Direct Primary Care (DPC) contracts, or "medical retainer agreements," are a healthcare delivery model whereby a provider offers unlimited specified routine health care services for a monthly fee.[1,2] Proponents of DPC suggest that the delivery method will improve access to care, reduce administrative costs, foster stronger patient-provider relationships, and reduce reliance on expensive emergency department services. Opponents of DPC contend that it double-charges for services already covered in insurance requirements, and that DPC contracts lack accountability for quality and access. This paper 1) describes proposed and existing DPC bills 2) reviews existing DPC experience and evaluative information, and 3) considers what effect DPC could have on health care in Wisconsin.

I. Federal Law and DPCs

The Patient Protection and Affordable Care Act (ACA) requires that a qualified health plan (QHP) issuer "may provide coverage through a direct primary care medical home…so long as the QHP meets all requirements that are otherwise applicable and the services covered by the direct primary care medical home are coordinated with the QHP issuer." That is, DPC may be included in plans sold on the ACA insurance exchanges, but must be paired with a wraparound insurance policy covering everything outside of primary care.[3]

In April 2018, the federal Centers for Medicare and Medicaid Services (CMS) released a public request for information regarding DPC models for primary care and other specialties, titled "Direct Provider Contracting." That document is available here: https://innovation.cms.gov/ini…/direct-provider-contracting/. CMS solicited input on direct provider contracting between payers and primary

[1] Wisconsin Legislative Council, Amendment Memo, 2017 Senate Bill 670, Senate Substitute Amendment 1. February 2, 2018. https://docs.legis.wisconsin.gov/2017/related/lcamendmemo/sb670.pdf

[2] Chappell GE. 2017. Health Care's Other "Big Deal": Direct Primary Care Regulation In Contemporary American Health Law.. Duke Law Journal. Vol. 66: 1330-1370.

[3] 45 C.F.R. § 156.245; Dave Chase, Direct Primary Care: Regulatory Trends, FORBES (July 10, 2013), http://www.forbes.com/sites/davechase/2013/07/10/direct-primary-care-regulatory-trends/

care or multi-specialty groups. This would inform potential testing of a DPC model within the Medicare fee-for-service program (Medicare Parts A and B), Medicare Advantage program (Medicare Part C), and Medicaid.

Current Internal Revenue Service (IRS) rules prohibit individuals with health savings accounts (HSAs) paired with high deductible health plans (HDHPs) from having an agreement with a DPC provider. The IRS interprets DPC arrangements as health plans under Section 223(c) of the Internal Revenue Code, The law is unclear whether primary care services are qualified health expenses under Section 213(d) of the code if paid for as a capitated periodic fee rather than on a fee for service basis. IRS regulations require HSAs be paired with an HDHP, and the HSA holder may not have a second health plan. The IRS interpretation of DPC as a health plan bars an individual who has an agreement with a DPC provider from funding an HSA.

A bipartisan bill in Congress, The Primary Care Enhancement Act (HR 365/S. 1358), clarifies the tax code regarding the use of HSAs for DPC. The bill would clarify the tax code to allow patients with HSAs paired with HDHPs to use those funds to pay for periodic fee-based DPC. As of June 2018, House of Representatives has introduced the bill, but the House Committee on Ways and Means has not yet considered it.

DPC and Medicaid

Federal Medicaid law requires that "The State Medicaid agency must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan in the fee-for-service program to be enrolled as participating Medicaid providers."[4] A DPC provider would need to be a Medicaid participating provider. However, CMS has determined that, in Medicaid risk-based managed care arrangements, states hold discretion over provider enrollment

[4] 42 CFR § 455.410(b)

requirements for the ordering or referring physicians.[5] An advocacy website of a group that supports expansion of DPC contracts reviews questions that DPC practices have about this CMS guidance.[6]

II. State DPC Laws

Twenty-five states have passed legislation generally defining DPC outside of state insurance regulation. This state action defines DPC as medical service, not a health plan. Wisconsin, Georgia, Maryland, Pennsylvania and South Carolina have introduced DPC legislation, but have not enacted those bills into law. Details on these bills are available at https://www.dpcare.org/state-level-progress-and-issues. Montana Governor Steve Bullock is the only governor to have vetoed a DPC bill, doing so in March, 2017.

Discussion of the origin, history, and legislative framework for each state's DPC bill are available with detailed tables as of 2017.[7,8] About half of enacted laws use the phrase "direct primary care" while the other half use the substantively equivalent phrase "medical retainer agreement." All bills include language expressly stating that DPC is not insurance, and that DPC is not subject to regulation by the state's Insurance Commissioner or other state insurance regulators. Each of these laws defines DPC similarly, as an agreement between a primary care provider and a patient to provide unlimited access to primary care services in exchange for an agreed-upon monthly fee for an agreed-upon period. Various state laws address other elements. Alabama, for example, expressly includes dentists as providers

CMS, DHHS. Cindy Mann, Director. Medicaid/CHIP Provider Screening and Enrollment. December 23, 2011. https://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-12-23-11.pdf

[6] DPC Frontier. Medicaid – A Full Analysis. https://www.dpcfrontier.com/medicaid/

[7] Eskew P. Direct Primary Care Business of Insurance and State Law Considerations. Unpublished Paper. https://static1.squarespace.com/static/54c15fbce4b06765d7d750d5/t/59cc42388fd4d26e72d28126/1506558521439/Direct+Primary+Care+Business+of+Insurance+and+State+Law+ConsiderationsNYSBA.pdf

[8] Appendix to Health Care's Other "Big Deal": Direct Primary Care Regulation in Contemporary American Health Law Glenn E. Chappell 66 DUKE L.J. (March 2017) https://pdfs.semanticscholar.org/4774/9abed07d68ebbb7006599b15c568e62350c2.pdf

covered under the bill. The Direct Primary Care Coalition, a group that advocates for expansion of DPC, has drafted model DPC legislation.[9]

In theory, DPC paired with a wrap-around health plan, may be offered in ACA exchanges, by self-insured employers, unions, and by Medicare Advantage and Medicaid managed care organizations. State laws vary in whether they allow DPCs to engage in third-party billing, or the ability of DPC providers to be reimbursed by private insurers or state Medicaid agencies:

- Only Washington and Louisiana allow insurer reimbursement for member DPC subscriptions.
- Missouri, Arkansas, and Oklahoma do not prohibit DPCs from billing insurers for services. Missouri's law expressly allows payments from health savings accounts, flexible spending arrangements, or health reimbursement arrangements.
- Three states – Nebraska,[10] Louisiana,[11] and West Virginia[12] have statutory language that permit Medicaid payments for DPCs, while Mississippi and Texas preclude DPCs from billing Medicaid.[13]

Wisconsin DPC Bills: 2017AB 798 and SB 670

2017 Wisconsin Assembly Bill 798 (AB 798) was introduced in December 2017, along with companion Senate Bill 670 (SB 670).[14] The Senate Committee on Public Benefits and the Assembly Committee on Small Business Development passed identical substitute amendments to SB 670 and AB 798, respectively, in February 2018.[15] The full Assembly passed AB 798, as amended, but the Senate did not take up the bill before the end of the legislative session, and did not enact DPC-related law.

[9] https://www.dpcare.org/dpcc-model-legislation
[10] Nebraska Neb. Rev.St. § 71-9510.
[11] La. Stat. § 37:1360.85.
[12] W. Va. Code. § 30-3F-2.
[13] Miss. Code Ann. § 83-81-3(c) (2015); Tex. Occ. Code § 162.254 (2015).
[14] https://docs.legis.wisconsin.gov/2017/proposals/sb670
[15] https://docs.legis.wisconsin.gov/2017/related/amendments/sb670/ssa1_sb670

The original bill would have specified that DPC does not fall under regulation as an insurance plan, and required that the Wisconsin Department of Health Services (DHS) establish and implement a DPC program for Medicaid enrollees. The Legislative Reference Bureau summarizes SB 670 as follows:

> The bill allows a health care provider and an individual patient or employer to enter into a direct primary care agreement and requires the Department of Health Services to establish and implement a direct primary care program for Medical Assistance recipients. A direct primary care agreement is a contract in which the health care provider agrees to provide routine health services such as screening, assessment, diagnosis, and treatment for the purpose of promotion of health or the detection and management of disease or injury, dispensing of medical supplies and prescription drugs, and certain laboratory services for a specified fee over a specified duration. A valid direct primary care agreement outside of the Medical Assistance program must, among other things, state that the agreement is not health insurance and that the agreement alone may not satisfy individual or employer insurance coverage requirements under federal law. The bill exempts direct primary care agreements from the application of insurance law. The bill also allows DHS to investigate complaints related to private direct primary care agreements.

Services. The bill defines "routine health care service" to mean screening, assessment, diagnosis, and treatment for the purpose of promotion of health or the detection and treatment for the purpose of promotion of health or the detection and management of disease or injury. The substitute amendment removed the bill's specific provisions on laboratory services and dispensing of medical supplies and prescription drugs.

Medicaid Pilot Program

The Wisconsin Legislative Council summarizes the provisions of the bill and substitute amendment as follows:

> The bill requires the Department of Health Services (DHS) to contract with one or more primary care providers to implement a direct primary care program for MA recipients. DHS must enter participants into a direct primary care agreement to receive routine health services from one of these providers for a monthly fee, as will be specified in the agreement. After the program is implemented, DHS must submit annual reports to the Legislature.
> The substitute amendment removes these provisions and instead requires DHS to convene a work group to propose a direct primary care pilot program. A hearing must be held on the proposal, and legislation must be introduced following the hearing. The work group is also directed to submit a report regarding implementation of an "alternative payment model" for potentially preventable hospital readmissions of MA recipients.

The bill text, prior to removal by substitute amendment, contemplates how the Medicaid pilot might operate, specifically noting an average fee of $70 per month:

1. The monthly fee for each participant in the direct primary care program is no more than the amount determined under par. (d).

2. A primary care provider providing services to a participant in the direct primary care program may not accept 3rd-party payments for health care services provided to that participant, except the primary care provider may accept retainer fees from any managed care organization with which he or she has a contract.

3. If a participant in the direct primary care program is enrolled in managed care through the Medical Assistance program, all of the following:

a. The managed care provider shall designate a primary care provider who is accepting participants in the direct primary care program to be the care manager for the participant as it relates to access to care and services that are not routine health care services.

b. The managed care provider may not impose conditions on the primary care provider that would alter the delivery of service under a direct primary care agreement.

c. The managed care provider is not liable for increased costs resulting from participation of primary care providers in their network of providers in the direct primary care program.

(d) The department, after consulting with primary care providers who are willing to accept agreements with participants in the direct primary care program, shall determine a monthly fee for an enrollee in each population of Medical Assistance recipients participating in the program such that the average fee would be $70 per month if there are equal numbers of participants from each population.

(e) By March 1, 2020, and annually thereafter, the department shall submit a report under s. 13.172 (3) to the joint committee on finance and the appropriate

standing committees of the legislature with jurisdiction over health, Medical Assistance, or public assistance programs on the implementation of the direct primary care program under this subsection that includes all of the following:

III. Evaluations and Case Studies

This section provides information from existing research and reports on DPC practices, and examples of DPC implementation in other states.

Review of Existing Literature. A review of existing reports related to DPC practices, published in the Journal of the American Board of Family Medicine in 2015, finds that DPC charged patients an average $77.38 per month.[16] This level of payment falls substantially short of the average of $182.76 per month charged by "concierge" or "boutique" medical practices, which also usually bill insurers for their services. The study also reports a general lack of data related to the quality of care provided by DPC practices.

West Virginia. In 2006, West Virginia enacted the Preventive and Primary Care Pilot Program to provide such services to the uninsured for a prepaid fee (West Virginia Code § 16-2J.)[17] The law specified that health care providers in this program were not providing insurance or offering insurance services. A DPC advocate has reviewed the West Virginia program and how various elements, such as limiting its scope to the uninsured population, might restrict the success of DPC practices.[18] This writer compares the West Virginia provisions to a DPC law passed in 2007 by State of Washington, and concludes that Washington's legislation, along with elements of other states' laws, better promotes successful DPC practice:

> *States considering passing similar legislation should consider enacting a hybrid of the West Virginia, Washington, Utah, and Oregon statutes, taking the most helpful portions from each.*

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[16] Eskew P, Klink K. Direct Primary Care: Practice Distribution and Cost Across the Nation. JABFM, Journal of the American Board of Family Medicine. November–December 2015 Vol. 28 No. 6. http://www.jabfm.org/content/28/6/793

[17] West Virginia Health Care Authority. Primary Care Pilot Program. https://hca.wv.gov/primarycare/Pages/default.aspx

[18] Eskew P. Direct Primary Care Membership Medicine. West Virginia Medical Journal. March/April 2014 Vol. 110: 8-11. http://cdn.coverstand.com/30875/197958/83364ec4719c32123930be5019940709e1e49d59.5.pdf

Physicians should be able to market their services directly to patients or employers without regard to the current insurance status. Avoiding unneeded scope of service restrictions will magnify the economic benefits experienced by patients of the DPCMM practices. Rules regarding the acceptance of new patients and discontinuing care re helpful, and the Washington legislation provides an excellent example in this regard.

West Virginia renewed its pilot program through 2016, then adopted a new statutory provision for Direct Primary Care Practice in 2017. The new law (§30-3F-1) allows that, while a provider may not bill third parties for services rendered under the DPC agreement, "[a] primary care provider may accept payment for medical services or medical products provided to a Medicaid or Medicare beneficiary" and "[a] patient or legal representative does not forfeit insurance benefits, Medicaid benefits or Medicare benefits by purchasing medical services or medical products outside the system."[19]

Nebraska. Governor Pete Ricketts signed 2015 NE L.B. 817 into law on March 30, 2016. With DPC available on the commercial market, Nebraska's legislature introduced NE L.B. 1119,[20] which the Governor signed in April 2018 as the Direct Primary Care Pilot Program Act. The program begins in fiscal year 2019-2020 and runs through fiscal year 2021-2022. This law requires the State Health Insurance Program to include two direct primary care coverage options for participating state employees.[21]

Qliance Medical Group.

Qliance Medical Group, founded in 2007 in Seattle, established itself as the nation's largest DPC healthcare consortia. Supported by Washington State's permissive DPC law, Qliance served individuals, employers, and Medicaid members.[22] In 2014, the company became the nation's first DPC provider to

[19] W. Va. Code § 30-3F-2. See also: West Virginia Board of Medicine, Direct Primary Care Practice. https://wvbom.wv.gov/Direct_Primary_Care_Practice.asp#30-3F-2

[20] https://nebraskalegislature.gov/bills/view_bill.php?DocumentID=34744

[21] Office of Governor Pete Ricketts, State of Nebraska. Gov. Ricketts Signs Legislation Expanding Healthcare Options. April 13, 2018. https://governor.nebraska.gov/press/gov-ricketts-signs-legislation-expanding-healthcare-options

[22] Qliance and Healthcare Reform Fact Sheet for Individuals http://qliance.com/wp-content/uploads/2011/10/Qliance-and-Healthcare-Reform-Fact-Sheet_Final.pdf

join the ACA health insurance exchange. By 2015, Qliance groups served 35,000 patients in the Seattle area, for which Medicaid covered about half.[23]

Despite this early success, Qliance faltered financially and, by 2017, had closed all clinic operations.[24] The Qliance Medical Group filed for Chapter 7 bankruptcy on May 7, 2018.[25] The payment levels apparently proved insufficient to cover the DPC costs.

No independent evaluations have been reported of Qliance performance. Qliance, in a 2015 press release, announced that its model "delivers 20% lower overall healthcare costs, increases patient satisfaction, and delivers better care."[26] Qliance attributed these savings to a substantial reduction in ER visits, inpatient days, specialist visits, advanced radiology visits, along with more primary care visits. However, the study was not conducted by external evaluators or subject to peer review, and was not published in a scientific journal. It does not specify whether the underlying risk status differed between those who joined Qliance relative to a comparison group, how long the Qliance members had been with Qliance, or whether the Qliance members might have visited any providers outside of their Qliance contract that went unrecorded in the study. For these reasons, the reported results from Qliance may not be attributable to the DPC as a delivery model. DPC may attract a lower risk member population,

[23] David von Drehle, Medicine Is About to Get Personal, TIME (Dec. 22, 2014), http://time.com/3643841/medicine-gets-personal

[24] Andrews M. A Pioneer In 'Flat-Fee Primary Care' Had To Close Its Clinics. What Went Wrong? NPR Shots. June 20, 2017. https://www.npr.org/sections/health-shots/2017/06/20/533562142/a-pioneer-in-flat-fee-primary-care-had-to-close-its-clinics-what-went-wrong

[25] Ellison Ayla. Direct primary care group files for bankruptcy after abruptly closing clinics. Becker's Hospital Review. May 30, 2018. https://www.beckershospitalreview.com/finance/direct-primary-care-group-files-for-bankruptcy-after-abruptly-closing-clinics.html

[26] Qliance. New Primary Care Model Delivers 20 Percent Lower Overall Healthcare Costs, Increases Patient Satisfaction and Delivers Better Care. January 15, 2015. https://www.prnewswire.com/news-releases/new-primary-care-model-delivers-20-percent-lower-overall-healthcare-costs-increases-patient-satisfaction-and-delivers-better-care-300021116.html

and some observers suggest that unlimited primary care encourages the "worried well" to get more care than they need, but does not necessarily promote evidence-based services that improve health.

IV. Benefit Design and Financial Relationship to Insurance Coverage

A. Volume of Care, In- and Out-of-Network

Most consumers use very little health care, and can meet most of their care needs at the primary care level. The question is how much a consumer would need to spend outside of the monthly DPC subscription fee to have sufficient coverage. About half of all U.S. residents visit the physician three or fewer times in a year, while another quarter incur 4-9 visits annually.[27]These include all visits – for primary and specialty care services. On a national level, 51% of those visits occur with primary care physicians, 28% with another medical specialist and 21% with a surgical specialist. [28]

Average Number of Physician Office Visits Annually				
	None	1-3	4-9	10 or more
Total Population (age adjusted	15.0	48.4	23.7	12..8
Medicaid	12.4	43.4	25.4	18.8

https://www.cdc.gov/nchs/data/hus/2016/065.pdf

The figures above suggest that most U.S. residents incur fewer than five primary care visits annually, and about half would incur none, or only one or two visits, for which they could would make use of their DPC contract provider. The other half of their medical needs, along with the lab, imaging, and pharmacy services associated with their primary care visits, would fall outside of the DPC contract and depend on their insurance coverage and related cost-sharing exposure.

[27] U.S. CDC. Health, United States 2016. Table 65 Health care visits to doctor offices, emergency departments, and home visits within the past 12 months, by selected characteristics: United States, selected years 1997–2015. https://www.cdc.gov/nchs/data/hus/hus16.pdf#065

[28] National Ambulatory Medical Care Survey: 2015 State and National Summary Tables. Table 1. Physician office visits, by selected physician characteristics. https://www.cdc.gov/nchs/data/ahcd/namcs_summary/2015_namcs_web_tables.pdf

A low-risk consumer could likely get many, if not most, needs met in the DPC environment. That consumer would then need to get a simple wrap-around plan with a high deductible and co-payments in the event of a hospitalization or need for specialist services. However, with the ACA's preventive services requirement, that plan will already provide coverage for many, if not most, of the screening and preventive services that the DPC would also provide. The question here becomes whether the DPC subscription fee adds value beyond the preventive services already built into any other coverage that includes mandated preventive services.

B. Preventive Services Covered by Private Health Plans

The ACA requires that private insurance plans cover recommended preventive services without any patient cost-sharing.[29] This means that consumers paying for both insurance and DPC will be paying twice for those services, unless the insurance plan can carve out the required preventive service benefit and use the DPC provider to fulfill the requirement.

IRS Notice 2013-57 confirms that high-deductible health plans (HDHPs) also must cover all preventive services mandated under the ACA without imposing a deductible.[30] Private health plans must cover a range of preventive services and may not impose cost-sharing (such as copayments, deductibles, or co-insurance) on patients receiving these services. These requirements apply to all private plans – including individual, small group, large group, and self-insured, except plans that maintain "grandfathered" status. To have been classified as "grandfathered," plans must have existed prior to March 23, 2010, and cannot make significant changes to their coverage (for example, increasing patient cost-sharing, cutting benefits, or reducing employer contributions).

[29] Healthcare.gov. Preventive health services. https://www.healthcare.gov/coverage/preventive-care-benefits/
See also: Preventive Services Covered under the Affordable Care Act. Quartz. https://unityhealth.com/docs/default-source/docs/acapreventiveservices.pdf?sfvrsn=2

[30] IRS Notice 2013-57. https://www.irs.gov/pub/irs-drop/n-13-57.pdf

The clinical preventive services fall into four categories:

1. Evidence-Based Screenings and Counseling
2. Routine immunizations
3. Preventive Services for Children and Youth
4. Preventive Services for Women

Individual and small group plans in the health insurance marketplaces must also cover an essential health benefit (EHB) package. There is some crossover, as several of the specific preventive services fall into the EHB categories. However, only preventive services in the four categories are covered without cost-sharing.[31]

The table below compares the coverage that consumers might have for services under a DPC agreement, as defined by SB 670, relative to what they would have under an ACA-compliant health plan. A consumer within a DPC agreement would presumably also purchase a complimentary "wrap-around" health plan to cover the services not provided within by the DPC contract, including most prescription drugs, laboratory, specialist, and hospitalization services. The degree to which a consumer would need such coverage would will depend on risk profile and the consumer's pre-existing health conditions.

	Direct Primary Care	**ACA-Compliant Health Plan Coverage**
Screening	No additional cost to consumer for screening services that fall within the scope of the DPC's ability and scope.	No out-of-pocket cost to the consumer; most screening services will fall within the ACA's preventive services mandate and therefore would be covered.
Assessment, Diagnosis, and Treatment	No additional cost to consumer for assessment, diagnosis, and treatment services that fall within the scope of the DPC's ability and scope.	No out-of-pocket cost to consumer for some assessment, diagnosis, and treatment that occur incidental to the preventive services. For example, removal of polyps during a routine colonoscopy

[31] For Detail, see https://www.kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/#endnote_link_160040-3

	Consumer remains exposed to full cost for assessment, diagnosis, and treatment services by other providers beyond the DPC, including referrals, specialists, and second opinions.	would be included as a "free preventive service." Other assessment, diagnosis, and treatment services would be covered under the essential health benefits package, subject to the health plan's specific provisions related to co-payments and deductibles.
Dispensing of Medical Supplies and Prescription Drugs	Limited only to product dispensed directly within the clinic by the DPC provider. Consumer remains fully exposed to most prescription drug costs, as those are generally dispensed by a licensed pharmacy outside of the primary care office setting.	Covered, subject to health plan's cost-sharing and deductible provisions.
Laboratory services, including routine blood screening and routine pathology screening	No coverage for any laboratory services that fall outside of the DPC's on-site lab or the lab that has entered into an agreement with the DPC.	Covered at no out-of-pocket cost to consumer: Some laboratory services that fall within the ACA 's preventive services mandates. Other laboratory services covered subject to health plan copayment and deductible provisions.
Specialist services	No coverage	Covered, subject to health plan co-payment and deductible provisions
Emergency Department	No coverage	Covered, subject to health plan co-payment and deductible provisions
Hospitalization	No coverage	Covered, subject to health plan co-payment and deductible provisions

C. Value-Added Calculation

The value of a DPC arrangement to a consumer would depend on comparison of these two cost bundles:

Direct Primary Care Cost to Consumer	Comprehensive Insurance Cost to Consumer
• Monthly DPC fee • Monthly HDHP premium with HSA deposits • Out-of-Pocket costs for specialist, lab, prescription drug, and hospitalization services pre-deductible	• Monthly premium for comprehensive insurance • Out-of-pocket costs not covered by comprehensive insurance, less any applicable cost-sharing reductions, pre-deductible.

Note also that the bills considered by the Legislature in the 2017-19 session specify that direct primary care payments may not count towards the patient's insurance deductibles or out-of-pocket expenses. A consumer using an insurance plan rather than a DPC would have their payments for primary care services applied toward any deductibles.

- **Individual Comprehensive Coverage vs DPC-plus-HDHP**

A consumer who enters into a DPC arrangement would have to pay the DPC fees, and decide whether to enroll in a plan that offers coverage for services not included in the DPC contract, such as a high-deductible health plan. This section compares premiums and cost-sharing requirements for individual comprehensive coverage and HDHP coverage that could be purchased in addition to DPC.

The table below displays the premiums required of Wisconsin consumers for 2018 ACA-compliant comprehensive coverage at the various ACA metal levels, before and after federal premiums subsidy. Note that most consumers purchasing individual coverage qualify for premium subsidies, while 43% also qualified for cost-sharing reductions.

Wisconsin 2018: Premiums, Before and After Advance Premium Tax Credit (APTC) Federal Subsidy, by Metal Level				
Wisconsin 2018: ACA-compliance health plans on Exchange	**Overall**	**Bronze Plan**	**Silver Plan**	**Gold Plan**
Percent (#) of Consumers Selecting Plans	100% (225,435)	33.4% 75,342	54.1% 121,876	11.4% 25,752
Average Premium (monthly)	$750	$626	$833	$759
Average premium after APTC (monthly)	**$190**	**$209**	**$158**	**$278**
Consumers with APTC	84.1%	73%	92%	81%
Average APTC among consumers receiving APTC (monthly)	$667	$568	$730	$594
Average Premiums after APTC among consumers receiving APTC (monthly)	**$106**	**$74**	**$105**	**$193**
Consumers with Cost-Sharing Reductions (CSR)	43%	1%	80%	NA

The table below displays the average deductibles and average maximum out-of-pocket expenses required for 2018 health plans (ACA-compliant comprehensive coverage) for each metal level.

	Individual Coverage Average Cost, 2018		
Cost-Sharing Category	Bronze	Silver	Gold
Deductible (Medical)	$5,861	$4,033	$1,320
Maximum Annual Out-Of-Pocket Costs	$6,953	$6,863	$5,878

Source: HealthPocket. Available at https://www.healthpocket.com/healthcare-research/infostat/2018-obamacare-premiums-deductibles

Outside of difference in the monthly premium, the scope of coverage and cost-sharing elements under an HSA model and comprehensive insurance model are comparable, as the table below displays

Sample 2018 HSA Individual and Family Plan Options, Wisconsin[32]

	Bronze HSA	Silver HSA	Gold HSA
Deductible – In Network (Single/Family)	$6,650/$13,300	$3,200/$6,400	$1,800/$3,600
Out-of-Pocket– In Network (Single/Family)	$6,650/$13,300	$6,550/$13,100	$6,550/$13,100
Coinsurance In-Network	0%	25%	10%
In Network Preventive Care	$0	$0	$0
PCP (In-Network)	Deductible	Deductible with Coinsurance	Deductible with Coinsurance
Specialist (In-Network)	Deductible	Deductible with Coinsurance	Deductible with Coinsurance
Urgent Care (In-Network	Deductible	Deductible with Coinsurance	Deductible with Coinsurance
Emergency Room (In-Network)	Deductible	Deductible with Coinsurance	Deductible with Coinsurance
Prescription Drugs	Deductible	Deductible with Coinsurance	Deductible with Coinsurance

- **Comprehensive Medicaid vs. DPC-plus-HDHP-plus-Medicaid-wraparound**

The Affordable Care Act defines Minimal Essential Coverage (MEC);[33] persons with such coverage are not eligible for federal premium tax credits (subsidies) to purchase ACA Marketplace plans.[34] Most

[32] Samples from Quartz Health Plans:
https://unityhealth.com/docs/default-source/docs/uh01445-(0817)-primeoverview-v5_final56382ad2b2e76b509b7eff0000a05e52.pdf?sfvrsn=2
and from Common Ground Healthcare Cooperative:
https://www.commongroundhealthcare.org/our-plans/individuals-families/

[33] Medicaid.gov. Minimum Essential Coverage.
https://www.medicaid.gov/medicaid/eligibility/minimum/index.html

[34] CMS, DHHS. Letter of State Health Officials and State Medicaid Directors Re Minimum Essential Coverage. SHO # 14-002. November 7, 2014. https://www.medicaid.gov/federal-policy-guidance/downloads/sho-14-002.pdf
See also: CMS. DHHS. Medicaid Secretary-approved Minimum Essential Coverage. February 16, 2016.
https://www.medicaid.gov/medicaid/benefits/downloads/state-mec-designations.pdf

employer-sponsored coverage, Wisconsin Medicaid, BadgerCare, and Medicaid for low-income pregnant women all count as MEC.[35]

The Wisconsin Legislative Fiscal Bureau reports the average benefit cost by eligibility group in Medicaid, for 2015-16, as follows:[36]

	Average Annual Per Member Cost	Average Per Member Per Month (calculated by author)
Children	$1,762	$147
Parents	$4,128	$344
Childless Adults	$5,770	$481
BadgerCare Plus Total	$3,228	$269

If DHS ended up recommending a DPC benefit that cost $70 per month (as contemplated in the original Wisconsin bill), the DPC model would need to reduce these Medicaid PMPM costs by at least $70 per month in order to save costs. This would depend on several factors:

- Do the health plans continue to price in the required preventive services into their premiums, apart from the DPC, or carve out these services and rely on the DPC to provide them?
- Does the DPC provide and participate in after-hours care, or do their enrolled patients rely on other sources of care for after hours services?
- How much does the DPC rely on laboratory, imaging, and specialist referrals?

- **Quality and Accountability.** Finally, it will be important for the DPC to report its encounter data to the health plan, to allow for health plan quality review and report of Medicaid and HEDIS performance measures. Lacking insurance regulation or payer oversight, DPC theoretically lack

[35] Healthcare.gov. Find out if your Medicaid program counts as minimum essential coverage https://www.healthcare.gov/medicaid-limited-benefits/

[36] Wisconsin Legislative Fiscal Bureau. Medical Assistance and Related Programs (BadgerCare Plus, EBD Medicaid, Family Care,and SeniorCare) Information Paper 41. Table 1.5: 2015-16 Total and Average Benefit Cost by Eligibility Group. January 2017. http://docs.legis.wisconsin.gov/misc/lfb/informational_papers/january_2017/0041_medical_assistance_and_related_programs_informational_paper_41.pdf

accountability to professional review; They could overload their practices with subscribing patients and compromise on quality of care. Wisconsin's DPC bill, with its substitute amendment, relies on insurance plans to regulate such conduct, specifying that direct primary care providers who wish to be part of an insurance network must comply with the insurance carrier's terms of participation. \

Conclusion

Many states, including Wisconsin, have adopted or are considering legislation to define DPC arrangements as medical services rather than an insurance plan, and provide a framework for Medicaid coverage of DPC services. The evidence has not yet established the effect of DPC on health care spending, quality, or access. As these discussions continue in Wisconsin, particularly regarding direction of Medicaid funding, lawmakers may want to consider some of the following questions to guide their decisions:

- Will the DPC services be available in parallel to other covering for required preventive service paid for within supplementary insurance, within an HSA or other wrap-around policy, or will the insurance premiums and products carve-out the preventive care component and include that in the DPC subscription?
- What are the actuarial projections for use of DPC services within the subscription fee relative to the cost of other laboratory, imaging, prescription, drug, specialist referral, and hospital services for which the consumer will experience cost exposure?
- Will the price of subscribed DPC services avert additional care needs such that the consumer does not experience exposure to higher differential price of non-covered services that would have been available at a negotiated discount within a comprehensive health plan?

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