

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL: CS/SB 240

INTRODUCER: Banking and Insurance Committee and Senator Lee

SUBJECT: Direct Primary Care

DATE: February 7, 2017

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	Fav/CS
2.			HP	
3.			AHS	
4.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Technical Changes

I. Summary:

CS/SB 240 amends the Florida Insurance Code (code) to provide that a direct primary care agreement is not insurance and is not subject to regulation under the code. Direct primary care (DPC) is a primary care medical practice model that eliminates third party payers from the primary care provider-patient relationship. Through a contractual agreement, a patient pays a monthly fee, usually between \$50 and \$100 per individual, to the primary care provider for defined primary care services. As of June 2016, 16 states have adopted DPC laws that define DPC as a medical service outside the scope of state insurance regulation. The bill defines terms and specifies certain provisions, including consumer disclosures, which must be included in a direct primary care agreement.

II. Present Situation:

Direct Primary Care

Direct primary care (DPC) is a primary care medical practice model that eliminates third party payers from the provider-patient relationship. Through a contractual agreement, a patient generally pays a monthly retainer fee, on average \$77 per individual,¹ to the primary care

¹ A study of 141 DPC practices found the average monthly retainer fee to be \$77.38. Of the 141 practices identified, 116 (82 percent) have cost information available online. When these 116 practices were analyzed, the average monthly cost to the patient was \$93.26 (median monthly cost, \$75.00; range, \$26.67 to \$562.50 per month). Of the 116 DPCs noted, 36 charged a

provider for defined primary care services, such as office visits, preventative care, annual physical examination, and routine laboratory tests.

After paying the monthly fee, a patient can access all services under the agreement at no extra charge contingent upon the agreement. Typically, DPC practices provide routine preventative services, screenings, or tests, like lab tests, mammograms, Pap screenings, and vaccinations. A primary care provider DPC model can be designed to address most health care issues, including women's health services, pediatric care, urgent care, wellness education, and chronic disease management.

Some of the potential benefits of the DPC model for providers include reducing patient volume, minimizing administrative and staffing expenses; increasing time with patients; and increasing revenues. In the DPC practice model, the primary care provider eliminates administrative costs associated with filing and resolving insurance claims. Direct primary care practices claim to reduce expenses by more than 40 percent by eliminating administrative staff resources associated with third-party costs.²

In 2014, the American Academy of Private Physicians estimated that approximately 5,500 physicians operate under some type of direct financial relationship with their patients, outside of standard insurance coverage. According to the AAPP, that number has increased around 25 percent per year since 2010.³ The Direct Primary Care Coalition has adopted model state legislation for DPC agreements.⁴ As of June 2016, 16 states have adopted DPC legislation, which defines DPC as a medical service outside the scope of state insurance regulation.⁵

Federal Health Care Reform and Direct Primary Care

The federal Patient Protection and Affordable Care Act (PPACA)⁶ requires health insurers to make guaranteed issue coverage available to all individuals and employers, without exclusions for preexisting conditions and without basing premiums on any health-related factors. The PPACA also mandates that insurers that offer qualified health plans (QHPs) provide 10 categories of essential health benefits,⁷ which includes preventative⁸ care and other benefits.

one-time enrollment fee and the average enrollment fee was \$78. Twenty-eight of 116 DPCs charged a fee for office visits in addition to the retainer fee, and the average visit fee was \$16. See Phillip M. Eskew and Kathleen Klink, *Direct Primary Care: Practice Distribution and Cost Across the Nation*, Journal of the Amer. Bd. of Family Med. (Nov.-Dec. 2015) Vol. 28, No. 6, p. 797, available at: <http://www.jabfm.org/content/28/6/793.full.pdf> (last viewed Jan. 28, 2017).

² Lisa Zamosky, Direct-Pay Medical Practices Could Diminish Payer Headaches, MEDICAL ECONOMICS, (April 24, 2014), <http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/concierge-service/direct-pay-medical-practices-could-diminish-payer-h>. (last viewed January 28, 2017).

³ David Twiddy, *Practice Transformation: Taking the Direct Primary Care Route*, Family Practice Management, No. 3, (May-June 2014), available at: <http://www.aafp.org/fpm/2014/0500/p10.html> (last viewed Jan. 29, 2017).

⁴ Direct Primary Care Coalition Model State Legislation available at: <http://www.dpcare.org/dpcc-model-legislation>. (last viewed January 28, 2017).

⁵ See <http://www.dpcare.org/> (last viewed January 26, 2017).

⁶ Pub. Law No. 111-148 (Mar. 23, 2010) amended by Pub. Law. No. 111-152 (Mar. 30, 2010).

⁷ 42 U.S.C. s.18022.

⁸ Available at: <https://www.hhs.gov/healthcare/about-the-law/preventive-care/index.html#>. (last viewed Feb. 5, 2017). Many of these preventive services must be covered without any cost sharing by the patient.

The PPACA addresses the DPC practice model as part of health care reform. A QHP may provide coverage through a DPC medical home plan that meets criteria⁹ established by the federal Department of Health and Human Services, provided the QHP meets all other applicable requirements.¹⁰ Insureds who are enrolled in a DPC medical home plan are compliant with the individual mandate if they have coverage for other services, such as a wraparound catastrophic health policy¹¹ or high deductible, health insurance plans¹² to provide coverage for severe injuries or chronic conditions. In Colorado and Washington, qualified health plans offer DPC medical home coverage on the state-based health insurance exchanges.¹³

State Regulation of Insurance

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, HMOs, and other risk-bearing entities. These specified entities must meet certain. Agency for Health Care Administration (agency) regulations regarding the quality of care provided by HMOs and prepaid health clinics under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, a HMO and a prepaid health clinic must receive a Health Care Provider Certificate¹⁴ from the agency pursuant to part III of ch. 641, F.S.¹⁵

Currently, Florida law does not address direct primary care agreements. However, a medical provider offering direct primary care agreements may be considered to be operating a prepaid health clinic if the medical provider is offering to provide services in exchange for a prepaid fixed fee.¹⁶

Prepaid Health Clinics

Prepaid health clinics¹⁷ are required to obtain a certificate of authority from the OIR pursuant to part II of Chapter 641, F.S. The entity must meet minimum surplus requirements¹⁸ and comply with solvency protections for the benefit of subscribers by securing insurance or filing a surety bond with the OIR.¹⁹ Part II also provides that the procedures for offering basic services and

⁹ The HHS has not adopted criteria to date.

¹⁰ See 42 U.S.C. ss. 18021(a)(3) and 18022.

¹¹ Catastrophic plans are a form of high deductible plans, which meet the minimum essential coverage requirements. See 42 U.S.C 18021 for eligibility and coverage requirements.

¹² A high deductible health plan (HDHP) has a higher deductible than typical plans and a maximum limit on amount of the annual deductible and out-of-pocket medical expenses that an insured must pay for covered expenses. Out-of-pocket expenses include copayments and other amounts, excluding premiums.

¹³ See http://www.akleg.gov/basis/get_documents.asp?session=29&docid=7936 (last visited Feb. 5, 2017).

¹⁴ Section 641.49, F.S.

¹⁵ Section 641.48, F.S., provides that the purpose of part III of ch. 641, F.S., is to ensure that HMOs and prepaid health clinics deliver high-quality care to their subscribers.

¹⁶ Part II of ch. 641, F.S.

¹⁷ Section 641.402, F.S., defines the term, “prepaid health clinic,” to mean any organization authorized under part II that provides, either directly or through arrangements with other persons, basic services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed-sum basis, including those basic services which subscribers might reasonably require to maintain good health. However, no clinic that provides or contracts for, either directly or indirectly, inpatient hospital services, hospital inpatient physician services, or indemnity against the cost of such services shall be a prepaid health clinic.

¹⁸ Section 641.406, F.S. Each prepaid health clinic must maintain minimum surplus in the amount \$150,000 or 10 percent of total liabilities, whichever is greater.

¹⁹ Section 641.409, F.S.

offering and terminating contracts to subscribers may not unfairly discriminate based on age, health, or economic status.²⁰

Prepaid Limited Health Service Organizations

Prepaid limited health service organizations provide limited health services to enrollees through an exclusive panel of providers in exchange for a prepayment authorized under ch. 636, F.S. Limited health services include ambulance, dental, vision, mental health, substance abuse, chiropractic, podiatric, and pharmaceutical. Provider arrangements for prepaid limited health service organizations are authorized in s. 636.035, F.S., and must comply with the requirements in that section.

III. Effect of Proposed Changes:

Section 1 creates s. 624.27, F.S. The bill provides that a direct primary care agreement is not insurance and entering into such an agreement is not the business of insurance. The bill exempts both the agreement and the activity of entering into a direct primary care agreement from the Florida Insurance Code (code). The bill also exempts a primary care provider, or his or her agent, from obtaining a certificate of authority or license under the code to market, sell, or offer to sell a direct primary care agreement. The bill creates the following definitions:

- “Direct primary care agreement” is a contract between a primary care provider and a patient, the patient’s legal representative, or an employer which must satisfy certain requirements within the bill and does not indemnify for services provided by a third party.
- “Primary care provider” is a licensed health care practitioner under ch. 458 (medical doctor or physician assistant), ch. 459 (osteopathic doctor or physician assistant), ch. 460 (chiropractic physician), or ch. 464, F.S., (nurses and advanced registered nurse practitioners), or a primary care group practice that provides medical services which are commonly provided without referral from another health care provider.
- “Primary care service” is the screening, assessment, diagnosis, and treatment of a patient for the purpose of promoting health or detecting and managing disease or injury within the competency and training of the primary care provider.

The bill specifies the following minimum requirements and disclosures for direct primary care agreements:

- Be in writing and signed by the provider or their agent and the patient, their legal representative or their employer;
- Allow a party to terminate the agreement with 30 days’ advance written notice and provide for the immediate termination of the agreement if the physician-patient relationship is violated or a party breaches the terms of the agreement;
- Describe the scope of primary care services covered by the monthly fee.
- Specify the monthly fee and any fees for primary care services not covered by the monthly fee.
- Specify the duration of the agreement and any automatic renewal provisions.
- Offer a refund of monthly fees paid in advance if the provider ceases to offer primary care services for any reason.

²⁰ Section 641.406, F.S.

- Contain the following statements in contrasting color and 12-point or larger type, on the same page as the applicant's signature:
 - "This agreement is not insurance, and the primary care provider will not file any claims against the patient's health insurance policy or plan for reimbursement of any primary care services covered by this agreement."
 - "This agreement does not qualify as minimum essential coverage to satisfy the individual shared responsibility provisions of the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148."
 - "This agreement is not workers' compensation insurance and may not replace the employer's obligations under ch. 440, F.S."

Section 2 provides the bill is effective July 1, 2017.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill removes regulatory uncertainty for health care providers by stating that the direct primary care agreement is not insurance, and as a result, the OIR does not regulate the agreements. This statutory change eliminates a long-standing concern with part II of ch. 641, F.S., which requires licensure and regulation of prepaid health clinics. Currently, that section of the code is unclear about the treatment of these types of arrangements with providers. To date, the OIR has not licensed any direct primary care providers under part II to provide such services.²¹

Additional primary care providers may elect to pursue a direct primary care model and establish direct primary care practices, which may increase patients' access to affordable primary care services.

²¹ Office of Insurance Regulation, *Senate Bill Analysis 240* (Jan. 17, 2017) (on file with the Senate Committee on Banking and Insurance).

Many individuals have high deductible policies and must meet a significant out of pocket cost to access many types of medical care. The DPC agreements may provide a less expensive option for accessing certain services. For many patients, the greater use of direct primary care agreements may decrease reliance on emergency rooms as a source of routine care.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill does not include a provision relating to non-discrimination based on health status. The model bill provides the following:

Direct primary care practices may not decline to accept new direct primary care patients or discontinue care to existing patients solely because of the patient's health status. A direct practice may decline to accept a patient if the practice has reached its maximum capacity, or if the patient's medical condition is such that the provider is unable to provide the appropriate level and type of primary care services the patient requires.²²

VIII. Statutes Affected:

This bill substantially amends section 624.27 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Banking and Insurance on February 7, 2017:

The CS provides an additional mandatory disclosure to the direct primary care agreement that states that the agreement is not workers' compensation insurance and may not replace the employer's obligation under ch. 440, F.S.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

²² See <http://www.dpcare.org/dpcc-model-legislation> (last viewed Feb. 1, 2017).