

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 Health Policy

BILL: CS/SB 80

INTRODUCER: Banking and Insurance Committee and Senator Lee

SUBJECT: Direct Primary Care Agreements

DATE: October 19, 2017

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	<u>Johnson</u>	<u>Knudson</u>	<u>BI</u>	<u>Fav/CS</u>
2.	<u>Lloyd</u>	<u>Stovall</u>	<u>HP</u>	<u>Pre-meeting</u>
3.	_____	_____	<u>AP</u>	_____

Please see Section IX. for Additional Information:

PLEASE MAKE SELECTION

I. Summary:

CS/SB 80 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. The bill also defines DPC agreements and requires them to meet statutory requirements, including consumer disclosures. A contract that does not meet these requirements is not a DPC agreement, and thus will not be exempt from the code.

As of September 2017, 23 states have adopted DPC laws that define DPC as a medical service outside the scope of state insurance regulation.

II. Present Situation:

Direct Primary Care

Direct primary care is a primary care medical practice model that eliminates third party payers from the provider-patient relationship.¹ Through a contractual agreement, a patient generally

¹ The DPC practice model is often compared to the concierge practice model. However, while both provide access to primary care services for a periodic fee, the concierge model generally continues to bill third party payers, such as insurers on a fee for service basis, in addition to the collection of membership and retainer fees. See Phillip M. Eskew and Kathleen Klink,

pays a monthly retainer fee, on average \$77 per individual,² to the primary care provider for defined primary care services, such as office visits, preventive 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 based on the terms of the agreement. Typically, DPC practices provide routine preventive 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.³

In 2014, the American Academy of Private Physicians (AAPP) 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 2010.⁴ The Direct Primary Care Coalition has adopted model state legislation for DPC agreements.⁵ As of September 2017, 23 states have adopted DPC legislation, which defines DPC as a medical service outside the scope of state insurance regulation.⁶

Federal Health Care Reform and Direct Primary Care

The federal Patient Protection and Affordable Care Act (PPACA)⁷ requires health insurers to make guaranteed issue coverage available to all individuals and employers without exclusions for preexisting conditions. The PPACA also mandates that insurers that offer qualified health

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 Oct. 19, 2017).

² *Id.* 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. The average monthly cost to the patient was \$93.26 (median monthly cost, \$75.00; range, \$26.67 to \$562.50 per month) for these 116 practices. Of the 116 DPCs noted, 36 charged a 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.

³ Lisa Zamosky, *Direct-Pay Medical Practices Could Diminish Payer Headaches*, MEDICAL ECONOMICS, (Apr. 24, 2014).

⁴ 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 Oct. 19, 2017).

⁵ Direct Primary Care Coalition Model State Legislation, available at <http://www.dpcare.org/dpcc-model-legislation>. (last viewed Oct. 19, 2017).

⁶ See <https://www.dpcare.org/state-level-progress-and-issues> (last viewed Oct. 19, 2017).

⁷ Pub. Law No. 111-148 (Mar. 23, 2010) amended by Pub. Law. No. 111-152 (Mar. 30, 2010).

plans (QHPs) provide 10 categories of essential health benefits,⁸ which includes preventive⁹ care and other benefits.

The PPACA addresses the DPC practice model as part of health care reform.¹⁰ Federal regulations provide that a QHP may provide coverage through a DPC medical home plan that meets criteria¹¹ established by the federal Department of Health and Human Services (HHS), if the plan meets all other applicable requirements.¹² For example, an individual could enroll in a DPC plan and obtain coverage through a high deductible health plan (HDHP),¹³ which would provide coverage for severe injuries or chronic conditions. Such an individual may benefit from enrolling in a DPC medical home plan since it may provide greater degree of access to health care for a monthly fee that is substantially less than the annual deductible of the HDHP.

Federal Tax Treatment of Direct Primary Care

Currently the federal tax treatment of direct primary care medical home plans may discourage the use of such plans. For an individual to be eligible to make tax-deductible contributions to a Health Savings Account (HSA), the individual must be covered by an HDHP and no other plan that is not an HDHP, unless the other plan qualifies as disregarded coverage.¹⁴ A DPC medical home plan is not delineated as one of the disregarded coverages under the Internal Revenue Service (IRS) Code. According to the IRS, 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 plan provided preventive care only.¹⁵ Further, the IRS Code does not permit the periodic payments made to primary care physicians under a DPC model to qualify as a medical expense.¹⁶ Federal legislation is pending to address these issues.¹⁷

State Regulation of Insurance

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, health maintenance organizations (HMOs), and other risk-bearing entities. These specified entities must meet certain requirements for licensure. The Agency for Health Care Administration (AHCA)

⁸ 42 U.S.C. s. 18022.

⁹ Available at: <https://www.hhs.gov/healthcare/about-the-law/preventive-care/index.html#> (last viewed Oct. 19, 2017).

¹⁰ See 42 U.S.C. ss. 18021. The Secretary of Health and Human Services shall permit a qualified health plan to provide coverage through a qualified direct primary care medical home plan that meets criteria established by the Secretary, so long as the qualified health plan meets all requirements that are otherwise applicable and the services covered by the medical home plan are coordinated with the entity offering the qualified health plan.

¹¹ The HHS has not adopted criteria to date.

¹² See 45 C.F.R. 156.245.

¹³ A high deductible health plan (HDHP) has a higher deductible than typical plans and a maximum limit on the amount of the annual deductible and out-of-pocket medical expenses an insured must pay for covered services. In 2017, for self-only coverage, the annual minimum deductible is \$1,300 and the maximum is \$6,550. An HDHP may provide preventive care benefits without a deductible or with a deductible less than the minimum annual deductible. See https://www.irs.gov/publications/p969#en_US_2016_publink1000204030 (last viewed Oct. 19, 2017).

¹⁴ 26 U.S.C. s. 223(c).

¹⁵ See U.S. Department of Treasury letter from John A. Koskinen, Commissioner of the Internal Revenue Service, to U.S. Senator Patty Murray (Jun. 30, 2014) (on filed with Senate Committee on Banking and Insurance).

¹⁶ See 26 U.S.C. s. 213(d).

¹⁷ The Primary Care Enhancement Act of 2017 available at <https://www.congress.gov/bill/115th-congress/house-bill/365/text> (last viewed Oct. 19, 2017).

establishes quality of care standards for HMOs and prepaid health clinics under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO and a prepaid health clinic must receive a Health Care Provider Certificate¹⁸ from the AHCA pursuant to part III of ch. 641, F.S.¹⁹

Currently, Florida law does not address DPC agreements. However, a medical provider offering DPC 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.²⁰

Prepaid Health Clinics

Prepaid health clinics²¹ are required to obtain a certificate of authority from the OIR pursuant to part II of ch. 641, F.S. The entity must meet minimum surplus requirements,²² and comply with solvency protections for the benefit of subscribers by securing insurance or filing a surety bond with the OIR.²³ Part II also provides that the procedures for offering basic services and offering and terminating contracts to subscribers may not unfairly discriminate based on age, health, or economic status.²⁴

Prepaid Limited Health Services Organizations

Prepaid limited health services 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 includes 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. These organizations must comply with the requirements of s. 636.035, F.S., obtain a certificate of authority from the OIR,²⁵ and meet the minimum solvency requirements. The statute allows organizations to meet the solvency component through evidence of a fidelity bond of at least \$50,000 or the deposit of an equal amount in cash or securities with the OIR.²⁶

¹⁸ Section 641.49, F.S.

¹⁹ 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.

²⁰ Part II of ch. 641, F.S.

²¹ 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.

²² Section 641.406, F.S.

²³ Section 641.409, F.S.

²⁴ Section 641.406, F.S.

²⁵ Section 636.007, F.S.

²⁶ Section 636.046, F.S., provides the statutory requirements for insolvency protection for prepaid limited health service organizations, including the minimum market value of the deposit with the OIR for insolvency protection of \$50,000. The options to provide the \$50,000 through a blanket fidelity bond, cash, securities or other investments can be found on the *Office of Insurance Regulation Company Admissions, Application for Certificate of Authority, Prepaid Limited Health Service Organization Application, Section III-4 Insurance*, which is at, https://www.floir.com/siteDocuments/plhso_all_forms.pdf (last visited Oct. 19, 2017).

State Regulation of Health Care Practitioners

The Department of Health (DOH) is responsible for the licensure and regulation of most health care practitioners in the state. In addition to the regulatory authority in specific practice acts for each profession or occupation, ch. 456, F.S., provides the general regulatory provisions for health care professions within the DOH, Medical Quality Assurance Division.

Section 456.001, F.S., defines “health care practitioner” as any person licensed under chs. 457, (acupuncture); 458 (medicine); 459 (osteopathic medicine); 460 (chiropractic medicine); 461 (podiatric medicine); 462 (naturopathic medicine); 463 (optometry); 464 (nursing); 465 (pharmacy); 466 (dentistry and dental hygiene); 467 (midwifery); 478 (electrology or electrolysis); 480 (massage therapy); 484 (opticianry and hearing aid specialists); 486 (physical therapy); 490 (psychology); 491 (psychotherapy); F.S., or parts III or IV of ch. 483 (clinical laboratory personnel or medical physics), F.S.

Additionally, the miscellaneous professions and occupations regulated in parts I, II, III, V, X, XIII, or XIV (speech-language pathology and audiology; nursing home administration; occupational therapy; respiratory therapy; dietetics and nutrition practice; athletic trainers; and orthotics, prosthetics, and pedorthics) of ch. 468, F.S., are considered health care practitioners under s. 456.001, F.S.

III. Effect of Proposed Changes:

Section 1 creates s. 624.27, F.S., which expressly exempts DPC agreements from the Florida Insurance Code. The section provides that the act of entering into a DPC agreement does not constitute the business of insurance and is not subject to the Florida Insurance Code. The section also provides that a primary care provider or an agent of a primary care provider is not required to obtain a certification of authority or license under any chapter of the Florida Insurance Code, in order to market, sell, or offer to sell a DPC agreement.

To qualify for the exemption, a direct primary care agreement must meet the following minimum requirements and disclosures:

- Be in writing and signed by the provider or the provider’s agent and the patient, the patient’s 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; and
- 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 health 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 provision of the federal Patient Protection and Affordable Care Act, 26 U.S.C. s. 5000A.”
- “This agreement is not workers’ compensation insurance and does not replace an employer’s obligations under ch. 440, F.S.”

Further, the section defines the following terms:

- “Direct primary care agreement” means a contract between a primary care provider and a patient, the patient’s legal representative, or an employer which must satisfy the requirements regarding contract terms and disclosures within subsection (4) of the bill and does not indemnify for services provided by a third party.
- “Primary care provider” means a licensed health care practitioner under ch. 458, F.S., (medical doctor or physician assistant); ch. 459, F.S., (osteopathic doctor or physician assistant); ch. 460, F.S., (chiropractic physician); or ch. 464, F.S., (nurses and advanced registered nurse practitioners); or a primary care group practice, who provides primary care services to patients.
- “Primary care services” means the screening, assessment, diagnosis, and treatment conducted within the competency and training of the primary care provider for the purpose of promoting health or detecting and managing disease or injury.

Section 2 provides that the bill takes effect July 1, 2018.

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:

This 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 regarding 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.

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

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:

According to the Department of Management Services, the bill would not have a direct impact on the department, which includes the Division of State Group Insurance.²⁷

The Agency for Health Care Administration and the DOH report no direct impact to their respective agencies.^{28, 29}

VI. Technical Deficiencies:

None.

VII. Related Issues:

The OIR notes that the direct primary care contract is required to offer a refund if the primary care provider ceases to provide primary care services for any reason. However, the legislation does not require any collateral be posted for the refund payments such as a surety bond. Therefore, there is some risk to consumers potentially that they may not receive their refunds if a provider ceases to provide services in the future.³⁰

²⁷ Florida Department of Management Services, *Analysis of SB 80* (Oct. 4, 2017) (on file with the Senate Committee on Banking and Insurance).

²⁸ Agency for Health Care Administration, *2018 No Agency Impact Statement* (Oct. 17, 2017) (on file with the Senate Committee on Health Policy).

²⁹ Florida Department of Health, *E-Mail Communication from Paul Runk – No Fiscal Impact* (Oct. 17, 2017) (on file with the Senate Committee on Health Policy).

³⁰ The Florida Office of Insurance Regulation, *2018 Agency Bill Analysis – CS/SB 80* (Oct. 17, 2017) (on file with the Senate Committee on Health Policy).

VIII. Statutes Affected:

This bill creates 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 October 10, 2017:

The CS places the direct primary care contracting requirements within the Florida Insurance Code, rather than ch. 456, F.S.

- B. **Amendments:**

None.