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January 24, 2018

State Rep. Joe Sanfelippo's Testimony on 2017 Assembly Bill 798

Chairman Tauchen and committee members, thank you for holding a hearing today on Assembly Bill 798 relating to the direct primary care program for Medical Assistance recipients and direct primary care agreements.

Americans across the country have come to find that the Affordable Care Act is anything but affordable.

With many Americans struggling financially to pay for health care and businesses being required to offer extensive health care benefits under the law, legislators across the country have been looking for ways to provide citizens with different options so that they can find the best plans that work for them.

2017 Assembly Bill 798 allows health care providers and individual patients to enter into a direct primary care agreement. A direct primary care agreement, which is not health insurance, is a contract in which a health care provider agrees to offer routine health services for a specified fee over a stated time period.

This proposal also includes the creation of a pilot program administered by DHS for BadgerCare Plus members. Directly connecting members with primary care providers could greatly improve the overall health of our Medicaid population and improve their quality of life while helping us control program costs.

The federal government is encouraging states to incorporate direct primary care programs into their Medicaid systems in order to increase access, for example, to physicians who currently do not see Medical Assistance patients; to improve the quality of life for members; and to control costs. In fact, I'd like to share with you an excerpt from the US Department of Health and Human Services's 2018 budget:

"***Medicaid Direct Primary Care Initiative***

Starting in FY 2018, the Department looks forward to collaborating with States to expand Medicaid Direct Primary Care (DPC), which provides an enhanced focus on direct physician-patient relationships through enrolling Medicaid patients in DPC practices. These practices enhance physicians' focus on patient care by simplifying health care payments for patients and physicians. DPC arrangements also often include benefits such as extended visits and electronic communication, which allow for improved patient access to primary care services. DPC arrangements have the potential to improve Medicaid in the following manner:

- **Increasing access.** While approximately 70 percent of physicians are accepting new Medicaid patients nationally, there is wide variation across States and one-third of physicians still do not accept Medicaid patients. Specialists are also more likely to take Medicaid patients than primary care physicians. Moreover, many physicians refuse to treat Medicaid patients for various reasons including low reimbursement rates.

- **Supporting positive health outcomes for Medicaid patients.** While limited, data available for patient outcomes for patients in DPC practices has been relatively positive. The American Journal of Managed Care evaluated a DPC group with practices in many States, and data illustrated positive patient outcomes with decreases in preventable hospital use that resulted in considerable savings.

- **Putting patients and doctors in more control of health care.** DPC practices will support the vital role primary care plays in patient health, including providing preventive services, monitoring health conditions, and improving the crucial physician-patient relationship. By creating DPC practices that would encourage affordable care for patients, these patient-centered reforms would help build a more innovative and responsive health care system—one that empowers patients and ensures they and their doctor have the freedom to make health care decisions without bureaucratic interference or influence.

Working with States and primary care physicians, HHS will support the development of DPC practices, identify barriers to their entry into Medicaid, and outline flexibilities under existing authorities to facilitate these innovative approaches to strengthening the relationships between patients and physicians."

There's clearly momentum at the national level towards integrating Direct Primary Care into the Medicaid framework. A carefully crafted, successful Medicaid Pilot could once again make Wisconsin the national leader in innovative health care, similar to our respected managed care model.

According to Direct Primary Care Frontier, **23 states in the country have enacted direct primary care legislation into law**, including Midwestern states such as Indiana and Michigan.

According to an article written by the Institute for Healthcare Consumerism, employers "can work with third party administrators to rent provider networks and track claims. They can also have a stop-loss insurance plan in place to cap annual out-of-pocket costs. These employers will typically **save 30-40 percent off of their routine insurance expenses**, and their employees will pay nothing out-of-pocket for their routine care with the direct primary care agreement."

The Wisconsin Academy of Family Physicians supports this legislation and recently issued a memo stating, **"Please support this innovative initiative that reduces costs for patients and increases access to services."**

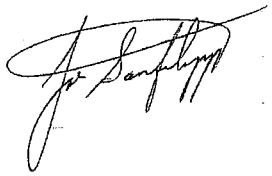
One of the great advantages of the Direct Primary Care model is the close coordination of care that patients can enjoy when their primary care physicians have the time and willingness to directly reach out to, and follow-up with, any specialists the patient needs. When one doctor is closely overseeing every aspect of a patient's health care, nothing slips through the cracks. It's the way that health care was always supposed to be.

We've worked closely with doctors, patients, health care companies and the Department of Health Services to make sure that all Direct Primary Care agreements give patients a clear understanding of what the Direct Primary Care relationship is and, just as importantly, what it isn't meant to be. We want them to know that they'll still want to carry a more affordable catastrophic insurance plan to cover their secondary medical costs should they develop the need, and we want them to know about the many consumer protections we've required the agreements to provide.

2017 Assembly Bill 798 will give our constituents greater access to health care and more options. Wisconsin businesses and citizens struggle daily to pay the high cost of health care thrust upon them as a result of the one-size-fits-all approach dictated by the federal Affordable Care Act. Gaining insurance through federal mandates does not improve the lives of our citizens who are unable to utilize the coverage because they cannot afford the copays and deductibles. Direct Primary Care offers unlimited access at fixed, transparent, and affordable rates.

I would like to thank Senator Patrick Colbeck from Michigan for submitting testimony to the committee today and sharing his deep knowledge on this important issue. Senator Colbeck has been a leader on Direct Primary Care for a long time, and I would encourage all committee members to please read his testimony.

Again, thank you for holding a public hearing on 2017 Assembly Bill 798. Please contact my office with any questions.



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THE SENATE
STATE OF MICHIGAN

Testimony Before Wisconsin Committee on Small Business Development, January 24, 2018

I am honored to submit this written testimony in support of Assembly Bill 798 and I would like to thank the sponsors of this legislation and members of the Small Business Development Committee for this opportunity. The proposed statutory changes within Assembly Bill 798 offer a significant opportunity for the Wisconsin legislature to improve the access to quality health care for all of Wisconsin's citizens all while easing the burden of escalating Medicaid costs upon Wisconsin taxpayers. This opportunity is made possible via a unique health care service model referred to as Direct Primary Care Services.

Under Section 10104 of the 2010 Law HR 3590 also known as the Affordable Care Act, Direct Primary Care Medical Home Plans are authorized components of a comprehensive, Qualified Health Plan under Section 1301 of the same act. In subsequent rules defined by the Federal Department of Health and Human Services, Direct Primary Care Medical Home Plans are "arrangements where a fee is paid by an individual, or on behalf of an individual, directly to a medical home for primary care services, consistent with the program established in Washington". In 2007, the State of Washington became the first state to define and regulate direct primary care practices.

So, what is Direct Primary Care? The key word is "Direct". Enrollees in Direct Primary Care Service agreements engage in a direct relationship with the doctor. There is no third party interference in that relationship be it from the government or private insurer. In a Direct Primary Care Service agreement, enrollees agree to pay a fixed monthly or annual membership fee in exchange for a specified list of routine health care services specific to the primary care practices. Fees often range between $50 and $125 per month. The services provided in exchange for these fees often include unlimited access to a primary care physician along with wholesale prescription drug prices, several free procedures, and "at cost" labs. Under the Affordable Care Act, enrollees would still need to supplement their DPC agreement with insurance for so-called "catastrophic services" such as hospitalization or treatment for chronic illnesses.

It might help to think of the difference between primary care services and catastrophic services via the lens of auto insurance. Drivers do not pull out their insurance card every time they fill up with gas, change the oil or purchase new wiper blades. The costs for these items are considered

part of routine maintenance. Drivers do pull out their insurance card, though, when they experience significantly more expensive events such as a collision or theft.

Health care experts across the country agree that the key to lowering the total cost of health care is preventive care. Much like changing the oil on a frequent basis prevents catastrophic engine failure, preventive primary care services keep patients from needing catastrophic services. Catastrophic services can be significantly more expensive than primary care services. The Direct Primary Care Service delivery model opens the door to better preventive care than traditional, insurance-based models.

How does Direct Primary Care improve preventive care? There are numerous ways but I would like to focus upon the central reason. Doctors spend less time examining their electronic tablets and more time examining their patients. It is common practice for physicians to spend almost 50% of their day on administrative activities such as CPT-coding so that they can receive reimbursements from insurance companies. In the latest guide for CPT-coding known as ICD-10, there are over 70,000 unique billing codes. As an aerospace engineer, two of my favorite ICD codes are "V97.33XD: Sucked into jet engine, subsequent encounter" and "W22.02XD: V95.43XS: Spacecraft collision injuring occupant, sequela."

Direct Primary Care physicians don't have to decipher CPT-codes. They can focus upon decoding the malady of their patient. Whereas traditional primary care practices need a patient cohort of over 2,500 patients to be profitable, direct primary care practices need as few as 400 to keep the lights on.

What are potential savings? Direct Primary Care has been demonstrated to save 20% or more on the overall cost of delivering health care. In this light, I often refer to Direct Primary Care as "governments Swiss Army knife". In Michigan, our latest Medicaid budget for 2.4 Million enrollees in the wake of Medicaid Expansion is $18B. A 20% savings on the delivery of translates to a potential annual savings of $3.6B. In Wisconsin, the 2016 Medicaid spending for roughly 1 Million enrollees is $7.74B. A 20% savings on the delivery of Medicaid in WI translates to a potential annual savings of $1.5B.

The savings potential does not stop at the Medicaid budget. Taxpayer funding also goes to pay for the healthcare of state and municipal employees including, in many states, retirees.

The savings potential also does not stop with government budgets. As the footprint of Direct Primary Care Service practices expands in WI, the private sector also benefits from access to higher quality and lower cost health care options. Lower cost health care not only relieves the burden on taxpayers, it also relieves pressures upon the financial bottom lines for businesses in Wisconsin.

It is important to point out that these savings are not obtained by rationing of care. Quite the contrary, enrollees actually receive BETTER care via enhanced attention to prevention and more time spent diagnosing patient maladies. DPC patients have been shown to spend up to 60% less time in hospitals and 14% less time with specialists. That's where the 20% savings comes from...not from denial of care.

Assembly Bill 798 provides the citizens of Wisconsin with a rare opportunity to improve the quality of services while saving taxpayers money. It is my sincere hope that you will pass this legislation and join a growing number of states across the nation seeking to fix our nation's health care system by the adoption and promotion of the Direct Primary Care Service model.

Thank you for this opportunity to address this body.

Sincerely,

Patrick Colbeck
Michigan State Senator
7th District

Sponsor of Michigan PA 522 of 2013 regarding Direct Primary Care Services

Sponsor of Michigan Direct Primary Care Medicaid Pilot

SOLSTICE HEALTH

Testimony

January 24, 2018

Direct Primary Care

Testimony before the Assembly Committee on Small Business Development in support of AB 798

by Timothy J. Murray, M.D., Founder & CEO of Solstice Health

Chairman and Members of the Committee,

I'd like to first thank each of you and your staff, for the invitation to testify at this very important hearing regarding Direct Primary Care (DPC) and AB 798. Additionally, I'd like to thank Rep. Sanfelippo and his staff for taking the time and effort last year to learn more about DPC and how it has and will continue to shape the landscape of healthcare delivery. I count it an honor to appear before this Committee to discuss a proven model and how it can be implemented to allow access to the best Primary Care for Wisconsinites of all income levels and beyond.

My name is Timothy J. Murray. I am the Founder & CEO of Solstice Health, a thriving DPC clinic, leveraging an integrative medical approach, with multiple locations in the SE Wisconsin market. Over the past 7 years, we have found that education about DPC and our healthcare system is likely the most crucial aspect of our mission. I trust most of us in the room have some knowledge of DPC, but I'd like to offer a brief description, starting with what DPC is not. DPC is not insurance. This is important to understand not only as we discuss AB 798, but also at the Federal level. Also, it is not concierge medicine, with overpriced access fees and a fee for service model which still leverages insurance. DPC is a paradigm shift in healthcare delivery. It is an age-based, monthly membership style, direct primary care model. With unlimited visits, no copays, and no deductibles, patients are guaranteed to get the time and attention they deserve. By eliminating insurance and associated bureaucracy, providers are available when patients need care, which allows for same day or next day appointments, as well as phone, email, or virtual visits 24/7. Within this model, members have unlimited access to wholesale labs, pharmaceuticals, and imaging, creating 80-90% savings. In addition to those savings, we have same-day access to over 100 specialists through eConsults, which decreases downstream utilization by 40%, increases quality of care, and provides a more comprehensive treatment plan in one location. The reality of that brief description, is evidence that DPC is a powerful catalyst toward comprehensive knowledge of the healthcare system, which evades the population at large, due to a lack of transparency, and is critical for our leaders to understand as they put forth new legislation at the State and Federal level.

By way of example, I would like to briefly share two patient experiences and the savings incurred by utilizing our DPC practice. The first patient is a 34 yo uninsured male with a significant history of asthma who presented to our clinic to establish care, with the expectations of

better quality care and reduction in his overall expenses which were around $400/month for medication alone. CDC research estimates that asthma patients average about 5 outpatient visits per year at a cost of about $235 per visit. For visits and medications, his annual expense is around $6,000 for his asthma diagnosis alone. After spending time with him and reviewing his medications, we were able to obtain his monthly prescriptions as well as our monthly DPC membership service for $300/month. That translates into a savings of $2,400 per year, which would pay for almost 3.5 years of unlimited care with us. We were also able to add additional therapies through our integrative approach reducing his medication needs thus extending his savings. The second patient is a 43 yo insured (high deductible) male who is a newer member of our program who developed a skin condition that would traditionally be referred out to a dermatology specialist. After leveraging our eConsult platform, we were able to effectively provide a treatment plan and avoid a dermatology referral. Considering consult, diagnosis, and punch biopsy, we were able to save this patient over $1000, which translates into 1.5 years of care at our clinic. As you can imagine, these are just 2 examples of our routinely very happy patients!

Over the past 10-15 years healthcare as an industry, has become increasingly difficult for providers to navigate successfully thus affecting the quality of care provided. With the autocratic offensive for physician employment along with the unilateral passage of the Affordable Care Act (ACA), the independent doctor-patient relationship and aligned incentives have been severely compromised. Average face time with a physician is only 7 minutes after waiting upwards of 20 days for an appointment. Compared to the burden of 2,000 to 3,000 patients and resultant physician burn out, DPC salvages that relationship with only around 600 patients allowing for more time spent with each patient and therefore a higher level of care. With that, and the savings noted above, you can now imagine those happy patients being cared for by providers with a renewed passion and dignity for what they do best.

In Sections 10104 and 1301, the ACA does in fact recognize the benefits of DPC, however, there are some handicaps at the State and Federal level including how DPC is implemented within the structure of the ACA and associated healthcare exchanges. Arbitrary statutes within the IRS Code related to Health Savings Accounts and assuring payments from Medicare beneficiaries are for "non-covered services", unless a provider opts out completely, are additional hurdles at the Federal level which are being addressed. Medicaid laws, on the other hand, do not prohibit states from paying providers a capitated rate for beneficiaries, which brings us to AB 798. As laid out before this Committee, DPC is positioned to deliver and unmatched and easily accessible healthcare experience for Medicaid patients in Wisconsin. Evidence has shown that DPC patients face lower hospital admissions rates and fewer ER and specialist visits which would translate into tremendous savings for the State Budget. A similar pilot in Michigan has projected savings of $3.4B per year if fully deployed. Another major issue addressed by AB 798 as I mentioned above, is to establish that DPC practices are not "risk bearing entities" and therefore exempt from insurance regulations. This will benefit the State with physician recruitment and retainment and promote further DPC growth.

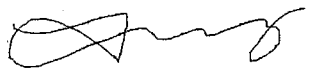
Solstice Health was the first successful insurance-free DPC clinic in the State of Wisconsin and as we continue to grow, we remain one of few full-time operations. We are committed to a transparent shift in

healthcare delivery, and with your help, DPC can become accessible to many more Wisconsinites across the income spectrum as quality care should be blinded to these measures.

DPC has been and continues to be a grassroots movement and has successfully sought to reestablish the doctor-patient relationship and eliminate bureaucracy from the exam room. With AB 798, Wisconsin would join 23 other states with active DPC legislation. I would be remiss in this setting to not communicate our desire to maintain the integrity of what we have accomplished and avoid jeopardizing the innovatively lean structure of DPC, with gratuitous regulations at any level.

In closing, I urge the Committee to carefully consider AB 798 and the positive impact it would have for the State of Wisconsin. I would also like to again thank each one of you for allowing my testimony before the Committee. Please feel free to reach out to me any time if I can be of any assistance and I look forward to working with you in the future. I would be happy to answer any questions. FORWARD!

Respectfully,



Timothy J. Murray, M.D.

epiphany
HEALTH

January 24, 2018

Re: Testimony for AB 798 – Direct Primary Care

Rep. Gary Tauchen
Chairman; Wisconsin Assembly Committee on Small Business Development

Chairman Tauchen and distinguished Committee members:

Thank you for designating important committee time to consider testimony on the subject of Direct Primary Care. I am a practicing primary care physician in Southwest Florida, and co-founder of Epiphany Health Direct Primary Care, a pioneer Direct Primary Care (DPC) practice started in 2010. The primary care landscape has drastically changed over recent decades. Tired of the endless hassles, headaches and expenses that are increasingly being levied upon them by third-party payers, including government payers, primary care physicians (PCPs) are suffering burnout and being driven out of practice. Most are forced to consolidate into large networks or hospitals, while others are trying to save their practices by switching to a more personalized approach through a direct financial arrangement with their patients. The latter healthcare delivery model has since come to be known as Direct Primary Care (DPC).

DPC practices charge patients a low flat monthly fee, under terms of a contract, in exchange for access to a broad range of primary care services. (Epiphany Health's monthly fee is $60 for an individual, $120 for a patient and partner, $25 for the first child and $10 for each additional child) The DPC practice framework serves to replace the traditional system of third party insurance coverage for primary care services. The DPC contract between a patient and his/her physician provides for regular, recurring monthly revenue to practices, which replaces traditional fee-for-service billing to third party insurance plan providers. DPC practices differ from "concierge" practices that charge a fee in addition to typical fee-for-service. For family physicians, the DPC revenue model can stabilize practice finances, allowing the physician and office staff to focus on the needs of the patient and improving their health outcomes, rather than coding and billing. In the DPC model, 100% of the patients' healthcare dollars go directly towards their care, boosting the revenue for the traditionally undervalued PCP.

Patients, in turn, benefit from having a DPC practice because the low monthly fee covers the cost of all primary care services furnished in the DPC practice at no additional out of pocket expense, including any in-office testing. Many DPC practices offer wholesale and price-transparent pharmacy, labs, imaging and more. This effectively removes additional financial barriers the patient may encounter in accessing routine care, including preventive, wellness, and chronic disease management. This would adequately meet the needs of nearly 90% of the non-Medicare population that can be effectively treated at the primary care level. DPC combined with a high deductible health plan for coverage of healthcare services that cannot be provided in the primary care setting, such as specialty care and hospitalizations, provides unobstructed access to routine care with an affordable safety net backup.

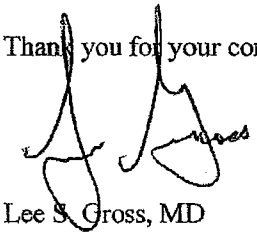
The DPC model is ideally structured to emphasize and prioritize the intrinsic power of the relationship between a patient and his/her doctor to improve health outcomes and lower overall health care costs. The DPC structure can enable physicians to spend more time with their patients, both in face-to-face visits, and through telephonic or electronic communications mediums should they choose, since they are not

bound by office-based insurance reimbursement restrictions. By freeing PCPs from the third party system, it allows them to compete for patients on price and quality, allowing free market forces to create a built-in pay for performance system. If a primary care physician could earn specialty-like wages while practicing without the headaches of the third-party payer system, primary care residency slots would be among the most competitive in the nation.

In Florida, a local county health department had to close its primary care program due to lack of funds. In their letter to their patients, they listed 2 resources for care. 1.) The Federally Qualified Health Center, 2.) Epiphany Health. Phones rang off the hook. By providing truly affordable care with complete price transparency, we are allowing patients to get off of public assistance and pay a reasonable fee for their new affordable patient-centered medical home. We now work closely with local charitable organizations to provide affordable care, when patients fall through the cracks. We are becoming the safety net's safety net.

Finally, to exemplify the cost savings potential of the DPC model: The Affordable Care Act was projected to cost $1.9 trillion over 10 years. It was estimated that 32 million would gain coverage (many through Medicaid expansion), while 26 million would remain uncovered. Note that "coverage" is not the same thing as "care". Many primary care doctors don't accept Medicaid, so their "coverage" gives them a card with no guarantee of "care". We could enroll every uninsured patient in the country into Epiphany Health DPC for a cost of $417 billion over 10 years. This would provide essential care for 100% of the nation's uninsured for $1.48 trillion less than the ACA over 10 years. That savings could fund a tremendous safety net for the truly needy. By supporting Direct Primary Care, Wisconsin has the opportunity to lead the nation out of its healthcare crisis.

Thank you for your consideration,



Lee S. Gross, MD

President, Docs 4 Patient Care Foundation
Founder, Epiphany Health Direct Primary Care
Past-President, Charlotte County Medical Society
Delegate, Florida Medical Association
FMA Council on Medical Economics and Practice Innovation

ATLAS MD

January 24, 2018

Hearing AB 798, the Direct Primary Care Bill:

Direct primary care is a national movement designed improve the access to medical services, decrease the cost of medical care, and work with insurance companies and the government to decrease the cost of public and private health insurance.

We started our direct care practice in September 2010 with the idea that we could make primary care much more affordable if we made it more efficient. We have since helped over 400 physicians convert to the DPC model.

Our model is $10 for kids and $50 per month for most adults for unlimited home visits, office visits, telemedicine visits, NO co-pays, ALL office procedures are included free of charge. We are also able to provide access to our wholesale medications, labs, imaging, consults for up to 95% savings.

Many medications are a penny a pill and we have even decrease the cost of some breast cancer treatments by 99%, down to six dollars per month.

We are then able to take this value and work with small businesses AND their health insurance companies to decrease the cost of health insurance premiums by 30 to 60% the first year. Initially some are concerned that this may negatively affect the insurance companies, but our experience has shown that their profit margins are actually higher when collaborating with the direct care model – in large part to improved efficiencies and market competition.

This means healthier small businesses, happier employees, and more sustainable health insurance. Furthermore, I feel that the direct primary care option even benefits the Medicaid population because it can decrease the cost of healthcare to the state, effectively increasing the budget by increasing the purchasing power... Allowing the state to care for more patients in a budget friendly or budget neutral way.

I agree with Dr. Phil Eskew's assessment of the Medicaid portion of the direct primary care bill: http://www.dpcfrontier.com/wisconsin

Section 1(3)(a) comes close to the old HMO gatekeeper provision and I am not convinced that the language in Section 1(3)(b) will be easily enforced.

Section 2(2)(h) is missing important language. As written this section prohibits employers, Medicaid (the pilot proposed in Section 1) or theoretically the patient's Grandma from paying the monthly DPC fee. I would propose the following language addition. "The health care provider and the patient are prohibited from billing an insurer or any other third party on a fee for service basis for the routine health care services provided under the Agreement.

Section 2(3) is not the ideal scenario. Ideally this entire section should not be needed. DPC physicians should be policed by the medical board, not the department of insurance.

Thank you for your time and consideration,

Josh Umbehr, MD

[10500 E. Berkeley Square Parkway | Suite 200 | Wichita, KS 67206 PH 316-260-6454 FAX 316-260-8479 | atlas.md]

Hello, my name is Suzanne Gehl. I am Board Certified in Family Medicine and a Direct Primary Care physician in Delafield. I am also Past-President of the Wisconsin Academy of Family Physicians. Today I am speaking on behalf of Assembly Bill 798.

For many years, I was working in the traditional medical system—the "fee for service" model. I would see 20-30+ patients a day, was frequently running behind schedule, and was getting more and more frustrated with our health care system. Six years ago, I learned about Direct Primary Care, and had the opportunity to work for a company providing this model of care to corporations—employees and their families. Recently, I opened an Independent DPC clinic. Let me share with you how Direct Primary Care works.

Rather than having 2-3000 patients, I take care of 500-600 maximum. This allows me to spend valuable time with patients. Not only know them well, but empower them to optimize their health. Appointments are a minimum of 30 minutes, and patients may call, text, e-mail or have a webcam/video visit.They may reach me 24/7. If they are ill or injured, they are seen the same day. Home visits? Sure! I'm their Family Doctor. For a monthly membership fee, patients not only have unparalleled access to their personal physician, they have the privilege of NO COPAYS, minimal or no waiting time in the clinic, some in-office lab tests for FREE, with other labs discounted 90-95%, some low cost generic meds dispensed from the clinic, and THE GIFT OF TIME. Time to address ALL of the patients' concerns and questions. MORE time to focus on health goals and help prevent disease or complications from illnesses, MORE time to diagnose problems early, when treatment is easier and less expensive. LESS time away from work or home due to sitting in a waiting room.

Costs are reduced with less emergency room and urgent care clinic visits, and improved long-term health. It was incredible to witness the many people employed by companies who had not seen a doctor in 10-20 or more years. Once the barriers of cost and access were removed, many health issues were identified-high blood pressure, diabetes, thyroid problems, and even cancer. Once they were able to get easily accessible medical care, their health issues were addressed quickly and their health improved within a few months.

One young, healthy woman I met in the community was telling me about a visit to an urgent care center for a sore throat. She did't have a doctor, but she had insurance with a deductible. After the visit, and a rapid strep test, she was diagnosed with strep throat. Her bill was $240, in addition to the co-pay, and she hadn't even picked up her prescription yet! She had to pay this, on top of her insurance premiums, because she had't met her deductible for the year yet. Had she been a member of a DPC, she wouldn't have had a copay, the rapid strep test would have been free, and she would have walked out of the clinic with medication for less than $1.74. She could have had 5 months of comprehensive medical care in a DPC for the price of this one sore throat visit.

Assisting patients with weight loss, increasing exercise, getting diabetes and high blood pressure under control has been rewarding and effective. With time and the RELATIONSHIP with a physician, everyone benefits—patients, families, employers, communities and physicians! Doctors are being reinvigorated with this model. DPC provides High-value healthcare with high access and low cost.

Currently, there are about 1,000 DPC doctors across the country—it's growing. 23 other states have passed legislation similar to this Bill. It correctly DEFINES DPC as a health care SERVICE, not an insurance. The Office of the Commissioner of Insurance should not be regulating us. We're not insurance! We HAVE a Medical Board that provides oversight and regulation of physicians. DPC is a SERVICE. Correctly defining DPC helps encourage further development of DPC's in Wisconsin. And this will subsequently provide opportunities for a Medicaid pilot. This Bill is a Win-Win for Wisconsin.

Steven "Steve" Edward Bondow MD

Steven Bondow MD:

Jan 24 2018
(edited)

1/23/2018

Direct Primary Care (DPC) Support Statement for AB 798

DPC is all about restoring the doctor-patient relationship. It is not only a pursuit of a return to a better interpersonal experience between patient and physician, but it is an effort to make that improved relationship and service affordable for all.

The model of using insurance to manage primary care is severely flawed. You do not insure your car for oil changes, fixing brakes or replacing parts and tires. These are low risk areas in owning a car. We should not be insuring primary care as it is a low risk area of medical care! Insurance adds too many layers of cost to the provision of primary care. The burdens of insurance at the primary care level include increased physician time to document care, the costs of staffing for coding and billing the care, and other major administrative costs that have severely escalated in the past 5 decades. The effect on costs in the medical industry is similar to a snowball rolling downhill gathering size rapidly.

The DPC model requires a low monthly fee to fund the relationship. Our fees are $20 ages 0-19, $50 for ages 20-44, $75 for ages 45-65 and $100 for age over 65. In return for this fee, individuals, companies or the government are able to purchase direct 24/7 access to a physician. This access includes cell phone, texts, email and skyping as examples.

The first benefit of this close connection is that patients receive the best answer possible to their medical questions. The physician is able to best analyze information in the most complete fashion to direct further care for the patient. This avoids delays in evaluation and treatment when patients have to work through multiple levels of triage or protocols to schedule care. This connection also decreases the use of emergency room and urgent care facilites. Patients quickly learn how easy it can be to get a phone call with your doctor!

This model avoids fee-for-service medical care and the multiple disincentives for triage and care by phone. In the for fee-for-service world, the physician needs to see the patient to get paid. The patient frequently delays requesting care to avoid co-pays.

The DPC model also functions by providing generic medications at wholesale cost, accepting only a handling fee but no intended profit. We also provide inexpensive routine labs that are used both in acute care and for monitoring chronic health conditions such as hypertension, diabetes and high cholesterol. Lab studies such as a complete chemistry panel, blood cell counts, cholesterol panel and a thyroid check will cost several $300 or more in our current health systems. My cost to the patient for these is $18.46.

The medical industry needs a major overall. The implementation of the DPC model is revolutionary, designed to make a major impact in a short time. This could be demonstrated in the Medicaid and Medicare world by comparing similar populations functioning under traditional and DPC models of care in a pilot project. We support the passage of this bill to further our efforts in all these regards

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Testimony before the Wisconsin Assembly Committee on Small Business Development
Wednesday, January 24, 2018
Charlie Katebi, State Government Relations Manager, The Heartland Institute

Chairman Gary Tauchen and Members of the Committee:

Thank you for offering me the opportunity to testify today. My name is Charlie Katebi, and I am a state government relations manager for The Heartland Institute, a 33-year old independent national nonprofit organization. Heartland's mission is to develop and promote public policy solutions that expand opportunity and empower people. The Heartland Institute is headquartered in Illinois and focuses on providing national, state, and local elected officials with reliable and timely analyses on important policy issues.

The reforms outlined in Assembly Bill 798 to expand direct primary care offer enormous promise for Wisconsinites, especially those on Medicaid who have faced increasing challenges when trying to obtain medical care. Over the past 18 years, Medicaid's share of Wisconsin's budgets has risen from 11 percent to nearly 20 percent. These costs burden the taxpayers who pay them, but they also hurt the vulnerable patients who rely on this program.

Medicaid currently reimburses Wisconsin physicians just 49 cents for every dollar they receive from private insurance. And if Medicaid's costs continue to rise, Wisconsin will be forced to further slash payments to physicians, which will make it all but impossible to serve patients in need.

To ensure Medicaid continues to provide these critical services, Wisconsin must introduce reforms that both lower costs and make it easier for physicians to care for their patients.

One of the most promising reforms is direct primary care. Under this model, physicians opt out of billing for each individual treatment and instead charge a flat monthly payment for routine services. According to physician advocates, private practices could save as much as 40 percent on their operating costs by shifting to direct pay. This is because they no longer have to spend precious time and money billing insurers and can instead spend more time treating patients, allowing doctors to more effectively treat patients and ensure they remain in good health.

A study in the *American Journal of Managed Care* found that individuals who receive direct primary care are 52 percent less likely to enter a hospital than patients with a traditional private practice. The authors concluded that "increased physician interaction is the reason for the lower hospital utilization and ultimately lower healthcare costs."

Wisconsin would likewise generate dramatic taxpayer savings by allowing direct primary care physicians to treat Medicaid patients. In 2015, a county in North Carolina decided to partner with a direct primary care network called Paladina Health to care for county employees. After just one year, workers that enrolled in direct care spent 23 percent less than those who stayed with conventional physicians. This translated to an annual savings of greater than $3,000 for each and

every patient.

In conclusion, direct primary care would provide enormous benefits to Wisconsin, and especially those on Medicaid. It simplifies the doctor-patient relationship, enhances health care access, and accomplishes all of this at a price taxpayers can afford.

Thank you for the opportunity to testify on this important issue.

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For more information about The Heartland Institute's work, please visit our websites at www.heartland.org and http:/news.heartland.org, or call Charlie Katebi at 312/377-4000 or reach him by email at ckatebi@heartland.org.

CHRIS KAPENGA
WISCONSIN STATE SENATOR

SB 670/AB 798 Testimony
Committee on Small Business Development
Wednesday January 24, 2018

Thank you Chairman Tauchen and committee members for hearing testimony on AB 798 today, regarding direct primary care. This bill has two main components. The first part defines direct primary care in statute, while the second directs the Department of Health Services (DHS) to research a direct primary care pilot program in Medicaid and report an implementation plan to the legislature.

Direct primary care (DPC), often compared to a gym membership, is a model of care whereby a patient pays a monthly fee for a set menu of services. Direct primary care offers patients greater access to their doctors, as well as much more time with their physicians at each visit. Additionally, price transparency means patients see a significant savings with the DPC model. Some DPC providers are successfully delivering care resulting in savings of 15 to 30 percent. Additionally, health outcomes improved, with data showing 35% fewer hospitalizations, 65% fewer emergency department visits, and 66% fewer specialist visits.

Several direct primary care providers are currently operating in Wisconsin, however they are practicing with legal uncertainty. In Wisconsin, without a statutory definition, doctors are at risk of being treated as insurance companies despite the fact that they are actually providing a service, not coverage. Twenty-three other states nationwide have already adapted to this new market, and have practices that are operating without issue. Defining DPC would specify that direct primary care is not insurance and remove the ambiguity that currently exists. The Office of the Commissioner of Insurance has also recognized that DPC, as defined in this bill, does not qualify as insurance.

AB 798 also directs the Department of Health Services to establish a work group of stakeholders for the purpose of researching a pilot program for Medical Assistance recipients to study efficiencies, health outcomes and cost savings and then report back to the legislature with an implementation plan. In the last decade, Medicaid spending has continued to balloon, accounting for almost 20% of our entire state budget. With this reform, DHS will be tasked with engaging stakeholders to evaluate how to best utilize the principles of direct primary care to achieve even more savings in Medicaid while still improving health outcomes.

Thank you, Mr. Chairman and Committee members, for your time and consideration of this bill.

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WISCONSIN ACADEMY of FAMILY PHYSICIANS

TO: Wisconsin State Legislators
FROM: The Wisconsin Academy of Family Physicians
DATE: January 24, 2018
RE: Senate Bill 670/Assembly Bill 798 – Direct Primary Care

The Wisconsin Academy of Family Physicians (WAFP) is a statewide association of Family Medicine Physicians. With nearly 3,000 members, WAFP members provide continuing and comprehensive primary care health care for individuals and families. Our mission is to promote excellence in health care, increase access, and improve the health of the citizens of Wisconsin.

One aspect of increasing access to care is finding innovative strategies to reduce health care costs. As such, WAFP asks you to support Senate Bill 670 and Assembly Bill 798, authored by Senator Chris Kapenga and Representative Joe Sanfelippo. The legislation allows physicians to engage in direct primary care agreements with patients. Direct primary care is a model for delivering and purchasing primary care services that gives physicians and their patients an alternative to the third party, fee-for-service system.

For a flat fee, patients have access to their doctor for a range of comprehensive primary care services over a specified period of time. Primary care services include regular checkups, preventive care, chronic disease management, care coordination, and urgent care.

In a direct primary care practice, patients have a personal relationship with their primary care physician, which diminishes the dependence on more expensive parts of the health care system, such as specialist care, urgent care, emergency rooms, and advanced imaging. Additionally, initial research suggests direct primary care may decrease unnecessary hospital admission rates.

Please support this innovative initiative that reduces costs for patients and increases access to services.

Furthermore, if you have any questions on how this will benefit family medical practices and the patients they serve, please contact WAFP's government affairs team Tim Hoven or Erik Kanter at (608) 310-8833.

NeuCare

WRITTEN TESTIMONY FOR WISCONSIN AB 798

01/24/2017

Dear Legislators,

I am a family physician in Lawrence, KS. I have operated a Direct Primary Care practice since 2011. My motivations for pursuing a better way to practice model started early in my career.

As I advanced through medical school and into my family medicine residency, I was increasingly exposed to the "inner workings" of health care. Behind the scenes I saw much of the doctors' time spent on issues other than patients' health. Seemingly, the documentation about what they did took more time that what they actually did. My mentors frequently vented behind a mountain of charts about the decline of their profession.

Hospital and clinic staffs consisted of small armies of people to do coding, billing, following up on denied claims, prior-authorizations and on and on. To financially support this administrative structure, the doctor would take on more patients. The average primary care physician is now responsible for 1500-3000 people! I was frequently told "efficient" doctors could handle double and triple booked schedules – and it would be required to keep a private practice afloat. Unfortunately, this efficient pace allowed very little time to answer patient questions, educate about chronic diseases, calm somebody's fears or listen to a patient's bad joke.

Worst of all, patients were suffering under this system. They would frequently tell me about frustrations with their health care experience. While most people personally liked their physician, many felt disconnected and fed-up with the complexities of basic communication. After hearing the same stories again and again, I started to feel sympathetic towards these complaints. Despite our hard work and good intentions, medical practices often treated patients merely as vessels for billing codes. Doctors seemed to be unwittingly insulating themselves from the very people whom they committed to providing care. And this sympathy was directed towards the fortunate insured people with so-called 'access'.

From my perspective, the doctors and patients were both losing in this system. I increasingly asked my colleagues, "Why do we do it this way?", "Wouldn't it be more efficient if ...." and other annoying questions. Usually my inquiries were met with puzzling stares and flippant answers such as, "Because this is just the way it's done." Despite everyone agreeing that the system "sucked", all parties seemed miserably complacent

When I started my DPC practice in 2011, I knew there would be immense skepticism from my colleagues. Many days I was unsure of my own crazy ideas and their potential impacts.

Explaining the vision of my practice was not easy. The common response I got was, "Oh, so like a concierge doctor?". That perception and label really perturbed me. My goal was to care for a diverse

group of people. I spent the majority of my residency clinic hours in an urban safety net clinic, but certainly didn't want to swing the pendulum to the opposite 1%. So, I honed my pitch to focus on serving middle class people.

Our first patients were an interesting bunch: diabetic plumbers, homeschooling families, alcoholic bartenders, but very few with homes on the golf course. Most hadn't had primary care for years. Many had sworn off traditional medicine altogether. The vast majority were middle income or lower; typically uninsured or struggling with high deductibles (the so-called "under-insured").

What I learned from these patients is that-- even when "covered"-- the traditional medical system was failing them. They often lacked true relationship or access to a trusted medical provider. They often did not understand their chronic conditions, frequently visited ERs and fell through the cracks in numerous ways.

The level of service that my DPC practice could provide them was a revelation to most. Just as importantly, my patients had full transparency in their costs of care and for many, the first time they could really afford to stay on top of their health issues.

DPC practices are able to return value to patients in a number of ways. Being membership-supported — and not needing to make a profit on ancillary services — we can offer drastic discounts on labs, diagnostic testing, medications, procedures and more. Just last week, I was able to provide nine doses of sumatriptan to a new patient for $8.12. She had previously been paying more than $100 per month through her insurance for the same amount of the drug.I also recently managed a forearm fracture in an uninsured patient for a total cost of $45 ($10 for a splint, $25 for an X-ray, and $10 for cast a few days later).

Many of my patients, including those with insurance, save more money on these ancillary services (versus traditional prices) than they pay for their membership each month. And they get unlimited visits with their personal physician without copays.

As the Direct Primary Care (DPC) movement grew, I connected with like-minded physicians who were also fed up with a broken system. We shared the successes and struggles of our growing practices. Although we were each creating our own little universes, our experiences were strikingly similar. I was refreshed by their talents, energy, and dedication. Ultimately, I knew that these were the physicians that would fix healthcare in America.

Our grassroots movement hasn't grown due to financial investments or legislative actions. Our success has been the result of the physicians and their patients partnering to show us a better way. This must continue be the heart of the DPC movement. We now realize the transformative potential of the DPC model and are at the advent of moving beyond novelty. But, many hurdles exist for us to achieve that vision.

Current laws are geared around insurance and fee-for-service payment arrangements. This has posed a dilemma for patients and DPC practices trying to stay on the right side of the law. In over 20 states,

laws have been passed to clarify that the DPC model is NOT a health insurance product and provide basic protections to patients who opt for this type of care. I would urge the State of Wisconsin to do the same. It would greatly benefit innovative primary care physicians and the citizens of your state.

Sincerely,

W. Ryan Neuhofel, DO, MPH
Family Physician/Owner, NeuCare
Lawrence, KS

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James Price

Junior Medical Student, Medical College of Wisconsin Class of 2019

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Testimony for AB 798

My name is James Price; I am from Neenah, Wisconsin and I am a third year medical student at Medical College of Wisconsin in Milwaukee. At present, I am considered family medicine most strongly as my specialty, a specialty that goes hand-in-hand with direct primary care (DPC). I hope that my fellow students and I face an equal playing field if and when we consider establishing direct primary care practices.

My first year of medical school, I joined Benjamin Rush Institute, a national organization that emphasizes the physician-patient relationship and the power of free markets. Through conferences and events organized by Benjamin Rush, I have encountered direct primary care physicians from Mequon, WI, Kansas, Oklahoma, Texas, and Washington state. Each one of them emphasized that DPC represents an old-fashioned form of medicine that many people still desire. The doctor and the patient are able to form long-term, mutually-beneficial relationships. The patient is able to see the doctor as often as they desire (an average of 4 times per year, compared to 1.66 times per year in traditional primary care practices).[1,2] This places an emphasis on preventative medicine. In today's environment, many healthcare providers are forced to focus on patching up a patient and getting them out the door, whether it be in the hospital or the emergency room. In contrast, DPC physicians have the ability to get to know their patients deeply and aid them in pursuing true, long-term health. A traditional primary care physician will see an individual patient for an average of 33 minutes per year.[1] In contrast, a DPC physician will see an individual patient for an average of 140 minutes per year.[2] This leads to DPC patients visiting emergency departments, urgent care, and specialists less often than the average traditional patient, making them less burdensome on the entire healthcare system in both terms of time and cost.[3]

This brings me to my first point I want you to take away, which is the value of direct primary care. DPC costs are transparent, and labs and diagnostic studies are offered to patients at near-cost whenever possible. DPC offices will go out of their way to find an MRI that costs $500 or less, instead of $1500 or more. Another reason DPC offers such tremendous value is that it vastly reduces the involvement of third-parties such as insurance companies or HMOs, which increase costs and interfere in decision-making.

Second, direct primary care delivers satisfaction for both patients and physicians. Because of the increased quality of care and the increased time spent with physicians, patients are more satisfied. Likewise, physicians are more satisfied with and fulfilled by their careers.[3] I have spoken with many physicians who would not be practicing medicine anymore if DPC was not an option. They would not be part of a healthcare workforce that is already facing severe shortages. DPC has time and again revitalized the careers of burnt-out physicians.

Thus, direct primary care should be an accessible option for all patients and physicians. This includes patients with health savings accounts and patients on Medicaid. I promise that increasing accessibility to

direct primary care will improve the quality of healthcare in Wisconsin and aid Wisconsin in retaining primary care physicians. Thank you.

1. Hing E, Schappert SM. Generalist and specialty physicians: supply and access, 2009–2010. *NCHS Data Brief.* 2012;105:1–8. http://www.cdc.gov/nchs/products/databriefs/db105.htm.
2. Eskew P, Klink K. Direct primary care: practice distribution and cost across the nation. *J Am Board Fam Med.* 2015;28(6):793–801.
3. Wu WN, Bliss G, Bliss EB, Green LA. Practice profile. A direct primary care medical home: the Qliance experience. *Health Aff (Millwood).* 2010;29(5):959–962.

AHI

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Anthem Blue Cross and Blue Shield in Wisconsin
Children's Community Health Plan
Delta Dental of Wisconsin, Inc.
MHS Health Wisconsin.
Molina Healthcare of Wisconsin
UnitedHealthcare of Wisconsin
WPS Health Insurance

To: Chairperson Gary Tauchen
Members, Assembly Committee on Small Business Development
From: R.J. Pirlot, Executive Director
Subject: **AB 798, relating to direct primary care agreements**
For Information Only
Date: January 24, 2018

Assembly Bill 798 allows a health care provider and an individual patient or employer to enter an agreement whereby the health care provider agrees to provide routine health care services to the individual patient or employees for an agreed-upon fee and period of time. The bill as originally introduced also requires the Department of Health Services to study and propose a direct primary care program for Medical Assistance recipients.

The Alliance of Health Insurers thanks the bill's authors Sen. Kapenga and Rep. Sanfelippo for addressing many of our concerns. The authors are drafting a Substitute Amendment that would resolve our concerns about the potential for confusion for consumers in the commercial market. Though the Alliance of Health Insurers still has reservations about the Medical Assistance provisions, in light of the Substitute Amendment, the Alliance is neutral on the bill and welcomes the opportunity to participate in the work group the amendment would create.

Regarding our concerns about direct primary care agreements in the commercial marketplace, the Substitute Amendment satisfies many of our original concerns. For example, the original bill requires, in addition to stating such an agreement is not insurance, that the agreement:

- Be in writing.
- Allows either party to terminate the agreement.
- Describes and quantifies the specific services provided.
- Specifies the fee.
- Specifies the duration of the agreement.
- Alone may not satisfy individual or employer insurance coverage requirements under federal law.

In addition, the bill provides that the health care provider and the patient are prohibited from billing an insurer or any other third party for the routine health care services provided under the agreement and that the individual patient must pay the provider for all services that are not specified under the agreement and are not otherwise covered by insurance.

In addition to these provisions, the Substitute Amendment adds that:

- In order to protect the integrity of our existing provider networks, a health care provider who participates in a direct primary care agreement may participate in a health insurance carrier network only to the extent that the provider is willing and able to comply with the terms of the participation agreement and meet any other terms and conditions of network participation as determined by the health insurance carrier.
- In addition to specifying the fee for the agreement, such an agreement specify the terms for termination of the agreement, including any possible refund of fees to the patient.
- The agreement prominently state, in writing, that the patient is encouraged to consult with the patient's health insurance carrier before entering into the agreement; and that direct primary care fees might not be credited against patient deductibles or out-of-pocket maximum amounts under the patient's health benefit plan.

AHI supports these provisions because these valuable consumer protections help ensure such agreements, under the law, are treated distinctly from commercial insurance.

Regarding the provisions of the bill related to implementing a direct primary care program for Medical Assistance recipients, the Substitute Amendment would create a work group within the Department of Health Services to study integrating direct primary care into the Medical Assistance program. While AHI members would be interested in participating in this study of how to implement direct primary care in Medical Assistance, AHI is still skeptical of how the program will work in the current Medical Assistance managed care structure.

Managed care plays a key role within Medical Assistance and, thanks to care coordination, plays a key role in ensuring better outcomes for participants and savings for taxpayers compared to a fee-for-service payment model.

Specifically, AHI's concerns with implementing direct primary care in Medical Assistance is that a direct primary care agreement between a Medical Assistance participant and a provider would compromise the ability of both the providers and managed care plans to coordinate care for participants, particularly those with complex conditions. Our member managed care plans, for example, work hard so that care under Medical Assistance is well coordinated and appropriately managed. In fact, under the contacts our managed care plans have with the Department of Health Services, the agency requires our plans to meet outcome and performance benchmarks to fully earn the contracted payment amounts. It is not clear to us how direct primary care agreements would work within Medical Assistance, and our members are concerned care would become less well coordinated, backing away from state's commitment to managed care and, essentially, revert to fee-for-service.

As such, AHI's original preference was that section one of the bill be eliminated in its entirety. We are not aware of a state which includes a direct primary care agreement within its Medical Assistance program. However, AHI's managed care plans are willing to participate in the work group created under the Substitute Amendment and to keep discussing more fruitful areas of reform with the bills' authors and all other interested stakeholders in an effort to improve upon the state's Medical Assistance program.

Again, we thank Sen. Kapenga and Rep. Sanfelippo for their willingness to work with us to address many of our concerns. We look forward to continuing to work with them.

Wisconsin Medical Society

Your Doctor. Your Health.

TO: Assembly Committee on Small Business Development
Representative Gary Tauchen, Chair

FROM: Mark Grapentine, JD – Senior Vice President, Government Relations

DATE: January 24, 2018

RE: Testimony on Assembly Bill 798

On behalf of nearly 13,000 members statewide, the Wisconsin Medical Society thanks you for this opportunity to share our testimony on Assembly Bill 798, which concerns patients contracting for direct primary care. The Society's Council on Legislation met in mid-December on the proposal and reached the following conclusions:

Language Clarifying the Ability to Contract (Section 2 of the bill)
The Society supports the portion of the bill adding statutory language to make it clear that patients can enter into a contract to receive primary care services. Many physicians in Wisconsin already have such agreements with patients; statutory clarification of what constitutes a valid agreement is helpful.

The requirement to disclose that such contacts are *not* health insurance is also important. Easier access to routine health care services can be very cost-effective and beneficial to the patient, and allows a physician to provide high quality care while avoiding some of the administrative burdens that often come with insurance company-based coverage. That said, a contact for direct primary care is a supplement to, not a substitute for, insurance coverage for catastrophic care – making that clear to the patient is vital, and the Society supports that requirement.

Medicaid Pilot (Section 1 of the bill)
The Society is concerned with the proposal that would establish a Medicaid pilot that does not ensure patients will have access to physicians as part of their care. While adults are generally considered to have the capability to decide what kind of contracts are appropriate for their particular health care situation, children are not. Any children included as part of a Medicaid pilot for direct primary care should have access to physician-led care to ensure comprehensive assessment and potential treatment.

We appreciate Rep. Joe Sanfilippo's willingness to work with the state's Department of Health Services and advocacy groups like the Society in considering potential amendments to the Medicaid pilot requirement. The Society is happy to assist in developing legislative language that helps ensure children's access to physician care as part of a direct primary care program for Medicaid recipients.

Thank you again for this opportunity to provide our testimony on Assembly Bill 798. Please feel free to contact the Society on this and other health-related issues.

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