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Assembly Committee on Health, Aging and Long-Term Care
Testimony on Assembly Bill 953
Agreements for Direct Primary Care
February 14, 2024

Thank you Chairman Moses, and members of the Assembly Committee on Health, Aging and Long-Term Care for holding a hearing on Assembly Bill 953, agreements for direct primary care. Direct Primary Care (DPC) is a healthcare model already being used in Wisconsin as a supplement to traditional healthcare. This legislation will ensure that DPC can continue to be used as intended, and deliver high-quality, low-cost care.

In the traditional model for healthcare, costs are usually billed by the doctor and submitted to the insurance company. The insurance company pays some or all of the cost, and the patient is responsible for paying the rest of the bill. As you can imagine, this can be a fairly expensive process.

By contrast, DPC operates on a direct payment or subscription basis, where patients pay a monthly or annual fee directly to the primary care provider. Instead of working through an insurance company for paying claims, the membership fee covers routine check-ups, preventive care, and basic medical services. People using DPC often have high-deductible insurance to cover larger, unexpected claims that could not be handled in a smaller clinical setting. Because there is no need to process insurance claims for routine care, DPC practices can reduce administrative overhead.

Although the DPC model is already being used successfully in our state, doctors and health professionals are concerned that direct primary care agreements might be classified as insurance. This would negate the entire point of the DPC model.

This bill clarifies that Direct Primary Care is not health insurance, requires providers to clearly explain what services are covered, outlines the elements of a valid DPC agreement, and prohibits discrimination.

I hope you'll join me in supporting this legislation and ensuring that individuals in Wisconsin can continue to have access to this patient-centered approach to health care. Thank you again for your time today. I'm happy to answer any questions you might have.

RACHAEL A. CABRAL-GUEVARA

STATE SENATOR • 19TH SENATE DISTRICT

Testimony before the Assembly Committee on Health, Aging and Long-Term Care

Senator Rachael Cabral-Guevara

February 14, 2024

Thank you committee members for allowing me to testify on Assembly Bill 953, a straightforward bill targeted at increasing accessibility and affordability in healthcare.

This bill would have Wisconsin join over 20 states that specifically define direct primary care (DPC) in statute. DPC is an agreement for primary health care services where patients pay a monthly fee to a provider. These agreements enable both doctors and patients to avoid the bureaucratic complexity, additional paperwork, and costly hassle of the claims process; allowing for more time to be spent caring for patients. DPC is an alternative health care model, not a health coverage plan or means to replace insurance, and membership is voluntary where it can be cancelled or entered into at any time.

In Wisconsin, there are around 35 practices that are using some form of a DPC model. Many of these practices that use this model are small, employing one or two providers. Despite their small size, they are a key component of the health care team in Wisconsin and care for thousands of patients.

Though these agreements currently operate in Wisconsin, there is no statutory authorization for them. 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 protects consumers by clarifying that DSPS and DATCP have regulatory authority over these practices and providers.

I know there have been questions about what types of care can be provided in this model, what is required of the provider, and the anti-discrimination provisions. Let me clarify: this bill would not mandate any form of primary care outside of a provider's scope of practice and the anti-discrimination provisions only apply when entering in to or terminating the agreement itself.

Thank you again for allowing me to testify on this important piece of legislation and I am hopeful you will support it.

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Sen.Cabral-Guevara@legis.wisconsin.gov

Wisconsin Medical Society

TO: Assembly Committee on Health, Aging and Long-Term Care
Representative Clint Moses, Chair

FROM: Mark Grapentine, JD – Chief Policy and Advocacy Officer

DATE: February 14, 2024

RE: **Support** for Assembly Bill 953

On behalf of the largest association of physicians in Wisconsin, the Wisconsin Medical Society (WisMed) thanks you for this opportunity to share our support for Assembly Bill 953, which concerns direct primary care agreements.

WisMed's policy on direct primary care arrangements expresses support for this type of patient- and physician-friendly health care relationship:

> **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)

WisMed supports adding statutory language clarifying that patients may enter into a direct primary care agreement without fear that this type of structure could be deemed health insurance. Many physicians in Wisconsin already have such agreements with their patients and statutory clarification in this area would be helpful.

The requirement to disclose that such contracts are not health insurance is also important. Easier access to routine health care services can be very cost-effective and beneficial for patients 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 contract for direct primary care is a supplement to, not a substitute for, insurance coverage for catastrophic care. Making that distinction clear to the patient is vital, and WisMed 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 continue to feel the effects of professional burnout. Direct primary care can be a model where both the patient and physician benefit.

Thank you again for this opportunity to provide our testimony supporting Assembly Bill 953. Please feel free to contact WisMed on this and other health-related issues.

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Wisconsin Family Action
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TESTIMONY ON ASSEMBLY BILL 953
ASSEMBLY COMMITTEE ON HEALTH, AGING AND LONG-TERM CARE
WEDNESDAY, FEBRUARY 14, 2024
JACK HOOGENDYK, LEGISLATIVE AND POLICY DIRECTOR

Chairman Moses and committee members, thank you for the opportunity to testify on Assembly Bill 953. I am Jack Hoogendyk, Legislative and Policy Director for Wisconsin Family Action. We are opposed to this bill for one key reason.

We have no objection to the effort to make direct primary care more accessible to Wisconsin residents. We do, however object to the inclusion of gender identity in the non-discrimination clause.

While we recognize and affirm that all people deserve to be treated with respect and to be given medically appropriate care, we believe that it is **not** unjust discrimination to refuse certain medical services, whether because they are medically unnecessary or because the provider cannot in good conscience provide them.

There are several reasons we believe gender identity language is not necessary.

1. A non-discrimination clause should only include immutable (unchanging over time or unable to be changed) characteristics or strongly held religious beliefs. Gender identity is not an immutable characteristic.
2. Putting this specific group into the non-discrimination policy would open a direct primary care physician to lawsuits over refusing to provide certain types of "medical care" to someone who is transgender based on the provider's reliance on sound medical judgments or his/her conscience or religious rights.
3. Putting this identified group into this bill will provide a strong precedent for inclusion of the group in any number of future legislative efforts. It may actually further settle in law the erroneous idea that gender identity is immutable.
4. Wisconsin law does not require non-discrimination clauses in healthcare law.
5. The Supreme Court decision *Bostock v. Clayton County* of 2020 held that gender identity discrimination in employment amounts to sex discrimination under Title VII of the Civil Rights Act of 1964. This decision has been cited in numerous lower courts in an attempt to expand *Bostock's* reasoning, but Justice Gorsuch and the majority in *Bostock* explicitly stated that *Bostock* does not apply to any other statute besides Title VII, or even to any other set of facts under Title VII. It is only about hiring and firing on the basis of sexual orientation or gender identity.

Mr. Chairman, we would ask that unless an amendment is introduced to remove gender identity from the non-discrimination clause, you would vote not to advance this bill to the floor.

Thank you.

WISCONSIN CATHOLIC CONFERENCE

TO: Representative Clint Moses, Chair
Members, Assembly Committee on Health, Aging, and Long-Term Care

FROM: David Earleywine, Associate Director for Education and Religious Liberty

DATE: February 14, 2024

RE: AB 953, Agreements for Direct Primary Care

The Wisconsin Catholic Conference (WCC), the public policy voice of the Catholic bishops of Wisconsin, urges you to oppose AB 953, which establishes agreements for direct primary care (DPC).

The Catholic Church supports universal access to health care and holds that health care must respect life and dignity, be accessible and affordable to all, honor conscience rights, and be comprehensive and of high quality. Catholic health care facilities exist to welcome and serve all people, no matter their age, sex, race, or religion. So, we are not opposed to direct primary care providers as such. In fact, it would be good if there were more of them.

We also want to stress that no matter a person's condition, abilities, or self-identification, every person is created in the image and likeness of God and deserves to be treated with dignity, respect, and compassion. No one should ever face harassment, mistreatment, or unjust discrimination.

Our objection to the bill stems solely from how it embeds gender identity into Wisconsin law. Doing so would separate gender from biology and lead to serious consequences. As Pope Francis has written, "'biological sex and the socio-cultural role of sex (gender) can be distinguished but not separated.'...It is one thing to be understanding of human weakness and the complexities of life, and another to accept ideologies that attempt to sunder what are inseparable aspects of reality."[1]

When healthcare decisions are based on a patient's self-determined gender identity and not on the biological reality of sex as male and female, medicine suffers. For medical purposes, it is essential to record medical facts accurately and to provide appropriate care. A biological female has certain specific physiological conditions that a biological male does not, and vice versa.

If a medical professional declines to order a pap smear for a biological male, that is not an act of unjust discrimination. If the same medical professional declines to provide a flu shot simply because the patient identifies as transgender, that is discrimination.

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[1] Pope Francis, *Amoris Laetitia*, no. 56; quoting the *Relatio Finalis*, no. 58.

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In addition, there are free speech and religious and conscience rights that must be considered. Health care workers objecting on conscience and religious grounds should not have their constitutional rights violated. For example, the Catholic Church teaches that "Catholic health care services must not perform interventions, whether surgical or chemical, that aim to transform the sexual characteristics of a human body into those of the opposite sex or take part in the development of such procedures."[2]

If AB 953 were to become law, Catholic and other medical professionals could find themselves accused of discrimination if they do not provide certain medical services or affirm the gender identity of their patients. For example, there are Catholic DPCs that prescribe certain hormones to biological females but decline to prescribe the same hormones to biological males. Objecting to gender transition services or procedures does not constitute unjust discrimination. The objection is focused on the action, not the person.

Similarly, no medical professional, nor anyone else, should be forced to say that a biological female is a male, or vice versa. It bears repeating that all patients must be treated with respect and never be scorned or mistreated. However, compelled speech is not the way to ensure this.

Some today will argue that the 2020 U.S. Supreme Court ruling in *Bostock v. Clayton County*, which held that gender identity discrimination in employment amounts to sex discrimination under Title VII of the Civil Rights Act of 1964, necessitates the inclusion of gender identity in this bill. But this is not true.

Justice Gorsuch and the majority in *Bostock* explicitly stated that *Bostock* does not apply to any other statute besides Title VII, or even to any other set of facts under Title VII. It is only about hiring and firing on the basis of sexual orientation or transgender status. As the majority opinion noted:

> "The employers worry that our decision will sweep beyond Title VII to other federal or state laws that prohibit sex discrimination. And, under Title VII itself, they say sex-segregated bathrooms, locker rooms, and dress codes will prove unsustainable after our decision today. But...*we do not purport to address bathrooms, locker rooms, or anything else of the kind*. The only question before us is whether an employer who *fires* someone *simply for being homosexual or transgender* has discharged or otherwise discriminated against that individual 'because of such individual's sex.'" *Bostock v. Clayton County*, 140 S. Ct. 1731, 1753 (2020) (emphasis added).

In short, *Bostock* was about how to construe a specific federal statute, not other federal or state statutes. While there have been several subsequent lower court rulings holding that other sex nondiscrimination statutes must also be interpreted in light of *Bostock* to prohibit sexual orientation and gender identity discrimination, other rulings found no such foundation.[3] In short, this area of the law is far from settled.

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[2] "Doctrinal Note on the Moral Limits to Technological Manipulation of the Human Body," Committee on Doctrine, United States Conference of Catholic Bishops (March 20, 2023), https://www.usccb.org/resources/Doctrinal%20Note%202023-03-20.pdf.

[3] See *Neece v. Becerra* (2022) https://law.justia.com/cases/federal/district-courts/texas/txndce/2:2021cv00163/352435/66/

Once gender identity is enshrined into this health care law, it can and will be used to argue that objective biology, with all its attendant considerations, is secondary to subjective identity.

Views on human sexuality necessarily involve views about reality and the nature of the human person. No one should be forced to act in a manner contrary to his or her own conscience or religious beliefs, whether privately or publicly, whether alone or in association with others, within due limits. This right is especially in need of protection in the healthcare field, where decisions about life and death are made every day.

It is for this reason that conscience and religious rights are paramount.

Article I, Section 18 of the Wisconsin Constitution states that "[t]he right of every person to worship Almighty God according to the dictates of conscience shall never be infringed;...nor shall any control of, or interference with, the rights of conscience be permitted..." It should be noted that this language is even stronger than the First Amendment of the U.S. Constitution.

In conclusion, it is essential to find a way to treat each other with mutual respect. This can be done without enshrining in the law a view that opposes biological reality and forces compliance and compelled speech on those who have sound medical objections, conscience, and religious freedom claims.

We respectfully urge the committee to do one of three things: 1) remove the entire nondiscrimination clause, 2) remove gender identity, or 3) reject the bill in its current form.

Thank you.

WISCONSIN ACADEMY of PHYSICIAN ASSISTANTS

To: Chairperson Moses

Members, Assembly Committee on Health, Aging and Long-Term Care

From: Stephanie Ludtke, PA-C, Legislative & Governmental Affairs Committee Co-Chair

Irum Ziauddin, PA-C, Legislative & Governmental Affairs Committee Co-Chair

Date: February 14, 2024

Re: Support for Assembly Bill 953 – Direct Primary Care

We serve as the co-chairs of the Legislative & Government Affairs Committee of the Wisconsin Academy of Physician Assistants (WAPA). On behalf of WAPA, we are submitting this testimony in support of Assembly Bill 953.

WAPA represents physician assistants (PAs) practicing in Wisconsin. Over 4,600 PAs practice in Wisconsin, working with physicians to provide quality, cost-effective, and 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 Assembly Bill 953, 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 Assembly Bill 953, 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.

If have any questions after today's hearing, please feel free to contact R.J. Pirlot of the Hamilton Consulting Group at 608-258-9506.

BADGER INSTITUTE

Free Markets ▪ Opportunity ▪ Prosperity

New Wisconsin bill directly solves the problem with growing healthcare costs

by Dan Sem
February 2024

Direct primary care can complement insurance

Healthcare spending continues to grow. Average per person spending was $13,493 in 2022 in the U.S., or $4.5 trillion total, according to federal data.
Fortunately, a bill being considered in the Legislature, SB905, provides a solution that could make it both cheaper and more accessible via direct primary care.

The problem

A recent RAND report makes it clear that hospital consolidation, via both vertical and horizontal integration, is on the rise and decreasing competition.
It doesn't appear that the consolidations, which work against free and open markets, are helping to control costs. Generally, consumers have not shopped around because they cannot see prices — and the legacy reimbursement model of health coverage has not traditionally incentivized them to pay attention to prices anyway.

That is starting to change. Because deductibles are often high, many people must pay full price, are becoming price-sensitive, and are beginning to shop. The elements are almost in place now for a market to work.
Free and competitive markets can only operate, however, if consumers can see prices.

The recent birth of price transparency

It is only recently, thanks to the federal Hospital Price Transparency Rule, that transparency has been mandated. Starting Jan. 1, 2021, hospitals were required to provide "clear, accessible pricing information online."

Price transparency has uncovered some surprising financial realities about the medical industry, such as that prices in hospitals are higher when using insurance. One example is the provider-negotiated price for a colonoscopy, which is over $5,000, compared with the national median cash price (i.e. no insurance) of $1,635.

Johns Hopkins University accounting professor and health policy expert Ge Bai spoke recently at the Healthcare Economics Summit at Concordia University Wisconsin and noted that her study, published last year in Healthcare Affairs (April 2023), led her to conclude, "Health-care prices rise in America because most Americans have insurance" (Washington Post, April 11, 2023). She did an analysis of pricing data from 2,373 hospitals across the U.S. and found that cash prices in general were lower than those negotiated by hospitals with insurance companies.

It is because of these inflated prices when insurance is used that there has been growth in paying cash for drugs, rather than using insurance. Consumers are increasingly using tools such as GoodRx or Mark Cuban's Cost Plus Drug Co., as well as Amazon Pharmacy and Amazon One Medical, the latter of which provides primary care at $9 per month and offers 24/7 on-demand virtual care (including for mental health), with on-site clinics in some cities. Walmart and others are offering similar low-cost direct pay services for primary care. These are a type of direct primary care.

Direct primary care is a much-needed complement to insurance

The direct delivery of care, outside of the opaque reimbursement-driven model that is associated with insurance, Medicare or Medicaid, is called direct primary care, or DPC. Care is obtained directly from providers such as physicians, without the direct involvement of insurance, though additional services such as surgeries and in-hospital procedures might then use insurance.

DPC and insurance are complementary. A patient can choose to use insurance for certain more expensive procedures, presuming they also have insurance through, for example, their employer or the federal Affordable Care Act exchanges.
Under a DPC arrangement, typically with an individual physician or a small physician group, patients pay a monthly fee, typically $40 to $100, in exchange for a wide variety of services. Membership is voluntary and can be canceled or entered into at any time. Patients have 24/7 access to comprehensive and personalized primary care. Lab tests and imaging are offered at nominal extra cost.

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The arrangement avoids bureaucracy, paperwork and costly claims processing. Physicians do not engage in any kind of risk analysis for billing and consider age only in deciding how much to charge for membership rates.

The advantage of direct primary care is that no approvals are needed for procedures or services, so the physician and patient are more empowered. Care can be obtained faster and at lower cost.

DPC is a form of access to healthcare that is not meant to replace insurance, and is not insurance — so should not be regulated as insurance. Regulating DPC as if it were insurance would restrict providers' flexibility to innovate and at least partly negate DPC's cost and service advantages that stem from having less overhead for expenses such as the large buildings, infrastructure and administrative staff of hospitals.

DPC legislation in Wisconsin

More than 30 other states have already enacted laws to ensure that DPC arrangements are not regulated as if they were insurance. Such legislation was discussed in Wisconsin in 2021, but it never made it to the floor for a vote.

I attended the public hearing for that bill, 2021 Senate Bill 889, on Feb. 8, 2022, and spoke in favor of it along with DPC physicians, including Wendy Molaska, the former president of the Wisconsin Medical Society. One of the bill's sponsors, Sen. Mary Felzkowski (R-Tomahawk) spoke at our annual Healthcare Economics Summit about the importance of DPC, especially for rural communities.

The current iteration of the bill, SB905, was introduced on Jan. 11 of this year. The Senate Health Committee advanced it on a 4-2 vote on Feb. 9. If the bill does not pass the Assembly before it wraps up its session at the end of this week, then it's dead for this year. If the Assembly passes it, the Senate could take it up in March before it adjourns.

The bill includes a better recognition of the role that employers play, including them among those who may sign a DPC agreement. Employers are important stakeholders, as they typically provide healthcare benefits to employees, and the change allows DPC to be offered as an option.

The current bill also extends the criteria by which DPC providers cannot reject new patients. Previously, providers could not reject new patients based on pre-existing medical conditions. Now, the list includes race, gender, religious affiliation and disability, among others.

Among other disclosures that must be given to DPC patients by providers:

- DPC is not insurance.
- Patients must expect to pay for things that are not included in the DPC subscription fee.
- Patients are strongly encouraged to discuss the DPC plan with their insurance provider, adviser or employer-sponsored plan.

Arguably, these notifications might scare away patients new to direct-pay options. Fortunately, this version of the bill also requires that patients be made aware of the fact that "some services covered under the agreement may be covered under any health insurance the patient has."

It is good for consumers to learn that they can sometimes pay cash and sometimes use insurance, and that the two approaches are complementary. While incumbent players in an anticompetitive healthcare system might resist, direct payment will control costs while also empowering patients, physicians and employers that pay for benefits.

Daniel Sem, Ph.D., MBA, JD, is a visiting fellow of the Badger Institute. He is also an associate vice president for research and innovation, as well as a professor of business and of pharmaceutical sciences at Concordia University Wisconsin. He is also the CEO of Bridge to Cures Inc. and advisor to Retham Technologies, co-founder and vice president for business development of Estrigenix Therapeutics and serves as director of the Remedium eXchange (Rx) Think Tank.