STATE SENATOR KATHY BERNIER
TWENTY-THIRD SENATE DISTRICT

State Capitol • P.O. Box 7882 • Madison, WI 53707
Office: (608) 266-7511 • Toll Free: (888) 437-9436
Sen.Bernier@legis.wi.gov • www.SenatorBernier.com

From: **Senator Kathy Bernier**

To: **The Senate Committee on Government Operations, Legal Review and Consumer Protection**

Re: **Testimony on Senate Bill 889**
Relating to: agreements for direct primary care.

Date: **February 8, 2022**

Thank you Chairman Stroebel and committee members for hearing this important bill today. Direct Primary Care (DPC) is happening in Wisconsin already. It is an innovative model wherein patients pay a monthly fee to a primary care provider in exchange for unlimited access to physicians who practice within their scope. Membership is voluntary. Under this model, doctors and patients alike can avoid costly and inflexible bureaucracy.

Although this type of practice is occurring, Wisconsin is not one of the 30 states that specifically designates DPC in statute. Direct Primary Care is a form of access to health care. It is not health coverage. It is not meant to replace insurance. It is time for us to update our state statutes to define Direct Primary Care in order to provide certainty for the many physicians and thousands of their patients who use this model.

Senate Bill 889 specifically states that Direct Primary Care is *not* insurance and therefore is exempt from regulations from the Office of the Commisioner of Insurance. It reaffirms that the Department of Safety and Professional Services and the Department of Agriculture, Trade and Consumer Protection *do* have regulatory authority over the practice of Direct Primary Care. Because consumer protection is paramount, SB 889 includes several consumer protections in law that are already commonplace in the industry, such as: requiring DPC providers to clearly explain what services are covered by the agreement, and provisions that prohibit DPC practices from discriminating against patients based on preexisting conditions.

Continuing that theme of consumer protection, SB 889 reaffirms that no physician can use a Direct Primary Care agreement to practice outside of his or her scope. Futhermore, it explicitly includes only two permissible reasons for which a DPC provider may decline to enter into a DPC agreement: 1) if the provider's practice is full, or 2) if the provider is unable to provide the appropriate level and type of primary care services the patient requires.

Direct Primary care offers benefits to consumers like longer office visits, savings on services, and same or next day appointments. Doctors also benefit, through lower administrative costs and additional freedom. Direct Primary Care encourages patients to get care proactively. This type of model is a fantastic and innovative approach to healthcare and I personally wish to see its use grow.

Thank you for your time and consideration of this important bill.

RACHAEL A. CABRAL-GUEVARA

STATE REPRESENTATIVE • 55TH ASSEMBLY DISTRICT

Testimony before the Senate Committee on Government Operations, Legal Review and Consumer Protection

Representative Rachael Cabral-Guevara

February 8th, 2022

Thank you Chairman Stroebel and committee members for allowing me to testify on Senate bill 889 today, a straightforward bill created to increase accessibility and affordability in healthcare.

This bill would allow Wisconsin to become one of 30 states that specifically define direct primary care in statute. Direct primary care is a membership for primary health care services, in which patients pay a monthly fee to a provider, in exchange for a wide variety of services in primary health care. Patients who are engaged in this care have an unlimited access to providers who deliver continuous, comprehensive, and personalized care to them. Additionally, it enables both doctors and patients to avoid the bureaucratic complexity, wasteful paperwork, and costly hassle of the claims process; which in turn allows for more time being spent with patients and focusing on their health and wellbeing. DPC is a form of access to health care, it is not a health coverage plan or meant to replace insurance, and membership is voluntary where it can be cancelled or entered into at any time.

Currently, in Wisconsin, there are close to 35 practices that are using some form of a DPC model. A great deal of these practices that use this model employ one or two providers. In addition, research has shown that DPC providers generally maintain a panel of 600 to 800 patients.

These practices who are operating in Wisconsin have no statutory language, which puts the practices at a great risk of being regulated out of business. This legislation will protect both these practices and their many patients by explicitly stating that DPC is not insurance, and thus is exempt from any OCI regulations. This bill also includes many consumer protection laws that are commonplace in the health care industry. The bill includes a reaffirmation that DSPS and DATCP have regulatory authority over these practices and providers, which also ensures that nobody can use a DPC agreement to practice outside of their scope. Finally, in the realm of care denial, this bill includes only two permissible reasons for which a primary care provider may deny entry into a DPC. Such as, if the provider's practice is at capacity, or if the provider is unable to provide the necessary level and type of care services the patient requires.

Thank you again for allowing me to testify on this important piece of legislation, I hope you consider supporting Senate bill 889. I would be happy to answer any questions you or any committee members may have.

P.O. Box 8952 • Madison, WI 53708-8952 • (608) 266-5719 • Toll Free: (888) 534-0055

Rep.Cabral-Guevara@legis.wi.gov

Wisconsin Medical Society

TO: Senate Committee on Government Operations, Legal Review and Consumer Protection
Senator Duey Stroebel, Chair

FROM: Wendy Molaska, MD, FAAFP
President-Elect

DATE: February 8, 2022

RE: **Support** for Senate Bill 889

Good afternoon and thank you for this opportunity to provide testimony in support of Senate Bill 889. I have been a Family Medicine physician for over 20 years and am a Fellow of the American Academy of Family Practice. I am currently President-Elect of Wisconsin Medical Society and serve on their Justice, Equity, Diversity, and Inclusion (JEDI) Taskforce. Through the state's Department of Health Services (DHS), I serve on the Advisory Council for the Wisconsin Council of Immunization Practices. I am also Co-chair for Advisory Council of the Wisconsin affiliate of Reach Out and Read, which is an early pediatric literacy program based in primary care clinics.

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

As both a physician and a patient I have been frustrated with our current health care system. As a physician I kept hearing from my patients:

- "Doc it takes 3 months to get an appointment with you or I have to see whomever is available."
- "Doc I only ever get a 15 minute appointment with you."
- "Doc how much is this lab test, Xray, medication, going to cost? What do you mean you don't know? That there are too many different insurances and plans to be able to keep track?"

January was always the worst month when I was a physician working in a large healthcare system. Insurers would negotiate new prices with drug companies, hospitals, etc. My patients would get sent letters that the medication they had been taking, and were doing well on, was no longer covered by their insurance and they had to change meds. This is not in the best interest of the patient - this is meant to save the insurance companies a few dollars.

As a patient:
I was due for my follow up breast MRI after my unilateral (one-sided) mastectomy. I was contacted prior to the MRI by the large health system to tell me the cost of the MRI would be $6,700 without insurance. With my insurance because of co-pays, deductibles, and co-insurance I would be responsible for $2,100 of the $6,700 cost. At this time I had started my Direct Primary care (DPC) clinic and knew that if I drove to an independent radiology group in Milwaukee I would get the same 1.5 Tesla MRI, with the same gadolinium injection, with a board certified radiologist reading it for $650.

I also was due for blood work - a CBC (complete blood count) and was charged $83 for the blood work and $30 draw fee = $113 which I was responsible for the entire amount as I hadn't yet met my deductible. The price that my patients pay for a CBC that is run through Quest is $3.25.
Many patients have expressed frustration at the inability to see their physician in a timely manner and also at the costs for health care. Not only are they paying monthly premiums, but there are also copays, deductibles, and co-insurance.

Even though my patient panel is varied I would say the majority of my patients are patients that are falling through the cracks of our current system. They don't have insurance for a myriad of reasons. Their employer does not offer insurance, or if they do, the employee cannot afford the cost of the premiums. They cannot afford what they are finding on the ACA, or even if they get a high deductible plan they don't actually use it because the deductibles are so high. Patients have said they have contemplated working less so they would qualify for BadgerCare but they actually like their job and want to keep working but are concerned about going without health care coverage.

I argue what they get currently is not health care coverage - it is sick care coverage. Patients put off seeing their doctor until things get too out of control and then end up in ER and then end up with a bunch of medical debt and still no good follow up.

My patient panel is really varied but I find it telling when I have other physicians who are signing up for my services. One has state sponsored insurance and finds it easier to get in to see me than the primary care physician he was assigned. He has also discovered that getting labs and meds through my office is usually often cheaper than going through his insurance.

I'll give you a real-life example from my clinic. By cutting out insurance and the associated costs of overhead and middlemen this is the breakdown for one of my patients:

New patient to me with no medical care for over 15 years. He doesn't like to see doctors and doesn't like pills. He says he previously had a diagnosis of high blood pressure but isn't taking meds for it. He decided, after checking his BP at home and finding it to be 180's/110's that perhaps he did need to see someone. He owns his own business and does not have any other insurance. He found my clinic because he could sign up for a monthly membership fee of $85/month without insurance. He did not want to go to an ER or urgent care. When he came in his BP indeed was high. I discussed with him risks and benefits of different blood work, tests and work up options, we developed a plan. During that first month this is the cost breakdown:

- $85/month membership fee for DPC
- Labs: vitamin D level, cholesterol panel, comprehensive metabolic profile (CMP) - which showed elevated blood sugar and liver tests so we added a HgbA1c to check for diabetes and a hepatitis panel to check for hepatitis. Also checked a TSH which was abnormal so added a free T4 (thyroid tests) to confirm diagnosis. $58.10
- Due to concerns of palpitations did an EKG in my office (included in membership price) and also ordered a Holter monitor that he wore for 48 hours. $75
- Because of heart concerns he also underwent an echocardiogram. $191
- He agreed to start medication for his thyroid and BP initially and 90 supply of levothyroxine AND losartan total cost $12.60
- Current working diagnoses: Hypertension, Hyperlipidemia, Type 2 Diabetes mellitus, obesity, elevated liver function tests (likely non-alcoholic steatohepatitis or NASH), hypothyroidism, hypovitaminosis D, palpitations, smoker.

- We are still working through his diagnoses and working through starting to update his preventative care. But he seems to trust me, and he texts me daily with his blood pressure and blood sugar readings and in the course of the last 2 months we have gotten both under control.
- Total for 1 month of care including all the initial testing and meds = $421.70

This is part of why I love being a doctor again. I get to focus on the whole patient and spend time with them and really get to know them and address their problems. I spend as much time doing non-patient care as previous but now what I am doing directly benefits the patient. Instead of saving the insurance company money I am directly saving the patient money. I also now have the time to really sit down with patients and address lifestyle changes that will ultimately have the most impact on their health. For example, a patient has pre-diabetes but does want to take medications. We need to work on diet and exercise and lifestyle changes. These are hard so let's set some realistic goals together and then I can help hold you accountable by texting you in two weeks to see if you are meeting these goals and then we start to set further goals.

There are several arguments I hear against DPC and I would like to address those.

1. DPCs exacerbate the physician shortage.
We have a crisis with burnout of physicians, and I was about to be one of them. I was burnt out and about to go back to work as a waitress. Then I wouldn't be taking care of any patients. With DPC if I have a full panel I will take care of 500-800 patients. So do you want me taking care of 500-800 patients, or no patients?

We already need to grow the physician population to meet the projected needs so how about we don't burn out our existing physicians causing them to retire early or commit suicide? And retain as many as we can so we can continue to take care of patients?

Also, if we have happier primary care physicians maybe we would be better able to recruit medical students to primary care instead of specialties. In the U.S. we have 70% specialists and 30% PCPs – in most other countries that statistic is the other way around. Here our students go into specialties because these are better compensated than primary care.

2. DPCs are essentially unregulated insurance that is capitated and does not provide patient protection.
The argument is that DPCs only take on healthy patients and don't abide by HIPAA or sell patient data or don't use best practices data or guidelines. Senate Bill 889 includes language to address the concern of not treating complex patients. And if you actually look at my (or just about any DPC) patient panel we have hugely complex patients that (in my opinion) are actually getting better care. I literally have 1 - ONE - adult patient on my panel currently that I would consider "healthy" with no underlying diagnoses. All the rest have no less than one, but most have at least three chronic diagnoses. I think you would also be hard-pressed to find a DPC physician who doesn't do everything they can to be HIPAA compliant and meet all the other regulations. I pay for my CLIA waiver and my DEA and my license and my HIPAA compliant EMR. I also have to maintain my license which means I have to have a certain number of continuing medical education (CME) credits every year which means I have to stay on top of best practices. Also since I get to spend more time with patients I get to also dive deep into their problems and better research the newest practices, guidelines and evidence. Without the added burdens of being considered insurance I get to find the highest quality, most affordable options for my patients, as well as spend more time with each patient so I can better address their individual needs.

3. DPCs rely on an erosion of medical benefits.
DPCs help patients get the care they need when they need it, so they are not putting off the little things until they become big things. DPCs are also going to help you find the best pricing for your MRI and labs

and specialists (especially as more specialists move into DSC - Direct Specialty Care). The argument is also that patients with DPC and high deductible plans then have to pay "full retail pricing" which is expensive. And true - see my quote for my breast MRI. However, there are "cash pay" prices available that are often pennies on the dollar compared to using insurance. Always ask for the cash pay price of your medical service, and it will usually be less than what your insurance would pay for it. DPC docs know this and often negotiate the best prices for their patients.

Also, since I can utilize all methods of communication with patients it is easier than ever to get in touch with me - phone, email, text, telehealth, in-person. If you are traveling and something comes up, a telehealth visit with a provider who knows you may save you a trip to the urgent care. And the argument that you are locked in to a physician is potentially true. But you are pretty much guaranteed to see your physician, not whomever is available, and can get same day and next day appointments. I feel the DPC personal doctor-patient relationship trumps the insurer network-assigned PCP who you never see because you have to wait three months for an appointment and so they don't really know you as a person anyway.

4. DPCs exacerbate disparities in care.
One of my reasons for opening a DPC was to address some of our disparities in care. I have a large Latino population of patients. Most do not have insurance from employers as they are service industry workers. 28% of my patients have diabetes. Many DPCs (like Our Lady of Hope clinic here in Madison) actually provide charity care. I hope to do this in the future and currently have reduced rates for many patients who are having financial hardships. I also will be hiring an RN who is originally from Bolivia and also a certified medical translator to better reach out to the Latino community. My clinic is in a neighborhood with a large Latino population and close to Allied drive and Badger Road which are historically underserved areas of Madison.

Rather than exacerbate disparities I argue that DPC helps address disparities. In Montana they are finding that DPC physicians are helping with doctor shortages and needs in rural areas. By opening a DPC, physicians can go back to their rural hometowns and have an economically viable practice instead of having to go to the bigger cities to join large groups to have a viable practice.

I am hoping this is one bill we can all come together on - as I believe we all have the same goal at heart - we want what is in the best interests of our patients. We want our patients to be able to receive high quality, affordable healthcare and have options to do so.

Thank you again for this opportunity to testify.

Testimony before the Wisconsin Senate

Committee on Government Operations, Legal Review and Consumer Protection

Feb 8th, 2022

Wisconsin State Senate, State Capitol, Room 201 SE, 12:00 PM

Senate Bill 889 Chief Author Kathleen Bernier Senate District 23

Dear Chairman Stroebel and members of the committee,

Thank you for the opportunity to testify today on Senate Bill 889. I would like to thank Senator Bernier for bringing this legislation forward. My name is Matt Dean, and I am a senior policy fellow with the Heartland Institute. The Heartland Institute is a 37-year-old independent, national nonprofit organization whose mission is to discover, develop and promote free-market solutions to social and economic problems. Heartland is in Illinois and focuses on providing national, state and local elected officials with reliable and timely research and analysis on important policy issues.

Being cognizant of the bills before you, I may abbreviate my testimony, however you will find an email copy of this testimony in its entirety in your in-box.

The most important role a legislator has is to protect constituents. Any changes in how care is delivered needs to address this first. DPC has been tested in more than thirty states and has been developed to work within the Affordable Care Act and state law to allow greater access to primary care, while safeguarding the best interests of the patient. Because of the ACA, patients are still required to buy an insurance policy on top of their DPC fee, protecting them from non-routine medical costs.

Renewing the old-time doctor-patient relationship turns out to provide better care. In DPC, Doctors spend more time with their patients, and that relationship is key to managing chronic disease and preventing hospitalization. Developing that strong relationship can aid in care coordination and prevent fragmented, expensive, and often unnecessary care. Its good for the doctor and the patient. (7)

Finally, creating DPC saves money. Because doctors can eliminate time dealing with insurance companies, they are freed up to spend time with patients, who save money by utilizing efficient and proactive healthcare. Although the idea is fairly new and growing, the results are coming in and they are good. Total medical spend in DPC has been shown to save 20% (6) and provide higher patient satisfaction.

Consolidation in healthcare delivery systems, and a strong demand for more personalized care (1) have fueled rapid growth for DPC since its beginning in 2006. Doctors spend more time with patients, spend less of that time in documentation. DPC practices usually have fewer patients than traditional primary care practices, typically fewer than 1,000 and most often around 200 to 600. In the past five years, developments in personal home health monitoring, and the popularity of telehealth options offered during the coronavirus pandemic have redoubled interest and demand for more direct primary care options. In the past year, states like Montana (3) and South Dakota (5) have passed legislation, and several other states hope to expand this tool.

To: Chairperson Duey Stroebel

Members, Committee on Government Operations, Legal Review and Consumer Protection

From: Reid Bowers, MPAS, PA-C

Date: February 8, 2022

Re: **Support for Senate Bill 889 – Direct Primary Care**

I am a physician assistant and I currently practice at Aurora Healthcare. I also serve as the co-chair of the Legislative & Government Affairs Committee of the Wisconsin Academy of Physician Assistants (WAPA). On behalf of WAPA, I am submitting this testimony in support of Senate Bill 889.

WAPA represents physician assistants (PAs) practicing in Wisconsin. Over 2,700 PAs practice in Wisconsin, working with physicians to provide quality, cost-effective team-based care to patients across the state. While PAs work in all areas of medicine, every PA is initially educated as a primary care provider. No matter where a PA practices, every six to ten years he or she must recertify by taking a primary-care based board examination. PAs' practice can include performing physical exams, diagnosing and treating illnesses, assisting in surgery, and prescribing medication.

WAPA supports Senate Bill 889, which provides regulatory parameters for health care providers entering into direct primary care agreements with patients. Under the bill, PAs are included in the types of health care providers who may enter into direct primary care agreements with patients. Advanced practice clinicians like PAs are crucial in maintaining and increasing cost-effective access to primary care, especially in underserved rural areas of the state. Allowing PAs to enter into direct primary care agreements supports more opportunities for PAs to practice across the state and helps expand patient access to primary care.

It is important to note that PAs entering into direct primary care agreements with patients would still be required to have a relationship with a physician, as required under current law. The bill also provides that health care providers, including PAs, provide primary care services "under the provider's scope of practice."

WAPA respectfully asks your support for Senate Bill 889, which will provide PAs opportunities to help reduce health care costs and increase quality primary care access for patients across Wisconsin through direct primary care agreements.

To: Members of Senate Committee on Government Operations, Legal Review and Consumer Protection

From: Megan Novak, Legislative Director, Americans for Prosperity - Wisconsin

Date: February 8, 2022

Subject: Support for Senate Bill 889, relating to agreements for direct primary care

---

Chairman Stroebel and members of the committee, thank you for the opportunity to provide comments in support of Senate Bill 889 which would protect patients' ability to access direct primary care in Wisconsin.

Americans for Prosperity – Wisconsin (AFP-Wisconsin) works to break down government-imposed barriers that impact all of our lives. Our health care system continues to be plagued by government regulations and threats of new rules that hinder our ability to easily access the quality and affordable health care of our choosing. AFP-Wisconsin supports health care policies that give each of us a "Personal Option" – a commonsense alternative to plans like the public option that put government in complete control.

Direct Primary Care (DPC) provides better access to better care at a better cost for patients across Wisconsin. DPC providers offer patients a range of high-quality health care services, including chronic disease treatment, check-ups and various health tests in exchange for flat fee payments. It does not engage with a patient's insurance provider.

This bill explicitly defines DPC as not being insurance – an important distinction to ensure that DPC isn't improperly regulated as an insurance product. These costly and time-consuming insurance regulations could threaten the viability of patients accessing direct primary care in Wisconsin moving forward.

Senate Bill 889 will provide crucial legal certainty for providers who already practice or plan to practice direct primary care in the Badger state, and help increase access to quality, affordable care for Wisconsinites. Passing Senate Bill 889 is crucial to ensuring all Wisconsinites have access to a Personal Option that gives them the choice and control we want, the affordability we need, the quality we deserve from the medical professionals we trust.

AFP-Wisconsin encourages all members of the Senate Committee on Government Operations, Legal Review and Consumer Protection to support Senate Bill 889 and protect access to direct primary care health care models for all Wisconsin patients.

WHAT IS DIRECT PRIMARY CARE (DPC)

DPC is a relationship between you and your doctor for basic healthcare services on a subscription basis. You sign up with your doctor, and she or he agrees to treat you and see you for basic primary care including telehealth visits, in office treatments, and most lab tests. The cost is significantly less than traditional health insurance (DPC patients typically spend $100/person/month) which is paid as a retainer by individuals directly to their doctor.

Some DPC doctors take insurance with some patients, and have a separate panel of patients under DPC, but it would defeat the purpose of DPC to have an insured relationship with your DPC provider. It is estimated that more than 50% of a primary care physician's time is spent on documentation, billing and arguing with insurance companies to get their patient's care covered. (2) Under DPC, that time previously spent on insurance related work can be spent on patient care. For this reason, DPC physicians see significantly fewer patients than their colleagues who take insurance. This allows DPC docs to spend longer time with each patient. The average reported current DPC patient panel size was 445, while the average target panel was 628. The average ratio of the current to target DPC patient panel sizes was 70% (i.e., on average, the current DPC patient panel was 30% below the target). For those DPC practices with a full DPC patient panel, the average length of time to fill the panel was 21 months.

DPC SAVES MONEY

A two-year (6) study across 4,000 patients found improved patient satisfaction and an overall reduction of 20% in medical spend through better disease management. That translates into real savings for families.

Say the price for a married couple is $10,000 per year for the highest deductible plan. The best plan available, which does have a $1,000 deductible and copay requirement, costs $20,000 per year. If this couple chooses the high deductible plan and enrolls in a direct primary care practice at $2,000/year they will save approximately $8,000 per year, assuming no emergencies occur.

WHAT DPC DOES NOT COVER

DPC does not cover specialty care, catastrophic illness, emergency care or prescriptions. DPC patients typically purchase a lower cost basic insurance plan (in addition to their DPC) to cover these costs. The Affordable Care Act mandates all Americans have a health insurance policy with a minimum benefit set defined as the bronze medal level. DPC patients are willing to pay for both the cost of the DPC retainer and ACA-compliant insurance premiums because they have found the combined cost to be a better value than any single policy.

CONCIERGE CARE AND DPC

Concierge care is often interchanged with DPC, even by some advocates and policy experts. (4) DPC does not take insurance and Concierge care often does. Generally, concierge care was developed to allow people ability to buy additional services not covered by insurance. This important difference highlights the need for states to define DPC laws in statute.

THE NEED FOR LEGISLATION

A DPC physician is agreeing to accept a capitated fee for a variable amount of service and is willing to treat a group of patients for a monthly rate, rather than a negotiated rate with a third party. But simply taking on unknown costs doesn't make a doctor a health insurance company. Because insurance companies are highly regulated, and the Affordable Care Act is very prescriptive with insurance mandates, DPC providers refrain from taking insurance, and their relationship with the patient must be defined specifically as not being health insurance. This is required for state's wanting to set up DPC.

Physicians and patient advocates are wise to ask congress for more guidance in creating a free space for DPC to safely grow in the states. Patients want access to a more personalized, less expensive care system and DPC delivers at lower cost.

Thank you for your time.

Nothing in this testimony is intended to influence the passage of legislation, and it does not necessarily represent the views of The Heartland Institute. For further information on this and other topics, The Heartland Institute's website provides a great link to many policy resources.

The Heartland Institute can send an expert to your state to testify or brief your caucus; host an event in your state, or send you further information on a topic. Please don't hesitate to contact us if we can be of assistance! If you have any questions or comments, contact Heartland's government relations department, at governmentrelations@heartland.org or 312/377-4000.

(1) "Direct Primary Care, Delivering Exceptional Care on Your Terms," American Family Physician Journal, Jan, 2021
https://www.aafp.org/family-physician/practice-and-career/delivery-payment-models/direct-primary-care.html

(2) Finnegan, Joanne, "Primary Care Doctors Spend More Than 50% of Workday on HER Tasks," Fierce Healthcare, September 13, 2017

https://www.fiercehealthcare.com/practices/primary-care-doctors-spend-more-than-50-workday-ehr-tasks

(3) Hall, Mari, "Gianforte signs drect primary care bill in Billings" Billings Gazette, April21, 2021
https://billingsgazette.com/news/state-and-regional/gianforte-signs-direct-primary-care-bill-in-billings/article_13d1da8d-0576-5d74-8d79-164cdef788fd.html

(4) Lamberts, Rob, MD "Difference Between Concierge and Direct Care, Medical Economics, February 18th, 2018

https://www.medicaleconomics.com/view/difference-between-concierge-and-direct-care

(5) Maharrey, Mike "South Dakota Passes Bill that Would Set Stage to Expand Healthcare Freedom" The Tenth Amendment center, March 23rd, 2021

https://blog.tenthamendmentcenter.com/2021/03/south-dakota-house-passes-bill-that-would-set-the-stage-to-expand-healthcare-freedom/

(6) **Qliance, "New Primary Care Model Delivers 20% Lower Overall Costs, Increases Patient Satisfaction and Delivers Better Care, PR Newswire, Jan 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

(7) **Robeznieks, Andis, Pondering Direct Care? 13 Potential Benefits and Drawbacks, American Medical Association, October 10, 2018**

https://blog.tenthamendmentcenter.com/2021/03/south-dakota-house-passes-bill-that-would-set-the-stage-to-expand-healthcare-freedom/

Concordia University Wisconsin Testimony on SB 889
Dr. Dan Sem, Dean of Business
Senate Committee on Government Operations, Legal Review & Consumer Protection
February 8, 2022

Chairman Stroebel and Honorable Members –

I am before you to share some perspectives and hopefully objective information on the topic of direct primary care, as it relates to SB889. First, briefly, who am I and why should I be speaking to you on this topic?

At present, I am Dean of Business at Concordia University, and am a Professor of both Business and Pharmaceutical sciences. I am also cofounder and Director of the Rx ThinkTank, which is focused on healthcare policy. I am a Wisconsin native, from West Milwaukee, and I got my PhD from UW Madison, as well as Law and MBA degrees from Marquette, while I was a Professor there. I care deeply about our state and about healthcare in general, having devoted my life to healthcare or healthcare policy, first in the private sector and now in a university setting. The Think Tank I represent is focused on research and on exploring policy that leads to better, more affordable and accessible healthcare. I should add that out of this effort, we have formed a spinout company with business partners, called *Advocates for Healthcare*. It provides services to help patients navigate DPC; and, Concordia is creating a certificate program to train future healthcare navigators.

The Rx Think Tank has organized a healthcare economics summit for over 4 years, with contributors including hospital presidents or CEOs, providers – including two former American Medical Association Presidents, and leaders in healthcare policy from across the US, and in the federal government from CMS. Last summer, our focus was on direct primary care. Topics researched and discussed at these events, with input from 20 experts, are covered in my book – Purple Solutions – A bipartisan roadmap to better healthcare in America. I'll present to you briefly conclusions of this research, with input and perspectives of the 20 expert coauthors, as it pertains to direct primary care – in the short time I have with you now. I can leave some copies of the book too, if your ethics rules permit – there is a lot of data and well-reasoned arguments, from physicians, including the former AMA president, nurses, economists, politicians, and policy-makers, including those that were part of drafting DPC legislation in other states.

Direct Primary Care is healthcare received directly from physicians, without the intervention of insurance and without the bureaucracy found in our current medical system, which was referred to by the former President of the AMA as the medical industrial complex. DPC focuses

on the patient-physician interface, delivering medical treatment the way it was many years ago – and how we remember in the idealistic vision and days of house calls. Physicians prefer this also, as they get to spend more time with patients. There's a reason that 65% of physicians say burnout is a serious problem, due largely to this bureaucracy, and their suicide rate is the highest of any profession. The average patient load in a traditional practice is 2,000, whereas with DPC, a physician may manage 345 patients on average – thus permitting them to give each patient more attention.

For low cost, typically on average $70/month, patients can call or text their doctors 24/7, and get more in-person time and care with their doctor than is normally the case. So, for less than the cost of a single ER room visit ($1,500 in WI), you get a personal physician – and routine follow-up lab tests, prescriptions, and even imaging for typically nominal extra cost. This is more affordable, accessible and better care for over 90% of the problems people have. It is better for the doctor and better for the patient. The only ones to lose in all of this might be large hospitals and insurance companies who benefit from an opaque reimbursement-driven system that has led to unrelenting increases in healthcare costs in the US, now approaching 18% of GDP.

DPC is taking off across the country, and is going to provide a wonderful supplement to existing insurance-based care, including the ACA. But when payments for the Bronze plan are so unaffordable, with a $3,375 deductible in 2021, why not let average people get affordable care at far less than the cost of a copay with insurance – and then only use insurance for more expensive things. This approach was argued by author David Goldhill in his book Catastrophic Care; David, by the way, launched Sesame Care Health, a national-level portal to DPC providers. DPC is becoming available across the US, and will soon be a widely available healthcare option for all of us. Even the president of the Wisconsin Medical Society, Dr. Wendy Molaska, has switched to DPC, and loves it. There are an estimated 1,253 DPC practices in the US now, up from 250 five years ago.

So why do we need this bill? According to the *American Academy of Family Physicians*, 29 states and counting have already adopted DPC legislation. These states have adopted DPC legislation to ensure doctors can continue to provide this care, and not be blocked by the insurance industry, if they are somehow characterized insurance, which DPC isn't. This is a real fear, especially since the insurance industry may have much to gain by preventing DPC, and the associated empowerment of the patient-physician interface that delivers better care more efficiently, without insurance. The legislation you have in SB889 is based on and contains the major elements of the model legislation put forth by the DPC Alliance, a nonprofit focused on research and sharing information about DPC.

I should end by saying that it is a common misconception that DPC is concierge medicine, only for the wealthy. It is not that at all. At around $1,000 per year or less, it is more affordable that a single ER visit and a fraction of the Bronze plan deductible. Unless you are opposed to providing more affordable, accessible and better care to average people, I am sure this bill will pass – and assuming that, our next priority for the Rx Think Tank will be to explore how to get DPC memberships to even more underserved populations, perhaps financed through state or federal grants, by hospitals who now will have less burdened ERs, or employers who could easily provide this as a supplemental benefit to their insurance. But, one thing at a time.
I am happy to answer any questions.

Sources:

https://etactics.com/blog/physician-burnout-statistics

https://www.webmd.com/mental-health/news/20180508/doctors-suicide-rate-highest-of-any-profession

https://www.talktomira.com/post/how-much-does-an-er-visit-cost

https://healthcareinsider.com/affordable-care-act-deductibles-367400

https://sesamecare.com/

https://healingartsfamilymedicine.com/why-direct-primary-care-is-the-future/

https://www.dpcare.org/dpcc-model-legislation

AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

DIRECT PRIMARY CARE

KEY
29 states with DPC laws
21 states and the District of Columbia without DPC laws

AAFP Position
The American Academy of Family Physicians (AAFP) supports the physician and patient choice to provide and receive health care in any ethical health care delivery system model, including the Direct Primary Care (DPC) model. The DPC model is consistent with AAFP's advocacy of the advanced primary care functions and is a blended payment method of paying family medicine practices. The AAFP promotes and supports DPC as an innovative advanced practice model.

https://www.aafp.org/dam/AAFP/documents/advocacy/payment/dpc/BKG-DPC.pdf

Research done at Concordia with Advocates for Healthcare (https://www.advocatesforhealthcare.org/) interns, summarizing DPC clinics across the US (white dots), relative to Concordia system lives (purple). Yellow states done; others are still being tabulated. On right is for the Milwaukee area.