical expenses, but they are only available individuals enrolled in high-deductible health plans that meet specific criteria. I 2024, an HDHP must have a minimum deductible of $1,600 for individual covera $3,200 for family coverage, with out-of-pocket maximums capped at $8,050 and $16,100 respectively.

The HDHP requirement is not accidental. HSAs were designed to pair with high deductible plans as a way to give consumers more skin in the game and encourag cost-conscious healthcare purchasing. The theory was that if you are spending yo own HSA dollars on healthcare, you will shop around, ask about prices, and avoi unnecessary utilization. The evidence on whether HSAs actually create these behaviors is decidedly mixed, with most studies showing that people with HSAs simply reduce utilization across the board, including necessary care, rather than selectively reducing waste.

For the ACA marketplace population, most plans already meet HDHP criteria fo HSA eligibility given the prevalence of high deductibles. So the mechanical ques of whether subsidy recipients could even have HSAs is mostly answered: yes, mo could. The more complex question is whether DPC subscriptions count as quali medical expenses under existing HSA regulations.

The IRS has provided limited guidance on DPC and HSAs, but the general conse among tax attorneys is that DPC subscriptions are HSA-eligible as long as they a paying for actual medical care rather than just access or concierge services. This distinction matters. If a DPC practice is billing you $100 per month and providi unlimited primary care visits, laboratory testing, medications dispensed in-office care coordination, that is clearly medical care and should be HSA-eligible. If the charging you $100 per month for enhanced access and amenities but billing your insurance separately for services rendered, that probably is not HSA-eligible.

Most legitimate DPC practices structure their offerings to be HSA-qualified, bu there is enough ambiguity in the regulations that some employers and insurers h been reluctant to definitively bless DPC as an HSA-eligible expense. The IRS has issued definitive guidance despite repeated requests from DPC advocacy organizations. This regulatory uncertainty creates friction for DPC adoption and would need to be resolved before any subsidy-funded HSA-for-DPC program co work at scale.

There is also the practical question of how subsidy dollars would flow into HSAs Current premium subsidies are advance refundable tax credits that either reduc

monthly premium directly or get reconciled at tax time based on your actual inc
Converting $100 per month of that subsidy into an HSA contribution would req
new administrative infrastructure, coordination between the federal marketplac
HSA custodians, and mechanisms to ensure the HSA dollars are actually used fo
rather than other qualified expenses.

The HSA annual contribution limits would also come into play. For 2024, indivi
can contribute up to $4,150 to an HSA and families up to $8,300. If the governm
contributing $1,200 per year through subsidy redirection, that reduces how muc
individual can contribute from their own funds. For higher-income marketplace
enrollees who were already maxing out their HSA contributions, this could be se
a drawback rather than a benefit.

All of this is administratively solvable if there is political will to solve it, but the
complexity is real. HSAs were not designed to be a vehicle for redistributing
government subsidies, and retrofitting them for that purpose would require legi
changes, regulatory clarification, and new operational systems. The easier path v
be to create a separate DPC subsidy program outside the HSA framework, but tl
loses the tax advantages and administrative infrastructure that HSAs already pro

Market Availability and the Rural Problem

Chris Deacon's comment on Cuban's post highlights what may be the most signi
practical barrier to any DPC subsidy program: availability of DPC providers acr
markets. The DPC movement has grown substantially over the past decade, with
current estimates suggesting around 1,500 to 2,000 DPC practices operating in t
United States. But that translates to perhaps 3,000 to 4,000 individual DPC phys
serving maybe 1.5 to 2 million patients total out of a U.S. population of 330 milli

DPC practices cluster in suburban and affluent urban markets where there is
sufficient density of patients able to pay monthly subscription fees. You can finc
robust DPC options in places like Seattle, Austin, Kansas City, and Charlotte. Y
will struggle to find any DPC providers in rural Montana or West Virginia or th

Mississippi Delta. Even in major metropolitan areas, DPC coverage is patchy, wi
significant gaps in lower-income neighborhoods and communities of color.

This creates a fundamental equity problem for any DPC subsidy program. If you
going to redirect $100 per month of subsidy dollars toward DPC, you need to en
that DPC is actually available to subsidy recipients regardless of where they live
Otherwise you are creating a two-tiered system where some subsidy recipients g
enhanced primary care access through DPC while others are stuck with traditio
deductible-laden insurance through no fault of their own.

The market availability problem could theoretically solve itself if subsidy dollar
started flowing toward DPC at scale. If there is suddenly a population of several
million ACA marketplace enrollees with $100 per month to spend on DPC, that
creates a powerful incentive for providers to enter the market or for existing pri
care practices to convert to the DPC model. Basic economics suggests that supp
would rise to meet subsidized demand.

But healthcare markets do not always behave according to basic economics,
particularly in rural and underserved areas. The reason rural communities lack
primary care access is not because patients cannot pay, but because there are no
enough physicians willing to practice in those communities given lifestyle
considerations, professional isolation, and lack of infrastructure. Adding DPC
subsidies does not magically create more physicians or make rural practice more
attractive. It might accelerate the conversion of existing rural primary care pract
to DPC models, but that does not increase the total supply of primary care capa

There is also the question of what happens to existing primary care practices th
serve marketplace enrollees under fee-for-service arrangements. If a significant
portion of their patient population suddenly has subsidy dollars earmarked for I
those practices face a choice: convert to DPC and abandon insurance billing, or
patients to DPC competitors. For practices in financially marginal communities,
could force consolidation or closure, potentially reducing overall access even as
access increases for those who can find it.

The telemedicine angle offers a potential partial solution. Several companies hav launched virtual DPC offerings that provide remote primary care for monthly subscription fees lower than traditional in-person DPC. If DPC subsidies are available for telehealth-based primary care, that could address the geographic availability problem since virtual care is accessible anywhere with internet connectivity. But telehealth-only primary care has significant limitations for pat who need physical examinations, procedures, or local care coordination, and it d not build the kind of longitudinal relationship that makes DPC valuable in the f place.

A more sophisticated policy design might tier DPC subsidies based on local mar availability. In markets with robust DPC supply, offer the full $100 per month subsidy. In markets with limited DPC access, offer a reduced subsidy or alternat benefits. But this creates administrative complexity and potentially exacerbates geographic inequities rather than addressing them.

The Subsidy Economics Nobody Talks About

Cuban's core economic argument is that DPC should reduce plan costs by decre utilization of expensive services, which should allow premiums to be lowered ev subsidies are reduced by the $100 per month being redirected to DPC. On the su this makes intuitive sense, but the actual economics are more complicated than Cuban's formulation suggests.

First, we need to consider whose costs are being reduced. If DPC enrollment ke patient out of the emergency department, that is a win for the insurance plan, w avoids paying the ED claim. But the ED does not get paid, which might be a fina loss for the hospital that was counting on that revenue. At a system level we care about total cost of care, but at an individual plan level insurers care about their costs, and providers care about their own revenue. DPC might reduce total costs simultaneously harming provider finances, which affects provider willingness to participate in narrow network plans.

Second, the timeline for cost savings matters enormously. DPC's value comes frc better preventive care and chronic disease management, which produce savings (months and years rather than immediately. But insurance plans in the ACA marketplace have limited ability to capture long-term savings because enrollees switch plans frequently. The average marketplace enrollee changes plans every 1 24 months due to income changes, premium variations, or life circumstances. If is subsidizing DPC enrollment for members who might leave next year, they are bearing the cost of DPC subscriptions while their competitors potentially reap t downstream savings.

Third, there is a selection problem. The patients most likely to sign up for DPC given subsidized access are those who value primary care relationships and want better access, which tends to correlate with higher health engagement and bette underlying health status. These are exactly the patients who are least expensive t insure in the first place. Meanwhile, the patients who do not sign up for DPC ev when offered subsidy dollars are more likely to be those who do not regularly us primary care, have worse health outcomes, and generate higher costs. This adver selection could leave plans with a pool of more expensive non-DPC members wh spending subsidy dollars on healthier DPC members who would not have been expensive anyway.

Fourth, DPC does not eliminate the need for specialist care, hospital services, or expensive interventions. It might reduce their frequency, but it does not elimina them. A DPC patient who needs hip replacement surgery or cancer treatment or management of a complex autoimmune condition is going to generate just as mu cost as a non-DPC patient with the same clinical needs. DPC's cost savings come avoiding preventable utilization and catching problems earlier, which helps but a panacea.

The premium reduction math Cuban suggests requires several things to line up: enrollment has to materially reduce expensive utilization, those savings have to l large enough to offset both the DPC subscription cost and the reduced premium subsidy, plans have to actually pass those savings through to lower premiums rat

than capturing them as margin, and this all has to happen fast enough that indiv
plans can benefit before members churn to other coverage.

It is not impossible, but it is far from certain. The Milliman study that showed I
cost savings found reductions in total medical costs of around 10 to 20 percent f
DPC enrollees, but those analyses included the DPC subscription fee as part of
and looked at selected populations over limited time periods. Translating that tc
consistent, predictable premium reductions across diverse marketplace populati
a significant leap.

There is also the question of what happens to premium subsidies in a world whe
DPC is driving down costs. The ACA subsidy structure benchmarks to the secor
lowest-cost silver plan in each market. If DPC plus reduced subsidies leads to lc
premiums, the benchmark drops, which means subsidies drop further, which
potentially creates a downward spiral. The law includes some protections agains
subsidy erosion, but the interaction effects are complex.

From a federal budget perspective, redirecting subsidies toward DPC is roughly
budget-neutral in the short term since the money is just moving from premium
subsidies to HSA contributions. But if DPC does not actually reduce premiums
Cuban suggests, the government is spending the same amount on subsidies whil
enrollees are getting less generous coverage. And if DPC does reduce premiums
significantly, the federal government saves money on subsidies but states might
higher Medicaid costs as lower marketplace premiums create new Medicaid-elig
populations through the subsidy cliff dynamics.

Unintended Consequences and Second Order Effects

Any policy intervention in a market as complex as health insurance creates rippl
that are difficult to predict. Making DPC subsidies available through HSAs wou
change incentives for patients, providers, insurers, and employers in ways that n
undermine the policy's goals or create new problems.

For patients, having $100 per month in an HSA earmarked for DPC creates a use-or-lose-it mentality around finding a DPC provider even if DPC is not actually t best fit for their needs. Someone with complex chronic conditions requiring significant specialist care might be better served by a traditional primary care pı embedded in a health system with robust care coordination infrastructure. But i have $100 per month burning a hole in your HSA that can only be spent on DPC are incentivized to sign up for DPC regardless of clinical appropriateness.

For providers, widespread DPC subsidies could accelerate the shift away from insurance-based primary care in ways that fragment the care delivery system. If practices are operating outside insurance networks and being paid directly throu patient HSAs, they have less incentive to participate in value-based contracting, data with insurers or health systems, or coordinate care through standard care management programs. The whole theory of accountable care organizations and based payment is that primary care sits at the center of a coordinated network. I can undermine that if it exists as a parallel system.

For insurers, DPC subsidies create an interesting dilemma. On one hand, if DPC genuinely reduces utilization and costs, insurers should love it. On the other har DPC practices operating outside their networks mean less control over care patt less data visibility, and potentially higher medical loss ratios as they are still pay for hospital and specialist care without the primary care utilization that helps ju premium levels. Some insurers have experimented with DPC partnerships or off DPC as a supplemental benefit, but the economics have to work at scale.

There is also the question of what DPC subsidies do to existing value-based prir care models. Medicare Advantage plans have increasingly embraced capitated pı care arrangements where primary care groups take full risk for total cost of care Commercial ACOs and primary care risk-bearing entities have tried to replicate in the commercial market with mixed success. If marketplace enrollees are being pushed toward DPC through subsidy policy, that could undermine these alterna payment models by pulling patients out of risk-bearing primary care arrangemeı and into subscription-based DPC that is not at risk for downstream costs.

The provider payment implications are also non-trivial. Right now, primary care practices get paid through a mix of fee-for-service billing, capitation payments, c management fees, and quality bonuses depending on their contracts with variou insurers. This creates complexity but also creates multiple revenue streams that support practice operations. In a world where a large chunk of primary care is happening through DPC subscriptions paid by patient HSAs, that is one less rev stream for integrated delivery systems and one less lever for insurers to influenc patterns.

From a competition perspective, DPC subsidies could advantage certain types of primary care practices over others in ways that reduce rather than increase acces Small independent DPC practices might thrive with direct patient subscriptions while community health centers and large primary care groups embedded in safe systems might struggle to adopt DPC models given their mission to serve all pat regardless of ability to pay. If DPC subsidies pull healthier, more engaged patien of traditional primary care, that leaves traditional practices with a sicker, more expensive patient mix, potentially threatening their financial viability.

What This Means for Health Tech Investors

Setting aside the policy feasibility questions, Cuban's DPC subsidy idea points t several investment-relevant themes that are playing out in the healthcare market regardless of what happens with government policy.

The first theme is the continued unbundling of primary care from traditional insurance structures. Whether through DPC, employer-sponsored on-site clinics direct-to-consumer virtual care, or other models, primary care is increasingly be paid for through mechanisms other than fee-for-service insurance billing. This c opportunities for companies building infrastructure to support alternative prim care payment models, whether that is DPC practice management software, hybri DPC-plus-insurance care coordination tools, or consumer platforms that help pe find and pay for DPC.

Several companies have raised significant capital to build technology for DPC practices. Hint Health operates a platform that helps DPC practices manage subscriptions, coordinate with insurance for services outside the DPC scope, an comply with regulatory requirements. Sesame has built a marketplace connectin consumers with DPC practices and other direct-pay care options. These platforr become more valuable if the DPC market grows, whether through government subsidies or through organic employer and consumer adoption.

The second theme is the challenge of integrating DPC into existing benefit struc Most people with insurance today get it through employers, and employers are increasingly interested in DPC as a way to manage costs and improve employee l But figuring out how to layer DPC on top of traditional health insurance withou creating coverage gaps or administrative nightmares is genuinely difficult. Com that can solve the integration problem, whether through smart benefit design to care coordination platforms, or hybrid DPC-insurance products, are addressing market need.

Decent is one company working in this space, offering employers a combined DI and health plan product that wraps primary care subscriptions together with co for everything else. The theory is that if you design the insurance product and tl DPC offering together rather than trying to bolt them on after the fact, you can better economics and better patient experiences. The challenge is scaling this in market where most employers already have broker relationships and incumbent carrier contracts.

The third theme is the data and interoperability challenge. If primary care is happening in DPC practices that are not submitting claims, how do insurers, employers, and value-based care organizations get visibility into what care is bei delivered and what outcomes are being achieved? DPC practices need to be inte into health information exchanges, need to communicate with specialists and hospitals, and need to share data to demonstrate their value. Companies buildin interoperability infrastructure for non-traditional care settings are solving a rea problem that will become more acute as DPC adoption grows.

Redox and Particle Health have built APIs that allow DPC practices and other n traditional providers to exchange data with EHRs, claims clearinghouses, and he information networks. As DPC scales, these interoperability layers become criti infrastructure. But the business models are challenging since DPC practices are generally small and price-sensitive, which makes enterprise software sales diffic

The fourth theme is consumer engagement and healthcare literacy. One of the re DPC has not scaled more rapidly despite its apparent advantages is that most consumers do not understand how it works, do not know how to evaluate DPC practices, and are not accustomed to paying cash for primary care. If DPC is goi grow whether through subsidies or other mechanisms, there is a need for consu facing tools that educate people about DPC, help them find quality DPC provid and manage the complexity of having both DPC and insurance.

Certainly is building a platform that helps consumers understand their healthca costs and coverage options, including DPC. Amino Health provides transparenc for finding providers and estimating costs. These companies could benefit from growing DPC adoption if they can position themselves as the go-to resources fo consumers navigating hybrid insurance-plus-DPC arrangements.

The fifth theme is the opportunity in markets underserved by traditional DPC. I geographic availability is the biggest barrier to DPC subsidies as Chris Deacon suggests, then companies that can deliver high-quality virtual primary care at D subscription prices are potentially solving a major market problem. Several tele startups have launched virtual DPC offerings, but the challenge is delivering en value to justify subscription fees when consumers can get on-demand telehealth through their insurance or through pay-per-visit services.

SteadyMD and Galileo have built virtual primary care models that charge month subscriptions and promise continuity with a dedicated physician. The economic attractive since overhead is lower without physical office space, and geographic is much broader. But patient acquisition is expensive, and proving that virtual-o primary care can deliver the same outcomes as in-person DPC is still a work in progress.

The sixth theme is the potential for government innovation if DPC subsidies act happen. If states or the federal government start experimenting with DPC subsi that creates opportunities for companies building the administrative infrastruct support such programs. Subsidy calculation tools, HSA integration platforms, provider directories, quality measurement systems, and fraud detection capabili would all be needed. This is a classic government IT services opportunity, which to be lumpy and dependent on procurement cycles but can be very lucrative for companies that win contracts.

Castlight has built platforms for employers to manage benefits and engage empl in healthcare decision-making. If those capabilities could be adapted for govern subsidy programs, there might be business opportunities in helping states imple DPC subsidy initiatives.

Implementation Realities and Political Feasibility

The most important thing to understand about Cuban's DPC subsidy proposal i it is almost certainly not going to happen in the form he suggests, at least not at federal level in the near term. Restructuring ACA subsidies requires legislation, the current political environment makes healthcare legislation extremely difficu Democrats are generally protective of ACA subsidies and would resist any chang that could be framed as cutting benefits, even if the intent is to redirect rather t reduce support. Republicans have policy preferences that do not align well with government-funded DPC, and they would likely prefer either full ACA repeal or least movement toward less regulated markets rather than new subsidy program

The administrative complexity of implementing an HSA-based DPC subsidy pro is also significant. It would require coordination between the IRS, CMS, state insurance regulators, HSA custodians, DPC practices, and insurance carriers. T federal marketplace infrastructure would need to be modified to calculate and distribute both premium subsidies and HSA contributions. Systems for ensuring

dollars are spent appropriately and for reconciling subsidies at tax time would n
be built. All of this requires money, time, and political will.

There are also legitimate policy questions about whether subsidizing DPC speci
is the right approach to improving primary care access. Other options include
lowering deductibles for primary care services, requiring richer actuarial value p
for subsidy recipients, directly subsidizing federally qualified health centers, or
implementing prospective payment systems for primary care that do not depend
patient subscriptions. Each approach has tradeoffs, and reasonable people can
disagree about which would be most effective.

Where Cuban's idea might gain traction is at the state level or through pilot
programs. Several states have experimented with innovations in their state-basec
marketplaces, and there is more flexibility at the state level to test alternative be
designs. A state could potentially create a pilot program that offers additional
subsidies or tax credits for DPC subscriptions, collects data on utilization and
outcomes, and evaluates whether the economics work before trying to scale. Thi
would address some of the uncertainty about DPC's cost impact while allowing f
market-specific customization around provider availability and patient needs.

Centers for Medicare and Medicaid Innovation also has broad authority to test
alternative payment and service delivery models. CMMI could potentially desigr
DPC pilot for marketplace enrollees, providing enhanced subsidies for DPC
enrollment in selected markets and evaluating outcomes compared to control gr
If a well-designed pilot showed clear evidence of cost savings and improved outc
that could build political momentum for broader implementation.

The private market may also find ways to implement the core concept without
government intervention. Employers are already experimenting with subsidized
as a voluntary benefit, and some health plans have started offering DPC partners
as a way to improve care and reduce costs. If these private sector experiments pr
successful, that creates proof points that could inform eventual government poli

There is also the possibility that market forces push in this direction regardless
policy. If DPC continues growing organically and demonstrating value, if primar
access under high-deductible plans continues being a problem, and if consumer
increasingly demand better options for affordable primary care, insurers and
employers will respond with product innovations that look something like what
Cuban is proposing even if government subsidies never materialize.

What Cuban has done with this LinkedIn post is put a stake in the ground aroun
real problem and propose a specific solution, even if that solution is imperfect. T
value is not necessarily that his exact proposal will be implemented, but that it s
conversation about the mismatch between subsidy structures and care access, ab
whether DPC has a role in solving that mismatch, and about what alternative
approaches might work better. For those of us investing in healthcare innovatio
understanding these dynamics and identifying the companies positioned to bene
from various potential futures is what matters, regardless of whether Mark Cub
specific policy idea ever sees the light of day.

The tension he has identified between premium affordability and care access is r
The potential for DPC to address that tension is plausible but unproven at scale
infrastructure gaps that would need to be filled to make DPC accessible to subsi
populations represent genuine market opportunities. And the broader trend tow
unbundling primary care from traditional insurance is happening with or witho
government policy support. Cuban's post is less interesting as a policy proposal
as a marker of where the market is headed and what problems smart entreprene
and investors should be thinking about as we build the next generation of prima
care infrastructure. Whether through HSAs or some other mechanism, whether
through government subsidies or private benefit design, whether through in-per
DPC or virtual care or some hybrid model, the underlying question of how we m
primary care accessible and affordable for high-deductible populations remains
the most important unsolved problems in American healthcare. Whoever figures
how to solve that problem at scale is going to build a very large and valuable con
and the rest of us need to be paying close attention to the various approaches be
tried.

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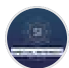

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