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September 4, 2019

State Rep. Joe Sanfelippo's Testimony on AB 26: Direct Primary Care

Chair Brandtjen and committee members, thank you for holding a hearing on Assembly Bill 26 and for inviting me to speak to you today regarding direct primary care. I am grateful that you have shown an interest in the potential that this healthcare delivery model holds for Wisconsin, and that's why I would like to talk to you about some of the issues that exist in our healthcare system and explain how direct primary care offers promise for addressing those challenges.

Americans across the country are struggling to afford healthcare for themselves and their loved ones. Many families are seeing their premiums grow and face difficult decisions: continuing to pay these rising prices or accepting the lower upfront costs of high-deductible health plans and trying to limit their out-of-pocket expenses by not using their healthcare. Alternatively, many individuals are forgoing health insurance altogether as a consequence of the individual mandate penalty being eliminated. Businesses are affected as well, straining under the heavy burden of having to offer extensive healthcare benefits to employees. Meanwhile, doctor burnout has contributed to a growing shortage of primary care physicians nationwide. This shortage has caused average wait times for initial visits to family physicians in major cities to skyrocket from 20.3 days in 2009 to 29.3 days in 2017; in mid-size cities, that wait is now over 54 days.

Faced with these realities, many states are recognizing that direct primary care can play an important role in healthcare policy. Direct primary care, also known as "DPC," is not health insurance. Instead, it's a contract agreement wherein a healthcare provider agrees to offer a set of routine health services for a specified fee over a stated period of time. This means is that, for a small, flat monthly fee, usually between $30 and $100 dollars, depending on a person's age, a patient can see their doctor as often as they need without additional fees per visit.

One of the most attractive aspects of the DPC model that caught my attention was how well it realigns healthcare incentives in favor of improving patient outcomes. The flat monthly fee encourages patients to get care when they need it and removes barriers to patients seeking out preventive care, as well as routine monitoring and treatment of chronic conditions. Too often, patients are deterred from receiving routine care due to per-visit costs. The Centers for Disease Control and Prevention specifically states that "cost-sharing such as deductibles, co-insurance, or copayments [...] reduce the likelihood that preventive services will be used," adding that "despite the benefits of many preventive health services, too many Americans go without needed preventive care, often because of financial barriers. Even families with insurance may be deterred by co-payments and deductibles." The DPC model encourages regular, proactive treatment and ongoing health management, thereby keeping patients healthier.

DPC also helps to address the primary care physician burnout problem, which is one of the chief reasons that many new doctors are foregoing careers in primary care and are, instead, choosing to enter into specialty fields, while older doctors are leaving the practice of medicine altogether. In typical insurance-

paid practices, physicians spend around 50% of their work time on procedure coding and other insurance requirements. They also need to absorb the costs of expensive administrative staffs to manage their complex billing and records systems. Consequently, doctors must see more patients to keep their practices profitable, which means less time spent with each patient.

The direct primary care model helps to relieve these counterproductive pressures on doctors and allows them to more meaningfully use their time to treat patients. With a steady and predictable income stream, doctors can reduce the size of their patient panels to 500-600 patients, as compared with up to 2,500 patients in many traditional practices. This lets doctors devote more time to each patient visit, giving them time to ask questions and take a deeper dive into a patient's health concerns. Indeed, whereas visits last only an average of 8 minutes in traditional practices, DPC office visits typically average 35 minutes in length. That's more time for doctors to get to know the patient and to formulate comprehensive diagnoses. It also provides them with time to offer personalized counseling to their patients, which is associated with positive lifestyle modifications that lead to better health.

By freeing doctors of the shackles of treating patients with billable insurance events in mind, doctors are not incentivized to order unnecessary tests or office visits; instead, DPC encourages doctors to be available to their patients 24/7, whether through same- or next-day appointments, phone calls, telemedicine, or even house visits. I've spoken with medical students and long-practicing physicians who have told me that the freedom DPC provides is making primary care attractive again. Encouraging the spread of the DPC model is a promising way to get new doctors into general practice and keep older physicians from retiring.

Shifting to a DPC model allows doctors to save as much as 40% on their administrative costs by eliminating compliance requirements of billing insurance and patients for each service rendered. And when a patient can have their health issue resolved with a phone call, instead of having to juggle work and family responsibilities around unnecessary pro-forma office visits, that's a tangible benefit to their quality of life.

The DPC model also has the advantage of empowering patients by putting them back in control of their healthcare decision-making. If a patient is unhappy with the level of service that their DPC physician is providing, they can cancel their DPC membership at any time and take their business to a competing practice. The virtue of the DPC model is that it has a built-in market check, in that doctors have to continually offer good service and value to their patients; otherwise, their patients will simply leave. DPC holds doctors directly accountable to their patients and not to the insurance company networks in which they participate.

Roughly 80% of a person's healthcare can be provided in a primary care setting. For that remaining care, DPC patients are still encouraged to carry an appropriate insurance plan to both comply with federal insurance mandates and to cover any additional expenses should they experience a serious illness or health emergency. However, due to the regular and in-depth preventive and ongoing care that DPC patients receive, they experience better healthcare outcomes, which translate into substantial cost-savings. Hospitalization costs for potentially-preventable conditions, which are those that statistically respond well to increased primary care, account for 10% of all hospital expenditures, or nearly $30 billion dollars annually. Meanwhile, DPC patients are 52% less likely to require hospitalization than those patients in a traditional insurance model. Moreover, with the individual mandate penalty for not having health insurance being eliminated, many people are foregoing coverage for financial reasons; DPC makes it possible for those

individuals to still have access to affordable preventive care and keeps that segment of the population healthier. If growing the use of direct primary care can even slightly reduce the 4.4 million potentially-preventable hospital stays that occur annually, it would make a transformative impact on our healthcare.

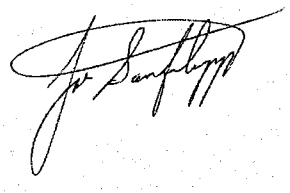
Direct primary care is not a new concept: DPC practices have existed throughout the US since the 2000s, and there has been a six-fold increase in DPC clinics since 2014. About 3% of doctors are practicing under this model nationally, and twenty-three other states have defined direct primary care in their laws. There are over 25 active DPC clinics already operating right here in Wisconsin, and all DPC providers are subject to the same board certification and licensing requirements as any other healthcare provider in the state. The Department of Safety and Professional Services has full disciplinary authority over DPC providers, as they would over any other healthcare provider, and the Departments of Trade and Consumer Protection, as well as Health Services, are also fully able and empowered to exercise their respective regulatory oversight over the conduct of DPC agreements. Additionally, while this bill clarifies that DPC is not insurance, the Office of the Commissioner of Insurance retains its authority to regulate any provider who goes beyond the definition of DPC in statute. This is all to say that DPC isn't a fly-by-night fad; it's a tested and growing model for delivering quality healthcare that's already in place here in Wisconsin.

The bill before you today is similar to what we introduced last session, but it also reflects the feedback that we received from various stakeholder groups, as well as this past summer's study committee. We have worked closely with stakeholders to further refine our bill to address their concerns, and we believe that the bill we have now adequately reflects those issues.

The reason our bill is necessary is that, while DPC currently exists in Wisconsin, the statutes are silent on the practice. By codifying DPC in law, we clarify precisely what qualifies as DPC and, more importantly, require a number of consumer protections in all DPC agreements. These include requirements regarding non-discrimination and covering pre-existing conditions. We also mandate a number of relevant disclosures that patients must receive to make it clear what services would and would not be covered, what costs they could expect, the duration of the agreement, their termination rights, and that the DPC agreement does not constitute health insurance. These specific requirements were ones that we arrived at after extensive consultation with DPC providers, health insurers, OCI, and other stakeholders. Many of these provisions are already common in DPC agreements, but codifying them ensures uniformity and offers consumers the transparency of knowing exactly what they're signing up for. We have worked hard to balance the need to protect and inform patients while taking care to not impose upon doctors the very sort of burdensome requirements and reporting that they were trying to leave behind in the traditional practice model.

One other substantial change we made to our bill was to remove a proposed DPC Medicaid pilot program. While we remain confident that DPC offers potential cost savings and better outcomes within Medicaid, and we hope to revisit it in the future, we felt that including the pilot overcomplicated our bill. Removing it focuses this bill on one thing: establishing a robust legal framework for DPC here in Wisconsin.

Thank you again for inviting me to share my testimony with you today and for taking the time to study this important issue.



CHRIS KAPENGA

WISCONSIN STATE SENATOR

Direct Primary Care Testimony
Assembly Committee on Small Business Development
Wednesday September 4th, 2019

Thank you Chairwoman Brandtjen and committee members for hearing testimony on Assembly Bill 26 today. AB 26 affirms in statute that direct primary care (DPC) is not insurance, provides security for patients and their providers, and adds consumer protections that do not currently exist. DPC is an increasingly popular option for consumers with 48 states having operational DPC practices, 27 states having DPC laws on the books, and 7 states currently considering DPC legislation.

Direct primary care is a model whereby a patient pays a monthly fee for a set menu of services. DPC offers patients unlimited access to primary care services and significantly more time with their doctors. Additionally, price transparency means patients see significant saving, with some providers reporting savings up to 30%. Also, studies have reported improved health outcomes, with data showing 35% fewer hospitalizations, 65% fewer emergency department visits, and 66% fewer specialist visits. For certain patients, DPC is a model that can provide significant benefits. However, it is not intended to be a replacement for insurance, nor a model that makes sense for all consumers. It is simply another option for consumers to consider in addition to a health plan.

While direct primary care providers are already operating in Wisconsin, they are practicing with legal uncertainty. In Wisconsin, without a statutory definition, doctors are at risk of being regulated as an insurer and effectively shut down. This change could happen at the whim of the insurance commissioner, causing patients to lose their doctors and doctors to lose their practices. Also, this change could occur despite the fact that they are actually providing a health service, not coverage for services. More than half of the country has already adapted to this new market, and practices are already operating without issue. For example, Washington State, which has had this law on the books for more than a decade, has never had an official or unofficial complaint filed against a DPC practice. This bill would give legal clarity to physicians practicing or considering opening a DPC practice and to patients who have no statutory consumer protections at the moment. The Office of the Commissioner of Insurance, under both Governor Walker and Governor Evers has recognized that DPC, as defined in this bill, does not qualify as insurance and it should not be regulated as such.

This session's draft includes some changes following comments from stakeholders, testimony from previous hearings, and the legislative council study committee. These changes include removing provisions regarding Medicaid, adding required disclosures that the product is not insurance, and specifying that the fee does not count towards your deductible. It also specifies agencies responsible for oversight, clarifies that no DPC practice can charge based on preexisting condition or health status, etc. Additionally, we have drafted a bipartisan amendment adopting language suggested by OCI at the senate hearing which clarifies that OCI still has the authority to regulate insurance products, including an invalid DPC practice that is acting as an insurer.

We have worked hard to address the concerns of everyone involved, which is reflected in the support of the Medical Society, the Family Physicians, and other medical professions, as well as the neutrality of a large portion of the insurance industry. Also, the only group in the state registered in opposition has members registered in support and neutral on this bill. This bill has urban and rural support, and has been bipartisan in most states. I ask for your support of this bill and support for the direct primary practitioners and patients in your districts.

Thank you, Madame Chair and Committee members, for your time and consideration of this bill.

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State of Wisconsin
2019 - 2020 LEGISLATURE

LRBa0343/1
TJD:skw

SENATE AMENDMENT 1,

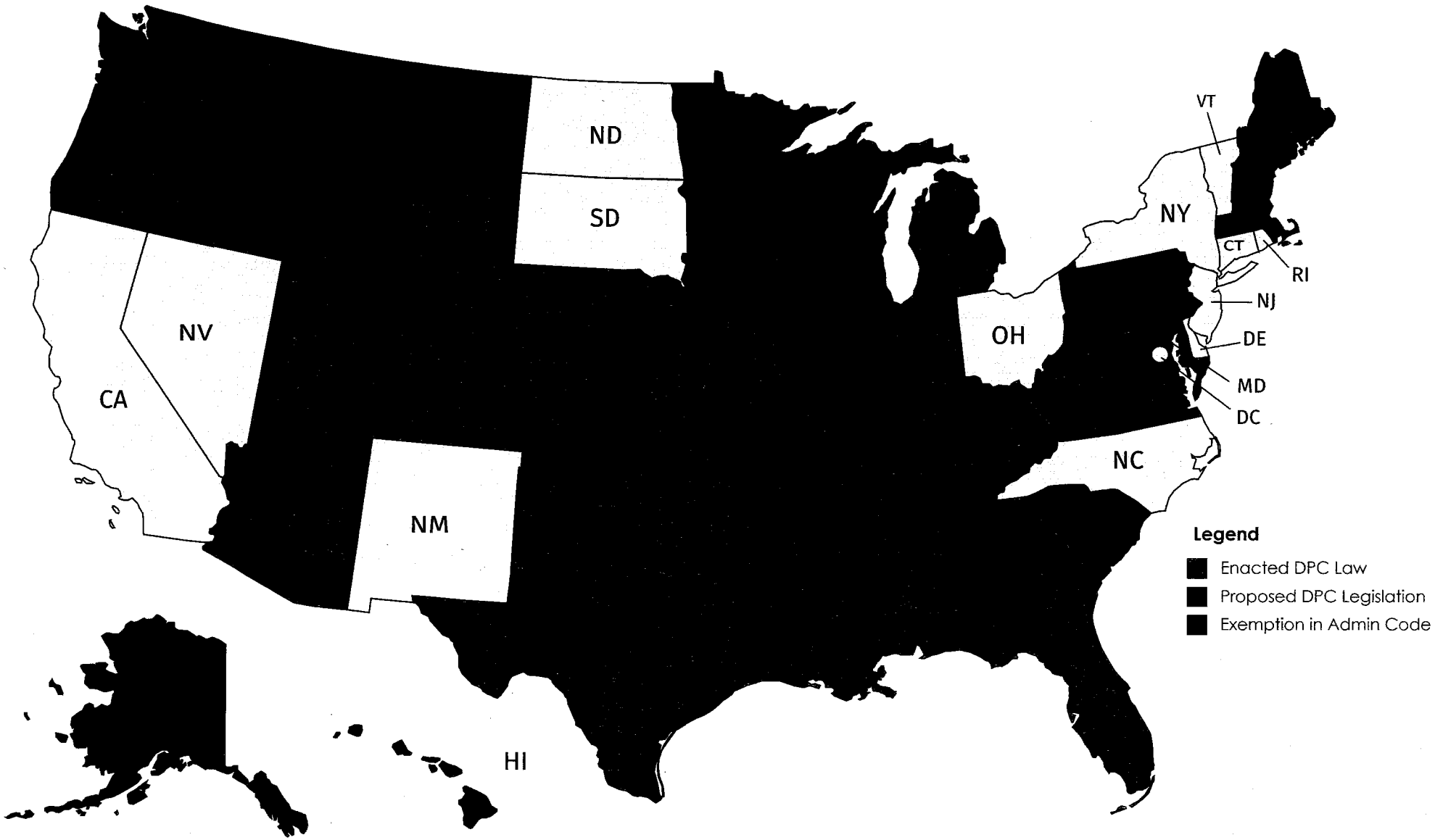
TO SENATE BILL 28

August 29, 2019 - Offered by Senators CARPENTER and KAPENGA.

At the locations indicated, amend the bill as follows:

1. Page 5, line 3: after "protection." insert "Nothing in this section shall be construed to limit the authority of the office of the commissioner of insurance to regulate contracts that do not satisfy the criteria to be a valid direct primary care agreement under s. 146.78 (2) and that meet the definition of insurance under s. 600.03 (25).".

(END)



Wisconsin Medical Society

TO: Assembly Committee on Small Business Development
Representative Janel Brandtjen, Chair

FROM: HJ Waukau – Manager, Advocacy and Regulatory Affairs

DATE: September 4, 2019

RE: **Support** for Assembly Bill 26

On behalf of the largest association of medical doctors in Wisconsin, the Wisconsin Medical Society thanks you for this opportunity to share our support for **Assembly Bill 26**, which concerns a patient contracting for direct primary care.

At its most recent annual meeting, the Society's House of Delegates approved a policy pertinent to AB-26:

> **INS-061: Use of Direct Primary Care and Other Direct Care Arrangements**
> The Wisconsin Medical Society supports expansion of consumer choice by supporting the following initiatives:
> 1) Legislation clarifying that direct primary care is not a plan, coverage, or insurance.
> 2) Legislation that enables consumers who have health savings accounts to use their health savings account to enter into fixed fee arrangements including direct primary care. (HOD, 0419)

The Society supports adding statutory language clarifying that patients entering into a contract to receive primary care services does not constitute health insurance. Many physicians in Wisconsin already have such agreements with their patients and a statutory clarification of this area would be helpful.

The requirement to disclose that such contracts are not health insurance is also important. Easier access to routine health care services can be very cost-effective and beneficial for patients 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 contract for direct primary care is a supplement to, not a substitute for, insurance coverage for catastrophic care. Making that distinction clear to the patient is vital, and the Society supports that requirement.

Access to and the cost of health care continues to be a growing issue both nationally and in Wisconsin. At the same time, physicians in Wisconsin are feeling the effects of professional burnout and dissatisfaction at a higher rate (53.5 percent) compared to national baselines (29 percent). Direct Primary Care can be a model where both the public and the profession benefit.

Thank you again for this opportunity to provide our testimony on Assembly Bill 26. Please feel free to contact the Society on this and other health-related issues.

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330 East Lakeside Street • PO Box 1109 • Madison, WI 53701-1109 • wisconsinmedicalsociety.org •

September 4, 2019

Dear Chairwoman Brandtjen and members of the Committee on Small Business Development:

On behalf of Americans for Prosperity (AFP) activists in Wisconsin, I am here to testify in support of Assembly Bill 26. AFP activists engage friends and neighbors on key issues and advocate for building a patient-centered health care system that lowers costs, increase choices, and improves access for millions of people seeking relief. The reforms outlined in AB 26 to expand access to Direct Primary Care (DPC) would promote all of these important goals and would also help address our state's large and growing doctor shortage.

The Direct Primary Care model is successful for providing better access to better care at a better cost because it does not need to engage in the insurance industry. This bill explicitly defines DPC as not insurance – an important definition to ensure that DPC is not regulated by the state as an insurance product and that the doctors are not required to be licensed insurance agents. These regulations are expensive and could threaten the viability of the DPC model in Wisconsin moving forward.

Wisconsin faces some of the worst physician shortages of any state in the nation. According to the US Department from Health and Human Services (HHS), over one million Wisconsinites live in areas that face a severe shortage of physicians.[i] Even worse, roughly 40 percent of Wisconsin's physicians are expected to retire by 2035, meaning patients will have to wait longer, travel further, and pay more for their health care in the years to come.[ii]

A major reason why there are so few physicians serving Wisconsin's health care needs is because our current third-party insurance system imposes a heavy financial toll on doctors. The compliance costs involved with billing and negotiating with insurance companies account for 40 percent of the average doctor's overhead expenses and consume half of their workday, leaving less time to care for patients.[iiiiv]

Fortunately, Direct Primary Care (DPC) would make it far easier for physicians to deliver care to patients. DPC doctors offer patients a range of high-quality health care services, including chronic disease treatment, check-ups and various health tests in exchange for a flat monthly membership fee. These new arrangements completely eliminate third-party insurance from the doctor-patient relationship. And as a result, DPC physicians can spend less time and money billing insurance companies and spend more time treating patients.

Research from the *Family Practice Management* Journal shows that DPC physician on average spend more than four times as much time with their patients as traditional fee-for-service physicians.[v] This allows physicians to develop incredibly strong relationships with their patients, thereby ensuring they remain in good health and out of the hospital.[vi]

AB 26 would provider crucial legal certainty for physicians seeking to practice DPC in the Badger state. The bill would explicitly define DPC as "not insurance" and shield DPC practices from expensive insurance rules that would threaten their financial viability. This committee can protect these innovative practices from insurance regulations by making clear DPC is not considered insurance under state law. Please vote "Yes" on AB 26 to help provide Wisconsinites with better access to better care at a better cost, while also helping address the physician shortage our state is facing.

We thank you for the opportunity to address this critical issue and we look forward to working with the Committee to craft real reforms that expand access and affordable and high-quality health care for all Wisconsinites.

Sincerely,

Megan Novak
Legislative Director
Americans for Prosperity-Wisconsin

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[i] https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[ii] https://static1.squarespace.com/static/5a3ac16af14aa15aede6d0ed/t/5b69ebb28a922d59c48f6d37/1533668280195/WCMEW+2018+Report+FINAL.pdf

[iii] https://www.tafp.org/news/tfp/spring-2015/cover

[iv] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0811

[v] https://www.jabfm.org/content/28/6/793

[vi] https://www.heartland.org/_template-assets/documents/publications/Paladina%20Health_City%20of%20Arvada_Case_Study.pdf

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tony Evers, Governor
Mark V. Afable, Commissioner

Wisconsin.gov

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Date: September 4, 2019

To: Representative Janel Brandtjen, Chair
Representative James Edming, Vice Chair
Members of the Assembly Committee on Small Business Development

From: Nathan Houdek, Deputy Commissioner
Office of the Commissioner of Insurance

Subject: Assembly Bill 26 Relating to direct primary care agreements

The Office of the Commissioner of Insurance (OCI) submits the following comments for your consideration regarding Assembly Bill 26 related to direct primary care agreements. These comments were previously shared with members of the Senate Committee on Health and Human Services for the public hearing on Senate Bill 28 (the companion bill to Assembly Bill 26) on June 6, 2019.

OCI believes it is important that the bill provide a clear delineation between direct primary care agreements and the business of insurance. OCI has concerns that the bill, as drafted, could be misconstrued as creating exemptions for certain activities that have been traditionally regulated as the business of insurance.

OCI suggests that language be added that makes clear that OCI has the authority to regulate contracts that include the assumption of risk and that are not valid direct primary care agreements. OCI is concerned that sponsors of these plans could expand the services offered beyond the primary care provider to third-party providers. For example, a direct primary care agreement that includes in its fee coverage for third-party lab tests or prescription drugs would look like a traditional insurance policy in that the primary care provider is assuming risk. For example, the provider is charging a flat fee for labs and does not know what the utilization level of the consumer will be. This is the practice of insurance and is regulated by OCI. OCI does not interpret current valid direct primary care agreements as being involved in the business of insurance, however, OCI should maintain the ability to regulate direct primary agreements that provide insurance services beyond those allowed by the bill.

Senate Amendment 1 to Senate Bill 28 would add the language suggested by OCI to address this concern. If this amendment is adopted, or an amendment that includes the same language is adopted to Assembly Bill 26, then OCI would not have concerns with this legislation.

Thank you for your consideration of OCI's comments.

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September 4, 2019

Testimony Supporting the Passage of Assembly Bill 26

Dear Chairman Brandtjen and members of the Assembly Committee on Small Business Development,

Thank you for the opportunity to submit testimony on AB 26.

At its core, this legislation is based on the premise that government should not put roadblocks between patients and their health care needs. Direct primary care (DPC) is the sort of disruptive, creative health care solution that government regulations often have difficulty assimilating—an Uber for the health care space. AB 26 works to remove those road blocks and increase the peace of mind for both DPC providers and the patients that rely increasingly on them.

Removing these roadblocks is important because Wisconsin, along with the rest of the United States, suffers from expensive health care. According to the most recent data available from the Kaiser Family Foundation,[1] the state ranks 18th in health care spending per private payer. Many families struggle with high deductibles and must make tough decisions on whether or not to seek out medical care. Indeed, a recent poll conducted by the CDC found that 10.8% of Wisconsinites said the cost of health care prevented them from seeking out a doctor.[2]

DPC is an increasingly popular solution to overcoming the high cost of care. It is also rapidly growing. The number of providers has skyrocketed in recent years, growing from 146 in 2000 to more than 4,400 by 2012.[3] By eliminating the insurance middleman, patients can cut costs by not having to pay the insurance company their "share of the pie." DPC plans are also attractive to many doctors who see such practices as an opportunity to step off the "hamster wheel" of schedules packed with back-to-back patients throughout the day. The average doctor in a DPC model sees between 600-800 patients per year rather than at least 2,000 in traditional practices.[4] Some research suggests the increased personal attention from doctors this allows can actually work to improve patient health outcomes.[5]

A few DPC providers already practicing in Wisconsin illustrate the potential savings. For example, YourMD in Mequon, which offers urgent and primary care. A family can purchase a membership with YourMD for only $150 per month for the parents and an additional $30 per month for each child. With a membership, each visit is only $25, including urgent care visits. A 2015 survey[6] of DPC providers found the average patient monthly cost to be $93.26 (with a range from $26.67 to $562.50).

But these DPCs operate with a constant concern about new regulation or lawsuits because they exist in a legal gray area. Without codifying the legal status of DPC providers, questions remain as to whether they could be subject to insurance regulation or forced to meet the requirements of health care plans under the Affordable Care Act. By formally recognizing these providers in state law and laying out explicitly the rights and responsibilities of both the DPC and the consumer using that DPC, as this bill does, there is the potential that many more providers could enter the marketplace.

This is the sort of common-sense legislation that legislators from both sides of the aisle ought to be able to get behind. After an attempt to pass similar legislation failed during the last session, a joint legislative study committee was formed under the leadership of state Sen. Alberta Darling to consider what direct primary care would look like in Wisconsin. This bi-partisan committee unanimously determined that DPC is a "valuable component of Wisconsin's health care market."

We agree with the sentiment of the committee. DPC by itself is not, of course, a silver bullet that will solve all of Wisconsin's health care woes. But, coupled with other free-market oriented reforms such as Dental Therapy licensure and improved health care price transparency, the legislature can effectively move the needle towards patient empowerment, lower costs, and better access to much needed health care options.

We urge the passage of AB 26. Thank you for your consideration.

Sincerely,

CJ Szafir
Executive Vice President
WILL

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[1] https://www.kff.org/other/state-indicator/health-spending-per-capita/?currentTimeframe=0&sortModel=%7B"colId":"Health%20Spending%20per%20Capita","sort":"desc"%7D

[2] https://www.cdc.gov/brfss/annual_data/annual_2017.html

[3] https://www.heritage.org/health-care-reform/report/direct-primary-care-innovative-alternative-conventional-health-insurance

[4] http://www.aafp.org/dam/AAFP/documents/practice_management/payment/DirectPrimaryCare.pdf

[5] https://s3.amazonaws.com/academia.edu.documents/46696131/S1081-1206_2810_2963296-620160621-8963-381xeh.pdf?response-content-disposition=inline%3B%20filename%3DImpact_of_the_physicians_participatory_s.pdf&X-Amz-Algorithm=AWS4-HMAC-SHA256&X-Amz-Credential=AKIAIWOWYYGZ2Y53UL3A%2F20190829%2Fus-east-1%2Fs3%2Faws4_request&X-Amz-Date=20190829T124441Z&X-Amz-Expires=3600&X-Amz-SignedHeaders=host&X-Amz-Signature=00d0b088f342acbb825cb3b6b8bc9bd3152c9fe02b0f13e6acdc279c776b04c4

[6] Eskew, Phillip and Kathleen Klink. 2015. "Direct Primary Care: Practice Distribution and Costs Across the Nation." Journal of the American Board of Family Medicine 28: 793-801. https://www.jabfm.org/content/28/6/793 2 https://docs.legis.wisconsin.gov/misc/lc/study/2018/1790/040_report_to_the_joint_legislative_council/lcr_2019_03

Priority Medical Partners DIRECT sc

Assembly Hearing Testimony Outline Regarding 2019 Assembly Bill 26
(Relating to Direct Primary Care Agreements)
Wednesday, September 4th at 10am
Room 415 NW of the Capitol

Firstly, I would like to thank **Rep. Joe Sanfelippo** and **Sen. Chris Kapenga** for introducing this legislation and to everyone who is providing support for this bill through co-sponsorship.

Secondly, I would like to thank **Committee Chair Rep. Janel Brandtjen** for scheduling the hearing and to **all of you committee members** for taking time out of your busy schedules to allow me to share with you my experience with DPC and why the passage of this legislation will benefit patients, doctors, and the state of Wisconsin.

Introduction
Kim & Brian Erdmann, PMP/PMPdirect, Wisconsin's first and only hybrid medical practice
DPC – PPV (Oneida County Story) - Ins

Effects of Our Current Healthcare System on the Delivery of Traditional Fee For Service Primary Care

- Current Estimates of Medical Practice Overhead are 40-70%
- Physician panel sizes increase – 2,500 to 3,000 patients per physician (too large!)
- Large patient panel size forces doctor to see more patients (approx. 25-30 pts/day)
- Physician employer charges more for physician services to cover the practice overhead
- Large physician patient panels lead to poor access (24 days on average)
- 8 Hr. Day = (32) 15min appt slots where only 50% of the 15 min office visit time is spent directly interacting with patients (approx. 8 minutes)
- Primary care physicians spend 27% of the workday on face to face visits and 73% on paperwork
- For every 1 hour of patient care a physician spends an additional 2 hours on "paperwork"
- Patients often experience impersonal, cursory, overly expensive visits

Effects of Our Current Fee For Service Primary Care System on Patients

- Lack of access to primary care and limited visit duration pushes patients to more expensive downstream care
- More visits to ER, Urgent Care, Hospital
- Increased referrals to specialists and increased ordering of expensive radiologic procedures
- Net result is an increase in health care costs for patients

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Effects of Our Current Healthcare System on Physicians

- 78% of primary care physicians are experiencing burnout
  - Regulatory and insurance requirements and other bureaucratic tasks
  - Loss of autonomy; inability to provide unhindered care to patients
- Only 21% of internal medicine and 23% of family practice physicians are happy at work
- 14% of physicians have thought of suicide
- 1% of physicians have tried committing suicide
- Physicians have the highest suicide rate of any profession
- **85% of primary care physicians state that the most satisfying aspect of their profession is the patient-physician relationship**

Effective Primary Care

- Majority of medical issues (80%) can be effectively addressed by a primary care physician
- Primary care can diagnose conditions early in the disease process before significant issues arise (prevention! proactive!)
- Meaningful time spent with a primary care physician can reduce the need for expensive, downstream care
- Meaningful time with a primary care physician requires that physicians have ample time to spend with their patients without interference from outside influences that detract from the patient-doctor relationship

Effective Primary Care Means Direct Primary Care

- Direct Primary Care (DPC) is an innovative alternative payment model improving access to primary healthcare with a simple, flat, affordable membership fee.
- The defining element of DPC is an enduring and trusting relationship between a patient and his or her primary care provider.
- Patients have extraordinary access to a physician of their choice and physicians are accountable first and foremost their patients.
- **Direct Primary Care is NOT insurance** – membership fee covers only primary care services; NOT specialty care, imaging, or surgery...Direct Primary Care does NOT "take on" risk.

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Benefits of Direct Primary Care

- Removes unnecessary regulatory requirements and associated "paperwork" allowing physician to spend more direct time caring for patients
- Lower practice overhead – savings passed on to the patient
  - Employer: Prevent visit + Labs = $1236: DPC $988.... $248 savings
  - 40 y.o diabetic: 1 visit FFS = $550; entire year of DPC = $828
  - Children adolescents: $15/mo or $180/yr for DPC
- Supports smaller more manageable patient panels (600-1200 patients)
- Improved patient access to their physician (no "24" day waits)
- Longer office visits (30-60 minutes)
- BEST price lab tests ≈ 85% lower than inflated Fee For Service lab prices
- 100% price transparency and bundled pricing! (fixed cost)
- Higher patient satisfaction and strong patient-doctor relationship

I like that this bill exempts valid Direct Primary Care Agreements from the application of insurance law.

But that doesn't mean I don't like insurance.

In fact, I feel that it is important for every patient to have access to affordable health insurance or other suitable healthcare coverage; however, I feel that health insurance should be used as it was used many years ago; to provide catastrophic coverage for expensive events that are unlikely to occur. When insurance is used to pay for routine, predictable, commonly occurring events, then health insurance costs rise as does the delivery of care such as primary care.

Before the early 1990's routine healthcare services were paid out of pocket and insurance coverage was only used for expensive healthcare services. Other types of insurance such as auto or homeowner's insurance still operate in a true, catastrophic fashion. For example, when was the last time you used automobile insurance for an oil change...or used homeowner's insurance to re-paint walls or replace damaged carpet?

Let us work together to pass this bill to provide patients access to affordable, lower cost, high quality primary care, to restore physician and patient autonomy, to allow physicians the ability to deliver unhindered care to patients and reclaim career satisfaction, and to strengthen the foundation of healthcare...the patient-doctor relationship.

Thank You,

Dr. Brian Erdmann

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Wisconsin Association of Health Plans

The Voice of Wisconsin's Community-Based Health Plans

Assembly Bill 26
Assembly Committee on Small Business Development
September 4, 2019

Chairperson Brandtjen, Members of the Committee, thank you for the opportunity to testify today.

My name is Tim Lundquist and I am the Director of Government and Public Affairs at the Wisconsin Association of Health Plans. The Association is the voice of 12 Wisconsin community-based health plans that provide employers and individuals across Wisconsin access to high-quality health care.

The Wisconsin Association of Health Plans is opposed to Assembly Bill 26 as drafted.

As an Association, we work with policymakers on a diverse range of issues. We ask the same questions when evaluating new proposals: what problem is the legislation or policy attempting to solve, and how will the change impact Wisconsin consumers?

What Problem Will Assembly Bill 26 Solve? A Legislative Council Study Committee on Direct Primary Care, convened in the summer and fall of 2018, to evaluate direct primary care (DPC) in Wisconsin. In the Study Committee's *Report to the Legislative Council*, the Committee affirmed that direct primary care (DPC) is a valuable component of Wisconsin's health care market, but did not recommend the Legislature introduce and consider a direct primary care bill. Less than half of the Committee was in favor of recommending legislation, due primarily to the fact that **members of the Committee, which included two practicing DPC physicians, failed to identify any barriers in Wisconsin law to providing DPC services**.

How Would Assembly Bill 26 Impact Consumers? Assembly Bill 26 would dilute current consumer protections by exempting certain DPC arrangements entirely from oversight by the Office of the Commissioner of Insurance (OCI).

Exempting direct primary care arrangements from oversight by OCI would create a significant loophole in Wisconsin consumer protection laws and increase the possibility of direct primary care arrangements becoming vehicles for unregulated insurance products.

Wisconsin's community-based health plans also believe DPC legislation should require DPC providers demonstrate proof of financial responsibility. Wisconsin consumers need to know that when they provide prepayment to a DPC provider for health services, those services will be provided to them or the payments will be returned if a DPC clinic closes its doors.

Wisconsin health plans oppose Assembly Bill 26 as drafted. Before any DPC proposal advances through the legislative process, it should at least be amended to ensure OCI oversight of all DPC arrangements and DPC financial responsibility to consumers.

Testimony of Dr. Suzanne Gehl
Assembly Bill 26 Direct Primary Care Agreements
Assembly Committee on Small Business Development
September 4th, 2019

Thank you for allowing me to testify today. My name is Suzanne Gehl, and I am a Family Physician, Past-President of WAFP, Owner/Operator of a solo DPC practice in Delafield, and Chief Medical Officer of Solidaritus Health-a Washington D.C. based organization bringing DPC to Labor Unions. I am speaking on behalf of WAFP, Direct Primary Care Physicians, current and future DPC patients and employers.

In my 30 years as a family physician, the past 7 have been spent delivering comprehensive services in the DPC model. What is this? For a low monthly membership fee, an individual or family has a personal physician accessible by phone, text, or e-mail 24/7, same day or next day appointments for urgent needs, office visits 30 minutes to an hour and a half in length, video visits, and even home visits if needed.

Physicians provide comprehensive care, management of chronic health issues, counseling, prevention and wellness coaching, skin biopsies, laceration repair, lung function testing, EKGs, joint injections, and other services. Labs performed in the office are free, and labs that are sent out are done at steeply discounted prices. Many generic medications are dispensed at cost. There are no co-pays for visits, and there is no billing of insurance companies for services provided by the DPC doctor. Basically, a concierge level of service at an affordable price.

This is beneficial for healthy people, and really ill, complex people; newborns to elderly-depending on the physicians training. What happens when people have this level of access at an affordable price? THEY GET HEALTHIER, they stay healthier, and prevent downstream healthcare costs. ER/Urgent care visits decrease, utilization of specialists becomes more appropriate, the patient saves money, and if employers provide this as a benefit to their people, the company saves money, too.

Corporate savings was demonstrated with Solidaritus Health recently. A US company was literally in the process of moving their operations out of the country, which would have meant the loss of almost 4000 jobs. Fortunately, Solidaritus Health worked closely with the Labor Union and employer, convincing them to give DPC a chance. With the predicted health care savings, it was anticipated the Relocation could be avoided. After 6 months, health care expenses decreased for the first time EVER, and as we are approaching the 1 year mark, the insurance premiums are increasing zero dollars. Again—1st time ever. Plans to move out of the US? CANCELED. And satisfaction? 9.9/10 score for the 4 physicians.

The patients love DPC, but what about doctors? They love it, too! Doctors care for a smaller panel of patients-500-1000, (as compared to 2-3,000 in the usual clinic setting). With the gift of time, doctors really get to know their patients, and can see results quickly as patients engage in proactive measures to optimize their health. A 2018 survey of 17,000 doctors found that 47% were considering retiring early or moving into

an alternate type of work. WHAT???? DPC is keeping physicians in practice, and rekindling their love of medicine and desire to serve.

This bill helps DPC thrive in the state of Wisconsin. It clearly states that DPC contracts are exempted from the application of insurance law, which is appropriate. DPC is a health care service, it is not insurance. In fact, people are strongly encouraged to have insurance or a health sharing program to cover their needs outside the DPC services.

I always like to describe it as, insurance is the cake, DPC is the frosting-it is on top of, or in addition to the insurance. The insurance company actually wins when DPC is involved, too. They collect their premiums, but end up paying out less in claims. DPC is a win-win for everyone. Passage of the bill will encourage further growth of DPC and economic benefits in the State.

More than half of the states in the country have already passed similar legislation, and it is our hope that Wisconsin will join this movement. Why? It's the right thing to do.

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Testimony before the Wisconsin Assembly Committee on Small Business Development
Wednesday, September 4, 2019
Cameron Sholty, Director of Government Relations, The Heartland Institute

Chairwoman Brandtjen and Members of the Committee:

Thank you for granting me the opportunity to testify today. My name is Cameron Sholty. I'm the Director of Government Relations at The Heartland Institute, a 35-year-old nonpartisan national nonprofit research organization. Heartland's mission is to develop and promote public policy solutions that expand opportunity and empower people. Heartland 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 26 would expand direct primary care, offering enormous opportunities for Wisconsinites, especially those enrolled in Medicaid, who have historically faced significant challenges when trying to obtain quality medical care.

Over the past 18 years, Medicaid's share of Wisconsin's budget 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.

Similar to most states, Wisconsin faces a severe primary care shortage. The Robert Graham Center estimates to maintain current rates of primary care utilization, Wisconsin would need "an additional 942 primary care physicians by 2030, a 22% increase compared to the state's current (as of 2010) 4,167 PCP [primary care physicians] workforce."

This shortage is exacerbated by the fact that many new physicians choose to practice specialty medicine instead of primary care medicine. Although there are many reasons for this shift, the high costs and logistical challenges inherent in primary care medicine are major contributing factors. According to the *American Journal of Medicine*, the percentage of U.S. primary care physicians comprising all physicians decreased from 50 percent in 1961 to 33 percent in 2015. Similarly, a United Health study found that only 288,000 out of 869,000 physicians choose to practice primary care.

The United Health Group study estimates that by 2030, there will only be 306,000 primary care providers in the nation. Additionally, by 2032, the number of Americans over the age of 65 will increase by 48 percent, according to the U.S. Census Bureau. This, along with several other factors, will magnify the need for primary care doctors.

To ensure Medicaid continues to provide critical services and that primary care physicians are available to cover the state's growing health care needs, Wisconsin must introduce reforms that

would 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 a direct pay model. This is because they no longer need to spend precious time and money billing insurers and can instead spend more resources and time treating patients.

A study in the *American Journal of Managed Care* found individuals who receive direct primary care are 52 percent less likely to be admitted into 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 continued to see physicians with conventional, insurance-based billing.

Previous legislation considered in 2017 would have required the Wisconsin Department of Health Services to set up a direct primary care pilot program for Medicaid recipients and would have made clear under state law that direct primary care providers are not subject to state insurance regulations. Future legislation should include these provisions.

Direct primary care, when paired with a catastrophic health insurance plan and a health savings account program, would provide Wisconsinites with an affordable and convenient alternative to traditional insurance or Medicaid. DPC agreements empower patients to choose the health care model that best suits their unique needs and circumstances. State lawmakers should remove unnecessary regulatory barriers to DPC, which would help alleviate the nation's primary care shortage.

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 these goals at a price taxpayers and families 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 Cameron Sholty at 312/377-4000 or reach him by email at csholty@heartland.org.

WISCONSIN ACADEMY of PHYSICIAN ASSISTANTS

To: Members, Assembly Committee on Small Business Development

From: Eric Elliot, DMSc, PA-C

Date: September 4, 2019

Re: **Support for Assembly Bill 26 – Direct Primary Care**

Thank you, Chairperson Brandtjen and committee members, for the opportunity to testify today in support of Assembly Bill 26. My name is Eric Elliot. I am a physician assistant and I currently practice at Allegiance Medical Group. We have clinics in Madison, Wales, and Green Bay. I also serve as the chairperson of the Advocacy Committee of the Wisconsin Academy of Physician Assistants (WAPA).

WAPA is the only professional organization whose mission is to represent all PAs statewide. Over 2,700 PAs practice in Wisconsin, working with physicians to provide quality, cost-effective team-based care to patients across the state. While PAs work in all areas of medicine, every PA is initially educated as a primary care provider. No matter where a PA practices, every six to ten years he or she must recertify by taking a primary care-based board examination. PAs' practice can include performing physical exams, diagnosing and treating illnesses, assisting in surgery, and prescribing medication.

WAPA supports Assembly Bill 26, which provides regulatory parameters for health care providers entering into direct primary care agreements with patients. Under the bill, PAs are included in the types of health care providers who may enter into direct primary care agreements with patients. Advanced practice clinicians like PAs are crucial in maintaining and increasing cost-effective access to primary care, especially in underserved rural areas of the state. Allowing PAs to enter into direct primary care agreements supports more opportunities for PAs to practice across the state and helps expand patient access to primary care.

It is important to note that PAs entering into direct primary care agreements with patients would still be required to have a relationship with a physician, as required under current law. The bill also provides that health care providers, including PAs, provide primary care services "under the provider's scope of practice."

WAPA respectfully asks your support for Assembly Bill 26, which will provide PAs opportunities to help reduce health care costs and increase quality primary care access for patients across Wisconsin through direct primary care agreements.

Thank you again, and I would be happy to take any questions from committee members.