Testimony on Direct Primary Care - SB 926

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Good morning Chairmen White and Street, members of the Senate Banking and Insurance Committee and Senator Browne. My name is Jessica Altman. I am the Acting Insurance Commissioner at the Pennsylvania Insurance Department. Thank you for the opportunity to be here today to speak about SB 926, which relates to direct primary care in the Commonwealth.

I applaud the committee's efforts to shed light on such an important topic. With health care spending routinely outpacing inflation, all methods of cost containment should be on the table. At the same time, we want to ensure that consumers are adequately protected, especially given that the Pennsylvania Insurance Department (PID) would not have oversight of the type of agreement between physician and patient that is envisioned under SB 926.

As currently drafted, Senator Browne's SB 926 and Representative Baker's HB 1739, which recently passed the House and was referred to this committee, would allow primary care physicians to offer their patients an alternative to the traditional model of health insurance. Physicians would charge a retainer or fee to their patients that would cover the patient's primary care needs. While the PID understands the unique and creative nature of this type of product, we have concerns we would like to bring to the committee's attention.

The first concern is whether the consumer who enters into a direct primary care agreement knows what he or she is purchasing – what does the agreement cover? Some consumers may think that a direct primary care agreement will be all that they need for their health care coverage. But a direct primary care arrangement does not provide comprehensive coverage; for example, by its very nature, it does not cover emergency services and hospitalization.

Under the Affordable Care Act, an individual health insurance policy must provide certain essential health benefits. The benefits required to be covered include:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Pregnancy, maternity, and newborn care (both before and after birth)

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- Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
- Prescription drugs
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)

Unlike this explicit list of comprehensive benefits that consumers can trust will be offered in an individual health insurance policy issued by a regulated insurance company, it is unclear what kinds of services physicians would offer under a direct primary care agreement as envisioned by SB 926. The definition of "primary medical care service" included in SB 926 is remarkably broad, and could be read to encompass either a wide range of health care services, or an extremely narrow offering. Does it cover just the "preventive and wellness services and chronic disease management" category, or does it cover other categories of services? Further, would all physicians who choose to offer some subset of services do so in a uniform manner?

At the very least, consumers should be able to have answers to the following questions about the coverage provided by their direct primary care agreement:

- Does it cover all of their anticipated health care needs?
- Does it cover their pre-existing conditions?
- Is there a limit on how frequently they can visit the provider?
- Is the agreement guaranteed renewable?

A second concern has to do with the financial implications of the arrangement. Will consumers entering into these arrangements be aware that membership payments for their direct primary care provider agreement and any additional charges for services will not count towards their health insurance policy deductible? Or to their maximum out of pocket limit, which is a cap on the most you will have to pay through deductibles, copayments and coinsurance for covered services in a plan year, after which your health plan pays 100% of the costs of covered

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benefits? (This assumes, of course, that the consumer also has an insurance policy.) If a consumer accesses primary care through this model, but then needs, for example, hospitalization that is covered by their health insurance policy, they would still have to satisfy the cost-sharing requirements of their policy.

Another aspect of the financial impact has to do with what recourse a consumer has if services are not delivered as promised. We are aware direct primary care providers are currently operating in Pennsylvania, either as concierge providers – for consumers who have the financial wherewithal to absorb the risk – or in conjunction with Medicaid managed care organizations – for consumers with the protection of Medicaid coverage requirements. But if SB 926 were to become law, it would define direct primary care as "other than" insurance, but result in a direct primary care provider assuming some level of financial risk or indemnification arrangement that would leave consumers open to a variety of potential harms that would impact the quality of care. If a direct primary care provider makes promises of care that he cannot keep, or makes promises to more people than he can realistically serve, what recourse will those consumers have?

It is worth noting that the Insurance Department serves as a trusted resource for consumers who feel that services are not delivered as promised when they have purchased health insurance coverage from a licensed insurer. In contrast to the direct primary care relationship contemplated in SB 926, licensed insurers must comply with various layers of regulatory scrutiny including a review of their financial solvency to ensure they can pay for health care services and guaranty fund protections to ensure some level of coverage for consumers in circumstances of insolvency. Further, health insurance plans sold by licensed health insurers are reviewed to ensure the amount of providers in their network are sufficient to serve the patient population; there is no correlation in the legislation's proposed direct primary care relationship to ensure the provider to patient ratio is adequate to ensure meaningful consumer access. Finally, the legislation's intention to pull direct primary care relationships outside of the scope of the PID's authority would hinder the PID's ability to take enforcement actions against bad actors, for wrongs such as misrepresentation.

There are two other financial concerns, both with tax ramifications. While the PID is not an authority on tax law – and this should not be taken as tax advice – we want to note for the

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committee that so long as the individual mandate remains a requirement of federal law, direct primary care agreements do not satisfy the "minimum essential coverage" (MEC) requirements that must be met to avoid the federal tax penalty for not having satisfactory health care coverage. If a consumer enters into a direct primary care agreement believing they will avoid that tax penalty, they would be mistaken.

Moreover, we also understand – and direct primary care provider organizations suggest on their websites[1] – that under federal tax law, Health Savings Accounts (HSAs) may not be used to pay for direct primary care monthly fees. For consumers who think they can save on taxes by using pre-tax dollars to fund an HSA, and then use the HSA dollars to fund a direct primary care arrangement for their health care, this will be an unwelcome surprise.

Let me pause here and mention another federal issue that is mentioned in the direct primary care discussion. We are aware that the Affordable Care Act mentions direct primary care, and some have shown an interest in establishing direct primary care arrangements thinking that they are expressly permitted by the ACA. But the ACA only contemplated direct primary care when coupled with a qualified health plan (QHP). Specifically, the law requires the Secretary of the federal Department of Health and Human Services (HHS) to permit a QHP to provide coverage through a qualified direct primary care medical home plan that meets the criteria established by HHS. Critically, however, the QHP must meet all the coverage and cost-sharing requirements of an individual health insurance policy, with the services provided by the direct primary care medical home coordinated with the QHP issuer. That coordination is critical, because the entity offering the QHP is an insurance entity regulated for solvency, network adequacy, and the like. In contrast, the relationship proposed in SB 926 does not propose a coupling with a QHP, and so does not provide the assurances that come with a regulated insurance product.

The PID understands the interest in this legislation. Innovative approaches to health care delivery are crucial to providing higher quality and lower cost health care. If SB 926 moves forward, the PID respectfully recommends, at the very least, that clear disclosures be provided

[1] *See, e.g.*, http://www.dpcfrontier.com/health-savings-accounts/ ; http://multicaredocs.com/faq/can-use-health-savings-account-pay-direct-primary-care/ ; https://www.dpcare.org/specialties (all accessed on 12/4/17).

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to consumers considering entering into direct primary care arrangements. For the protection of these consumers, these disclosures should include:

1. The direct primary care agreement does not satisfy the federal tax law requirement to have insurance: individuals must still purchase comprehensive health insurance or be subject to the tax penalty for failing to have health insurance.
2. Payments for the services under the direct primary care agreement do not count towards any deductible, cost-sharing, or maximum out of pocket limit for ACA-compliant coverage.
3. Membership payments for the primary care arrangement may not be made with pre-tax dollars. (This is, of course, subject to confirmation by the tax experts.)
4. The direct primary care agreement does not have a financial backstop to ensure claims are paid. If the direct primary care provider is insolvent or fails to cover promised services, there is no guaranty association such as the Pennsylvania Life & Health Insurance Guaranty Association to cover the consumer's claims.
5. The PID will not be able to assist consumers with a dispute they may have with the direct primary care provider, as the dispute would be outside the jurisdiction of the Department.
6. A consumer's dispute with a provider would be addressed, if at all, in accordance with the terms of the agreement, such as arbitration, litigation in court, or in consultation with the Attorney General's office. (SB 926 does not specify how disputes would be resolved.)

In addition, for the protection of consumers, this body may find it wise to incorporate language into SB 926 that coordinates direct primary care with ACA-compliant coverage. Similar to the federal approach, these agreements then would be a complement to overarching coverage issued by a regulated entity, with all the solvency, network adequacy, and claims handling protections that entails.

Finally, if there continues to be interest in moving this bill forward, the PID would be pleased to work with your staff to identify and address certain drafting and technical edits.

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Again, I would like to thank the Senate Banking and Insurance Committee and Senator Browne for organizing this hearing and allowing the PID to comment on this unique method of health care delivery. I am happy to answer any questions that you might have.