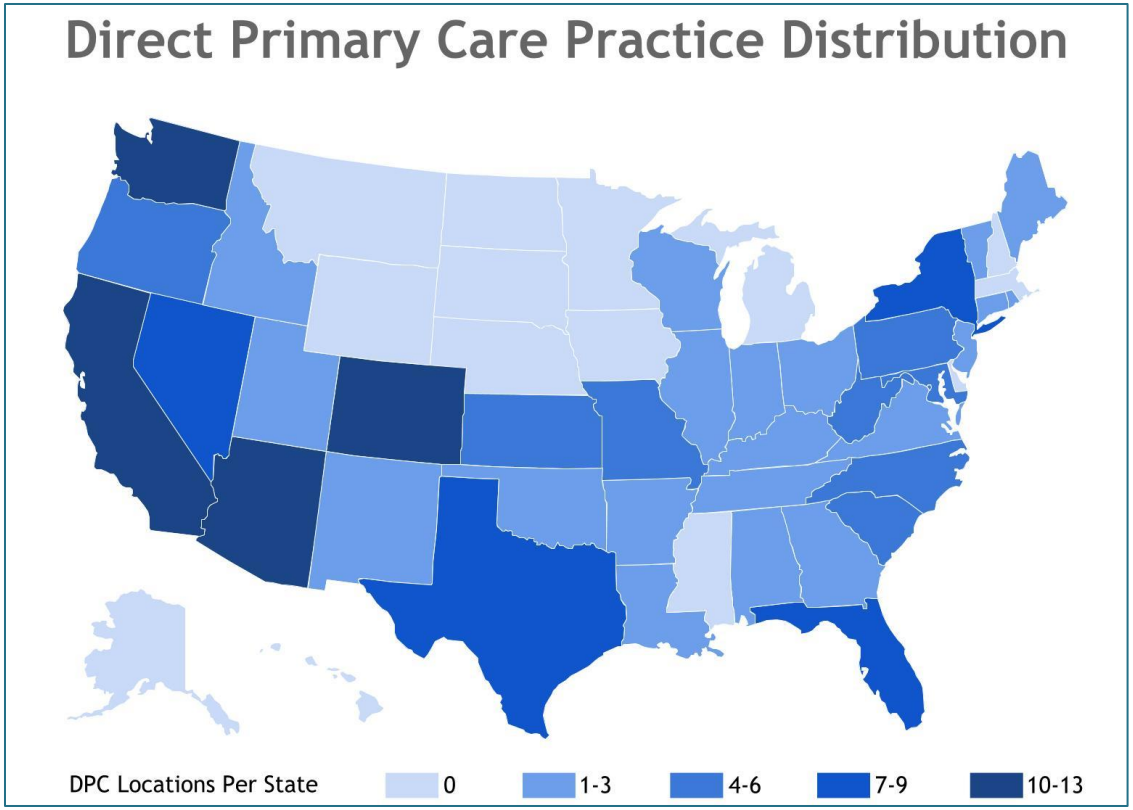
Direct Primary Care:
Legislative and Regulatory Update

AAFP Assembly

Jay Keese
Principal, Capitol Advocates
Executive Director,
Direct Primary Care Coalition
jpkeese@cagdc.com

What Is Direct Primary Care?

- Comprehensive Primary Care and Prevention Services
- Monthly Fee or Retainer: Payer Agnostic
- No Fee for Service Billing
- Medical Services - Not Insurance or a Health Plan
- Defined in ACA Sec. 1301 (a) (3) and state laws (WA 48.150 RCW)



- DPC Practices Identified in 37 States
- Median fee about $80 per member per month
- Improved Outcomes, Patient Satisfaction

Isn't DPC "Concierge" Medicine?

- **Concierge:** Provider access fees and non-covered services
  - *Patient bills insurance for services – still in a FFS environment*
- **DPC:** Completely outside insurance. Fees cover high access level *plus* all costs of primary care
  - *Misaligned FFS incentives, administrative costs gone from primary care*
- **DPC:** More affordable than concierge, usually lower than $100 per month
- **DPC:** Recognized health reform policy driving improved health outcomes and lower costs. Concierge may well improve care for some– *but only for those who can afford it*

DPC Can Reduce Health Costs by 20%

2013 data: DPC with employers

	Per 1,000 Qliance patients	Per 1,000 Non-Qliance patients	Difference (Qliance vs. Other)	Savings per patient per year
ER Visits	81	94	-14%	($5)
Inpatient (days)	100	250	-60%	$417
Specialist Visits	7,497	8,674	-14%	$436
Advanced Radiology	310	434	-29%	$82
Primary Care Visits	3,109	1,965	+58%	($251)
Savings Per Patient	---	---	---	$679
Total Savings per 1000 (after Qliance fees)				$679,000
% Saved Per Patient				20%

Data Sources: All claims data (except prescription claims) from carriers for selected large employers; Qliance EMR data; Employer eligibility data.

Claims Attribution: All claims incurred by Qliance patients prior to first Qliance visit were excluded; All employees with any interaction with Qliance included as our patients, even if the employee used another primary care provider (which is possible in some of the plan designs among clients); All claims incurred after any interaction with Qliance included, regardless of employee's intent to use Qliance as their primary care provider; All non-primary care provider visits included under "specialist" category (such as physical therapy, acupuncture, etc.)

Population: Eligible members in employer-sponsored health plan; Employees only, to remove confounding factors from differences in dependent benefits structures and participation variances among clients.

American Academy Of Family Physicians

- **DPC: A Centerpiece of AAFP's Future of Family Medicine Project (2.0)**
- DPC Benefits patients by providing substantial savings and a greater degree of access to, and time with, physicians.
- Gives family physicians a meaningful alternative to fee-for-service insurance billing.
- Rewards physicians for whole-person care, reducing negative FFS incentives, and third-party-payer billing overhead. DPC Benefits:
  - more time with patients
  - reduced patient volume
  - fewer medical errors
  - less exposure to risk
  - improved practice collections rates
  - zero insurance filing

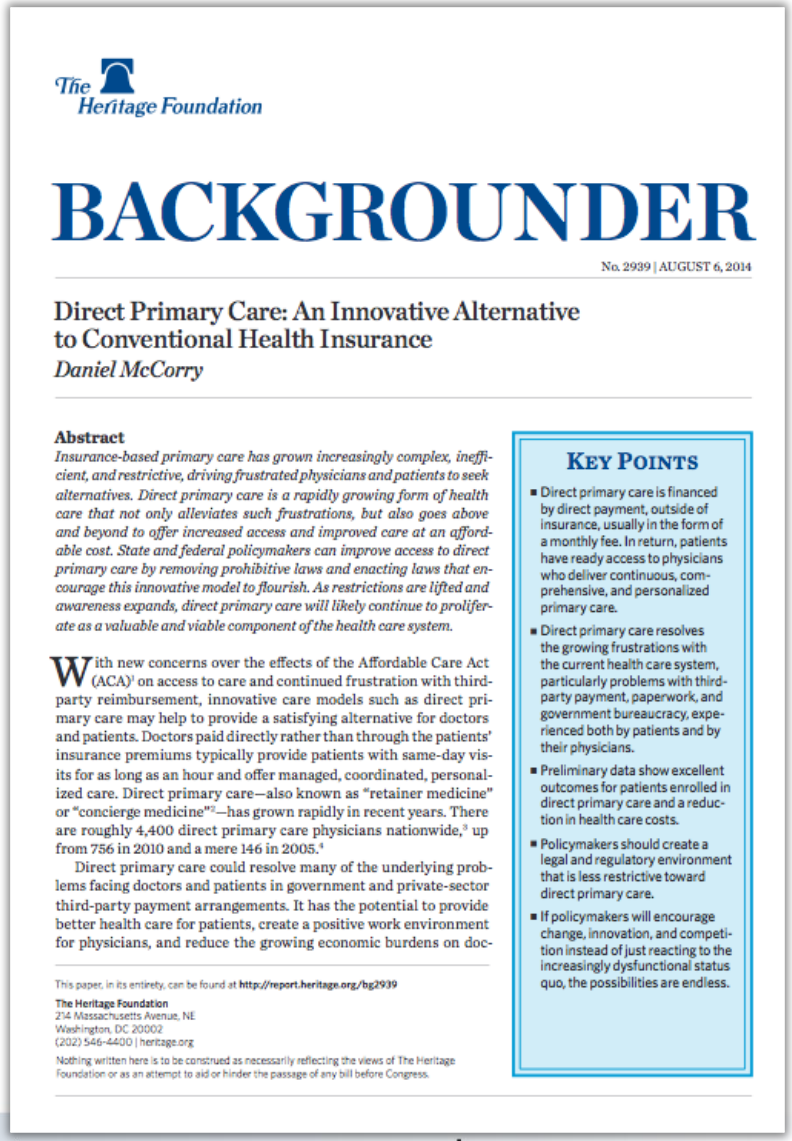
Heritage Foundation Study on DPC

- DPC fixes problems with third-party payment, paperwork, and government bureaucracy.
- Data shows excellent outcomes, reduced costs.
- Policymakers should create less restrictive regulations for DPC:

  … Reform the tax code to allow DPC payments through HSAs

- DPC encourages innovation and competition unlike the dysfunctional status quo

  … the possibilities are endless.



The Heritage Foundation

BACKGROUNDER

No. 2939 | AUGUST 6, 2014

Direct Primary Care: An Innovative Alternative to Conventional Health Insurance

Daniel McCorry

Abstract

Insurance-based primary care has grown increasingly complex, inefficient, and restrictive, driving frustrated physicians and patients to seek alternatives. Direct primary care is a rapidly growing form of health care that not only alleviates such frustrations, but also goes above and beyond to offer increased access and improved care at an affordable cost. State and federal policymakers can improve access to direct primary care by removing prohibitive laws and enacting laws that encourage this innovative model to flourish. As restrictions are lifted and awareness expands, direct primary care will likely continue to proliferate as a valuable and viable component of the health care system.

With new concerns over the effects of the Affordable Care Act (ACA)[1] on access to care and continued frustration with third-party reimbursement, innovative care models such as direct primary care may help to provide a satisfying alternative for doctors and patients. Doctors paid directly rather than through the patients' insurance premiums typically provide patients with same-day visits for as long as an hour and offer managed, coordinated, personalized care. Direct primary care—also known as "retainer medicine" or "concierge medicine"[2]—has grown rapidly in recent years. There are roughly 4,400 direct primary care physicians nationwide,[3] up from 756 in 2010 and a mere 146 in 2005.[4]

Direct primary care could resolve many of the underlying problems facing doctors and patients in government and private-sector third-party payment arrangements. It has the potential to provide better health care for patients, create a positive work environment for physicians, and reduce the growing economic burdens on doc-

This paper, in its entirety, can be found at **http://report.heritage.org/bg2939**

The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002
(202) 546-4400 | heritage.org

KEY POINTS

- Direct primary care is financed by direct payment, outside of insurance, usually in the form of a monthly fee. In return, patients have ready access to physicians who deliver continuous, comprehensive, and personalized primary care.
- Direct primary care resolves the growing frustrations with the current health care system, particularly problems with third-party payment, paperwork, and government bureaucracy, experienced both by patients and by their physicians.
- Preliminary data show excellent outcomes for patients enrolled in direct primary care and a reduction in health care costs.
- Policymakers should create a legal and regulatory environment that is less restrictive toward direct primary care.
- If policymakers will encourage change, innovation, and competition instead of just reacting to the increasingly dysfunctional status quo, the possibilities are endless.

DPC Policy Drivers:
Affordable Care Act Sec. 1301 (A) (3)

- Direct Primary Care Medical Homes may be offered in exchanges combined with insurance (QHP)
- Two plans together must ACA Essential Health Benefits requirements
- HHS Rulemaking:
  - CMS Rule Establishing Exchanges/QHPs
    - CMS-9989-P (RIN 0938-AQ67)
  - DPC Medical Homes are **NOT** insurance
  - Based on WA Direct Practice Act (RCW48-150)
  - States by State Decisions by Exchange Boards
- DPC in exchanges :
  - Qliance/Coordinated Care – Washington Exchange (Centene)
  - Nextera Health – Colorado Coop 2015

DPC State Legislation

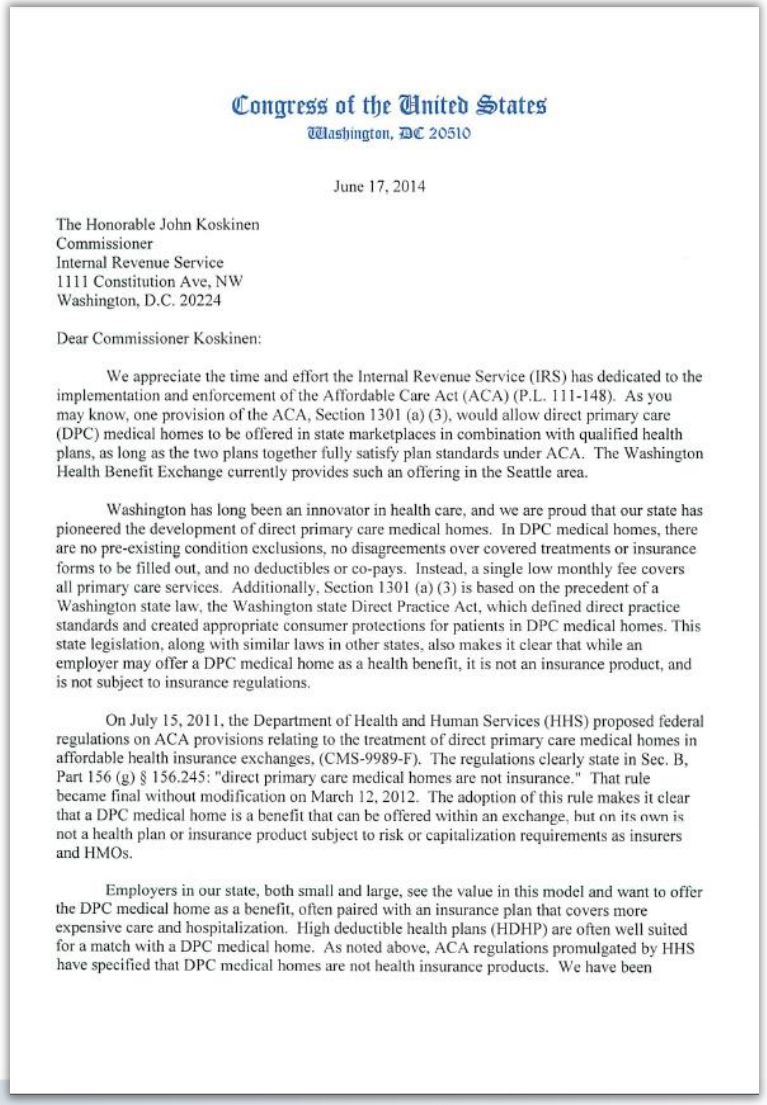
- Defines DPC as a health benefit outside the scope of Insurance regulation:
  - Washington - 48-150 RCW
  - Louisiana – S.B. 516
  - Utah – UT 31A-4-106.5
  - Oregon - ORS 735.500
  - West Virginia- WV-16-2J-1
  - Pending:
    - Michigan – S.B. 1033 (As passed by MI Senate)
  - Model Legislation – AAFP, DPCC

DPC Policy Barriers

- **Tax Code: - IRS HSA policy**
  - DPC considered a “second health plan” for HSAs (IRC 223 (c)
  - Not a qualified medical expense under (IRC 213 (d)
  - Not in keeping with ACA Essential Health Benefits Rules
  - Sec. 213 (d) qualified medical expenses: changes ahead?
- **DPC not offered in FFS Medicare/Medicaid**– the nation’s highest utilizers of health care
  - Qliance/Centene in Medicaid managed care in Washington
  - Iora Health/Humana in Medicare Advantage in 2015
  - SGR “Permanent Doc Fix” bills anticipate DPC as an “Advance Payment Model”
- **State Insurance Regulations**
  - Need to clarify that DPC practices fall outside insurance regulation
  - Some commissioners permissive
  - Other states need legislation

Congress to IRS: Apply ACA Definition of DPC to HSAs

- Sec. 213 (d) of Internal Revenue Code DPC payments not a qualified medical expense.
- Sec. 223(c) individuals with HDHP/HSA = no second health plan.
- ACA, state laws define DPC as a primary care service and not a health insurance plan, IRS does not.
- **Sens. Cantwell, Murray, Rep. McDermott:**
  - **IRS: Please harmonize IRS policy with HHS ACA essential health benefit rules.**



Congress of the United States
Washington, DC 20510

June 17, 2014

The Honorable John Koskinen
Commissioner
Internal Revenue Service
1111 Constitution Ave, NW
Washington, D.C. 20224

Dear Commissioner Koskinen:

We appreciate the time and effort the Internal Revenue Service (IRS) has dedicated to the implementation and enforcement of the Affordable Care Act (ACA) (P.L. 111-148). As you may know, one provision of the ACA, Section 1301 (a) (3), would allow direct primary care (DPC) medical homes to be offered in state marketplaces in combination with qualified health plans, as long as the two plans together fully satisfy plan standards under ACA. The Washington Health Benefit Exchange currently provides such an offering in the Seattle area.

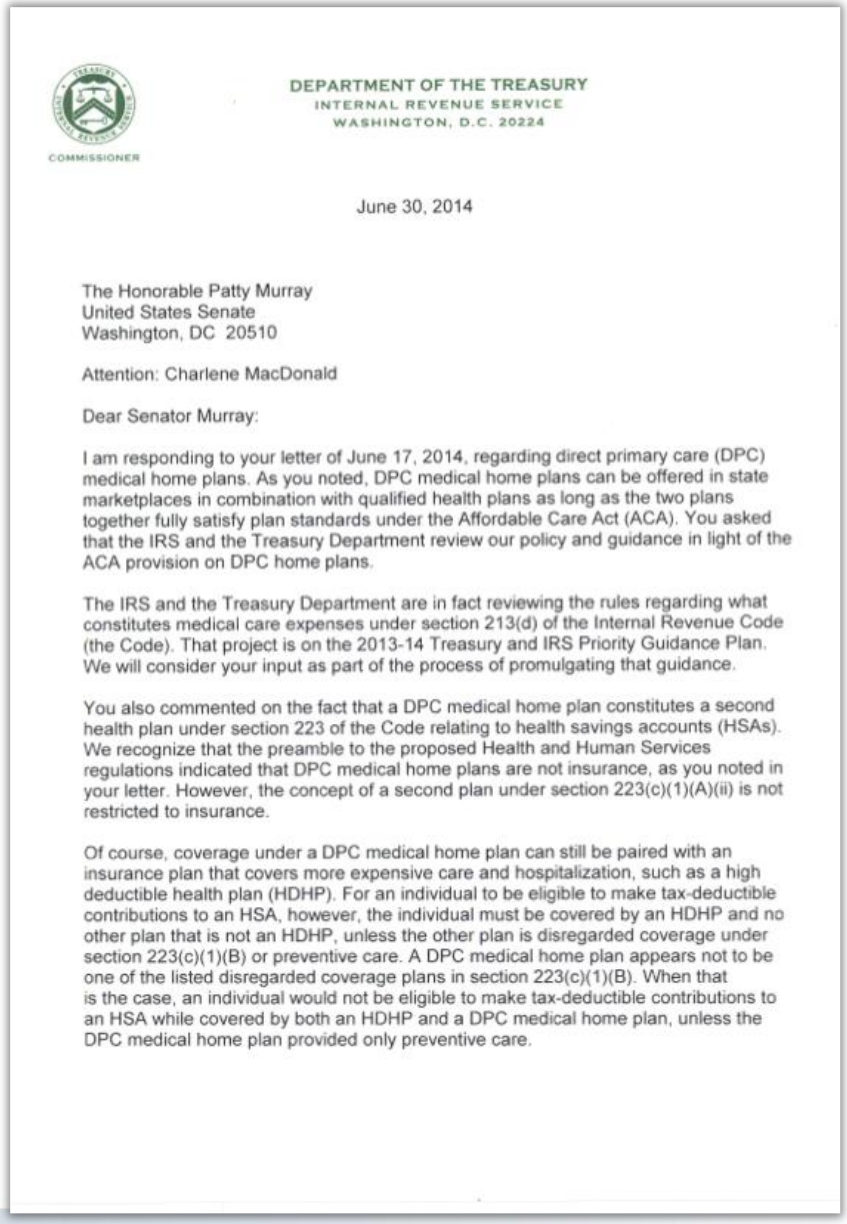
Washington has long been an innovator in health care, and we are proud that our state has pioneered the development of direct primary care medical homes. In DPC medical homes, there are no pre-existing condition exclusions, no disagreements over covered treatments or insurance forms to be filled out, and no deductibles or co-pays. Instead, a single low monthly fee covers all primary care services. Additionally, Section 1301 (a) (3) is based on the precedent of a Washington state law, the Washington state Direct Practice Act, which defined direct practice standards and created appropriate consumer protections for patients in DPC medical homes. This state legislation, along with similar laws in other states, also makes it clear that while an employer may offer a DPC medical home as a health benefit, it is not an insurance product, and is not subject to insurance regulations.

On July 15, 2011, the Department of Health and Human Services (HHS) proposed federal regulations on ACA provisions relating to the treatment of direct primary care medical homes in affordable health insurance exchanges, (CMS-9989-F). The regulations clearly state in Sec. B, Part 156 (g) § 156.245: "direct primary care medical homes are not insurance." That rule became final without modification on March 12, 2012. The adoption of this rule makes it clear that a DPC medical home is a benefit that can be offered within an exchange, but on its own is not a health plan or insurance product subject to risk or capitalization requirements as insurers and HMOs.

Employers in our state, both small and large, see the value in this model and want to offer the DPC medical home as a benefit, often paired with an insurance plan that covers more expensive care and hospitalization. High deductible health plans (HDHP) are often well suited for a match with a DPC medical home. As noted above, ACA regulations promulgated by HHS have specified that DPC medical homes are not health insurance products. We have been

IRS Response

- IRS reviewing qualified medical expenses under IRC Sec. 213 (d)
- Will Consider Congressional Input
- Second Health Plan – Not limited to Insurance products
- Coverage would be permitted if DPC care restricted to preventive care.



DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
WASHINGTON, D.C. 20224

COMMISSIONER

June 30, 2014

The Honorable Patty Murray
United States Senate
Washington, DC 20510

Attention: Charlene MacDonald

Dear Senator Murray:

I am responding to your letter of June 17, 2014, regarding direct primary care (DPC) medical home plans. As you noted, DPC medical home plans can be offered in state marketplaces in combination with qualified health plans as long as the two plans together fully satisfy plan standards under the Affordable Care Act (ACA). You asked that the IRS and the Treasury Department review our policy and guidance in light of the ACA provision on DPC home plans.

The IRS and the Treasury Department are in fact reviewing the rules regarding what constitutes medical care expenses under section 213(d) of the Internal Revenue Code (the Code). That project is on the 2013-14 Treasury and IRS Priority Guidance Plan. We will consider your input as part of the process of promulgating that guidance.

You also commented on the fact that a DPC medical home plan constitutes a second health plan under section 223 of the Code relating to health savings accounts (HSAs). We recognize that the preamble to the proposed Health and Human Services regulations indicated that DPC medical home plans are not insurance, as you noted in your letter. However, the concept of a second plan under section 223(c)(1)(A)(ii) is not restricted to insurance.

Of course, coverage under a DPC medical home plan can still be paired with an insurance plan that covers more expensive care and hospitalization, such as a high deductible health plan (HDHP). For an individual to be eligible to make tax-deductible contributions to an HSA, however, the individual must be covered by an HDHP and no other plan that is not an HDHP, unless the other plan is disregarded coverage under section 223(c)(1)(B) or preventive care. A DPC medical home plan appears not to be one of the listed disregarded coverage plans in section 223(c)(1)(B). When that is the case, an individual would not be eligible to make tax-deductible contributions to an HSA while covered by both an HDHP and a DPC medical home plan, unless the DPC medical home plan provided only preventive care.

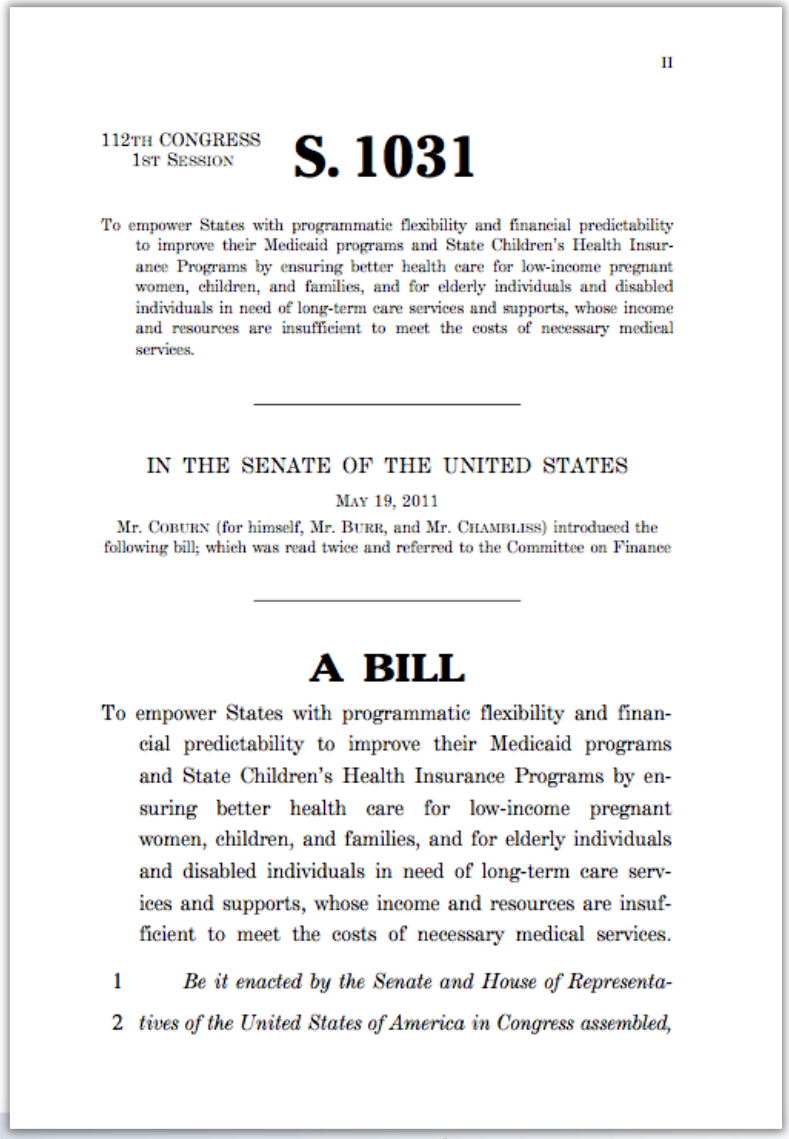
Family and Retirement Health Investment Act

- S.1031/H.R.2194
  - Hatch/Paulsen

- Sec. 116 clarifies that DPC is not a health plan

- Sec. 203 – DPC is a qualified medical expense

- Individuals with HSAs would be able to use DPC and pay fees with pre-tax HSA funds



II

112TH CONGRESS
1ST SESSION

S. 1031

To empower States with programmatic flexibility and financial predictability to improve their Medicaid programs and State Children's Health Insurance Programs by ensuring better health care for low-income pregnant women, children, and families, and for elderly individuals and disabled individuals in need of long-term care services and supports, whose income and resources are insufficient to meet the costs of necessary medical services.

IN THE SENATE OF THE UNITED STATES

MAY 19, 2011

Mr. COBURN (for himself, Mr. BURR, and Mr. CHAMBLISS) introduced the following bill; which was read twice and referred to the Committee on Finance

---

A BILL

To empower States with programmatic flexibility and financial predictability to improve their Medicaid programs and State Children's Health Insurance Programs by ensuring better health care for low-income pregnant women, children, and families, and for elderly individuals and disabled individuals in need of long-term care services and supports, whose income and resources are insufficient to meet the costs of necessary medical services.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Additional DPC Legislation

- S. 2000: The SGR Repeal and Medicare Provider Payment Act of 2014
  - Permanent SGR – “Doc Fix” DPC as “Alternative Payment Model”
- H.R. 1133: Direct MD Care Act – Bill Cassidy MD (R-LA)
  - Creates DPC Medicare and Dual Eligible Pilot
- State Legislation:
  - MI - S.B. 1033. LA - S.B. 516 Becomes Law,
  - Model Legislation
  - OK, TX, ID, Other states expected to introduce legislation