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Senator Kapenga Testimony
Legislative Council Study Committee on Direct Primary Care
Wednesday August 29, 2018 Public Hearing

Thank you Chairwoman Darling and committee members for hearing my testimony regarding Direct Primary Care (DPC). I will also speak on Senate Bill 670 and Assembly Bill 798, legislation that Representative Sanfelippo and I authored this past session. These bills had three main components. The first sought to direct the Department of Health Services to draft a pilot program to study integration of Direct Primary Care into the Medicaid system. The second portion of the bill was inspired by language that 24 other states have passed, exempting DPC from the insurance statutes, protecting private practices from being inaccurately regulated. The third portion added consumer protection language preventing discrimination in patient selection as well as additional disclosure requirement to ensure patients understand the agreements.

There is widespread agreement across the political spectrum that the rising costs of care and coverage are problematic. A recent Wall Street Journal article by Joseph Walker analyzed rising healthcare costs and commented that "a big part of the problem in analyzing health spending is the opacity of the industry," Walker continued "the bulk of consumers' health spending now goes to insurance, a shift from when patients paid directly for health services." Countless articles and studies have credited the breakdown of the doctor patient relationship in exacerbating rising costs and the growing physician and patient dissatisfaction with the healthcare system. Direct Primary Care (DPC) brings doctors and patients back together by offering unmatched access to physicians, unlimited primary care services, and unbeatable pricing.

Direct Primary Care is not a new or complex issue. This model has existed in the United States for decades and the first DPC legislation was enacted in West Virginia in 2006. As we debated our legislation this session, opponents worried that DPC practices would poach young, healthy payers and contribute to a death spiral within the insurance industry. Not only is there no evidence to support that hypothetical scenario, but there is evidence to the contrary. DPC legislation was enacted in Washington State a decade ago with practices open well before then. Data from Washington State showed 97 percent of DPC patients in 2017 had insurance. In the decades that DPC practices have been in existence, there has been no measurable impact to the insurance market, nor has it affected health systems ability to staff hospitals. In all but two states, DPC legislation has passed with bipartisan support, and in many states with direct input from the insurance market. For example, in Nebraska, the insurance industry had initial reservations, but ultimately became a supporter and partner in the effort.

The Office of the Commissioner of Insurance has stated multiple times that DPC contracts are not insurance by affirming that DPC doctors do not assess risk. Additionally, we accepted changes proposed by health insurers adding language to prevent selection based on age, health status, and pre-existing conditions. Additional language made changes requiring disclosure that payment may not count toward patient

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deductible, requiring that DPC doctors who work with insurers comply with carrier's terms of participation, etc. Ultimately, the choice is to regulate DPC out of existence or join 24 other states and continue to let DPC patient's contract with doctors who are applying an innovative healthcare model and delivering results.

At the most basic level, DPC laws are about protecting the ability of patients to choose a healthcare delivery model that works best for them. In addition, these laws recognize the potential benefits of price transparency and reduced administrative red tape. DPC also has the potential to generate savings for Medicaid and insurers through a reduction in utilization and fixed cost of care. In the first meeting of this committee, DPC doctors gave real life examples of savings, including:

- An EKG for 36 cents rather than $100.00;
- Stitches for $11.00 as opposed to $2000.00;
- Chemotherapy for $6.00 per month instead of over $700.00 per month; and
- Osteoporosis medication for $12.00 annually rather than $300.00 quarterly.

These are services that patients in the private market pay for in premiums, deductibles, copays and coinsurance often totaling more than the cost of annual DPC membership. It is undeniable that the potential exists for savings to consumers as well as the state with the DPC model. The federal Department of Health and Human Services also recognizes this potential and is urging states to incorporate DPC into their Medicaid programs. HHS guidance acknowledges that DPC arrangements could improve access, health outcomes, and strengthen the doctor patient relationship.

Studies also suggest that the DPC model could help with a potential physician shortage by providing additional avenues for doctors facing burnout to continue to practice medicine. The American Journal of Medicine, citing research by the University of California, Riverside School of Medicine, wrote "The doctor–patient relationship has sustained the happiness of both doctors and patients for generations. This centuries old relationship has only recently been threatened by a de facto insurer–employer–provider relationship." The publication goes on to explain how mandates on physicians and the destruction of the doctor patient relationship are the primary contributors to the spike in physician burnout. Their data shows an increase from 45.5% to 54.4% physician burnout, with more than half also saying that work was less meaningful. DPC inherently repairs the bond between doctors and patients, potentially improving job satisfaction and physician retention. I would encourage you to refer to the testimony provided by the Wisconsin Medical Society for more detailed information.

Direct Primary Care is a rare win-win situations whereby patients can receive unlimited access to great care at and pay less for it. I authored this bill because DPC simply makes sense. Free market healthcare is already delivering results in Wisconsin and our bill empowers patients and physicians to decide what model of care works best for them. Lastly, our bill seeks to pilot the successful and simple principles that DPC exemplifies in our state run health plans to learn more about potential improvements to benefit all stakeholders involved. We should make every effort to allow consumers to utilize this care model and examine it for potential improvements to our Medicaid population.

Thank you, Chairwoman Darling and Committee members, for your time and consideration of this bill.