Health Innovation Subcommittee

Tuesday, February 17, 2015
1:00 PM - 3:00 PM
306 HOB

Steve Crisafulli
Speaker

Kenneth Roberson
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health Innovation Subcommittee

Start Date and Time:	Tuesday, February 17, 2015 01:00 pm
End Date and Time:	Tuesday, February 17, 2015 03:00 pm
Location:	306 HOB
Duration:	2.00 hrs

Presentations on direct primary care:

Dr. Garrison Bliss, MD, Founder, Qliance Medical Group of Washington, Seattle, WA
Dr. Lee Gross, MD, President of Florida Chapter, Docs4PatientCare Foundation, North Port, FL
Jay Keese, Executive Director, Direct Primary Care Coalition, Washington, DC
Bill Herrle, Executive Director-Florida, National Federation of Independent Business, Tallahassee, FL

NOTICE FINALIZED on 02/10/2015 15:09 by Villar.Melissa

Dr. Garrison Bliss, MD

Qliance Medical Group of Washington, Seattle, WA

Dr. Bliss is a primary care internal medicine physician with over 35 years of experience in the practice of medicine. He was the founder of the second monthly fee non-insurance practice in the United States - Seattle Medical Associates. He has been focused intensively on the question of how to improve the quality, humanity and accessibility of primary medical care in the United States for most of his career. He is a cofounder of Qliance and currently serves as the Executive VP of Medical Affairs of Qliance Medical Management Inc. and the President of the Qliance Medical Group of Washington PC. He has been a leader of the national movement to liberate and empower primary care with innovative business models. He also continues to manage an active Qliance medical practice with 400 patients and serve on the Qliance Board of Directors.

Dr. Bliss received his BA in Biology from Harvard University and his MD from the University of Utah. He completed his internship and residency in Internal Medicine at the University of Washington. He is an active member of the King County Medical Society, Washington State Medical Association and the American Medical Association.

Qliance

Direct Primary Care and Florida

February 2015

Garrison Bliss MD
President, Qliance Medical Group
Chairman, Direct Primary Care Coalition

Primary Care is a Power Tool

It is the foundation of high functioning care systems:

When it works, care is less expensive, less invasive, safer, more accessible and more humanistic

When it is dysfunctional, patients get their care from ERs, hospitals, specialists, scanners and labs

Why does primary care matter?

- 1998 Study in the Journal of Family Practice:
  - Sample of 13,270 adults
  - Those reporting that they received their primary care from a Primary Care Family Medicine, Internal Medicine, or OB-GYN physician vs. a specialist:
  - After correction for disease burden, health insurance, smoking status, and health perception, those with primary care physicians spent 33% less money in the health care system and had a 19% lower mortality.

Why does primary care matter?

- Studied data from 1996-2000 in 99.9% of US counties – age adjusted standardized mortality rates in deaths per 1,000.
- Calculated the ratio of primary care providers (Gen Internal Med, Gen Practice, Family Practice, Gen Pediatrics) to all others (Specialists).
- An increase of one Primary care physician per 10,000 population was associated with a 6% decrease in all cause mortality (34.6 deaths).
- Higher ratios of specialists are associated with higher cardiac, cancer, neonatal and all cause mortality; higher numbers of surgeries and procedures; and higher cost of care.

- Health Affairs: March 15, 2005

How did we get here?

- The insurance system has paid impressive fees for invasive procedures, medications, imaging and hospital based work, but little for the work done by primary care.
- The fee-for-service system has created a deluge of diagnoses and treatments while disabling prevention, communication, empowerment and cure (no code, no payment).
- Primary care providers have sold their practices to hospitals and large clinics – where they are used as internal referral engines.
- Medical students largely avoid primary care because of the low prestige, hard work and poor reimbursement.
- Estimated 50,000 Primary care shortfall by 2025.

Fee-for-service creates waste & dysfunction in traditional primary care

Possible Pneumonia

Patient has fever & cough
Schedule appointment
Patient goes to ER
Wait 2 to 5 days
Collect co-payment
See patient
Diagnose and call patient
Patient goes to pharmacy for Rx
Patient recovers
Patient pays balance
$
Reconcile, bill patient
Send payment
Approved
Review charge
Send EOB to patient
Denied
Code and bill insurance
Results
Send blood to laboratory
Patient pays balance
Go to radiologist for x-ray
Results
Collect co-payment
Patient pays balance
$
Denied
$
Collect co-payment
Code and bill insurance
Reconcile, bill patient
Code and bill insurance
Reconcile, bill patient
Code and bill insurance
Denied
Review charge
Send payment
Review charge
Send payment
Review charge
Denied
Approved
Pay pharmacy
Send EOB to patient
Approved
Send EOB to patient
Approved

Key:
Practice
Insurance
Patient
Provider

Qliance

Confidential & Proprietary

How do you fix Primary Care?

Create independent primary care	Fix the incentives driving primary care
Work for patients, as directly as possible (be accountable to them no matter who pays the bill)	Create and live by a culture of service and relationship
Focus on effective and high value services	Focus on patient empowerment, not dependency
Focus on health, not just control of disease	Use the power of primary care to improve health care – understand and repair referral patterns
Create a business model for primary care that is stable, self-repairing, self-supporting and patient responsive	Do the right thing – and get paid for that, not something else

What is Direct Primary Care (DPC)?

- **In its simplest form:** Patients buying health care from their provider with fixed monthly fee.
- Monthly, Quarterly, Annual fee for all or nearly all primary care services.
- No Fee-for-Service insurance income.
- A culture of care in which the providers of care see themselves as fully accountable to their patients.
- **In its most complex form:** An independent medical culture that works for the patient, no matter who pays the bill – and the payers don't mind since it serves them too.

Why DPC?

- It breaks free from the fee-for-service model (move from volume to value).
- It is a business model that is stable and supportive of primary care, eliminating the FFS tax on primary care and empowering the doctor-patient relationship.
- It is an environment which encourages innovation responsive to our evolving economy and adaptable to the diversity of patient needs.
- Other primary care solutions have demonstrated uneven and disappointing results thus far.
- DPC is increasingly recognized by businesses, policy experts and organized medicine (AAFP) as the most promising model for the future of health care.

Fee-for-service creates waste & dysfunction in traditional primary care

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Results

Send blood to laboratory

Patient pays balance

Go to radiologist for x-ray

Results

Patient pays balance

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Collect co-payment

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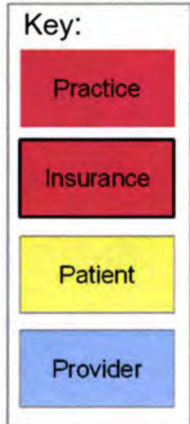
Code and bill insurance

Review charge

Denied

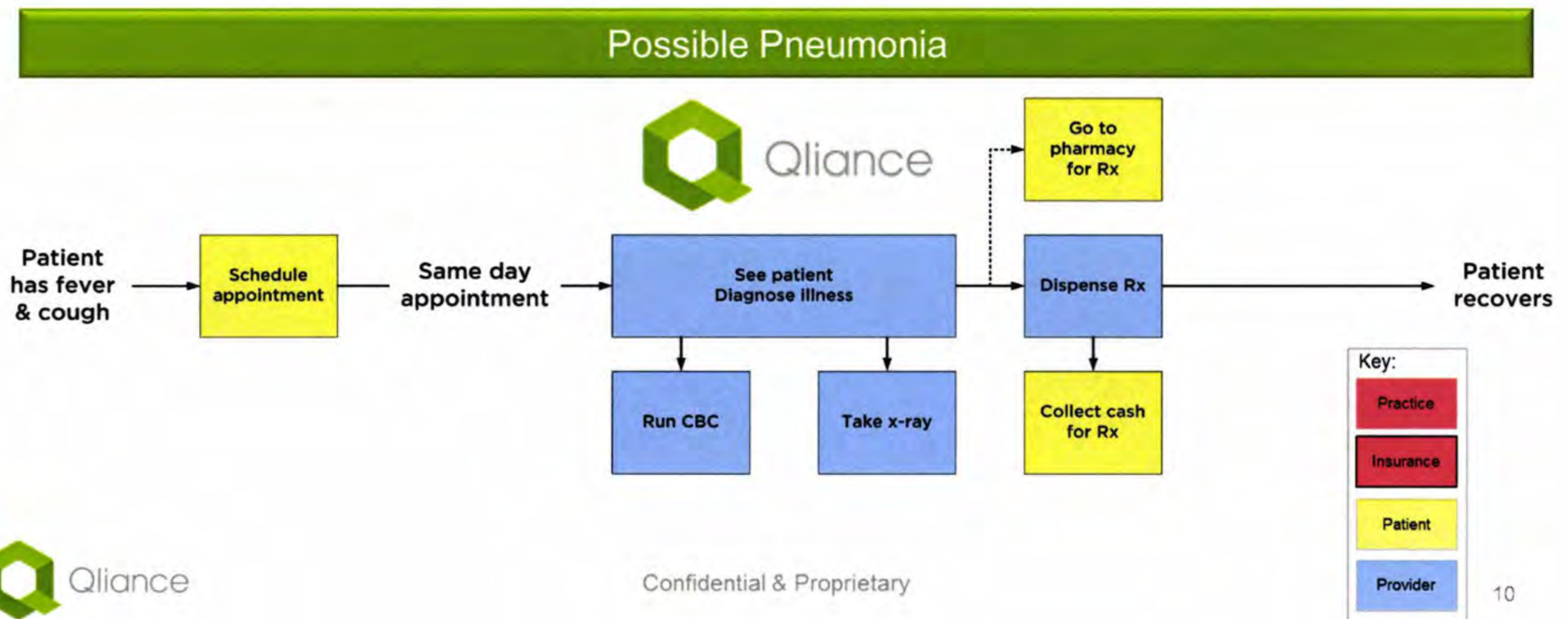
Approved

Pay pharmacy



DPC Changes the Dynamic

- DPC provides primary care services directly to patients using a PMPM model
- Operates either outside or alongside traditional insurance
  - Reserves insurance for undesirable, costly events
  - Lowers practice costs by eliminating fee-for-service billing



How does this differ from Concierge?

- Concierge is a workaround for the wealthy; DPC is a solution for everyone, including those paying for the care.
- Concierge monthly fees are higher, affordable to upper class and upper middle class patients.
- The majority of concierge practices also charge insurers on a fee-for-service basis for medical services, continuing the power of fee-for-service incentives on the practices.

How much DPC is there now?

There are about 10,000 monthly fee practices, many are concierge practices but substantial numbers are DPC. We are growing fast!

There are several ambitious organizations with an intention to be multi-location, multistate and possibly national:

Iora Health	**Qliance**
Vera Whole Health	**Paladina**
R Health	**MedLion**
AMG Medical	**Crossover Health**
Nextera	

We have organizations that understand and support our work

- American Academy of Private Physicians
- American College of Private Physicians
- Direct Primary Care Coalition
- American Medical Association
- American Osteopathic Association
- American Academy of Family Physicians (currently executing a rollout of DPC training across the US)

Who are our customers?

- Individuals
- Small employers
- Large employers (Expedia, Comcast)
- Unions (UFCW 21, Seattle Firefighters)
- Medicaid managed care (Coordinated Care)
- Medicare advantage plans
- Health benefits exchange (ACA)
- Municipalities

To whom might this appeal?

Patients

Doctors

Employers

Progressives

Governments

Conservatives

Wealthy people

Unions

Poor people

ACO's

Qliance DPC Model

- Doctors are employed, salaried; encourages focus on holistic care
- Limited patient panel size
- Flat monthly fee for unrestricted, 7 day a week access
- Wholly owned and operated community-based clinics
- Proprietary IT platform tailored to care delivery model, supports data integration with carriers, purchasers, and other systems
- Steward healthcare resources from the primary care level

How DPC works with Insurance (including Medicaid)

- Monthly fee
- Can be base fee plus shared savings (but base fee must be adequate to support enhanced services)
- Payment (total) more substantial than typical fee-for-service reimbursements
- Qliance submits “shadow” claims data to insurer so they can capture needed data
- One premium, patients can select or be assigned to Qliance as primary care provider
- Qliance works with Centene’s Medicaid plan in Washington State

A Reinvention of the Culture of Medicine

- **Stewardship:** Independent DPC can serve as steward of healthcare resources (the "general contractor" of the healthcare system) & reward high performing advanced care providers with referrals.
- **Workforce:** Primary care can once again become a rewarding and attractive career option; DPC has already become a workforce generator in primary care.
- **Innovation:** Primary care can serve as a laboratory of innovation in medicine and technology.
- **Reform:** Primary care can drive more rational use of the healthcare system and align behavior with larger public policy goals and patient needs.
- **Savings:** Primary care can drive dramatic and rapid savings for payers and individuals.

Qliance Savings Data
Large Employers – 2013

	Per 1,000 Qliance patients	Per 1,000 Non-Qliance patients	Difference (Qliance vs. Other)	Savings per patient per year
ER Visits	81	94	-14%	($5)
Inpatient (days)	100	250	-60%	$417
Specialist Visits	7,497	8,674	-14%	$436
Advanced Radiology	310	434	-29%	$82
Primary Care Visits	3,109	1,965	+58%	($251)
Savings Per Patient	---	---	---	$679
Total Savings per 1000 (after Qliance fees)				$679,000
% Saved Per Patient				20%

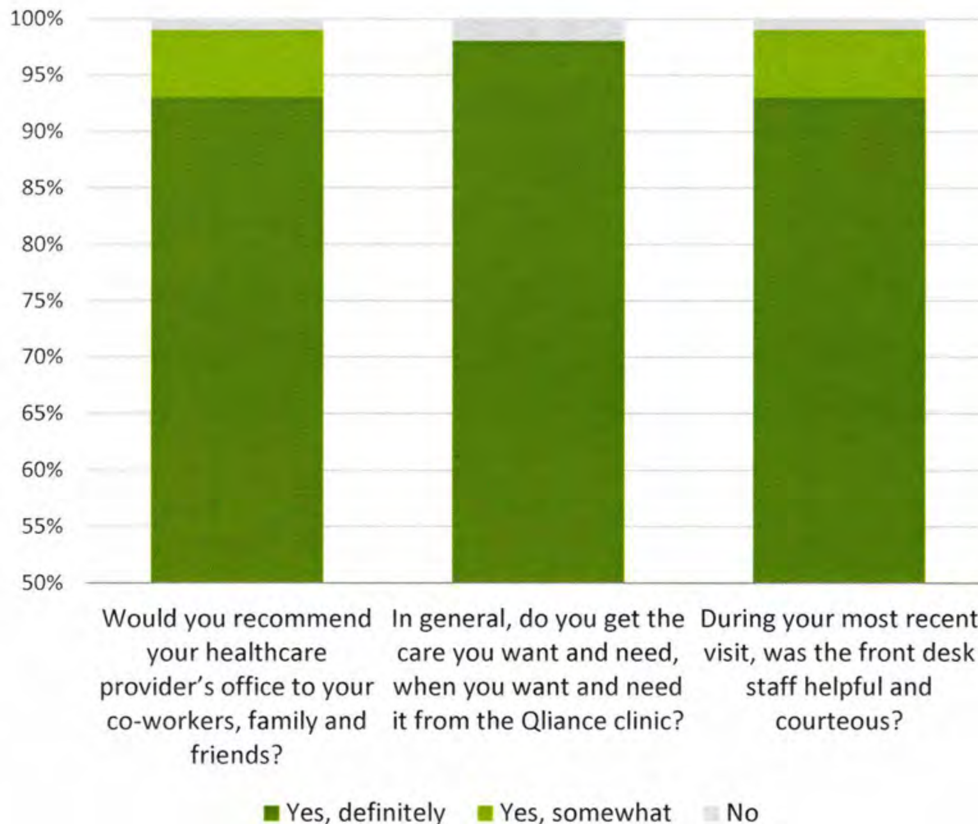
Data Sources: All claims data (except prescription claims) from carriers for selected large employers; Qliance EMR data; Employer eligibility data.

Claims Attribution: All claims incurred by Qliance patients prior to first Qliance visit were excluded; All employees with any interaction with Qliance included as our patients, even if the employee used another primary care provider (which is possible in some of the plan designs among clients); All claims incurred after any interaction with Qliance included, regardless of employee's intent to use Qliance as their primary care provider; All non-primary care provider visits included under "specialist" category (such as physical therapy, acupuncture, etc.)

Population: Eligible members in employer-sponsored health plan; Employees only, to remove confounding factors from differences in dependent benefits structures and participation variances among clients.

Midyear Patient Experience Survey

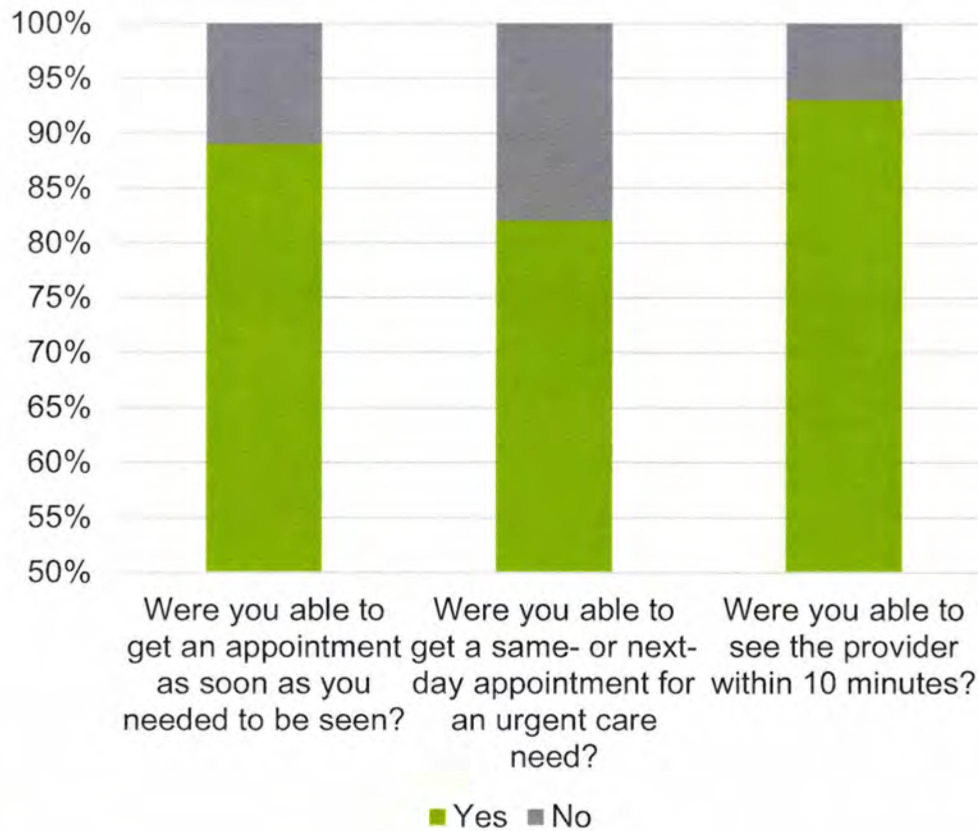
Overall



Compares to:

- Average in Puget Sound – 73.8% (90th %ile = 82%)
- 90th %ile nationally = 91%

Midyear Patient Experience Survey

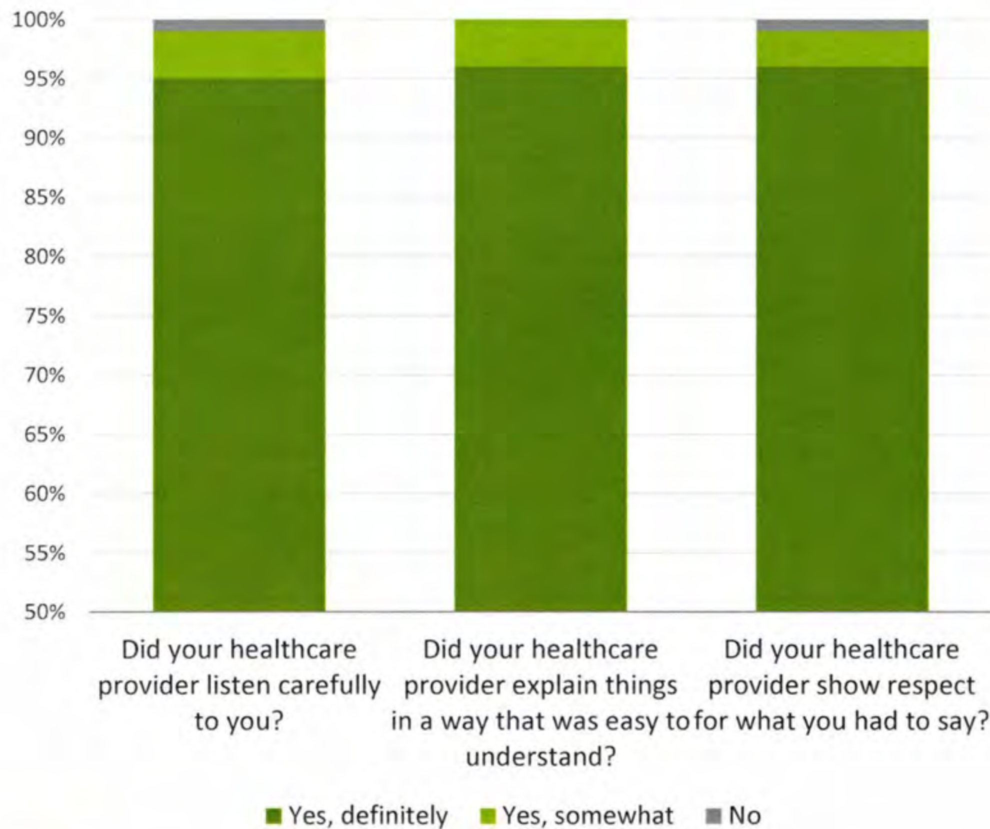


Compares to:

- Average in Puget Sound – 54% (90th %ile = 63%)
- 90th %ile nationally = 77%

Midyear Patient Experience Survey

Communication



Compares to:

- Average in Puget Sound – 79% (90th %ile = 853%)
- 90th %ile nationally = 92%

Midyear Patient Experience Survey – Sample Comments

- Truly a wonderful healthcare experience!
- I am impressed with the care and time that the Qliance practitioners take with each client.
- Love the model! Really appreciate not feeling rushed during appointments, and like I can bring up all concerns that I have.
- My provider responded to my emails promptly and with clarity - very appreciative of this service.
- I love the fact that my doctor is able to spend the time to get to know me, and that I feel well cared for there! I have recommended Qliance to my friends and family!
- I've been a diabetic for 18 years, and for the first time I feel that my Dr. cared about my medical problems. He was very understanding and took the time to explain every single thing about it.
- I am 53 years old and can honestly say that my doctor is the best Dr. I have ever seen - I have never felt more comfortable, listened to and understood.
- I thought it was really great that he took his time with me and we also talked a lot about nutrition and exercise influencing health which I found to be refreshing.
- Wonderful Doctor. Wonderful Assistant. Really, really pleased. Refreshing.

Qliance

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Lee S. Gross, MD

Originally from Cleveland, Ohio, Dr. Gross received his undergraduate degree from The Ohio State University. Following graduation, Gross coordinated years of clinical cardiology research for the nation's leading Cleveland Clinic cardiology program under the direct supervision of Chairman Dr. Eric Topol, now the Editor-in-Chief of Medscape. He attended Case Western Reserve University's School of Medicine. He completed his family medicine training as the elected chief resident at University Hospitals of Cleveland, one of the nation's leading family medicine training programs. He has been in private practice in Florida since 2002. Realizing the critical needs of the uninsured in their community, Dr. Gross and his colleagues created an affordable solution outside the boundaries of the traditional third-party payer system. Their pioneering program, Epiphany Health, provides access to affordable healthcare for those who have been neglected by the system for decades. Dr. Gross serves on the board of trustees of an HCA hospital, the president of his county medical society, as a delegate to the Florida Medical Association, and the president of the Docs 4 Patient Care Foundation.

Summary:

Primary care physicians are known for their ability to provide relatively affordable healthcare services. An insurer bundles the affordable primary care with high cost medical treatments. It sells them as a package, driving up the cost to most that need basic medical care. Watching their patients and community members increasingly priced out of the insurance market, and thus primary care services, these family physicians in Florida created a novel way to solve this problem without jeopardizing their existing practices. For less than what people pay for their cell phones, Epiphany Health provides routine outpatient care, chronic disease management and preventive health. Their program allows them to continue to care for their patients with traditional insurance coverage, but has created a win-win situation for their private medical practice and for the growing number of uninsured and underinsured –all without using taxpayer money.

Affordable Direct Primary Care

Lee S. Gross, M.D.
Founder, Epiphany Health
President, Docs4PatientCare Foundation

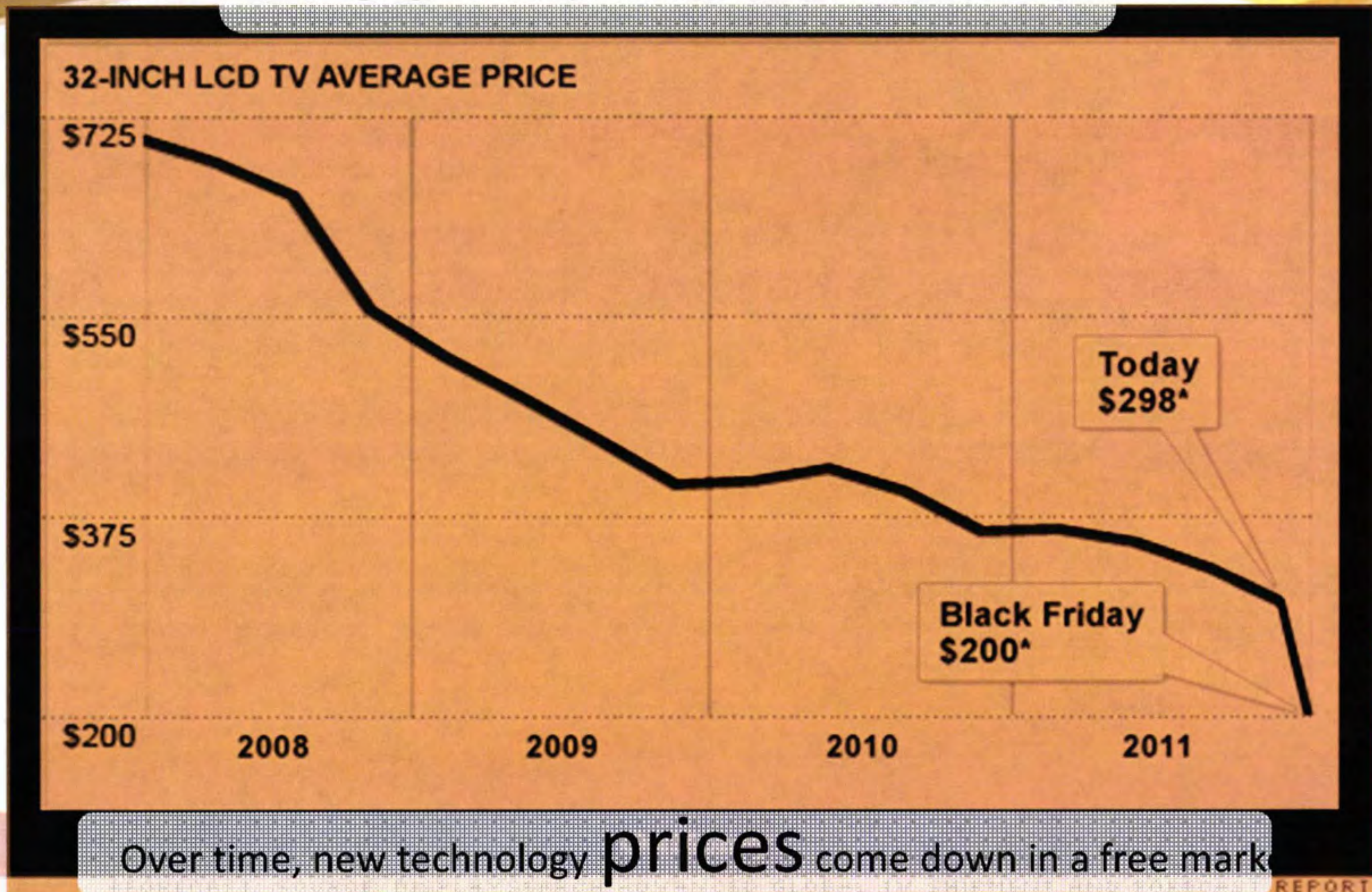
What was the Epiphany?

- **Primary care SHOULD be affordable!**
- Why is basic health care so expensive?
- Third party disconnect from cost makes it expensive.
- Outside factors drive cost
  - Hospital
  - Administrative costs
  - Pharmacy
  - Imaging
  - Labs
  - Specialty care
  - Physical Therapy

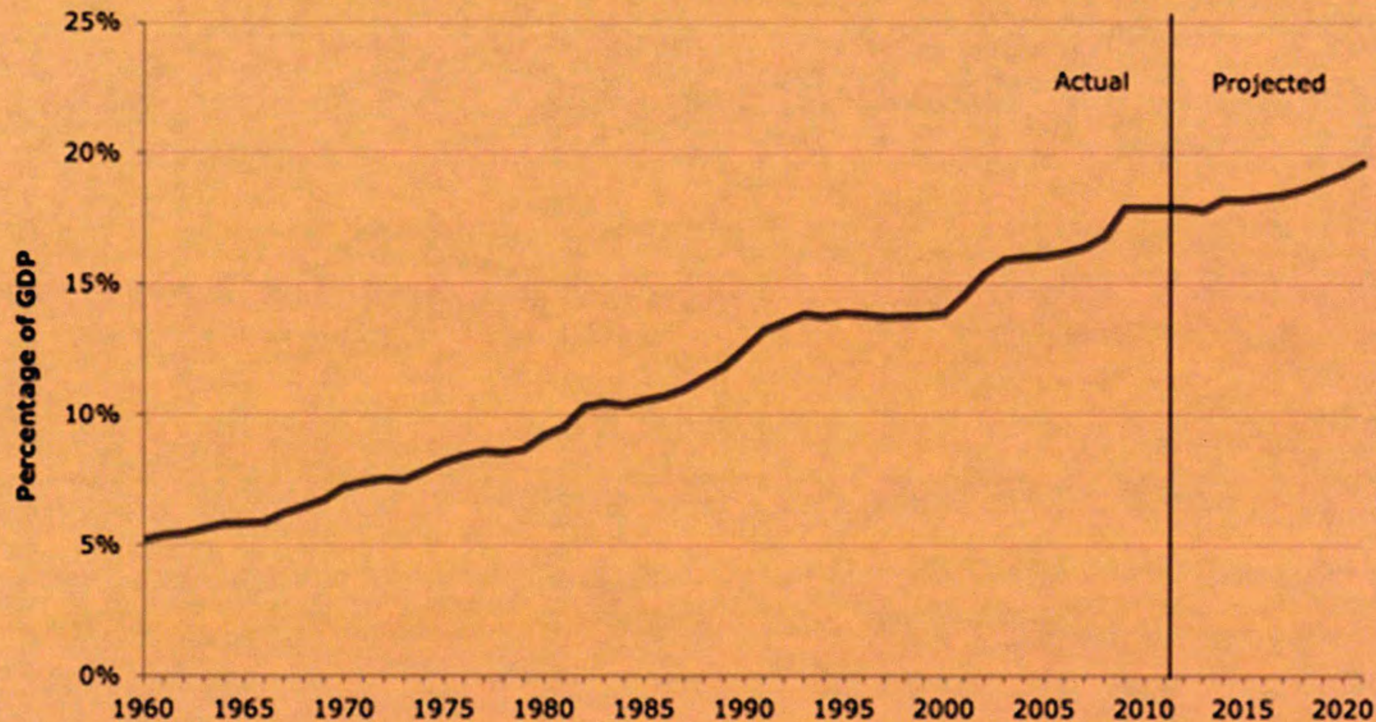
What is Epiphany Health?

- Direct Primary Care
  - Membership Based Patient-Centered Medical Home
- Includes:
  - Comprehensive primary care and wellness services
  - Access to a steeply discounted network of labs, imaging, specialty care, physical therapy, pharmacy and more.

Free Market Model



What about health care prices?

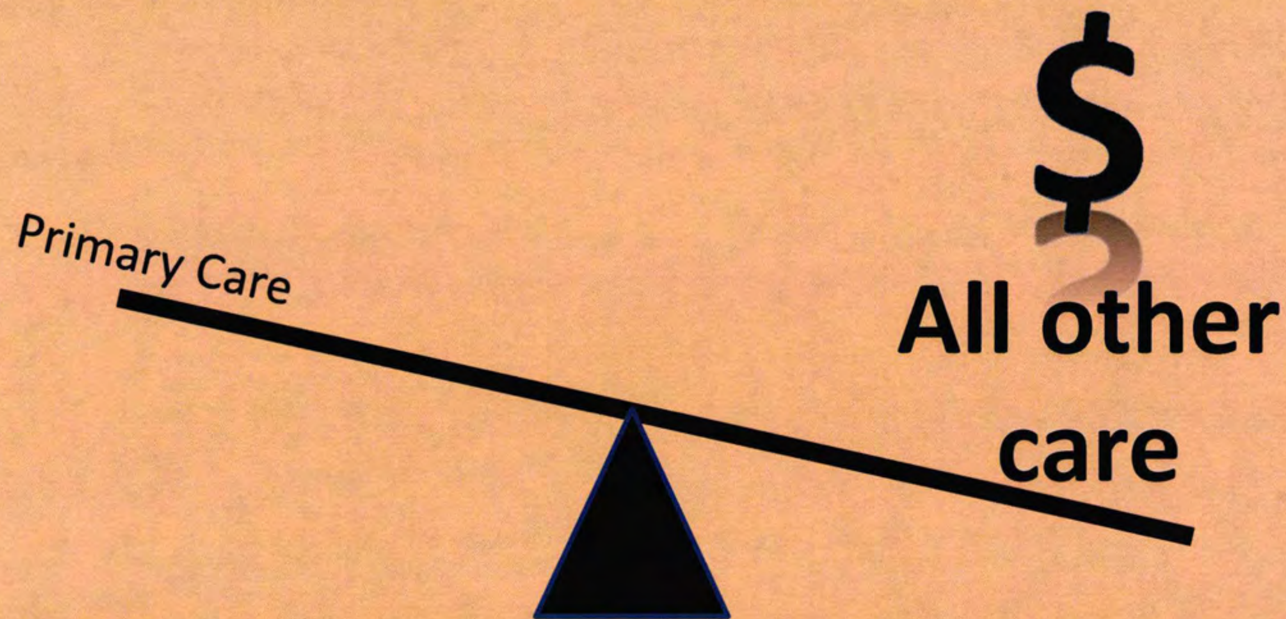


Why is health insurance so expensive?

- It's not insurance, it's health maintenance
- Traditional insurance is for catastrophic care, not first dollar coverage
  - What would homeowners' insurance cost?
    - Light bulb replacement
    - Landscape maintenance
    - Housekeeping
    - Routine repairs
  - Third party coverage drives up costs
    - "I'm paying for it, I'm going to use it."
    - Administrative costs

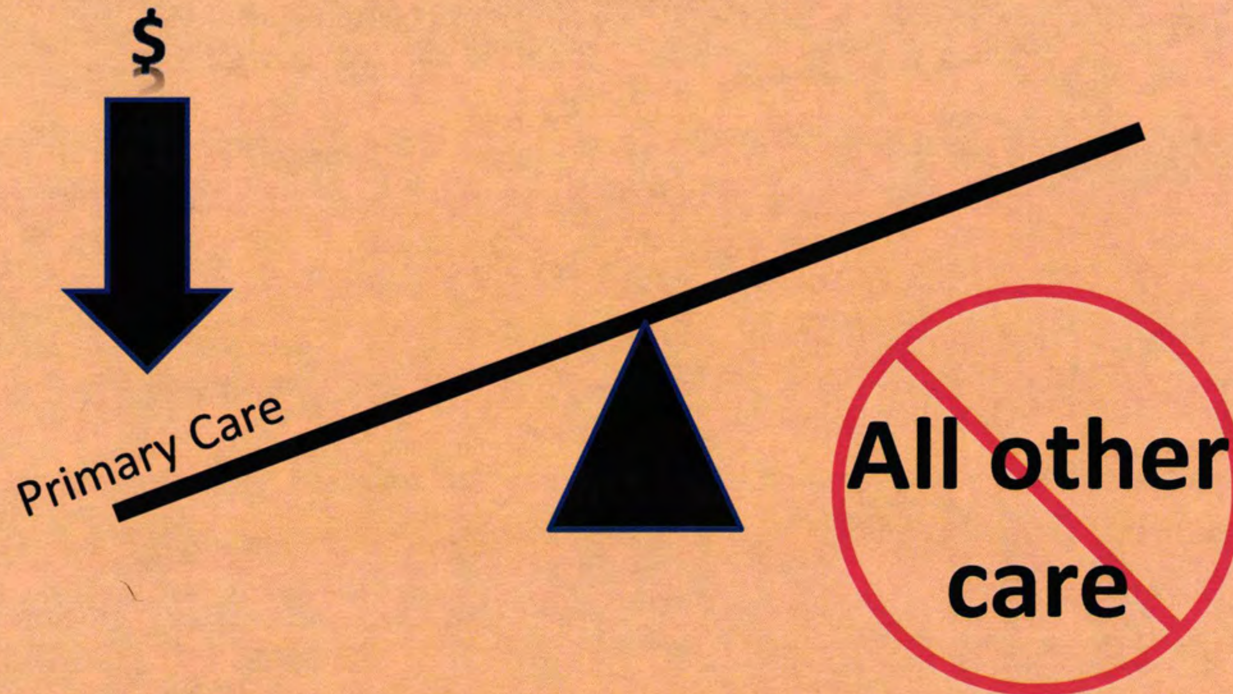
epiphany HEALTH

Balancing the cost of care



epiphany HEALTH

Remove the cost drivers



Direct Primary Care

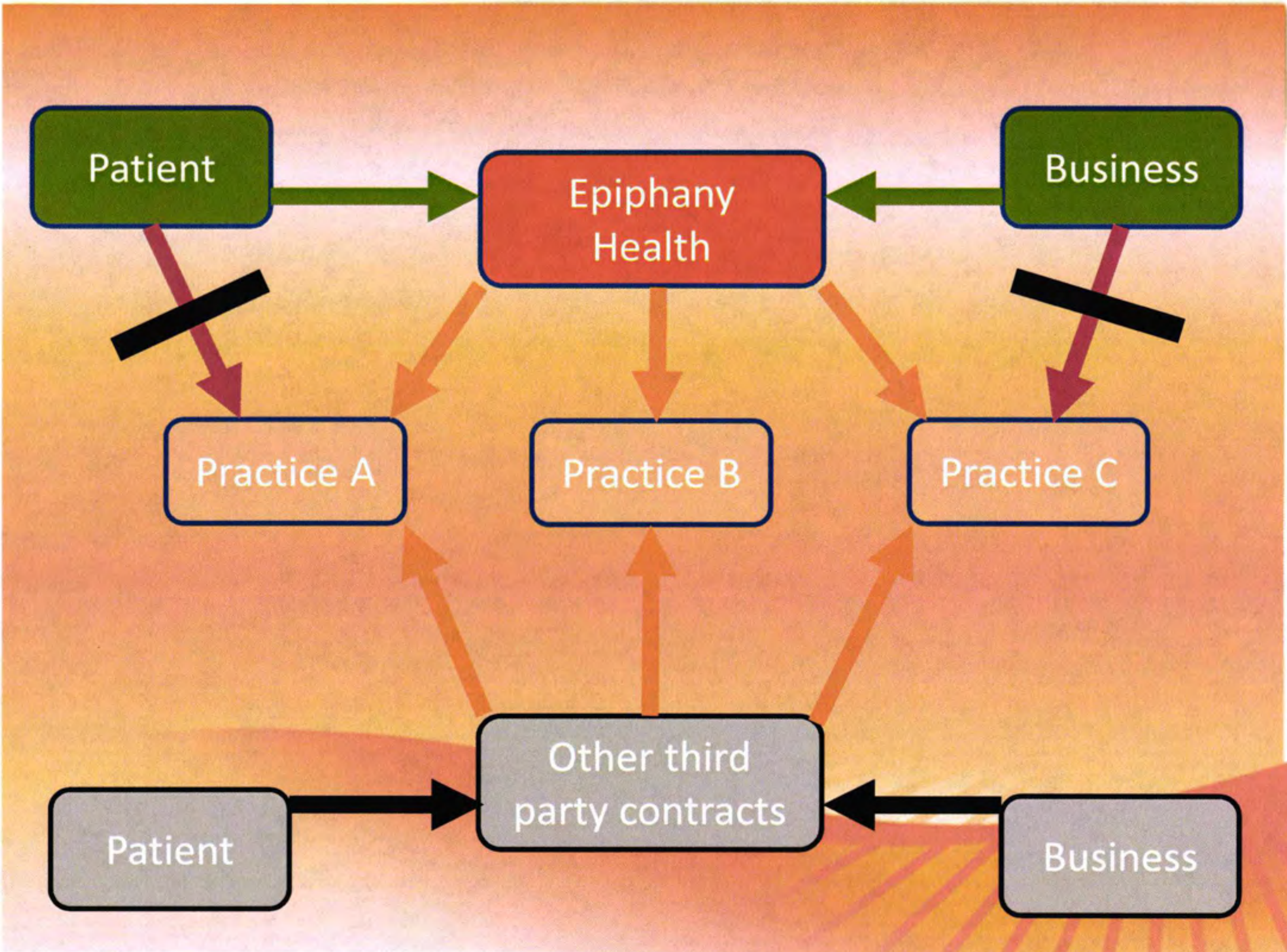
- Most patients can be cared for at the primary care level
- How does it work?
  - Separates routine from catastrophic care
  - Monthly membership fee for primary care
  - Clearly defined package of services
  - Fixes the cost of routine care
  - Catastrophic insurance becomes a true safety net again
  - Not fee for service
  - Total price transparency
  - Network of discount providers

What's Included?

MEMBER BENEFITS		
	Typical Fee	You Pay
Annual wellness exam	($200)	$0
25 additional Dr. visits	($2500)	$0
Annual Pap test	($150)	$0
Annual PSA test	($150)	$0
Annual Mammo	($200)	$0
Colon Cancer Screen	($25)	$0
Annual Labs	($500)	$0
Electrocardiogram	($50)	$0
Annual flu vaccine	($30)	$0
COPAYMENTS	(???)	$0
Typical cost of services	**$3,655**	**$0**

YOUR SAVINGS

$3,655!


Patient
Epiphany Health
Business
Practice A
Practice B
Practice C
Other third party contracts
Patient
Business

What's Excluded?

- No pre-existing condition exclusions
- No co-pays or deductibles
- Two exceptions
  - Doctors do not treat chronic pain
  - Doctors do not prescribe chronic controlled substances

Examples of in-office savings

Service	Typical Charge	Actual Cost in DPC
Additional labs	$50-350 each	$10 each
Joint injection (knee)	$150	$0
Skin biopsy	$160	$0
Drain abscess	$275	$0
Laceration repair	$260	$0

Examples of network savings

Service	Typical Charge	Actual Cost in DPC	Savings
Nuclear Stress Test	$1,470	$520	65%
CT of the chest w/contrast	$940	$211	78%
Carotid ultrasound	$425	$120	72%
Colonoscopy	$4,028	$1,127	71%
Chest x-ray	$220	$22	90%

Example of Itemized Hospital Bill

E OF VICE	BATCH REF	DEPT	F S	PROC	NDC/CPT-4/ HCPCS	QTY	SERVICE DESCRIPTION	CHARGES
300-LABORATORY								
511	15B201	0736		686912	36415	1	VENIPUNCTURE	38.14
							SUBTOTAL:	38.14
301-LAB/CHEMISTRY								
511	15B201	0736		679184	83880	1	NATRIURETIC PEPTIDE	149.44
511	15B201	0736		684162	80053	1	COMP METABOLIC PANEL	739.61
511	15B201	0736		684452	80061	1	LIPID PANEL	527.63
511	15B201	0736		684457	83735	1	MAGNESIUM BLD	323.29
511	15B201	0736		684574	84100	1	PHOSPHORUS BLD	51.85
511	15B201	0736		684439	83615	1	LDH (LD)	279.06
511	15B201	0736		684170	82550	1	CREAT KINASE (CK) TOTA	565.75
511	15B201	0736		684150	82553	1	CK MB	452.90
511	15B201	0736		684764	84484	1	TROPONIN QUANT	434.61
							SUBTOTAL:	3524.14
305-LAB/HEMATOLOGY								
511	15B201	0736		684130	85025	1	CBC PLATELET AUTO DIFF	789.92
511	15B201	0736		684611	85610	1	PROTIME	390.67
511	15B201	0736		684616	85730	1	PTT	602.36
							SUBTOTAL:	1782.95
307-LAB/UROLOGY								
511	15B201	0736		684772	81003	1	UA W O MICRO AUTO	231.79
							SUBTOTAL:	231.79
324-DX X-RAY/CHEST								
511	15B204	0728		680263	71010	1	XR CHEST 1 V	490.94
							SUBTOTAL:	490.94
352-CT SCAN/BODY								
511	15B204	0726		704848	74176	1	CT ABD&PELVIS W/O CONT	10955.13
							SUBTOTAL:	10955.13
450-EMERG ROOM								
511	17B363	0780		675003	9928425	1	EMER DEPT LEVEL 4	2700.18
							SUBTOTAL:	2700.18

Hospital Charges vs. DPC Charges

Hospital Charges

Service	Charge
Lab charges	$38.14
Chemistry	$3524.14
Hematology	$1,782.95
Urology	$231.79
Chest x-ray	$490.94
CT scan	$10,955.13
ER Level 4	$2,700.18
TOTAL:	**$19,723.27**

Epiphany Charges

Charge
$8.00
$70.79
$15.00
$4.50
$18.00
$185
$0
$278.79

What Does It Cost?

Member(s)	Monthly Fees
Individual	$50
with Spouse / Domestic partner	$100
Family of 4	$135

Savings with Epiphany DPC

Family of 4 = $ 135 per month

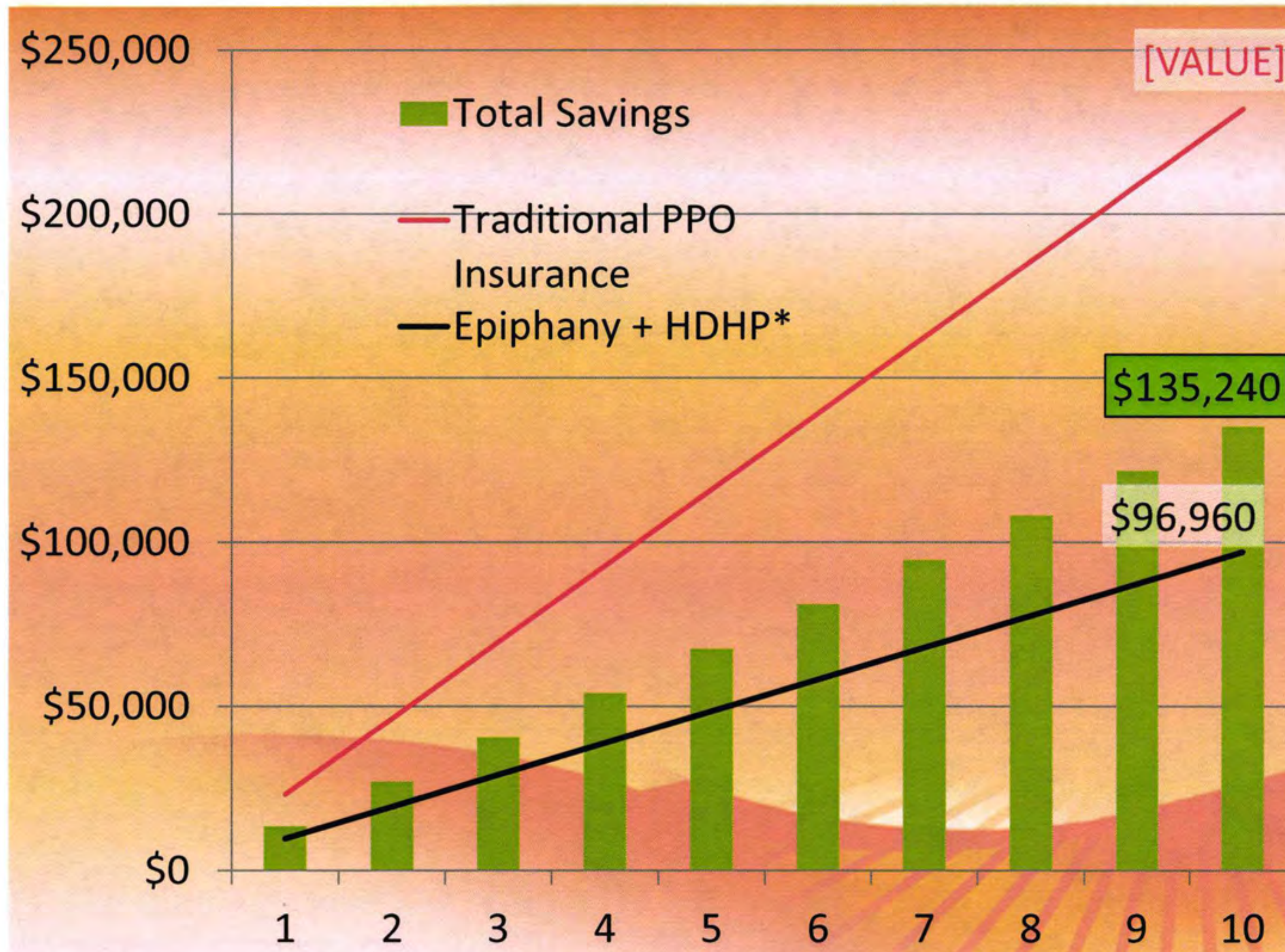
2014 Average PPO Insurance*

Family of 4 = $1,935 per month

Difference per year: **$21,600**

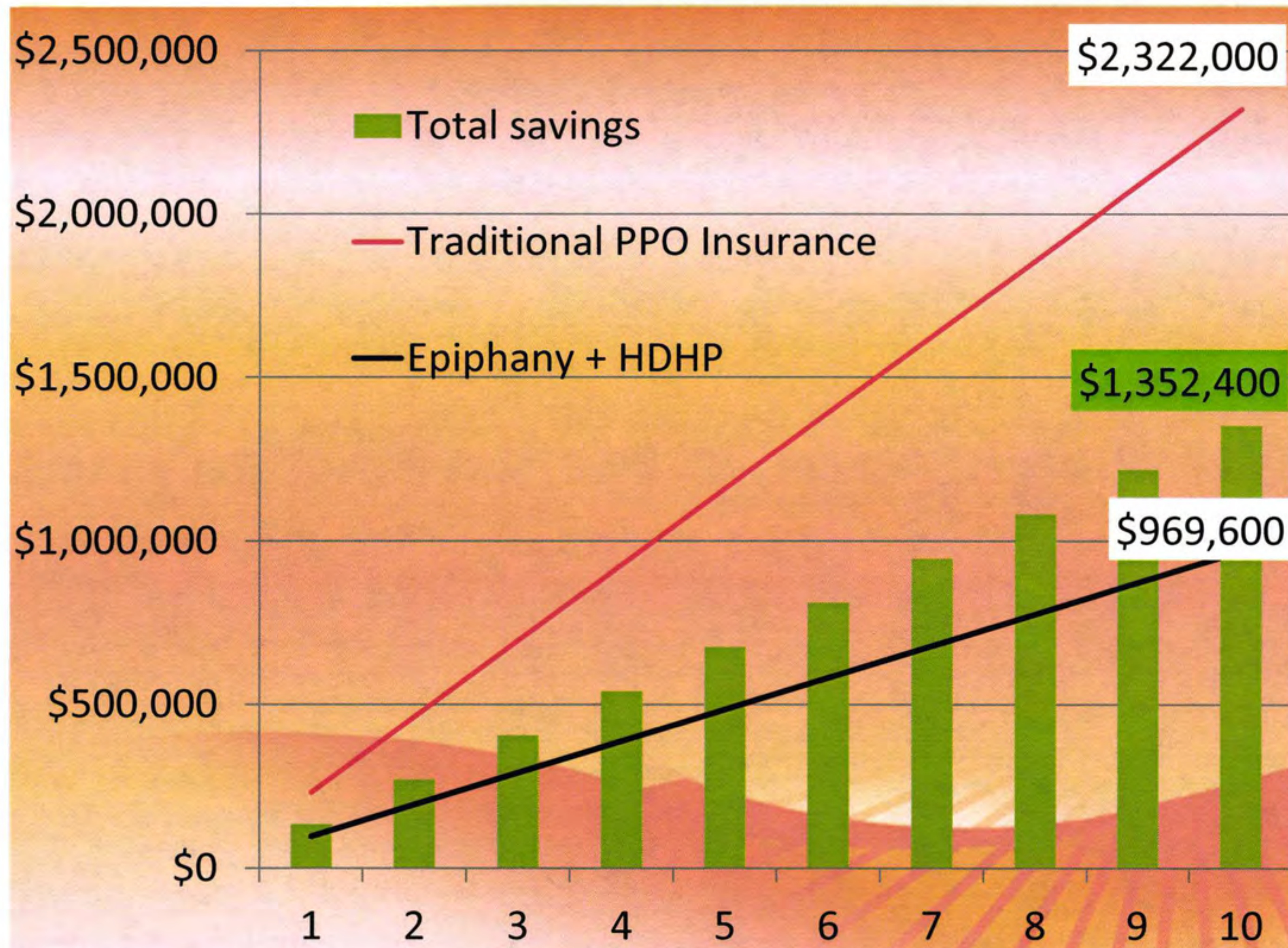
*2014 Milliman Medical Index

10 year projection – Family of 4



*2015 Aetna Bronze Deductible Only HSA Eligible Savings Plus HMO PD ($12.6 K deductible, $673/mos)

10 year projection – Employer of 10



Assumes middle aged employees with families of 4

Saving a profession

Service	Revenue	DPC Provider Cost
Annual patient dues	$600	
Labs		$30
Mammogram		$25
Influenza vaccine		$6
Pap smear		$28
25 office visits		50% overhead

Saving a profession

- Expenses of guaranteed services are covered with first month's dues
- Net revenue realized with dues over remaining 11 months
- Reduced overhead optimizes net revenue
- DPC model, like Epiphany, can be added to an existing practice
- Potential positive national impacts

Any questions?

National Federation of
Independent Business

Bill Herrle

Bill Herrle is the Executive Director of the National Federation of Independent Business (NFIB) in Florida. Herrle first joined the NFIB in 1989. From 2000 through 2006 he served as Vice President of Governmental Affairs at the Florida Retail Federation. He returned to the NFIB in 2007. Herrle also serves on the Office of Insurance Regulation Health Care Advisory Board. He is a graduate of the Pennsylvania State University.

The NFIB represents over 10,000 independent business owners across Florida.

Direct Primary Care
Coalition

Jay Keese has over three decades of experience as a public policy professional whose career has focused largely on healthcare issues. He is the founding Principal of Capitol Advocates, a Washington, DC based government relations firm, where he works with providers, employers, payers, healthcare technology firms and states on critical healthcare delivery and payment reforms.

Jay also serves as Executive Director of the Direct Primary Care Coalition, a group of primary care providers practicing in an innovative, cost effective monthly fee model. The coalition supports state and federal policies to improve the quality of primary care by giving Americans of all incomes and ages access to a personal physician.

Jay has worked extensively on healthcare technology issues, FDA and pharmaceutical issues, medical malpractice, reforms to the Medicare Secondary Payer program, as well as patient safety and quality issues. In the effort to create the Medicare Part D drug program, Jay worked with pharmaceutical and health plan clients to help shape Title II provisions on Medicare Advantage and played a role in the development of the first disease management program in fee-for-service Medicare.

Prior to founding Capitol Advocates, Jay was a Vice President at Columbus Public Affairs, where he managed the firm's healthcare lobbying practice. Previously, he held government relations positions at both the American Medical Association and the U.S. Chamber of Commerce.

Jay began his career as an aide to the late Senator John Heinz (R-PA), a member of the Senate Finance Committee and Chairman of the Senate Aging Committee. He has worked on numerous House and Senate campaigns with the National Republican Senatorial and Congressional Campaign Committees. Jay lives in Alexandria, Virginia with his wife Sara, and their three children Katie, Caroline and William.

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Direct Primary Care

Florida House of Representatives
Health Innovation Subcommittee

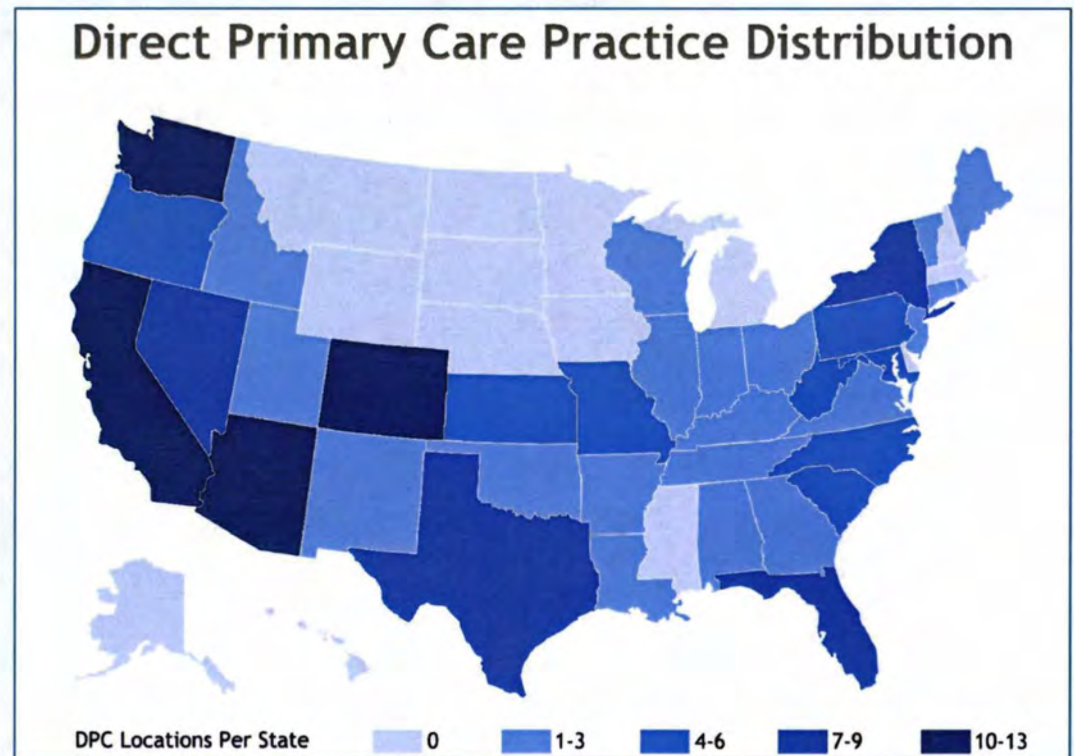
February 17, 2015

Jay Keese
Executive Director,
Direct Primary Care Coalition
jpkeese@cagdc.com

What Is Direct Primary Care (DPC)?

- Comprehensive Primary Care and Prevention Services
- Monthly Fee or Retainer: Payer Agnostic
- No Fee for Service Billing
- Medical Services - Not Insurance or a Health Plan
- Defined in ACA

  §1301 (a) (3) and state laws (WA 48.150 RCW)



- DPC Practices in at least 37 States
- Median fee about $80 per month
- Better Outcomes, Patient Satisfaction
- Savings of about 20%; employers, exchanges and Medicaid

Isn't DPC "Concierge" Medicine?

- **Concierge:** Provider access fees paid for "non-covered" services.
  - *Patient bills insurance for services – still in a FFS environment*
- **DPC:** Completely outside insurance. Fees cover high access level *plus* all costs of primary care.
  - *Avoids misaligned FFS incentives, minimal administrative costs for great primary care*
- **DPC:** More affordable than concierge, usually lower than $100 per month.
  - *Even offered with some Medicaid MCOs*
- **DPC:** Recognized health reform policy driving improved health outcomes and lower costs.
  - *Concierge may well improve care for some– but only for those who can afford it*

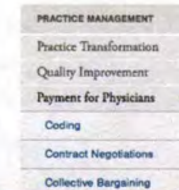
DPC Policy Drivers:

- Washington State Direct Practice Act (RCW48-150)
- ACA: DPC Medical Homes (§1301 (A) (3))
  - DPC in exchanges combined with insurance (QHP)
  - Two plans together must meet ACA Essential Health Benefits requirements
- HHS Rulemaking: DPC Medical Homes are NOT insurance
- DPC now in exchanges:
  - Washington: Qliance/Coordinated Care
  - Colorado: Nextera Health/Colorado HealthOP
- States looking to reduce costs and expand primary care

Who's talking about DPC?

- National Association of Manufacturers
  - Employers facing ACA compliance challenges need solutions to cut costs and improve care.
- American Academy of Family Physicians
  - DPC provides patients substantial savings, better access and more time with physicians.
  - Gives family physicians a meaningful alternative to fee-for-service insurance billing.
- Heritage Foundation
  - DPC fixes problems with third-party payment, paperwork, and government bureaucracy.

CME Journals Patient Care Medical School & Residency Practice Management Advocacy Events



Direct Primary Care

DPC: An Alternative to Fee-for-Service

The Direct Primary Care Model

Direct Primary Care Workshops

The Heritage Foundation

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Backgrounder #2939 on Health Care August 6, 2014

Direct Primary Care: An Innovative Alternative to Conventional Health Insurance

By Daniel McCorry

Abstract

Key Points

DPC Policy Barriers

- **State Insurance Regulations**
  - DPC legislation passed in 7 states; pending in another 8
  - Needed to prevent future regulation
  - Other states considering expanding DPC in Medicaid
- **Tax Code: Health Savings Accounts**
  - Primary Care (DPC) not a qualified medical expense {IRC 213 (d)}
  - IRS considers DPC a "health plan" for HSAs {IRC 223 (c)}
    - Not in keeping with HHS Rules {ACA §1301 (a) (3)}
  - IRS considering changes to medical expense definitions
  - Family Retirement and Health Reinvestment Act (S.1031) Hatch/Paulsen
    - *Clarifies that DPC is a qualified medical expense and is not a health plan*
- **Medicare/Medicaid**– *the nation's highest utilizers of care*
  - No Regular FFS Medicare/Medicaid payment methodology
  - DPC in Medicaid Managed Care: shows savings of up to 20% in WA state
  - DPC in Medicare Advantage in 2015
  - SGR "Doc Fix" Bills: DPC an "Advanced Payment Model" (S.2000/H.R. 4015)

DPC State Legislation

DPC Laws in 7 States

- Washington - 48-150 RCW
- Louisiana – LA Act 867
- Utah – UT 31A-4-106.5
- Oregon - ORS 735.500
- West Virginia- WV-16-2J-1
- Michigan – PA-0522-14
- Arizona: - AZ 20-123

2015 Pending Legislation

- Idaho
- Missouri
- Mississippi
- Oklahoma
- Texas
- Georgia
- New Hampshire
- Kansas