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Direct Primary Care State Approaches to Regulating Subscription-Based Medicine

Jessie Gibbons
legislative analyst



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One East Main Street, Suite 200, Madison, Wisconsin 53703
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Overview

Direct Primary Care (DPC) is a health care payment model in which physicians contract directly with patients to provide care outside the traditional insurance-based system. Instead of billing health insurers, DPC providers charge their subscribers a monthly fee per individual, ranging from approximately \$25 to \$125 per person. In exchange, subscribers receive unlimited primary care services—including physical exams, management of chronic diseases, and diagnoses of acute illness—usually at no additional cost.

Dozens of DPC providers are currently practicing in Wisconsin, and many physicians and patients who are using the model are satisfied with it. Patients appreciate that they can spend more time with their physicians and have more immediate access to care, while physicians like that the model allows them to streamline their practices and reduce the administrative burden of billing health insurers. However, many stakeholders in the health care industry have expressed concerns about the DPC model being a duplicative and unregulated form of health insurance.

In Wisconsin, medical practices currently using the DPC payment model are operating legally, and the agreements between patients and providers vary from practice to practice. State insurance law does not regulate DPC, though the Office of the Commissioner of Insurance (OCI) can decide on a case-by-case basis whether DPC practices are providing insurance unlawfully.¹ The only statutory requirement under current law—applicable to all practicing physicians regardless of which payment model they use—is that providers practice within the scope of their professional licenses, which are granted by the Wisconsin Medical Examining Board.²

In recent years, many states have adopted legislation that defines DPC, exempts providers from insurance regulations, and standardizes DPC agreements between patients and physicians. As of January 2020, 28 states have enacted DPC legislation.³ Although regulations have not yet been adopted in Wisconsin, legislation has been introduced in the state legislature.

This publication examines the practice of DPC in Wisconsin and beyond. Part I provides background information on the DPC payment model and the ways in which it differs from the traditional fee-for-service model. Part II briefly highlights the current status of DPC in Wisconsin. Part III analyzes the policies other states have implemented to regulate the DPC payment model. And Part IV reviews recent legislative efforts in this state. The publication concludes with part V, a summary of the policy options available to legislators in Wisconsin.

1. Wis. Legis. Council Study Committee on Direct Primary Care, Meeting Materials, Presentation by Elizabeth Hizmi and Zach Bemis, Office of the Commissioner of Insurance: *Direct Primary Care and Insurance* (July 24, 2018), <https://docs.legis.wisconsin.gov>.

2. Wis. Stat. § 448.03 (1).

3. See the Appendix for brief summaries of the existing DPC laws in these 28 states.

I. The DPC model

DPC has emerged as one of several alternatives to the traditional fee-for-service payment model. In a fee-for-service practice, health care providers are reimbursed—typically by health insurers—for each service they provide. Critics of the traditional fee-for-service model say it results in physicians providing an unnecessary volume of care, taking on large patient panels of 2,500 or more individuals, limiting face-to-face time with patients, and spending significant time on administrative work.⁴ According to the American Academy of Family Physicians (AAFP), under the fee-for-service model, nearly 50 percent of a physician’s time is spent outside of patient visits completing paperwork or communicating with other providers to coordinate care.⁵

Many physicians practicing under this traditional model cite this administrative burden—combined with large patient panels and limited patient interaction—as a driver of job dissatisfaction. In studies that measure stress and exhaustion among physicians, over half of those surveyed regularly say they are experiencing burnout.⁶ Physician burnout has been linked to medical errors, unnecessary referrals, higher hospital admissions and readmissions, and early retirement, among other things.⁷

Under the DPC model, health care providers charge patients directly, typically through a monthly subscription fee.⁸ In some states, providers may also contract with employers or Medicaid programs. When this occurs, employers or Medicaid programs cover the cost of their beneficiaries’ monthly subscription fees. According to one nationwide survey of DPC providers conducted in 2015, the median monthly subscription fee is \$75, and the average is \$93; a quarter of all providers surveyed charge additional fees per visit ranging from \$5 to \$35.⁹ Monthly subscription fees vary depending on the age of the subscriber, with younger patients typically paying the lowest fees and older patients paying the highest fees.

Since physicians can provide care only within the scope of their medical licenses, most providers advise their subscribers to purchase health insurance. Many are insured by high-deductible health plans, which have low monthly premiums and high deductibles

4. Robert Doherty, “Assessing the Patient Care Implications of ‘Concierge’ and Other Direct Patient Contracting Practices: A Policy Position Paper from the American College of Physicians,” *Annals of Internal Medicine*, 163, no. 12 (Dec. 2015), 949–52.

5. American Academy of Family Physicians, *Direct Primary Care: An Alternative Practice Model to the Fee-For-Service Framework* (American Academy of Family Physicians, April 2014), 1, <http://aafp.org>.

6. Agency for Healthcare Research and Quality, *Physician Burnout* (Rockville, MD: Agency for Healthcare Research and Quality, July 2017), 1, <http://ahrq.gov>.

7. John Noseworthy, James Madara, Delos Cosgrove, Mitchell Edgeworth, Ed Ellison, Sarah Krevans, Paul Rothman, Kevin Sowers, Steven Strongwater, David Torchiana, and Dean Harrison, “Physician Burnout Is A Public Health Crisis: A Message To Our Fellow Health Care CEOs,” *Health Affairs*, (March 28, 2017), <http://healthaffairs.org>.

8. DPC differs from concierge medicine—a payment model in which physicians often charge thousands of dollars per month in membership fees—in that it is more financially accessible to patients.

9. Andis Robeznieks, “Pondering Direct Care? 13 Potential Benefits and Drawbacks,” *American Medical Association*, (October 10, 2018), <http://ama-assn.org>.

and offer coverage when specialty or hospital care is needed. In some states, these plans can be purchased in combination with DPC subscriptions through the health insurance marketplaces created by the Patient Protection and Affordable Care Act.¹⁰ When combined, DPC subscriptions and high-deductible health plans provide individuals with a form of comprehensive health coverage.

Benefits of DPC

Proponents of the DPC model say the monthly subscription payment structure provides an incentive for physicians to prioritize the long-term health of their patients and to reduce unnecessary care and testing. They say the simplicity of the model makes primary care practices more efficient and allows many practices to reduce their administrative staffs. According to the AAFP, DPC practices have significantly reduced operating costs compared to those practicing under the traditional fee-for-service model.¹¹

Increased adoption of the DPC model could lead to reduced waste in the health care system, according to proponents. One 2019 study published in the *Journal of the American Medical Association* found the estimated cost of annual waste in the American health care system to be as high as \$935 billion—approximately 25 percent of total health care spending.¹² The study found that administrative complexity accounts for approximately \$257 billion in waste each year, and overtreatment accounts for up to \$101 billion.¹³ In a DPC setting, both administrative costs and the volume of care provided are typically reduced.

Proponents of DPC also prefer the smaller patient panels that these practices maintain. Established DPC physicians typically aim to keep their patient panels in the 600–800 range—a fraction of the size of a typical panel in the fee-for-service system.¹⁴ As a result, DPC providers often spend more time interacting with patients. A study of one large DPC practice found that patients spend an average of 35 minutes per visit with their providers; in a more traditional practice, the average is eight minutes.¹⁵

Another frequently cited benefit of DPC is that most physicians are available for same-day appointments and have on-call physicians 24 hours a day.¹⁶ DPC practices often provide care over the phone or Internet when needed—a service that is less frequently

10. 45 CFR § 156.245.

11. American Academy of Family Physicians, *Direct Primary Care*, 2.

12. William Shrank, Teresa Rogstad, and Natasha Parekh, “Waste in the US Health Care System: Estimated Costs and Potential for Savings,” *Journal of the American Medical Association*, 322, no. 15 (Oct. 2019), 1501-09.

13. Shrank, Rogstad, and Parekh, *Waste in the US Health Care System*, 1501–09.

14. Charlotte Huff, “Direct Primary Care: Concierge Care for the Masses,” *Health Affairs*, 34, no. 12 (Dec. 2015), 2016–19, p. 2017.

15. Philip Eskew and Kathleen Klink, “Direct Primary Care: Practice Distribution and Cost Across the Nation,” *The Journal of the American Board of Family Medicine*, 28, no. 6 (Nov. 2015), 793–801.

16. American Academy of Family Physicians, *Direct Primary Care*, 2.

used in the fee-for-service system as physicians do not receive insurance reimbursements for many telecommunications services. This increased accessibility may allow some DPC subscribers requiring immediate care to avoid costly emergency room visits.

Supporters of DPC believe the benefits of the model give it the potential to revitalize the primary care field, improve job satisfaction, and prevent physician burnout. They believe that increased adoption by both new and veteran physicians in the years ahead could improve access to care in geographic areas facing primary care shortages.

Drawbacks of DPC

Critics of the DPC model have several concerns, including the belief that the model does not fit into today's insurance-based health care system. Most health insurance plans offer comprehensive preventive and primary care at no or very little cost to patients, making DPC subscriptions duplicative and an unnecessary expense. For insured individuals, purchasing a DPC subscription at a typical rate of \$50 per month may not be economical. Additionally, because DPC providers do not bill health insurance, any care they provide to an insured individual does not count towards the individual's deductible or out-of-pocket limit. As a result, insured individuals who use care outside the DPC setting may pay more out-of-pocket than they otherwise would.

Critics also argue that individuals with DPC subscriptions may be more likely to opt out of purchasing comprehensive health insurance and rely solely on their DPC subscriptions for the medical care they require. When uninsured subscribers require specialty or hospital care, they must pay out-of-pocket, take on medical debt, or decline treatment.

Another concern is that the DPC model may not be financially sustainable in the long-term, despite the consistent income that is provided by the monthly subscription model. For instance, the Qliance Medical Group, a large practice in Seattle, Washington, opened its doors in 2007 and quickly became the nation's largest DPC practice, providing care to more than 35,000 patients, half of whom were Medicaid enrollees.¹⁷ It served as a model in the DPC sphere, showing health care providers and policymakers exactly what large-scale DPC practices could accomplish. However, after ten years, the group began facing financial challenges and closed its offices in 2017; in May 2018, it filed for bankruptcy.¹⁸ The failure of Qliance illustrates the financial risk involved with running large, subscription-based practices.

When DPC practices like Qliance close their doors unexpectedly, subscribers lose access to their DPC providers. They may also lose prepaid subscription fees. Because DPC contracts are unregulated in many states, including Wisconsin, patient protections

17. University of Wisconsin Population Health Institute, *Direct Primary Care: Potential Impact on Cost, Quality, Health Outcomes, and Provider Workforce Capacity* (Madison: WI: University of Wisconsin Population Health Institute, 2018), 20, <http://docs.legis.wisconsin.gov>.

18. University of Wisconsin Population Health Institute, *Direct Primary Care*, 20.

for those in DPC arrangements do not exist in statute beyond the general consumer protections that are in place. Patients who are unsatisfied with their care or who lose access to it unexpectedly could be affected financially under the subscription model.

The unregulated environment is a concern for physicians using the DPC model as well. Under current state law, the OCI determines on a case-by-case basis whether DPC practices are offering their subscribers health insurance or simply providing medical care.¹⁹ While no practices in Wisconsin have been affected by insurance determinations made by the OCI to date, providers in other states have received notices from insurance commissioners warning them to either discontinue the practice of DPC or “face criminal prosecution for engaging in the unlawful sale of insurance.”²⁰ Many DPC providers are supportive of defining the model in statute and exempting it from state insurance law, saying it would offer legal protection, bring stability to the industry, and result in increased adoption of the payment model.²¹

II. DPC in Wisconsin

Several DPC practices have been operating in Wisconsin for years, though the exact number of medical practices using the DPC model in the state is unknown. In a survey of the Wisconsin Academy of Family Practice Physicians’ 2,000 active members, around 25 physicians—just over 1 percent of the group’s members—said they were using the DPC model.²² Another source, an advocacy group called DPC Frontier, lists around 25 DPC providers in the state.²³ Nationwide, an estimated 13 percent of physicians are using the DPC model to some extent,²⁴ and as many as 43 percent are considering transitioning to a DPC payment model.²⁵

DPC agreements between patients and physicians are not standardized in Wisconsin, and they vary from practice to practice in the services that are provided and the cost of the subscriptions. The subscriptions for three typical DPC practices in Wisconsin are summarized in the table on page 6.

Among the three practices, monthly subscription fees vary from \$15 to \$110 per individual, depending on age. Distinct subscription offerings at these three practices

19. Wis. Legis. Council Study Committee on Direct Primary Care, *Direct Primary Care and Insurance*.

20. Philip Eskew, “Direct Primary Care Business of Insurance and State Law Considerations,” *Journal of Legal Medicine*, 37, no. 1–2 (Sept. 2017), 145–54.

21. Wis. Legis. Council Study Committee on Direct Primary Care, Presentations by Dr. Steve Bondow, Dr. Philip Eskew, and Dr. Joshua Umbeh, *Overview of the Direct Primary Care Model by DPC Provider Panel*, (July 24, 2018), <http://docs.legis.wisconsin.gov>.

22. Scott Gordon, “How Does Direct Primary Care Fit into Wisconsin’s Search for Health Solutions?” *WisContext*, April 14, 2018, wiscontext.org.

23. “DPC Frontier Mapper,” Direct Primary Care Frontier, accessed October 2, 2019, <http://mapper.dpcfrontier.com>.

24. Eli Adashi, Ryan Clodfelter, and Paul George, “Direct Primary Care: One Step Forward, Two Steps Back,” *Journal of the American Medical Association*, 320, no. 7 (Aug. 2018), 637–8.

25. Charlotte Huff, *Direct Primary Care*, 2017.

include a family membership for up to six individuals, an option specifically for nursing home residents, a group subscription for employers, and a hybrid DPC model that also allows patients to pay per visit or use health insurance. All three of the DPC subscriptions include comprehensive primary care and physical exams for both children and adults, along with same- or next-day appointments and access to physicians after regular business hours.

Summary of three direct primary care subscriptions in Wisconsin

Practice name and location	Monthly subscription fees	Sampling of services included in subscription
DIME Medical City: Darlington County: Lafayette	Child (under 18): \$25 Adult (18 and over): \$50 Family (up to 6 members): \$150 Note: Patient panel is capped at 300 members.	<ul style="list-style-type: none"> • Comprehensive primary care • Chronic disease management • Treatment of acute illness • Minor procedures, splinting, and casting • Low-cost lab tests • 24-hour physician access
MedLogic City: Kenosha County: Kenosha	Child (under 18): \$40 Adult (18–45): \$72 Adult (46–59): \$82 Adult (60 and older): \$95 Nursing home/assisted living: \$110 Corporate subscription (minimum of 10 adults per subscription): \$70	<ul style="list-style-type: none"> • Comprehensive primary care • Treatment of acute illness • Pediatric well visits (birth to 18 years of age) • Prenatal and postnatal care of pregnant women • Smoking cessation counseling • Same- or next-day appointments and after-hours cell phone access to physicians
Priority Medical Partners City: Rhineland County: Oneida	Child (6–17): \$15 Adult (18–29): \$59 Adult (30–44): \$69 Adult (45–64): \$79 Note: This practice also offers the option to pay per visit or using insurance.	<ul style="list-style-type: none"> • Comprehensive primary care • Office-based surgical procedures • Low-cost lab tests • Same- or next-day appointments and virtual visits

III. DPC regulations in 28 states

Twenty-eight states—including the midwestern states of Michigan, Iowa, and Indiana—have enacted legislation in recent years to define or regulate DPC in state law. Brief summaries of the legislation enacted in each state can be found in the appendix on page 12 of this publication. The DPC laws in most states include the following four basic components:

1. **A definition of DPC agreements and other key terms in statute.** In Iowa, for instance, a DPC agreement is defined as “an agreement between a direct provider and a direct patient, or the direct patient’s representative, in which the direct provider agrees to provide primary care health services for a specified period of time to the direct patient for a

direct service charge.”²⁶ Iowa’s statutes also define “direct patient,” “direct provider,” and “primary care health services,” among other things. Most DPC laws in other states include similar definitions.

2. An exemption of DPC practices from state insurance laws. In Indiana, for instance, the law states: “A direct primary care agreement is not insurance and is not subject to IC 27.”²⁷ It also states: “Entering into a direct primary care agreement is not the business of insurance and is not subject to IC 27.”²⁸ This language offers legal protection to DPC providers in Indiana and makes it clear that their practices are not subject to state insurance regulations. Most DPC laws in other states include similar provisions. However, the State of Oregon does not exempt DPC practices from insurance laws. In that state, the law requires practices to attain certification from the Oregon Department of Consumer and Business Services, and practices must be financially responsible and have the business experience needed to operate as a DPC practice.²⁹

3. A requirement that DPC agreements include specific disclaimers or state that DPC is not insurance. In Nebraska, for instance, state law requires all DPC agreements to include a specific notice that reads: “This direct primary care agreement does not constitute insurance and is not a medical plan that provides health insurance coverage for purposes of any federal mandates . . . It is recommended that insurance be obtained to cover medical services not provided for under this direct primary care agreement.”³⁰ In Michigan, the law does not require a certain disclaimer, but it does state that agreements must “prominently state in writing that the agreement is not health insurance.”³¹ Both of these provisions make it clear to patients signing DPC agreements that they are not purchasing insurance coverage. Most DPC laws in other states include similar requirements.

4. An outline of the requirements of DPC agreements. In Kentucky, for instance, DPC agreements must state all of the following: the agreed-upon subscription fee, the additional fees for services not included, the agreed-upon period of time for which the agreement will last, the automatic renewal periods, the included primary care services, that the provider will not bill a health insurance plan for the services provided, that patients are not required to pay more than 12 months in advance, that the fee may be paid by a third party, that either party may terminate the agreement in writing without penalty, that all unearned fees will be returned to the patient following termination, and that the agreement does not constitute health insurance.³² Most DPC laws in other states outline similar requirements for DPC agreements.

26. [Iowa Code § 135N.1 I. c.](#)

27. [Burns Ind. Code Ann. § 25-1-10-4-a](#)

28. [Burns Ind. Code Ann. § 25-1-10-4-b](#)

29. [Or. Rev. Stat. § 735.500 \(2\)](#)

30. [Neb. Rev. Stat. § 71-9504-1-k](#)

31. [Mich. Comp. Laws § 500.129 \(3\) \(g\)](#)

32. [Ky. Rev. Stat. § 311.6201 \(1\)](#)

Several state laws include provisions beyond these four basic components. Many states specify the conditions under which providers can decline patients wishing to subscribe. For instance, in Alabama, a DPC provider can decline to accept a patient if “the patient’s medical condition is such that the provider is unable to provide the appropriate level and type of health care.”³³ Louisiana state law includes a similar provision. It also allows providers to decline new patients “if the practice has reached its maximum capacity.”³⁴

Other state laws specify whether groups such as employers or Medicaid programs can or cannot purchase DPC subscriptions on behalf of patients. In Idaho, the law states: “A direct primary care agreement may not be sold to a group, employer or group of subscribers because it is an individual agreement between a primary care provider and a patient.”³⁵ The law in Nebraska is quite different. It states: “A direct provider may accept payment of direct service charges directly or indirectly from third parties. A direct provider may accept all or part of a direct service charge paid by an employer on behalf of an employee who is a direct patient.”³⁶

Three states have enacted legislation to create pilot programs to test the sale of DPC subscriptions. The West Virginia State Legislature was the first to pass such a law in 2006. It created a pilot program to test DPC subscriptions “for uninsured children of families with incomes between 200 and 300 percent of the federal poverty level.”³⁷ Michigan was the second state to create a DPC pilot program. In 2017, the Michigan State Legislature passed an appropriations bill that provided the funds to create a pilot program for up to 400 enrollees in the state-administered Medicaid program.³⁸ And in 2018, the Nebraska State Legislature passed legislation to create a DPC pilot program for state employees and their dependents under the Nebraska State Insurance Program.³⁹

Other key differences between the 28 laws that have been enacted at the state-level as of January 2020 can be seen in the appendix on page 12. The appendix includes hyperlinks to the DPC legislation and statutes of each state.

IV. Recent legislative action in Wisconsin

In recent years, the Wisconsin Legislature has introduced legislation to define DPC and exempt practices from state insurance law, but no proposals have been signed into law to date. In December 2017, State Representative Joe Sanfelippo, State Senator Chris Kapenga,

33. [Ala. Code § 22-7A-1-g](#)

34. [La. Stat. Ann. § 37:1360.85 \(A\)](#)

35. [Idaho Code § 39-9208](#)

36. [Neb. Rev. Stat. § 71-9508](#)

37. [West Virginia 2006 House Bill 4021](#)

38. [Michigan 2017 Senate Bill 253](#)

39. [Nebraska 2018 Legislative Bill 1119](#)

and several other legislators introduced companion proposals⁴⁰ 2017 Assembly Bill 798 and 2017 Senate Bill 670. Like DPC legislation in other states, these bills defined DPC agreements, outlined the requirements of valid agreements, stated that DPC is not health insurance, and created a pilot program within the state’s Medicaid program. The Assembly passed AB 798, as amended, in February 2018, but the Senate failed to concur.

If adopted as amended, the bill would have done the following:⁴¹

- Defined DPC agreements to mean: “A contract between a health care provider and an individual patient or his or her legal representative or employer in which the health care provider agrees to provide routine health care services to the individual patient or employees for an agreed-upon fee and period of time.”
- Required valid DPC agreements to be in writing, to be signed by both parties, to state that either party may terminate the agreement upon written notice, to describe the services provided under the agreement, to specify the fee and the terms of the agreement (including any possible refund of fees to the patient), to specify the duration of the agreement, to state that the agreement is not health insurance, to state that both parties are prohibited from billing insurers or third parties for services provided, to state that the patient must pay for all services that are not specified under the agreement, and to state that patients should consult with their insurance carriers prior to entering into DPC agreements.
- Prohibited DPC providers from discriminating on the basis of several factors, including age, sex, disability, health status, or the existence of preexisting medical conditions when deciding with which patients they will enter into DPC agreements. However, it would have allowed DPC providers to base subscription fees on age.
- Required the Department of Health Services to create a work group to study the integration of DPC agreements into the Medicaid program and to propose a DPC pilot program in the Medicaid program.

In 2018, the Legislative Council Study Committee on Direct Primary Care was created and tasked with reviewing the practice of DPC, recommending legislation regarding the requirements for DPC agreements in the private market, and recommending legislation regarding a DPC pilot program in the Medicaid program.⁴² The committee’s 14 members—consisting of both legislators, stakeholders, and members of the public—met publicly three times in the summer of 2018 and heard from dozens of DPC providers, professional associations, and health policy experts about the practice of DPC in Wisconsin and other states.

Some members of the study committee recommended legislative action to define or

40. Companion proposals are identical bills introduced in both houses for simultaneous consideration.

41. [2017 Wis. ASA 1 to AB 798](#)

42. “2018 Legislative Council Study Committee on Direct Primary Care,” Wisconsin State Legislature, <http://docs.legis.wisconsin.gov>.

regulate DPC, while others felt strongly that state regulation is unnecessary. Ultimately, members of the study committee could not reach consensus on defining DPC in statute, exempting it from state insurance law, adding additional consumer protections to state law, or recommending the creation of a pilot program in the Medicaid program.⁴³

The study committee members did, however, reach a consensus on the following two measures at their final meeting in September 2018:⁴⁴ (1) that the DPC model adds value to the health care system in Wisconsin; and (2) that a DPC pilot program should be considered within the current structure of the state employee health program. No other legislative activity occurred on the DPC issue in the remainder of the 2017–18 legislative session.

In the current legislative session, Representative Sanfelippo, Senator Kapenga, and several other legislators reintroduced a revised version of their DPC legislation. Like the bills that these legislators introduced in 2017, the current bills—companion proposals 2019 Assembly Bill 26 and 2019 Senate Bill 28—define DPC, outline the requirements of valid DPC agreements, and state that DPC agreements are not health insurance.⁴⁵ Unlike the 2017 version of the bills, the 2019 version does not create a workgroup to study the integration of DPC into the Medicaid program or propose a pilot program within the Medicaid program. At a Senate Committee on Health and Human Services hearing held on June 6, 2019, Senator Kapenga said the Medicaid provisions were removed from the bill due to concerns expressed by stakeholders.⁴⁶

Public hearings have been held on both AB 26 and SB 28 in the current legislative session, and many have expressed their support for them. As of January 2020, neither chamber has voted on the legislation.

V. The future of DPC in Wisconsin

Multiple paths forward are available to legislators in Wisconsin on the issue of DPC. Lawmakers can allow physicians to practice under the status quo. Under this option, the OCI would continue to determine on a case-by-case basis whether DPC physicians are practicing lawfully, and patients and physicians would continue benefiting from the value of the DPC model without legal protections or requirements in place.

Lawmakers can adopt legislation creating a pilot program for Wisconsin state employees, as members of the 2018 Legislative Council Study Committee on DPC recommended. If this option is selected, the Nebraska pilot program for state employees and

43. 2018 Legislative Council Study Committee on Direct Primary Care, *Report to the Joint Legislative Council* (Madison, WI: Wisconsin Legislative Council, January 10, 2019), 8, legis.wisconsin.gov.

44. 2018 Legislative Council Study Committee on Direct Primary Care, *Report to the Joint Legislative Council*, 11.

45. [2019 Wis. AB 26](#)

46. Senate Committee on Health and Human Services, *Public Hearing on 2019 SB 28* (June 6, 2019), <https://docs.legis.wisconsin.gov>.

their dependents could serve as a model. This path would allow legislators to continue studying DPC while providers adapt to the increased demand for services that could occur.

Finally, lawmakers can adopt 2019 AB 26 or SB 28, which have several supporters in the legislature and in Wisconsin's primary care field. If enacted, this option would define DPC in statute, exempt agreements from state insurance laws, and standardize DPC agreements. This path would offer protections to both providers and patients who use the payment model in Wisconsin. ■

Appendix

Summary of twenty-eight state Direct Primary Care (DPC) laws

State statute	Legislation	Key components of state law*
<u>Alabama</u>	<u>2017 Senate Bill 94</u>	<ul style="list-style-type: none">• Defines DPC• Exempts DPC from insurance law• Outlines requirements of DPC agreements• Allows DPC providers to decline patients with complex health needs• Requires agreements to include disclaimer
<u>Arizona</u>	2014 Senate Bill 1404 (law amended by <u>2019 House Bill 2113</u>)	<ul style="list-style-type: none">• Defines DPC• Exempts DPC from insurance law• Outlines requirements of DPC agreements• Requires agreements to include disclaimer
<u>Arkansas</u>	<u>2015 House Bill 1161</u> (law amended by <u>2017 House Bill 2240</u>)	<ul style="list-style-type: none">• Defines DPC• Exempts DPC from insurance law• Outlines requirements of DPC agreements• Requires agreements to include disclaimer
<u>Colorado</u>	<u>2017 House Bill 1115</u>	<ul style="list-style-type: none">• Defines DPC• Exempts DPC from insurance law• Outlines requirements of DPC agreements• Allows DPC providers to decline patients with complex health needs• Requires agreements to include disclaimer
<u>Florida</u>	<u>2018 House Bill 37</u>	<ul style="list-style-type: none">• Defines DPC• Exempts DPC from insurance law• Outlines requirements of DPC agreements• Requires agreements to include disclaimer
<u>Georgia</u>	<u>2019 Senate Bill 18</u>	<ul style="list-style-type: none">• Defines DPC• Exempts DPC from insurance law• Outlines requirements of DPC agreements• Allows DPC providers to decline patients with complex health needs• Requires agreements to include disclaimer
<u>Idaho</u>	<u>2015 Senate Bill 1062</u>	<ul style="list-style-type: none">• Defines DPC• Exempts DPC from insurance law• Outlines requirements of DPC agreements• Requires agreements to include disclaimer• Prohibits groups from subscribing to DPC
<u>Indiana</u>	<u>2017 Senate Bill 303</u>	<ul style="list-style-type: none">• Defines DPC• Exempts DPC from insurance law• Outlines requirements of DPC agreements• Requires agreements to include disclaimer
<u>Iowa</u>	<u>2018 House Bill 2275</u>	<ul style="list-style-type: none">• Defines DPC• Exempts DPC from insurance law• Outlines requirements of DPC agreements• Prohibits DPC providers from declining patients based solely on health status• Requires agreements to include disclaimer

State statute	Legislation	Key components of state law*
<u>Kansas</u>	<u>2015 House Bill 2225</u>	<ul style="list-style-type: none"> • Defines DPC • Exempts DPC from insurance law • Outlines requirements of DPC agreements • Requires agreements to include disclaimer
<u>Kentucky</u>	<u>2017 Senate Bill 79</u>	<ul style="list-style-type: none"> • Defines DPC • Exempts DPC from insurance law • Outlines requirements of DPC agreements • Requires agreements to include disclaimer
<u>Louisiana</u>	<u>2014 Senate Bill 516</u>	<ul style="list-style-type: none"> • Defines DPC • Exempts DPC from insurance law • Outlines requirements of DPC agreements • Allows DPC providers to decline patients with complex health needs • Allows DPC providers to decline patient when practice is at maximum capacity • Allows DPC providers to accept payment of fees from Medicaid • Requires agreements to include disclaimer
<u>Maine</u>	<u>2017 Senate Paper 472</u>	<ul style="list-style-type: none"> • Defines DPC • Exempts DPC from insurance law • Requires agreements to include disclaimer
<u>Michigan</u>	<u>2015 Senate Bill 1033</u> (law amended to include pilot program by <u>2017 Senate Bill 253</u>)	<ul style="list-style-type: none"> • Defines DPC • Exempts DPC from insurance law • Outlines requirements of DPC agreements • Requires agreements to include disclaimer • Appropriates funds for DPC pilot program for enrollees of Medicaid
<u>Mississippi</u>	<u>2015 Senate Bill 2687</u>	<ul style="list-style-type: none"> • Defines DPC • Exempts DPC from insurance law • Outlines requirements of DPC agreements • Allows DPC providers to decline patients with complex health needs • Allows DPC providers to decline patient when practice is at maximum capacity • Requires agreements to include disclaimer
<u>Missouri</u>	<u>2015 House Bill 769</u>	<ul style="list-style-type: none"> • Defines DPC • Exempts DPC from insurance law • Outlines requirements of DPC agreements • Allows patients to pay fees from health savings accounts, flexible spending arrangements, or health reimbursement arrangements • Requires agreements to include disclaimer
<u>Nebraska</u>	<u>2016 Legislative Bill 817</u> (law amended to create pilot program by <u>2018 Legislative Bill 1119</u>)	<ul style="list-style-type: none"> • Defines DPC • Exempts DPC from insurance law • Outlines requirements of DPC agreements • Prohibits DPC providers from declining patients based solely on health status • Allows DPC providers to accept payment of fees from Medicaid • Requires agreements to include disclaimer • Creates a DPC pilot program for state employees within the Nebraska State Insurance Program

State statute	Legislation	Key components of state law*
New Hampshire	2019 House Bill 508	<ul style="list-style-type: none"> • Defines DPC • Exempts DPC from insurance law • Outlines requirements of DPC agreements • Allows DPC providers to decline patients with complex health needs • Allows DPC providers to decline patient when practice is at maximum capacity • Requires agreements to include disclaimer
Ohio	2019 House Bill 166	<ul style="list-style-type: none"> • Exempts DPC from insurance law • Outlines requirements of DPC agreements
Oklahoma	2015 Senate Bill 560	<ul style="list-style-type: none"> • Defines DPC • Exempts DPC from insurance law • Outlines requirements of DPC agreements
Oregon	2011 Senate Bill 86	<ul style="list-style-type: none"> • Defines DPC • Requires DPC practices to attain certification from Department of Consumer and Business Services • Requires DPC practices to be financially responsible and have business experience or expertise to operate the practice
Tennessee	2016 House Bill 2323	<ul style="list-style-type: none"> • Defines DPC • Exempts DPC from insurance law • Outlines requirements of DPC agreements
Texas	2015 House Bill 1945	<ul style="list-style-type: none"> • Defines DPC • Exempts DPC from insurance law
Utah	2012 House Bill 240	<ul style="list-style-type: none"> • Defines DPC • Exempts DPC from insurance law • Outlines requirements of DPC agreements
Virginia	2017 Senate Bill 800	<ul style="list-style-type: none"> • Defines DPC • Exempts DPC from insurance law • Requires agreements to include disclaimer
Washington	2007 Senate Bill 5958	<ul style="list-style-type: none"> • Defines DPC • Exempts DPC from insurance law • Allows DPC providers to decline patients with complex health needs • Allows DPC providers to decline patient when practice is at maximum capacity • Requires providers to submit annual reports to Office of Insurance Commissioner • Requires agreements to include disclaimer
West Virginia	2006 House Bill 4021 (replaced by 2017 House Bill 2301)	<ul style="list-style-type: none"> • Defines DPC • Exempts DPC from insurance law • Allows DPC providers to accept payment for services provided to Medicaid enrollees • Outlines requirements of DPC agreements
Wyoming	2016 Senate File 0049	<ul style="list-style-type: none"> • Exempts DPC from insurance law • Outlines requirements of DPC agreements

*This table summarizes select components of DPC laws and is not a comprehensive list of provisions. To view the laws in full, click the hyperlinks in the “State statute” column.