PAFP on House Bill 1739 / Senate Bill 926 and Direct Primary Care
Edward Zurad, MD, President
Senate Banking and Insurance Committee
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Chairman White, Minority Chair Sharif, and distinguished members of the committee, thank you for conducting a hearing on Direct Primary Care (DPC) legislation.

The PAFP, which represents more than 5,500 physicians, residents, and students who specialize in family medicine, has been tracking the evolution of DPC for nearly a decade. In 2015, our association adopted a formal position on the model due to its growth and in order for us to be supportive of our members beginning or entering DPC practices.

The PAFP supports HB 1739 and SB 926 and thanks Senate Appropriations Committee Chairman Pat Browne and House Health Committee Chairman Matt Baker for their leadership. Yet before delving further, please know we understand that the majority of our members are more concerned with two other areas requiring legislative attention in matters also under your jurisdiction: prior authorization and credential reform. House Bill 125, credentialing reform, currently awaits action in this Committee and we urge you to work on that matter as well.

In 2015, the PAFP Board of Directors found that DPC as a care delivery model can exist within the physician-led, patient-centered medical home - a key component of the PAFP's 2015 mission statement.

Our policy statement looked at the principle elements of DPC: The direct primary care model is a variation of the retainer framework for primary care physicians. DPC practices charge patients a flat monthly or annual fee, under terms of a contract, in exchange for access to a broad range of primary care and medical administrative services. The retainer practice framework includes any practice model structured around direct contracting with patients for monthly or annual fees, which serve to replace the traditional system of third-party insurance coverage for primary care services.

Typically, these "retainer fees" guarantee patients enhanced services such as 24/7 access to their personal physician, extended visits, electronic communications; in some cases, even home based medical visits; and highly personalized, coordinated, and comprehensive care administration. The PAFP supports the physician and patient choice to, respectively, provide and receive health care in any ethical health care delivery system model, including the DPC practice setting.

The DPC contract between a patient and his or her physician provides for regular, recurring monthly revenue to practices which typically replaces traditional fee-for-service billing to third-party insurance plan providers. For family physicians, this revenue model can stabilize practice finances, allowing the physician and office staff and team members to focus on the needs of the patient and improving their health outcomes rather than coding and billing. Patients can benefit from having a DPC practice because the contract fee covers the cost of primary care services furnished in the DPC practice.

Ideally, the DPC model is structured to emphasize and prioritize the intrinsic power of the relationship between a patient and his or her family physician to improve health outcomes and lower overall health care costs. The DPC contract fee structure can enable physicians to spend more time with their patients, both in face-to-face visits, and through telephonic or electronic communications mediums, should they choose, since they are not bound by insurance reimbursement restrictions. For these reasons, the PAFP

supports the physician and patient choice to, respectively, provide and receive health care in any ethical health care delivery system model, including the DPC practice setting.

We do believe the growth in high-deductible health plans, or HDHP's, which should be maintained at a minimum by DPC patients for specialty care and events requiring hospitalization, is having an impact on both the physician and patient community in exploring DPC. According to a survey conducted in 2017 by Bankrate, a consumer financial services company, one in four Americans plans to avoid seeking medical care due to cost. We trust this committee is studying correlations between the lower cost of HDHP's premiums, the out-of-pocket expenses for individuals and families, and the implications for patients. With the growth of HDHP's, coupled with the exponential growth in Health Savings Accounts (HAS's), a constant monitoring of the effects is necessary.

It is with these principles and market forces that we look to advocate for protections for the DPC model. This is not because an overwhelming number of our members are engaged in DPC practices, but because we would like to see the option supported by state policy as has occurred throughout the nation in 23 states.

Federal attention to DPC is also germane to your examination of this issue. In January of 2017, U.S. Representative Erik Paulsen and Earl Blumenauer introduced the Primary Care Enhancement Act of 2017 (HR 365). Pennsylvania Congressmen Dent, Fitzpatrick, and Kelly are cosponsors. Along with its U.S. Senate companion bill, SB 1358, these bills propose to allow HSA enrollees to contract for services from a DPC practice and pay for it through a Health Savings Account. Our national association, the American Academy of Family Physicians, which leads our federal advocacy, supports these efforts.

DPC is not the be-all, end-all to address the ills of health care, but it is an option that we support and one that should be given statutory protections to flourish, as SB 926 and HB 1739 would provide.

We thank you for your thoughtful attention to this topic and for all the good work you do on behalf of the citizens of the Commonwealth of Pennsylvania.