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Assembly Committee on Health, Aging and Long-Term Care
Testimony on Assembly Bill 8
Agreements for Direct Primary Care
February 12, 2025

Thank you Chairman Moses, and members of the Assembly Committee on Health, Aging and Long-Term Care for holding a hearing on Assembly Bill 8, agreements for direct primary care. Direct Primary Care (DPC) is a healthcare model already being used in Wisconsin as a supplement to traditional healthcare. This legislation will ensure that DPC can continue to be used as intended, and deliver high-quality, low-cost care.

In the traditional model for healthcare, costs are usually billed by the doctor and submitted to the insurance company. The insurance company pays some or all of the cost, and the patient is responsible for paying the rest of the bill. As you can imagine, this can be a fairly expensive process.

By contrast, DPC operates on a direct payment or subscription basis, where patients pay a monthly or annual fee directly to the primary care provider. Instead of working through an insurance company for paying claims, the membership fee covers routine check-ups, preventive care, and basic medical services. People using DPC often have high-deductible insurance to cover larger, unexpected claims that could not be handled in a smaller clinical setting. Because there is no need to process insurance claims for routine care, DPC practices can reduce administrative overhead.

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Although the DPC model is already being used successfully in our state, doctors and health professionals are concerned that direct primary care agreements might be classified as insurance. This would negate the entire point of the DPC model.

This bill clarifies that Direct Primary Care is not health insurance, requires providers to clearly explain what services are covered, outlines the elements of a valid DPC agreement, and prohibits discrimination.

I hope you'll join me in supporting this legislation and ensuring that individuals in Wisconsin can continue to have access to this patient-centered approach to health care. Thank you again for your time today. I'm happy to answer any questions you might have.

RACHAEL A. CABRAL-GUEVARA

STATE SENATOR • 19TH SENATE DISTRICT

Testimony before the Assembly Committee on Health, Aging and Long-Term Care

Senator Rachael Cabral-Guevara

February 12, 2025

Thank you, committee members, for allowing me to testify on Assembly Bill 8, a straightforward bill targeted at increasing accessibility and affordability in healthcare.

This bill would have Wisconsin join over 20 states that specifically define direct primary care (DPC) in statute. DPC is an agreement for primary health care services where patients pay a monthly fee to a provider. These agreements enable both doctors and patients to avoid the bureaucratic complexity, additional paperwork, and costly hassle of the claims process; allowing for more time to be spent caring for patients. DPC is an alternative health care model, not a health coverage plan or means to replace insurance, and membership is voluntary where it can be canceled or entered into at any time.

In Wisconsin, there are around 35 practices that are using some form of a DPC model. Many of these practices that use this model are small, employing one or two providers. Despite their small size, they are a key component of the health care team in Wisconsin and care for thousands of patients.

Though these agreements currently operate in Wisconsin, there is no statutory authorization for them. This legislation will protect both these practices and their many patients by explicitly stating that DPC is not insurance, and thus is exempt from any OCI regulations. This bill also protects consumers by clarifying that DSPS and DATCP have regulatory authority over these practices and providers.

I know there have been questions about what types of care can be provided in this model, what is required of the provider, and the anti-discrimination provisions. Let me clarify: this bill would not mandate any form of primary care outside of a provider's scope of practice and the anti-discrimination provisions only apply when entering into or terminating the agreement itself.

Thank you again for allowing me to testify on this important piece of legislation and I am hopeful you will support it.

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Sen.Cabral-Guevara@legis.wisconsin.gov

Wisconsin Legislative Council

Anne Sappenfield
Director

TO: SENATOR RACHAEL CABRAL-GUEVARA

FROM: Margit Kelley, Principal Attorney

RE: Applicability of Discrimination Protections in Current Law to Draft LRB-3960/P2, Relating to Agreements for Direct Primary Care

DATE: September 12, 2023

You asked whether any nondiscrimination provisions would apply to a direct primary care (DPC) arrangement under LRB-3960/P2, a bill draft prepared for potential introduction in the current legislative session. Very briefly, current law prohibits discrimination by health care providers, which means that a provider considering a direct primary care agreement may not deny services to a patient because of sex, race, color, creed, disability, sexual orientation, national origin, or ancestry. A provider also may not decline to enter into an agreement based solely on the patient's health status, as provided in the bill draft, except in certain limited circumstances.

LRB-3960/P2

The bill draft defines direct primary care agreements and explicitly exempts those agreements from Wisconsin's insurance laws (chs. 600 to 646, Stats.). Under the bill draft, a direct primary care agreement is a contract between a health care provider and an individual patient (or other person on the patient's behalf) to provide agreed-upon primary care services over an agreed period of time, for a subscription fee.

Under the bill draft, in selecting patients with whom to enter into a direct primary care agreement, a health care provider may not decline to enter into, or terminate, an agreement with a patient solely because of the patient's health status. However, the bill draft authorizes a provider to decline to accept a patient in certain limited circumstances relating to the capacity to provide the needed care.

A health care provider is also limited in terminating an agreement for other reasons. In particular, a provider may terminate an agreement only in any of the following circumstances:

- Nonpayment of the subscription fee.
- Patient failure, repeatedly, to adhere to a treatment plan.
- Act of fraud by the patient related to the agreement.
- Abusive actions by the patient.
- The provider discontinues as a direct primary care agreement provider.
- The provider believes that the relationship is no longer therapeutic for a patient due to a dysfunctional relationship between provider and patient.

In addition, the bill draft specifies that the provisions in the bill draft do not limit the regulatory authority of the Department of Safety and Professional Services or the Department of Agriculture, Trade and Consumer Protection.

NONDISCRIMINATION LAWS

Current law prohibits discrimination in a public place of accommodation or amusement. The law broadly applies to places of business or recreation, lodging establishments, restaurants, taverns, barbers, cosmetologists, nursing homes, clinics, hospitals, cemeteries, and other places where accommodations, amusement, goods, or services, are available for free or for a consideration. [s. 106.52 (1) (e), Stats.] A person who provides health care services is subject to this provision and cannot deny services to a patient on any of the protected bases.

Under this provision, subject to certain exceptions, discrimination based on sex, race, color, creed, disability, sexual orientation, national origin, or ancestry, is prohibited. Protection for gender and gender identity is not explicit in the statute, but would likely be interpreted by a court as already being included in the broader category of "sex," in light of the U.S. Supreme Court decision in *Bostock v. Clayton County*, 590 U.S. ___ (2020). The decision held that a statutory protection in employment on the basis of sex included protection on the bases of sexuality and gender identity. The decision would likely be applied in a similar manner to the protection on the basis of sex in the public places of accommodation statute. [s. 106.52 (3) (a) 1., Stats.]

In addition to the statute prohibiting discrimination in public places of accommodation, health care professionals are generally subject to certain standards of conduct. A violation of those standards can lead to administrative actions against the provider, including a warning, suspension, or revocation of licensure. For example, a nurse may be found to engage in unsafe practice or substandard care if the nurse discriminates on the basis of age, marital status, gender, sexual preference, race, religion, diagnosis, socioeconomic status, or disability. [s. N 7.03 (6) (m), Wis. Adm. Code.]

DISCUSSION

As described above, under current law, a health care provider may not deny services to a patient because of sex, race, color, creed, disability, sexual orientation, national origin, or ancestry. Although not directly specified in the bill draft, that prohibition would apply to a health care provider in considering whether to enter into a direct primary care agreement as laid out in the bill draft. If a provider discriminates in denying an agreement on any of these bases, a provider violates the law, and may, in some cases, violate standards of professional conduct. A provider also may not decline to enter into an agreement based solely on the patient's health status, as provided in the bill draft, except in certain limited circumstances.

Please let me know if I can provide any further assistance.

MSK:jal

THE WEBER GROUP

Testimony in Support of Senate Bill 4/Assembly Bill 8
Libby Weber, The Weber Group
Wisconsin Senate and Assembly Committees on Health
February 12, 2025

To the members of the committee:

Thank you for the opportunity to testify in support of Senate Bill 4/Assembly Bill 8. My name is Libby Weber, I am CEO of The Weber Group in La Crosse. We are a family-owned organization with a portfolio of businesses in the hospitality, health care, and real estate development industries since 2006. I am proud to say we provide jobs for about 450 employees, and we understand that these employees remain our greatest asset. Investing in them – and their families – is our number one priority. Employers have the tremendous responsibility of ensuring the wellbeing of our employees. Without a healthy and stable workforce, achieving your business objectives becomes extremely difficult.

We know that putting our employees first leads to greater business results. Which is why The Weber Group has invested in offering DPC as part of an extensive and comprehensive benefit package for almost 15 years. We were one of the frontiers in participating in this model of health care for our area, and the benefits of doing so are great.

I'm sure you are already presented with the ongoing list of benefits that DPC can offer:

- Improved access to care
- Improved health outcomes with a focus on preventative care and managing/treating chronic disease
- Cost savings and ease of administration
- Enhanced employee satisfaction and positive workplace culture
- A tool for recruitment and retention
- A tool to offer health equity
- A healthier workforce leading to greater productivity and reduced absenteeism

I can attest that all these benefits are real. But to experience it firsthand, to see the positive impact on the lives of our employees and their families, is profound. Not to mention the financial advantages that has allowed The Weber Group to continue to reinvest in our company and employees – allowing wages to increase, affording capital investments in equipment and systems that support our teams and keep a competitive edge, and the overall opportunity to grow business rather than making cuts to operations or jobs.

As a self-funded employer, we have the opportunity to customize our health plan based on the claims data for our group. This allows us to be the best fiduciaries of our company spend, and for our employees' hard-earned dollar. However, only about 30% of our employee base is insurance-eligible – meaning that most of our team members do not meet the hour requirement that qualifies them for a company-sponsored health plan. These part-time or seasonal staff (common in the hospitality industry) are just as vital to our organization as anyone full-time. We offer ALL employees, regardless of status, tenure, or merit, access to health care with a DPC membership. The Weber Group uses this as a tool to promote health equity. Often,

we see those who need it most are the ones that have the greatest challenge in accessibility and affordability.

By investing approximately $70 per employee per month, we are able to help control our overall health care costs. It is much easier for us to budget and plan for this fixed cost than completely surrender to the consistently rising costs of insurance. Last year alone, The Weber Group saw a 6% reduction in claims as part of our health plan. By having employees utilize their DPC memberships, we are helping to keep them out of the emergency room or using urgent care when it's not necessary. But more importantly, as we focus on preventive health with the ability to help treat chronic disease, we are keeping our employees (and their families) healthier – which remains our top priority. Improving health outcomes is what it's all about, and the financial improvement that follows is a collateral benefit. As we become a healthier workforce, we can better negotiate renewals with our health plan, often times leading to a reduction in overall spend.

- Average net self-funded spend per member per month decreased 12% 2022 to 2023, compared to the average increase of 8.5%
- Our annual spend per employee was 8% less than our cohort average, and 22% less than the national average employer in 2023
- 2024 summary is yet to be presented, but we expect a continued downward trend in spending

It is because of all these reasons that The Weber Group took it upon itself to open its own DPC clinic because we, as an employer, needed it. Not only for our own group, but for our entire community. We are not the only ones that can benefit from having a DPC resource in our market. If we can achieve such great benefits in access, affordability, and quality of care, we can provide that to anyone else. Our health care organization is named ViaroHealth, and it is based in a strong foundation of the DPC model, and the first of its kind in the La Crosse area. We are an independent provider that is available to any employer (regardless of size, location, and health plan), as well as to the public. And our integrative approach to health care, which includes primary care, behavioral health, fitness and nutrition, alternative therapeutics, and health education, is available to EVERYONE. We base our subscription model on DPC, but separately we also accept insurance for those networks we have selected to participate, and we have low cash fees that make us competitive with other cash-only providers. Clearly, we are not insurance since we are accepting insurance in certain cases for individuals whose care is not otherwise covered under a subscription agreement.

Being an independent care provider gives us the ability and motivation to steer our patients to other high-value providers. Not only are we able to control costs for our patients, employees, and partners, but we are able to assist in additional cost containment through our relationships with the growing number of independent providers in various specialties – imaging, infusions, procedure and surgical centers, for example. As a health care company, we are motivated to keep our patients healthy. That is the only way we can make a DPC practice financially viable.

I ask that you support this legislation, which protects Direct Primary Care as a valuable resource for Wisconsin employers and the public with access to health care in a manner that is affordable, transparent, and high-quality. You can support the tremendous benefits of DPC by approving this bill, by opposing non-competes for providers that wish to move into independent practice, and by supporting any other measures that give more control to those that pay the expense of quality care – Wisconsin patients and employers.

Thank you.

VIAROHEALTH

Testimony in Support of Assembly Bill 8 and Senate Bill 4
Teresa Pulvermacher, FNP-C and President of Viaro Health
before the Assembly and Senate Committees on Health
February 12, 2025

Good [morning/afternoon], esteemed members of the legislature,

Thank you for the opportunity to speak today. I represent the healthcare providers within the Direct Primary Care (DPC) model at Viaro Health in La Crosse. We are a patient-centered, cost-effective approach to healthcare that focuses on value and quality. I'd like to share with you the significant benefits of DPC for me as a family nurse practitioner, especially when compared to the traditional fee-for-service insurance model.

1. More Time with Patients: In a Direct Primary Care model, I have more time to engage with my patients. Unlike the traditional fee-for-service insurance model, which often limits appointment times to just minutes due to the pressures of insurance reimbursements, DPC allows for longer visits. This enhanced time leads to better understanding of patients' needs, more thorough discussions of health concerns, and ultimately better care outcomes.

2. No Split Billing: In the traditional healthcare system, patients often receive multiple bills that are very confusing. DPC eliminates this complication by offering a simple, transparent, monthly membership fee. This means no hidden charges, facility fees, or co-pays—patients and providers can focus on care, not billing.

3. Improved Patient Adherence: When patients have more time with their providers and can openly communicate without financial barriers, they are more likely to adhere to care plans and follow up with necessary treatments, follow up for chronic diseases like A1C testing in diabetes, and medication rechecks for conditions like depression or hypertension. Research consistently shows that patients who have a closer, more accessible relationship with their provider are more likely to make healthier decisions, which leads to better outcomes in the long run.

4. Access to Ancillary Services: DPC doesn't just stop at traditional primary care. It offers access to ancillary services that improve the overall wellness of my patient. Many DPC practices, including ours, provide alternative therapies like massage, acupuncture, and chiropractic care. These services can complement traditional treatments and are often more affordable within the DPC model, giving our patients a holistic approach to managing their health.

5. Cost Control and Efficiency: One of the main advantages of DPC is that it enables providers like me to independently control costs. Without the complexity of insurance billing, there is greater ability to focus on efficient, effective care that minimizes unnecessary tests or treatments. Providers are incentivized to prevent health issues before they become expensive, offering cost-effective, proactive management.

6. Transparent Pricing: One of the frustrations of the traditional fee-for-service insurance model is surprise medical bills. In DPC, pricing is completely transparent. Patients know exactly what they are paying for

upfront, with no hidden fees or unexpected charges. This leads to financial peace of mind and the ability for patients to better budget for their healthcare.

7. Direct Access to Specialty Care: While DPC focuses on primary care, it also provides flexibility for patients to access specialty services when needed. Whether it's functional medicine, lifestyle medicine, cardiometabolic testing, or nutritional counseling, DPC providers can offer these services by nationally trained and certified, and/or licensed, credentialed practitioners in an affordable way. The Viaro care model integrates with these specialties, following all state and federal regulations, either as fully credentialed employees or as independent contractors. The model is also invested in the community and maintains referral-based or contracted relationships with the large healthcare systems, and independent practitioners such as radiologists, specialty and reference labs, and gastrointestinal specialists. This ensures that our patients receive the level of comprehensive care that fits their medical and personal needs, and their budgets.

8. Care Navigation and Fully Integrated Care: DPC providers are dedicated to navigating the complex healthcare system on behalf of their patients. This means helping patients with accessing care, coordinating specialists, and ensuring that follow-ups are streamlined. Whether a patient needs a referral to a cardiologist or wants guidance on managing a chronic illness, the provider is there to ensure continuity of care. In DPC, the provider becomes an advocate for the patient, navigating them through the system with the goal of achieving the highest quality care at the lowest possible cost.

9. Robust Communication through Technology: A key feature of DPC is its use of modern technology to improve communication. With an electronic medical record system, patients have direct access to their provider through secure patient portals. This allows for real-time communication, the ability to request prescriptions, ask questions, or schedule appointments, without the delays and potential hidden billing that can be seen in the traditional model. Additionally, the system enables seamless communication with specialists and other facilities, further ensuring that patients' care is coordinated and efficient.

10. Patient-Focused Care Transformation: In conclusion, Direct Primary Care offers an opportunity to transform healthcare into a more accessible, efficient, and patient-centered system. It empowers providers to focus on what truly matters: patient care. It ends many of the inefficiencies of the traditional fee-for-service model, reduces costs for patients, and promotes healthier communities through personalized, integrated care. This is one of the best opportunities we have today to improve healthcare for patients.

I appreciate your time and consideration, and I hope you will take the opportunity to explore how Direct Primary Care can contribute to a more sustainable and effective healthcare system.

Thank you.

[Optional: Questions/Comments]

Dedicated Family Care

Wendy Molaska MD, FAAFP
Susan Ferguson, MD

February 12, 2025

Thank you for this opportunity to provide testimony in support of Assembly Bill 8. I have been a Family Medicine physician for over 20 years and am a Fellow of the American Academy of Family Practice. I am a Past President of the Wisconsin Medical Society. Through the state's Department of Health Services (DHS), I serve on the Advisory Council for the Wisconsin Council of Immunization Practices. I am also Co-chair for the Advisory Council of the Wisconsin affiliate of Reach Out and Read, which is an early pediatric literacy program based in primary care clinics. Last year I had the honor of serving on Governor Evers' Healthcare Workforce Taskforce.

I am also a patient. I have Marfan syndrome and had open heart surgery at age 32 for an ascending aortic aneurysm and in 2019 I was diagnosed with breast cancer.

In May 2021 I opened my Direct Primary Care (DPC) clinic Dedicated Family Care in Fitchburg. I was in a 1 room suite and was the receptionist, nurse, phlebotomist, janitor and all things. Since then I have grown the clinic to the point we are running out of space in our current multi-room clinic. I have hired another physician and another physician just signed a contract to start later this year. My staff consists of 2 RNs and 1 administrative staff. They are all bilingual in English and Spanish and one RN is also a certified medical interpreter, while the other 2 staff are going through the process to get certified currently.

Demographics For Dedicated Family Care clinic - versus Fitchburg which is similar to the Madison area:
Fitchburg - white 62%, Latino 16%, Black 9%
My clinic - white 52% Latino 35% Black 12%
Fitchburg - without insurance 7.4%
My clinic 41.3%
Languages spoken at clinic English - 61% Spanish 31% other 7%
LGBTQ+ population at clinic - 10%

Dedicated Family Care

Wendy Molaska MD, FAAFP
Susan Ferguson, MD

Dedicated Family care Mission and Vision statements

Our mission is to champion health equity by providing an exceptional primary care experience that is personal, high-quality, accessible and affordable through the Direct Primary Care (DPC) model.

Our vision is to bridge the gap in healthcare disparities, ensuring that every individual, regardless of socioeconomic status, race, gender, or background, has the opportunity to achieve optimal health and well-being. Through advocacy, education, and community partnerships, we strive to transform the healthcare landscape, fostering a system where preventative care and patient-centered relationships are paramount, and where health equity is a reality for all.

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Because we are a DPC clinic we are able to pivot quickly and address issues that concern our community. During 2021, after the Dobbs decision, we made sure our patients had access to appropriate reproductive care and contraception. Currently many of our patients are experiencing stress for multiple reasons. Trans patients are concerned about not being able to get refills of their testosterone. Immigrants are concerned about their status, or that of their loved ones. Because I have autonomy at my clinic I was able to pursue becoming a Civil Surgeon for the United States government. At my clinic we are now able to help patients who need immigration exams to continue on their road to becoming citizens. Many things are much more easily done in a small independent practice because there is so much less red tape.

My diverse patient population also feels welcomed and heard at our clinic. A black man in his 40s, as he was leaving after his first visit, stopped and turned and said, "This is the most comfortable I have ever felt at a doctor's office." And while, on the one hand I wanted to pat our clinic on the back, on the other hand this is so very sad. As I got to know him he told me more about his experiences at regular clinics - where white people in the waiting room would get up and change seats when he sat down, where his white doctor kept telling him his blood pressure wasn't controlled because he wasn't taking meds correctly - despite him trying to the tell the doctor that he was indeed taking his meds correctly. We changed his meds and his blood pressure immediately improved and came under control. Sadly the other doctor assumed the issue was the patient and not the meds.

Dedicated Family Care

Wendy Molaska MD, FAAFP
Susan Ferguson, MD

A trans patient changed to my clinic due to ongoing issues with the larger healthcare system. He had a bilateral mastectomy and the big health system kept sending him reminders for a yearly mammogram. This creates more stress and trauma for the patient. I can relate, as my mom, who had a bilateral mastectomy for breast cancer was also receiving notices about her need for yearly mammograms after the surgery. Every time she received one of those automatic reminders from the system (because there are no easy ways to treat patients as individuals) it re-opened all the trauma of going through breast cancer again.

Multiple small, medium and large businesses have enrolled their employees at my clinic. For the medium and large businesses they find they save money on their employee healthcare expenditures. For small businesses, being able to offer primary care to their employees becomes a huge recruitment and retention tool. The small businesses are restaurants, cleaning businesses, daycares - all services where they often don't offer healthcare benefits. These employers also benefit - a cook cut their finger at one of my enrolled restaurants last week. Instead of having to go through the ER or urgent care they called me and were seen immediately in the clinic. No huge bill for work comp and barely any time lost.

One of the interesting things I learned during my time on the Healthcare Workforce Taskforce, was a term called the "benefits cliff." For those people working in lower paying jobs there was a "cliff" where they could only work up to a certain number of hours or they would end up making more money which would then make them ineligible for several benefits like food stamps and Medicaid. Since WI has not expanded Medicaid, I see so many patients in this gap. For them, having an affordable and accessible way to access primary care is invaluable. This ensures that they are getting the preventative care they need and are following up for the "little things" before they become "big things." About 80-90% of all care that people need is primary care. For the other parts I also have ways of helping patients by using independent groups such as an independent radiology group where my clinic has a deal and my patients can get X Rays for $50. The labs I send through Quest are also billed at a special client rate so if you want your kidneys, liver, blood sugar and electrolytes all checked (something we docs call a CMP) it is $3.85.

I never really went into medicine for the money. I went into it thinking I wanted to help people. As a family physician I have the privilege of providing womb-to-tomb medicine. However over the past 20 years I kept losing autonomy to treat my patients the way needed to be treated, to build the doctor physician relationships I wanted to have. I had to spend more and more time on coding and billing and paperwork and things that I felt were not enhancing patient care, while

spending less and less time with patients. I now feel I am practicing family medicine to the best of my abilities while helping a very diverse patient population from the wealthy - who have donated money to help those less fortunate at the clinic, to those that are underserved. We have never turned anyone away for lack of ability to pay. I couldn't be more excited by the growth of my clinic and the number of patients we are able to help. I am also lucky to have a staff that fully believes in the mission and vision of the clinic. Our only concern is that by not passing this bill, at some point we may no longer be able to practice in a cost effective way that benefits our patients. As more DPC clinics start up across our state I am hoping this is one bill we can all come together on. I believe we all have the same goal at heart - that we want what is in the best interests of our patients. We want our patients to be able to receive high quality, affordable healthcare and have options to do so.

Thank you for your time and consideration.

Wendy Molaska, MD, FAAFP

Pivotal HEALTH

February 12, 2025

From: Sal Braico
Chief Executive Officer
Pivotal Health, Inc.
Middleton, WI
sal.braico@pivotalhealth.care
(888) 688-4746

Testimony Before the WI State Senate Committee on Health Regarding Senate Bill 4 and the WI State Assembly Committee on Health, Aging, and Long-Term Care Regarding Assembly Bill 8

Chairman and Members of the Committee:

Thank you for the opportunity to testify today in support of Senate Bill 4 And Assembly Bill 8, which would provide clear legal framework for Direct Primary Care (DPC) agreements in Wisconsin. As the CEO of Pivotal Health, a Wisconsin-based healthcare company that provides innovative care delivery through house calls and telehealth services, I witness daily how the traditional healthcare payment model creates barriers to accessible, affordable care.

Direct Primary Care represents a transformative approach to healthcare delivery that benefits both providers and patients. Our experience at Pivotal Health demonstrates that when we remove the complexity of insurance from routine healthcare, we can deliver higher quality care at lower costs. Since October 2023, we have transitioned to a Direct Primary Care model, offering our patients unlimited access to primary and urgent care services for a transparent monthly fee.

This legislation would accomplish three crucial objectives:

First, it provides clear legal certainty that DPC agreements are not insurance products. This distinction is vital for healthcare innovation. While we recognize it's in the best interests of patients to maintain health insurance, the direct relationship between provider and patient for routine care reduces administrative overhead and allows us to focus on delivering care rather than managing claims.

Second, the bill establishes important consumer protection. The requirements for valid DPC agreements - including clear disclosure of terms, transparent pricing, and specific termination provisions - ensure that patients understand exactly what services they're receiving. The bill's prohibition on providers terminating agreements based on health status protects our most vulnerable patients.

Third, this legislation preserves provider autonomy while ensuring patient protection. At Pivotal Health, we've seen how this model allows us to spend more time with patients. Our providers can make house calls, provide telehealth services, and manage chronic conditions without the constraints of insurance-driven visit times and documentation requirements.

Let me share a specific example of how DPC benefits Wisconsin residents. Through our membership model, we provide unlimited urgent care and primary care house call visits, chronic disease management, and most diagnostic labs for a predictable, low monthly fee. This approach has proven particularly valuable for patients with chronic conditions like diabetes, hypertension, and COPD, who need regular monitoring and adjustments to their care plans.

With our direct employer model, we help employers and their employees significantly reduce the cost of healthcare while making healthcare more convenient and accessible.

The bill's provisions align perfectly with our experience of what makes DPC successful:

- Clear written agreements
- Transparent pricing
- Comprehensive service descriptions
- Explicit patient rights and responsibilities
- Protection against discriminatory practices

I want to emphasize that this bill maintains appropriate regulatory oversight while removing unnecessary barriers to the DPC model. It preserves the authority of the Department of Safety and Professional Services and the Office of the Commissioner of Insurance to protect consumers, while creating a clear pathway for innovative care delivery models.

In conclusion, Senate Bill 4 and Assembly Bill 8 would provide a solid foundation for expanding access to affordable primary care across Wisconsin. It protects consumers while allowing healthcare providers to innovate and deliver more personalized care. I strongly encourage this committee to support this legislation.

Thank you for your consideration.

The Alliance
Self-Funding Smart ®

Testimony in Support of Senate Bill 4/Assembly Bill 8

Melina Kambitsi, PhD - The Alliance

Senate and Assembly Committees on Health

February 12, 2025

I am Melina Kambitsi, SVP of Business Development and Strategic Marketing for The Alliance, a not-for-profit cooperative created 35 years ago by Wisconsin employers to enable them to combine their purchasing power when it comes to healthcare. With our help, employers are able to work with thousands of doctors, hospitals, and other clinicians to deliver the highest value healthcare possible to employees. This is important because every dollar going into health benefits is one that could otherwise go into employee wages and the broader economy. In fact, employers have a fiduciary duty under federal law to ensure the money we spend on health benefits is cost-effective - a duty we take seriously.

That's why I'm here on behalf of employers to speak in favor of AB 8 and SB 4 and explain how Direct Primary Care providers are a critical piece of our mission to take care of our employees with affordable, high-quality healthcare that they trust.

In Wisconsin, many working adults and families receive their health coverage through a self-funded employer. Self-funding means that instead of sending a check to an insurance company every month, the employer takes on the responsibility of paying the claims for medical care and prescription drugs themselves. Self-funding gives employers much more control over how their money, and their employees' money, is spent.

Many of our employers have found that on-site, near-site or shared-site clinics are a win-win for the company and their employees. This is when the employer creates a medical clinic within or near their buildings, or maybe works with other employers to do so, and hires a licensed clinician or clinicians to provide primary and preventive medical care to their employees. Oftentimes, those clinicians are Direct Primary Care providers. The employees love it – the care is oftentimes free to the employee, and it is incredibly convenient to simply go downstairs or down the street to receive care. Employees are able to spend more time with their doctor or NP, resulting in trusted relationships between doctor and patient.

Employee satisfaction is enough of a reason to pursue this model, but the cost savings that are associated with this type of care delivery are significant for both employers and employees. We have employers using onsite clinics that haven't seen a premium increase in five years or more. But the cost savings aren't simply a result of a more efficient, capitated payment model. It goes deeper than that.

We as a nation are only spending around 5 percent of the total medical spend on primary healthcare, but primary care providers are directing a significant percentage of the remainder of the dollars. They are guiding patients to specialty care, to hospital care, to labs and imaging.

And most of the primary care providers in this state are now working for healthcare systems keeping care within the system.

Direct Primary Care is different. It's PCPs that are operating independently of a larger hospital system. And this is vital to an employer that is working to steer their employees to the highest value healthcare possible, which may be one system for knee replacements and another system for heart issues and somewhere else altogether for pain management or imaging. And at The Alliance, we are able to access objective data through WHIO and other data sources to help us identify the highest value providers, to measure not just price but quality, and give that information to DPCs that are using it refer care.

The below illustrates the incredibly cost saving opportunities we have if we can just get more independent clinicians practicing in this state. SB 4 and AB 8 are important steps in the right direction.

Steerage Procedure Group	Entire Network		
	Estimated Cost for Non-Preferred Value Provider	Estimated Cost for Recommended Preferred-Value Provider	Estimated Savings
Back Surgery	$26,220	$9,000	$17,220
Carpal Tunnel	$8,148	$2,950	$5,198
Cataract Surgery	$10,728	$3,400	$7,328
Colonoscopy	$6,898	$1,900	$4,998
CT	$2,669	$330	$2,339
EGD	$7,375	$1,700	$5,675
Hip Replacement	$39,761	$22,000	~~$61~~ 17,761 typo
Knee Arthroscopy	$17,720	$5,710	$12,010
Knee Replacement	$43,207	$22,750	$20,457
MRI	$3,464	$450	$3,014
Shoulder Repair /Rotator Cuff	$32,456	$10,670	$21,786
Spinal Fusion	$77,927	$28,100	$49,827

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February 11, 2025

Subject: Support for Assembly Bill 8 / Senate Bill 4 – Direct Primary Care

To the Honorable Members of the Assembly and Senate of the State of Wisconsin:

We are currently in a moment of dramatic transformation. Transformation of our federal government, transformation of our economic and financial systems, transformation of communications and technology, and transformation of healthcare. This transformation provides a unique opportunity and an obligation to ensure that the transformation is toward a better system, not one that reinforces and makes permanent the institutions, systems, and dysfunctions of the present day.

For too long, patients have been trapped in a system that puts insurers and bureaucracy before their health. A system where consumer choice is a thin illusion, and market forces that should correct for unethical practices and abuse have no effect. A system where the entirety of our access to care is determined by a model tailored toward Insurance. In which employers, not individuals, choose that insurance, and insurers not patients, dictate providers and care. And in that paradigm, despite the best efforts of our legislators demanding transparency, real costs are still hidden behind layers of complexity and obscurity that make affordability an illusion rather than a reality, and accessing healthcare an anxiety-inducing trial for many.

There are however, valid, viable alternatives that restore patient freedom, ensure cost transparency, and make quality care accessible to all. One such model is Direct Primary Care, or DPC. And we must change our laws to protect it and give it the credibility and legitimacy that it deserves.

DPC is an antidote to a broken system. Instead of billing insurance for every visit, test, or procedure, DPC operates on one of two simple models: A fee per service that doesn't obscure the real cost behind arcane coverage rules, copays, deductibles, and claims exchanges or a membership in which patients pay a flat monthly fee—often less than a cable bill—to have

unrestricted access to their doctor and clinical services. No variable co-pays. No deductibles to track and fight over, No surprise bills. Just clear, predictable costs and a direct relationship between provider and patient.

Patients choose their physician not their insurance company. They get care when they need it—not when a poorly trained AI model with an automated MD's rubber stamp decides it's "medically necessary."

Patients deserve to know exactly what they're paying and what they're getting—not weeks later by having to correlate an "Explanation of Benefits" to a bill filled with surprise (and often erroneous) fees.

In contrast to the insurance model, Direct Primary Care (DPC) aligns provider incentives toward patient health and cost reduction by prioritizing proactive, preventive care over costly, reactive treatment. Unlike other models, which reward volume and increasing complexity of care on the provider side, and restricting care on the payment side, PMPM ensures providers are financially motivated and empowered to keep patients healthy, engaged, and out of costly interventions.

By focusing on early intervention, chronic disease management, and timely access to care, DPC providers reduce unnecessary demand on emergency departments, excess hospitalizations, and specialist referrals—lowering overall healthcare costs while improving patient outcomes. This model fosters long-term relationships, continuity of care, and an emphasis on wellness, making healthcare both more effective and more affordable.

And we know this model works because we have the data and studies from the Actuarial Associations to back it up.

This is what healthcare should be: Accountable, Accessible, Affordable.

Yet, a regulatory structure designed for insurance-based care hinders DPC's growth. Unnecessary restrictions on medical payment models, conflicting guidance between state and federal bodies, licensing rules designed for insurers, and allowing collusive anti-competitive practices between insurers and hospital networks push DPC providers out of the market, and reducing choices for your constituents. It's a tilted table, and it is tilted away from the most important people in the equation: the patients.

If we are going to truly advocate for free markets, if we believe in patient agency, then we must break down these barriers. We need legislation that recognizes DPC as a legitimate,

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independent alternative—not one that forces it to play by insurance industry rules. We need to remove restrictions that prevent doctors from offering direct care without interference. And we must stop policies that exclude people from sensible options, cutting them off from innovative, affordable alternatives like DPC.

To leave things as they are is to deny patient freedom. It is to accept a system where conflicting interests—not individual health—come first. Where access is determined by a third party, not a person's own needs. And where affordability remains an illusion for tens of thousands of the citizens of our state.

DPC isn't just a different way to do healthcare—it's a better way. A freer way. A way that restores the relationship between doctors and patients without interference. And it's time our laws reflected that. Let's take healthcare out of the hands of bureaucracies and back into the hands of the patients by protecting and expanding Direct Primary Care.

Thank you,

A.J. Moore

Director of Business Development & Strategy

ViaroHealth

BADGER INSTITUTE

Free Markets ▪ Opportunity ▪ Prosperity

Feb. 12, 2025
ASSEMBLY BILL 8

Chairman Moses and members of the Assembly Committee on Health, Aging and Long-Term Care,

Thank you for considering this extremely important piece of legislation on direct primary care. The Badger Institute is wholeheartedly in support. In fact, we have been pushing for a path toward direct primary care in this state for years for a fundamental reason: Healthcare in Wisconsin is too expensive and in decline.

We are now ranked 33rd in heath outcomes, according to America's Health Rankings — a precipitous drop from prior years.

Wisconsin's ranking for children's health outcomes is even worse, dropping to a record low of 39th in 2024.

Health costs, meanwhile, have soared. Our state has the highest hospital costs in the Midwest — and sixth highest in the country, according to the latest independent RAND Corporation report.

We're not alone. A December 2024 Gallup report showed record dissatisfaction with the health system nationally because of rising costs, denials by insurance companies, and a failure of the public health profession's handling of COVID.

Fortunately, Wisconsin has excellent physicians, nurses and other health professionals who can help get us back on track. Direct primary care is one way to accomplish that.

Direct primary care is healthcare directly from a provider to a patient, bought with cash instead of insurance. It is different than "concierge medicine," typically less expensive, with monthly fees of $50 to $150. In exchange, a patient can readily access a wide range of primary care services, personalized and comprehensive, without the high copays and deductibles now typical of insurance.

While it can mean lower costs, the first advantage is its focus on the relationship between patient and provider, with the delivery of a personalized and comprehensive experience preferred by patients.

And by providers: It means care delivered without the intervention of insurance and insurance's bureaucracy — the "medical industrial complex," as former American Medical Association president Barbara McAneny called it.

DPC has been catching on, with average annual growth of 36% per year reported as of 2022. There are now more than 2,400 DPC practices nationwide, including many in Wisconsin.

DPC and insurance are complementary: Patients can use insurance for costly procedures outside the scope of routine primary care. For most care, however, no approvals are needed, so care can be obtained faster and at lower cost.

DPC is not meant to replace insurance, and it is not insurance — so it should not be regulated as if it were insurance. Such a regulatory assumption would restrict providers' flexibility to innovate the model, and it would negate at least some of DPC's cost and service advantages.

DPC legislation in Wisconsin

More than 30 other states have already enacted laws similar to the one now again being considered in Wisconsin. A similar bill was considered in the last session but failed to make it out of the Senate.

There's good reason to hope it has more success this time around. It is good for consumers to learn that they can sometimes pay cash and sometimes use insurance, and that the two approaches are complementary. While incumbent players in an anticompetitive healthcare system might resist, direct payment will control costs while also empowering patients, physicians and employers that pay for benefits.

Patrick McIlheran
Policy Director
Badger Institute

I am an author and professor at Concordia University and Walsh College, and have held healthcare policy summits at Concordia for many years.

Healthcare spending continues to grow. This bill being considered provides a solution that could make healthcare services both cheaper and more accessible via direct primary care (DPC).

Under DPC, patients receive care from physicians or other providers without the involvement of insurance. DPC and insurance are complementary, though. Patients can choose to use their insurance for more expensive procedures. Under a DPC arrangement, typically with an individual physician or a small physician group, patients pay a monthly fee, typically $40 to $100, in exchange for a wide variety of services. Membership is voluntary and can be canceled or entered into at any time. Patients have 24/7 access to comprehensive and personalized primary care. Lab tests and imaging are offered at nominal extra cost.

The arrangement avoids bureaucracy, paperwork and costly claims processing. Physicians do not engage in any kind of risk analysis for billing and consider age only in deciding how much to charge for membership rates. No approvals are needed for procedures or services, so the physician and patient are more empowered. Care can be obtained faster and at lower cost.

DPC is not meant to replace insurance and is not insurance — so should not be regulated as insurance. Regulating DPC as if it were insurance would restrict providers' flexibility to innovate and at least partly negate DPC's cost and service advantages that stem from having less overhead for expenses such as the large buildings, infrastructure and administrative staff of hospitals.

More than 30 other states have already enacted laws similar to the one now again being considered in Wisconsin. A similar bill was considered in the last session but failed to make it out of the Senate. There's good reason to hope it has more success this time around. It is good for consumers to learn that they can sometimes pay cash and sometimes use insurance, and that the two approaches are complementary.

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