CHRIS KAPENGA
WISCONSIN STATE SENATOR

Testimony on SB 670/AB 798
Committee on Public Benefits, Licensing and State-Federal Relations
Thursday January 11, 2018 Public Hearing

Thank you committee members for hearing testimony on SB 670 today, regarding direct primary care. This bill has two main components. The first part defines direct primary care in statute, while the second directs the Department of Health Services (DHS) to implement a direct primary care pilot program in Medicaid.

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

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

SB 670 also directs the Department of Health Services to establish a pilot program for Medical Assistance recipients to study how the model could be integrated into our MA program to drive improved efficiencies, health outcomes and cost savings that have been seen in the Direct Primary Care model. In the last decade, Medicaid spending has continued to balloon, accounting for almost 20% of our entire state budget.

Thank you, Mr. Chairman and Committee members, for your time and consideration of this bill. At this time I am happy to answer any questions from the committee.

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January 11, 2018

State Rep. Joe Sanfelippo's Testimony on 2017 Senate Bill 670

Chairman Kapenga and committee members, thank you for holding a hearing on Senate Bill 670 relating to direct primary care program for Medical Assistance recipients and direct primary care agreements.

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

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

2017 Senate Bill 670 allows health care providers and individual patients to enter into a direct primary care agreement. A direct primary care agreement, which is not health insurance, is a contract in which a health care provider agrees to offer routine health services for a specified fee over a stated time period.

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

The federal government is encouraging states to incorporate direct primary care programs into Medicaid systems in order to increase access, for example, to physicians who currently do not see Medical Assistance patients, and to improve the quality of life for members and control costs. A carefully crafted, successful Medicaid Pilot could once again make Wisconsin the national leader in innovative health care similar to our respected managed care model.

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

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

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

2017 Senate Bill 670 will give our constituents greater access to health care and more options. Wisconsin businesses and citizens struggle daily to pay the high cost of health care thrust upon them as a result of the one-size-fits-all approach dictated by the federal Affordable Care Act. Gaining insurance through federal mandates does not improve the lives of our citizens who are unable to utilize the coverage because they cannot afford the copays and deductibles. Direct primary care offers unlimited access at fixed, transparent, and affordable rates.

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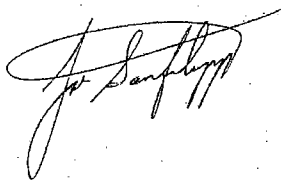
I would like to thank Senator Patrick Colbeck from Michigan for submitting testimony to the committee today and sharing his deep knowledge on this important issue. Senator Colbeck has been a leader on direct primary care for a long time, and I would encourage all committee members to please read his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

Again, thank you for holding a public hearing on 2017 Senate Bill 670. Please contact my office with any questions.



SOLSTICE HEALTH

Testimony

January 11, 2018

Direct Primary Care

Testimony before the Committee on Public Benefits, Licensing, and State-Federal Relations in support of SB 670

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

Chairman and Members of the Committee,

I'd like to first thank Senator Kapenga, and each of you, for the invitation to testify at this very important hearing regarding Direct Primary Care (DPC) and SB 670. I'd also like to thank Rep. Sanfelippo for taking the time and effort last year to learn more about DPC and how it has and will continue to shape the landscape of healthcare delivery. I count it an honor to appear before this Committee to discuss a proven model and how it can be implemented to allow access to the best Primary Care for Wisconsinites of all income levels and beyond.

My name is Timothy J. Murray. I am the Founder & CEO of Solstice Health, a thriving DPC clinic, leveraging an integrative medical approach, with multiple locations in the SE Wisconsin market. Over the past 7 years, we have found that education about DPC and our healthcare system is likely the most crucial aspect of our mission. I trust most of us in the room have some knowledge of DPC, but I'd like to offer a brief description, starting with what DPC is not. DPC is not insurance. This is important to understand not only as we discuss SB 670, but also at the Federal level. Also, it is not concierge medicine, with overpriced access fees and a fee for service model which still leverages insurance. DPC is a paradigm shift in healthcare delivery. It is an age-based, monthly membership style, direct primary care model. With unlimited visits, no copays, and no deductibles, patients are guaranteed to get the time and attention they deserve. By eliminating insurance and associated bureaucracy, providers are available when patients need care, which allows for same day or next day appointments, as well as phone, email, or virtual visits 24/7. Within this model, members have unlimited access to wholesale labs, pharmaceuticals, and imaging, creating 80-90% savings. In addition to those savings, we have same-day access to over 100 specialists through eConsults, which decreases downstream utilization by 40%, increases quality of care, and provides a more comprehensive treatment plan in one location. The reality of that brief description, is evidence that DPC is a powerful catalyst toward comprehensive knowledge of the healthcare system, which evades the population at large, due to a lack of transparency, and is critical for our leaders to understand as they put forth new legislation at the State and Federal level.

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

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

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

In Sections 10104 and 1301, the ACA does in fact recognize the benefits of DPC, however, there are some handicaps at the State and Federal level including how DPC is implemented within the structure of the ACA and associated healthcare exchanges. Arbitrary statutes within the IRS Code related to Health Savings Accounts and assuring payments from Medicare beneficiaries are for "non-covered services", unless a provider opts out completely, are additional hurdles at the Federal level which are being addressed. Medicaid laws, on the other hand, do not prohibit states from paying providers a capitated rate for beneficiaries, which brings us to SB 670. As laid out before this Committee, DPC is positioned to deliver and unmatched and easily accessible healthcare experience for Medicaid patients in Wisconsin. Evidence has shown that DPC patients face lower hospital admissions rates and fewer ER and specialist visits which would translate into tremendous savings for the State Budget. A similar pilot in Michigan has projected savings of $3.4B per year if fully deployed. Another major issue addressed by SB 670 as I mentioned above, is to establish that DPC practices are not "risk bearing entities" and therefore exempt from insurance regulations. This will benefit the State with physician recruitment and retainment and promote further DPC growth.

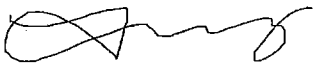
Solstice Health was the first successful insurance-free DPC clinic in the State of Wisconsin and as we continue to grow, we remain one of few full-time operations. We are committed to a transparent shift in healthcare delivery, and with your help, DPC can become accessible to many more

Wisconsinites across the income spectrum as quality care should be blinded to these measures.

DPC has been and continues to be a grassroots movement and has successfully sought to reestablish the doctor-patient relationship and eliminate bureaucracy from the exam room. With SB 670, Wisconsin would join 23 other states with active DPC legislation. I would be remiss in this setting to not communicate our desire to maintain the integrity of what we have accomplished and avoid jeopardizing the innovatively lean structure of DPC, with gratuitous regulations at any level.

In closing, I urge the Committee to carefully consider SB 670 and the positive impact it would have for the State of Wisconsin. I would also like to again thank each one of you for allowing my testimony before the Committee. Please feel free to reach out to me any time if I can be of any assistance and I look forward to working with you in the future. I would be happy to answer any questions. FORWARD!

Respectfully,



Timothy J. Murray, M.D.

Wisconsin Association of Health Plans

The Voice of Wisconsin's Community-Based Health Plans

Testimony Presented to the
Senate Committee on Public Benefits, Licensing, and State-Federal Relations
Senate Bill 670
January 11, 2018

Chairman Kapenga, Members of the Committee, thank you for the opportunity to testify today on this important legislation.

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 11 Wisconsin community-based health plans that provide employers and individuals across Wisconsin access to high-quality, integrated health care. Our members are also proud to partner with the state by serving Wisconsin's Medicaid Managed Care programs, as well as the State Group Health Program.

I am here today to express member health plans' questions and concerns about Senate Bill 670. Community-based health plans are concerned about its potential impact in Medicaid. Member health plans are concerned about the bill's potential to fragment care delivery. Finally, community-based health plans are concerned about the bill's potential to create consumer confusion.

The Wisconsin Association of Health Plans is opposed to Senate Bill 670, as drafted.

Impact in Medicaid– Senate Bill 670 requires the Department of Health Services (DHS) create a direct primary care (DPC) pilot, but leaves many questions about how DPC arrangements would work. Most individuals served by Medicaid today access health care through a Medicaid HMO, where health plans are paid a capitated rate to provide comprehensive care—including primary and specialty care. For most Medicaid members this year, HMOs will receive on average $118 per member per month.

The draft suggests a pilot program would pay primary care providers (PCP) up to $70 per member per month for primary care services. The draft suggests the PCP may also be paid a retainer by Medicaid HMOs. It is unclear how the draft envisions DPC arrangements operating inside managed care, and how the design will save state dollars.

I appreciate the bill only requires DHS engage in a pilot program, and does not itself make wholesale changes to Medicaid. However, health plans have many questions and concerns about how this model would work in Wisconsin, and its impact on care delivery and enrollee services.

Direct Primary Care Agreements – Health plans are also concerned about the potential impact of direct primary care agreements in the commercial market, as envisioned under the bill. Individuals may find value under direct primary care programs operating today in Wisconsin, but the text of the draft raises questions.

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For example, the bill authorizes an expansive list of professionals, typically not considered "primary care providers," the ability to offer "direct primary care agreements." I understand the desire to offer consumers options, but how will this work in practice?

Health plans also have concerns about the impact of increased enrollment in DPC arrangements. Health insurers today harness enormous amounts of data from integrated IT systems to work with providers of all sorts to address gaps in care delivery, and to ensure their members receive the right care at the right time. DPC arrangements could increase the fragmentation of care delivery, which leads to worse health outcomes and higher costs for consumers.

Consumer Confusion – Finally, health plans are concerned that DPC arrangements may increase consumer confusion about what is covered and where, particularly if an individual's health care needs change, and the enrollee must transition from seeking routine care to non-routine care. At that point, who is responsible for ensuring individuals have access to specialists? Who is responsible for ensuring an individual receives appropriate follow-up care? Isn't it possible the enrollee is also going to be surprised when they find out the money paid towards DPC services isn't applied to their insurance deductible?

Senate Bill 670 raises questions and concerns for Wisconsin's community-based health plans, and our Association is opposed to the legislation in its current form. I do understand the bill will likely change, and I look forward to continuing to work with bill authors and interested legislators on this proposal.

I appreciate the opportunity to testify, and welcome any questions from members of the Committee.

Testimony before the Committee on Public Benefits, Licensing and State-Federal Relations
Thursday, January 11, 2018
Charlie Katebi, State Government Relations Manager, The Heartland Institute

Chairman Chris Kapenga and Members of the Committee,

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

The reforms outlined in Senate Bill 670 to expand Direct Primary Care offer enormous promise for Wisconsinites, and especially those on Medicaid who face increasing challenges attaining medical care. Over the last 18 years, Medicaid's share of Wisconsin's budgets has risen from 11 percent to nearly 20 percent. While these rising costs certainly burden the taxpayers who pay them, they also hurt the vulnerable patients who rely on this program.

Medicaid currently reimburses Wisconsin physicians just 53 cents for every dollar they receive from private insurance. If Medicaid's costs continue to rise, Wisconsin will be forced to further slash payments to physicians which will make it all but impossible for them to serve patients in need.

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

And one of the most promising reforms is Direct Primary Care. Under this approach, physicians opt out of billing for each individual treatment and instead charge a flat monthly payment for routine services. According to physician advocates, private practices could save as much as 40 percent on their operating costs by shifting to direct pay. This is because they no longer have to spend precious time and money billing insurers and can instead spend more time treating patients.

This allows doctors to more effectively treat patients and ensure they remain in good health. A study in the American Journal of Managed Care found that individuals who receive direct primary care are 52 percent less likely to enter a hospital than patients with a traditional private practice. The authors concluded that, "increased physician interaction is the reason for the lower hospital utilization and ultimately lower healthcare costs."

Wisconsin would likewise generate dramatic taxpayers 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. And after just

one year, workers that enrolled in direct care spent 23 percent less than those who stayed with conventional physicians. This translated into an annual savings of over $3,000 for each and every patient.

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

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

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

Wisconsin Medical Society

Your Doctor. Your Health.

TO: Senate Committee on Public Benefits, Licensing and State-Federal Relations
Senator Chris Kapenga, Chair

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

DATE: January 11, 2018

RE: Testimony on Senate Bill 670

On behalf of nearly 13,000 members statewide, the Wisconsin Medical Society thanks you for this opportunity to share our testimony on Senate Bill 670, which concerns a patient contracting for direct primary care. Our Council on Legislation met in mid-December on the proposal, and

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

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

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

We understand that legislative leaders on this issue are in discussions with the state's Department of Health Services about potential amendments to the Medicaid pilot requirement. The Society is happy to assist in developing legislative language that helps ensure children's access to physician care as part of a direct primary care program for Medicaid recipients.

Thank you again for this opportunity to provide our testimony on Senate Bill 670. Please feel free to contact the Society on this and other health-related issues.

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AHI

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To: Chairperson Chris Kapenga
Members, Senate Committee on Public Benefits, Licensing and State-Federal Relations
From: R.J. Pirlot, Executive Director
Subject: **SB 670, relating to direct primary care agreements**
For Information Only
Date: January 11, 2018

Senate Bill 670 allows a health care provider and an individual patient or employer to enter an agreement whereby the health care provider agrees to provide routine health care services to the individual patient or employees for an agreed-upon fee and period of time. The bill also requires the Department of Health Services to design and implement a direct primary care program for Medical Assistance recipients.

The Alliance of Health Insurers are concerned that though bill requires such agreements clearly state they are *not* health insurance, there is some potential for some consumers to be confused about or not clearly understand how such agreements would interact with commercial insurance.

For example, the bill requires, in addition to stating such an agreement is not insurance, that the agreement:

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

In addition, the bill provides that the health care provider and the patient are prohibited from billing an insurer or any other 3rd party for the routine health care services provided under the agreement and that the individual patient must pay the provider for all services that are not specified under the agreement and are not otherwise covered by insurance.

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

In addition to these provisions, and to further help ensure such agreements are understood by consumer to be distinct from commercial insurance, AHI respectfully requests the following protections be added to the bill:

- In order to protect the integrity of our existing provider networks, a health care provider who participates in a direct primary care agreement may participate in a health insurance carrier network only to the extent that the provider is willing and able to comply with the terms of the participation agreement and meet any other terms and conditions of network participation as determined by the health insurance carrier.
- In addition to specifying the fee for the agreement, such an agreement provide that upon termination of the agreement, all unearned fees are to be refunded to the patient.
- In addition to disclosing to the consumer an agreement alone may not satisfy individual or employer insurance coverage requirements under federal law, that some services may be a covered benefit or covered service under the patient's existing health benefit plan at no additional cost to the patient.
- That the agreement prominently state, in writing, that the patient is encouraged to consult with the patient's health insurance carrier before entering into the agreement; and that direct primary care fees will not be credited against patient deductibles or out-of-pocket maximum amounts under the patient's health benefit plan.
- That the agreement prominently state, in writing, that disputes between the provider and the patient regarding a direct primary care agreement may be the subject of a complaint filed with the Department of Health Services, which has authority to investigate complaints related to direct primary care agreements.

AHI has already shared these specific suggestions with both Sen. Kapenga and Rep. Sanfelippo, the bill's authors, and are interested in continuing to work with them to address our concerns regarding such agreements in the commercial marketplace.

Regarding the provision of the bill creating the Department of Health Services to design and implement a direct primary care program for Medical Assistance recipients, we have deeper reservations which, again, we have already shared with Sen. Kapenga and Rep. Sanfelippo. Managed care plays a key role within Medical Assistance and, thanks to care coordination, plays a key role in ensuring better outcomes for participants and savings for taxpayers compared to a fee-for-service payment model.

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

As such, our preference is that section one of the bill be eliminated in its entirety. We are not aware of a state which includes a direct primary care agreement within its Medical Assistance program. Our managed care plans are happy to keep discussing more fruitful areas of reform with the bills' authors, and all other interested stakeholders, in an effort to improve upon the state's Medical Assistance program.

January 11, 2018

Michigan State Senator Patrick Colbeck Public Testimony on 2017 Senate Bill 670

I am honored to submit this written testimony in support of Senate Bill 670 and I would like to thank the sponsors of this legislation and members of the Committee on Public Benefits, Licensing, and State-Federal Relations for this opportunity. The proposed statutory changes within Senate Bill 670 offer a significant opportunity for the Wisconsin legislature to improve the access to quality health care for all of Wisconsin's citizens all while easing the burden of escalating Medicaid costs upon Wisconsin taxpayers. This opportunity is made possible via a unique health care service model referred to as Direct Primary Care Services.

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

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

It might help to think of the difference between primary care services and catastrophic services via the lens of auto insurance. Drivers do not pull out their insurance card every time they fill up with gas, change the oil or purchase new wiper blades. The costs for these items are considered part of routine maintenance. Drivers do pull out their insurance card, though, when they experience significantly more expensive events such as a collision or theft.

Health care experts across the country agree that the key to lowering the total cost of health care is preventive care. Much like changing the oil on a frequent basis prevents catastrophic engine failure, preventive primary

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care services keep patients from needing catastrophic services. Catastrophic services can be significantly more expensive than primary care services. The Direct Primary Care Service delivery model opens the door to better preventive care than traditional, insurance-based models.

How does Direct Primary Care improve preventive care? There are numerous ways but I would like to focus upon the central reason. Doctors spend less time examining their electronic tablets and more time examining their patients. It is common practice for physicians to spend almost 50% of their day on administrative activities such as CPT-coding so that they can receive reimbursements from insurance companies. In the latest guide for CPT-coding known as ICD-10, there are over 70,000 unique billing codes. As an aerospace engineer, two of my favorite ICD codes are "V97.33XD: Sucked into jet engine, subsequent encounter" and "W22.02XD: V95.43XS: Spacecraft collision injuring occupant, sequela." Direct Primary Care physicians don't have to decipher CPT-codes. They can focus upon decoding the malady of their patient. Whereas traditional primary care practices need a patient cohort of over 2,500 patients to be profitable, direct primary care practices need as few as 400 to keep the lights on.

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

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

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

It is important to point out that these savings are not obtained by rationing of care. Quite the contrary, enrollees actually receive BETTER care via enhanced attention to prevention and more time spent diagnosing patient maladies. DPC patients have been shown to spend up to 60% less time in hospitals and 14% less time with specialists. That's where the 20% savings comes from...not from denial of care.
Senate Bill 670 provides the citizens of Wisconsin with a rare opportunity to improve the quality of services while saving taxpayers money. It is my sincere hope that you will pass this legislation and join a growing number of states across the nation seeking to fix our nation's health care system by the adoption and promotion of the Direct Primary Care Service model.

Thank you for this opportunity to address this body.
Sincerely,

Patrick Colbeck

Michigan State Senator, 7th District
Sponsor of Michigan PA 522 of 2013 regarding Direct Primary Care Services
Sponsor of Michigan Direct Primary Care Medicaid Pilot

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THE SENATE
STATE OF MICHIGAN

Testimony Before Wisconsin Committee on Public Benefits, Licensing, and State-Federal Relations, January 10, 2018

I am honored to submit this written testimony in support of Senate Bill 670 and I would like to thank the sponsors of this legislation and members of the Committee on Public Benefits, Licensing, and State-Federal Relations for this opportunity. The proposed statutory changes within Senate Bill 670 offer a significant opportunity for the Wisconsin legislature to improve the access to quality health care for all of Wisconsin's citizens all while easing the burden of escalating Medicaid costs upon Wisconsin taxpayers. This opportunity is made possible via a unique health care service model referred to as Direct Primary Care Services.

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

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

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

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

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

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

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

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

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

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

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

Senate Bill 670 provides the citizens of Wisconsin with a rare opportunity to improve the quality of services while saving taxpayers money. It is my sincere hope that you will pass this legislation and join a growing number of states across the nation seeking to fix our nation's health care system by the adoption and promotion of the Direct Primary Care Service model.

Thank you for this opportunity to address this body.

Sincerely,

Patrick Colbeck
Michigan State Senator
7th District

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

Sponsor of Michigan Direct Primary Care Medicaid Pilot

WAFP

WISCONSIN ACADEMY of FAMILY PHYSICIANS

TO:	Wisconsin State Legislators
FROM:	The Wisconsin Academy of Family Physicians
DATE:	January 11, 2018
RE:	Senate Bill 670/Assembly Bill 798 – Direct Primary Care

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

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

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

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

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

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