HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 7 Direct Health Care Agreements
SPONSOR(S): Health Market Reform Subcommittee, Duggan
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	13 Y, 0 N, As CS	Gilani	Crosier
2) Health & Human Services Committee	15 Y, 2 N	Gilani	Calamas

SUMMARY ANALYSIS

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 $25 and $100 per individual, to the primary care provider for defined primary care services. After paying the fee, a patient can utilize all services under the agreement at no extra charge. Some DPC practices also include routine preventative services, women's health services, pediatric care, urgent care, wellness education, chronic disease management, and home visits.

Section 624.27, F.S., provides that a direct primary care agreement and the act of entering into such an agreement are not insurance and not subject to regulation under the Florida Insurance Code (Code). The section also exempts a primary care provider, which includes a primary care group practice, or his or her agent, from any certification or licensure requirements in the Code for marketing, selling, or offering to sell an agreement, and establishes criteria for direct primary care agreements.

Direct care agreements are currently limited to primary care services offered by primary care providers licensed under chs. 458 (medicine), 459 (osteopathic medicine), 460 (chiropractic medicine), or 464 (nursing), or a primary care group practice. The bill adds health care providers licensed under ch. 466 (dentistry) to this list and authorizes direct care agreements with these health care providers for any health care service within their competency and training, not just primary care.

The bill has no fiscal impact on state or local government.

The bill provides an effective date of July 1, 2019

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Direct Primary Care Agreements

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 fixed monthly fee, usually between $50 and $100 per individual,[1] to the primary care provider for defined primary care services.[2] Theses primary care services may include:[3]

- Office visits;
- Annual physical examination;
- Routine laboratory tests;
- Vaccinations;
- Wound care;[4]
- Splinting or casting of fractured or broken bones;
- Other routine testing, e.g. echocardiogram and colon cancer screening; or
- Other medically necessary primary care procedures.

After paying the fee, patients generally have unrestricted access to all services under the agreement at no extra charge, which can also include 24/7 access to a physician by phone and electronically. Some DPC practices also include in-house pharmacies and routine preventative services, like laboratory tests, mammograms, Pap screenings, vaccinations, and home visits.[5] A primary care provider DPC model can be designed to address the large majority of health care issues, including women's health services, pediatric care, urgent care, wellness education, and chronic disease management.

Advocates for the DPC model claim that it reduces overhead costs for the practice and increases positive patient outcomes at an affordable price to the patient.[6] The DPC practice model eliminates practice overhead costs associated with filing claims, coding, refiling claims, write-offs, appealing denials, and employing billing staff. The cost and time savings can be reinvested into the practice, allowing more time with patients to address their primary care needs.

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[1] In 2017, over 70% of practices charged between $25 and $100, and less than 2% charged more than $175. The average monthly fee was $82.86 and the median monthly rate was $65. HINT, *DPC Trends Report 2017*, available at: https://cdn2.hubspot.net/hubfs/2562809/pdf-assets/dpc-trends-2017/Hint-DPC-Trends-Report-2017.pdf (last visited Mar. 5, 2019); In 2014, a study of 141 DPC practices found the average monthly fee to be $77.38, Philip M. Eskew & Kathleen Klink, *Direct Primary Care: Practice Distribution and Cost Across the Nation*, 28:6 J. AM. BD. FAM. MED. 797 (Nov-Dec. 2015), available at: https://www.jabfm.org/content/28/6/793 (last visited Mar. 10, 2019);

[2] AMERICAN ACADEMY OF FAMILY PHYSICIANS, *Direct Primary Care: An Alternative Practice Model to the Fee-for-Service Framework*, https://www.aafp.org/dam/AAFP/documents/practice_management/payment/DirectPrimaryCare.pdf (last visited Mar. 11, 2019).

[3] Id. *See also,* Dave Chase, *Direct Primary Care: Value Proposition, Scope of Practice and Pricing,* FORBES (July 8, 2013), available at: https://www.forbes.com/sites/davechase/2013/07/08/direct-primary-care-value-proposition-scope-of-practice-and-pricing/#7511816d5ada (last visited Mar. 11, 2019).

[4] E.g., stitches and sterile dressings.

[5] CALIFORNIA HEALTH CARE FOUNDATION, *Issue Brief, April 2013: On Retainer: Direct Primary Care Practices Bypass Insurance*, p. 4, available at: https://www.chcf.org/wp-content/uploads/2017/12/PDF-OnRetainerDirectPrimaryCare.pdf (last visited Mar. 10, 2019); *See also,* Direct Primary Care Journal, *DPC Journal Releases Two-Year Industry Analysis of Direct Primary Care Marketplace; Shows Trends, Demographics, DPC Hot Zones*, available at: http://directprimarycarejournal.com/2015/08/24/dpc-journal-releases-two-year-industry-analysis-of-direct-primary-care-marketplace-shows-trends-demographics-dpc-hot-zones/ (last visited Mar. 10, 2019).

[6] DIRECT PRIMARY CARE COALITION, *What Is Direct Primary Care?*, https://www.dpcare.org/ (last visited Mar. 10, 2019).

Some research suggests that a high-intensity primary care model, such as the DPC practice model, that delivers care through very frequent patient-provider interactions is helpful in managing chronic conditions and preventing or delaying the occurrence of health complications.[7]

One study of a DPC practice in Seattle found that its patients saved 20% in costs of reduced visits to the emergency room, inpatient care, specialists, and advanced radiology, and the overall patient satisfaction of the DPC practice was above the 95th percentile nationally.[8] Additionally, the DPC practice found that if its patients purchased a low-premium wraparound insurance to plan to cover non-primary health care, patients could save 35% or more in the cost of comprehensive care depending on what level of deductible they chose.[9]

The federal Patient Protection and Affordable Care Act (PPACA)[10] addresses the DPC practice model. The individual responsibility provision of PPACA requires individuals to obtain health insurance coverage that meets minimum essential coverage standards in the law.

Direct primary care arrangements alone do not constitute minimum essential coverage because they do not cover catastrophic medical events. A qualified health plan under PPACA is permitted to offer coverage through a DPC medical home plan if it provides essential health benefits and meets all other criteria in the law.[11] Patients enrolled in a DPC medical home plan may be compliant with the individual mandate if they have coverage for other services, such as a wraparound catastrophic health policy to cover treatment for serious illnesses, like cancer, or severe injuries that require lengthy hospital stays and rehabilitation.[12] In Colorado and Washington, qualified health plans are offering DPC medical home coverage on each state-based health insurance exchange.[13]

In 2017, the federal Centers for Medicare and Medicaid Services (CMS) issued a Request for Information (RFI) on direct provider contracting models seeking input from all stakeholders on direct provider contracting between payers and primary care or multi-specialty group practices so that CMS may test this approach within the Medicare fee-for-service program, Medicare Part C program, and Medicaid.[14] In April 2018, after reviewing all of the responses to the RFI, CMS announced that it is developing a potential model that will incorporate direct provider contracting.[15]

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[7] One study of 17,711 senior primary care patients compared the standard care model to that of a "high-touch" model with more frequent patient-provider interactions and found that patients in the "high-touch" model took more medication, had lower healthcare costs, and had fewer hospitalizations. The study concluded that a "high-touch" preventative model with frequent and easy access to primary, specialty, pharmacy, and ancillary care can improve heathcare utilization and reduce healthcare costs in spite of higher frequency of outpatient visits, especially in senior populations. Reyan Ghany, MD, et al., *High-Touch Care Leads to Better Outcomes and Lower Costs in Senior Population,* 24:9 AM. J. MANAGED CARE e300-e304 (2018), available at: https://ajmc.s3.amazonaws.com/_media/_pdf/AJMC_09_2018_Ghany%20final.pdf (last visited Mar. 11, 2019).

[8] DPC patients experienced 35% fewer hospitalizations, 65% fewer ER visits, 66% fewer specialists visits, and 82% fewer surgeries. The study compared two years of insurance claims data for 4,000 of its DPC patients compared to their coworkers that were covered by traditional fee-for-service practice models. The overall patient satisfaction was measured by the national Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. William N. Wu, et al., *A Direct Primary Care Medical Home: The Qliance Experience,* 29:5 HEALTH AFFAIRS 959, 959-62 (2010), *available at:* http://content.healthaffairs.org/content/29/5/959; *See also,* David Von Drehle, *Medicine is About to Get Personal,* TIME HEALTH (Dec. 20, 2014), http://bostonshoulderinstitute.com/wp-content/uploads/2015/03/Medicine-Is-About-to-Get-Personal-_-TIME.pdf (last visited Mar. 6, 2019); *See also*, Leigh Page, *The Rise and Further Rise of Concierge Medicine, 347:6465* BRIT. MED. J. 347 (Oct. 28, 2013).

[9] Id.

[10] Pub. L. No. 111-148, H.R. 3590, 111th Cong. (Mar. 23, 2010).

[11] 42 U.S.C. §1802 (a)(3); 45 C.F.R. §156.245

[12] 42 U.S.C. §18021(a)(3).

[13] Jay Keese, Direct Primary Care Coalition, *Direct Primary Care*, PowerPoint presentation before the House Health Innovation Subcommittee, slide 2, February 17, 2015 (on file with Health and Human Services Committee staff).

[14] CENTERS FOR MEDICARE & MEDICAID SERVICES, *Innovation Center New Direction*, https://innovation.cms.gov/initiatives/direction/index.html (last visited Mar. 10, 2019); RFI available here: https://innovation.cms.gov/Files/x/dpc-rfi.pdf (last visited Mar. 10, 2019); Under Section 1115A of the Social Security Act, CMS is authorized to test innovative payment and service delivery models that have the potential to reduce program expenditures while preserving or enhancing the quality of care for Medicare, Medicaid, and CHIP beneficiaries.

[15] Press Release, Centers for Medicare & Medicaid Services, Feedback on New Direction Request for Inforation (RFI) Released, CMS Innovation Center's Market-Driven Reforms to Focus on Patient-Centered Care, available at: https://www.cms.gov/newsroom/press-

As of December 2018, 25 states, including Florida, have laws that define DPC agreements or services as outside the scope of state insurance regulation,[16] and at least eight of which do not limit the agreements to primary care services.[17] Nationwide, there are approximately 954 DPC practices, with approximately 61 DPC practices in Florida.[18]

Florida

Section 624.27, F.S., provides that a direct primary care provider may contract with individuals to provide pre-determined primary care services for a set monthly fee. Primary care providers are defined as health care providers licensed under chapter 458 (physicians), chapter 459 (osteopathic physicians), chapter 460 (chiropractors) and chapter 464 (nurses), or a primary care group practice who provide primary care services to patients.[19] Primary care services include the screening, assessment, diagnosis, and treatment of a patient conducted within the training of the primary care provider for the purpose of promoting health or detecting and managing disease or injury.[20] Currently, individuals may only contract with primary care providers for primary care services.

The direct primary care agreement between the health care provider and the individual is not insurance and entering into such an agreement is not the business of insurance.[21] Both the agreement and the activity of entering into the agreement are exempt from the Florida Insurance Code (Code).[22] Therefore, the Office of Insurance Regulation does not have authority to regulate a direct primary care agreement or entering into such an agreement. Additionally, s. 624.27(3), F.S., exempts a primary care provider, or his or her agent, from the certification or licensing requirements under the Code to market, sell, or offer to sell a direct primary care agreement.

The Code establishes criteria for direct primary care agreements. They must:[23]

- Be in writing;
- Be signed by the primary care provider, or his or her agent, and the patient, the patient's legal representative, or the patient's employer;
- Allow either party to terminate the agreement by giving the other party 30 days' advance written notice;
- Allow immediate termination of the agreement for a violation of physician-patient relationship or a breach of the terms of the agreement;
- Describe the scope of primary care services that are covered by the monthly fee;
- Specify the monthly fee and any fees for primary care services not covered under the agreement;
- Specify the duration of the agreement and any automatic renewal provisions;
- Offer a refund to the patient of monthly fees paid in advance if the primary care provider stops offering primary care services for any reason;
- State that the agreement is not health insurance and that the primary care provider will not bill the patient's health insurance policy or plan for services covered under the agreement;
- State that the agreement does not qualify as minimum essential coverage to satisfy the individual responsibility provision of the Patient Protection and Affordable Care Act; and

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releases/feedback-new-direction-request-information-rfi-released-cms-innovation-centers-market-driven-reforms (last visited Mar. 10, 2019).

[16] AL, AZ, AR, CO, FL, ID, IN, IA, LA, KS, KY, ME, MI, MS, MO, NE, OK, OR, TN, TX, UT, VA, WA, WV, and WY Direct Primary Care Coalition, *2018 DPC Laws Passed in 25 States*, available at: https://www.dpcare.org/state-level-progress-and-issues (last visited Mar. 4, 2019).

[17] Alabama, Arkansas, Kansas, Michigan, Missouri, Oklahoma, Utah, and Wyoming.

[18] As of Mar. 10, 2019, DPC FRONTIER, *DPC Mapper*, available at: https://www.dpcfrontier.com/mapper/ (last visited Mar. 10, 2019).

[19] s. 624.27(1)(b), F.S.

[20] s. 624.27(1)(c), F.S.

[21] s. 624.27(2), F.S.

[22] s. 624.27(2), F.S.

[23] s. 624.27(4), F.S.

- State that the agreement is not workers' compensation insurance and may not replace the employer's workers' compensation obligations.

Effect of Proposed Changes

Section 624.27, F.S., currently allows individuals to contract directly with certain health care providers outside the scope of insurance, but only for primary care services. The bill removes this limitation and expands the scope of these agreements to allow "direct health care agreements." The bill also adds a person licensed under ch. 466 (dentistry) to the list of health care providers recognized by this section. This allows individuals to contract directly with health care providers licensed under chs. 458 (medicine), 459 (osteopathic medicine), 460 (chiropractic medicine), 464 (nursing), or 466 (dentistry), or a health care group practice, for any health care service that is within the competency and training of the healthcare provider.

The bill revises definitions and makes other various conforming changes to remove reference to "primary care," and replace it with "health care" to reflect the broadened scope of the agreements under the bill.

Under the bill, direct health care agreements will still have the same contract requirements as direct primary care agreements and will also receive the same regulatory exemptions from the Code.

The bill provides an effective date of July 1, 2019.

B. SECTION DIRECTORY:

Section 1: Amends s. 624.27, F.S., relating to direct primary care agreements.
Section 2: Provides an effective date of July 1, 2019.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Health care providers authorized under the bill may establish practices that use direct health care agreements to provide health care services throughout the state without concern of facing regulatory action by OIR, which would increase access to such services.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 7, 2019, the Health Market Reform Subcommittee adopted an amendment that revises the list of health care providers recognized under the bill to include those who are licensed to practice dentistry under ch. 466, F.S.

The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute as passed by the Health Market Reform Subcommittee.