Statement on SB 926
Direct Primary Care Medical Service Agreements

Pennsylvania State Senate Banking & Insurance Committee

December 12, 2017

My name is Jay Keese. I am Executive Director of the Direct Primary Care Coalition in Washington, DC. Thank you for the opportunity to testify today on SB 926 and the growth of direct primary care across the nation. As a native Pennsylvanian, born and raised in Delaware County, it is an honor to come before the Committee with novel ideas about to how to give Pennsylvanians of all incomes unfettered access to great primary care. By doing this we can help improve health outcomes, and reduce costs, particularly for patients struggling with rising premiums and out of pocket expenses.

The Coalition's goal is to promote good public policy improving access to primary care using a model called direct primary care (DPC) – an innovative alternative payment model that puts patients and their physicians back in the driver's seat to make decisions about their healthcare. We are a grassroots organization; our members are mostly physicians who have been leading the charge across America to simplify and improve the care continuum. About a quarter of our members are students and residents who are clamoring for changes to the system to make primary care a viable career option for them. We also have institutional members such as the American Academy of Family Physicians, and state chapters which support DPC as the most effective alternative payment model for primary care providers in both small and larger practices.

We've been active in passing Direct Primary Care legislation at the Federal level and in 23 states around the country. These state laws, like SB 926 on Direct Primary Care Medical Service Agreements, generally define DPC as a medical service, like any other, regulated by state boards of medicine outside of the jurisdiction of insurance regulation. Legislation has also initiated DPC programs in Medicaid and for state employees. The coalition was first established

to support the inclusion of language in the Affordable Care Act defining DPC as a delivery reform, allowing DPC to be offered in combination with qualified health plans as a covered essential health benefit with employer sponsored plans and in the exchanges. Regulations promulgated by the U.S. Department of Health and Human Services defines direct primary care as medical services which are not insurance and are based on the model described in the Washington state Direct Practice Act (48.150 RCW).

So What is Direct Primary Care? Simply put, DPC offers high-functioning primary care and prevention services outside of third party fee-for-service insurance paid for directly with a periodic fee; usually a monthly retainer. These fees can be paid by an individual, employer, or health plan. Increasingly it is smaller, self-insured employers who are interested in creating seamless first dollar coverage for their employees while minding premium costs using a high deductible.

There are about 700 DPC Practices in 48 States and DC. In Pennsylvania, there are more than 27 practices in almost every corner of the state. Currently, the national median fee is about $70 per month. DPC is recognized as a significant payment and delivery reform achieving the goals of the often touted "triple aim" of health reform: better health outcomes, greater patient satisfaction, and reduced costs.

Patients with high deductible health plans can significantly reduce out of pocket expenses using a fixed DPC arrangement without copays or deductibles. Providers also typically arrange discounts for services beyond the DPC agreement, like labs, imaging, and pharmacy. Savings of $3,000 per patient per year are not uncommon. [1] Employer claims data shows that by preventing and treating more health conditions in a fixed cost primary care setting, reductions

[1] Chad Savage, MD Presentation using actual e-identified patient data 10/12/17 (Florida Medical Association, Physicians Foundation)

in the total cost of care among patients using DPC up to 20 percent are possible. [2] Claims data also shows inpatient hospital admissions have been reduced by 37%[3] using DPC.

DPC reduces administrative expenses because there are no claims filed through insurers. Overhead costs, typically about 40 percent, can be reduced to as little as 10 percent. DPC is not insurance, but it partners well with insurance to provide an affordable benefit package with what amounts to first dollar coverage.

A key part of DPC is a direct agreement; a contract between doctor and patient, which outlines all the services provided by a DPC practitioner. In SB 926, it's referred to as a Medical Service Agreement. This agreement also outlines the patient's rights and responsibilities in the relationship. The fee can be paid for by the individual, an employer, or a third-party payer such as an insurer. DPC is completely agnostic as to who pays the monthly fees. DPC is not insurance, but DPC providers partner well with insurance to provide a comprehensive benefit. Medical services outside the agreement, such as specialty care, hospitalization, or tests not routinely done in a physician's office are still covered by insurance. Insurance can then do what is does best; which is to insure against unpredictable, risky, and potentially high cost episodes of care, such as Cancer or traumatic injury.

Primary docs then do what they do best; routine healthcare, prevention, wellness and medical advice that is better offered outside the misaligned incentives in fee-for-service healthcare. In a DPC arrangement, the fees paid to the physician are not tied to a visit or a procedure. Patients use technology such as email, text, phone, and web-based patient portals to communicate regularly with their physician. So, the context of the relationship goes well beyond the traditional visit. When a visit is needed, typically there are extended hours and same day appointments available. Some DPC docs even do house calls.

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[2] *Journal American Board of Family Medicine, Nov. 2015*

[3] *Iora Claims Database, Las Vegas NV*

The heart and soul of a DPC arrangement is the relationship between the doctor and patient. Doctors in fee for service practices must see 25 to 30 patients per day to generate enough revenue to cover costs, which leads to appointment time of about 10 minutes. CDC says the average physician's panel size is about 2500 patients. In DPC, providers have significantly reduced patient panel sizes—on average about 400—and as such are free to spend more time with patients. With more time to appropriately diagnose and prevent disease, they can treat patients in the less costly and invasive primary care environment, instead of referring them on to more expensive and potentially complex specialty care.

In DPC, there is no third-party, fee for service billing for services outlined in the agreement. All primary care services are paid for outside of the insurance system, which leads to significantly reduced administrative costs.

DPC is not concierge medicine. DPC is often lumped in with what is called "concierge care", but there are significant differences. In concierge, fees are essentially access charges for "non-covered" services. Patients still bill insurance for all the typical primary care services – so it's still in a FFS environment. DPC, alternatively, is completely outside insurance. Fees cover a high level of access care, plus all costs of the primary care costs. DPC avoids all FFS charges and is typically far less expensive – usually lower than $100 per month. It is even offered in Medicaid in some states. In short, DPC is a recognized health reform policy driving improved health outcomes and lower costs. Concierge does improve care for some– but only for those who can afford it.

Bipartisan legislation has been passed in 23 states. The best of these laws have important protections and clarifications for patients in addition to defining DPC outside of insurance regulations. Among these protections are that:

- Medical services offered are clearly defined in a direct primary care agreement between doctor and patient, or his or her employer or third party payer on the patient's behalf.

- Agreements must state clearly that the services outlined do not constitute health insurance, and that patients still need to have insurance to cover health care services not covered by the DPC agreement or to comply with State and Federal law;
- Providers and patients who enter into a DPC agreement should not be allowed to "double dip," or bill insurance companies for the services that are already paid for by the periodic fee in the DPC agreement; and,
- Patients have the freedom to switch providers at any time without penalty or enrollment period, and both patient or provider may terminate an agreement any time.

In closing, we were very pleased that the Pennsylvania House unanimously passed House Bill 1739 and we look forward to working with the Senate on this important bill to help promote better access to primary care for all Pennsylvanians.