SB 727 - Direct Primary Care Agreements
Maryland State Senate Finance Committee

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Thank you for the opportunity to speak out in support of SB 727 and the growth of direct primary care (DPC) across the nation to the Senate Finance Committee. On behalf of the Direct Primary Care Coalition, patients, doctors, and large and small employers, I want to thank Senator Lam for his leadership introducing this important piece of legislation designed to clarify the legal status DPC as a medical service and provide important consumer protections for patients and employers who are excited about getting or provider better care.

DPC offers high-functioning primary care and prevention services outside of third party fee-for-service reimbursement 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 high-value coverage for their employees while minding premium costs using a high deductible.

Today there are 1200 DPC Practices nationwide, and about a dozen in Maryland, in Baltimore, Montgomery and Howard counties as well as one here in Annapolis. Currently, the national median fee is about $70 per month. The ACA recognizes that 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]. 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 727, it's referred to as a Direct Primary Care 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] Harvard Business School - *Iora Claims Database, https://rctom.hbs.org/submission/iora-health-redefining-primary-care-medicine/*

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.

Specific Provisions of Senate Bill 727, Application to Direct Primary Care Agreements, *Introduced by Senator Lam, February 3, 2020:*

Scope. Like most of the 32 similar bills and regulations passed around the country, SB 727 has two essential components. This legislation:

1.) Appropriately defines direct primary care (DPC) agreements as medical services, limited to the scope of the provider's license which are outside the scope of state insurance regulations and;
2.) Sets forth several important patient and consumer protections to guide these agreements so that patients understand exactly what services are covered by the agreements and what is not covered.

Direct Primary Care agreements are designed to provide unfettered access to primary care services, not unlimited comprehensive insurance coverage. Since these arrangements are for predictable for primary care, and not expensive and unpredictable acute care services, the need for capitalization required for insurers is not appropriate, as is the case with all primary care

services, whether delivered in a traditional fee for service manner, or any other payment model.

Patient Protections. SB 727 enacts no fewer than 10 important patient protections, many of which do not exist in current law and are not within the scope of the insurance department.

(1) The legislation authorizes the Health Education and Advocacy Unit in the Consumer Protection Division of the Office of the Attorney General to assist consumers in understanding their direct primary care agreements.
(2) The bill requires any DPC agreement to conspicuously state that:
    a. The agreement is not health insurance; and does not meet any individual health insurance mandates.
    b. The provider may not decline to accept a new patient or discontinue care to an existing patient solely because of the health status of the patient.
    c. May not decline to accept a new patient or discontinue care to an existing patient solely because of the health status of the patient;
(3) Requires that the DPC agreement is signed by both patient and provider, regardless of who pays for the agreement (e.g. employer, union trust, health plan).
(4) Requires the provider to be licensed under the Health Occupations Act Article.
(5) Authorizes either party to terminate the agreement on written notice of the other party
(6) Requires that unearned funds be returned to the patient on termination of the agreement.
(7) Describes the primary care services to be provided in exchange for payment of a periodic fee and any ongoing care for which an additional fee will be charged.
(8) Specifies the amount of the periodic fee and any additional fees that may be charged for ongoing care and specifies the duration the agreement and any automatic renewal periods.
(9) Prohibits the patient from being required to pay more than 12 months of the periodic fee in advance.
(10) Prohibits the primary care provider from double billing—billing a third party on a fee-for-service basis for services already covered within the scope of the agreement.

Maryland Insurance Administration Oversight. Our interpretation of the bill is that if these conditions are not complied with the practice may still be subject regulatory discretion of the Insurance Administration.

Consistency with the ACA. The clarifications in SB 727 help to harmonize state law with the Affordable Care Act—ACA Sec. 1301 (a) (3), on essential health benefits, recognizes DPC as a novel alternative payment and care delivery model, and allows DPC medical homes, when paired with a qualified health plan to meet essential health benefits requirements. Regulations promulgated by the U.S. Department of Health and Human Services define 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). However, it's important to note that standing alone, DPC is not comprehensive insurance and does not meet any of the ACA mandates. SB 727 appropriately requires a DPC agreement to state that prominently. Despite the recent repeal of the individual mandates, best practices in care require physicians to recommend to their patients that they have comprehensive coverage, which goes beyond the scope of these agreements, and the bill appropriately requires DPC agreements to state that.

Coverage of Preventive Services. While the ACA essential health benefits provisions require all plans, including High Deductible Health Plans (HDHP) to cover preventative health services rated A and B by the U.S. Preventive Services Task Force (USPSTF) without copayments, DPC agreements cover those (mainly screenings) and any primary care based treatments that arise from the screenings without any copayments and without billing a third-party insurer for those primary care services. While health plans, including DPC plans must cover the screenings, patients opting for DPC have access to a far greater range of preventive services and full coverage of treatments that may be needed in the primary care setting. For services that are needed beyond the scope of the PCP, individuals still need to have insurance to cover them. Patients with DPC agreements are not purchasing "double coverage," they are simply opting to chose a provider that promises to cover prevention services well beyond the minimum floor established by the ACA, which is all that most ACA-compliant health policies provide.

Coordinated Care. The heart and soul of a DPC arrangement is the relationship between the doctor and patient. One of the primary responsibilities of the PCP is coordinate care for the patient, even when that care falls outside the scope of primary care. However, in today 's fee for service environment, PCPs simply do not have the time, and don't usually get reimbursed for coordinating care outside the office. The U.S. Centers for Medicare and Medicaid Services

(CMS) and other payers have established Patient Centered Medical Home (PCMH) demonstrations and Accountable Care Organizations (ACOs) to attempt better care coordination, but the experience has been met with mixed success. It's just very difficult to coordinate care across a wide spectrum of care when payment is being made in silos to treat specific conditions, and not the patient. DPC can remedy this. Because the doctor has been hired by the patient, and is accountable to them, the DPC doc has more time to appropriately diagnose and prevent disease. So 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—which is all most docs in FFS have time to do in the confines of a seven-minute visit. Doctors in fee for service practices must see 25 to 30 patients per day to generate enough revenue to cover costs, which leads to these brief appointment times. 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.

Shortage of Primary Care Physicians. One of the questions often raised about DPC relates to how this impacts our current shortage of PCPs. Given that DPC docs often reduce their panel size, one would think that it could create even more shortage, but the evidence is quite the opposite. DPC is growing fast; over 500 new practices have been established in the last few years. DPC has been particularly appealing to students and residents, who are grappling with a desire to go into primary care but may be concerned that appropriate income may not generated to take care of their student debt. It has also proven to be very appealing to physicians at the end of their careers, who have complained about burn out due to excessive documentation requirements from payers. In these cases, DPC is serving as an engine to generate new found interest in primary care. We believe SB 727 will have this positive impact on the primary care physician population in Maryland.

Restrictions in the Tax Code. SB 727, appropriately does not address issues regarding federal tax law, as these are federal issues and fall outside the scope of the Maryland General Assembly.

Bipartisan legislation has been passed in more than 32 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 Senate has introduced SB 727, and we look forward to working with the General Assembly on this important bill to help promote better access to primary care for all Marylanders.