JOE SANFELIPPO

STATE REPRESENTATIVE • 15th ASSEMBLY DISTRICT

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

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

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State Rep. Joe Sanfelippo's Testimony for Legislative Council Study Committee on Direct Primary Care

Chair Darling, Vice-Chair Nygren, and committee members, thank you for inviting me to speak to you regarding direct primary care. I appreciate that the legislature has shown interest in the potential that this healthcare delivery model holds for Wisconsin and is eager to learn more about it through this study committee. 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 health insurance premiums grow and are faced with difficult decisions: continue to pay these rising prices or accept the lower upfront costs of high-deductible health plans and try 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 last year. Businesses are affected as well, straining under the heavy burden of having to offer extensive healthcare benefits to their 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, the average wait is now over 54 days.

Faced with these realities, legislators across the country continue to search for ways to provide their constituents with affordable healthcare options while operating within their states' fiscal constraints. Increasingly, many states are recognizing that direct primary care can play an important role in addressing these healthcare policy dilemmas. 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. What 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, 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 the 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 child care responsibilities around an unnecessary pro-forma office visit, that's a real, tangible benefit to a patient's quality of life.

The DPC model also has the advantage of empowering patients by putting them back in ultimate control of their healthcare decision-making. If a patient is unhappy with the level of service that their DPC physician is providing, they have the ability to cancel their DPC membership at any time and to 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. Twenty-three other states have defined direct primary care in their laws and the federal Department of Health and Human Services has issued guidance in 2018 that it will be working with states to incorporate DPC into their Medicaid programs. 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 Department of Trade and Consumer Protection as well as the Department of Health Services are also fully able and empowered to exercise their respective regulatory oversight over the conduct of DPC agreements. This is all to say that DPC isn't a fly-by-night fad; it's a real and growing model for delivering quality healthcare that's already in place here in Wisconsin.

As you know, Senator Kapenga and I introduced legislation on direct primary care during this session, and I'd like to briefly explain what we sought to achieve. Our bill had two goals: formally codifying DPC in law and also asking the Wisconsin Department of Health Services to work with healthcare experts to study DPC and come up with what a pilot program for incorporating DPC into the Medical Assistance program would look like.

We wanted to codify DPC in law for a number of reasons. First, although direct primary care currently exists in Wisconsin, the law is silent on the model. By codifying it, as has been done in about half of the other states in the US, we hope to give direct primary care the imprimatur of the law and offer consumers and businesses confidence in dealing with DPC here in Wisconsin. Second, we wanted to implement some fundamental consumer protections, such as requirements regarding non-discrimination and covering pre-existing conditions.

We also mandated what information and disclosures the DPC agreements that patients signed had to contain. The purpose of this was to make it clear to consumers what services would and wouldn't be covered, what costs they could expect, the duration of the agreement, their termination rights, and that the direct primary care agreement did not constitute health insurance. These specific requirements were ones that we arrived at after extensive consultation with DPC providers, health insurers, DHS, the Wisconsin Office of the Commissioner of Insurance, and other interested stakeholders. Many of these provisions are already common in DPC agreements, but codifying them ensures uniformity and provides consumers with confidence through the transparency of knowing exactly what they're signing up for. We 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.

With respect to the Medicaid pilot program, we're excited by the promise that DPC brings to the healthcare system, and we want to see if there's a fit for it in the MA program. Other states are currently in the process of piloting DPC in their Medicaid programs, and the US Department of Health and Human Services is encouraging states like Wisconsin to explore how it could fit into their programs. We initially proposed a detailed model for what the DPC pilot could look like based on what Michigan was considering, but, after talking with experts across the healthcare field, we realized that it was important for us in the legislature to have the humility to acknowledge that we're not the ones best-equipped to lay out all the specifics of what a pilot would look like. That's why we amended our bill to, instead, ask DHS to convene a work group of healthcare experts from across the industry to take some time to carefully study the issue and come back to us in the legislature with an actionable proposal for what a pilot would look like. We think that there's real promise for DPC to help provide Wisconsin's Medicaid population with greater access to better healthcare, while offering the state significant cost savings. Wisconsin has always been a leader in healthcare, and part of being a leader is having the courage to explore new and innovative approaches. We welcome the opportunity that a pilot would afford to gather data and learn more about ways in which we could improve our healthcare system 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.