LEGISLATIVE RESEARCH OFFICE

SNAPSHOT

A policy brief from the Legislative Research Office

Direct Primary Care: Part of the cure?

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Beginning in 2019, Nebraska state employees and their dependents have the choice during open enrollment to select a direct primary care (DPC) health plan.[1] Although 25 states have recognized DPC agreements in their statutes, including Nebraska in 2016[2], the state appears to be among the first to test DPC in its employee benefits package.[3]

In 2018, the Legislature approved a three-year pilot program testing how DPC could fit into employer provided health plans. Introduced by Senators Riepe, Geist, Hilgers, Hughes, Kolterman, and Stinner, LB 1119 adopts the Direct Primary Care Pilot Program Act and establishes it within the Nebraska State Insurance Program.

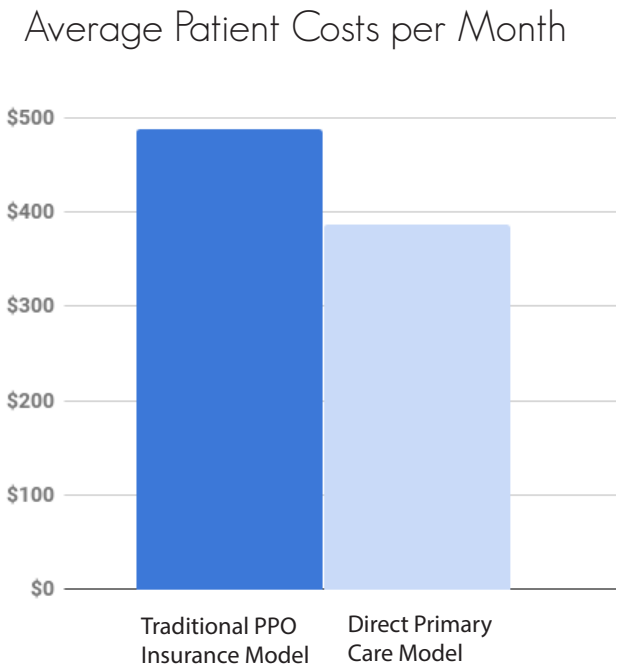
The act defines a "direct primary care health plan" as "a health plan which includes primary care services provided by a participating provider, pharmaceutical care . . . as provided by a licensed pharmacist, and health care coverage for medical specialists, hospitals, pharmacy, and other medical coverage."

What is direct primary care?

According to DPC Frontier[4], for a practice to qualify as a direct primary care practice, it must:

- Charge a periodic fee;
- Not bill any third parties on a fee-for-service basis; and
- Any per visit charge must be less than the monthly equivalent of the periodic fee.

DPC differs from traditional primary care practices in several significant ways. DPC is not insurance nor is it paid based on fee-for-service. Instead, DPC is a contract between a physician and a patient that cuts out the middleman of insurance. Under this contract, the physician agrees to deliver specific health care services in exchange for the payment of a periodic fee. The fee typically runs between $50 and $150 per month, or as Senator Merv Riepe noted in his introduction of the 2016 legislation, "the price of a standard utility bill."



Source: CHI Health DPC Pilot Program

A DPC contract generally includes outpatient nonspecialty services such as preventive care, basic lab services, and chronic disease management, but does not cover many services found in standard health care insurance, such as prescription drugs, specialists, or hospitalization. A catastrophic or wraparound health policy is recommended for those other services. (The Nebraska pilot will offer enrollees the choice of a high or low deductible health plan to cover services not included in the DPC contract.)

DPC proponents tout the model as providing greater access to and more time per visit with one's doctor. Critics fear it will limit patient access because DPC practices typically see fewer

1. United Healthcare, the state's health insurance provider, is subcontracting with a direct primary care provider to offer this plan.
2. Laws 2016, LB 817.
3. New Jersey began a pilot program in 2016 that offers a DPC option to employees in its State Health Benefits Program and School Employees' Health Benefits Program. The pilot is slated to run for three years, after which it will be evaluated. The plans cover the monthly DPC fees for enrollees.
4. DPC Frontier is an online clearinghouse for information about direct primary care.

overall patients, potentially exacerbating a looming shortage of primary care practitioners, the effects of which are most acute in rural and low-income communities. Proponents counter that greater physician satisfaction with DPC—as reported in early studies and anecdotally—will ultimately draw more medical students into primary care and retain those physicians already practicing.

The legislative role in direct primary care

Strictly speaking, DPC practices do not require statutory authority to operate. The advocacy group Direct Primary Care Coalition reports there are DPC practices in 48 states (the Dakotas are the two outliers), but only 25 states have passed legislation to recognize it.[5]

So, why legislate? States such as Nebraska, which became the 16th state to adopt DPC legislation, see value in providing a framework that allows state insurance regulators clear guidance, while freeing practitioners from insurance regulations that do not pertain to their practices. Legislation also is seen as a valuable tool to provide consumer protections to patients.

The DPC Coalition's Model Legislation contains these suggested provisions:

- Definitions for "primary care provider," "direct primary care agreement," and "primary care services;"
- An unambiguous statement that a direct primary care agreement (DPCA) does not constitute insurance;
- No licensure requirements for providers or their agents who market a DPCA;
- A list of requirements a DPCA must meet, including that it be in writing, describe the scope of services covered under the periodic fee and specify any additional fees, and allow either party to terminate the agreement upon written notice; and
- A statement about the acceptance or discontinuance of patients, including that the DPC practice cannot reject new patients or discontinue current ones based on health status.

Nebraska's Direct Primary Care Agreement Act (Neb. Rev. Stat. secs. 71-9501 to 71-9511) hits those markers. Senator Riepe, the act's primary sponsor, modeled Nebraska's law on a review of the 13 states with a DPC statute at that time.

But regulators and others see additional concerns states may want to address. Among them whether some DPC practices 1) essentially act as insurance and should be regulated as such; 2) discriminate based on undesirable patient characteristics; or 3) employ pricing practices that offer more services to premium-paying, usually higher-income patients, leading to a de facto healthcare stratification based on wealth.

In summary

Many ills beset the U.S. health care system. The traditional fee-for-service payment model almost always figures into critiques because it incentivizes volume over value and does little to control costs. As one commentator[6] stated, "We need a payment system that stops rewarding health-care providers as if they are factories and, instead, one that will be beneficial for providers, payers, and patients."

Nebraska is among the states testing whether direct primary care is part of the cure.

Last year, the Catholic Health Initiatives (CHI) division for Nebraska and southwest Iowa launched its first direct primary care (DPC) pilot project with one salaried doctor and one advanced practice registered nurse. The model is a throwback to a different time in medicine, when independent physicians billed their patients directly. Instead of a fee-for-service model, patients or employers pay a monthly subscription directly to the health care provider.[7]

Photo Credit: CHI Health Midlands

5. The federal government also recognized DPC agreements in the Affordable Care Act by allowing qualified health plans to include DPC agreements so long as the plans included catastrophic coverage for medical care outside the scope of the DPC agreements.
6. Dr. Kenneth L. Davis, president and CEO of Mount Sinai Health System.
7. S. Porter, "Direct Primary Care: A Segue to Direct-to-Employer." October 21, 2018. Health Leaders Magazine.