**ALASKA STATE LEGISLATURE**
**HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE**
May 2, 2019
3:06 p.m.

**MEMBERS PRESENT**

Representative Ivy Spohnholz, Co-Chair
Representative Tiffany Zulkosky, Co-Chair
Representative Matt Claman
Representative Harriet Drummond
Representative Geran Tarr
Representative Sharon Jackson

**MEMBERS ABSENT**

Representative Lance Pruitt

**COMMITTEE CALENDAR**

HOUSE BILL NO. 92
"An Act exempting direct health care agreements from regulation as insurance; establishing a direct care payment program for medical assistance recipients; and providing for an effective date."

- HEARD & HELD

**PREVIOUS COMMITTEE ACTION**

BILL: HB 92
SHORT TITLE: DIRECT HEALTH: NOT INSUR; ADD TO MEDICAID
SPONSOR(s): REPRESENTATIVE(s) JOHNSTON

| | | |
|---|---|---|
| 03/13/19 | (H) | READ THE FIRST TIME - REFERRALS |
| 03/13/19 | (H) | HSS, FIN |
| 04/04/19 | (H) | HSS AT 3:00 PM CAPITOL 106 |
| 04/04/19 | (H) | Heard & Held |
| 04/04/19 | (H) | MINUTE(HSS) |
| 05/02/19 | (H) | HSS AT 3:00 PM CAPITOL 106 |

**WITNESS REGISTER**

ERIN SHINE, Staff
Representative Jennifer Johnston
Alaska State Legislature
Juneau, Alaska

**POSITION STATEMENT:** During the hearing of HB 92, on behalf of the bill sponsor, Representative Johnston, provided a sectional analysis of Version E, the proposed committee substitute.

DONNA STEWARD, Deputy Commissioner
Office of the Commissioner
Department of Health and Social Services (DHSS)
Anchorage, Alaska
**POSITION STATEMENT:** During the hearing of HB 92, answered a question related to the bill.

CYNTHIA FRANKLIN, Assistant Attorney General
Special Litigation and Consumer Protection
Civil Division (Anchorage)
Department of Law (DOL)
Anchorage, Alaska
**POSITION STATEMENT:** During the hearing of HB 92, answered questions related to the bill.

REPRESENTATIVE JENNIFER JOHNSTON
Alaska State Legislature
Juneau, Alaska
**POSITION STATEMENT:** Speaking as the sponsor of HB 92, answered a question during the hearing of the bill.

JAY KEESE, Executive Director
Direct Primary Care Coalition
Washington, DC
**POSITION STATEMENT:** During the hearing of HB 92, provided a PowerPoint presentation titled "Direct Primary Care in 2019."

PHILIP ESKEW, DO, JD, MBA
Family Medicine Physician & Attorney
DPC Frontier
No address provided
**POSITION STATEMENT:** During the hearing of HB 92, provided testimony and answered questions.

ERIKA BLISS, MD
Equinox Primary Care
Seattle, Washington
**POSITION STATEMENT:** During the hearing of HB 92, provided testimony and answered questions.

MANDY WEEKS GREEN, Senior Health Policy Analyst
Office of the Insurance Commissioner (OIC)
Washington State

Olympia, Washington
**POSITION STATEMENT:** During the hearing of HB 92, provided testimony and answered questions.

**ACTION NARRATIVE**

3:06:50 PM

**CO-CHAIR IVY SPOHNHOLZ** called the House Health and Social Services Standing Committee meeting to order at [3:06] p.m. Representatives Jackson, Claman, Tarr, Zulkosky, and Spohnholz were present at the call to order. Representative Drummond arrived as the meeting was in progress.

## HB 92-DIRECT HEALTH: NOT INSUR; ADD TO MEDICAID

3:07:26 PM

CO-CHAIR SPOHNHOLZ announced the only order of business would be HOUSE BILL NO. 92, "An Act exempting direct health care agreements from regulation as insurance; establishing a direct care payment program for medical assistance recipients; and providing for an effective date."

3:07:49 PM

CO-CHAIR ZULKOSKY moved to adopt the proposed committee substitute (CS) for HB 92, Version 31-LS0243\E, Marx, 4/26/19, as the working document. There being no objection, Version E was before the committee.

3:08:19 PM

ERIN SHINE, Staff, Representative Jennifer Johnston, Alaska State Legislature, on behalf of Representative Johnston, sponsor, stated Version E maintains the underlying intent of the original version of HB 92, which is to exempt direct practices from the definition of insurance. She said Version E makes two major changes from the original bill (Version U): 1) it limits to direct primary care; 2) it removes Sections 2 through 7 of Version U related to mandatory Medicare/Medicaid participation. Further, Version E adds a new section in response to concerns about transparency and consumer protection.

MS. SHINE began the sectional analysis of Version E by drawing attention to the updated title on page 1, lines 1-2, which read:

"An Act relating to insurance; relating to direct primary care agreements for health care; and relating to the Alaska Unfair Trade Practices and Consumer Protection Act."

MS. SHINE explained the updated title identifies that it is direct primary care; removes the medical assistance recipients, which is the Medicare/Medicaid language; and adds that it relates to Alaska's Unfair Trade Practices and Consumer Protection Act (UTPA).

MS. SHINE noted Section 1 of Version E is a new whole section while in Version U it was a subsection. Section 1 would create a new title, Sec. 21.03.031, for direct primary care agreements. This would exempt direct primary care agreements from the application of Title 21, relating to insurance, if a written health care agreement contains the following information: describes the services provided in exchange for a periodic fee; allows either party to terminate the agreement as long as 60 days' notice is given; clearly states that the agreement is not health insurance in at least 12-point font in plain language; and prohibits the provider from receiving additional compensation for the services rendered.

3:10:56 PM

MS. SHINE detailed the changes made in Section 1 of Version E. She brought attention to subsection (a), paragraph (5), page 2, lines 7-8, which state, "is written in a font not smaller than 12 points and in plain language that an individual with no medical training can understand". She said this language is new and was added in response to concerns about transparency and to ensure consumer understanding of the direct care agreement. She explained that subsection (b), page 2, lines 12-13, is new language that was added to include consumer protection statutes and regulations under AS 45.45.915. She noted subsection (c), page 2, lines 14-25, is new language that was added to require direct primary care providers to submit certain information no later than September 1 of each year to the [Division of Insurance, Department of Commerce, Community & Economic Development]. This information includes the number of providers in a practice, the [practice's] capacity for direct primary care patients, the number of direct primary care patients and periodic fees paid for the preceding calendar year, and any other information requested by the division. She stated that subsection (d), beginning on page 2, line 26, defines health care, health care practices, and health care provider for

purposes of [Section 1]. Paragraph (2) of subsection (d) is new language that was added to provide a definition of health care practice.

MS. SHINE pointed out that all the language on page 3 from line 5 onward is new to this bill. She explained Section 2 is for direct primary care agreements for health care. It adds a new section restricting a direct primary care provider from terminating agreements solely based upon health status, or declining to accept a new patient unless the practice has received its maximum capacity of patients, or is unable to provide the level of care required by the patient. This also provides definitions and citations for the definitions of direct primary care agreement and health care provider. She said Section 3, beginning on line 21, adds a new violation under the Unfair Trade Practices and Consumer Protection Act (UTPA) for violating AS 45.45.915.

3:13:47 PM

REPRESENTATIVE TARR asked why payments related to Medicare and Medicaid were removed from the bill.

MS. SHINE replied the sponsor sought to simplify the bill because it is unclear how the state would be affected by Medicare and Medicaid patients participating in [direct primary care] agreements. She noted that after [Version E] was drafted, the Centers for Medicare and Medicaid Services (CMS) issued guidance, which the Department of Health and Social Services (DHSS) would be able to speak to. Furthermore, the inclusion of Medicare and Medicaid recipients in primary care agreements - that was part of previous versions of the bill - would have established Alaska as the first state to do so. Ms. Shine urged that there be more discussion on this issue.

REPRESENTATIVE TARR asked whether Ms. Shine is saying that the billing codes for this service don't yet exist in Medicaid and so it would be unclear whether a Medicaid enrollee could participate, and have it covered by Medicaid.

MS. SHINE responded it is unclear how the state would interact with CMS on how to pay for services. She posited payments may be structured in a manner similar to compensation by a health management organization (HMO) or another model. The previous version of the bill, which included this provision, contained "cumbersome" conditional language.

3:16:13 PM

DONNA STEWARD, Deputy Commissioner, Office of the Commissioner, Department of Health and Social Services (DHSS), addressed Representative Tarr's questions about what potentially might be involved. She spoke as follows:

> The situation with CMS is what they have offered, an opportunity for the Medicare program to have models that move forward, that look at direct primary care. They've not necessarily extended the same modeling to the Medicaid program but all that means is in order for us to move forward, we would need to engage with a demonstration waiver, so an 1115 waiver, sketch out what it is that we are hoping will, you know, be accomplished through moving through that process and then beginning that negotiation with CMS to potentially adopt both a new provider type and then a new way to bill for that service. Right now in fee for service Medicaid programs, which Alaska, that is the design for our program, we are not allowed to prepay for a service, and so at this point that is kind of how the direct primary care is used because we would be paying a monthly fee for a service that potentially the individual may not need that month, and so it just needs to be a negotiation through that waiver process in order to develop the new provider type, how the structure would work, and then get the payment mechanism and model in place.

3:17:52 PM

CO-CHAIR ZULKOSKY recalled that the bill's language related to Medicaid percentage is a problem because of the way Alaska's Medicaid payments are structured; for example, Washington has a managed care payment plan and Alaska is fee for service.

MS. SHINE agreed Alaska's [plan] is currently fee for service, although there are Medicaid demonstration projects that might be coming online that utilize managed care forms of payment. She offered her belief that there are other states that do have participation from Medicaid in direct primary care, but she doesn't believe it is available to Alaska currently.

3:18:56 PM

REPRESENTATIVE CLAMAN turned attention to Section 3 of Version E related to the Unfair Trade Practices and Consumer Protection Act (UTPA). He asked what portion of the services by providers would be subject to the UTPA.

MS. SHINE offered her belief it would have to be governed by what's in the contract between the provider and the patient, such as a breach of contract related to reimbursement or services.

REPRESENTATIVE CLAMAN posed a scenario in which the patient of a primary care provider alleges that the services provided constitute malpractice. He inquired whether this provision would mean that a malpractice claim on the services would be subject to the treble damage provisions of the UTPA.

MS. SHINE offered her understanding that they would be different and a claim for malpractice would be in a different section. This is what governs the contract. She deferred to the Department of Law (DOL) to identify what would be covered under this new section that would be added to the UTPA. She offered her belief that anything that happens currently under practice for medical malpractice would still be covered in the same way. This is adding a section specifically to these direct primary care agreements, so that if there is a consumer complaint that there is something within the Consumer Protection Unit that has the authority to be able to address them. Ms. Shine said she would get back to the committee with clarification.

3:21:28 PM

REPRESENTATIVE CLAMAN posed a scenario in which there is an argument that [the provider] was supposed to provide a certain amount of services as a function of the contract and the failure to provide those services. For example, prescription medication was part of the contract but [the provider] didn't provide consumer medication that was covered by it. He surmised there'd be a claim under the "deceptive trade practices act" for the failure to provide the medication, but that the treatment itself wouldn't be covered.

MS. SHINE offered her belief that that is how it is set up. She said she believes that if there was malpractice within the process of providing the medication that is outside of what would be constituted as malpractice it would be under a different section. She said she will get back to the committee with clarification.

REPRESENTATIVE CLAMAN asked about circumstances related to contracts with primary care clinics outside of the participating groups [of direct care providers]. He asked whether those providers would be subject to the provisions of the UTPA.

MS. SHINE responded she doesn't believe so because it would not be a direct primary care practice. She said she would get back to the committee with clarification.

3:23:45 PM

The committee took an at-ease from 3:23 p.m. to 3:28 p.m.

3:28:08 PM

REPRESENTATIVE CLAMAN drew attention to Section 3 of Version E, which would add provisions into the Unfair Trade Practices and Consumer Protection Act (UTPA). He noted he is aware of the treble damages provision of the UTPA. In a situation of a malpractice allegation against a clinic that has one of these contracts in place, he asked whether Section 3 would open the care provided to a treble-damages claim.

3:28:56 PM

CYNTHIA FRANKLIN, Assistant Attorney General, Special Litigation and Consumer Protection, Civil Division (Anchorage), Department of Law (DOL), answered that the treble damages section in UTPA belongs to individual litigants alone. Thus, in an action by the state under UTPA, "the civil penalty section trumps the treble damages section." So, the interaction would be between a consumer's individual UTPA lawsuit against the clinic or provider, and their medical malpractice claim. How those two legal claims would interact would be a question for a private attorney. However, the UTPA claim damages would be limited to whatever damages arose from the violations of the section of the direct primary care provider statutes. So, if HB 92 is passed, the consumer would be limited to claim damages for whatever actions by the clinic violated the provision in the bill.

3:30:13 PM

REPRESENTATIVE CLAMAN posed an example of a man who signs a contract with a clinic to provide services at a certain monthly fee to come as often as the patient wants. The man's wife has a child with the clinic and the man believes there was malpractice

committed in the course of delivering that child. He asked whether that means the man has a malpractice claim under the contract.

MS. FRANKLIN responded, "I don't know how the malpractice claim would interact with the contract, but I don't believe that Section 3 and the patient's individual lawsuit under the UTP would come into play in that scenario."

REPRESENTATIVE CLAMAN inquired whether Section 2 and Section 3 give the Division of Insurance the ability to supervise and regulate as a governmental matter what the clinic is doing. He further asked what these two sections of the bill are doing.

MS. FRANKLIN replied:

> It's my understanding that Section 3 is added because ... the lack of characterization of this type of provider care as insurance would prevent the Division of Insurance from regulating, and in most circumstances when we have some kind of consumer transaction, and there's no other regulating authority, it falls under the Unfair Trade Practices Act, and is added as a section here. So, in terms of governmental regulation, it defaults to the Department of Law, the Attorney General's office, to monitor consumer complaints on a business and determine whether or not any of the actions complained of violate any section of the Unfair Trade Practices Act. In this case it would include sections 1 and 2 of the bill in front of you. And so we, as AGs, would evaluate whether the complaint of conduct violated sections 1 and 2 and then theoretically, could, if there was a pattern of conduct on a particular clinic or provider, that was cheating, so to speak, or not playing by those rules that are set out in sections 1 and 2, then theoretically, we could bring a state action in superior court seeking civil penalties for the business violating those other sections, and that would act as ... the governmental regulatory authority. But because it's placed in the Unfair Trade Practices Act, it also gives individual patients, as consumers of the services, individual rights of action under the Act.

3:33:32 PM

REPRESENTATIVE JACKSON stated she likes that Medicaid and Medicare [patients] were removed from the bill because [direct care providers] fulfil the needs of those who do not qualify for Medicaid and for whom "regular" insurance is too expensive. Also, the bill provides entrepreneurial opportunities for physicians. She said she doesn't like the provision requiring that 20 percent of patients are qualified for Medicaid. She said Medicaid does not pay before a service and asked whether Medicaid is able to reimburse a patient if [direct care] is preferred by the patient. Representative Jackson recalled previous testimony that in Florida, Medicaid patients do not use Medicaid to see [direct care providers]. She questioned whether Medicaid patients could get reimbursed for services provided [by direct care providers].

3:35:41 PM

REPRESENTATIVE JENNIFER JOHNSTON, Alaska State Legislature, speaking as the sponsor of HB 92, said Florida has a different program for its Medicaid expansion group. Another bill has been introduced that proposes for Alaska "to have a plan similar to help people as they get off Medicaid expansion." However, it is a plan that Alaska doesn't have currently, and it is a plan that requires patients to pay some amount. That is why in Florida this does work with the Medicaid program, but it does not work in Alaska.

REPRESENTATIVE JACKSON recalled testimony from a speaker who said people [who qualified for Medicaid] were willing to pay for services.

MS. SHINE answered that each state implements the program differently; [in Alaska], Medicaid is not currently set up to pay fees. She continued:

> I think it's not targeted at one population; these are direct primary care agreements. I think you'll hear through testimony from other states and how it's worked, that I think that there are people ... that have Medicaid, people that have Medicare, people that are uninsured, people that have employer sponsored or exchange insurance that are accessing direct primary care. We included that language to make sure that ... Medicaid and Medicare patients were not excluded from them. I think it is still part of the conversation, but it is not in the bill.

3:38:12 PM

CO-CHAIR ZULKOSKY asked Ms. Franklin to clarify the unfair trade practice protections added in Section 3 and whether it would mean that any claims resulting out of a direct care agreement would be limited to damages from violations of the agreement and would not be related to malpractice damages.

MS. FRANKLIN replied that she thinks an individual patient would have both claims; the [Unfair Trade Practices Act] claim would be unrelated to the medical malpractice claim because the medical malpractice claim addresses the quality of the professional treatment and the [Unfair Trade Practices Act] claim would be a claim that something about the business setup or the billing violated the Unfair Trade Practice Act or violated Section 1 or Section 2.

CO-CHAIR ZULKOSKY surmised the unfair trade practices reference in Section 3 does not withhold or hold harmless any direct care agreement from malpractice claims.

MS. FRANKLIN responded correct.

3:40:02 PM

REPRESENTATIVE CLAMAN posed a scenario in which [the office of Special Litigation and Consumer Protection], DOL, filed a claim related to direct care agreements in [violation of the consumer protection act]. He surmised this claim would be limited to the kinds of issues within Section 1, such as the terms of the contract itself.

MS. FRANKLIN answered correct.

REPRESENTATIVE CLAMAN requested Ms. Franklin to describe what kind of complaints those might be.

MS. FRANKLIN replied it would be a situation where a clinic advertised services at some rate or advertised services in a particular way so as to attract consumers to that business in competition with other businesses and was somehow misleading or deceptive in the way that the contract was presented and the way that the consumer was attracted to the business or was treated by the business in opposition to the way that the statute requires the business to operate. So, in the situation of a state action against a business, DOL would look for a pattern of multiple consumer complaints where, in its business model, the

primary care provider was attempting to get an edge up on its competition by appearing to offer something it really didn't offer or appearing to have rates that were substantially lower.

3:42:22 PM

REPRESENTATIVE CLAMAN concluded DOL would investigate the false or deceptive advertising of services.

MS. FRANKLIN responded yes. In further response, she confirmed [the office of Special Litigation and Consumer Protection, DOL], does not participate in medical malpractice claims.

REPRESENTATIVE CLAMAN inquired whether, in the case of an individual complaint for malpractice against a clinic, it is DOL's view that [under Section 3] the Unfair Trade Practices Act provisions would now apply to the individual complaint.

MS. FRANKLIN answered yes. If HB 92 were passed, a complaint by an individual patient against a physician in a direct primary care practice could have counts of medical malpractice and, theoretically, also a complaint of unfair trade practices. From a legal perspective, the bill could provide for additional claims.

3:44:09 PM

CO-CHAIR SPOHNHOLZ asked how claims of noncompliance with consumer protection laws are typically brought to the [office of Special Litigation and Consumer Protection, DOL].

MS. FRANKLIN replied that consumer complaints from individuals are first brought for mediation of consumer issues and, if multiple complaints are received against one business, an investigation may be opened. In addition, cases are referred by other state agencies and professional licensing boards. After an investigation, the attorney general determines whether the Unfair Trade Practices Act has been violated.

CO-CHAIR SPOHNHOLZ inquired whether it is typically attorneys or members of the public that come to Ms. Franklin's office with a concern about unfair trade practices.

MS. FRANKLIN responded it is individual consumers, they are anyone filing a complaint with her office.

3:46:00 PM

CO-CHAIR SPOHNHOLZ opened invited testimony.

3:46:21 PM

The committee took a brief at-ease.

3:46:41 PM

JAY KEESE, Executive Director, Direct Primary Care Coalition, provided a PowerPoint presentation entitled, "Direct Primary Care in 2019." Turning to slide 1, Mr. Keese informed the committee that the history of this starts with a direct practice act that passed in Washington State. It was essentially included in the Affordable Care Act (ACA), to define direct primary care (DPC) - also known as medical homes - as a medical service that could be offered in conjunction with qualified health plans. Thus, patients covered by ACA through exchanges, or through their employer, could contract directly with a qualified health care practice; primary care was removed from qualified health plans to allow DPC practices to deliver primary care and to allow insurers to insure against risk and medical circumstances, such as acute care and hospitalization. Subsequently, [DPC] practices have grown to over 1,000 practices in 48 states and Washington, D.C. Mr. Keese said the median fee is about $70 per person per month, and about $165 for a family of four. He advised employer claims data has shown savings of up to 20 percent of the total cost of care because service by primary care providers is less expensive and reduces downstream expenses such as hospitalization and specialty care.

3:48:54 PM

MR. KEESE moved to slide 2 and said that since ACA was enacted, DPC legislation has passed in [26] states, including recent legislation in Georgia.

MR. KEESE drew attention to slide 3 and noted there is confusion between DPC and concierge medicine. The primary distinction, he explained, is concierge medicine provides medical services that are typically covered by insurance and there are extra fees for noncovered services and a higher level of access to a physician. In DPC, fees cover expanded access, in addition to all payments for medical care, without third party insurance reimbursement.

MR. KEESE said slide 4 illustrates prices for lab tests, procedures, and drugs offered at a "typical primary care

practice." He explained that a DPC practice provides primary care by physicians as well as access to drugs to labs at greatly discounted prices. For example, the prescription cost of Lexapro is $113 for 30 pills, but it can be had at a cash pay price of $4.80. He pointed out drugs can be obtained for less than an insurance co-pay and savings on prescriptions are beyond that of savings on primary care.

3:51:19 PM

MR. KEESE continued to slide 5 which illustrated some of the arrangements between direct primary care practices and self-insured employers, Medicare Advantage, state and local employee funds, and other entities. Slide 6 listed data related to DPC arrangements with large employers, such as Boeing. He said the data indicates reductions in total cost of care up to 20 percent and that employees with higher health care costs have reduced their expenses.

MR. KEESE turned to slides 7 and 8 to discuss state legislation. He advised some states are clarifying that DPC practices are outside of state insurance regulation and are medical services. Because federal interpretation of health saving account (HSA) eligibility rules differ, pending federal legislature would clarify that individuals with HSAs are eligible to have a DPC and an HSA. He cautioned that the aforementioned legislation is not currently in effect, thus the Internal Revenue Service (IRS) has interpreted DPCs as "other" coverage and DPCs are not compatible with HSAs.

3:55:52 PM

PHILIP ESKEW, DO, JD, MBA, Family Medicine Physician and Attorney, DPC Frontier, noted he is a family physician doing direct primary care as well as a DPC attorney. He said 26 states now have legislation that define DPC as not being insurance. The motivation for defining DPC is to save DPC physicians, patients and the Division of Insurance headaches - it is taking a grey area in the law and making it more black and white and the Division of Insurance has better things to do than reading each contract in detail for each DPC practice that opens up. States that have done this well and been happy about it have given a clear definition of what DPC is and [Version E] does that. He said [Version E] defines DPC as outside of insurance and prohibits what he calls "double dipping" which distinguishes DPC from concierge, and the bill defines the mandatory disclosures in the [direct care] contract and avoids

inadvertently blocking the state or an employer down the road from adopting and paying for DPC.

DR. ESKEW returned to the earlier discussion about patient/consumer protection. He said his impression is that even without the consumer protection provision in this bill, "that department" would probably still default and have jurisdiction to be involved in a patient protection dispute even when it isn't explicitly stated. He said he thinks that would already apply to a standard fee for service practice that might be open and independent in the state of Alaska presently. He said most states have not felt the need to explicitly state that jurisdiction.

3:58:09 PM

DR. ESKEW stated he is concerned about Version E's reporting requirements to the [Division] of Insurance on page 2, which is modeled after Washington's law. He pointed out that of the 26 states that DPC laws, only two have any reporting requirements to the department of insurance, which are Washington and Oregon; the others have not found it necessary for a variety of reasons. He pointed out that the intent of the bill is to reduce the burdens on the Division of Insurance and the bill states that the Division of Insurance does not have jurisdiction over these types of contracts because they are not a transfer of risk and they involve a relationship between a physician and a patient and historically those relationships are policed by the state medical board. He said he thinks it would be wise to have this policed by Alaska's state medical board as well and that reporting to the Division of Insurance would be a burden to that division. He advised that a 2018 report from Washington State indicates there has not been one patient complaint in Washington State for ten years [document not provided].

DR. ESKEW noted 48 states already allow DPC physicians to see Medicaid patients in the sense that freedom of contract applies, and those patients allowed to pay to join a DPC practice. However, laws in Kentucky and Colorado prohibit any private contracting with Medicaid patients in those states, DPC or otherwise. He supported Version E's removal of references to Medicaid and Medicare because the initial bill about DPC should be about just defining it. If Alaska wants to do a pilot program, be it in the Medicaid space or be it with state employees, he would do that with a second piece of legislation down the road after people understand what DPC is and should be.

4:01:30 PM

REPRESENTATIVE DRUMMOND understood that 48 states allow DPC physicians to see Medicaid patients. She asked about provisions in state legislation that address Medicare patients.

DR. ESKEW replied that Medicare is different than Medicaid. He explained physicians volunteer to participate/enroll in Medicaid programs. In some states, physicians can participate in Medicaid and still have the freedom to privately contract, but other states don't allow physicians who privately contract to formally enroll in Medicaid. Medicare is different. In order to privately contract for covered services under Medicare, physicians must choose to "opt-out" of Medicare, which means the physician is still credentialed with Medicare, but the physician promises not to charge Medicare, and the patient agrees not to seek reimbursement from Medicare, thereby allowing the physician and the patient to contract for services that Medicare covers.

4:03:00 PM

REPRESENTATIVE TARR stated Alaska's health care system is more fragile than that of other states. She spoke in support of the reporting requirement provisions of the bill and requested Dr. Eskew's thoughts on this being overly burdensome for providers.

DR. ESKEW responded DPC physicians seek to spend more time with patients and less time with documentation. He suggested that if Alaska wants to track data it should be specific about what is wanted and specific about where to house it. He pointed out that Version E puts the burden of aggregating data on the [Division] of Insurance, which he thinks a strange decision since it is being said that this is not insurance. He suggested the burden of aggregating data be put elsewhere, such as with the state medical board and that there be specifics on what the medical board should track. Currently, he noted, the bill includes a statement that gives [the division] cart Blanche to add lots of additional requirements and things that must be tracked and that could become quite burdensome in theory.

4:05:28 PM

REPRESENTATIVE TARR asked whether the provision for additional reporting might discourage providers from participating.

DR. ESKEW answered that if the burdens became great enough then providers might not sign up. He advised that if the bill does

not become law, DPC practices in Alaska will continue to operate under the purview of the [Division] of Insurance, which is the situation HB 92 seeks to avoid by defining DPC.

4:06:45 PM

CO-CHAIR SPOHNHOLZ reviewed the limited reports required by the bill: the number of health care providers in the practice; the number of patients the practice has the capacity to serve; the number of patients who entered in or maintained a DPC agreement with the health care practice in the previous calendar year and the fee paid. She said any practice would have this information readily available.

DR. ESKEW agreed that those reports are easy to do, except for [Section 1] (c)(4), which states, "other information requested by the division."

CO-CHAIR SPOHNHOLZ asked for the number of states that allow Medicaid payments for direct care agreements.

DR. ESKEW replied that there are some states that have or had Medicaid pilots in place, such as Michigan and Washington State; however, most states have not formalized Medicaid payments for DPC. Oklahoma debated a reimbursement system in which the patient would be reimbursed for a portion of the monthly fee, similar to a voucher or food stamp system. If Alaska takes no action on Medicaid [by HB 92], he said, "physicians will be able to find a way to see Medicaid patients should [ these patients] choose to join a DPC practice and pay for care on their own.

4:10:11 PM

ERIKA BLISS, MD, Equinox Primary Care, informed the committee she was formally CEO of [Qliance Medical Group (Qliance)]. She said she supports the previous testimony by Mr. Keese and Dr. Eskew. Dr. Bliss said, "We were active in getting the initial - and then subsequent amended - laws passed in Washington and things have operated fairly well since then." She agreed with Dr. Eskew that the monitoring process in Washington State is not useful and explained the intent of reporting was to protect consumers from situations that did not occur. She said DPC practices are organizations trying to revive primary care and create a successful business model that allows providers the time needed to care for patients. Further, Dr. Bliss said the reported data has not been utilized and assured the committee that [if HB 92 becomes law] there are other avenues for consumer

recourse. Although Qliance was closed in 2017, DPC practices are growing around the country due to the needs of those who do not have any, or adequate insurance, or adequate insurance-based primary care. She said she now has a solo DPC practice in Seattle, which is the only way she can provide comprehensive primary care to patients who have significant medical issues. She said she has more time to provide care, avoids the hassles of billing insurance companies, and sets her prices.

4:14:54 PM

DR. BLISS further explained her practice is not unique in that she serves a wide range of socioeconomic levels; some of her economically-deprived patients pay full costs, however, it is up to her and her patients to work out discounts and payment plans to maintain patients' access to care when their economic circumstances change. Qliance was the first DPC organization to undertake a largescale Medicaid program pilot. Unlike Alaska, Washington State has a Medicaid managed care environment and in 2014, Qliance had a combination of two-thirds Medicaid patients and one-third ACA exchange patients for a total of 35,000 members. Although Qliance failed due to problems with the Medicaid managed care companies and the lack of controls at the state level, the program reduced the cost of care for Medicaid recipients, especially for chronically sick and disabled patients. In addition, patients were very pleased with their care and improved health. Dr. Bliss remarked:

> We got quite a few people actually off of Medicaid and back to work, and I think that that probably didn't mesh well with the goals of some of the managed care folks, and unfortunately, it's sort of perverse incentives in some cases. But ... in Alaska, you might want to really think about it, since you still have a direct contracting relationship with providers, this could be a really interesting opportunity for you....

DR. BLISS continued to explain Alaska could create an incentive for providers to serve Medicaid patients well, and over time, by paying a reasonable monthly fee, similar to Qliance; however, Qliance overinvested in its Medicaid pilot and relied on assurances from the plan and the state.

4:19:38 PM

REPRESENTATIVE TARR surmised that as a business owner Dr. Bliss can determine how many discounted rates she can offer.

DR. BLISS replied correct. At one time, she recalled, medical practices were expected to provide a certain amount of charity care, but some HMOs are prevented from doing so. She said DPC providers can choose rates for patients.

REPRESENTATIVE TARR offered her understanding that DPC practices can discount medical care, but not prescriptions.

DR. BLISS responded correct and said a benefit of the DPC business model is that it allows her and her staff to advocate for patients and search for better prices. In certain states DPC practices can work together and negotiate "package deals" on, say, radiology studies.

4:23:29 PM

REPRESENTATIVE TARR, speaking from her experience, related that insurance rates in the price range of $70-$100 per month usually have a high deductible and little or no preventative care. She asked how DPC contracts for the same price can provide primary care as described.

DR. BLISS answered that a catastrophic insurance plan provides coverage against a terrible event; in Washington State, the cheapest insurance possible - including a high deductible - costs $300 per month. In contrast, an individual entering in a DPC contract purchases care and a membership in the practice that will provide on-demand primary care: all an individual's preventable and primary care needs, when and where they are needed. She described several DPC office efficiencies that lower the cost of the delivery of care and increase flexibility for the patient and provider; further, DPC lowers the barriers to care and encourages individuals to use primary care more often in order to avoid complications and emergencies. Dr. Bliss said that pairing DPC with a catastrophic insurance plan would provide "pretty decent" health care and health coverage.

4:28:39 PM

CO-CHAIR SPOHNHOLZ returned attention to the reporting requirements in Washington State and asked what elements of reporting are onerous to Washington's DPC providers.

DR. BLISS replied that the requirements are not onerous. She said her objection at first was that DPC providers have nothing to do with the insurance commissioner because DPC practices are not insurance, they are businesses providing medical care and therefore should be governed by the appropriate agencies for commerce and for medical affairs. She cautioned Americans don't know that the difference between health care and health insurance is that health insurance protects one against risk.

CO-CHAIR SPOHNHOLZ understood Dr. Bliss to be saying that the reporting isn't onerous, it is just in the wrong place.

DR. BLISS clarified it is onerous because the reporting isn't being put to good use and perpetuates the notion that all things have to eventually roll up into insurance. She related that most [DPC providers] would like to see the departments of health in their states or legislators assign some other body to look at the system of delivery of care and take it seriously as a piece of the delivery system and study it as such.

4:32:18 PM

REPRESENTATIVE JACKSON commented that she looks at this as "old fashioned doctor-patient care before insurance blew up ... when they did house calls." She said she therefore understands the statement of having to report anything to insurance companies because this isn't insurance, it is a business with health care professionals to their patients. She surmised that Dr. Bliss is saying the reporting should go to the state medical board, not the [Division of Insurance].

DR. BLISS replied yes.

REPRESENTATIVE JACKSON surmised [HB 92] would attract more doctors because they wouldn't have to go through the rigors of insurance.

DR. BLISS agreed that this is true. In her experience, medical doctors, residents, and medical students around the country are excited about practicing primary care, although not all doctors are willing to take the risk of entering a DPC business.

4:36:05 PM

MANDY WEEKS GREEN, Senior Health Policy Analyst, Office of the Insurance Commissioner (OIC), Washington State, said she is responsible for reviewing and approving DPC registrations,

reporting noncompliance, and monitoring DPC practices. She related that the laws of Washington State consider direct practices to be insurance unless they apply for - and qualify for - the exception for insurance. So, it is not that all direct practices are an exception, but if a practice does apply and is conducting its business within the bounds of the statute, then it does qualify for the exception. However, many practices do not apply to OIC and do not initially qualify because they offer other services, or do not operate within the legal boundaries of DPC, thus OIC helps practices comply with the laws and attain the exception.

4:37:48 PM

CO-CHAIR SPOHNHOLZ surmised that in Washington State, practices must apply [to OIC] to be exempted from insurance.

MS. WEEKS GREEN replied yes. She explained that a practice applies for registration before operating a DPC practice. This registration requirement before a direct practice operates is an important protection for consumers because it enables the OIC to review a direct practitioner's application, contract, and marketing materials before services are offered to consumers. It is the best time for OIC to intervene and help make corrections to prevent consumers from being harmed and ensure compliance with the direct practice laws. For example, OIC has been able to prevent several billing structures that were based on a person's health status, such as charging higher fees for consumers with certain conditions or chronic conditions. Washington State has a general prohibition on discrimination as well as a specific prohibition to prevent billing fees that are based on a person's health status.

4:38:52 PM

MS. WEEKS GREEN pointed out that Washington restricts a provider's reasons for declining or terminating a patient. This helps OIC when reviewing contracts to ensure that consumers are properly advised of their rights around termination. When reviewing applications containing contracts that reserve the right to terminate, accept, or decline patients for any reason, OIC works with those practices to revise their language to reflect the lawful language requirements.

MS. WEEKS GREEN further pointed out that Washington law has been helpful in setting limitations around billing, cancelation, and retaining unused fees. Direct practices typically bill on a

monthly basis in advance for the month. Washington law requires a refund for the pro-rated unused fees from the date the provider was notified of cancelation. Having this provision has enabled OIC to remove clauses in several direct practice contracts that sought to retain the money through the contract period. The OIC has also been able to prevent direct practices from charging consumers cancelation fees. Additionally, if a provider would like to collect money for more than a month in advance - for example, on an annual basis - Washington statute says a trust account must be set up to retain the collected money and ensure that those fees are still only withdrawn from the account on a monthly basis. There are also several requirements that must be contained within the contract which were developed to protect consumers. One of those is that the contracts must encourage the consumers to retain insurance or purchase supplemental plans to cover emergencies.

4:40:33 PM

CO-CHAIR ZULKOSKY remarked that these consumer protections are interesting and comprehensive, as she wants to ensure that Alaskans are protected as legislators consider this proposal. She requested Ms. Weeks Green to discuss the resources that are needed within the Washington OIC to uphold these protections and to provide the work being described.

MS. WEEKS GREEN responded she is the sole person who manages direct practices. It's only a small portion of her duties, she said, because she is a health care policy analyst, so it doesn't take her an exceptional amount of time to review a contract, communicate with a provider, and discuss needed changes. What may involve more time for investigation and some additional resources, but not very much, is when unlicensed, unregistered entities are offering services that are inappropriate under the statute.

CO-CHAIR ZULKOSKY requested a written copy of Ms. Weeks Green's testimony.

MS. WEEKS GREEN answered she would be happy to.

4:42:13 PM

REPRESENTATIVE CLAMAN observed the committee has been provided with the Washington statutes. He inquired whether regulations have been issued that relate to this or whether everything is in statute.

MS. WEEKS GREEN replied everything is in statute and currently there are not any regulations.

REPRESENTATIVE CLAMAN offered his understanding that even though this is technically not insurance, the Washington Legislature effectively decided that it would be subject to insurance department supervision as opposed to the consumer protection division.

MS. WEEKS GREEN responded that this is insurance if it is looked at from the definition of insurance because insurance is risk shifting. This means that [a practitioner] accepts the risk of whether [the practitioner] or the client is going to receive more benefit or less benefit from the contract. So, if billing on a monthly basis, a doctor may receive more payment from the patient if the patient doesn't see the doctor every month, so the doctor would be receiving the benefit of that contract. The risk shifting comes when the patient utilizes the service more than has been use accounted for.

REPRESENTATIVE CLAMAN asked whether Washington has specifically defined these agreements as a form of an insurance agreement, whereas the proposal before the committee would specifically say that it's not an insurance agreement.

MS. WEEKS GREEN answered: "It is an insurance agreement. It's what is accepted from the insurance code as long as everything is done appropriately. So ... we accept it from regulation as long as everything is operating smoothly."

4:44:18 PM

REPRESENTATIVE JACKSON offered her understanding that Ms. Weeks Green is saying that direct primary care is an insurance, but technically it is a service between a medical provider and a patient. She inquired whether this threatens the insurance industry in any way and is competitive.

MS. WEEKS GREEN replied she doesn't know that competition is the underlying element of why Washington regulates [direct primary care practices]. She said Washington is concerned about them because they can cause consumer harm when they're not operated appropriately and within the bounds. She added she doesn't believe that insurance companies are necessarily threatened by the practice of direct practices, but she does think that healthier people might be pulled out of the market into direct

practices. However, Washington doesn't know anything about that necessarily because it is unable to get into studies on that.

REPRESENTATIVE JACKSON understood Ms. Weeks Green to be saying insurance is in it to protect the patient. She asked whether that wouldn't be the purpose of the state medical board to make sure the doctors are licensed and have the qualifications.

MS. WEEKS GREEN responded that OIC can report to the state medical board. Any violation of the insurance code is also a violation. Any violation under the direct practice statute is also a violation under the ethics board of the medical board, so there is the ability to cooperate for investigations.

REPRESENTATIVE JACKSON clarified she is asking as to why Washington has the OIC looking out for the concerns and safety of the people rather than Washington's medical board.

MS. WEEKS GREEN answered that OIC is where it landed. The OIC does consider it insurance, it isn't a pay-for-service model, it isn't "I pay my provider $10 to go see them." It is one thing if a provider wanted to charge patients a nominal fee and because the provider wants to operate a low-income clinic and charge the patient $5 instead of $80 although those $5 could add up to $80 a month. It is another thing when a provider says he or she is going to take the risk that a patient may or may not use this service.

REPRESENTATIVE JACKSON maintained that that is exactly what it is doing, just like when she purchases an extra maintenance plan on her vehicle, she realizes she may not use it, but if she needs it it's there. So, she concluded, that would be the choice of the patient.

MS. WEEKS GREEN replied that that is insurance, too.

4:47:50 PM

CO-CHAIR SPOHNHOLZ observed from the [Direct health care practices in Washington, Annual report to the Legislature, dated 12/1/18] that there were over 18,000 direct practice [patients]. She inquired about the number of contracts out of the number of practitioners that are found by OIC to be problematic or not in compliance with state law on an annual basis.

MS. WEEKS GREEN responded that OIC doesn't receive that many, which is why it doesn't involve a lot of her time.

CO-CHAIR SPOHNHOLZ observed from the report that there were 41 direct practices in 2018 in the state of Washington.

MS. WEEKS GREEN answered that those 41 practices are practices that are continuing to operate. She guessed OIC receives maybe five applications a year, but OIC suspects there are many entities that are not applying with the OIC and are operating without a permission to operate. The number of practices applying is very low, but the number of practices that have clauses within their contract that create some problem with the direct practice statute is fairly high. She has conversations with about 50-75 percent of direct practitioners to help them resolve their contractual issues, just to protect consumers during the registration process. As long as [practitioners] are coming in before they are operating it is usually very easy - she discusses it with them, reviews the law, talks to them about why it doesn't fit within the law confines, or why it harms consumers, and usually the practitioners readily agree to make the change.

4:49:51 PM

REPRESENTATIVE CLAMAN asked whether it is the case that if people have this insurance for the direct practice, they are also required to have another layer of insurance behind that as part of Washington's insurance coverage requirements.

MS. WEEKS GREEN replied no, it is just required that the practices encourage people to have an emergency plan like a high-deductible health plan.

4:50:30 PM

MS. WEEKS GREEN pointed out that Washington is seeing a changing landscape of direct practices. She said Washington is seeing more and more innovation and expansion into new models of direct practice bundling with non-primary care services and bundling and discounts on services with labs, providers, and pharmacies. Also being seen are entities that are trying to create direct care practice networks and network plans. An important part of Washington law, she continued, is that Washington prevents employer direct practice plans. Despite this, OIC receives consumer complaints about employer based direct practice plans and OIC has discovered many entities that are offering these plans without being registered. When Washington's laws were reviewed and written, these changes in technology and innovation

were not expected. Currently, OIC has received an application for direct practice that isn't located in Washington, but it would like to provide tele-med primary care services entirely to consumers.

MS. WEEKS GREEN advised that it is important to note that these innovations and expansions are not coming from registered direct practices or networks; the consumer complaints are not about those practices. Many of these entities have never sought OIC's approval to operate or OIC's guidance. She said she believes that had Washington been able to foresee these changes happening in direct practice it likely would have set more parameters around permissible direct practice structures. While it once seemed like a small number of providers, it has exploded due to innovation and technology and it is probably going to continue. She offered her hope that this helps the committee to prepare to address these changes and innovations in the direct practice because it will help to preserve the model that the committee envisions in the future.

4:52:20 PM

CO-CHAIR SPOHNHOLZ observed from the 2018 Washington report that there were 40 practices in 2017 and 41 in 2018, but that Ms. Weeks Green used the word "exploded" to describe the increase in the number of participants and that doesn't sound like exploding to her. She requested Ms. Weeks Green to explain.

MS. WEEKS GREEN responded OIC thinks there are many plans that are operating without OIC's permission.

CO-CHAIR SPOHNHOLZ asked whether OIC is doing anything about that.

MS. WEEKS GREEN answered that OIC is looking into it. She said OIC gets consumer reports on a regular basis and this is the first that OIC is learning of these other entities. She noted OIC doesn't put consumer complaints in its report if they're not about licensed direct practices. A lot of the complaints are about unlicensed entities, so those numbers are not seen in the report that OIC files with the legislature. The OIC is seeing a lot of new models and new innovations that it hasn't seen before, but they are not from entities that are contacting OIC. Usually OIC is hearing about it from consumer complaints or being notified about it from other direct practices. For OIC it feels like an explosion because it feels like a rush, a lot of change happening very quickly. In further response to Co-Chair

Spohnholz, she confirmed it is primarily amongst unlicensed practices or complaints about potentially unlicensed practices.

4:54:11 PM

CO-CHAIR SPOHNHOLZ held over HB 92.

4:55:16 PM

**ADJOURNMENT**

There being no further business before the committee, the Health and Social Services Committee meeting was adjourned at 4:55 p.m.