WISCONSIN LEGISLATIVE COUNCIL

MEETING MINUTES

STUDY COMMITTEE ON DIRECT PRIMARY CARE

Room 412 East
State Capitol
Madison, WI

September 18, 2018
10:00 a.m. – 2:10 p.m.

Call to Order and Roll Call

Chair Darling called the meeting to order. A quorum was determined to be present.

COMMITTEE MEMBERS PRESENT:	Sen. Alberta Darling, Chair; Rep. John Nygren, Vice-Chair; Sens. LaTonya Johnson and Tom Tiffany; Reps. Mary Felzkowski and Debra Kolste; and Public Members Greg Banaszynski, Coreen Dicus-Johnson, Suzanne Gehl, Maureen McNally, Tim Murray, Mark Rakowski, and Elizabeth Trowbridge.
COMMITTEE MEMBERS EXCUSED:	Public Member Bob Van Meeteren.
COUNCIL STAFF PRESENT:	Brian Larson, Senior Staff Attorney; and Andrea Brauer, Staff Attorney.
APPEARANCES:	Steven Hook, Vice President of Business Development, Paladina Health; Traci Dehring, Colleen Prostek, Kelly Zimmerman, and Chad Waldron, DPC patients.

ATTENTION: This was the final meeting of the Study Committee on Direct Primary Care. Committee members are requested to send any corrections regarding these minutes to the Legislative Council staff. After the incorporation of any corrections, these minutes will be considered approved by the committee.

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Approval of the Minutes of the August 29, 2018 Meeting

Ms. Dicus-Johnson requested two corrections to the minutes of the August 29, 2018 meeting. First, she requested that the last sentence under the description of observations from Tim Lundquist be revised to state: "If legislation is recommended, Mr. Lundquist urges the committee to not exempt DPC from state insurance law, to designate a state agency for oversight, and to require DPC practices to provide proof of financial responsibility." Second, she requested that the description of committee discussion of options and plans for future meetings be revised to include a statement that the committee discussed recommending no legislation as an option.

> *Ms. Dicus-Johnson moved, seconded by Chair Darling, that the above corrections be accepted, and that the minutes of the August 29, 2018 meeting be approved with the corrections. The motions passed by unanimous consent.*

Discussion of Direct Primary Care Model by Providers and Patients

Traci Dehring, DPC patient and mother of a DPC patient

Colleen Prostek, DPC patient

Kelly Zimmerman, DPC patient

Chad Waldron, DPC patient

The committee heard from four individuals, who are DPC patients of Dr. Gehl and Solstice Health, Dr. Murray's DPC practice. The patients described their positive experiences with DPC, including their relationships with the DPC providers. Ms. Dehring, whose young daughter is a DPC patient, described a number of incidents in which Dr. Gehl provided care to her newborn, including during weekend and evening hours. Ms. Prostek, Ms. Zimmerman, and Mr. Waldron also described the care they receive from Solstice Health.

The patients expressed that they are satisfied with the price of the monthly DPC fee. Ms. Zimmerman stated that, in her opinion, high insurance deductibles can limit access to care, and her DPC membership allows her to access primary care while she is looking for an insurance plan. Ms. Dehring and Mr. Waldron purchase insurance plans to supplement their DPC memberships, and Ms. Prostek supplements her DPC membership with Medi-Share. All four patients stated that they understand DPC is not insurance, and believe that the terms of their DPC agreements are clear. They also explained that the DPC providers have negotiated for them to obtain certain services outside of the DPC agreement, such as x-rays, at cost. In response to committee questions, the patients stated that they do not have consumer protection concerns related to DPC, and if they were unhappy with the services, they could cancel the agreement.

Steven Hook, Vice President of Business Development, Paladina Health

Mr. Hook presented to the committee about Paladina Health, a company that operates primary care clinics for employers, and employs 50 DPC physicians across 11 states. Mr. Hook stated that Paladina generally contracts with employers that have self-funded health insurance plans to provide DPC to employees at on-site workplace clinics as well as clinic-based care. In Wisconsin, Paladina employs nine physicians, and contracts to provide primary care services to 16 employers, covering approximately 3,500 patients.

Mr. Hook presented information regarding cost savings that Paladina has achieved, and stated that Paladina aims to make primary care more accessible, align physician incentives with patient health, and focus on prevention of chronic conditions such as diabetes. Paladina charges employers a capitated rate by member, and pays its physicians a yearly salary, with bonuses for attaining certain metrics, including, for example, patient satisfaction. Mr. Hook stated that he does not believe Paladina has experienced any specific regulatory challenges in Wisconsin, and that the main regulatory issue facing DPC is the fact that federal law does not generally allow patients to use their health savings accounts to pay DPC fees.

Discussion of Committee Assignment

Chair Darling directed the committee to discuss the following four questions, with the goal of reaching a consensus where possible: (1) whether DPC should be statutorily exempt from state insurance law; (2) what the definition of DPC is; (3) whether additional consumer protection requirements are needed for DPC; and (4) whether there should be a DPC pilot in the state Medicaid program. Twenty-five states have enacted DPC legislation, and Legislative Council staff provided a brief overview of other states' laws, referencing the following two documents: "Options for Committee Discussion" (September 11, 2018); and Memorandum to Chair Darling, "Comparison of Provisions in State Direct Primary Care Legislation" (September 17, 2018).

Should DPC be Statutorily Exempt From State Insurance Law?

Committee members were divided on the question of whether DPC should be statutorily exempt from state insurance law. During the committee's discussion, the question was raised whether Wisconsin needs DPC legislation. Members discussed the Office of the Commissioner of Insurance's (OCI) approach to regulating DPC, and consumer protection requirements that apply to DPC under current law. The committee also discussed the advantages and disadvantages of leaving the statutes silent on DPC, as compared to defining it in statute.

Some committee members stated that OCI should continue to determine whether DPC providers are offering insurance on a case-by-case basis. Currently, OCI does not generally recognize DPC as insurance, and it was noted that the committee did not hear testimony that there are significant barriers to DPC practices in Wisconsin under current law. Several members indicated that they would prefer to leave DPC out of state statutes, which they said would allow innovation to continue while retaining OCI's ability to consider risk distribution and other nuances in determining whether a DPC practice may border on the definition of insurance. Some members expressed the opinion that the DPC model is too new and difficult to define to create a statutory exemption. Committee members also discussed the option of directing OCI to issue guidance or promulgate an administrative rule regarding DPC, rather than placing DPC into the statutes, but the committee did not reach consensus on this issue.

Other committee members expressed their view that Wisconsin should enact DPC legislation, that defines DPC in statute and clearly exempts it from regulation under state insurance laws. They said that providing legal certainty to existing DPC practices would allow the model to grow. Several members stated that enacting DPC legislation would clarify DPC for consumers and allow consumer protection provisions, such as mandatory disclosures and contract terms, to be placed into statute. Members also stated that it is important to statutorily exempt DPC from state insurance regulation, because OCI could otherwise change its interpretation in the future. Several members argued in favor of DPC legislation similar to 2017 Assembly Bill 798, as amended ("the bill"). They said that DPC practices in states that have enacted DPC legislation are functioning without harm to consumers or the insurance market, that DPC has existed since the 1990s and is not too new to define, and that they would like the bill to be enacted next session.

Chair Darling asked members to indicate whether they think DPC should be placed in statute. She noted that less than half of the present members indicated they were in favor of recommending DPC legislation.

What is the Definition of DPC?

Committee members disagreed about how to define DPC. Some members supported the definition of DPC used in the bill,[1] while others said they thought it was too broad. There was disagreement about what range of health care practitioners should be permitted to offer DPC. Some members commented that any licensed health care provider acting within his or her scope of practice should be allowed to offer DPC. Other committee members commented that DPC practices should align with the examples of DPC providers the committee had discussed, which typically involved physicians, sometimes working with other health care practitioners in a team setting, but did not generally involve other types of licensees.

Committee members were also divided with regard to the range of services a DPC practice should be authorized to provide. Some committee members stated that they agreed with the provision in the bill, which allows DPC to cover "screening, assessment, diagnosis, and treatment for the purpose of promotion of health or the detection and management of injury." Others stated this language is too broad, and could potentially include specialized medicine that is outside of the scope of primary care.

In addition, committee members discussed whether DPC should be defined based on how the payments are structured, as opposed to the type of care that is being provided, but the committee did not reach consensus on this issue.

Are Additional Consumer Protections Needed for DPC?

Some committee members expressed the view that strong consumer protections would be needed if DPC were statutorily exempted from state insurance law. Committee members generally agreed that if DPC legislation were enacted, it should include some required disclosures and other consumer protection provisions, which could be similar to those in other states' DPC laws. Some committee members commented that consumer protections are included in the bill and that under both current law and the bill, DPC providers would be subject to

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[1] The bill defined a DPC agreement to mean a contract between a "health care provider" (which includes a long list of licensed health care professionals) and an individual patient or his or her legal representative or employer, in which the health care provider agrees to provide "routine health care services" (defined to mean "screening, assessment, diagnosis, and treatment for the purpose of promotion of health or the detection and management of injury") to the individual patient or employees for an agreed-upon fee and period of time.

professional licensing standards, as well as general contract law and other state laws that prohibit unfair trade and business practices.

<u>DPC Medicaid Pilot</u>

Finally, the committee discussed whether a DPC pilot should be created in the state Medicaid program. Some members stated that they are in favor of a Medicaid pilot because it could positively affect health outcomes, and they are interested in expanding and testing DPC. Other members stated that the Medicaid population is not the right group for testing DPC, and it is unclear how a Medicaid pilot would save money, at least in the short-term. Some members also expressed concern that a pilot could take funds away from other types of care. It was also noted that there are few examples of other states incorporating DPC into Medicaid. Chair Darling noted that Michigan has recently started a DPC Medicaid pilot, but results of the pilot are not yet available, and Wisconsin recently enacted legislation to create an intensive care coordination Medicaid pilot, which has a similar goal of focusing resources on preventive care.

Some members also noted that Nebraska and New Jersey have created DPC pilots in their state employee health plans, rather than in Medicaid, and they suggested that this should also be considered as a population for testing DPC in Wisconsin.

<u>Recommendations</u>

Chair Darling thanked committee members for their participation in the robust discussion, and said she found two areas in which the committee could reach a consensus. She asked the committee to vote on the following recommendations:

> *<u>Recommendation 1</u>: The Study Committee finds that direct primary care is a valuable component of Wisconsin's health care market. (Approved by unanimous consent.)*
>
> *<u>Recommendation 2</u>: The Study Committee recommends that the Group Insurance Board should explore the possibility of integrating an employer-sponsored direct primary care program into the state employee health plan under its current structure, and submit any recommendations to the standing committees in each house of the Legislature with jurisdiction over health and the Joint Committee on Finance. (Approved by unanimous consent.)*

With regard to the other topics of committee discussion, Chair Darling determined that the committee could not reach a consensus on: whether Wisconsin should enact DPC legislation; how DPC should be defined; whether DPC is insurance; what consumer protections should be required for DPC providers; and whether there should be a DPC Medicaid pilot. She informed the committee that it had concluded its work, and thanked members and staff for their service.

Adjournment

The meeting adjourned at 2:10 p.m.

AB:jal

[The preceding is a summary of the September 18, 2018 meeting of the Study Committee on Direct Primary Care, which was recorded by WisconsinEye. The video recording is available in the WisconsinEye archives at http://www.wiseye.org/Video-Archive.]