(608) 266-0620
FAX: (608) 282-3615
Toll-Free: (888) 534-0015
Rep.Sanfelippo@legis.wi.gov

JOE SANFELIPPO

STATE REPRESENTATIVE • 15th ASSEMBLY DISTRICT

P.O. Box 8953
Madison, WI 53708-8953

June 6, 2019

State Rep. Joe Sanfelippo's Testimony on SB 28: Direct Primary Care

Chair Testin and committee members, thank you for holding a hearing on Senate Bill 28 and for inviting me to speak to you today regarding direct primary care. I am grateful that you have shown an interest in the potential that this healthcare delivery model holds for Wisconsin, and that's why I would like to talk to you about some of the issues that exist in our healthcare system and explain how direct primary care offers promise for addressing those challenges.

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

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

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

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

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

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

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

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

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

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

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

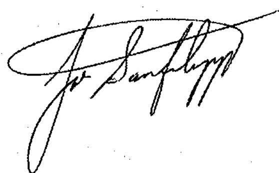
Direct primary care is not a new concept: DPC practices have existed throughout the US since the 2000s, and there has been a six-fold increase in DPC clinics since 2014. About 3% of doctors are practicing under this model nationally, and twenty-three other states have defined direct primary care in their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

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

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

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

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



CHRIS KAPENGA

WISCONSIN STATE SENATOR

SB 28/AB 26 Testimony

Senate Committee on Health and Human Services

Thursday June 6th, 2018

Thank you Chairman Testin and committee members for hearing testimony on SB 28 today, regarding direct primary care. This bill has passed in more than twenty-five states, and is currently introduced in eight. SB 28 affirms in statute that direct primary care is not insurance, provides security for consumers and providers, and adds consumer protections that do not currently exist.

This session's draft includes some changes following comments from stakeholders, last session's testimony, and the legislative council study committee. These changes include removing provisions regarding Medicaid, adding required disclosures that the product is not insurance and that it does not count towards your deductible. It also specifies agencies responsible for oversight, clarifies that no DPC practice can charge based on preexisting condition or health status, and addresses any concerns about creating a loophole for bad actors. Additionally, today we introduced an amendment to clarify that OCI still has the authority to regulate insurance products, including any invalid practice that does not abide by the terms described in the bill.

Direct primary care (DPC) is a model of care whereby a patient pays a monthly fee for a set menu of services. Direct primary care offers patients unlimited access to primary care services and significantly more time with their doctors. Additionally, price transparency means patients see a significant savings with the DPC model. Some DPC providers are delivering savings of 15 to 30 percent. Also, health outcomes improved, with data showing 35% fewer hospitalizations, 65% fewer emergency department visits, and 66% fewer specialist visits. For certain patients, DPC is a model that can provide significant benefits. However, it is not intended to be a replacement for insurance, nor a model that makes sense for all consumers. It is simply another option for consumers to consider in addition to a health plan.

Direct primary care providers are already operating successfully in Wisconsin; however, they are practicing with legal uncertainty. In Wisconsin, without a statutory definition, doctors are at risk of being regulated as insurance companies and effectively shut down. This change could happen at the whim of the insurance commissioner, causing patients to lose their doctors and doctors to lose their livelihood. Also, this change could occur despite the fact that they are actually providing a health service, not coverage for services. Twenty-five other states nationwide have already adopted to this new market, and forty-eight states 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, under both Governor Walker and Governor Evers have recognized that DPC, as defined in this bill, does not qualify as insurance.

We have worked hard to address the concerns of everyone involved, which is reflected in the support of the Medical Society this session, the neutrality of a large portion of the insurance industry, support from family physicians, and support by other medical professions, etc. This bill has urban and rural support, and has been unanimous and bipartisan in most states. I ask for your support of this bill and support for the direct primary practitioners and patients in your districts.

Thank you, Mr. Chairman and Committee members, for your time and consideration of this bill.

Post Office Box 7882 • Madison, WI 53707-7882

(608) 266-9174 • Toll-Free: (800) 863-8883 • Fax: (608) 282-3573

www.SenatorKapenga.com • Twitter: @SenatorKapenga • Facebook: SenatorKapenga

Wisconsin Medical Society

Your Doctor. Your Health.

TO: Senate Committee on Health and Human Services
Senator Patrick Testin, Chair

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

DATE: June 6, 2019

RE: **Support** for Senate Bill 28

On behalf of the largest association of medical doctors in Wisconsin, the Wisconsin Medical Society thanks you for this opportunity to share our support for Senate Bill 28, which concerns a patient contracting for direct primary care.

At its most recent annual meeting, the Society's House of Delegates approved a policy pertinent to SB 28:

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

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

Access to and the cost of health care continues to be a growing issue both nationally and in Wisconsin. At the same time, physicians in Wisconsin are feeling the effects of professional burnout and dissatisfaction at a rate higher than in other states where this is measured. Direct Primary Care can be a method where both the public and the profession benefit.

Thank you again for this opportunity to provide our testimony on Senate Bill 28. Please feel free to contact the Society on this and other health-related issues.

Phone 608.442.3800 • Toll Free 866.442.3800 • Fax 608.442.3802

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

Wisconsin Association of Health Plans

The Voice of Wisconsin's Community-Based Health Plans

Senate Bill 28
Senate Committee on Health & Human Services
June 6, 2019

Chairman Testin, Members of the Committee, thank you for the opportunity to testify today.

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

The Wisconsin Association of Health Plans is opposed to Senate Bill 28 as drafted.

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

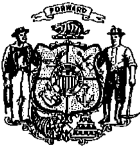
What Problem Will Senate Bill 28 Solve? A Legislative Council Study Committee on Direct Primary Care, convened in the summer and fall of 2018, to evaluate direct primary care (DPC) in Wisconsin. In the Study Committee's *Report to the Legislative Council*, the Committee affirmed that direct primary care (DPC) is a valuable component of Wisconsin's health care market, but did not recommend the Legislature introduce and consider a direct primary care bill. Less than half of the Committee was in favor of recommending legislation, due primarily to the fact that **members of the Committee, which included two practicing DPC physicians, failed to identify any barriers in Wisconsin law to providing DPC services.**

How Would Senate Bill 28 Impact Consumers? Senate Bill 28 would dilute current consumer protections by exempting certain DPC arrangements entirely from oversight by the Office of the Commissioner of Insurance (OCI).

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

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

Wisconsin health plans oppose Senate Bill 28 as drafted. Before any DPC proposal advances through the legislative process, it should at least be amended to ensure OCI oversight of all DPC arrangements and DPC financial responsibility to consumers.



State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tony Evers, Governor
Mark V. Afable, Commissioner

Wisconsin.gov

125 South Webster Street • P.O. Box 7873
Madison, Wisconsin 53707-7873
Phone: (608) 267-9586 • Fax: (608) 264-6228
oci.wi.gov

Date: June 6, 2019

To: Senator Testin, Chair
Senator Kooyenga, Vice Chair
Members of the Senate Committee on Health and Human Services

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

Subject: Senate Bill 28 Relating to direct primary care agreements

The Office of the Commissioner of Insurance (OCI) submits the following comments for your consideration regarding Senate Bill 28 related to direct primary care agreements. The comments were also previously shared with the bill's authors. OCI is providing suggestions for technical amendments we believe reduce the potential for unintended consequences of the bill, without compromising its original intent.

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

First, we suggest adding language to preclude the sponsor of a direct primary care agreement from advising consumers regarding health insurance coverage without an insurance agent license. The concern is that providers and their employees may provide recommendations regarding insurance coverage at the point of sale of the direct primary care agreement. As I am sure the committee is aware, direct primary care agreements do not include a comprehensive scope of services for all of a consumer's healthcare needs and additional insurance may need to be purchased with the direct primary care agreement. Under current law, an insurance agent license is required when a person "advises other persons about insurance needs and coverage." Primary care providers and their employees should obtain the required licensure if they begin advising consumers regarding insurance coverage the consumer needs in addition to the direct primary care agreement.

OCI suggests a new section with the following language:

> INSURANCE INTERMEDIARY LICENSE REQUIREMENT
>
> "Nothing in this section shall be construed as relieving a person who engages in the activities of an insurance intermediary, as defined in s. 628.02(1)(a), from obtaining the required license under s. 628.03."

Second, language should be added to the end of Section 5., p. 5, line 3, that makes clear that OCI has the authority to regulate contracts that include the assumption of

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

> "Nothing in this section shall be construed to limit the regulatory authority of the Office of Commissioner of Insurance to regulate contracts that do not meet the definition of a valid direct primary care agreement and meet the definition of insurance under s. 600.03(25)."

Thank you for your consideration of OCI's comments.

SB 28 - Direct Primary Care Agreements
Wisconsin Senate Committee on Health and Human Services

Eric Miller, MD Regional Medical Director, Paladina Health
Direct Primary Care Coalition
June 6, 2019

Mr. Chairman, Members of the Committee on Health and Human Services, thank you for the opportunity to testify in support of SB 28. I would like to thank Senator Chris Kapenga for his leadership in authoring this important clarification of state insurance law that will help the citizens of Wisconsin improve their health by expanding access to essential primary care services. My name is Eric Miller; I am a direct primary care family physician from Beaver Dam, WI. I've grown up in WI all my life and received my undergraduate degree and MD right here in Madison from our great University of Wisconsin Medical School. I'm here today on behalf of the Direct Primary Care Coalition as well as Paladina Health, which is one of the largest direct primary care practices in the country, serving over 150,000 patients in 18 states. Throughout WI, Paladina serves 7 different small and medium size employers, providing essential, convenient access for their employees and dependents at 10 different on-site or near-site clinics. In my role with Paladina Health, I serve as the Regional Medical Director for the Eastern US, but I still continue to care for patients, working closely with my NP, serving over 1000 patients for Metalcraft of Mayville.

First, a little about the direct primary care movement (DPC). Today there are over 1,000 practices in 48 states and DC. DPC offers patients high-value primary care services paid for directly by a monthly fee, outside of third party fee-for-service reimbursement. These fees, which average around $70/month nationally, can be paid by an individual, an employer, or a health plan. Increasingly, many smaller, self-insured employers are looking at DPC as an innovative way to create seamless first dollar coverage for their employees while reducing premium costs using a wrap-around, high deductible health plan. In many states, we are starting to sign contracts with state governments or municipalities who recognize DPC as a way to provide enhanced primary care benefits to employees while reducing total health care spend.

Using Metalcraft of Mayville as an example, it is easy to see why DPC is such a rapidly growing and popular model of healthcare delivery. I've been serving their employees and families for 5.5 years and we've received excellent feedback from the patients and the employer. In our most recent data collection, 92% of Metalcraft patients report an overall positive experience, while 94% report a high level of trust with the care team and; 68% report their health has actually improved since joining the program and 79% say their opinion of their employer has improved because of the Paladina benefit. Metalcraft tells us that it has become an important recruitment and retention tool for them.

On a personal level, moving to a DPC practice has restored my passion for practicing family medicine when I was facing burn-out after 18 years in the fee-for-service world. I feel like I am truly making a difference again for my patients. Just last month I was able to spend an hour & a half with a 30 yo male patient who had not seen a PCP in over 10 years, but was severely depressed and had been contemplating suicide. The fact that his employer offered this benefit that was free to him with easy, convenient access, convinced him to come in for a physical. The time I set aside to get to know him and develop trust, allowed me to uncover this chronic depression. That very day I was able to get him started on a low cost generic medication that I dispensed from my office and get him connected him with a counselor. I just saw him back for a 4 week f/u and it was so rewarding to find that he was already feeling substantially better.

Month after month at Metalcraft, we've experienced countless similar stories of improved outcomes. We've discovered that last year alone we saved an estimated 1,258 hours of work time simply by having a conveniently located clinic where patients don't have to travel or wait more than 5 minutes to see us. We've also been able to achieve strong clinical outcomes, substantially exceeding WI reported HEDIS benchmarks in every category, sometimes by over 30%. We know that this will undoubtedly result in massive downstream cost savings for chronic conditions like diabetes and HTN, not to mention the human element, saving individuals and families preventable morbidity and mortality. When comparing enrolled vs non-enrolled employees, we've been able to reduce Metalcraft's HC spending across the board on specialty care, ER visits, inpatient hospitalizations and pharmacy spend and we've reduced Gross healthcare costs by up to 41% for this population.

This kind of success is not unique to Metalcraft or even to Paladina, but DPC practices across the state and across the country report similar positive outcomes. DPC health reform legislation is a bipartisan effort. The Affordable Care Act recognizes that DPC is a significant payment and delivery reform achieving the goals of the "triple aim" of health reform: better health outcomes, greater patient satisfaction, and reduced costs. The Trump Administration has supported the growth of DPC, most recently with an announcement by the HHS Secretary of a new program which aims to put one quarter of all Medicare beneficiaries and into direct contracting relationships with doctors that put primary care services first.

Like most of the similar bills passed 26 states around the country, SB 28 has two essential components. This legislation:

1.) Appropriately defines direct primary care (DPC) agreements as medical services, limited to the scope of the provider's license which are outside of the scope of state insurance regulations and;
2.) Sets forth no fewer than 10 important patient and consumer protections, which do not exist in law today. These protections guide these DPC agreements so that patients understand exactly what services are covered by the agreements and what is not covered.

Direct Primary Care agreements are designed to promote access to primary care services; they are not intended to be unlimited comprehensive insurance coverage. However, when coupled with an appropriate insurance product they provide comprehensive coverage that encourages WI citizens to appropriately utilize primary care first - for access to acute care needs, chronic condition management as well as prevention and wellness services. SB 28 is a step in the right direction as we work to solve our current healthcare crisis. I hope you can support this important legislation as WI continues to be a leader in providing high quality, consistent & cost-effective healthcare for our citizens.

Thank you for the opportunity to present this testimony today. I would be happy to answer any questions.

Chairman and members of the committee, I would like to thank you and especially Senator Kapenga for inviting me to speak to you about Senate bill 28 and give my observations and reasons for transitioning from corporate medicine to direct primary care.

I would like to first commemorate this day, June 6th for the world war two soldiers with the anniversary of D Day. My father was a surgeon on the beaches of Normandy helping wounded soldiers. Thank you, dad! He was the reason I became a physician and passionate about this proven model of care.

My name is Dr. Charles Sammis. I have been in the practice of medicine nearly 35 years. My current practice location is in a small town in south eastern Wisconsin with population of approximately 5000 people.

I don't want to bore you about statistics regarding Direct Primary Care but instead give a brief history of my journey of practicing medicine. I initially started in the early 1980's in a small rural community. I delivered babies, did routine nursery care, rotated ER night shifts weekly to cover the local hospital, assisted in all surgeries, did nursing homes and home visits. On top of that, handling a full time family practice. People paid a $12 office call, with approximately 10% of this was donated care. People paid cash and there was a true doctor-patient relationship. It was grueling at times but very rewarding. I was the true patient advocate then.

Then HMO's appeared to the area. The older doctors jumped for it because there was fear of losing their patients. The HMO paid $5/month a patient and the only way you could keep yours lights on was to have a large patient load which then reduced care and promoted more medical mistakes. I resisted until I saw my patient's leave me one by one causing me to cave in and join.

Autonomy was lost then. We weren't even called doctors any more but gate keepers. Rationing care became the mode and turning poor care into what was more profitable for the insurance company instead.

All the physicians were independent at that time in the region I practiced but I could see the winds of change occurring.

PPO's then started, which seemed better but again a lot of regulatory red tape ensued and causing billing and front office confusion. This is due to all the different regulations and restrictions per individual plan . Patients didn't know what their insurance coverage offered and blamed my office staff for this. Many days my office staff ended up so frustrated to obtain approval for consults and testing that it felt we were running in circles. I was trying to understand how insurance companies had so much power to affect a person's health, good or bad.

So by now my office staff for one doctor consisted of 6 employees which made making a living somewhat more difficult. The extra staff was needed for dealing with coding, billing and approvals for tests. None of these extra costs improved patient care.

I worked longer hours being swallowed in paper work. I stopped my OB practice and assisting in surgery due to the escalation of malpractice medical insurance. So the next event became very predictable. The hospitals were in the hunt to buy up practices. They could see the frustrations physicians expressed running a practice. The complexity of the business part becoming so difficult to handle that I agreed for sale my practice to the hospital with their promise to then let me just practice medicine and they can handle the business and insurance. It was not long

after this, actually about one year later, I bought my practice back after seeing how the hospital totally mismanaged things causing me to start losing patients. To counter this I hired a PA, and more staff, built onto my existing office to 4000 square feet. By doing this I felt could obtain better care and access for my patients. But wait. Now ICD codes kept changing and with that we had to abandon our paper charts which to this day I still regret and purchase our first EMR (electronic medical record) which was terrible. I invested in 3 different EMR's loosing over 35,000 dollars. The paper charts were more secure, locked every night in my chart room and easy to manage with no expensive and time consuming training. There was no down time if power failure occurred or loosing data. But the EMR was required because Medicare insisted it would expedite my billing. I should have known this was platform for more events to occur. Less time with patient is wasted time.

So after 20 years of practicing family medicine, my wife and I decided to sell everything and move to Wisconsin so I wouldn't have to pay $70,000 a year for malpractice coverage in the county I practiced. I was the last of only 2 family doctors in my whole county and the last family physician in my home town of 9,500 people.

A new and exciting life started in Wisconsin which I told my wife was God's intervention. I left behind my maximum $42 office call to come to a state that equates to 135 dollars for the same care. I was perplexed why that was but I became acquainted with the corporate world of medicine. The year was 2005.

Working for corporate medicine after a while made me feel like going home and taking a shower after realizing patient care was not the primary source of their concern. Higher coding

and more procedures to extract the most out of their health plan was the primary objective. People with high deductibles or poor insurance pay extremely high bills for basic health care. An office visit for a child with strep throat would be $300 and $150 for strep test. A mother with her small child coming in for a 10 minute well preventative office call and receiving their vaccinations would leave with a $900 bill. Then following up 2months later, due to quality standards, for another $900 visit. You start seeing the contempt in the patient's eyes for the system. EMR's became more complex with updates occurring regular to keep up with all the meaningful use charting for physicians in order to get their golden carrot of a bonus to their salary. Meetings with midlevel managers loved to show grafts of all the physicians together to belittle them with their peers to bow down to corporate interests to only improve their bottom line. Patient care consisted of a 7 minute visit with the doctor because the other 8 minutes of a 15minute complex physical was nursing staff putting in their data. Centralized scheduling then started with schedulers not knowing the patients, would place them anywhere in the schedule just to fill in slots to keep the physicians busy as they can be. This caused longer wait times due to longer complex patients being placed in shorter time slots. Screen time on the EMR outpaced our face time with a patient 3 to 1 ratio with all the so called necessary documentation. Again I couldn't keep up with the nonsense of what medicine turned in to be. It is really about money and not what the billboards portray to the general public about caring for patients. I realized at that point I turned in my white coat for becoming a data collecting clerk just transforming my patients into a pile of numbers.

I left the corporate world of medicine and went back to solo practice trying to regain that doctor –patient relationship I desired. Patients needed to become people again and not just commodities.

After one year after seeing how the insurance industry rules everything from what I can prescribe, to what tests I can order, I realized I wasn't the doctor I wanted to be. This is when I decided to look into DIRECT PRIMARY CARE.

What a novel idea. Lower patient's cost and improve quality for primary care. Prescribe wholesale medications out of the office which saves patient's time and money. 95% off labs and 80 % of imaging. But the best part of all, reestablishing doctor – patient relationship in a quality manner were I can see patients for as much time as they needed. Access to my care with same day and no waiting in the waiting room, so care can begin immediately. Costly procedures for free or very minimal cost. No more contempt or angry patients and no frustrated staff. This is pure quality medicine. And you can see why this is so appealing for me as a doctor and a patient advocate. Leaving the confusion of what the corporate world thinks is medicine. I don't want to have anything to do with it anymore. This is what it's all about.

I talked to medical students and other primary care physicians currently practicing about this model. The interest is really high which could improve the primary care shortage we have in this country. So objecting to senate bill 28 will just delay helping the people you are sworn to serve to receive better access to quality care. This bill is critical and opposing special interests need to understand this.

Thank you very much for letting me speak at this time.

Hello, my name is Nicole Hemkes and I am a Board Certified Family Medicine physician here in Madison. I am the owner and Medical Director of Advocate MD Direct Primary Care in Middleton WI. I would like to share my story to demonstrate why I feel that Direct Primary Care is an essential model of healthcare delivery and to support Senate Bill 28.

When I graduated medical school 13 years ago and residency training 10 years ago, I felt excited and energized to go out into the world and start helping patients. I have had the opportunity to practice in a variety of settings- hospitals, emergency rooms, urgent cares, and outpatient clinics, in locations urban and rural. What i became aware of over last 10 years was the realization that of our current Fee-for -Service, insurance- based healthcare system is broken. I left primary care because I didn't feel that in the current system, I would be able to practice medicine in a way that would allow me to help patients.

In the last 10 years I have seen doctors turned into employees

Patients turned into customers

Visits became DRG and ICD-10 codes

As hospitals and health systems became bigger and bigger and gobbled up more and more independent physician practices...

Barriers between the patient and the physician became greater and greater.

I realized for every 1 hour I spent talking to a patient I would spend 2 hours typing into a computer

I realized that there was more emphasis on the documentation and coding and maximizing reimbursement

Than there was concern for the patients' physical, emotional, and financial well-being.

The patient, who should be the focus in all this, was being lost

Patients are desperate for a different way

Physicians are desperate for a different way

Direct Primary Care is a different, better way.

Direct Primary Care is a healthcare delivery model, it is not health insurance.

There seems to be a misconception that health insurance equals health "care"

With passage of the Affordable care act in 2010, which sought to increase the number of people who had health insurance, but resulted in many unintended consequences:

individual and family health insurance premium double over the last 10 years

insurance deductible continues to rise

health plans have been consolidating leaving patients with less choices

And, businesses find it more and more unaffordable to provide healthcare coverage to their employees

Health insurance does not guarantee access to quality, timely, affordable care.

I operate a non-insurance based, non- fee for service, membership based model called Direct primary care.

Even though 2/3 of my patients have some form of health insurance/health coverage, yet they still come to see me. Why you might ask?

Wisconsin is considered a "heavily insured" state, we have an uninsured rate less than half of the nation average, yet patients still have difficulty accessing care.

Many of my patients who have $5,000 deductibles, or $8,000 deductible or $10,000 deductibles-This means they are paying out of pocket for visits, x-rays, labs, and medication. DPC decreases their out of pocket costs

I have patients who have insurance but have avoiding going to the doctor for 10 years or 20 years because they cannot navigate the over-complicated overly bureaucratic health system. DPC simplify this system for them

I have patients who were $100-$150 per month on their chronic medications
Now they get these medications for $20-30/month from me

Many of my patients were being shuttled from specialist to specialist for testing because their primary care doctor didn't have enough time in their 8 min visit to diagnose their issue,
I spend time with them

Our current trajectory is unsustainable.

Every year individuals pay more and more for less and less coverage

We have the most expensive healthcare system in the world, yet we still have people that don't access to basic medical care, regardless of their insurance status.

As Healthcare and insurance costs are skyrocketing, we look at the reason for these soaring healthcare costs.

#1-FIRST the exponential growth of healthcare administration (in excess of physician growth)
#2-SECOND lack of price transparency and the monopolies that have been created by large health system.

DPC saves money - both micro level (with individual patients) and macro level (will save our state money on healthcare costs and resources)

How? We break down healthcare to its most basic elements - a doctor and a patient

I don't need a lot of staff, extravagant facilities, billers and coders, or an expensive electronic medical record

I, like other DPC doctors, provide complete transparency of pricing- membership costs, medications, procedures, labs...

The patient will never get an unexpected medical bill, Imagine that!

For my patients, I provide all primary care services in the office for an average of \$80/month for adult, \$ 30/month for child

additional benefits of membership-

discounted wholesale medications

discounted labs

discounted radiology

no copays, no deductibles

complete transparency of pricing, no artificial price inflation

How does this save money in overall healthcare spending-?

What they have found is the longer a doctor spends sitting in front of a patient: asking questions, discussing symptoms, examining the patient, the less testing they order -

the less they refer to specialists

Now I have the time to manage what I was trained to manage

The less expensive laboratory testing and radiology is ordered
(although another misconception that labs and radiology are expensive!!! -
a panel of labs is <$10, I get X-rays for $40, a CT scan $250, and MRI $350

Unfortunately, we cannot rely on health systems, hospitals or insurance companies to fix these things as they are PROFITING off the current broken system. SO, we as physicians and patients have found our own solution-that solution is DIRECT PRIMARY CARE

We talked about the financial aspects, even more significant is that the level of care, accessibility, and quality of services that patients receive is UNPRECENTED IN THE CURRENT FEE FOR SERVICE MODEL-

I wanted to provide some "real life examples "of how DPC has impacted my patients, many of whom have been lost in the current system. (specific details changed to protect anonymity)

example 1 – Julia young lady with partial face paralysis-- thorough interview, exam, diagnosis Bell's Palsy, steroids from office, close f/u -phone calls, visits... all for $66 membership
Saved $3-4,000 ER visit

example 2- Marty is gentleman severe anxiety, social anxiety panic

Cannot sit in waiting room, nervous with new people, having to tell his story 4-5 times

Personalized, patient centered care. Development of trust,"this isn't like a regular doctor office"

example 3- Sandra chronic skin problems, sent around to specialists, given diagnosis of skin cancer, only required some time to be taken, routine labs to be done. Diagnosed a common chronic medical condition that Skin was side effect. Saved a costly unnecessary surgical procedure

example 4- Mr and Ms. Lin, elderly couple, husband has Alzheimer's disease, difficulty leaving the house, availability and accessibly to call after hours, reassure, can make home visit if needed

example 5- Oliver, young child with asthma, worsening respiratory difficulty overnight, mother call, doctor triages call directly , bring into office, breathing treatment, child improved, stable, goes home... saved unnecessary ER visit , saved resources

Finally, I would ask that you approve this bill that provides some protections to Direct Primary care which clearly is benefiting patients (your constituents) here in the state of WI already and solidifies that it is NOT insurance.. Protecting this affordable, quality healthcare option so that it remains a viable alternative to the people of Wisconsin. Patients deserve the right to choose a lower cost, higher quality alternative. As this model grows and becomes accessible to more patients in our state, this will result improving the health of the people of Wisconsin while also decreasing healthcare costs.

In a time where we are hearing increasingly of physician burnout and worsening physician shortages, especially in the area of Primary care... Direct Primary care brought me back to practicing primary care. Taking care of patients in my practice has been more professionally and personally rewarding than any "job" I have ever had. I feel very lucky to have the opportunity to practice medicine in this way and to truly help patients. Thank you for your consideration on this Bill.

MERCATUS CENTER
George Mason University

TESTIMONY

IMPROVING QUALITY AND REDUCING COSTS IN PRIMARY CARE

Darcy Nikol Bryan, MD
Associate Clinical Professor, UC Riverside School of Medicine

Senate Committee on Health and Human Services

June 6, 2019

Dear Chair Testin, Vice Chair Kooyenga, and members of the Senate Committee on Health and Human Services:

My name is Darcy Bryan and I am an associate clinical professor at UC Riverside School of Medicine and an obstetrician gynecologist surgeon. I also conduct research on the impact of regulations on healthcare access, quality, and affordability. Thank you for the opportunity to testify regarding SB28 and the opportunities for healthcare delivery through direct primary care (DPC).

The country is in the midst of a primary care physician shortage, and the DPC model can serve to remedy this shortage. DPC allows patients to receive the routine services they need—consultations, laboratory tests, preventive care, etc.—from a primary care doctor as frequently as they need against a monthly membership fee paid directly to the physician. No third parties are charged on a fee-for-service basis. The price of a single visit is lower than the periodic fee.[1]

This model allows physicians to take on a smaller panel size of patients (600–800 instead of the traditional primary care provider average of 2,300),[2] which, in turn, allows the doctor to spend more time with each patient. Patient visits average 30 to 60 minutes, compared to the 12 to 15 minutes observed for traditional primary care visits.[3] Consequently, administrative costs to the physician are 40 percent less than the industry average.[4]

However, many physicians are currently hesitant to open a DPC practice because of the threat of criminal prosecution for the unlawful sale of insurance.[5] As of March 2019, 23 states have already recognized this problem and enacted legislation establishing that DPC does not constitute an insurance product.[6] This ensures that DPC physicians are not burdened with the regulations and financial risk borne by insurance providers.

[1] Philip M. Eskew and Kathleen Klink, "Direct Primary Care: Practice Distribution and Cost across the Nation," *Journal of the American Board of Family Medicine* 28, no. 6 (2015): 793–801.
[2] Ian Pelto et al., *Direct Primary Care: A New Way to Deliver Health Care* (Denver, CO: Colorado Health Institute, 2018).
[3] Pelto et al., *Direct Primary Care*.
[4] Eskew and Klink, "Direct Primary Care."
[5] Philip M. Eskew, *Direct Primary Care: A Legal and Regulatory Review of an Emerging Practice Model* (Arlington, Heights, IL: The Heartland Institute, 2015).
[6] DPC Frontier, DPC Frontier home page, accessed March 22, 2019, https://www.dpcfrontier.com/states/.

The ideas presented in this document do not represent official positions of the Mercatus Center or George Mason University.

Wisconsin stands to gain from following suit and giving DPC the legal status it deserves. From the perspective of physicians, the DPC model offers physicians a work-life balance that can hardly be found anywhere else in the medical world. The average physician spends over 10 hours a week handling administrative tasks, and 32 percent of physicians spend over 20 hours per week.[7] The DPC physicians, by contrast, are able to focus on the patient instead of spending half of each patient visit entering data.[8] Patients benefit as well: they receive the full attention of their doctor, have access to them outside of work hours, and enjoy increased price transparency.[9] Furthermore, important cost savings were observed as a result of scaling DPC. For example, savings of over $1.4 million were achieved in Union County, North Carolina, as a result of individuals switching from their employers' consumer-directed health plans to DPC.[10] Clarifying the legal gray areas surrounding DPC can thus lead to lower overall healthcare costs without sacrificing quality of care provided to patients.

Sincerely,

Darcy Nikol Bryan, MD
Associate Clinical Professor, UC Riverside School of Medicine

ATTACHMENT

Darcy Nikol Bryan, contribution to "Better Health for More People at Lower Cost, Year after Year" (Letter to Chairman Alexander) (Mercatus Center at George Mason University, Arlington, VA, February 28, 2019)

[7] Tanya Albert Henry, "Do You Spend More Time on Administrative Tasks Than Your Peers?," *American Medical Association*, November 13, 2018.
[8] Charlie Katebi, "Research & Commentary: Missouri Should Expand Direct Primary Access to Medicaid Patients," *The Heartland Institute*, November 20, 2017.
[9] Philip M. Eskew, "In Defense of Direct Primary Care," *Family Practice Management* 23, no. 5 (2016): 12–14.
[10] Katherine Restrepo, "Direct Primary Care Helping North Carolina Public Sector Save Big on Health Care Claims: Part II," *Forbes*, July 19, 2016.

3434 WASHINGTON BLVD.
4TH FLOOR
ARLINGTON, VA 22201

PHONE: 703.993.4930 / 800.815.5711
FAX: 703.993.4935
WWW.MERCATUS.ORG

From the Desk of Darcy Nikol Bryan

February 28, 2019

Chairman Lamar Alexander
United States Senate
455 Dirksen Office Building
Washington, DC 20510

Chairman Alexander,

Thank you for the opportunity to respond to your call for ideas on rising healthcare costs and to discuss direct primary care (DPC) with you. DPC is a practice and payment model where patients pay their physician or practice directly in the form of periodic payments, usually monthly or annually, for a defined set of primary care services that aim to address 90 percent of the reasons for which patients see a doctor.[1] A free-market solution, DPC lowers the costs of and access to primary care. It does so by eliminating fee-for-service payments and by encouraging more physicians to become primary care providers through a humane and flexible practice model rather than the crushing workload of volume-driven care and compliance with insurance administration demands. Given the variety of retainer practice models and the resulting legislative confusion, it is important to define DPC accurately. A DPC practice (1) charges a periodic fee for services (generally $25 to $85 per month),[2] (2) does not bill any third parties on a fee-for-service basis, and (3) assesses any per-visit charges at less than the monthly equivalent of the periodic fee.[3] Through this mechanism, DPC practices claim to reduce administrative overhead by approximately 40 percent.[4] Patients can join a DPC practice without regard to their insurance or socioeconomic status. Doctors may see a smaller volume of patients in clinic through use of telemedicine and secured email exchange, while targeting longer in-person appointments for patients with complex needs. As a supplement, patients are encouraged to enroll in a catastrophic health plan that meets federal medical insurance requirements.

DPC clinics boast extended facetime with doctors, resulting in more comprehensive doctor- patient relationships highlighting preventative care as a major aspect.[5] Evidence of this can be seen in the average length of a patient's visit: DPC physicians' visit times with patients average 30 to 60 minutes versus 12 to 15 minutes at a traditional primary care provider.[6] This is likely owing to a 40 percent reduction in administrative overhead, as surveys show that almost half of traditional primary care

[1] Qliance, "New Primary Care Model Delivers 20 Percent Lower Overall Healthcare Costs, Increases Patient Satisfaction and Delivers Better Care," news release, January 15, 2015, https://www.prnewswire.com/news-releases/new-primary-care-model-delivers-20-percent-lower-overall-healthcare-costs-increases-patient-satisfaction-and-delivers-better-care-300021116.html.
[2] Charlotte Huff, "Direct Primary Care: Concierge Care for the Masses," *Health Affairs* 34, no. 12 (2015): 2016–19.
[3] Phillip Eskew and Kathleen Klink, "Direct Primary Care: Practice Distribution and Cost across the Nation," *Journal of the American Board of Family Medicine* 28, no. 6 (2015): 793–801.
[4] Eskew and Klink, "Direct Primary Care."
[5] Ian Pelto, *Direct Primary Care: A New Way to Deliver Health Care* (Denver, CO: Colorado Health Institute, 2018).
[6] Pelto, *Direct Primary Care*.

As an entity organized under section 501(c)(3) of the Internal Revenue Code, the Mercatus Center does not engage in any political activity. The Mercatus Center is providing this public information to you in the same format and in the same means as it would to any other organization or individual upon request.

doctors spend one-third of their day on data entry and one-half of a patient's visit inputting data into a computer.[7] Lengthening average visit times and strengthening doctor-patient relationships in DPC could also be explained by the smaller average patient panel size, or the number of patients a physician serves. DPC physicians typically have an average panel size of 600–800 patients, compared to an average panel size of 2,300 patients at traditional primary care providers.[8]

In 2015, Colorado-based DigitalGlobe partnered with Colorado's first DPC provider, Nextera Healthcare, to facilitate a case study focused on reducing insurance costs for the company. DigitalGlobe enrolled 205 of its 971 Colorado-based employees into Nextera's DPC pilot program.[9] Over a seven-month period, DigitalGlobe employees saw a 25.4 percent drop in per-member per-month costs, compared to only a 4.1 percent reduction in costs among the employees not participating in the DPC program.[10] In 2017, the Colorado Academy of Family Physicians wrote a letter to the Colorado Commission of Affordable Healthcare to "initiate a Health First Colorado (Medicaid) DPC pilot program similar to the Qliance DPC program in the State of Washington."[11] The state of Michigan has applied to the Centers for Medicare & Medicaid Services for a waiver allowing a DPC pilot program for Medicaid enrollees.[12] Similar calls have been made for allowing Missouri Medicaid patients to have access to the DPC model.[13]

However, there is a real concern among physicians about adopting the DPC model. Pioneers of the model have faced aggressive state insurance commissioners who threaten criminal prosecution for the unlawful sale of insurance, deeming DPC an insurance product.[14] Per state commissioners' analysis, too much risk was being transferred from patient to physician for a fixed monthly fee, with the following concerns: What might happen should too many ill patients need to be seen at once by a DPC physician? What guarantees could be made that care would be delivered as promised?

The DPC movement has responded by advocating for state-level protective legislation clarifying that DPC is not an insurance product, along with other measures protecting the ability of physicians and patients to access this model. Currently a small number of states have laws protecting DPC practices against complex insurance regulations.[15] The Affordable Care Act (ACA) contains a provision stating that the US Department of Health and Human Services "shall permit a qualified health plan to provide coverage through a qualified direct primary care medical home plan that meets criteria established by the Secretary."[16] Additionally, the ACA allows for DPC

---

[7] Charlie Katebi, "Research & Commentary: Missouri Should Expand Direct Primary Access to Medicaid Patients," The Heartland Institute, November 20, 2017.
[8] Ian Pelto, *Direct Primary Care*.
[9] Nextera Healthcare, "Nextera Healthcare, DigitalGlobe Case Study Highlights Health Benefits, Cost Savings of Direct Primary Care. Double-Digit Reduction in Costs Leads to Company-Wide DPC Implementation for 2017," news release, February 5, 2019, https://nexterahealthcare.com/nextera-healthcare-digitalglobe-case-study-highlights-health-benefits-cost-savings-direct-primary-care-double-digit-reduction-costs-leads-company-wide-dpc-implementation-2017/.
[10] Tamaan K. Osbourne-Roberts, Letter to Bill Lindsay, Colorado Commission on Affordable Healthcare, February 24, 2017, https://www.colorado.gov/pacific/sites/default/files/CAFP_DPC%20Recommendations%20to%20Cost%20Commission%20February%202017.pdf.
[11] Osbourne-Roberts, Letter to Bill Lindsay.
[12] Michigan Department of Health & Human Services, *Implementation of the Direct Primary Care Pilot Program Quarterly Report 1*, January 19, 2018, https://www.michigan.gov/documents/mdhhs/Section_14078_PA_158_of_2017_Quarterly_Rpt_1_614860_7.pdf.
[13] Katebi, "Research & Commentary."
[14] Philip Eskew, "Direct Primary Care: A Legal and Regulatory Review of an Emerging Practice Model," The Heartland Institute, January 1, 2015.
[15] Bill Kramer, "Direct Primary Care: The Future of Health Care?," *MultiState Insider*, April 1, 2015.
[16] Eskew, "Direct Primary Care."

practices to be marketed in state exchanges as long as they are combined with a "wrap around" insurance policy that will cover other medical costs such as catastrophic care.[17]

Sincerely,

Darcy Nikol Bryan, MD
Associate Clinical Professor, UC Riverside School of Medicine

[17] Huff, "Direct Primary Care: Concierge Care for the Masses."

TO: Senate Committee on Health and Human Services
State Senator Chris Kapenga
FROM: Joel Bessmer, MD – Chief Medical Officer, Strada Healthcare
DATE: June 3, 2019
RE: Testimony on Senate Bill 28

Dear Legislators,

I am writing you to voice my strong support for Senate Bill 28 which will make Direct Primary Care (DPC) agreements legal in the state of Wisconsin. In April of 2016, we lead LB-817 through the Nebraska legislature to bring Direct Primary Care to the state of Nebraska. Direct Primary Care is a solution to our broken healthcare system because it eliminates barriers that exist between patients and their primary care physician. The results that are being published from around the Nation show that DPC improves the health of patients, reduces healthcare spend for individuals and employers, and produces better economic outcomes for physicians. In fact, the State of Nebraska recently passed LB-1119 which is a pilot study of Direct Primary Care for State Employees. Strada is excited to begin providing care for them starting July 1st, 2019.

We have a sick healthcare system today where physicians are only compensated when patients are sick. This system requires doctors to see as many patients as they can every day, spending limited time with each patient. Physicians want to provide better care by spending more time providing patient care. The current system diverts their time to coding, billing, following up on denied claims, and prior-authorizations; none of which improve outcomes or lower costs.

Under Senate Bill 28, physicians will be able to contract directly with their patients outside of insurance. For a flat monthly fee, patients will receive anytime access to their primary care physician without ever needing to worry about copays, deductibles or insurance. The physician can spend more time with their patients and focus on relationship-based care. We know that one of the key indicators in good healthcare outcomes is a quality relationship with a primary care physician. The DPC movement is the main initiative in our Nation that is bringing about relationship-based care.

Over 20 states including Nebraska have passed laws to clarify that DPC is not health insurance and to provide basic protections to patients who opt for this type of care. I would urge the State of Wisconsin to do the same and join us in the Direct Primary Care movement. I assure you that this legislation will bring free-market principles back into healthcare and greatly benefit innovative primary care physicians and their patients.

Highest Regards,

Joel Bessmer, MD, FACP
Chief Medical Officer
Strada Healthcare

June 6, 2019

Dear Chairman Testin and members of the Committee:

On behalf of Americans for Prosperity (AFP) activists in Wisconsin, I am here to testify in support of Senate Bill 28. AFP activists engage friends and neighbors on key issues and advocate for building a patient-centered health care system that lowers costs, increase choices, and improves access for millions of people seeking relief. The reforms outlined in SB 28 to expand access to Direct Primary Care would promote all of these important goals by addressing our state's large and growing doctor shortage.

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

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

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

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

SB 28 would provider crucial legal certainty for physicians seeking to practice DPC in the Badger state. The bill would explicitly define DPC as "not insurance" and shield DPC practices

from expensive insurance rules that would threaten their financial viability. This committee can protect these innovative practices from insurance regulations by making clear DPC is not considered insurance under state law. Please vote "Yes" on SB 28 in committee to strengthen health care access, lower costs, and end Wisconsin's crippling doctor shortage.

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

Sincerely,

Megan Novak
Legislative Director
Americans for Prosperity-Wisconsin

---

[i] https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[ii] https://static1.squarespace.com/static/5a3ac16af14aa15aede6d0ed/t/5b69ebb28a922d59c48f6d37/1533668280195/WCMEW+2018+Report+FINAL.pdf
[iii] https://www.tafp.org/news/tfp/spring-2015/cover
[iv] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0811
[v] https://www.jabfm.org/content/28/6/793
[vi] https://www.heartland.org/_template-assets/documents/publications/Paladina%20Health_City%20of%20Arvada_Case_Study.pdf

Letter of Support Regarding 2019 Wisconsin Senate Bill 28
(Relating to Direct Primary Care Agreements)
Wisconsin Senate Committee on Health and Human Services Public Hearing
June 6, 2019

Mr. Chairman and committee members,

Thank you for the opportunity to provide a written letter of support regarding the 2019 Senate Bill 28 relating to direct primary care (DPC) agreements. My name is Dr. Brian Erdmann. I am a direct primary care physician who, together with my wife Dr. Kim Erdmann, owns and operates a direct primary care clinic located in Rhinelander, WI. We are devoted to "prioritizing" the doctor-patient relationship (as our practice name and logo implies) and strive to provide the highest quality care at the lowest cost to our patients, which is why we believe it is imperative that Senate Bill 28 passes legislation and becomes law.

My wife and I both graduated from the Medical College of Wisconsin, and after completing our residencies in Internal Medicine at the Sinai Samaritan Aurora Health Care Milwaukee Clinical Campus, we took traditional positions as primary care physicians in the rural Northwoods of Rhinelander, Wisconsin, first with Ministry Medical Group for about seven years, and then with Aspirus Clinics for another more than ten years. Both organizations are large health care corporations where the care delivered is tailored for delivery under the rules and agreements dictated by third party insurance contracts. Although the care delivered at these organizations was very professional and quality, we couldn't help but find that the majority of our time, even for minor routine primary health care, was spent trying to attend to required third party insurance documenting, and coding and billing according to insurance rules, regulations and coverage. We also noticed as the administrative burden increased, our quality time with patients decreased, and the cost of healthcare for primary care and even trivial routine issues increased. We started feeling like the patient-doctor relationship was not the priority anymore and no one could afford their basic health care.

In 2016, we created Priority Medical Partners Direct. Our goal was to re-prioritize the doctor-patient relationship by providing basic primary care that was affordable to all, by delivering it outside the extra third party administrative burden of insurance documenting, billing, coding, and coverage denial issues. By reducing this burden, we were able to reduce our overhead cost dramatically and use that time saved spending it with our patients where it was needed most. Direct Primary Care further reduced the overhead burden by eliminating time spent billing for the individual services we provide on a daily basis, by calculating a FAIR price for the services we provide to the average patient over a year, and automating that direct payment by billing over smaller, and more affordable, monthly payments. Our Direct Primary Care membership provides patients with FREE office visits, FREE procedures, same/next business day appointment access, and the very lowest prices we can offer on labs for one LOW monthly fee. DPC removes financial disincentive to see your doctor because all office visits and office procedures are included in the monthly fee, which means patients will be more likely to be seen early in the disease course when things are easier and less expensive to take care of, which further minimizes time off work

580 Shepard Street Rhinelander, WI 54501 phone: (715) 420-1831 fax: (715) 420-1829

and expensive downstream care such as specialty care, ER visits, and hospitalization. Patients know at the time of service how much their health care costs, pay us DIRECTLY outside the visit, and can focus on their care while they are seen. There is no time-consuming filing and refiling of third-party paperwork or waiting to see if something is paid for by that third party, for primary care that is simple, inexpensive, and basic. The focus of the visit is only about an affordable, quality, doctor patient interaction- and that relationship without anyone else coming between it. We as the provider, and the patient, love the simplicity, quality, and affordability of it.
Here are a few of our patient testimonials (as seen on our web site) regarding direct primary care:

> "I have been a patient of Dr. Brian Erdmann since early 2014. When he and his wife, Dr. Kim Erdmann decided to open their own clinic in Rhinelander, my wife and I elected to follow them, despite their clinic being an 80-minute drive from our home. It is refreshing to be able to discuss your health with your own knowledgeable doctor rather than being shuffled from waiting room to exam room, assistant to assistant, in hopes of a cameo appearance by a real doctor."

> "I have seen Dr. Brian Erdmann several times at the small family clinic he runs with his wife, Dr. Kim Erdmann. The clinic offers several payment options. I pay cash and save over ½ of what I would be billed using the health insurance option. Most people like myself will never meet their health insurance deductible. Since I will not meet my high deductible unless I have a major surgery, I pay cash to Dr. Erdmann. My costs are incredibly reasonable. This makes total sense to see a doctor that will allow cash payments instead of paying a "middleman" in a non-flexible "corporate care" environment. Cutting out the HMOs allows Dr. Erdmann to concentrate on his patients, not red tape and insurance company bureaucracy. Dr. Erdmann's approach is a logical path to medical problem discovery and solution. He is easily accessible and takes the time I need to listen to my concerns and responds with information in an easily understood manner. He cares about his patients and is driven to excel in healthcare delivery. He has an excellent website with a secure patient portal for appointment notes, communication and follow up. This is what I believe excellent healthcare is supposed to be like."

> "Recently I had cellulitis. I let it go for a few days until my leg was very swollen, red and painful. I emailed Priority Medical Partners on a Tuesday night and was seen by Dr. Kim Erdmann the next morning. This is typical of them; you have direct and quick contact with the doctors. After Dr. Kim Erdmann looked it over, she had Dr. Brian Erdmann take a look too. They both decided on the proper antibiotics. Their concern was obvious. Dr. Kim went above and beyond explaining to me how serious the situation was and even provided me with an emergency kit just in case it was a DVT; to be sure, they had me go to Aspirus for a Doppler to check for blood clots. They spent an hour and a half with me and that visit cost me nothing. I expected a huge bill and had my check book ready. Dr. Brian came out and reminded me I pay a monthly fee (at the cost of a gym membership) and all my office visits are free. They have a menu of prices for procedures on their website and they are fraction of the cost I've paid at other clinics. I'm sure most clinics would not want her prices known out front. Doctors Kim and Brian Erdmann will answer questions about anything you may be concerned with even if it's unrelated to the problem you went in there for. Theirs is

580 Shepard Street Rhinelander, WI 54501 phone: (715) 420-1831 fax: (715) 420-1829

the most thorough and personal healthcare I've ever gotten. Since then I saw Dr. Brian on a follow-up after hospitalization. I was worried about my medications and he went over them and is helping me get 2 of them. The care Drs. Erdmann provide is stress relieving and reassuring."

"I absolutely love the DPC model. I feel like the doctor/patient relationship is much stronger and personal and by cutting out insurance from the equation there is far less money going to waste. I always can get in right away and again feel like the relationship with my doctor is much more personal, I'm not just a number."

Many DPC physicians believe, as do I, that health insurance is important, but that third-party health insurance should be used as it was used many years ago; to provide catastrophic coverage for expensive events that are unlikely to occur, not for routine primary care. Before the early 1990's, routine healthcare services were affordable and paid out of pocket, and insurance coverage was only used for expensive healthcare services. Patients need that option again! - especially as health care, as it currently is, is becoming unaffordable and patients have less choice or say in their own primary care healthcare. Other types of insurance, such as auto or homeowner's insurance, still operate in a true, catastrophic fashion. For example, when was the last time you used automobile insurance for an oil change or used homeowner's insurance to re-paint walls or replace carpet? If healthcare is to become affordable, we need to work together and to acknowledge that the formula for high quality affordable primary care includes the understanding that:

1. Insurance is not necessary for all healthcare

2. Not all healthcare is expensive

3. Quality increases when doctors spend more time directly interacting with their patients

4. Removing all unnecessary administrative tasks that are unrelated to the care of the patient will decrease costs and allow doctors to focus more time on direct patient care

Direct Primary Care is not insurance. It is up front 100% price transparency- directly between doctors providing primary health care services and patients and employers paying for the health care that they decide they want and need, with no hidden fees, processing, or questions about coverage. Because this relationship is direct, and not through a third-party payor such as insurance, the elimination of the overhead burden of billing, coding, and coverage denials significantly minimizes out of pocket costs for patients and employers and increases the time doctors spend with their patients allowing them to provide high quality care. Because DPC is not third-party insurance, and the key to its ability to deliver low-cost high-quality care depends on its lack of third-party administrative burden, exempting DPC practices from insurance regulation is both proper and imperative. Subjecting DPC practices and patients to the insurance regulations that are understandably necessary for indirect

580 Shepard Street Rhinelander, WI 54501 phone: (715) 420-1831 fax: (715) 420-1829

third-party payors would destroy clinics and options such as our direct primary care clinic. DPC is, and needs to be, an excellent option for employers looking for affordable primary care for their employees, for patients with moderate to high deductibles and healthcare ministerial coverage, or any patient who values and desires a strong doctor-patient relationship without interference. It also needs to be an option for providers who are as passionate about promoting an affordable, high-quality health care experience that promotes the bonds of the doctor-patient relationship as much as we are.

I strongly support the passage of 2019 Wisconsin Senate Bill 28 because it supports DPC 's affordability and quality initiative - it prioritizes the doctor-patient relationship by minimizing unnecessary third-party intrusions and cost into the that relationship. DPC is a "patient-centric" delivery model that puts patients first- allowing those involved an option to experience quality primary care the way it was and still can be delivered.

Sincerely,

Brian (and Kim) Erdmann, MD

580 Shepard Street Rhinelander, WI 54501 phone: (715) 420-1831 fax: (715) 420-1829