
ACCESS TO PRIMARY CARE AND HEALTH CARE FRAGMENTATION

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This Article examines the growing crisis of long primary care wait times and the health care fragmentation that is associated with them. Patients who feel ill or are worried about new symptoms must often wait weeks or longer for appointments. In the wake of excessive wait times for primary care physician (“PCP”) appointments, patients increasingly turn to convenience care models such as urgent care centers, retail clinics, direct-to-consumer telemedicine, and at-home testing. While these alternatives offer prompt attention, they sacrifice other core functions of primary care and may exacerbate poor health outcomes and inequities. The Article argues that long wait times and resulting care fragmentation have significant spending, quality, access, and equity implications. Furthermore, they expose health care providers to potential medical malpractice and discrimination claims. The PCP shortage, rooted in factors such as physician burn-out, inadequate compensation, and insufficient residency positions, underlies the problem.

This is the first law journal article to comprehensively analyze the legal and policy implications of long PCP wait times. It recommends that policymakers and payers support strategies to improve primary care capacity and lower wait times, for example, by using artificial intelligence to facilitate administrative tasks and adopting creative scheduling policies. The Article also critiques laws and regulations that directly address appointment wait times and suggests modifications to improve their efficacy. It concludes with a brief examination of legal interventions that aim to increase the supply of PCPs and ease the financial and workload burdens that PCPs face. As the population ages and demands for care grow,

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addressing primary care access barriers is crucial for maintaining the health of the American population.

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I. INTRODUCTION

A 2024 report about primary care in the United States was entitled *The Health of US Primary Care: 2024 Scorecard Report—No One Can See You Now*.¹ The report's introduction asserted: "For individual patients, fewer health care needs are being met, new patients are struggling to get appointments with primary care offices, and wait times to see a primary care clinician (for those who already have one) are nearly a month long."²

An often-cited 2022 survey conducted by Merritt Hawkins examined how long new patients must wait for family medicine³ appointments in fifteen major cities.⁴ It determined that the average wait time was 20.6 days.⁵ The report did not address how long it took established (rather than new) patients to obtain appointments.⁶ Such information is much more difficult to acquire because researchers can pretend to be new patients but cannot assume the identities of existing patients.⁷ Moreover, the study was limited in scope, basing its conclusion on calls to only 1,034 physician offices in fifteen locations.⁸ A 2024 ECG Management Consultants study that focused on eleven medical specialties in twenty-three metropolitan areas found that the average wait time for new patient family medicine appointments was twenty-nine days, though in Seattle it was as high as fifty-eight days.⁹ Even a three-week wait for an appointment can seem like an eternity for patients experiencing very uncomfortable or worrisome symptoms.

1. YALDA JABBARPOUR ET AL., MILBANK MEM'L FUND, *THE HEALTH OF US PRIMARY CARE: 2024 SCORECARD REPORT—NO ONE CAN SEE YOU NOW* (2024), <https://www.milbank.org/publications/the-health-of-us-primary-care-2024-scorecard-report-no-one-can-see-you-now/introduction-access-to-primary-care-is-worsening/> [https://perma.cc/L2QM-JG4W].

2. *Id.* at 8.

3. Family medicine doctors are primary care physicians. *See The Specialty of Family Medicine*, AAFP, <https://www.aafp.org/about/dive-into-family-medicine/family-medicine-specialty.html> [https://perma.cc/XPZ9-T6U7] (last visited Jan. 14, 2026).

4. AMN HEALTHCARE & MERRITT HAWKINS, *2022 SURVEY OF PHYSICIAN APPOINTMENT WAIT TIMES AND MEDICARE AND MEDICAID ACCEPTANCE RATES 3* (2022), <https://web.archive.org/web/20250306140044/https://www.wsha.org/wp-content/uploads/mha2022waittimesurveyfinal.pdf> [https://perma.cc/7L38-BA8C].

5. *Id.* at 4.

6. *See id.* at 3 ("From March, 2022 through mid-May, 2022 research specialists working for AMN/Merritt Hawkins called physician offices in 15 major metropolitan areas with the purpose of scheduling a *new* patient appointment.") (emphasis added).

7. *See infra* notes 86–88 and accompanying text.

8. AMN HEALTHCARE & MERRITT HAWKINS, *supra* note 4, at 3.

9. JENNIFER MOODY, STEVE McMILLEN, NIKI PETROFF & ANNA BERENBEYM, *THE WAITING GAME: NEW-PATIENT APPOINTMENT ACCESS FOR US PHYSICIANS* 5, app. A, at 17 (2024), <https://www.ecgmc.com/insights/whitepaper/the-waiting-game-new-patient-appointment-access-for-us-physicians> [https://perma.cc/U76Q-P6FS]. Researchers contacted 3,712 physician offices. *Id.* at 7. They focused on the third-next available appointment, which is a common access benchmark. *Id.* at 5 ("In the callers' scripts, they prompted schedulers to offer a handful of appointments to document the third next available" because "the number of days to the first or second available appointment may be artificially short in the event of a late cancellation or other event."); *see* HEALTHTEAMWORKS, *THIRD NEXT AVAILABLE APPOINTMENT: A REFERENCE GUIDE* (2014), https://h1ccp.com/util/forms/Third_Next_Available_Appt_RG-fillable.pdf [https://perma.cc/G8CS-FRDS].

A survey of 149 individuals in Boston found that 77% of those who had primary care physicians (“PCP”) had difficulty scheduling appointments.¹⁰ One patient related the following anecdote: “Had an appointment for a yearly physical scheduled this May [2024] and had to reschedule due to a scheduling conflict. The next available date was also in May, which is great—until you realize it is May of 2025.”¹¹

This Article is the first law journal paper to shine a spotlight on primary care appointment wait times and their medical, ethical, and legal implications. To be sure, there are often even longer delays for appointments with specialists.¹² For the sake of clarity and focus, however, this Article concentrates on primary care, which is the foundation of the health care system.¹³ Primary care is defined as serving four core functions: first contact access, continuity of care, comprehensiveness of care, and care coordination.¹⁴ PCPs most often specialize in family medicine, internal medicine, geriatrics, or pediatrics.¹⁵

Long appointment wait times can raise serious medical concerns. Many patients become frustrated and abandon their efforts to consult a PCP despite needing medical attention.¹⁶ Even when patients do persist in seeking care, delays often worsen health care outcomes.¹⁷ For example, a large study found that veterans aged sixty-five and older who had to wait thirty-one or more days for appointments at Veterans Affairs (“VA”) geriatric outpatient clinics were more likely to die within six months than patients with shorter wait times.¹⁸

10. Zipporah Osei, *Long Waits for Doctor Visits Leave Readers Frustrated, Without Health Care*, BOSTON.COM (Feb. 29, 2024), <https://www.boston.com/community/readers-say/long-waits-for-doctor-visits-leave-readers-frustrated-without-health-care/> [https://perma.cc/7NQU-NDTT]. PCP can also stand for “primary care provider” (rather than physician). It can thus include clinicians such as physician assistants and nurse practitioners. For purposes of clarity, PCP will mean only primary care physician in this paper.

11. *Id.*

12. AMN HEALTHCARE & MERRITT HAWKINS, *supra* note 4, at 4.

13. Colin P. West & Karen E. Hauer, *Reducing Burnout in Primary Care: A Step Toward Solutions*, 30 J. GEN. INTERNAL MED. 1056, 1056 (2015) (“Primary care is the cornerstone of high-quality health care systems across the world . . .”).

14. Mark W. Friedberg, Peter S. Hussey & Eric C. Schneider, *Primary Care: A Critical Review of the Evidence on Quality and Costs of Health Care*, 10 HEALTH AFFS. 766, 767 (2010); Geronimo Jimenez et al., *Revisiting the Four Core Functions (4Cs) of Primary Care: Operational Definitions and Complexities*, PRIMARY HEALTH CARE RSCH. & DEV., Nov. 10, 2021, at 1. See *infra* Subsection II.A.1 for a discussion of PCP care.

15. NAT’L CTR. FOR HEALTH WORKFORCE ANALYSIS, STATE OF THE PRIMARY CARE WORKFORCE 1 (2024), <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/state-of-primary-care-workforce-2023.pdf> [https://perma.cc/28YF-R235].

16. Jennifer M. Taber, Bryan Leyva & Alexander Persoskie, *Why Do People Avoid Medical Care? A Qualitative Study Using National Data*, 30 J. GEN. INTERNAL MED. 290, 294 (2014).

17. *Id.* at 294 fig. 2; Dominique Ansell, James A. G. Crispo, Benjamin Simard & Lise M. Bjerre, *Interventions to Reduce Wait Times for Primary Care Appointments: A Systematic Review*, 17 BMC HEALTH SERVS. RSCH. 295, 296 (2017); Sarah Heath, *A Quarter of Patients Face Two-Month Appointment Wait Times*, TECHTARGET (July 13, 2023), <https://patientengagementhit.com/news/a-quarter-of-patients-face-two-month-appointment-wait-times> [https://perma.cc/PQM7-K786] (“Delayed or deferred care can put an individual’s health at greater risk for complications, which may also lead to a negative impact on mental health and lost wages for those patients.”).

18. Julia C. Prentice & Steven D. Pizer, *Delayed Access to Health Care and Mortality*, 42 HEALTH SERVS. RSCH. 644, 656–57 (2007).

Even seemingly benign conditions can develop into lethal ones.¹⁹ In one instance, a healthy twelve-year old died from an untreated toothache because his mother could not find a dentist who would accept Medicaid.²⁰ By the time she obtained an appointment, the boy had developed a brain abscess that ultimately killed him.²¹ In the words of one commentator, “[l]ong wait times are not just an inconvenience, they’re a public health disaster.”²²

Legal concerns exist as well. Diagnosis and treatment delays may harm patients and lead to malpractice litigation.²³ If PCP offices fail to triage patients with severe symptoms appropriately, deny them prompt attention, or fail to advise them to get care elsewhere immediately, they may be vulnerable to malpractice claims.²⁴ In addition, lack of timely appointments may generate allegations of unlawful disparate treatment or disparate impact discrimination.²⁵ For example, some patients may be deprioritized for appointments because of their race or because they have Medicaid, which reimburses for office visits at lower rates than other insurers and serves a disproportionate number of patients from minority racial and ethnic groups.²⁶

Inability to obtain timely primary care appointments threatens patient welfare in other ways as well. One of this Article’s primary contributions is to highlight how poor access results in the fragmentation and segmentation of health care.²⁷ Patients who must wait too long for a PCP appointment when they are sick often opt for other, same-day care models, such as urgent care.²⁸ In fact, the Merritt Hawkins survey posited that wait times for new patient PCP appointments in 2022 were 30% lower than they were in 2017.²⁹ The authors attribute

19. MOODY ET AL., *supra* note 9, at 4.

20. Emma Parker-Newton, *Cavities in Care: Medicaid Dental Coverage Presents Ongoing Challenges for Children*, NAT’L HEALTH L. PROGRAM (Apr. 26, 2023), <https://healthlaw.org/cavities-in-care-medicaid-dental-coverage-presents-ongoing-challenges-for-children/> [<https://perma.cc/9AZQ-82AN>].

21. *Id.*

22. Oliver Kharraz, *Long Waits to See a Doctor Are a Public Health Crisis*, STAT (May 2, 2023), <https://www.statnews.com/2023/05/02/doctor-appointment-wait-times-solutions/> [<https://perma.cc/Q5GR-V4VD>]; *see infra* Section III.A.2.

23. William Meadow & Cass R. Sunstein, *Statistics, Not Experts*, 51 DUKE L.J. 629, 636 (2001) (“In medical malpractice cases, the question often arises whether treatment of a particular child was unduly ‘delayed,’ because delay can cause serious harm.”).

24. *See infra* Subsection III.B.1.

25. *See infra* Subsection III.B.2.

26. Walter R. Hsiang et al., *Medicaid Patients Have Greater Difficulty Scheduling Health Care Appointments Compared with Private Insurance Patients: A Meta-Analysis*, J. HEALTH CARE ORG., PROVISION, & FIN., April 5, 2019, at 1 (“Medicaid insurance is associated with a 1.6-fold lower likelihood in successfully scheduling a primary care appointment and a 3.3-fold lower likelihood in successfully scheduling a specialty appointment when compared with private insurance.”); *Judge Gives Green Light to Civil Rights Lawsuit Affecting 1 in 3 Californians*, SEIU-UHW UNITED HEALTHCARE WORKERS W. (June 25, 2019), <https://www.seiu-uhw.org/press/judge-gives-green-light-to-civil-rights-lawsuit-affecting-1-in-3-californians/> [<https://perma.cc/T25S-SWC2>] (stating that California Medi-Cal patients often cannot find primary care and specialty physicians who are willing to accept them, and “[w]hen they do, they often wait weeks or months for appointments”).

27. *See infra* Section II.B.

28. JABBARPOUR ET AL., *supra* note 1.

29. AMN HEALTHCARE & MERRITT HAWKINS, *supra* note 4, at 4 (“The average wait time to see a family medicine physician is 20.6 days, down from 29.3 days in 2017, a decrease of 30%.”).

this change to the fact that instead of seeking PCP care, “more patients are using urgent care centers, retail clinics and [direct to consumer] telemedicine as the first stop on their path to care,”³⁰ thus freeing up PCP appointments for other patients. In recent years another alternative has emerged in the form of at-home or “do-it-yourself” (“DIY”) tests and wellness treatments that may require no contact with health care professionals.³¹

While patients may gain prompt attention through convenience care models, they may sacrifice other benefits of primary care such as care comprehensiveness, continuity, and coordination.³² To the extent that using same-day care facilities on an as-needed basis comes at the expense of building a relationship with a PCP, this practice may detract from patients’ long-term health.³³

There is also evidence of another type of health care fragmentation that is associated with long PCP wait times. Patients who can afford to do so increasingly opt for concierge medicine and direct primary care.³⁴ These are subscription or retainer forms of primary care practice in which each PCP cares for a small panel of patients who pay monthly fees in return for greater physician availability.³⁵ Consequently, there is an emerging divide whereby many people of means abandon the standard primary care system in favor of these more exclusive models.³⁶

30. *Id.* at 25; see *infra* Subsection II.B.3 for discussion of direct-to-consumer telemedicine.

31. Elizabeth Dwoskin, Daniel Gilbert & Tatum Hunter, *Doctors Couldn’t Help. They Turned to a Shadow System of DIY Medical Tests*, WASH. POST (June 9, 2024), <https://www.washingtonpost.com/technology/2024/06/09/home-health-tests-doctors-fda/> [https://perma.cc/K5BA-9XCK].

32. See Holly Jeffers & Maureen Baker, *Continuity of Care: Still Important in Modern-Day General Practice*, 66 BRIT. J. GEN. PRAC. 396, 396 (2016).

33. Noam N. Levey, *A Primary Care Physician for Every American*, SCIENCE PANEL URGES, KFF HEALTH NEWS (May 4, 2021), <https://kffhealthnews.org/news/article/primary-care-physician-for-every-american-national-academies-recommendation-empement/> [https://perma.cc/74P6-YH4Y].

34. Sharon Hoffman, *Healing the Healers: Legal Remedies for Physician Burnout*, 18 YALE J. HEALTH POL’Y L. & ETHICS 56, 95–99 (2019).

35. *Id.* at 95–96; Rob Lamberts, *Concierge Medicine vs. Direct Care: What’s the Difference?*, PHYSICIANS PRAC. (Mar. 8, 2023), <https://www.physicianspractice.com/view/concierge-medicine-vs-direct-care-what-s-the-difference-> [https://perma.cc/P9J5-HF4K].

36. Robert M. Portman & Kate Romanow, *Concierge Medicine: Legal Issues, Ethical Dilemmas, and Policy Challenges*, 1 J. HEALTH & LIFE SCIS. L. 1, 35 (2008) (expressing concern that concierge medicine “may create a multi-tiered system of healthcare, with lower-income patients having decreased access to primary and other types of medical care”).

Spending, quality, and access have been described as the “iron triangle”³⁷ or “canonical themes” of health policy.³⁸ Another overarching value is health equity.³⁹ Long appointment wait times undermine all these core principles.⁴⁰

Unfortunately, there are no simple legal solutions to the problem. Some states have enacted laws and regulations to restrict wait times.⁴¹ But these laws are limited in scope and are often poorly enforced.⁴² One impediment is limited PCP availability due to the growing complexity of primary care work for an aging population.⁴³ Full time PCPs are estimated to have approximately 2500 patients in their panels on average, though actual numbers can range from 500 to over 5000.⁴⁴ PCPs provide three types of services: preventive care, chronic disease care, and acute care.⁴⁵ One study found that in order to provide “guideline-recommended primary care” in all three categories for a 2500 patient panel, PCPs would need to work an obviously impossible 26.7 hours per day.⁴⁶ PCPs’ care coordination work has also become more complex because patients are seeing growing numbers of specialists.⁴⁷

Unmanageably large patient panels do not usually reflect PCPs’ preferences. PCPs who are employed by practice groups or health systems may face pressure from their employers to have larger panels to generate more revenue.⁴⁸

37. David N. van der Goes, Nicholas Edwardson, Veeshan Rayamajhee, Christine Hollis & Dawn Hunter, *An Iron Triangle ROI Model for Health Care*, 11 CLINICOECONOMICS & OUTCOMES RSCH. 335, 335 (2019); BRIETTA R. CLARK, ERIN C. FUSE BROWN, ROBERT GATTER, ELIZABETH Y. MCCUSKEY & ELIZABETH PENDO, THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE 4 (9th ed. 2022).

38. Nathan Cortez, *Patients Without Borders: The Emerging Global Market for Patients and the Evolution of Modern Health Care*, 83 IND. L.J. 71, 73–74 (2008).

39. CLARK ET AL., *supra* note 37, at 2–4; Wendy Netter Epstein, *The Health Equity Mandate*, J.L. & BIOSCIENCES, Jan.–June 2022, at 1. Some experts use somewhat different frameworks. One formulation is the “quadruple aim” of enhancing patient experience, improving population health, reducing costs, and improving clinician wellbeing. Thomas Bodenheimer & Christine Sinsky, *From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider*, 12 ANNALS FAMILY MED. 573, 573 (2014). Another articulates six aims for the healthcare system, asserting that care must be safe, effective, patient-centered, timely, efficient, and equitable. *Six Domains of Healthcare Quality*, AHRQ, <https://www.ahrq.gov/talkingquality/measures/six-domains.html> [https://perma.cc/2AFB-EHLM] (last visited Jan. 14, 2026).

40. *See infra* Section III.A.

41. *See infra* Subsection V.B.1.a.

42. *See infra* Subsection V.B.1.b.

43. Peter Grinspoon, *Why Is It So Challenging to Find a Primary Care Physician?*, HARV. HEALTH PUBL’G (Sep. 28, 2022), <https://www.health.harvard.edu/blog/why-is-it-so-challenging-to-find-a-primary-care-physician-202209282822> [https://perma.cc/WGA3-5KPK].

44. Caroline Harrington, *Considerations for Patient Panel Size*, 8 DEL. J. PUB. HEALTH 154, 154 (2022); Michael F. Mayo-Smith et al., *Analysis of Variation in Organizational Definitions of Primary Care Panels: A Systematic Review*, JAMA NETWORK OPEN, Apr. 2022, at 2.

45. Justin Porter, Cynthia Boyd, M. Reza Skandari & Neda Laiterapong, *Revisiting the Time Needed to Provide Adult Primary Care*, 38 J. GEN. INTERNAL MED. 147, 147 (2022).

46. *Id.*

47. Michael L. Barnett, Asaf Bitton, Jeff Souza & Bruce E. Landon, *Trends in Outpatient Care for Medicare Beneficiaries and Implications for Primary Care, 2000–19*, 174 ANN. INTERNAL MED. 1658, 1659 (2021).

48. *See* Grinspoon, *supra* note 43. Employers may pressure physicians to bring in more direct revenue through visits or indirect revenue through specialist referrals, or to include more “covered lives” for provider groups in value-based risk-sharing arrangements like accountable care organizations. *See* Zirui Song, *Accountable Care Organizations in the U.S. Health Care System*, 21 J. CLINICAL OUTCOMES MGMT. 364, 371 (2014) (“Increasing the number of covered lives is a dominant growth strategy under risk contracts . . .”); Anna Wilde

Moreover, there is insufficient primary care capacity to meet population needs.⁴⁹ Some experts anticipate a shortage of 68,000 or more PCPs by 2036.⁵⁰ The U.S. Health Resources and Services Administration estimates that already there is a shortage of over 19,000 physicians in the areas of primary care and mental health care.⁵¹ Physicians entering primary care,⁵² which is relatively low-paying compared to many other medical and surgical specialties, are outnumbered by physicians departing the field because of retirement or burnout.⁵³ At the same time, the demand for care is growing because of the aging American population.⁵⁴

The Article analyzes different legal and policy approaches to remedying primary care access barriers and health care fragmentation. Achieving meaningful change inevitably requires funding expenditures and thus may initially hinder efforts to slow the growth of health care spending.⁵⁵ The long-term gains from improving access and shortening wait times, however, will be well worth the effort.⁵⁶ The Article thus formulates several recommendations.

First, new payment models can support and incentivize the adoption of strategies to reduce appointment wait times.⁵⁷ For instance, alternative or value-based payment models such as Medicare's Accountable Care Organization

Mathews & Melanie Evans, *The Hidden System That Explains How Your Doctor Makes Referrals*, WALL ST. J. (Dec. 27, 2018, at 10:56 ET), <https://www.wsj.com/articles/the-hidden-system-that-explains-how-your-doctor-makes-referrals-11545926166> [<https://perma.cc/AF3V-UFBQ>]. For a discussion of value-based payments and accountable care organizations, see *infra* notes 364–72 and accompanying text.

49. NAT'L CTR. FOR HEALTH WORKFORCE ANALYSIS, *supra* note 15; see *infra* Part IV.

50. GLOBALDATA PLC., *THE COMPLEXITIES OF PHYSICIAN SUPPLY AND DEMAND: PROJECTIONS FROM 2021 TO 2036*, at vii (2024), <https://www.aamc.org/media/75236/download?attachment> [<https://perma.cc/3CYZ-7WBB>] (projecting a “shortage of between 20,200 and 40,400 primary care physicians”); NAT'L CTR. FOR HEALTH WORKFORCE ANALYSIS, *supra* note 15 (“There is a projected shortage of 87,150 full-time equivalent (FTE) primary care physicians by 2037, which will be particularly acute in nonmetro areas.”).

51. Bobby Mukkamala, *The Physician Shortage Will Worsen—Unless Congress Acts Now*, AMA (June 16, 2025), <https://www.ama-assn.org/about/leadership/physician-shortage-will-worsen-unless-congress-acts-now> [<https://perma.cc/ELD4-EMDN>].

52. Aaron E. Carroll, *Why Doctors Aren't Going into Pediatrics*, N.Y. TIMES (July 1, 2024), <https://www.nytimes.com/2024/07/01/opinion/pediatrician-shortage.html> [<https://perma.cc/XD3R-HYRL>] (“The elephant in the exam room, though, is that pediatricians earn less than specialists in almost every other medical field in the United States.”); Richard Payerchin, *Primary Care Physician Pay Up 2.13% in 2021, Still Lower than Specialists*, MED. ECON. (May 25, 2022), <https://www.medicaleconomics.com/view/primary-care-physician-pay-up-2-13-in-2021-still-lower-than-specialists> [<https://perma.cc/BTX8-MN2W>] (reporting that the “[m]edian total compensation for primary care physicians was \$286,525 for 2021,” while surgical specialists’ “median total compensation was \$517,501” and nonsurgical specialists’ median was over \$400,000).

53. See *infra* Section IV.A.

54. Zoe Caplan, *2020 Census: 1 in 6 People in the United States Were 65 and Over*, U.S. CENSUS BUREAU (May 25, 2023), <https://www.census.gov/library/stories/2023/05/2020-census-united-states-older-population-grew.html> [<https://perma.cc/CE4X-FX5L>].

55. See *infra* Subsection III.A.1 (discussing cost concerns).

56. See *infra* notes 350–52 and accompanying text.

57. Kelsey Brykman, Rob Houston, Shilpa Patel & Anne Smithey, *Leveraging Primary Care Population-Based Payments in Medicaid to Advance Health Equity*, HEALTHAFFAIRS (Mar. 3, 2023), <https://www.healthaffairs.org/content/forefront/leveraging-primary-care-population-based-payments-medicare-advance-health-equity> [<https://perma.cc/A7DZ-MX6D>]; Celli Horstman & Corinne Lewis, *Engaging Primary Care in Value-Based Payment: New Findings from the 2022 Commonwealth Fund Survey of Primary Care Physicians*, COMMONWEALTH FUND (Apr. 13, 2023), <https://www.commonwealthfund.org/blog/2023/engaging-primary-care-value-based-payment-new-findings-2022-commonwealth-fund-survey> [<https://perma.cc/AV8F-ZLZF>].

model hold provider groups accountable for total medical spending and care quality for a defined population of patients who receive primary care with that provider group.⁵⁸ Such models may offer the financial flexibility and incentive structure to encourage providers to adopt practices such as using artificial intelligence to facilitate administrative tasks and implementing creative scheduling procedures.⁵⁹ Second, many of the existing legal provisions that address PCP wait times need to be modified to provide clearer guidance as to what constitutes “urgent” and “nonurgent” care along with more robust enforcement mechanisms.⁶⁰ Moreover, Congress should consider enacting a federal mandate concerning appointment wait times for purposes of consistency, uniformity, and clarity.⁶¹ Finally, Congress should pass several proposed bills to increase the supply of PCPs and ease the financial and workload burdens that they face.⁶² While it is admittedly impossible to formulate a comprehensive solution to the challenge of long appointment wait times in primary care, it is essential that government authorities and the medical community make every effort to enhance access to timely primary care.

The remainder of this Article will proceed as follows. Part II describes the benefits of PCP care and the phenomenon of long PCP appointment wait times. It also examines the alternative sources of primary care that have emerged, including urgent care, retail clinics, direct-to-consumer telemedicine, DIY testing, and concierge and direct primary care medicine.⁶³ Part III discusses the cost, quality, access, and equity implications of PCP appointment barriers. It also analyzes the legal risks of medical malpractice and unlawful discrimination claims.⁶⁴ Part IV probes the PCP shortage. Part V evaluates several legal and policy interventions that may shorten appointment wait times and improve access to PCPs. Part VI concludes.

II. PCP WAIT TIMES AND ALTERNATIVE MODELS OF PRIMARY CARE

Obtaining timely PCP appointments is becoming increasingly difficult for American patients.⁶⁵ This section will explain the value of primary care and analyze the appointment wait time phenomenon. It will also discuss one of the consequences of appointment barriers: care fragmentation due to the use of alternatives that have emerged to fill the PCP gap. These include urgent care centers, retail clinics, direct-to-consumer telemedicine, DIY tests, and concierge and direct primary care physicians.

58. Horstman & Lewis, *supra* note 57.

59. Brykman et al., *supra* note 57; *see infra* Subsection V.A.1.

60. *See infra* notes 431–40 and accompanying text.

61. *See infra* notes 449–50 and accompanying text.

62. *See infra* Subsection V.B.2.

63. *See infra* Section II.B.

64. *See infra* Section II.B.

65. *See, e.g.,* Osei, *supra* note 10.

A. Primary Care and Appointment Wait Times

The seriousness of long appointment wait times cannot be understood without an appreciation of the value of primary care.⁶⁶ Its benefits are at risk when patients are unable to obtain timely PCP attention.⁶⁷

1. The Value of Primary Care

The value of primary care is defined by the four core functions (the “4Cs”) of primary care: first contact access, continuity, comprehensiveness, and care coordination.⁶⁸ First contact access means that PCPs provide patients with an entryway into the medical system and should be patients’ first contact point when they have new symptoms.⁶⁹

Continuity of care can be defined as “the ongoing relationship between the physician and the patient.”⁷⁰ It refers to a trusted, longstanding relationship with a PCP who knows the patient’s medical history, drug list, personality, and preferences and can base diagnostic and treatment decisions on these factors.⁷¹ Continuity of care is “vital to high-quality primary care” and is associated with patient trust, patient satisfaction, positive health care outcomes, and even lower spending.⁷²

Research has shown that there is a benefit to seeing one’s own PCP rather than other PCPs in the same practice.⁷³ If patients cannot see their own PCP, it is better for them to see another PCP in the same practice than to see a doctor outside the practice.⁷⁴ Thus, both physician-level and practice-level continuity are beneficial.⁷⁵

66. Douglas B. Jacobs, Christiane T. LaBonte & Meena Seshamani, *Changing Medicare Payment to Strengthen Primary Care*, 392 NEW ENG. J. MED. 211, 211 (2025) (“Few relationships in medicine are as sacred as the relationship between patients and their primary care practitioners.”).

67. *Id.*

68. Jimenez et al., *supra* note 14, at 1.

69. Friedberg et al., *supra* note 14, at 770–71.

70. Andrew Bazemore, Zach Merenstein, Lara Handler & John W. Saultz, *The Impact of Interpersonal Continuity of Primary Care on Health Care Costs and Use: A Critical Review*, 21 ANNALS FAM. MED. 274, 274 (2023).

71. Nan Liu, Stacey R. Finkelstein, Margaret E. Kruk & David Rosenthal, *When Waiting to See a Doctor Is Less Irritating: Understanding Patient Preferences and Choice Behavior in Appointment Scheduling*, 64 MGMT. SCI. 1975, 1979 (2018) (“[I]t can be considered risky to not see one’s regular doctor because seeing a doctor who is familiar with one’s condition and medical history can increase continuity of care and decrease the likelihood of mistakes being made . . .”).

72. Ishani Ganguli et al., *Who’s Accountable? Low-Value Care Received by Medicare Beneficiaries Outside of Their Attributed Health Systems*, 42 HEALTH AFFS. 1128, 1128 (2023) (linking care continuity with less use of low-value care); Vidya Sudhakar-Krishnan & Mary CJ Rudolf, *How Important Is Continuity of Care?*, 92 ARCHIVES DISEASE CHILDHOOD 381, 381 (2007).

73. Zhou Yang et al., *Physician- Versus Practice-Level Primary Care Continuity and Association with Outcomes in Medicare Beneficiaries*, 57 HEALTH SERVS. RSCH. 914, 921 (2022).

74. *Id.*

75. *Id.* at 914.

Primary care is also defined by care comprehensiveness and care coordination.⁷⁶ Care comprehensiveness refers to the extent to which the PCP and team recognize and meet the totality of their patients' medical needs.⁷⁷ PCPs also coordinate patients' care across care settings (like a hospital or skilled nursing facility) and across clinicians when patients see multiple specialists.⁷⁸ For example, PCPs often review patients' prescription lists to ensure they will not experience drug-drug interactions or other harm from medications that different specialists prescribe.⁷⁹

PCPs also oversee patients' preventive care, such as vaccines and mammograms, and they monitor chronic conditions.⁸⁰ PCPs, therefore, do far more than offer discrete services.⁸¹ They treat patients holistically, striving to ensure that their medical needs are fully met.⁸²

2. PCP Appointment Wait Times

The Merritt Hawkins and ECG Management Consultants surveys discussed above focused on family medicine doctors.⁸³ They did not address other types of primary care physicians (*e.g.*, internists, geriatricians).⁸⁴ They also did not address wait times for established rather than new patients.⁸⁵ It is very difficult to find reliable scheduling statistics about existing patients because few health care providers publicly report waiting times.⁸⁶ For purposes of determining new patient appointment availability, researchers were able to call physician offices and

76. See Jimenez et al., *supra* note 14, at 1.

77. Ann S. O'Malley et al., *Medicare Beneficiaries with More Comprehensive Primary Care Physicians Report Better Primary Care*, 58 HEALTH SERVS. RSCH. 264, 265 (2023).

78. *Care Coordination*, CTRS. MEDICARE & MEDICAID SERVS., <https://www.cms.gov/priorities/innovation/key-concepts/care-coordination> [<https://perma.cc/2LBN-J8MQ>] (last visited Jan. 14, 2026).

79. Knvul Sheikh, *Taking Multiple Medications? You May Need to Scale Back*, N.Y. TIMES (Apr. 22, 2024), <https://www.nytimes.com/2024/04/22/well/live/medication-prescription-drug-use.html> [<https://perma.cc/8RLU-VL4D>].

80. See, *e.g.*, Elisabeth Rosenthal, *The Shrinking Number of Primary Care Physicians Is Reaching a Tipping Point*, KFF HEALTH NEWS (Sep. 8, 2023), <https://kffhealthnews.org/news/article/lack-of-primary-care-tipping-point/> [<https://perma.cc/98Q5-4CLS>].

81. *Id.*

82. Yang et al., *supra* note 73, at 915.

83. AMN HEALTHCARE & MERRITT HAWKINS, *supra* note 4, at 3; MOODY ET AL., *supra* note 9, at 17 (discussing pediatric practices and other specialties as well).

84. Beth Averbeck, *5 Types of Primary Care Doctors and How to Choose Which Is Right for You*, HEALTHPARTNERS, <https://www.healthpartners.com/blog/5-types-primary-care-doctors/> [<https://perma.cc/GSR3-ED7L>] (last visited Jan. 14, 2026).

85. *Id.*

86. Molly Gamble, *The 38-Day Delay: What the Wait Time Average Says About Healthcare Access*, BECKER'S HOSP. REV. (July 23, 2024), <https://www.beckershospitalreview.com/strategy/the-38-day-delay-what-the-wait-time-average-says-about-healthcare-access.html> [<https://perma.cc/6HTQ-U5Y7>] (“Not only are patient wait times difficult for health systems to track, but the data can also reside in various departments of a health system” and thus be fragmented); Elisabeth Rosenthal, *The Health Care Waiting Game*, N.Y. TIMES (July 5, 2014), <https://www.nytimes.com/2014/07/06/sunday-review/long-waits-for-doctors-appointments-have-become-the-norm.html> [<https://perma.cc/Q3KC-UETG>] (noting that the Department of Veterans Affairs is “one of the only health care systems in the nation that openly tracks waiting times and has standards for what they should be”).

profess to be new patients who needed appointments, or they were able to access online scheduling calendars.⁸⁷ But they could not pretend to be existing patients because they would not have access to the names and personal details of such individuals.⁸⁸

One available figure is that 60% of established patients who wish to see their primary care physicians are given appointments that are two weeks away, and only 10% can see their physicians the same day they call.⁸⁹ Another source states that at outpatient family medicine clinics, the average timespan between requesting an appointment and receiving care is twenty-four days.⁹⁰ Anecdotally, wait times can be far longer, on the order of several or many months.⁹¹

For a patient who feels acutely ill with symptoms such as a fever and sore throat or who is concerned about new, unfamiliar symptoms, a delay of two or more weeks can seem interminable.⁹² In some cases, the condition might resolve on its own and may not have truly required a medical visit.⁹³ In many other cases, lack of prompt treatment, such as Paxlovid for COVID-19 or antibiotics for serious infections, can also put patients at risk of more severe disease.⁹⁴ Schedulers who answer phones at physicians' offices may not have the medical knowledge needed to triage patients appropriately and determine whether they need to be seen immediately.⁹⁵

Under some health plans, patients must receive referrals from PCPs in order to visit specialists.⁹⁶ This can lead to additional frustration for patients if they wait weeks to see their PCPs only to wait many additional weeks or months to see a specialist after a referral.⁹⁷

87. AMN HEALTHCARE & MERRITT HAWKINS, *supra* note 4, at 3; MOODY ET AL., *supra* note 9, at 6.

88. AMN HEALTHCARE & MERRITT HAWKINS, *supra* note 4, at 3; MOODY ET AL., *supra* note 9, at 6.

89. Rebekah Bernard, *Considering a Direct Care Practice*, MED. ECON. (Mar. 31, 2022), <https://www.medicaleconomics.com/view/considering-a-direct-care-practice> [<https://perma.cc/UHY9-AWWH>].

90. Sharan Srinivas & A. Ravi Ravindran, *Designing Schedule Configuration of a Hybrid Appointment System for a Two-Stage Outpatient Clinic with Multiple Servers*, 23 HEALTH CARE MGMT. SCI. 360, 360 (2020).

91. *New Survey Finds 26% of Patients Wait Two or More Months for Care*, AANP NEWS (July 12, 2023), <https://www.aanp.org/news-feed/two-in-five-americans-report-unreasonable-health-care-wait-times> [<https://perma.cc/2LG9-BFU2>].

92. *See* discussion, *supra* Part I.

93. *See, e.g., Viral Infections, Care Instructions*, KAISER PERMANENTE, <https://healthy.kaiserpermanente.org/health-wellness/health-encyclopedia/he.viral-infections-care-instructions.abn3526> [<https://perma.cc/226T-L7C8>] (last visited Jan. 14, 2026).

94. Jacobs et al., *supra* note 66, at 211 (“Without primary care, minor illnesses can evolve into chronic conditions”); Dallas J. Smith, Anastasia Lambrou & Pragna Patel, *SARS-CoV-2 Rebound with and Without Use of COVID-19 Oral Antivirals*, 72 MORBIDITY & MORTALITY WKLY. REP. 1357, 1363 (2023) (“Early recommended antiviral treatment prevents hospitalizations and deaths among patients with mild-to-moderate COVID-19 who are at risk for severe disease.”); Evan J. Zasowski et al., *A Systematic Review of the Effect of Delayed Appropriate Antibiotic Treatment on the Outcomes of Patients with Severe Bacterial Infections*, 158 CHEST 929, 929 (2020) (“Avoiding delayed appropriate therapy is essential to reduce mortality in patients with severe bacterial infections.”).

95. *See* Debra Kane Hill & Richard F. Cahill, *Telephone Triage and Advice: Patient Safety Strategies*, DRS. CO., <https://www.thedoctors.com/articles/telephone-triage-and-advice-patient-safety-strategies/> [<https://perma.cc/9AUW-XGRW>] (last visited Jan. 14, 2026).

96. *HMO, PPO, POS, EPO & HDHP: What's the Difference*, AETNA, <https://www.aetna.com/health-guide/hmo-pos-ppo-hdhp-whats-the-difference.html> [<https://perma.cc/996J-2BEF>] (last visited Jan. 14, 2026).

97. *Id.*

PCP appointment wait times have lengthened in recent decades because primary care capacity has not kept up with an overall increase in patient demand for care, particularly among older adults.⁹⁸ Increased demand is attributable in part to the Affordable Care Act, which enabled more Americans to gain insurance coverage for primary care visits.⁹⁹ In addition, the population has aged, and older people have more complex and frequent medical needs.¹⁰⁰

B. Health Care Fragmentation Resulting from PCP Access Barriers

How have patients responded to the PCP appointment wait time phenomenon? Some individuals forego necessary care altogether.¹⁰¹ Others needlessly visit emergency rooms.¹⁰² According to one survey, three out of four respondents believed that it was easier to visit an emergency room than to get a PCP appointment.¹⁰³ Yet, emergency rooms are an extremely expensive care source, costing on average over \$2,400 per visit.¹⁰⁴

Contemporary patients can also turn to new sources of primary care services that have emerged to fill existing gaps.¹⁰⁵ These include urgent care centers, retail clinics, and direct-to-consumer telemedicine platforms.¹⁰⁶ Thus, patients may receive care on different occasions from a variety of sources, opting for the most convenient source each time.¹⁰⁷ There is much to be said for being able to access a visit within hours of developing symptoms, and often patients obtain good care.¹⁰⁸ But care fragmentation can be problematic for reasons explained below in Part III.¹⁰⁹ The proliferation of DIY at-home testing that does not involve clinicians at all also raises concerns about patient welfare.¹¹⁰

Long PCP appointment wait times are also associated with another form of fragmentation. Patients with financial means increasingly opt for concierge medicine or direct primary care, in which each PCP cares for a small panel of

98. *AMA President Sounds Alarm on National Physician Shortage*, AM. MED. ASS'N (Oct. 25, 2023), <https://www.ama-assn.org/press-center/press-releases/ama-president-sounds-alarm-national-physician-shortage> [<https://perma.cc/S3SZ-LM9U>].

99. Rosenthal, *supra* note 86.

100. GLOBALDATA, *supra* note 50, at viii.

101. Ilana Yurkiewicz, *Why It Takes Forever to Get a Doctor's Appointment*, TIME (Sep. 12, 2023, at 14:00 ET), <https://time.com/6313270/doctors-overworked-patients-access/> [<https://perma.cc/7R7T-HTAU>] (“Patients who can’t get appointments navigate their own lose-lose options: they try to self-manage medical concerns . . .”).

102. *Id.*

103. Kharraz, *supra* note 22.

104. Hope Schwartz et al., *Emergency Department Visits Exceed Affordability Threshold for Many Consumers with Private Insurance*, PETERSON-KFF HEALTH SYS. TRACKER (Dec. 16, 2022), <https://www.healthsystemtracker.org/brief/emergency-department-visits-exceed-affordability-thresholds-for-many-consumers-with-private-insurance/> [<https://perma.cc/74SC-XSYR>] (“Large employer plan enrollees’ emergency department visits cost \$2,453, on average, with enrollees responsible for \$646 in out-of-pocket costs.”).

105. *See infra* Subsections II.B.1–3.

106. *See infra* Subsections II.B.1–3.

107. *See infra* Subsections II.B.1–3.

108. *See infra* Subsections II.B.1–3.

109. *See infra* Part III.

110. Dwoskin et al., *supra* note 31.

patients.¹¹¹ These models require retainer fees but promise patients a far greater degree of responsiveness from their PCPs.¹¹² Individual patients, therefore, enjoy greater continuity of care and timelier first contact access to care.¹¹³ At the same time, these models raise health equity concerns as their availability depends on patients' financial resources.¹¹⁴

1. Urgent Care Centers

Urgent care centers are flourishing in the United States.¹¹⁵ The American Academy of Urgent Care Medicine defines urgent care medicine as “the provision of immediate medical service offering outpatient care for the treatment of acute and chronic illness and injury.”¹¹⁶ According to the Urgent Care Association (“UCA”), as of November 2025, there were 15,239 urgent care centers across the nation,¹¹⁷ though approximately half are concentrated in ten densely populated states, such as California, Florida, and Texas.¹¹⁸ Consequently, individuals in rural and other sparsely populated areas may have difficulty locating urgent care facilities.¹¹⁹

The UCA has established a certification program that details what staffing and capacities certified urgent care centers must have.¹²⁰ The UCA describes certified urgent care centers' requirements as follows:

[their] capabilities must include X-ray (chest X-ray, c-spine, long bone films, abdomen and extremities) laboratory and EKG. Certified centers must have designated exam rooms, treatment rooms, radiology rooms and laboratories. Emergency equipment supplies and medications must be stocked for both adult and pediatric populations,

111. See *infra* Subsection II.B.5.

112. Portman & Romanow, *supra* note 36, at 3.

113. *Id.* at 5.

114. *Id.* at 27.

115. Joshua Lefcowitz, *Valuation of Urgent Medical Care Centers in U.S.*, 19 VALUATION STRATEGIES 14, 16 (2016).

116. *Welcome to the AAUCM*, AM. ACAD. URGENT CARE MED., <https://aaucm.org/> [<https://perma.cc/TFZ3-MSQ6>] (last visited Jan. 18, 2026).

117. *Urgent Care Association Numbers*, URGENT CARE ASS'N, <https://urgentcareassociation.org/> [<https://perma.cc/39MN-WDD7>] (last visited Jan. 14, 2026).

118. *How Many Urgent Care Centers Are in Each U.S. State?*, DEFINITIVE HEALTHCARE (June 30, 2025), <https://www.definitivehc.com/resources/healthcare-insights/us-urgent-care-centers-by-state> [<https://perma.cc/M8JP-ZQ7F>]; URGENT CARE ASSOCIATION, URGENT CARE INDUSTRY WHITE PAPER: THE ESSENTIAL NATURE OF URGENT CARE IN THE HEALTHCARE ECOSYSTEM POST-COVID-19, at 6–7 (2023), <https://urgentcareassociation.org/wp-content/uploads/2023-Urgent-Care-Industry-White-Paper.pdf> [<https://perma.cc/U97S-HRB6>] [hereinafter *UCA Whitepaper*].

119. Alan A. Ayers, *Successful Site Selection in Urgent Care*, J. URGENT CARE MED. (Feb. 1, 2018), <https://www.jucm.com/successful-site-selection-urgent-care/> [<https://perma.cc/E6TQ-5WXY>] (asserting that urgent care gravitates “toward the more affluent suburbs of larger cities”).

120. *UCA Certification Types*, URGENT CARE ASS'N, <https://urgentcareassociation.org/wp-content/uploads/UCA-Certification-Types-Grid-20FEB2024.pdf> [<https://perma.cc/QV6U-WKET>] (last visited Jan. 14, 2026); *UCA Whitepaper*, *supra* note 118, at 11.

and the center's Medical Director must have an unrestricted license. Certified centers must accept walk-ins during all hours.¹²¹

In addition, the UCA offers accreditation to “recognize Urgent Care centers that meet specific quality, safety and scope of service standards” so that centers can be both certified and accredited.¹²² The National Urgent Care Center Accreditation classifies urgent care centers into four levels, based on their staffing and the scope of services they provide.¹²³

The out-of-pocket cost of an urgent care visit varies widely based on factors including location, the services rendered, the clinician, and insurance coverage.¹²⁴ An article in *Forbes Advisor* indicates that obtaining up to 5 stitches costs approximately \$150, an EKG costs about \$109, and a visit for a urinary tract infection costs \$142, though insurance generally covers at least part of the charges.¹²⁵

Urgent care centers are commonly staffed by physician assistants and nurse practitioners and do not have a physician regularly present.¹²⁶ Only a few states have enacted laws that govern staffing at urgent care centers.¹²⁷ For example, Arizona requires that urgent care centers without a physician on-site post a sign in the waiting room indicating the absence of a doctor.¹²⁸ New Hampshire requires only the presence of one “licensed practitioner,” which is defined to include doctors, physician assistants, and advanced practice registered nurses, among others.¹²⁹

121. *UCA Whitepaper*, *supra* note 118, at 11.

122. *Id.* at 21.

123. *Classification of Urgent Care Centers*, NAT'L URGENT CARE CTR. ACCREDITATION, <http://ucaccreditation.org/classification-of-uccs.html> [https://perma.cc/ZR2G-BHFN] (last visited Jan. 14, 2026).

124. Penny Gusner, *How Much Does an Urgent Care Visit Cost in 2024?*, FORBES: ADVISOR (July 23, 2025, at 12:39 ET), <https://www.forbes.com/advisor/health-insurance/urgent-care-cost/> [https://perma.cc/CAX2-8PDS].

125. *Id.*

126. Benjamin Barlow, Monte Sandler & Alan A. Ayers, *How Urgent Care Can Address Its Degrading Scope of Practice*, J. URGENT CARE MED. (Nov. 30, 2022), <https://www.jucm.com/how-urgent-care-can-address-its-degrading-scope-of-practice/> [https://perma.cc/FTT7-4TVQ] (“Today, 84% of providers working in urgent care clinics are APPs [advanced practice providers] . . .”); Ed Phippen, *New Survey: Physician Appointment Wait Times Getting Longer*, WASH. STATE HOSP. ASS'N (Jan. 5, 2023), <https://web.archive.org/web/20230127182343/https://www.wsha.org/articles/new-survey-physician-appointment-wait-times-getting-longer/> [https://perma.cc/4GFC-K99M]; Jamie Reno, *Why You Might See a Nurse Practitioner and Not a Doctor at Your Urgent Care Clinic*, HEALTHLINE (Nov. 4, 2019), <https://www.healthline.com/health-news/nurse-practitioner-no-doctor-urgent-care-center> [https://perma.cc/AV6E-2MLU]; *Evolving Decision Support for PAs, NPs, and the Rise of Urgent Care*, WOLTERS KLUWER (Sep. 12, 2022), <https://www.wolterskluwer.com/en/expert-insights/evolving-decision-support-for-pa-np-and-the-rise-of-urgent-care> [https://perma.cc/VR7M-5FPD].

127. TESS SOLOMON, KELLY JO POPKIN, AMY CHEN, LOIS UTTLLEY & SUSANNAH BARUCH, CMTY. CATALYST & NAT'L HEALTH L. PROGRAM, MAKING “CONVENIENT CARE” THE RIGHT CARE FOR ALL: IMPROVING STATE OVERSIGHT OF URGENT CARE CENTERS AND RETAIL HEALTH CLINICS 14 (2022), <https://www.communitycatalyst.org/wp-content/uploads/2022/11/Urgent-Care-Center-Brief-1.pdf> [https://perma.cc/5MKR-D5KZ].

128. ARIZ. REV. STAT. ANN. §§ 36-432 (2025).

129. N.H. CODE ADMIN. R. ANN. He-P 806.03(ap), 806.16(a) (2019).

Most states do not issue state licenses for urgent care centers and allow them to operate under physicians' or hospital licenses.¹³⁰ Consequently, these facilities are subject to limited oversight by state departments of health.¹³¹

2. Retail Health Clinics

Retail health clinics ("RHC") are "in-store clinics that provide health care and treat minor illnesses and injuries."¹³² RHCs are often found in pharmacies, grocery stores, and discount or mass merchandise stores such as Target.¹³³ Retail clinics can be staffed by advanced practice clinicians such as nurse practitioners and physician assistants with remote supervision by a licensed physician.¹³⁴ They must be able to provide basic laboratory services on-site but do not perform imaging or suturing.¹³⁵

As of July 2024, there were 1,733 RHCs in forty-three states, typically located in large metropolitan areas, while in 2023 there had been 1,801.¹³⁶ During the intervening year, both Walmart and Walgreens closed dozens of RHCs for financial reasons.¹³⁷ Ninety-six percent of RHCs are located in urban rather than rural areas because they can be more profitable in cities.¹³⁸

RHC visits often cost less than care at other types of facilities.¹³⁹ According to one analysis of claims for ten common diagnoses, on average, RHCs submitted claims that were \$38 lower than those submitted by urgent care centers, \$471 lower than physician offices' claims, and \$746 lower than emergency room

130. Alan A. Ayers, *States Grapple with Their Own Regulatory Approach to Urgent Care*, J. URGENT CARE MED. (Nov. 24, 2015), <https://www.jucm.com/states-grapple-with-their-own-regulatory-approach-to-urgent-care/> [https://perma.cc/4EHJ-58ZP]; SOLOMON ET AL., *supra* note 127, at 6; *Urgent Care Centers*, AM. COLL. EMERGENCY PHYSICIANS (Jan. 2022), <https://www.acep.org/patient-care/policy-statements/urgent-care-centers> [https://perma.cc/8TNC-TDNC]. *But see* ARIZ. ADMIN. CODE § R9-10-1002 (effective May 1, 2016); CONN. GEN. STAT. ANN. §§ 19a-493d(a)(2)–(b) (West 2018); MASS. GEN. LAWS ANN. ch. 111, § 51 (West 2021), § 52 (West 2015); N.H. REV. STAT. ANN. § 151:2(I)(d) (2025); 216 R.I.C.R. 40-10-3.3.A(2), (11) (LexisNexis 2022); 216 R.I.C.R. 40-10-3.4.1(A) (LexisNexis 2022).

131. *See supra* note 127–31 and accompanying text.

132. Alice Zawacki, Joey Marshall, Donald Cherry, Xianghua Yin & Brian W. Ward, *Is There a Retail Health Clinic Near You? Two Thousand Retail Health Clinics Provided Walk-In Health Services Mostly in Metropolitan Areas*, U.S. CENSUS BUREAU (Mar. 28, 2023), <https://www.census.gov/library/stories/2023/03/retail-health-clinics-near-you.html> [https://perma.cc/77AS-3KKT].

133. Kristin E. Schleiter, *Retail Medical Clinics: Increasing Access to Low Cost Medical Care Amongst a Developing Legal Environment*, 19 ANNALS HEALTH L. 527, 531 (2010).

134. *Classification of Urgent Care Centers*, *supra* note 123.

135. *Id.*

136. Jeff Lagasse, *Retail Clinics Seeing Utilization Soar, Popularity Grow*, HEALTHLINE FIN. (June 1, 2023), <https://www.healthcarefinancenews.com/news/retail-clinics-seeing-utilization-soar-popularity-grow> [https://perma.cc/5B8R-HWWQ]; *How Many Retail Clinics Are in the U.S.?*, DEFINITIVE HEALTHCARE (July 17, 2024), <https://www.definitivehc.com/resources/healthcare-insights/retail-clinics-us> [https://perma.cc/5FTQ-M23Y].

137. Susan Morse, *Retail Clinic Failures Show Collaboration May Work Better than Competition*, HEALTHCARE FIN. (May 15, 2024, at 12:18 CT), <https://www.healthcarefinancenews.com/news/retail-clinic-failures-show-collaboration-may-work-better-competition> [https://perma.cc/WL6L-CC9P].

138. *Id.*

139. Lagasse, *supra* note 136.

claims.¹⁴⁰ As one example, Northern California's Sutter Walk-In Care advertises the following prices on its website for people paying out of pocket: "Standard visit: Approximately \$192; Vaccines: Approximately \$50 to \$288; Screenings: \$99."¹⁴¹

Like urgent care centers, RHCs are generally exempt from state licensure requirements and regulatory oversight.¹⁴² Only a handful of states have implemented licensing regulations.¹⁴³

3. *Direct-to-Consumer Telemedicine*

Instead of visiting a clinician in person, some patients opt to remain in the comfort of their own homes and to access care through telemedicine.¹⁴⁴ Telemedicine is the use of "telecommunications technologies to support the delivery of . . . medical, diagnostic and treatment-related services usually by doctors."¹⁴⁵

In the wake of the COVID-19 pandemic, most physician practices developed telemedicine capabilities.¹⁴⁶ A 2023 American Medical Association report states that over 74% of physicians work in practices that offer telehealth, but only a small percentage of appointments are conducted by videoconference or audio-only technology (seven and five visits per week respectively).¹⁴⁷

Patients with overscheduled PCPs may have to wait for telemedicine appointments even though they are foregoing in-person visits.¹⁴⁸ Consequently, some patients who want immediate care turn to third party telemedicine providers that offer remote services similar to those available at RHCs.¹⁴⁹ Costco,

140. *Id.*

141. *Walk-In Care*, SUTTER HEALTH, <https://www.sutterhealth.org/services/primary/walk-in-care-cost-health-plans> [<https://perma.cc/4NUA-AD53>] (last visited Jan. 14, 2026).

142. SOLOMON ET AL., *supra* note 127, at 8.

143. ARIZ. ADMIN. CODE R9-10-101.158, R9-10-102.A.16 (2022); MASS. GEN. LAWS ANN. ch. 111, §§ 51 (2021), 52 (2015); N.H. REV. STAT. ANN. § 151:2(I)(d) (2023); 216 R.I.C.R. § 40-10-3.3.A(2), (11), § 40-10-3.4.1(A) (LexisNexis 2022).

144. Fran Kritz, *Would You Try Costco Virtual Healthcare? What to Know About Retailer-Sponsored Telehealth*, VERYWELL HEALTH (Jan. 2, 2024), <https://web.archive.org/web/20250320145907/https://www.verywellhealth.com/major-retailers-offer-dtc-telehealth-8418818> [<https://perma.cc/ZAC4-BHCG>].

145. *Telehealth, Telemedicine, and Telecare: What's What?*, FCC, <https://www.fcc.gov/general/telehealth-telemedicine-and-telecare-whats-what> [<https://perma.cc/LN5D-5Z8E>] (last visited Jan. 14, 2026); *see also* Laura C. Hoffman, *Reconnecting the Patient: Why Telehealth Policy Solutions Must Consider the Deepening Digital Divide*, 36 J.L. & HEALTH 1, 6–7 (2022) (defining telehealth and telemedicine).

146. CAROL K. KANE, AM. MED. ASS'N, *TELEHEALTH IN 2022: AVAILABILITY REMAINS STRONG BUT ACCOUNTS FOR A SMALL SHARE OF PATIENT VISITS FOR MOST PHYSICIANS 1* (2023), <https://www.ama-assn.org/system/files/2022-prp-telehealth.pdf> [<https://perma.cc/SDB8-WXL4>]; Michael Anne Kyle, Renuka Tipirneni, Nitya Thakore, Sneha Dave & Ishani Ganguli, *Primary Care Access During the COVID-19 Pandemic: A Simulated Patient Study*, 36 J. GEN. INTERNAL MED. 3766, 3766 (2021).

147. KANE, *supra* note 146.

148. Gillian Singer, *How Long to Wait for a Telehealth Appointment: Here's What to Know*, EVERLYWELL (Mar. 20, 2023), <https://www.everlywell.com/blog/virtual-care/how-long-to-wait-for-a-telehealth-appointment/> [<https://perma.cc/9XU2-T83Y>] ("If only a few providers are available or if many people are requesting telehealth appointments simultaneously, the wait times can be longer.")

149. Kritz, *supra* note 144.

Walgreens, GNC, Walmart, CVS and Amazon Clinic have all entered the market,¹⁵⁰ providing what is known as direct-to-consumer (“DTC”) telemedicine.¹⁵¹

Telemedicine visits can cost as little as \$29 at Costco.¹⁵² A provider called Family Urgent Care states on its website that patients without insurance coverage can expect to pay between \$40 and \$90 per virtual visit on average.¹⁵³ Many of the retailers listed above do not accept insurance for telemedicine visits.¹⁵⁴

DTC telemedicine can serve patients well if they have simple, discrete needs such as obtaining Paxlovid for COVID-19.¹⁵⁵ However, it does not provide patients with continuous or comprehensive care.¹⁵⁶ In addition, virtual visits do not allow for physical examinations and on-site lab work, thus raising questions about the quality of care provided during some telemedicine encounters.¹⁵⁷ Telemedicine is also available only to those who have access to and are facile with the needed technology.¹⁵⁸ Consequently, it is used disproportionately by younger, wealthier, urban-dwelling, White individuals.¹⁵⁹ Because of its remote nature, telemedicine has also been criticized for facilitating the perpetration of fraudulent health care schemes.¹⁶⁰ In addition, experts have expressed concern

150. *Id.*

151. MARK VANDERWERF, NAT’L TELEHEALTH TECH. ASSESSMENT CTR., DIRECT TO CONSUMER (DTC) TELEMEDICINE 3 (May 2020), <https://telehealthtechnology.org/wp-content/uploads/2020/09/Direct-to-Consumer-DTC-Telemedicine.pdf> [<https://perma.cc/2NEX-MSZF>] (“Direct to Consumer (DTC) Telemedicine is the provision of healthcare consultations directly to a consumer.”).

152. Adriel Bettelheim, *Costco Joins Retail Push into Primary Care with \$29 Telehealth Visits*, AXIOS (Sep. 26, 2023), <https://www.axios.com/2023/09/26/costco-primary-care-retail> [<https://perma.cc/U3PD-CUN3>].

153. Abeer Fatima, *How Much Does a Telehealth Visit Cost?*, FAM. URGENT CARE, <https://famurgentcare.com/blog/how-much-does-telehealth-virtual-visit-cost/> [<https://perma.cc/2QHG-AB7Z>] (last visited Jan. 18, 2026).

154. Kritz, *supra* note 144.

155. *Id.*

156. Robert S. Huckman, Vivian S. Lee & Bradley R. Staats, *Retailers and Health Systems Can Improve Care Together*, HARV. BUS. REV. (Mar.–April 2024), <https://hbr.org/2024/03/retailers-and-health-systems-can-improve-care-together> [<https://perma.cc/42K5-A6AC>]. See *supra* Subsection II.A.1 for discussion of the importance of care continuity, comprehensiveness, and coordination.

157. Julia Shaver, *The State of Telehealth Before and After the COVID-19 Pandemic*, 49 PRIMARY CARE CLINICAL OFF. PRAC. 517, 522–23 (2022) (discussing studies that found that direct-to-consumer telemedicine patients “may be more likely to receive inappropriate antibiotics than when seen in face-to-face care and are less likely to receive an appropriate rapid strep test for evaluation of pharyngitis”); Todd Shryock, *Telemedicine Still Popular with Patients, but There Are Concerns*, MED. ECONS. (Sep. 16, 2022), <https://www.medicaleconomics.com/view/telemedicine-still-popular-with-patients-but-there-are-concerns> [<https://perma.cc/FZ7X-E8AR>].

158. Shryock, *supra* note 157.

159. Hoffman, *supra* note 145, at 14–20; Tara Jain & Ateev Mehrotra, *Comparison of Direct-to-Consumer Telemedicine Visits with Primary Care Visits*, 3 JAMA NETWORK OPEN, Dec. 8, 2020, at 3E; Shaver, *supra* note 157, at 521, 526.

160. Katrice Bridges Copeland, *Telemedicine Scams*, 108 IOWA L. REV. 69, 69 (2022); Chinelo Diké-Minor, *Be Careful What You Wish for: An Overreliance on Telemedicine Could Harm Health Equity*, 33 ANNALS HEALTH L. & LIFE SCIS. 137, 158 (2024) (“Telemedicine fraud schemes combine the complexity of most health care fraud schemes with other difficulties that make these schemes more difficult to investigate and prosecute . . .”); OFF. INSPECTOR GEN., U.S. DEP’T HEALTH & HUM. SERVS., SPECIAL FRAUD ALERT: OIG ALERTS PRACTITIONERS TO EXERCISE CAUTION WHEN ENTERING INTO ARRANGEMENTS WITH PURPORTED TELEMEDICINE COMPANIES 1 (2022), <https://oig.hhs.gov/documents/root/1045/sfa-telefraud.pdf> [<https://perma.cc/EH2F-LRSL>].

about a dearth of applicable regulations, especially with respect to telemedicine providers' ability to prescribe controlled substances.¹⁶¹

4. *DIY Testing*

At-home tests have long been available for conditions such as pregnancy, diabetes, COVID-19, and many more.¹⁶² But the *Washington Post* reported that a “new world of DIY testing is changing the relationship between physicians and patients, allowing people . . . to bypass the doctors [sic] office and take medical tests on their own.”¹⁶³ Silicon Valley start-up companies are offering tests for menopause, food allergies, thyroid and testosterone levels, ADHD, and even sexually-transmitted diseases.¹⁶⁴

For their part, physicians question the validity and accuracy of some of these tests.¹⁶⁵ Moreover, many tests are not subject to regulation by the Food and Drug Administration,¹⁶⁶ though the agency is working to broaden its authority over laboratory tests.¹⁶⁷ In addition to DIY testing, some patients are turning to DIY treatments such as dietary changes and supplements and are avoiding physicians' offices altogether.¹⁶⁸ As appointment wait times lengthen and patients become increasingly frustrated, the DIY trend may well grow.

5. *Concierge Medicine and Direct Primary Care*

Patients who become dissatisfied with appointment wait times and lack of attentiveness from their PCP offices may opt for two “membership models” of care if they can afford them: concierge practices and direct primary care.¹⁶⁹ Concierge patients pay fees that can range from \$1,200 to \$10,000 or more a year in

161. Kaitlin Campanini, “*TikTok Told Me I Have ADHD*”: *Regulatory Outlook for the Telehealth Revolution*, 18 WASH. J.L. TECH. & ARTS 41, 41 (2023) (“This paper argues that the Drug Enforcement Administration’s (‘DEA’) sparse regulatory structure for telehealth companies has fostered an environment where ADHD telehealth companies prescribe controlled substances with impunity.”); Teresa Carr, *Amid Regulatory Gaps, Telehealth Prescribers Flourish*, UNDARK (Nov. 1, 2023), <https://undark.org/2023/11/01/telehealth-drugs/> [<https://perma.cc/DT5R-L6U8>] (“Congress could update laws so that telehealth platforms are subject to the same regulations as drug companies [sic] marketing and promotion.”); Laura C. Hoffman, *Shedding Light on Telemedicine & Online Prescribing: The Need to Balance Access to Health Care and Quality of Care*, 46 AM. J.L. & MED. 237, 251 (2020) (calling upon the “the federal government to provide national regulation on DTC telemedicine companies” and noting that “[t]he variety of state laws complicate” the problems of “overprescribing and inappropriate prescribing”).

162. *At-Home Medical Tests*, MEDLINEPLUS (Sep. 10, 2024), <https://medlineplus.gov/lab-tests/at-home-medical-tests/> [<https://perma.cc/JV3D-4W95>].

163. Dwoskin et al., *supra* note 31.

164. *Id.*

165. *Id.*

166. *Id.*

167. Rachel Roubein & Daniel Gilbert, *FDA Moves to Regulate Some Tests It Says May Be Unreliable*, WASH. POST (Apr. 29, 2024), <https://www.washingtonpost.com/health/2024/04/29/fda-lab-developed-test-medical/> [<https://perma.cc/M785-EJYG>].

168. Dwoskin et al., *supra* note 31.

169. Craig Konnoth, *Health Information Equity*, 165 U. PA. L. REV. 1317, 1332–33 (2017) (“Many of the richest individuals rely on ‘concierge medicine.’”).

return for much greater access to their PCPs.¹⁷⁰ Unlike traditional PCPs who may have upwards of 2500 patients, concierge doctors average a patient panel of approximately 450.¹⁷¹ Consequently, patients can expect same-day or next-day appointments that are as long as necessary, along with after-hours access through phone calls, texting, or email.¹⁷²

Concierge practices are a growing phenomenon.¹⁷³ It is difficult to find data about the precise number of concierge offices in the United States, but a 2021 publication estimated that the figure was 12,000.¹⁷⁴ Many concierge practices bill patients' insurance plans for services, so their income consists of both membership fees and insurance payments.¹⁷⁵

A newer and less expensive version of concierge medicine is direct primary care ("DPC").¹⁷⁶ Like concierge practices, DPC physicians charge patients monthly membership fees in lieu of fee-for-service charges, but they typically do not bill insurers in order to avoid administrative costs and burdens.¹⁷⁷ According to a 2022 study, the average monthly DPC fee is \$77.¹⁷⁸ In return, patients enjoy

170. Brian Eastwood, *What Is Concierge Medicine? How Does It Improve Outcomes?*, HEALTHTECH (Dec. 27, 2022), <https://healthtechmagazine.net/article/2022/12/concierge-medicine-creates-better-patient-outcomes-perforcon> [<https://perma.cc/A3KD-5N25>] (stating that fees can exceed \$20,000 annually); Dawnielle Robinson-Walker, *What Is Concierge Medicine and Is It Worth the Price Tag?*, FORBES (May 18, 2023, at 12:41 CT), <https://www.forbes.com/health/healthy-aging/concierge-medicine/> [<https://perma.cc/5W82-4GKL>].

171. Jeffrey Carr, *Five Compelling Trends to Watch for in 2024 with Concierge Medicine and Healthcare Membership Models*, WORLDCLINIC (Jan. 14, 2024), <https://worldclinic.com/blog/concierge-medicine-trends/> [<https://perma.cc/7T95-5MEP>].

172. Eastwood, *supra* note 170; Robinson-Walker, *supra* note 170.

173. Terry Bauer, *Concierge Medicine Set to Soar in 2024*, MED. ECON. (Jan. 5, 2024), <https://www.medicaleconomics.com/view/concierge-medicine-set-to-soar-in-2024> [<https://perma.cc/7DJL-JFCS>].

174. Michelle Konstantinovsky, *Many Doctors Are Switching to Concierge Medicine, Exacerbating Physician Shortages*, SCI. AM. (Oct. 19, 2021), <https://www.scientificamerican.com/article/many-doctors-are-switching-to-concierge-medicine-exacerbating-physician-shortages/> [<https://perma.cc/9UAN-27PS>].

175. *Direct Primary Care*, AM. ACAD. FAM. PHYSICIANS, <https://www.aafp.org/family-physician/practice-and-career/delivery-payment-models/direct-primary-care.html> [<https://perma.cc/VF57-A4D8>] (last visited Jan. 15, 2026).

176. *Id.*

177. FRITZ BUSCH, DUSTIN GRZESKOWIAK & ERIK HUTH, SOC'Y OF ACTUARIES, *DIRECT PRIMARY CARE: EVALUATING A NEW MODEL OF DELIVERY AND FINANCING 12* (2020), <https://www.soa.org/49c889/globalassets/assets/files/resources/research-report/2020/direct-primary-care-eval-model.pdf> [<https://perma.cc/A3H9-T935>]; Glenn E. Chappell, *Health Care's Other "Big Deal": Direct Primary Care Regulation in Contemporary American Health Law*, 66 DUKE L.J. 1331, 1334 (2017) (stating that in direct primary care "patients pay a periodic—usually monthly—flat-rate fee for all or most of their primary medical care, usually without insurer involvement").

178. Leila C. Tou, Shereen J. Jeyakumar, Taha A. Siddiqui, Srekar Ravi & Nirmala Prakash, *Understanding Patient Perceptions Towards Direct Primary Care: A Focus Group Study*, J. PATIENT EXPERIENCE, Aug. 2022, at 1; *see also* BUSCH ET AL., *supra* note 177, at 14 (reporting monthly fees of \$65 for adults ages 19-24, \$85 for seniors, and \$150 per family); *Answers to Six Common Questions about Direct Primary Care*, QUICK TIPS (Oct. 28, 2025), <https://www.aafp.org/pubs/fpm/blogs/inpractice/entry/dpc-faqs.html> [<https://perma.cc/A8FQ-YJ4A>] ("Monthly DPC membership fees range from \$50 to \$100 for individual adults, \$20 to 49 for children, and \$100 or more for families.").

same day or next-day appointments, thirty-to-sixty-minute appointment slots, and an ability to communicate with their physicians after hours.¹⁷⁹

DPC practices have somewhat larger patient panels than concierge doctors, ranging from four hundred to eight hundred, by one estimate.¹⁸⁰ According to some experts, there are well over two thousand direct primary care practices in the country, but this number is far lower than that of concierge medicine providers.¹⁸¹ It thus may be difficult for many patients to locate DPC physicians.¹⁸² The number of DPC practices may be relatively small because it can be difficult for DPC physicians to maintain profitable practices given their relatively modest fees and the absence of insurance payments.¹⁸³

Beyond lower subscription fees and larger patient loads, there are other differences between DPC and concierge practices. One commentator asserts that unlike DPC, concierge medicine tends “to focus on ‘premium’ services, such as vascular scans, ‘executive’ lab panels, extended office visits, and even going along with patients to specialist visits.”¹⁸⁴ Researchers have found that some of the services routinely included in executive physicals are of low value or appropriate only for subpopulations of patients.¹⁸⁵

Note that patients in both membership models need to maintain health insurance to cover specialists, hospitalizations, and other services that DPC and concierge physicians do not offer.¹⁸⁶ They thus must pay both health insurance premiums and subscription fees.¹⁸⁷ For patients who can afford the fees and value the access and attention that membership practices provide, the payments can be a good investment.¹⁸⁸ But they may be out of reach for individuals with modest incomes.¹⁸⁹ According to a 2020 report, 22% of those in the top 1% of income

179. Gina Roberts-Grey, *Direct Primary Care (DPC): A Consumer's Guide to This Payment Model*, GOODRX (May 21, 2024), <https://www.goodrx.com/insurance/alternative/direct-primary-care> [<https://perma.cc/B6BH-RKYM>].

180. Lamberts, *supra* note 35.

181. Jim Axelrod, *Direct Primary Care Gains Traction as Providers Look for a Better Way to Treat Patients—Without Insurance*, CBS NEWS (Oct. 28, 2025), <https://www.cbsnews.com/news/direct-primary-care-treat-patients-without-insurance/> [<https://perma.cc/J6CH-D5BP>] (stating that there are nearly 3,000 DPC practices in the United States); BUSCH ET AL., *supra* note 177, at 79 (“Unfortunately, the DPCMM model of care remains in its infancy more than ten years after its initial development.”); Jennifer Nelson, *The Evolution of Direct Care and Concierge Medicine*, MEDSCAPE (Nov. 1, 2023), <https://www.medscape.com/viewarticle/997969> [<https://perma.cc/V67J-XAT7>]; *see supra* note 174 and accompanying text.

182. *See supra* note 181 and accompanying text.

183. Eyal Press, *The Moral Crisis of America's Doctors*, N.Y. TIMES (July 14, 2023), <https://www.nytimes.com/2023/06/15/magazine/doctors-moral-crises.html> [<https://perma.cc/M9XA-68C2>].

184. Lamberts, *supra* note 35; *see also* *Direct Primary Care*, *supra* note 175 (indicating that concierge medicine practices offer “in-depth physical exam[s] and screenings” and “[c]ater to higher income populations”).

185. Deborah Korenstein, Maha Mamoor & Peter B. Bach, *Preventive Services Offered in Executive Physicals at Top-Ranked Hospitals*, 322 JAMA NETWORK 1101, 1102 (2019), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6749532/> [<https://perma.cc/RXT6-B9VV>] (“Services with insufficient evidence designations by USPSTF or that are only recommended in subpopulations were frequently included. Some important recommended services, such as risk-based lung cancer screening, were missing from all packages.”).

186. BUSCH ET AL., *supra* note 177, at 82.

187. *See id.*

188. *See id.*

189. *See infra* notes 170, 178 and accompanying text.

earners participate in concierge medicine, while fewer than 10% of middle and lower-income adults do so.¹⁹⁰ The emerging model of retainer fees for attentive primary care thus could lead to significant inequities based on income and socioeconomic status.¹⁹¹

One patient relates the following relevant experience:

I liked my primary care doctor but because I had to wait so long to get an appointment with her, when I was sick, I would go to urgent care. I would only see her for my yearly check-up. . . . Eventually, I got a letter from her practice saying she was going into concierge medicine. You could get same-day appointments, longer appointments that started on time, and reach her by phone, email, or text. But it was \$2,000 a year to join the program, so I opted out and don't currently have a primary care doctor.¹⁹²

A growing trend of primary care physicians shifting to concierge or direct primary care models in which they care for fewer patients will further exacerbate primary care workforce shortages and, in turn, long wait times for patients who do not participate in these models.¹⁹³

III. THE CONSEQUENCES OF LONG PRIMARY CARE WAIT TIMES

Long wait times and the care fragmentation that is associated with them can have practical, ethical, and legal consequences. At times, postponement may allow many medical problems to resolve on their own and spare patients the burden and expense of unneeded care.¹⁹⁴ But in many other cases, long wait times have cost, quality, access, and equity implications and can potentially lead to medical malpractice and discrimination litigation.

A. *Spending, Quality, Access, and Equity*

Spending, quality, and access are the “iron triangle” of health care.¹⁹⁵ Another core theme in health policy is equity.¹⁹⁶ Underlying the “iron triangle” is the notion that spending containment, quality, and access can be in tension with each other.¹⁹⁷ In order to enhance one, such as quality or access, at least one other

190. NPR, ROBERT WOOD JOHNSON FOUND. & HARV. T.H. CHAN SCH. OF PUB. HEALTH, LIFE EXPERIENCES AND INCOME INEQUALITY IN THE UNITED STATES 11 (2020), https://www.hsph.harvard.edu/horp/wp-content/uploads/sites/94/2020/01/Income-inequality-report-topline_January2020.pdf [<https://perma.cc/9SPJ-9M45>].

191. *See id.*

192. JABBARPOUR ET AL., *supra* note 1.

193. *See id.*

194. *See, e.g., Viral Infections, Care Instructions, supra* note 93.

195. Erin C. Fuse Brown, Matthew B. Lawrence, Elizabeth Y. McCuskey & Lindsay F. Wiley, *Social Solidarity in Health Care, American Style*, 48 J.L. MED. & ETHICS 411, 423 (2020); Aaron Carroll, *The “Iron Triangle” of Health Care: Access, Cost, and Quality*, JAMA F. (Oct. 3, 2012), <https://jamanetwork.com/channels/health-forum/fullarticle/2760240> [<https://perma.cc/G2ZT-KLW9>]; *see supra* note 39 for alternative ways to frame the core values of health care.

196. CLARK ET AL., *supra* note 37, at 2; Alicia Fernandez & Marshall H. Chin, *Keep Your Eyes on the Prize—Focusing on Health Care Equity*, 390 NEW ENG. J. MED. 1733, 1733 (2024).

197. van der Goes et al., *supra* note 37, at 335.

may be compromised—*e.g.*, reducing spending.¹⁹⁸ In other words, when one angle in a triangle grows, another shrinks.¹⁹⁹ There are exceptions, however. Reducing expenditures on low-value care, for example, can also enhance quality, access, and equity.²⁰⁰ Long PCP wait times, by contrast, can undercut all four attributes simultaneously.²⁰¹

1. Spending

Patients who opt for urgent care, retail health clinics, or DTC telemedicine in lieu of waiting weeks for an appointment with their PCP do not necessarily pay more for their care.²⁰² In fact, in some cases, they pay less.²⁰³

But some individuals who are told to wait too long for a PCP appointment simply forego care.²⁰⁴ When patients neglect symptoms, they may allow medical problems to fester and intensify and ultimately require costly care that could have been avoided.²⁰⁵ Moreover, primary care has the potential to reduce spending long term by providing preventive care, monitoring chronic diseases, and coordinating care when patients see different specialists.²⁰⁶ One study examined the records of five million VA patients over four fiscal years (2016–19).²⁰⁷ It concluded that a first primary care visit was associated with an average saving of \$3,976, and each subsequent in-person visit saved on average \$721 per patient per year.²⁰⁸ These benefits are lost when patients do not establish a relationship with a PCP and obtain ongoing care.²⁰⁹

Some patients who feel they cannot wait for PCP appointments visit emergency rooms unnecessarily, and doing so is an expensive proposition.²¹⁰ According to one source, 25% of emergency room visits cost patients over \$3,000 without insurance, and patients with insurance on average, pay \$646 out of pocket for an emergency room visit in addition to the insurer's payment.²¹¹ Individuals

198. *Id.*

199. *Id.*

200. *See infra* notes 365–67 and accompanying text.

201. *See infra* Section III.A.

202. *See supra* notes 124–125, 139–141, 152–153 and accompanying text.

203. *See supra* note 202.

204. Taber et al., *supra* note 16, at 294; Yurkiewicz, *supra* note 100.

205. *See* Taber et al., *supra* note 16, at 290 (“Avoiding medical care may result in late detection of disease . . .”).

206. Jian Gao, Eileen Moran, Rachel Grimm, Andrew Toporek & Christopher Ruser, *The Effect of Primary Care Visits on Total Patient Care Cost: Evidence from the Veterans Health Administration*, J. PRIMARY CARE & CMTY. HEALTH, Dec. 2022, at 1.

207. *Id.* at 5 (noting that “an increase in PC use was associated with decreases in avoidable hospitalizations and outpatient visits to mental health providers”).

208. *Id.* at 1.

209. *See id.* at 6–7.

210. *Patient Price Information List*, CLEVELAND CLINIC, <https://my.clevelandclinic.org/-/scassets/files/org/locations/price-lists/main-campus-hospital-patient-price-list.pdf?la=en> [<https://perma.cc/48PE-F3L4>] (last visited Jan. 15, 2026); Kharraz, *supra* note 22.

211. Geoff Williams, *Using the ER for Non-Emergencies Is Expensive—Here Are Other Options*, GOODRX HEALTH (Mar. 23, 2023), <https://www.goodrx.com/healthcare-access/patient-advocacy/avoid-er-for-non-emergencies> [<https://perma.cc/H2YZ-U8UB>].

who appropriately visit emergency rooms because they could not obtain prompt PCP appointments when their symptoms were less severe likewise pay high fees that could have been avoided.²¹²

A growing phenomenon is freestanding emergency departments (“FSED”).²¹³ These licensed facilities may be either associated with hospitals or operated independently and owned by individuals or entities.²¹⁴ Patients often find that they have shorter wait times in FSEDs and that these facilities are located closer to home.²¹⁵ In 2022, there were 841 FSEDs in the United States.²¹⁶ The cost of treatment at FSEDs is comparable to the cost of standard emergency department care.²¹⁷

There is some evidence that retail clinics also contribute to increased spending.²¹⁸ In some cases, they are so convenient that patients visit them for low-acuity conditions such as viral sinusitis for which they would not have otherwise sought medical attention.²¹⁹ Because they have sought care, such patients may receive antibiotic prescriptions that do not help their viral infections, cause adverse side effects, and exacerbate the problem of antibiotic resistance.²²⁰

2. *Quality*

Research has shown that the difference between patients with strong PCP relationships and those without it is measurable.²²¹ One study, for example, found that patients who lose a longstanding PCP experience a 4% increase in

212. See Mayo Clinic Staff, *7 Signs and Symptoms Not to Ignore*, MAYO CLINIC (Feb. 1, 2025), <https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/symptoms-not-to-ignore/art-20045276> [https://perma.cc/62QP-LG5U].

213. *Freestanding Emergency Departments*, AM. COLL. EMERGENCY PHYSICIANS (Apr. 2020), <https://www.acep.org/patient-care/policy-statements/freestanding-emergency-departments> [https://perma.cc/N52X-4LXE].

214. *Id.*; see also *Classification of Urgent Care Centers*, *supra* note 123 (outlining requirements for freestanding emergency departments, which the organization classifies as Level 1 urgent care centers).

215. Alexis Kayser, *The Rise of the Freestanding ED*, BECKER'S HOSP. REV. (Nov. 17, 2023), <https://www.beckershospitalreview.com/capital/the-rise-of-the-freestanding-ed.html> [https://perma.cc/BK9G-C96U]; Erin L. Simon et al., *Same Provider, Different Location: Variation in Patient Satisfaction Scores Between Freestanding and Hospital-Based Emergency Departments*, 38 AM. J. EMERGENCY MED. 968, 968 (2020) (finding that FSEDs “have shorter wait times, higher patient satisfaction and few patients who left without being seen”).

216. EMNet, *Research Finds Rapidly Increasing Number of FSEDs*, EM. MED. NETWORK (July 31, 2024), <https://www.emnet-usa.org/research-finds-rapidly-increasing-number-of-fseds/> [https://perma.cc/6BKP-K4FG].

217. Vivian Ho et al., *Comparing Utilization and Costs of Care in Freestanding Emergency Departments, Hospital Emergency Departments, and Urgent Care Centers*, 70 ANNALS EMERGENCY MED. 846, 846 (2017).

218. J. Scott Ashwood et al., *Retail Clinic Visits for Low-Acuity Conditions Increase Utilization and Spending*, 35 HEALTH AFFS. 449, 449 (2016).

219. *Id.*

220. Candace Nelson, *Antibiotics & the Dangers of Overprescribing*, MAYO CLINIC (Apr. 10, 2023), <https://mcpress.mayoclinic.org/parenting/antibiotics-the-dangers-of-overprescribing/> [https://perma.cc/8R9U-PDY2]; *Antibiotic Use in Retail Health Clinics, While Encouraging, Shows Room for Improvement*, PEW (July 16, 2018), <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2018/07/antibiotic-use-in-retail-health-clinics-while-encouraging-shows-room-for-improvement> [https://perma.cc/CU86-SSKZ].

221. Adrienne Sabety, *The Value of Relationships in Healthcare*, 225 J. PUB. ECON., Sep. 2023, at 1.

mortality, 4% increase in emergency room visits, and 3% increase in hospital admissions.²²²

Yet, many individuals who would like to see their PCPs quickly when they feel ill are unable to do so.²²³ Consequently, they either wait, forego care, or choose another alternative that may be less desirable.²²⁴ Indeed, researchers have found that Americans' primary care visit rates have decreased in the past decade.²²⁵ If some patients give up on PCP care, other patients may benefit from shorter appointment wait times.²²⁶ But this is not necessarily a positive development. Most obviously, delaying or relinquishing needed care can cause individuals to suffer complications and get sicker.²²⁷

Furthermore, relying largely or exclusively on PCP alternatives is far from an optimal approach.²²⁸ Obtaining care on a one-time basis from urgent care centers, retail health clinics, and direct to consumer telemedicine disrupts care continuity.²²⁹ Such providers cannot easily assess patients' concerns in the contexts of their general health status and medical histories.²³⁰ Even if they had time to carefully review patients' electronic health records, these record systems often lack interoperability and are inaccessible to new providers.²³¹

Patients who do not see a PCP may also fail to receive preventive care and to enjoy the benefits of care comprehensiveness and coordination.²³² All of these are associated with favorable health outcomes.²³³ In the words of one expert:

Rapid-fire visits with a rotating cast of doctors, nurses, or physician assistants might be fine for a sprained ankle or strep throat. But they will not replace a physician who tells you to get preventive tests and

222. *Id.*

223. *See supra* Subsection II.A.2.

224. *See supra* Subsections II.B.1–4.

225. Ishani Ganguli et al., *Declining Use of Primary Care Among Commercially Insured Adults in the United States, 2008-2016*, 172 *ANNALS INTERNAL MED.* 240, 240 (2020) (finding that “[c]ommercially insured adults have been visiting PCPs less often, and nearly one half had no PCP visits in a given year by 2016,” a phenomenon that might be partially explained by “use of alternative sources of care”); Sanjula Jain, *Deferral of Primary Care Signals a Troubled Future for Americans' Health*, *STAT* (Dec. 7, 2022), <https://www.statnews.com/2022/12/07/deferral-primary-care-trouble-americans-health/> [<https://perma.cc/56A5-M8H8>] (“Primary care visits are down 10.3% on average across U.S. cities relative to pre-pandemic levels.”).

226. AMN HEALTHCARE & MERRITT HAWKINS, *supra* note 4, at 4 (finding that wait times for new patient family medicine appointments had decreased by 30% since 2017, though they were still long, averaging 20.6 days).

227. *See* Jain, *supra* note 225; Jessica Mantel, *How Efforts to Lower Health Care Costs Are Putting Patients and Providers on a Collision Course*, 44 *OHIO N.U. L. REV.* 371, 374 (2018).

228. Rachel O. Reid et al., *Retail Clinic Visits and Receipt of Primary Care*, 28 *J. GEN. INTERNAL MED.* 504, 504 (2012).

229. *Id.*; *see supra* Subsection II.A.1 for discussion of continuity of care and its importance.

230. Julie A. Muroff, *Retail Health Care*, 30 *J. LEGAL MED.* 151, 161 (2008).

231. Steve Adler, *EHR Interoperability*, *THE HIPAA J.* (Dec. 31, 2023), <https://www.hipaajournal.com/ehr-interoperability/> [<https://perma.cc/BD9S-BJL5>] (“Unfortunately, while EHRs have been adopted by most healthcare organizations, the EHRs used by each are often different which makes data exchange problematic.”).

232. *See supra* Subsection II.A.1.

233. Adrienne H. Sabety, Anupam B. Jena & Michael L. Barnett, *Changes in Health Care Use and Outcomes After Turnover in Primary Care*, 181 *JAMA INTERNAL MED.* 122, 122 (2021) (“Interrupting primary care relationships could have a negative association with health outcomes and future engagement with primary care.”).

keeps tabs on your blood pressure and cholesterol—the doctor who knows your health history and has the time to figure out whether the pain in your shoulder is from your basketball game, an aneurysm, or a clogged artery in your heart.²³⁴

Experts express significant concerns not only about care fragmentation, but also about the nature of the care that patients receive from some alternative sources. An international survey of health care leaders revealed that 70% believed that the quality of care in retail health clinics is inferior to that available in primary care offices.²³⁵ In addition, a 2018 Pew study concluded that antibiotics are overprescribed at urgent care centers.²³⁶ Doctors also have quality concerns about DIY testing.²³⁷

3. Access and Equity

By definition, long appointment wait times translate into diminished access to traditional primary care.²³⁸ Existing barriers likewise undercut equity.²³⁹ Financially disadvantaged people may have less access to PCP alternatives that can provide prompt medical attention.²⁴⁰ They often live in rural or poor areas with no nearby urgent care or retail clinic facilities and may not have the needed technological infrastructure to use telemedicine.²⁴¹ In addition, they may not be able to afford direct primary care or concierge doctors' membership fees.²⁴²

Another equity concern is that appointment scarcity can lead to unlawful discrimination.²⁴³ There is evidence that some physician offices discriminate against people from minority or minoritized racial and ethnic groups when scheduling appointments.²⁴⁴ Researchers from Tulane University recruited seven racially diverse individuals to call 800 Texas primary care offices for appointments using fabricated names that clearly indicated that the caller was White, Black, or

234. Rosenthal, *supra* note 80.

235. 4 *Takeaways from Survey on Retail Health Clinics and Quality*, AM. HOSP. ASS'N, <https://www.aha.org/aha-center-health-innovation-market-scan/2022-11-01-4-takeaways-survey-retail-health-clinics-and-quality> [<https://perma.cc/M6X6-FV53>] (last visited Jan. 15, 2026) (reporting that “[m]ore than 70% of health care leaders globally believe the quality of care in retail settings is lower than in primary care practices . . . [and that almost half] voiced concerns about the difficulty of tracking patients who use retail clinics over time along with challenges in managing continuity of care”); Jonathan Bees, *Retail Health Care Improves Access, but Quality Concerns Remain*, NEW ENG. J. MED. CATALYST INNOVATIONS CARE DELIVERY, Nov. 2022, at 1.

236. David Hyun & Rachel Zetts, *Antibiotics Are Overprescribed in Urgent Care*, PEW (July 16, 2018), <https://www.pewtrusts.org/en/research-and-analysis/articles/2018/07/16/antibiotics-are-overprescribed-in-urgent-care> [<https://perma.cc/A5V4-7KUR>].

237. Dwoskin et al., *supra* note 31.

238. See Ansell et al., *supra* note 17, at 1.

239. See Jain & Mehrotra, *supra* note 159, at 3.

240. See *supra* Part I.

241. Jain & Mehrotra, *supra* note 159; Lagasse, *supra* note 136; Jennifer Tsui et al., *Patterns in Geographic Access to Health Care Facilities Across Neighborhoods in the United States Based on Data from the National Establishment Time-Series Between 2000 and 2014*, 3 JAMA NETWORK OPEN 1, 2 (2020).

242. See *supra* Subsection II.B.5.

243. Janna M. Wisniewski & Brigham Walker, *Association of Simulated Patient Race/Ethnicity with Scheduling of Primary Care Appointments*, 3 JAMA NETWORK OPEN, May 15, 2020, at 7.

244. *Id.* at 2.

Hispanic.²⁴⁵ The researchers found that individuals who were perceived as Black were 44% more likely to be asked about their insurance status than White individuals, and Hispanic individuals were 25% more likely to be asked about insurance than White individuals.²⁴⁶ In addition, patients in racial minority groups had to wait a larger number of days than White patients for their appointments.²⁴⁷ On average, patients who were thought to be White were given appointments that were 8.6 days away, patients who seemed to be Black were scheduled for appointments in 12.2 days, and those presumed to be Hispanic had an 11.2 day wait time.²⁴⁸ A 2021 study by the Urban Institute found that African American patients felt they had difficulty scheduling medical appointments.²⁴⁹

Medicaid patients may also face longer wait times for appointments than privately insured patients.²⁵⁰ According to one study, on average, Medicaid patients waited 1.3 days longer for scheduled appointments than other patients.²⁵¹ This disparity is not surprising because Medicaid pays physicians less for services than Medicare and commercial insurance do, and thus PCP offices may deprioritize patients with this form of public insurance.²⁵²

B. Legal Implications

Appointment delays create two different legal vulnerabilities for physicians. First, if patients are harmed because they did not receive timely PCP appointments and were not advised to seek immediate care from another source, they may bring medical malpractice claims.²⁵³ Second, if members of minority groups or patients on Medicaid experience longer wait times than others, they may allege unlawful discrimination.²⁵⁴

245. *Id.* at 1.

246. *Id.* at 1.

247. *Id.*

248. *Id.* at 6.

249. MARLA MCDANIEL ET AL., URBAN INST., BLACK AND AFRICAN AMERICAN ADULTS' PERSPECTIVES ON DISCRIMINATION AND UNFAIR JUDGMENT IN HEALTH CARE 13 (2021), https://www.urban.org/sites/default/files/publication/104568/black-and-african-american-adults-perspectives-on-discrimination-and-unfair-judgment-in-health-care_0.pdf [<https://perma.cc/H3HM-UV8Z>].

250. Evelyn G. Gotlieb, Karin V. Rhodes & Molly K. Candon, *Disparities in Primary Care Wait Times in Medicaid Versus Commercial Insurance*, 34 J. AM. BD. FAM. MED. 571, 571 (2021). *See also* Joanna Bisgaier & Karin V. Rhodes, *Auditing Access to Specialty Care for Children with Public Insurance*, 364 NEW ENG. J. MED. 2324, 2324 (2011) (“We found a disparity in access to outpatient specialty care between children with public insurance and those with private insurance.”).

251. Gotlieb et al., *supra* note 250; *see also* Thomas Waldrop, *The Truth on Wait Times in Universal Coverage Systems*, CTR. AM. PROGRESS (Oct. 18, 2019), <https://www.americanprogress.org/article/truth-wait-times-universal-coverage-systems/> [<https://perma.cc/W9Z2-GK2C>] (finding that “privately insured patients have shorter wait times than publicly insured patients”).

252. Waldrop, *supra* note 251 (“This difference in wait times is largely attributable to differences in payment rates between payers . . .”); Cindy Mann & Adam Friar, *How Differences in Medicaid, Medicare, and Commercial Health Insurance Payment Rates Impact Access, Health Equity, and Cost*, COMMONWEALTH FUND (Aug. 17, 2022), <https://www.commonwealthfund.org/blog/2022/how-differences-medicaid-medicare-and-commercial-health-insurance-payment-rates-impact> [<https://perma.cc/QSV8-EL7Z>] (“Medicaid rates are generally well below Medicare rates, which are themselves well below commercial rates.”).

253. *See infra* Subsection III.B.1.

254. *See infra* Subsection III.B.2.

1. *Medical Malpractice*

Excessively long appointment wait times may not only harm patients, but also can expose physicians to medical malpractice claims.²⁵⁵ Patients who must wait many weeks for an appointment may fail to obtain timely treatment for acute conditions or referrals to specialists.²⁵⁶ They may not take the initiative to seek care elsewhere or incorrectly interpret the scheduler's lack of urgency as an indication that they do not require immediate care.²⁵⁷ According to a 2023 survey by the American Association of Nurse Practitioners, "nearly half of those who experienced unreasonable wait times gave up seeking an appointment and did not receive care."²⁵⁸

Medical malpractice claimants must establish four elements in litigation.²⁵⁹ These are:

- The defendant owes a duty of care to the plaintiff;
- The defendant breached that duty through conduct that does not meet the applicable standard of care;
- The plaintiff suffered harm or injury; and
- There is a causal link between the injury and the breach of duty.²⁶⁰

Extensive research failed to identify any reported cases in which malpractice claims were explicitly linked to appointment wait times.²⁶¹ Indeed, it would be challenging for plaintiffs to prevail in such cases even if they suffered harm because of appointment delays.²⁶² First, medical malpractice plaintiffs must prove that they have an existing doctor-patient relationship with the defendant,²⁶³ so new patients seeking first appointments with a PCP have no cause of action. Second, plaintiffs would need to prove that their PCPs deviated from the standard of care by failing to provide timely appointments or to advise them to seek care

255. See *infra* Subsection III.B.1.

256. See Bryan Black, *New Survey Finds 26% of Patients Wait Two or More Months for Care*, AANP NEWS (July 12, 2023), <https://www.aanp.org/news-feed/two-in-five-americans-report-unreasonable-health-care-wait-times> [<https://perma.cc/9S3D-4YPH>].

257. See *id.*

258. *Id.*

259. Sharona Hoffman & Andy Podgurski, *E-Health Hazards: Provider Liability and Electronic Health Record Systems*, 24 BERKELEY TECH. L.J. 1523, 1533–34 (2009).

260. *Id.* at 1534; *McDowell v. Brown*, 392 F.3d 1283, 1295 (11th Cir. 2004); *Hanson v. Grode*, 90 Cal.Rptr.2d 396, 400 (Cal. Ct. App. 1999).

261. See, e.g., *Farley v. United States*, 98 F. Supp. 3d 299, 331–32 (D.N.H. 2015).

262. See, e.g., *Jackson v. Isaac*, 76 S.W.3d 177, 184 (Tex. App. 2002).

263. *Davis v. Weiskopf*, 439 N.E.2d 60, 64 (Ill. App. Ct. 1982) (“[Courts] have considered that a physician’s duty of care arises only upon the creation of a physician-patient relationship”); *Jackson*, 76 S.W.3d at 184 (“[T]he mere scheduling of a diagnostic procedure and an appointment by a medical specialist or his staff does not create a physician-patient relationship.”); *Thurston v. Physician Healthcare Network, PC*, No. 360071, 2023 WL 4832492, at *8 (Mich. Ct. App. July 27, 2023) (“[A] physician-patient relationship is not established with every doctor involved in the chain of communication regarding a particular patient.”); see also Karen H. Rothenberg et al., *The AIDS Project: Creating a Public Health Policy—Rights and Obligations of Health Care Workers*, 48 MD. L. REV. 93, 201 (1989) (“[A]bsent a consensual doctor-patient relationship a physician is not obligated to treat any particular patient.”).

elsewhere.²⁶⁴ It would be difficult to establish what the standard of care is with respect to scheduling given the national epidemic of excessively long appointment wait times.²⁶⁵ In addition, it is possible or even likely that physicians would successfully assert contributory negligence or assumption of the risk defenses, claiming that patients with urgent medical needs could have turned to emergency rooms or other alternatives and chose not to do so.²⁶⁶

Nevertheless, there are numerous cases in which patients have successfully sued health care providers for harm resulting from delayed diagnoses.²⁶⁷ Furthermore, critics have expressed concern about primary care patients being routed to call centers when they phone with acute symptoms and being scheduled for appointments rather than told to come in immediately or go to an emergency room.²⁶⁸ If patients are not properly triaged, patients at risk of severe health problems may be neglected.²⁶⁹

Missed or delayed diagnoses could result not only directly from long appointment wait times, but also indirectly from care fragmentation.²⁷⁰ If patients visit a variety of care facilities on different occasions, their PCPs may not be fully informed about their health histories.²⁷¹ In the face of care fragmentation, PCPs must scour electronic health records for visits to urgent care centers or retail clinics and hope that such information is available electronically.²⁷² Despite the brevity of most PCP visits,²⁷³ doctors should also thoroughly question

264. Health care providers meet the standard of care if they exercise “that reasonable degree of skill, knowledge and care ordinarily possessed and exercised by members of their profession under similar circumstances.” *Scott v. C.R. Bard, Inc.*, 180 Cal. Rptr. 3d 479, 489 (Cal. Ct. App. 2014) (quoting *Alef v. Alta Bates Hosp.*, 6 Cal. Rptr. 2d 900, 904 (Cal. Ct. App. 1992)). A variety of statutes codify the standard of care and establish a reasonable competence standard. *See* ALA. CODE § 6-5-484(a) (2025); ARIZ. REV. STAT. ANN. § 12-563 (2025); CONN. GEN. STAT. § 52-184(c) (2025); FLA. STAT. § 766.102(1) (2025); GA. CODE ANN. § 51-1-27 (2025); NEB. REV. STAT. § 44-2810 (2025); N.H. REV. STAT. ANN. § 507-E:2(I) (2025).

265. *See supra* Subsection II.A.2.

266. Sharon W. Murphy, *Contributory Negligence in Medical Malpractice: Are the Standards Changing to Reflect Society’s Growing Health Care Consumerism?*, 17 U. DAYTON L. REV. 151, 178 (1991) (arguing that courts often accept contributory negligence as a defense in medical malpractice lawsuits); Nadia N. Sawicki, *Defining the Known Risk: Context-Sensitivity in Tort Law Defenses*, 12 J. TORT L. 9, 11 (2019) (“[A]ssumption of risk and comparative negligence can be valid and legitimate defenses in medical malpractice cases.”).

267. *See* *Santiago v. Abramovici*, 208 N.Y.S.3d 289, 290 (N.Y. App. Div. 2024) (denying doctor’s motion for summary judgment as to whether physician deviated from the standard of care “in a manner that led to a delayed diagnosis of the patient’s multiple myeloma,” thereby causing patient’s claimed injuries); *Farley v. United States*, 98 F. Supp. 3d 299, 331–32, 347–48 (D.N.H. 2015) (awarding stroke patient’s wife \$8,100,000 in a case involving a delayed echocardiogram and delayed referral to a cardiologist); *Rhodes v. United States*, 967 F. Supp. 2d 246, 250, 326 (D.D.C. 2013) (finding for patient who alleged physician failed to “timely diagnose and treat [her] breast cancer”).

268. Caroline O’Donovan, *Leaked Documents Reveal Patient Safety Issues at Amazon’s One Medical*, WASH. POST (June 15, 2024, at 09:50 ET), <https://www.washingtonpost.com/technology/2024/06/15/amazon-one-medical-patient-safety/> [<https://perma.cc/BBM8-KD5Z>].

269. *See id.*

270. *See supra* Subsections II.B.1–4.

271. *See* Adler, *supra* note 231.

272. Electronic health records often are not interoperable, so a PCPs record may not include information about care received at other facilities. *See id.*

273. Hannah T. Neprash et al., *Measuring Primary Care Exam Length Using Electronic Health Record Data*, 59 MED. CARE 62, 64 (2021).

patients about treatments they have received elsewhere. If they fail to take these steps, they may remain ignorant of critical details that could influence their clinical decisions.²⁷⁴

There may already be unreported cases arising from appointment scheduling problems, and future plaintiffs may well pursue such claims.²⁷⁵ Given the right set of facts, it is certainly possible that courts would be receptive to these malpractice claims.²⁷⁶

2. *Discrimination*

Federal law prohibits race and national origin discrimination in health care.²⁷⁷ Title VI of the Civil Rights Act of 1964 (“Title VI”) prohibits programs receiving federal financial assistance from engaging in discrimination based on race, color, or national origin.²⁷⁸ The law covers health care providers who receive payments from Medicare and Medicaid.²⁷⁹ Section 1557 of the Patient Protection and Affordable Care Act (“Section 1557”) prohibits discrimination based on race, color, national origin, sex, age, or disability in particular health programs or activities.²⁸⁰ The Biden Administration’s Final Rule on Section 1557, entitled *Nondiscrimination in Health Programs and Activities*,²⁸¹ clarified that the provision applies to physician practices.²⁸²

These laws prohibit both intentional and unintentional discrimination based on the protected categories.²⁸³ A clear example of intentional discrimination (also called disparate treatment) is purposely forcing Black individuals to wait longer for appointments than White patients.²⁸⁴ Treating Medicaid patients differently from other patients can also constitute race or national origin discrimination because the program disproportionately serves members of minority groups.²⁸⁵ This type of discrimination is known as disparate impact

274. PCP appointments are generally short and provide physicians too little time to interact with patients. It thus could be very challenging for PCPs to thoroughly investigate patients’ visits to other primary care facilities. *Id.* at 62, 65 (“[T]he average primary care exam was 18.0 minutes long.”).

275. *See, e.g.*, *Thurston v. Physician Healthcare Network, PC*, No. 360071, 2023 WL 4832492, at *22–23 (Mich. Ct. App. July 27, 2023) (finding no physician-patient relationship existed when a doctor received a call confirming his hospital could provide services and had availability to provide those services).

276. *See id.* at *23.

277. *See* 42 U.S.C. § 2000(d); 42 U.S.C. § 18116(a).

278. 42 U.S.C. § 2000d.

279. BRIETTA R. CLARK, ERIN C. FUSE BROWN, ROBERT GATTER, ELIZABETH Y. MCCUSKEY & ELIZABETH PENDO, *LAW AND HEALTH CARE QUALITY, PATIENT SAFETY, AND LIABILITY* 315 (9th ed. 2022).

280. 42 U.S.C. § 18116(a).

281. *Nondiscrimination in Health Programs and Activities*, 89 Fed. Reg. 37522, 37522 (May 6, 2024) (to be codified at 45 C.F.R. pts. 80, 84, 92, 147, 155, 156).

282. *Section 1557 Final Rule: Frequently Asked Questions*, U.S. DEP’T HEALTH & HUM. SERVS., <https://www.hhs.gov/sites/default/files/section-1557-final-rule-faqs-7282017rev15.pdf> [<https://perma.cc/A57T-CHVC>] (last visited Jan. 15, 2026); *see also* Mary Crossley, *Affirmatively Furthering Health Equity*, 89 BROOK. L. REV. 495, 529 (2024) (discussing Title VI and Section 1557 coverage of individual physicians).

283. CLARK ET AL., *supra* note 279, at 315–19.

284. *See supra* notes 244–49 and accompanying text.

285. *See supra* notes 250–51 and accompanying text; KIMÁ JOY TAYLOR, SOFIA HINOJOSA, EVA H. ALLEN & TAYLOR NELSON, URBAN INST., *GUIDE TO EQUITY IN MEDICAID 2* (2023), <https://www.urban.org/sites/default/>

discrimination.²⁸⁶ In disparate impact cases, defendants make adverse decisions based on facially neutral criteria, such as Medicaid enrollment, but their conduct disproportionately harms one or more racial and ethnic minority groups.²⁸⁷ Though disparate impact discrimination may be more subtle or even unintentional, it nevertheless is unlawful.²⁸⁸

The U.S. Department of Health and Human Services (“DHHS”) Office of Civil Rights enforces Title VI and Section 1557.²⁸⁹ It can litigate both disparate treatment and disparate impact cases, though it has been criticized for its anemic enforcement efforts.²⁹⁰ While the statutes empower private parties to pursue disparate treatment claims, Title VI and Section 1557 have been interpreted as disallowing private litigation under the disparate impact theory.²⁹¹ Therefore, patients themselves may only pursue intentional discrimination claims.²⁹² Nevertheless, health care providers remain at risk of being sued by DHHS if they engage in practices that have an adverse disparate impact on non-White individuals, though the current administration may be loath to pursue such cases.²⁹³

files/2024-01/Guide%20to%20Equity%20in%20Medicaid.pdf [https://perma.cc/4LAT-WAR5] (“While white people are the single largest group served by Medicaid, nonwhite people rely on it at higher rates. In particular, more than half of children who are American Indian/Alaska Native, Black/African American, Hispanic/Latinx, and Native Hawaiian or other Pacific Islander are covered by Medicaid.”).

286. See Sharona Hoffman & Andy Podgurski, *Artificial Intelligence and Discrimination in Health Care*, 19 YALE J. HEALTH POL’Y, L. & ETHICS 1, 24–26 (2020).

287. See *id.* at 25.

288. See *id.*

289. *Civil Rights Laws, Regulations, and Guidance for Providers of Health Care and Social Services*, U.S. DEP’T OF HEALTH & HUM. SERVS., <https://www.hhs.gov/civil-rights/for-providers/laws-regulations-guidance/laws/index.html> [https://perma.cc/DD2U-ZA5T] (last visited Jan. 15, 2026); *Section 1557 of the Patient Protection and Affordable Care Act*, U.S. DEP’T OF HEALTH & HUM. SERVS., <https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html> [https://perma.cc/SXX2-97QT] (last visited Jan. 15, 2026).

290. Hoffman & Podgurski, *supra* note 286, at 26.

291. *Id.* at 26–29; *Alexander v. Sandoval*, 532 U.S. 275, 293 (2001) (holding that there is no private right of action under Title VI); *HHS Finalizes Rule on Section 1557 Protecting Civil Rights in Healthcare, Restoring the Rule of Law, and Relieving Americans of Billions in Excessive Costs*, U.S. DEP’T OF HEALTH & HUM. SERVS. (June 12, 2020), <https://www.hhs.gov/about/news/2020/06/12/hhs-finalizes-rule-section-1557-protecting-civil-rights-healthcare.html> [https://perma.cc/W4HR-QTTY] (establishing that Section 1557 does not allow for a private cause of action to pursue disparate impact cases).

292. See *Alexander*, 532 U.S. at 279–81.

293. See *HHS Finalizes Rule on Section 1557 Protecting Civil Rights in Healthcare*, *supra* note 291; *HHS’ Civil Rights Office Investigates Alleged Discrimination in Health Care Workforce and Training to Restore Merit-Based Opportunity*, U.S. DEP’T OF HEALTH & HUM. SERVS. (Mar. 7, 2025), <https://www.hhs.gov/press-room/restoring-merit-based-opportunity.html> [https://perma.cc/RXT6-A7GK] (emphasizing the Administration’s priority of combatting “illegal private sector DEI [diversity, equity and inclusion] preferences, mandates, policies, programs, and activities”).

IV. THE PCP SHORTAGE

Why do patients have to wait so long for PCP appointments? One might be quick to place the blame squarely on the shoulders of physicians.²⁹⁴ But the reasons for the phenomenon are multifaceted and complex. Long appointment delays are rooted in large part in the primary care workforce not growing fast enough to meet the American population's needs.²⁹⁵ While demand for primary care is rising because of the United States' aging population, the supply of PCPs is not keeping pace with the country's needs.²⁹⁶ In 2022 there were 83.8 PCPs per 100,000 Americans.²⁹⁷ By comparison, Canada had a ratio of 119 family physicians per 100,000 residents.²⁹⁸ In the words of one physician, "[t]his is the paradox that defines modern American medicine: Doctors are working harder and longer, all while patients can access us less."²⁹⁹ A 2018 national poll revealed that 45% of individuals under thirty did not have a PCP.³⁰⁰ The National Association of Community Health Centers asserts that "[o]ver 100 million people in America lack reliable access to primary care."³⁰¹ By some estimates the PCP deficit will be 68,000 or more doctors by 2036.³⁰² This Part will analyze the U.S. PCP shortage and its causes.

294. See JABBARPOUR ET AL., *supra* note 1, at 8.

295. See *id.* at 6; Christopher Koller, Kyu Rhee & R. Shawn Martin, *No Appointments Available: America's Escalating Primary Care Shortage*, HEALTHCARE DIVE (Apr. 15, 2024), <https://www.healthcaredive.com/news/no-appointments-available-americas-escalating-primary-care-shortage/712049/> [<https://perma.cc/M2TP-7E3M>].

296. *New AAMC Report Shows Continuing Projected Physician Shortage*, ASS'N AM. MED. COLLS. (Mar. 21, 2024), <https://www.aamc.org/news/press-releases/new-aamc-report-shows-continuing-projected-physician-shortage> [<https://perma.cc/92SY-XJ9J>]; Jeffrey D. Shahidullah, *The Hidden Crisis in Primary Care*, U.S. NEWS & WORLD REP. (Jan. 4, 2023), <https://www.usnews.com/news/health-news/articles/2023-01-04/the-hidden-crisis-in-primary-care-medicine> [<https://perma.cc/Y3NV-9J2P>].

297. NAT'L CENTER FOR HEALTH WORKFORCE ANALYSIS, STATE OF THE PRIMARY CARE WORKFORCE, 2024 3 (Nov. 2024), <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/state-of-the-primary-care-workforce-report-2024.pdf> [<https://perma.cc/N7GW-RBTZ>].

298. *Physicians*, CANADIAN INST. FOR HEALTH INFO. (Oct. 30, 2025), <https://www.cihi.ca/en/physicians> [<https://perma.cc/5AL7-XANH>].

299. Yurkiewicz, *supra* note 101.

300. *One-Fourth of Adults and Nearly Half of Adults Under 30 Don't Have a Primary Care Doctor*, KFF (Feb. 8, 2019), <https://www.kff.org/other-health/one-fourth-of-adults-and-nearly-half-of-adults-under-30-dont-have-a-primary-care-doctor/> [<https://perma.cc/CG8F-ACL8>].

301. *Closing the Primary Care Gap: How Community Health Centers Can Address the Nation's Primary Care Crisis*, NAT'L ASS'N CMTY. HEALTH CTRS. (Feb. 7, 2023), <https://www.nachc.org/resource/closing-the-primary-care-gap-how-community-health-centers-can-address-the-nations-primary-care-crisis/> [<https://perma.cc/M6M2-FYYB>].

302. See *supra* note 50 and accompanying text.

A. PCP Exits: Retirements, Burnout, and Other Departures

Experts agree that there is a worrisome trend of attrition among primary care physicians.³⁰³ The Association of American Medical Colleges asserts that 23.2% of active physicians were age sixty-five or older in 2022, and only 16.9% were under age forty.³⁰⁴ The average age of physicians in all specialties was 54.4 in 2025.³⁰⁵ The retirement rate and resulting physician supply gaps are very unlikely to diminish.³⁰⁶ In addition, a growing number of primary care physicians opt to stop participating in fee-for-service Medicare and thus no longer serve older patients even if they continue accepting other forms of insurance.³⁰⁷

Age-related retirements are not the only reason for accelerating PCP departures. Physician burnout is another prominent cause and is a much-discussed topic.³⁰⁸ Burnout can be defined as “a syndrome characterized by emotional exhaustion and depersonalization (which includes negativity, cynicism, and the inability to express empathy or grief), a feeling of reduced personal accomplishment, loss of work fulfillment, and reduced effectiveness.”³⁰⁹ Medscape’s *Physician Burnout & Depression Report* revealed that in 2024, 49% of physicians reported experiencing burnout.³¹⁰ Pediatrics, family medicine, and internal

303. *Psychiatry, Primary Care, and OB/GYN Subspecialties Experience Highest Physician Attrition Rates*, BIOENGINEERING (Oct. 6, 2025), <https://bioengineer.org/psychiatry-primary-care-and-ob-gyn-subspecialties-experience-highest-physician-attrition-rates/> [https://perma.cc/D9N4-PCER]; Rosenthal, *supra* note 80; Mahima Samraik, *Increases in Physician Attrition Rates Could Worsen Shortages*, YALE SCH. OF MED. (Oct. 7, 2025), <https://medicine.yale.edu/news-article/increases-in-physician-attrition-rates-could-worsen-shortages/> [https://perma.cc/382B-GLFZ].

304. *U.S. Physician Workforce Data Dashboard 2023 Key Findings and Definitions*, ASS’N AM. MED. COLLS., <https://www.aamc.org/data-reports/data/2023-key-findings-and-definitions> [https://perma.cc/TQ4J-6L9N] (last visited Jan. 14, 2026). *See also* Jeff Decker, *Physicians Are Aging Out of the System*, AMN HEALTHCARE (Mar. 11, 2025), <https://www.amnhealthcare.com/amn-insights/physician/blog/physicians-are-aging-out-of-the-system/> [https://perma.cc/2S2Q-GWWMG] (“30% [of U.S. physicians] are 60 or older, while 23% are 65 or older.”).

305. *Average Age of Doctors and Providers by Medical Specialty*, DEFINITIVE HEALTHCARE (Mar. 24, 2025), <https://www.definitivehc.com/resources/healthcare-insights/average-provider-age-medical-specialty> [https://perma.cc/2YVK-VWDU].

306. Mukkamala, *supra* note 51.

307. Hannah T. Neprash & Michael E. Chernew, *Trends in Physician Exit from Fee-for-Service Medicare*, 18 JAMA HEALTH F. Jul. 2025, at 1 (“The exit rate among primary care physicians (PCPs; 4.41% . . .) exceeded that of hospital-based specialists (3.50% . . .)”; Austin Littrell, *More Physicians Are Leaving Traditional Medicare, with Primary Care Hit Hardest*, MED. ECON. (July 21, 2025), <https://www.medicaleconomics.com/view/more-physicians-are-leaving-traditional-medicare-with-primary-care-hit-hardest> [https://perma.cc/2FXW-TN22] (“Primary care physicians (PCPs) had the highest exit rate of any specialty group in 2023 at 4.41%, compared to 3.5% for hospital-based specialists, 2.99% for surgical specialists and 2.49% for medical specialists.”).

308. *See* Hoffman, *supra* note 34, at 61; *Physician Burnout*, AGENCY FOR HEALTHCARE RSCH. & QUALITY (Nov. 2023), <https://www.ahrq.gov/prevention/clinician/ahrq-works/burnout/index.html> [https://perma.cc/86B-S-UDHK]; Laura M. Hahn, *Unsustainable: Why I Left Primary Care*, 43 HEALTH AFFS. 1475, 1478 (2024); Franziska Ulrike Jung, Erik Bodendieck, Alexander Pabst, Melanie Luppá & Steffi G. Riedel-Heller, *Exploring the Link Between Physician Burnout and Intentions to Retire Early*, 25 BMC PUB. HEALTH 3557, 3557 (2025) (“[B]urnout constitutes a significant risk factor for the early retirement of physicians.”).

309. Victor J. Dzau, Darrell G. Kirch & Thomas J. Nasca, *To Care Is Human—Collectively Confronting the Clinician-Burnout Crisis*, 378 NEW ENG. J. MED. 312, 312 (2018).

310. Jon McKenna, *Medscape Physician Burnout & Depression Report 2024: ‘We Have Much Work to Do’*, slide 2, MEDSCAPE (Jan. 26, 2024), <https://www.medscape.com/slideshow/2024-lifestyle-burnout-60168>

medicine have some of the highest burnout rates, exceeding 49%.³¹¹ 14% of male doctors and 16% of female doctors indicated in the survey that their burnout was so severe that they may leave the profession.³¹² Likewise, a 2023 Massachusetts Medical Society survey found that a quarter of Massachusetts physicians planned to abandon their careers in medicine within two years.³¹³

The American Medical Association's President has described physician burnout as an "insidious crisis going on in medicine today that is having a profound impact on our ability to care for patients."³¹⁴ Almost half of physicians who leave the workforce identify burnout as a major trigger for their decision.³¹⁵

According to a Surgeon General's Advisory, burnout is caused by a myriad of "societal, cultural, structural, and organizational factors."³¹⁶ Some of these are:

- "Misaligned reimbursement policies
- Burdensome administrative paperwork . . .
- Excessive workload and work hours
- Limited flexibility, autonomy, and voice . . .
- Limited time with patients and colleagues
- Absence of focus on health worker well-being . . ."³¹⁷

Electronic health records have many benefits, potentially enabling medical practices to improve efficiency, productivity, and quality of care.³¹⁸ But they have caused many physicians particular misery, swelling their documentation workload and diminishing the time available to interact with patients.³¹⁹

65#2 [https://perma.cc/5W3B-X2CN]; see also Sara Berg, *Physician Burnout Rate Drops Below 50% for First Time in 4 Years*, AM. MED. ASS'N (July 2, 2024), https://www.ama-assn.org/practice-management/physician-health/physician-burnout-rate-drops-below-50-first-time-4-years [https://perma.cc/SU9M-ZUTJ] ("For 2023, 48.2% of physicians reported experiencing at least one symptom of burnout . . .").

311. McKenna, *supra* note 310, at slide 3; NAT'L CTR. FOR HEALTH WORKFORCE ANALYSIS, *supra* note 15, at 6 ("Common factors contributing to physician burnout are workload, long working hours, clerical duties, and a large number of patients.").

312. McKenna, *supra* note 310, at slide 9.

313. Priyanka Dayal McCluskey, *1 in 4 Mass. Doctors Plan to Leave Medicine in Coming Years, Survey Finds*, WBUR (Mar. 3, 2023), https://www.wbur.org/news/2023/03/02/massachusetts-doctors-physicians-cut-hours-staff-shortages [https://perma.cc/T6AM-HKQC].

314. *AMA President Sounds Alarm on National Physician Shortage*, *supra* note 98.

315. Tara Oakman & Vina Smith-Ramakrishnan, *Physician Burnout Will Burn All of Us*, CENTURY FOUND. (Oct. 25, 2023), https://tcf.org/content/report/physician-burnout-will-burn-all-of-us/ [https://perma.cc/X2H3-678P].

316. OFF. SURGEON GEN., ADDRESSING HEALTH WORKER BURNOUT: THE U.S. SURGEON GENERAL'S ADVISORY ON BUILDING A THRIVING HEALTH WORKFORCE 11 (2022), https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf [https://perma.cc/9ANK-GZNG].

317. *Id.* at 12; NAT'L CTR. FOR HEALTH WORKFORCE ANALYSIS, *supra* note 15, at 7.

318. Adler, *supra* note 231.

319. Jeffrey Budd, *Burnout Related to Electronic Health Record Use in Primary Care*, 14 J. PRIMARY CARE & CMTY. HEALTH 1, 1 (2023); Debora Goetz Goldberg, Tulay Soylu, Carolyn Faith Hoffman, Rachel E. Kishton & Peter F. Cronholm, "Anxiety, COVID, Burnout and Now Depression": A Qualitative Study of Primary Care Clinicians' Perceptions of Burnout, 39 J. GEN. INTERNAL MED. 1317, 1317 (2023); Hoffman, *supra* note 34, at 73-79.

Physicians have described feeling overwhelmed by “office work” that leaves too little time for “doctor work.”³²⁰

Another factor that is likely contributing to burnout is private equity acquisition³²¹ of primary care practices.³²² According to the Milbank Memorial Fund, private equity owns more than 6,000 physician practices.³²³ One study found that, between 2009 and 2022, 1.5% of primary care practices (2483) affiliated with private equity firms.³²⁴ A recent survey showed that over 60% of physicians considered private equity ownership to have a negative impact on health care, and a majority felt it diminished their autonomy and well-being.³²⁵ Corporate pressures increase stress, diminish job satisfaction, and reduce physicians’ ability to control their medical practices.³²⁶

Private equity investors’ goal is to maximize profits, which may conflict with physicians’ commitment to act in the best interest of patients.³²⁷ Physicians are pressured to see more patients, and they lose control over a variety of matters, including some aspects of clinical decision-making.³²⁸ Thus, even when patients

320. Sumit D. Agarwal, Erika Pabo, Ronen Rozenblum & Karen M. Sherritt, *Professional Dissonance and Burnout in Primary Care: A Qualitative Study*, 180 JAMA INTERNAL MED. 395, 397 (2020).

321. Private equity acquisitions can be explained as follows:

Private equity funds are pooled investments that are generally not open to small investors. Private equity firms invest the money they collect on behalf of the fund’s investors, usually by taking controlling stakes in companies. The private equity firm then works with company executives to make the businesses—called portfolio companies—more valuable so they can sell them later at a profit.

Chris Morran & Daniel Petty, *What Private Equity Firms Are and How They Operate*, PROPUBLICA (Aug. 3, 2022, at 05:00 CT), <https://www.propublica.org/article/what-is-private-equity> [<https://perma.cc/LJC3-GT6E>]; *Private Equity Funds*, SEC, <https://www.investor.gov/introduction-investing/investing-basics/investment-products/private-investment-funds/private-equity> [<https://perma.cc/M4AL-CRMB>] (last visited Jan. 14, 2026).

322. Joseph Dov Bruch et al., *Workforce Composition in Private Equity-Acquired Versus Non-Private Equity-Acquired Physician Practices*, 42 HEALTH AFFS. 121, 121 (2023) (discussing the “concern that PE [private equity] ownership structures and their associated financial incentives may reduce clinicians’ autonomy or contribute to operational changes that affect longer-term job satisfaction and retention”); Patrick D. Souter & Andrew N. Meyercord, *Private Equity Investment in the Physician Practice: Has Its Time Finally Come or Will the Mistakes of the Past Be Repeated?*, 13 J. HEALTH & LIFE SCIS. L. 84, 84 (2020) (discussing private equity acquisitions of physician practices).

323. Richard M. Scheffler & David Blumenthal, *Private Equity Impacts On Health Care: Federal and State Legislative and Regulatory Actions, Will It Matter?*, MILBANK Q. (Apr. 29, 2024), <https://www.milbank.org/quarterly/opinions/private-equity-impacts-on-health-care-federal-and-state-legislative-and-regulatory-actions-will-it-matter/> [<https://perma.cc/6KFP-5P2R>].

324. Yashaswini Singh, Nandita Radhakrishnan & Loren Adler, *Growth of Private Equity and Hospital Consolidation in Primary Care and Price Implications*, JAMA HEALTH F., at 1 (Jan. 17, 2025).

325. Michael DePeau-Wilson, *Most Physicians Down on Private Equity in Healthcare*, MEDPAGE TODAY (Mar. 11, 2024), <https://www.medpagetoday.com/special-reports/features/109108> [<https://perma.cc/IQ34-CVP2>].

326. Reed Abelson, *Corporate Giants Buy Up Primary Care Practices at Rapid Pace*, N.Y. TIMES (May 12, 2023), <https://www.nytimes.com/2023/05/08/health/primary-care-doctors-consolidation.html> [<https://perma.cc/A4F5-228S>] (“Many doctors say they are becoming mere employees.”); Oakman & Smith-Ramakrishnan, *supra* note 315.

327. Edward P. Hoffer, *Private Equity and Medicine: A Marriage Made in Hell*, 137 AM. J. MED. 5, 6 (2024).

328. *Id.*; Nathaniel Arana, *How Physician Groups Can Fight Back Against Private Equity*, HIT CONSULTANT (Feb. 20, 2024), <https://hitconsultant.net/2024/02/20/how-physician-groups-can-fight-back-against-private-equity/> [<https://perma.cc/3PCG-6TEG>]; Tim N. Nolte, Felix Miedaner & Sandra Sülz, *Physicians’ Perspectives Regarding Private Equity Transactions in Outpatient Health Care—A Scoping Review and*

finally see their PCPs, appointments may be rushed.³²⁹ Unhappy, pressured work environments and loss of autonomy undoubtedly exacerbate physician burn-out.³³⁰

Another form of migration is the shift to concierge and direct primary care medicine.³³¹ This trend contributes to physician shortages because it takes PCPs away from offices with standard, large patient panels.³³² These “membership models” constitute an appealing strategy to combat burnout.³³³ But because concierge and direct primary care doctors see far fewer patients than is the norm, their departure from traditional practices intensifies the PCP access problem.³³⁴

B. *Entering the Profession: New PCP Shortfalls*

An additional reason for insufficient primary care capacity is a shortfall in the number of individuals entering the profession. According to the National Center for Health Workforce Analysis, between 2016 and 2021, the primary care physician workforce grew by only 3.6%, compared to an increase of 8.7% among other specialties.³³⁵ One study found that new physicians trained in general internal medicine increasingly go on to practice the relatively new specialty of hospital medicine rather than practicing outpatient primary care.³³⁶ Moreover, between 2010 and 2020 the U.S. population grew by 7.4%, rising from 308.7 million to 331.5 million.³³⁷ During that decade, the number of seniors, the

Qualitative Analysis, 19 INT’L J. ENV’T RSCH. & PUB. HEALTH 15480, 15480 (2022); Marty Stempniak, *Loss of Autonomy a Top Concern Among Physicians Working for Private Equity or Other Corporate Owners*, RADIOLOGY BUS. (Dec. 6, 2023), <https://radiologybusiness.com/topics/healthcare-management/leadership/loss-of-autonomy-top-concern-among-physicians-working-private-equity-or-other-corporate-owners> [<https://perma.cc/6TPY-BAT8>].

329. In the United States, primary care appointments last on average eighteen minutes. Hannah T. Neprash et al., *Association of Primary Care Visit Length with Potentially Inappropriate Prescribing*, 4 JAMA HEALTH F., Mar. 10, 2023, at 2; Neprash et al., *supra* note 273, at 62. Researchers have found that primary care visit lengths increased by 2.4 minutes between 2008 and 2015. Aarti Rao, Zhuo Shi, Kristin N. Ray, Ateev Mehrotra & Ishani Ganguli, *National Trends in Primary Care Visit Use and Practice Capabilities, 2008–2015*, 17 ANNALS FAM. MED. 538, 538 (2019).

330. Sukyung Chung, Ellis C. Dillon, Amy E. Meehan, Robert Nordgren & Dominick L. Frosch, *The Relationship Between Primary Care Physician Burnout and Patient-Reported Care Experiences: A Cross-Sectional Study*, 35 J. GEN. INTERNAL MED. 2357, 2362 (2020) (“Department climate and degree of physician autonomy in scheduling are important contributors of burnout.”); Jessica Creager, Anastasia J. Coutinho & Lars E. Peterson, *Associations Between Burnout and Practice Organization in Family Physicians*, 17 ANNALS FAM. MED. 502, 507 (2019) (“Our study strengthens the evidence that loss of control and insufficient time for documentation contribute to physician burnout.”).

331. *See supra* Subsection II.B.5.

332. *See supra* Subsection II.B.5.

333. *See supra* Subsection II.B.5.

334. *See supra* Subsection II.B.5.

335. NAT’L CTR. FOR HEALTH WORKFORCE ANALYSIS, *supra* note 15.

336. Bradley M. Gray, Jonathan L. Vandergrift, Jennifer P. Stevens & Bruce E. Landon, *Evolving Practice Choices by Newly Certified and More Senior General Internists: A Cross-Sectional and Panel Comparison*, 175 ANNALS INTERNAL MED. 1022, 1022 (2022).

337. Andis Robeznieks, *Doctor Shortages Are Here—and They’ll Get Worse if We Don’t Act Fast*, AM. MED. ASS’N (Apr. 13, 2022), <https://www.ama-assn.org/practice-management/sustainability/doctor-shortages-are-here-and-they-ll-get-worse-if-we-don-t-act> [<https://perma.cc/P8PN-3TUH>].

biggest consumers of medical care, increased by 15.5 million people to 55.8 million (growing from 13 to 16.8% of the population) and reaching 61.2 million in 2024.³³⁸ As two commentators noted, “The math is simple: Medical schools just aren’t churning out doctors fast enough to keep pace with the population.”³³⁹

One explanation for the PCP workforce’s relatively slow expansion is financial.³⁴⁰ Experts estimate that medical students graduate with an average debt of \$250,000 and a median debt level of \$200,000.³⁴¹ PCPs earn considerably less than other specialists, and thus primary care is a less attractive field for many medical students.³⁴² In 2024, PCPs’ average compensation was \$287,000, while specialists enjoyed average earnings of \$404,000.³⁴³

Another significant problem is that the number of residencies available in the United States is inadequate to meet the demand for PCPs.³⁴⁴ Medicare, Medicaid, and other federal programs pay the vast majority of the cost of medical residencies, and Medicare is by far the largest contributor to graduate medical education (“GME”).³⁴⁵ But Medicare’s payments to teaching hospitals are capped so that they support only the number of residents a hospital had in

338. Zoe Caplan, *U.S. Older Population Grew from 2010 to 2020 at Fastest Rate Since 1880 to 1890*, U.S. CENSUS BUREAU (May 25, 2023), <https://www.census.gov/library/stories/2023/05/2020-census-united-states-older-population-grew.html> [<https://perma.cc/CE4X-FX5L>]; *Older Adults Outnumber Children in 11 States and Nearly Half of U.S. Counties*, U.S. CENSUS BUREAU (June 26, 2025), <https://www.census.gov/newsroom/press-releases/2025/older-adults-outnumber-children.html> [<https://perma.cc/LMZ2-6TPR>].

339. Daniel Payne & Erin Schumaker, *No One’s Promising You Can Keep Your Doctor Anymore*, POLITICO (Nov. 26, 2023, at 07:00 ET), <https://www.politico.com/news/2023/11/26/future-of-primary-care-family-medicine-00128547> [<https://perma.cc/ZLB4-4SUG>].

340. Ishani Ganguli, *The Case for Primary Care—A Medical Student’s Perspective*, 363 N. ENGL. J. MED. 207, 208 (2010); Melanie Hanson, *Average Medical School Debt*, EDUC. DATA INITIATIVE (Sep. 14, 2025), <https://educationdata.org/average-medical-school-debt> [<https://perma.cc/HBC3-6HAH>] (“Including undergraduate debt, medical school graduates owe approximately \$246,659.”).

341. *AMA President Sounds Alarm on National Physician Shortage*, *supra* note 98; *Student Debt: Ensuring Medical School Remains Affordable*, ASS’N AM. MED. COLLS., <https://students-residents.aamc.org/advocacy/student-debt-ensuring-medical-school-remains-affordable> [<https://perma.cc/7VPG-A43Q>] (last visited Jan. 15, 2026).

342. Brendan Murphy, *6 Things Medical Students Should Know About Physician Compensation*, AM. MED. ASS’N (June 1, 2022), <https://www.ama-assn.org/medical-students/specialty-profiles/6-things-medical-students-should-know-about-physician> [<https://perma.cc/Q34C-U6LE>].

343. John McKenna, *Comparing Your Pay Against Your Peers’: Medscape Physician Compensation Report 2025*, MEDSCAPE (Jul. 8, 2025), <https://www.medscape.com/slideshow/2025-compensation-overview-6018103#2> [<https://perma.cc/K5EH-3WJ8>].

344. Keren Landman, *Why Well-Qualified Medical School Graduates Can’t Get Jobs—Despite Doctor Shortages*, VOX (Mar. 25, 2022, at 13:00 CT), <https://www.vox.com/22989930/residency-match-day-physician-doctor-shortage-pandemic-medical-school> [<https://perma.cc/DNV9-8JLH>].

345. Ramon Martinez, *State-Supported Physician Residency Programs*, MOST POL’Y INITIATIVE (Feb. 10, 2023), <https://mostpolicyinitiative.org/science-note/state-supported-physician-residency-programs/> [<https://perma.cc/9LL9-D5CZ>] (“About 86% of U.S. medical residencies are federally funded through Medicaid, Medicare, and Veterans Affairs.”); Stacey A. Tovino, *I Need a Doctor: A Critique of Medicare Financing of Graduate Medical Education*, 71 WASH. & LEE L. REV. 2431, 2464–70 (2014); Marco A. Villagrana, *Medicare Graduate Medical Education Payments: An Overview*, CONGRESS.GOV (Sep. 29, 2022), <https://crsreports.congress.gov/product/pdf/IF/IF10960> [<https://perma.cc/6ZST-VWBG>].

1996.³⁴⁶ Ironically, the caps were implemented because of a concern that without them, the country would have a surplus of physicians.³⁴⁷ While hospitals can start new residency programs and Medicare is not the only source of GME funding, the number of residencies grew by only 8% in the ten-year span of 1997–2007.³⁴⁸ In 2020, Congress passed Section 126 of the Consolidated Appropriations Act of 2021, which provided for the addition of one-thousand residency slots over five years beginning in fiscal year 2023.³⁴⁹ Two-hundred slots will be added each year, and among the first two-hundred, one hundred twenty-five were dedicated to primary care, including obstetrics and gynecology.³⁵⁰ In 2024, there were a record 19,423 primary care residency positions available, consisting of slots in family medicine, internal medicine, internal medicine-pediatrics, and pediatrics.³⁵¹ Yet, this step, however positive, is likely insufficient to fill the acute need for more PCPs.³⁵²

V. ADDRESSING PCP APPOINTMENT AVAILABILITY AND CARE FRAGMENTATION

This Article has highlighted the importance of having a trusted PCP who can provide first contact access, care continuity, comprehensiveness, and coordination.³⁵³ In response to long appointment wait times and other health care challenges, new care sources have emerged, including urgent care, retail clinics, DTC telemedicine, DIY testing, and concierge and direct primary care medicine.³⁵⁴ But these alternatives can exacerbate care fragmentation and health inequities.³⁵⁵

346. Justin Leventhal, *Congress Limits the Number of Doctors*, OPEN HEALTH POL'Y (Dec. 9, 2022), <https://www.openhealthpolicy.com/p/medical-residency-slots-congress> [<https://perma.cc/755N-8JFE>]; Villagrana, *supra* note 345.

347. Brian Wu, *Residency Caps: What Medical Students Should Know*, STUDENT DR. NETWORK (Jan. 24, 2017), <https://www.studentdoctor.net/2017/01/24/medical-students-know-fight-residency-caps/> [<https://perma.cc/5PPS-55WR>].

348. Leventhal, *supra* note 346; *see* Villagrana, *supra* note 345.

349. Consolidated Appropriations Act, Pub. L. No. 116-260, § 126(a)(4)(A)(ii), 134 Stat. 1182, 2967 (2020); *Direct Graduate Medical Education (DGME)*, CTRS. MEDICARE & MEDICAID SERVS. (Sep. 3, 2025, at 12:14 CT), <https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/direct-graduate-medical-education-dgme> [<https://perma.cc/9BJN-Y49E>]; Landman, *supra* note 344.

350. *CMS Awards 200 New Medicare-Funded Residency Slots to Hospitals Serving Underserved Communities*, CTRS. MEDICARE & MEDICAID SERVS. (Jan. 9, 2023), <https://www.cms.gov/newsroom/press-releases/cms-awards-200-new-medicare-funded-residency-slots-hospitals-serving-underserved-communities> [<https://perma.cc/7QTS-QWQZ>].

351. *NRMP® Celebrates Match Day for the 2024 Main Residency Match*, THE MATCH (Mar. 15, 2024), <https://www.nrmp.org/about/news/2024/03/nrmp-celebrates-match-day-for-the-2024-main-residency-match-releases-results-for-over-44000-applicants-and-almost-6400-residency-programs/> [<https://perma.cc/2VLV-9DKE>].

352. Landman, *supra* note 344.

353. *See supra* Subsection II.A.1.

354. *See supra* Section II.B.

355. *See supra* Section III.A.

Unfortunately, there is no single remedy for the PCP access problem, and addressing it requires a multi-pronged approach.³⁵⁶ It also requires a willingness to tolerate new spending initially to advance long-term goals.³⁵⁷ Ignoring the problem of access delays, however, is irresponsible, dangerous, and costly in terms of patient welfare and potential malpractice and discrimination claims.³⁵⁸

Improving primary care access and appointment wait times is not an unattainable goal. In 2014, an investigation revealed that VA patients had to wait an average of 115 days for a primary care appointment, especially at one Phoenix hospital.³⁵⁹ Up to forty veterans may have died as a result of these care delays.³⁶⁰ Demonstrating dramatic progress, in 2024, the VA boasted wait times of twenty-two days for primary care appointments.³⁶¹ The improvement is attributable to a variety of interventions that eliminated perverse incentives for VA administrators and enhanced infrastructure and support, as well as to the hiring of 61,000 new employees in fiscal year 2023.³⁶²

Many commentators have decried physician burnout and shortages, which are key components of the appointment delay problem.³⁶³ We will not repeat the full range of recommendations that have been offered to combat burnout and shortages. This Section will focus on a few strategies that might do the most to shorten appointment wait times, analyzing their strengths and weaknesses. First, policymakers and payers can promote value-based payment models that can support and incentivize PCP adoption of practices that may shorten appointment wait times. These might include harnessing artificial intelligence (“AI”) and changing scheduling procedures. In addition, this Section considers a variety of other legal interventions, including provisions that directly address appointment wait times and proposals aiming to reduce PCP shortages.

356. See *supra* Sections II.B and III.A.

357. See *supra* Sections II.B and III.A.

358. See *supra* Part III.

359. German Lopez, *The VA Scandal of 2014, Explained*, VOX (May 13, 2015, at 15:43 ET), <https://www.vox.com/2014/9/26/18080592/va-scandal-explained> [<https://perma.cc/5W4N-7T6W>].

360. *Id.*

361. Jory Heckman, *VA Sees More Patients, Cuts Wait Times, Despite Higher Workload*, FED. NEWS NETWORK (May 24, 2024, at 14:15 CT), <https://federalnewsnetwork.com/veterans-affairs/2024/05/va-sees-more-patients-cuts-wait-times-despite-higher-workload/> [<https://perma.cc/LZ7T-CF9F>]. *But see* Eric Katz, *Years After Scandal, the VA Is Still Reporting Misleading Medical Appointment Wait Times for Veterans*, GOV'T EXEC. (Apr. 7, 2022), <https://www.govexec.com/oversight/2022/04/years-after-scandal-va-still-reporting-misleading-medical-appointment-wait-times-veterans/365406/> [<https://perma.cc/U5YC-DJ4M>] (accusing the VA of false reporting).

362. Heckman, *supra* note 361 (noting, however, that the VA “expects to reduce its headcount to just over 380,000 by the end of fiscal 2025”); Lopez, *supra* note 359.

363. See, e.g., Hoffman, *supra* note 34, at 56; *AMA President Sounds Alarm on National Physician Shortage*, *supra* note 98.

A. *Value-Based Payment Models and Incentivizing Appointment Availability*

To enhance quality of care and curb spending growth, CMS and other payers have begun shifting from fee-for service payment models to value-based payment (“VBP”) or alternative payment models.³⁶⁴ VBPs, also called bundled payments or population-based payments, aim to pay providers “based on the quality of care they provide rather than the volume of services they deliver.”³⁶⁵ For example, Medicaid primary care population-based payment models pay providers with upfront, flexible amounts that are linked to quality incentives.³⁶⁶ In another example, Medicare contracts with provider groups through accountable care organization (“ACO”) arrangements that involve setting spending targets for a defined population of patients alongside quality checks.³⁶⁷ If the provider groups are able to keep spending below the target, they share in the savings.³⁶⁸ ACOs and other VBP models theoretically furnish provider groups with the flexibility and incentive structure to decrease wait times for high value primary care visits and to broaden access points to health care.³⁶⁹ In such models, clinician leaders could adopt strategies designed to reduce wait times, such as using artificial intelligence to handle routine administrative tasks and instituting more efficient scheduling practices.³⁷⁰ Experts warn that VBPs could have unintended consequences, such as PCPs reducing the number of available visits because payment no longer depends on the quantity of services delivered.³⁷¹ Program implementers will need to monitor outcomes and make necessary adjustments, but new payment models may well lead to meaningful progress in primary care access.³⁷²

1. *Artificial Intelligence*

VBP rewards could be offered to physicians who employ AI to reduce appointment wait times. AI has the potential to alleviate administrative burdens for physicians and thus open more time in their day to see patients.³⁷³ It can spare PCPs the need to review patients’ medical histories extensively prior to entering the exam room by creating summaries that highlight the information the doctor needs to know for the visit.³⁷⁴ AI could also assist PCPs with time-consuming

364. Horstman & Lewis, *supra* note 57 (stating that VBP models increased “from 30 percent to 40 percent of payments between 2016 and 2021”).

365. CLARK ET AL., *supra* note 37, at 461, 504.

366. Brykman et al., *supra* note 57.

367. Ishani Ganguli & Timothy G. Ferris, *Accountable Care at the Frontlines of a Health System: Bridging Aspiration and Reality*, 319 JAMA 655, 655 (2018).

368. *Id.*

369. *Id.*; Ishani Ganguli, Jason H. Wasfy & Timothy G. Ferris, *What Is the Right Number of Clinic Appointments? Visit Frequency and the Accountable Care Organization*, 313 JAMA 1905, 1905 (2015).

370. *See id.*

371. Brykman et al., *supra* note 57.

372. *Id.*

373. W. Nicholson Price II, *Artificial Intelligence in the Medical System: Four Roles for Potential Transformation*, 18 YALE J. HEALTH POL’Y, L. & ETHICS 122, 128–29 (2019) (discussing “automating drudgery”).

374. Andy Marso & Steven E. Waldren, *Five Administrative Tasks Technology Could Make Easier for Physicians*, 29 FAM. PRAC. MGMT. 5, 6–7 (2022).

documentation.³⁷⁵ Physicians can speak to voice recognition tools that act as virtual scribes, entering data in electronic health records, editing and organizing information, and following users' commands.³⁷⁶ AI may even be able to help clinicians with the often-cumbersome task of obtaining prior authorization for treatment from insurers.³⁷⁷

Advocates note that AI will be most effective in assisting PCPs if AI developers seek their input and guidance as to how to tailor the technology to clinicians' needs.³⁷⁸ Many are optimistic that AI will significantly shorten the time it takes to complete PCPs' administrative work and thereby reduce overcrowding in physicians' schedules, burnout, and physician departures.³⁷⁹

At the same time, AI can be prone to errors and can fabricate material, a phenomenon known as "hallucinations."³⁸⁰ Any practice employing AI must not give the technology full autonomy and must have human beings overseeing and checking its work.³⁸¹ Policymakers will also need to consider implementing AI regulations to ensure patient safety.³⁸²

2. Appointment Scheduling Strategies

PCP practices may be able to shorten appointment wait times by adopting prudent scheduling policies. One option that some offices have found to be helpful is open access scheduling by which patients are given same-day appointments

375. *Id.* at 7.

376. *Id.* at 6; Winston Liaw, Ioannis A. Kakadiaris & Zhou Yang, *Is Artificial Intelligence the Key to Reclaiming Relationships in Primary Care?*, 104 AM. FAM. PHYSICIAN 558, 558 (2021); Marso & Waldren, *supra* note 374, at 6.

377. Marso & Waldren, *supra* note 374, at 7–8. Prior authorization is approval that clinicians must obtain from health insurers in some cases to have particular services or drugs covered. *Prior Authorization*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/prior-authorization/> [<https://perma.cc/N4M7-D3FP>] (last visited Jan. 15, 2026).

378. Liaw et al., *supra* note 376, at 559.

379. PHYSICIAN SENTIMENTS AROUND THE USE OF AI IN HEALTH CARE: MOTIVATIONS, OPPORTUNITIES, RISKS, AND USE CASES, AM. MED. ASS'N 7, 12 (2025), <https://www.ama-assn.org/system/files/physician-ai-sentiment-report.pdf> [<https://perma.cc/8TFR-YLYJ>] (finding that 68% of physicians "say AI is an advantage in patient care" and they feel most enthusiastic about AI tools that can help reduce administrative burdens including "[d]ocumentation of billing codes, medical charts or visit notes" (59%), "[c]reation of discharge instructions, care plans and/or progress notes" (52%), and "[g]eneration of chart summaries" (47%)); see Jock Putney, *How Artificial Intelligence Can Help Primary Care Doctors—and Their Patients*, MED. ECON. (Apr. 10, 2023), <https://www.medicaleconomics.com/view/how-artificial-intelligence-can-help-primary-care-doctors-and-their-patients> [<https://perma.cc/EB3W-35CL>].

380. See Garance Burke & Hilke Schellmann, *Researchers Say an AI-Powered Transcription Tool Used in Hospitals Invents Things No One Ever Said*, AP NEWS (Oct. 26, 2024, at 13:22 CT), <https://apnews.com/article/ai-artificial-intelligence-health-business-90020cdf5fa16c79ca2e5b6c4c9bbb14> [<https://perma.cc/G4G7-BZ9T>]; Robin Emsley, *ChatGPT: These Are Not Hallucinations—They're Fabrications and Falsifications*, SCHIZOPHRENIA (Aug. 19, 2023), <https://www.nature.com/articles/s41537-023-00379-4> [<https://perma.cc/K8A2-KQDX>].

381. See *Google's AI Tool Producing Misleading Responses That Have Experts Worried*, VOICE AM. (May 25, 2024, at 13:13 CT), <https://www.voanews.com/a/google-s-ai-tool-producing-misleading-responses-that-have-experts-worried/7626590.html> [<https://perma.cc/Y66C-M53V>].

382. Sandeep Reddy, *Navigating the AI Revolution: The Case for Precise Regulation in Health Care*, 25 J. MED. INTERNET RSCH. (2023).

with their personal physician when they call.³⁸³ To make this possible, schedulers leave a portion of each day open for callers who seek immediate medical attention rather than booking all appointments well in advance.³⁸⁴ This model can enhance continuity of care, patient satisfaction, efficiency, and even profitability because patients are less likely to forget or miss an appointment they have booked the same day.³⁸⁵ Many patients who feel acutely ill greatly value the opportunity to see their own PCP on the very day they request an appointment.³⁸⁶

Open access scheduling, however, requires practices to accept the risk that on any given day, some appointments will not be filled or too many patients will seek visits.³⁸⁷ In addition, some patients prefer to schedule appointments in advance or cannot attend same-day appointments because of transportation needs, work obligations, or other barriers.³⁸⁸

Another mechanism to improve convenience for patients and reduce no-show rates is online self-scheduling.³⁸⁹ Self-scheduling enables patients to book appointments on their own without communicating with office personnel.³⁹⁰ Patients can access the appointment website at any hour and can avoid being put on hold or forgotten by staff members.³⁹¹ The technology can also generate reminders that reduce the likelihood of missed appointments.³⁹² Researchers have found that self-scheduling in fact reduces the rate of no-shows along with appointment wait times.³⁹³ Another study concluded that self-scheduling was also associated

383. *Strategy 6A: Open Access Scheduling for Routine and Urgent Appointments*, AGENCY FOR HEALTHCARE RSCH. & QUALITY, <https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/quality-improvement/improvement-guide/6-strategies-for-improving/access/cahps-section-6a.pdf> [https://perma.cc/LY4H-5FZK] (last visited Jan. 15, 2026); Ansell et al., *supra* note 17; C. Dennis O'Hare & John Corlett, *The Outcomes of Open-Access Scheduling*, 11 FAM. PRAC. MGMT. 35, 35 (2004).

384. *Strategy 6A: Open Access Scheduling for Routine and Urgent Appointments*, *supra* note 383.

385. *Id.*

386. *See* Ansell et al., *supra* note 17.

387. David Cho & Kyle Cattani, *The Patient Patient: The Performance of Traditional Versus Open-Access Scheduling Policies*, 50 DECISION SCIS. 756, 756 (2019) (finding that compared to open access, “the traditional policy may be more profitable by providing doctors more control over their schedule and ability to limit over-time”).

388. Ansell et al., *supra* note 17 (reporting that “older patient population . . . seemed to favour pre-booked appointments”).

389. *See* Elizabeth W. Woodcock, *Barriers to and Facilitators of Automated Patient Self-Scheduling for Health Care Organizations: Scoping Review*, J. MED. INTERNET RSCH., Jan. 2022, at 1–11.

390. Jon Tornetta, *Patient Self-Scheduling Is a Necessity*, PHYSICIAN'S WKLY. (Oct. 21, 2021), <https://web.archive.org/web/20250524204026/https://www.physiciansweekly.com/patient-self-scheduling-is-a-necessity/> [https://perma.cc/9XW5-VNLS].

391. *Id.*; Ishani Ganguli, E. John Orav, Claire Lupo, Joshua P. Metlay & Thomas D. Sequist, *Patient and Visit Characteristics Associated with Use of Direct Scheduling in Primary Care Practices*, JAMA NETWORK OPEN, Aug. 2020, at 6–7 (“[B]y one estimate, it took a mean of 8.1 minutes to schedule a doctor’s appointment by telephone, with calls transferred 63% of the time.”).

392. Tornetta, *supra* note 390.

393. Peng Zhao, Illhoi Yoo, Jaie Lavoie, Beau James Lavoie & Eduardo Simoes, *Web-Based Medical Appointment Systems: A Systematic Review*, J. MED. INTERNET RSCH., Apr. 2017, at 5–7; *see also* Ganguli et al., *supra* note 391, at 6 (“Our results suggest that direct scheduling may contribute to continuity and access, core aspects of high-functioning primary care that are associated with better health outcomes and lower costs.”). *But see* Frederick North et al., *Impact of Web-Based Self-Scheduling on Finalization of Well-Child Appointments in a Primary Care Setting: Retrospective Comparison Study*, JMIR MED. INFORMATICS, Mar. 2021, at 4–10 (finding that self-scheduling slightly reduced no shows, but not by a statistically significant amount).

with improved continuity of care because self-scheduled visits were more likely to be with one's own primary care doctor than visits that were scheduled by others.³⁹⁴ When patients attend their appointments and do not need to reschedule them, more appointments become available for others. Moreover, because self-scheduling systems are automated, patients can claim appointments that are cancelled online so that the time slots are not wasted.³⁹⁵

Nevertheless, uptake of self-scheduling has been limited.³⁹⁶ When available, self-scheduling may appeal primarily to younger, commercially insured patients, while others may prefer to speak to a human being over the phone.³⁹⁷ There is no reliable data regarding the number of practices that have adopted self-scheduling.³⁹⁸ Some note that the system is inflexible in that the timeslots it offers are fixed regardless of patients' and physicians' needs on particular occasions.³⁹⁹ The lack of human contact also means that patients cannot be advised to go to an emergency room instead of scheduling an appointment, and clinicians may generally feel that automated systems deprive them of control over their work schedule.⁴⁰⁰ Experts have developed a variety of suggestions to address these concerns and have called for further research regarding automated self-scheduling of medical appointments.⁴⁰¹ VBP incentives may motivate PCP practices to adopt open access and self-scheduling and to address their shortcomings.⁴⁰²

B. Other Legal Interventions

The law also has an important role to play in curbing appointment delays more directly. This Section will address two types of legal mandates. The first are laws and regulations that establish specific boundaries for appointment wait times. The second are proposals aimed at addressing the critical problem of physician shortages.

1. Laws and Regulations Directly Targeting Appointment Wait Times

An intuitive approach to addressing PCP access barriers is to establish statutory or regulatory limits for appointment wait times. Many states have in fact done so, at least to a limited extent.

394. See Ganguli et al., *supra* note 391, at 1.

395. Zhao et al., *supra* note 393, at 7.

396. Elizabeth Woodcock, Aditi Sen & Jonathan Weiner, *Automated Patient Self-Scheduling: Case Study*, 29 J. AM. MED. INFORMATICS ASSOC. 1637, 1637 (2022) (finding that between January 2019 and June 2021, "uptake of self-scheduling increased from 4% to 15% of kept appointments").

397. *Id.*; Ganguli et al., *supra* note 391, at 7 (expressing concern that self-scheduling may exacerbate health disparities because it could enable "younger, White, commercially insured patients . . . [to] crowd out [other patients'] visit access"); North et al., *supra* note 393.

398. Woodcock, *supra* note 389.

399. Zhao et al., *supra* note 393, at 8.

400. *Id.*

401. Woodcock, *supra* note 389, at 1640; Zhao et al., *supra* note 393, at 9.

402. See Horstman & Lewis, *supra* note 57.

The states that have chosen to regulate appointment wait times have opted for health insurance mandates rather than physician mandates.⁴⁰³ Thus, they require insurers to make sure that clinicians within their networks provide timely care.⁴⁰⁴ This approach is sensible and efficient. Rather than overseeing thousands of physicians, states regulate only insurers for this purpose and delegate enforcement work to them.⁴⁰⁵ Insurers negotiate contracts with physicians to form insurance networks and are thus empowered to establish various requirements for their health care providers.⁴⁰⁶ Many states have enacted network adequacy laws, and the ability to meet appointment wait time limits is one criterion by which adequacy can be measured.⁴⁰⁷

a. Examples of State Laws

Some state laws apply to health insurers generally or more specifically to managed care plans, which currently constitute the majority of insurance plans.⁴⁰⁸ For example, California and Maine require that plan enrollees receive urgent care appointments within forty-eight to ninety-six hours, depending on whether prior authorization is needed.⁴⁰⁹ Nonurgent primary care appointments must be available within ten business days of the request, with some exceptions.⁴¹⁰ Under Colorado law patients must be able to obtain urgent care appointments within twenty-four hours and appointments for non-urgent symptoms within seven calendar days.⁴¹¹ Other jurisdictions are less strict with respect to

403. See *infra* notes 408–21 and accompanying text.

404. See *infra* notes 408–21 and accompanying text.

405. See, e.g., CAL. HEALTH & SAFETY CODE § 1367(a)(1) (West 2023) (providing health insurance plans “shall establish and maintain networks, policies, procedures, and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard”).

406. *Private Practice Toolkit: Payor Contracting 101*, AMA (2021), <https://www.ama-assn.org/system/files/payor-contracting-toolkit.pdf> [<https://perma.cc/L4P3-DHFM>].

407. *Health Insurance Network Adequacy Requirements*, NAT’L CONF. ST. LEGISLATURES (June 1, 2023), <https://www.ncsl.org/health/health-insurance-network-adequacy-requirements> [<https://perma.cc/E97Z-W357>].

408. CLARK ET AL., *supra* note 37, at 47–48 (explaining that managed care plans “contract with medical professionals to manage the cost, utilization, and quality of care” and that “between eighty and ninety-eight percent of . . . private health insurers appear to fall into the broad category of managed care”); NLM, *Managed Care: Summary*, MEDLINEPLUS, <https://medlineplus.gov/managedcare.html> [<https://perma.cc/TSM4-3W3F>] (last visited Jan. 15, 2026) (explaining that managed care plans “have contracts with health care providers and medical facilities to provide care for members at reduced costs,” and these providers and facilities constitute the plan’s “network”).

409. CAL. HEALTH & SAFETY CODE § 1367.03(a)(5) (2023); CAL. INS. CODE § 10133.54(b)(5) (2023); 02-031-850 ME. CODE R. § 7(C)(2) (2020).

410. *Id.*

411. COLO. CODE REGS. § 702-4:4-2-53-6 (2023); see also ARIZ. ADMIN. CODE § R20-6-1914 (2024) (requiring health care services organizations to provide enrollees with PCP preventive care appointments within 60 days of requesting them and routine-care PCP appointments within fifteen days or sooner if necessary); MD. CODE REGS. 31.10.44.06(E) (2023) (requiring the provision of urgent care services within 72 hours and routine primary care within 15 days); MONT. ADMIN. R. 6.6.8827 (2023) (requiring the provision of urgent care services within 24 hours and nonurgent care for patients with symptoms within 10 calendar days); N.J. ADMIN. CODE § 11:24A-4.10(b)(iii) (2024) (“Routine appointments can be scheduled within at least two weeks” and “Routine physical exams can be scheduled within at least four months”); N.M. CODE R. § 8.308.2.12(D) (2024) (allowing only 14 calendar day request-to-appointment times when patients with symptoms seek appointments); OR. ADMIN. R. 410-141-3515(15)(a) (2024) (requiring that urgent care be provided with 72 hours and well visits

wait times. New Hampshire, for example, establishes a time limit of forty-eight hours for urgent care and thirty days for other types of care.⁴¹²

Florida's regulations govern health maintenance organizations ("HMOs").⁴¹³ HMOs must ensure that members can see clinicians within twenty-four hours in urgent cases and within two weeks for nonurgent cases.⁴¹⁴ Likewise, New Jersey requires HMOs to provide urgent care within twenty-four hours, to schedule routine appointments within two weeks, and to provide routine physicals within four months of a request.⁴¹⁵

Many jurisdictions focus appointment availability regulations on Medicaid managed care programs.⁴¹⁶ Federal regulations require that states "draft and implement a written quality strategy for assessing and improving the quality of health care and services" that managed care organizations provide to Medicaid enrollees.⁴¹⁷ Appointment wait-time standards are one strategy that states implement for compliance purposes.⁴¹⁸ Permissible wait times range from ten to forty-five days for routine primary care and one to four days for urgent care.⁴¹⁹ For example, the District of Columbia establishes that the Medicaid Managed Care Program for Children & Youth with Disabilities must ensure appointment availability the same or next day for urgent care and within three weeks of a request for nonurgent care.⁴²⁰ Under Kentucky and Maryland law, wait times for primary care appointments cannot exceed thirty calendar days for routine or preventive services.⁴²¹

within four weeks); TEX. INS. CODE ANN. art. 1301.00555 (2023) (requiring insurers to ensure that "routine care is available and accessible from preferred providers . . . within three weeks for medical conditions" and that preventive care is accessible within three months for adults); 12 VA. ADMIN. CODE § 5-408-270(D) (2002) (providing "[r]outine appointments for nonemergency or nonurgent care shall be available within two weeks of the covered person's request"); 4-5 VT. CODE R. § 3:5(B) (2017) (establishing maximum wait times of 24 hours for urgent care, two weeks for nonurgent care, and 90 days for routine physical examinations); WASH. ADMIN. CODE § 284-170-200(13)(b)(iii) (2023) (establishing that "[e]nrollees [must] have access to an appointment, for other than preventive services, with a primary care provider within 10 business days of requesting one"); W. VA. CODE § 114-100-3.2 (2024) (establishing that routine primary care must be available within 15 business days).

412. N.H. CODE ADMIN. R. ANN. INS. 2701.09 (2018).

413. FLA. ADMIN. CODE ANN. r. 59A-12.006(3)(b) (2003).

414. *Id.*

415. N.J. ADMIN. CODE § 11:24-6.2 (2024); MO. CODE REGS. ANN. tit. 20, § 400-7.095(2)(A)3.A.(III)(a)-(d); 28 TEX. ADMIN. CODE § 11.1607 (2021).

416. All states provide at least some of their Medicaid services through managed care plans. *See* SUZANNE MURRIN, U.S. DEP'T HEALTH & HUM. SERVS., STATE STANDARDS FOR ACCESS TO CARE IN MEDICAID MANAGED CARE 2 (2014); *Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule (CMS-2439-F)*, CTRS. MEDICARE & MEDICAID SERVS. (Apr. 22, 2024), <https://www.cms.gov/newsroom/fact-sheets/medicaid-and-childrens-health-insurance-program-managed-care-access-finance-and-quality-final-rule> [<https://perma.cc/M9U7-KLGU>] ("[O]ver 70% of Medicaid and CHIP beneficiaries receive[e] some or all of their care through a managed care plan.").

417. 42 C.F.R. § 438.340(a).

418. Karen Pollitz, *Network Adequacy Standards and Enforcement*, KFF (Feb. 4, 2022), <https://www.kff.org/affordable-care-act/issue-brief/network-adequacy-standards-and-enforcement/> [<https://perma.cc/PE9H-9EZL>].

419. *Id.*

420. D.C. MUN. REGS. tit. 29, § 5606.12(b) (2024).

421. 907 KY. ADMIN. REG. 17:015 § 2(7) (2021); MD. CODE REGS. 10.67.05.07 (2019); *see also* N.Y. COMP. CODES R. & REGS. tit. 10, § 85.44(e)(3)(v) (2021) (providing "[a]ppointments for non-urgent visits for current

The federal government has enacted regulations that govern the public health insurance programs that it operates. Tricare, a military health benefits program,⁴²² is subject to specific wait time requirements.⁴²³ Similarly, the DHHS Centers for Medicare and Medicaid Services (“CMS”) established wait time constraints for Medicare Advantage plans.⁴²⁴

In 2024, CMS issued a final rule that will establish national (rather than state-by-state) maximum appointment wait times for Medicaid and Children’s Health Insurance Program enrollees, to be effective in 2027.⁴²⁵ The longest allowable wait for routine primary care appointments will be fifteen business days.⁴²⁶ Furthermore, starting in 2028, states will be obligated to conduct yearly “secret shopper” surveys⁴²⁷ using independent entities to verify that managed care plans are complying with the appointment wait time standards.⁴²⁸ States will also be required to conduct yearly enrollee experience surveys for each managed care plan, to implement remedial strategies for plans that fail to meet access standards, and to maintain accessible, user-friendly webpages containing specified information.⁴²⁹

patients of the program shall be available in no more than two weeks from the time of request, 90 percent of the time. Appointments for non-urgent visits by new patients shall be available in no more than four weeks from the time of request”); 210 R.I.C.R. 30-05-2.15(B) (2024) (explaining “[t]he MCO must make services available within thirty (30) days for treatment of a non-emergent, non-urgent medical problem”).

422. *Eligibility*, TRICARE (Feb. 28, 2025), <https://www.tricare.mil/Plans/Eligibility> [<https://perma.cc/ZFF6-KK3C>].

423. 32 C.F.R. § 199.17(p)(5)(ii) (2024) (“The wait time for an appointment for a well-patient visit or a specialty care referral shall not exceed four weeks; for a routine visit, the wait time for an appointment shall not exceed one week; and for an urgent care visit the wait time for an appointment shall generally not exceed 24 hours.”).

424. 42 C.F.R. § 422.112(a)(6)(i) (2023) (establishing the following standards for primary care appointment wait times: “(A) Urgently needed services or emergency—immediately; (B) Services that are not emergency or urgently needed, but the enrollee requires medical attention—within 7 business days; and (C) Routine and preventive care—within 30 business days”). Medicare Advantage plans are an alternative to traditional Medicare, and slightly over half of Medicare beneficiaries now select these plans. See Kimberly Lankford, *What is Medicare Advantage?*, AARP (Nov. 22, 2023), <https://www.aarp.org/health/medicare-qa-tool/what-is-medicare-advantage/> [<https://perma.cc/6BVQ-ZZ3D>].

425. Medicaid Program; Medicaid and Children’s Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, 89 Fed. Reg. 41002 (May 10, 2024); Elizabeth Hinton & Jada Raphael, *10 Things to Know About Medicaid Managed Care*, KFF (May 1, 2024), <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicare-managed-care/> [<https://perma.cc/FT57-S6P3>].

426. *Medicaid and Children’s Health Insurance Program Managed Care Access, Finance, and Quality Final Rule*, *supra* note 416, at 17. Hinton & Raphael, *supra* note 425.

427. “Secret shopper” surveys involve individuals who contact medical offices and pose as patients seeking care in order to gather data for research purposes. Kelsey A. Rankin, Alison Mosier-Mills, Walter Hsiang & Daniel H. Wiznia, *Secret Shopper Studies: An Unorthodox Design that Measures Inequities in Healthcare Access*, 80 ARCHIVES PUB. HEALTH 226, 226 (2022).

428. 42 C.F.R. § 438.68(f) (2024). The survey must (1) use a random sample (2) include all areas of the state covered by the insurance contract and (3) “be completed for a statistically valid number of providers.” *Id.* § 438.68(f)(4).

429. See *Medicaid and Children’s Health Insurance Program Managed Care Access, Finance, and Quality Final Rule*, *supra* note 416; Hinton & Raphael, *supra* note 425.

b. Critique

Despite the many statutory provisions, excessively long appointment wait times persist.⁴³⁰ One challenge is defining the term “urgent care.”⁴³¹ It is difficult for patients, and sometime even for health care professionals, to distinguish a priori truly urgent and emergent symptoms from less critical symptoms.⁴³²

In its new Final Rule, CMS declined to furnish a definition.⁴³³ It explained that “‘urgent’ and ‘emergent’ for appointment wait time standards are complex given the standards of practice by specialty and the patient-specific considerations necessary to determine those situations.”⁴³⁴

Nevertheless, some statutes offer definitions, albeit broad ones that leave ample room for discretion. For example, Vermont defines urgent care as “health care services that are necessary to treat a condition or illness of an individual that if not treated within twenty-four (24) hours presents a serious risk of harm.”⁴³⁵

Similarly, Rhode Island defines “Urgent medical problem” as

a medical, physical, or mental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of medical attention within twenty-four (24) hours could reasonably be expected to result in:

- a) Placing the patient’s health in serious jeopardy;
- b) Serious impairment to bodily function; or
- c) Serious dysfunction of any bodily organ or part.⁴³⁶

Weak enforcement is an additional hurdle. State health departments face chronic funding shortfalls that shackle their enforcement efforts.⁴³⁷ Several studies have scrutinized enforcement of Medicaid managed care access standards. A 2018 Medicaid and CHIP Payment and Access Commission report found that most states have not implemented enforcement mechanisms for access-related noncompliance.⁴³⁸ The DHHS Office of Inspector General reported in 2014 that when states identified access violations, they generally did no more than require

430. *See supra* Subsection II.A.2.

431. *See infra* notes 435–36 and accompanying text.

432. Paul Hyman, *The Disappearance of the Primary Care Physical Examination—Losing Touch*, 180 JAMA INTERNAL MED. 1417, 1417 (2020); Jessica Migala, *Five Times You Should Definitely Go to the ER*, CNN (Sep. 2, 2016, at 06:51 ET), <https://www.cnn.com/2016/09/02/health/go-to-emergency-room/index.html> [<https://perma.cc/EG8F-LQYJ>].

433. 89 Fed. Reg. 41016 (May 10, 2024).

434. *Id.* at 41012.

435. 13-710 VT. CODE R. § 7101.3(a)(10) (2018).

436. 210 R.I. CODE R. § 30-05-2.4.A(28) (2024).

437. MATT MCKILLOP & DARA ALPERT LIEBERMAN, TR. FOR AM.’S HEALTH, THE IMPACT OF CHRONIC UNDERFUNDING ON AMERICA’S PUBLIC HEALTH SYSTEM: TRENDS, RISKS, AND RECOMMENDATIONS 5 (2023), <https://www.tfah.org/wp-content/uploads/2023/06/TFAH-2023-PublicHealthFundingFINALc.pdf> [<https://perma.cc/A7NH-28GT>] (“Many health departments face a funding cliff as pandemic response funding ends.”).

438. Elizabeth Hinton & Jada Raphael, *Medicaid Managed Care Network Adequacy & Access: Current Standards and Proposed Changes*, KFF (June 15, 2023), <https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-network-adequacy-access-current-standards-and-proposed-changes/> [<https://perma.cc/7AUC-AEQN>].

offenders to take corrective action.⁴³⁹ When states do impose fines, the penalties are so small that they fail to serve as an effective deterrent to misconduct.⁴⁴⁰

A Commonwealth Fund survey suggests that CMS's Medicare Advantage wait time regulations also suffer from deficient enforcement.⁴⁴¹ It found that one-third of Medicare Advantage enrollees must wait over a month or more to see a doctor, though the finding is not specific to PCPs.⁴⁴²

Finally, states are significantly constrained in their ability to regulate the private health insurance market.⁴⁴³ Laws that attempt to impose appointment availability standards on all insurers have limited reach because a large portion of insurance policies are not subject to statutory compliance.⁴⁴⁴ Under the "deemer clause" in the Employee Retirement Income Security Act of 1974 ("ERISA"), state laws regulating insurance are preempted with respect to self-funded health insurance plans.⁴⁴⁵ Employers with self-funded plans collect premiums and pay all medical claims out-of-pocket, though they may use third parties to administer the plans (*e.g.*, handle enrollment and claims processing).⁴⁴⁶ According to the Henry J. Kaiser Family Foundation, in 2023, 65% of workers were enrolled in fully or partially self-funded health plans, which are particularly popular among large companies.⁴⁴⁷ The ERISA exemption thus significantly diminishes the efficacy of state laws targeting private health insurers, such as those requiring the establishment of maximum appointment wait times.⁴⁴⁸

c. Recommendations—Greater Clarity and a Federal Mandate

Legal mandates regarding appointment availability are a good first step to addressing unacceptable appointment delays. But without guidance as to what constitutes a need for urgent or emergent care, robust enforcement, and the ability to regulate self-insured health plans at the state level, their efficacy is limited.

439. MURRIN, *supra* note 416, at 17.

440. DANIEL YOUNG, NAT'L HEALTH L. PROGRAM, MANAGED CARE SANCTIONS: AN IMPORTANT TOOL FOR ACCOUNTABILITY 1 (2022), https://healthlaw.org/wp-content/uploads/2022/12/Managed-Care-Sanctions_DY-updated-final.pdf [<https://perma.cc/9AZQ-82AN>] ("[T]he fines imposed on MCOs are miniscule compared to their yearly revenues and profits.")

441. Gretchen Jacobson, Faith Leonard, Elizabeth Sciupac & Robyn Rapoport, *What Do Medicare Beneficiaries Value About Their Coverage?*, COMMONWEALTH FUND (Feb. 22, 2024), <https://www.commonwealthfund.org/publications/surveys/2024/feb/what-do-medicare-beneficiaries-value-about-their-coverage> [<https://perma.cc/7DGZ-2QRQ>]. For the regulations at issue, see 42 C.F.R. § 422.112(a)(6)(1)(i).

442. Jacobson et al., *supra* note 441.

443. For state regulations that target private health insurance and HMOs, see *supra* notes 409–15 and accompanying text.

444. Sharona Hoffman & Isaac D. Buck, *Specialty Drugs and the Health Care Cost Crisis*, 55 WAKE FOREST L. REV. 55, 70, 83–86 (2020).

445. *Id.* at 84; 29 U.S.C. § 1144(b)(2)(B).

446. *Self-Insured Plan*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/self-insured-plan/> [<https://perma.cc/6XS6-JGAR>] (last visited Jan. 18, 2026).

447. GARY CLAXTON, MATTHEW RAE, AUBREY WINGER & EMMA WAGER, KFF, EMPLOYER HEALTH BENEFITS 2023 ANNUAL SURVEY 11 (2023), <https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2023-Annual-Survey.pdf> [<https://perma.cc/4CUH-2NKS>].

448. For suggestions to overcome the ERISA problem, see Hoffman & Buck, *supra* note 441, at 83–86.

Nothing can be done about regulating self-insured health plans at the state level in the absence of an ERISA amendment.⁴⁴⁹ Consequently, Congress should consider enacting a national appointment time mandate to eliminate the confusing patchwork of laws that currently exists and promote national uniformity. Such a law would reflect a shared understanding of the access patients deserve and a common target. This could perhaps be achieved through a modification to the Affordable Care Act.⁴⁵⁰ The federal provision would require all health insurers to establish specified wait time limits for participating in-network PCPs.

Contemporary patients have a variety of access points to their primary care providers. Traditional, in-person visits with PCPs play an important role in primary care.⁴⁵¹ But primary care increasingly includes telemedicine appointments with PCPs,⁴⁵² visits with other members of the primary care team (*e.g.*, physician assistants, nurse practitioners, registered nurses),⁴⁵³ and secure messaging with PCPs through patient portals.⁴⁵⁴ Regulators should take account of these mechanisms when setting wait time requirements, and PCPs may use them prudently to comply with regulatory standards.

Any legislation, whether state or federal, should feature clear definitions and strong enforcement mechanisms. Admittedly, it is challenging to formulate precise definitions for the terms “urgent” and “emergent.”⁴⁵⁵ It can be difficult to discern just how sick patients are prior to examination because, for example, stomach aches can stem from either gas or appendicitis.⁴⁵⁶ Nevertheless, all relevant regulatory provisions should include definitions that are as thoughtful as possible.⁴⁵⁷ Moreover, all physician practices should train schedulers to make sound decisions regarding how quickly PCPs should see particular patients. This can include transferring callers to advanced practice clinicians or nurses in the office who can preliminarily assess their conditions.⁴⁵⁸

Health authorities should pursue more robust enforcement efforts as well. CMS’ new “Medicaid and Children’s Health Insurance Program Managed Care

449. *See id.*

450. *See* Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119.

451. *See supra* Subsection III.A.1.

452. *See supra* notes 147 and accompanying text.

453. Advanced practice providers are clinicians, such as nurse practitioners and physician assistants, who have medical training and are licensed to diagnose and treat common medical conditions. *Advanced Practice Provider*, NAT’L CANCER INST., <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/advanced-practice-provider> [https://perma.cc/8DEB-FAS3] (last visited Jan. 18, 2026).

454. Elizabeth Baltaro, Wendy Henderson & Karen M. Goldstein, *Patient Electronic Messaging: 12 Tips to Save Time*, 29 FAM. PRACT. MGMT. 5, 5–9 (2022); *see also* Sharona Hoffman & Andy Podgurski, *E-Health Hazards: Provider Liability and Electronic Health Record Systems*, 24 BERKELEY TECH. L.J. 1523, 1549–52 (2009) (discussing clinician responsiveness to electronic communication and patient access to portals); Smriti Joshi, *Is Texting the Future of Patient-Centric Care?*, MED. ECON. (Oct. 19, 2023), <https://www.medicaleconomics.com/view/is-texting-the-future-of-patient-centric-care-> [https://perma.cc/6RG2-6NBS] (providing guidance as to when online communication with patients is appropriate).

455. *See infra* notes 435–36 and accompanying text.

456. James Roland, *How Can You Tell the Difference Between Appendicitis and Gas?*, HEALTHLINE (Apr. 19, 2023), <https://www.healthline.com/health/appendicitis-or-gas> [https://perma.cc/64M4-ZXAS].

457. *See, e.g., supra* notes 431–32 and accompanying text.

458. For the definition of advanced practice providers, *see supra* note 453.

Access, Finance, and Quality Final Rule” provides a promising model.⁴⁵⁹ CMS should implement a similar approach for Medicare, as should states regulating private insurers. Secret shoppers can be effective tools to identify compliance shortcomings⁴⁶⁰ and could help determine whether new patients can get timely appointments.⁴⁶¹ If callers provide names that suggest particular racial or ethnic identities and are given later appointments than other callers, they may also help uncover unlawful discrimination.⁴⁶² Medicare and private health insurers could be required to send patients surveys regarding their appointment wait times and to provide summary reports to the appropriate government authorities.⁴⁶³ The law should require regulators that become aware of access deficiencies to work with insurers to implement remedial plans.⁴⁶⁴ In addition, the law should mandate that all insurers distribute to patients information about their right to timely appointments and instructions regarding how to report violations to insurers and government authorities.⁴⁶⁵

Critics may perceive appointment availability requirements to be somewhat unfair and unrealistic in today’s health care environment. They may argue that there is little hope for shorter wait times if physician shortages continue to worsen.⁴⁶⁶ Legislative mandates should account for PCP availability, and the provisions described above generally allow for delays of several weeks for “non-urgent” medical problems.⁴⁶⁷ In addition, PCP practices can employ a variety of tools to promote appointment availability, such as prudently using AI, adopting suitable scheduling strategies,⁴⁶⁸ and providing different access mechanisms to patients.⁴⁶⁹ Nevertheless, PCP shortages are critical public health problems that require legal intervention.⁴⁷⁰

2. *Proposals to Address Insufficient Primary Care Capacity*

One might assume that physician shortages are an entrenched reality about which the law can do little. But several bills have been introduced in Congress

459. *See supra* notes 416, 425–29.

460. MURRIN, *supra* note 416, at 14–15 (“One State Medicaid official noted that there were barriers to access that would never have been discovered without conducting secret-shopper calls.”). Beginning in 2025 CMS also plans to use secret shoppers to assess appointment wait time compliance by Qualified Health Plan issuers participating in federally facilitated exchanges. DEP’T OF HEALTH & HUM. SERVS., 2025 FINAL LETTER TO ISSUERS IN THE FEDERALLY-FACILITATED EXCHANGES 17 (2024), <https://www.cms.gov/files/document/2025-letter-issuers.pdf> [<https://perma.cc/F67S-QGVX>].

461. *See supra* notes 427–28 (discussing secret shoppers). It will not be possible for callers to pretend to be existing patients because they will not have access to such patients’ personal details. *See supra* notes 86–87 and accompanying text.

462. *See supra* Subsection III.B.2 (discussing discrimination).

463. *See supra* notes 429 and accompanying text.

464. *See supra* notes 429 and accompanying text.

465. *See supra* notes 429 and accompanying text.

466. *See supra* Subsection II.A.2.

467. *See supra* Subsection V.B.1.a.

468. *See supra* Section V.A.

469. *See supra* notes 452–54.

470. *See supra* Section III.A.

in the last few years that could help remediate some of the causes of physician shortages.⁴⁷¹ Most of the bills do not specifically target the primary care field but could help support and grow the PCP workforce.⁴⁷² None has become law thus far, but it is worth compiling a short list of potential legal strategies.

- The *Pay PCPs Act of 2024*⁴⁷³ aimed to encourage CMS to adopt “hybrid payments” for non-visit-based care that PCPs provide, such as care management services and communication with patients through emails, phone calls, and patient portal messages.⁴⁷⁴
- The *Strengthening Medicare for Patients and Providers Act*⁴⁷⁵ sought to revise certain payment adjustments under the Medicare physician fee schedule to enhance physician compensation.⁴⁷⁶ Higher pay could attract young physicians to the primary care field since many cite comparatively low pay and crushing student debt as barriers.⁴⁷⁷
- The *Healthcare Workforce Resilience Act*⁴⁷⁸ would expedite immigration status adjustment for physicians with approved immigration petitions.⁴⁷⁹ Under the bill, the government would “recapture” up to 15,000 unused visas and grant them to physicians and thus would not need to create any new visas.⁴⁸⁰
- The *Resident Physician Shortage Reduction Act of 2025*⁴⁸¹ would increase the number of residency positions eligible for Medicare GME payments.⁴⁸² It would add 14,000 slots over seven years.⁴⁸³
- The *Improving Seniors’ Timely Access to Care Act*⁴⁸⁴ would require Medicare Advantage plans to comply with new prior authorization requirements, including automation, transparency, and other standards related to quality and timeliness.⁴⁸⁵ This law would be consistent with a variety of state legislative efforts to expedite and simplify prior

471. See, e.g., *infra* notes 473–87 and accompanying text.

472. See, e.g., *infra* notes 473–87 and accompanying text.

473. S. 4338, 118th Cong. (2024).

474. NAT’L ACADS. OF SCIS., ENG’G, & MED., RESPONSE TO THE “PAY PCPs ACT OF 2024” REQUEST FOR INFORMATION 2 (Lauren Hughes, Mary Wakefield & Marc Meisner eds., 2024).

475. H.R. 2474, 118th Cong. (2023).

476. Summary: *H.R.2474—118th Congress (2023-2024)*, CONGRESS.GOV, <https://www.congress.gov/bills/118th-congress/house-bill/2474> [<https://perma.cc/7R5S-VQYZ>] (last visited Jan. 14, 2025).

477. See *supra* notes 339–41 and accompanying text.

478. H.R. 5283, 119th Cong. (2025); S. 2759, 119th Cong. (2025).

479. DICK DURBIN: U.S. SENATOR FOR ILL., HEALTHCARE WORKFORCE RESILIENCE ACT—SUMMARY, <https://www.durbin.senate.gov/imo/media/doc/Healthcare%20Workforce%20Resilience%20Act%20Summary.pdf> [<https://perma.cc/RXS5-AYLE>] (last visited Jan. 14, 2026).

480. *Id.*; see S. 32111 § 2(d)(2)(B)(i)–(ii).

481. H.R. 3890, 119th Cong. (2025); S. 2439, 119th Cong. (2025).

482. Press Release, U.S. Congresswoman Terri Sewell, Fitzpatrick Introduce Bipartisan Legislation to Combat Doctor Shortage, Improve Access to Health Care (June 10, 2025), <https://sewell.house.gov/press-releases/?ID=6E52DBEB-B4A0-4916-AEAF-912F3E917781> [<https://perma.cc/M8G2-58K7>].

483. *Id.*

484. H.R. 3514, 119th Cong. (2025); S. 1816, 19th Congress (2025).

485. Press Release, U.S. Representative Ami Bera, Colleagues Reintroduce Bipartisan Improving Seniors’ Timely Access to Care Act (May 21, 2025), <https://bera.house.gov/news/press-releases/rep-bera-colleagues-reintroduce-bipartisan-improving-seniors-timely-access-to-care-act> [<https://perma.cc/86U8-4WH2>].

authorization.⁴⁸⁶ Advocates argue that reducing the work and frustration entailed in obtaining prior authorization could meaningfully diminish burnout and associated physician departures.⁴⁸⁷

Extensive analysis of these and other proposals is beyond the scope of this Article. Suffice it to say that the problem of physician shortages is unlikely to be solved without legal interventions.⁴⁸⁸ So long as physician shortages persist and grow, patients can have little hope of shorter appointment wait times.⁴⁸⁹

It is important to note that the federal government has already undertaken initiatives to support and enlarge the primary care physician workforce. For example, the National Health Service Corps has established a Loan Repayment Program.⁴⁹⁰ It is available to licensed primary care clinicians who serve at least two years at approved sites in Health Professional Shortage Areas.⁴⁹¹ Federal, state, and local governments sponsor a variety of other loan forgiveness programs as well.⁴⁹² These must be continued and expanded in order to attract more individuals to the primary care field.

DHHS has acknowledged that Medicare provides “lower reimbursement for primary care services relative to specialty care services, which . . . has . . . resulted in fewer medical school graduates electing to go into primary care over time.”⁴⁹³ The government should continue to be mindful of the reimbursement gap and strive to narrow it.

Legal change cannot be implemented without funding and administrative resources. As noted earlier, there are tradeoffs among the competing values of controlling spending growth, improving quality, and expanding access.⁴⁹⁴ To advance the latter two, fiscal restraint may initially have to be deprioritized to some degree.⁴⁹⁵ But the new laws’ investments would be richly rewarded with

486. See Tanya Albert Henry, *9 States Pass Bills to Fix Prior Authorization*, AM. MED. ASS’N (Mar. 8, 2024), <https://www.ama-assn.org/practice-management/prior-authorization/9-states-pass-bills-fix-prior-authorization> [<https://perma.cc/CRC3-PHCV>].

487. See, e.g., *AMA President Sounds Alarm on National Physician Shortage*, *supra* note 98.

488. See *supra* Part IV, Section V.B.

489. See *supra* Part IV.

490. *NHSC Loan Repayment Program*, HEALTH RES. & SERVS. ADMIN. (Sep. 2025), <https://nhsc.hrsa.gov/loan-repayment/nhsc-loan-repayment-program> [<https://perma.cc/CC4W-S5UL>].

491. *Id.*; *What Is Shortage Designation?*, HEALTH RES. & SERVS. ADMIN. (June 2023), <https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation> [<https://perma.cc/QSY2-QL6C>] (explaining that health professional shortage areas are areas with “a shortage of primary, dental, or mental health care providers”).

492. *Loan Forgiveness for Medical School Debt*, AAFP, <https://www.aafp.org/students-residents/medical-students/begin-your-medical-education/debt-management/funding-options/forgiveness.html> [<https://perma.cc/FJ6L-RDDY>] (last visited Jan. 14, 2025).

493. OFFICE OF ASSISTANT SEC’Y FOR PLAN. & EVALUATION, *PRIMARY CARE SPENDING IN MEDICARE FEE-FOR-SERVICE: AN ILLUSTRATIVE ANALYSIS USING ALTERNATIVE DEFINITIONS OF PRIMARY CARE 2* (2024), https://www.ncbi.nlm.nih.gov/books/NBK611350/pdf/Bookshelf_NBK611350.pdf [<https://perma.cc/EN89-6JTW>]; see also *HHS Proposes Physician Payment Rule to Drive Whole-Person Care and Improve Health Quality for All Individuals with Medicare*, CMS.GOV: NEWSROOM (Jul. 10, 2024), <https://www.cms.gov/newsroom/press-releases/hhs-proposes-physician-payment-rule-drive-whole-person-care-and-improve-health-quality-all> [<https://perma.cc/R475-Y6LN>] (describing a “proposed payment . . . [that would make adjustments] for patient medical and social complexity to promote health equity”).

494. See *supra* Section III.A.

495. See *supra* notes 197–200 and accompanying text.

significant reductions in physician workforce depletion and associated poor health outcomes that currently plague the United States' health care system.⁴⁹⁶

VI. CONCLUSION

Excessively long primary care appointment wait times constitute a serious and multi-layered health care problem. They are not rooted in a single cause, and no single solution can resolve the problem.⁴⁹⁷ The consequences of appointment delays are also varied and complex. They include care fragmentation and neglect that have significant adverse cost, quality, access, and equity implications.⁴⁹⁸ These leave both patients and physicians feeling frustrated and devalued.⁴⁹⁹ Furthermore, care fragmentation and neglect may expose clinicians to legal liability arising from medical malpractice and discrimination claims.⁵⁰⁰

This Article has outlined several legal and other approaches to addressing long appointment wait times and PCP inaccessibility.⁵⁰¹ In combination, they could significantly enhance efforts to remove primary care access barriers.⁵⁰² Adoption of such strategies could likewise improve access to physicians in other specialties.⁵⁰³ Many states have recognized the need to regulate appointment wait times, though they have done so to limited effect.⁵⁰⁴ All Americans should be able to see their PCPs as often as necessary and should expect (rather than dream of) timely attention from their doctors. It is time for policymakers and the medical community at large to recognize the seriousness of this public health challenge and renew efforts to address it.

496. *See supra* notes 194–200 and accompanying text.

497. *See* notes 98–100 and accompanying text.

498. *See supra* Section II.B, Part III.

499. *See supra* notes 16, 309–21 and accompanying text.

500. *See supra* Section III.B.

501. *See* Part V.

502. *See* Part V.

503. *See* Part V.

504. *See supra* Subsection V.B.1.a.

