

State and Federal Policy Update

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Participate in polling questions and submit your questions to <https://aafp4.cnf.io>



June 28-30, 2019

#dpcsummit

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Learning Objectives

1. Describe recent federal and statewide legislative trends
2. Evaluate the major regulatory hurdles facing new DPC practices.
3. Develop and implement appropriate compliance and mitigation strategies to minimize regulatory risks.
4. Evaluate the existing resources available to support physicians interested in becoming engaged with DPC advocacy efforts



Federal HHS Updates

04/22/19 CMS new “Primary Cares Initiative”

1. Primary Care First
 1. General
 2. High Need Populations
2. Direct Contracting
 1. Global
 2. Professional
 3. Geographic



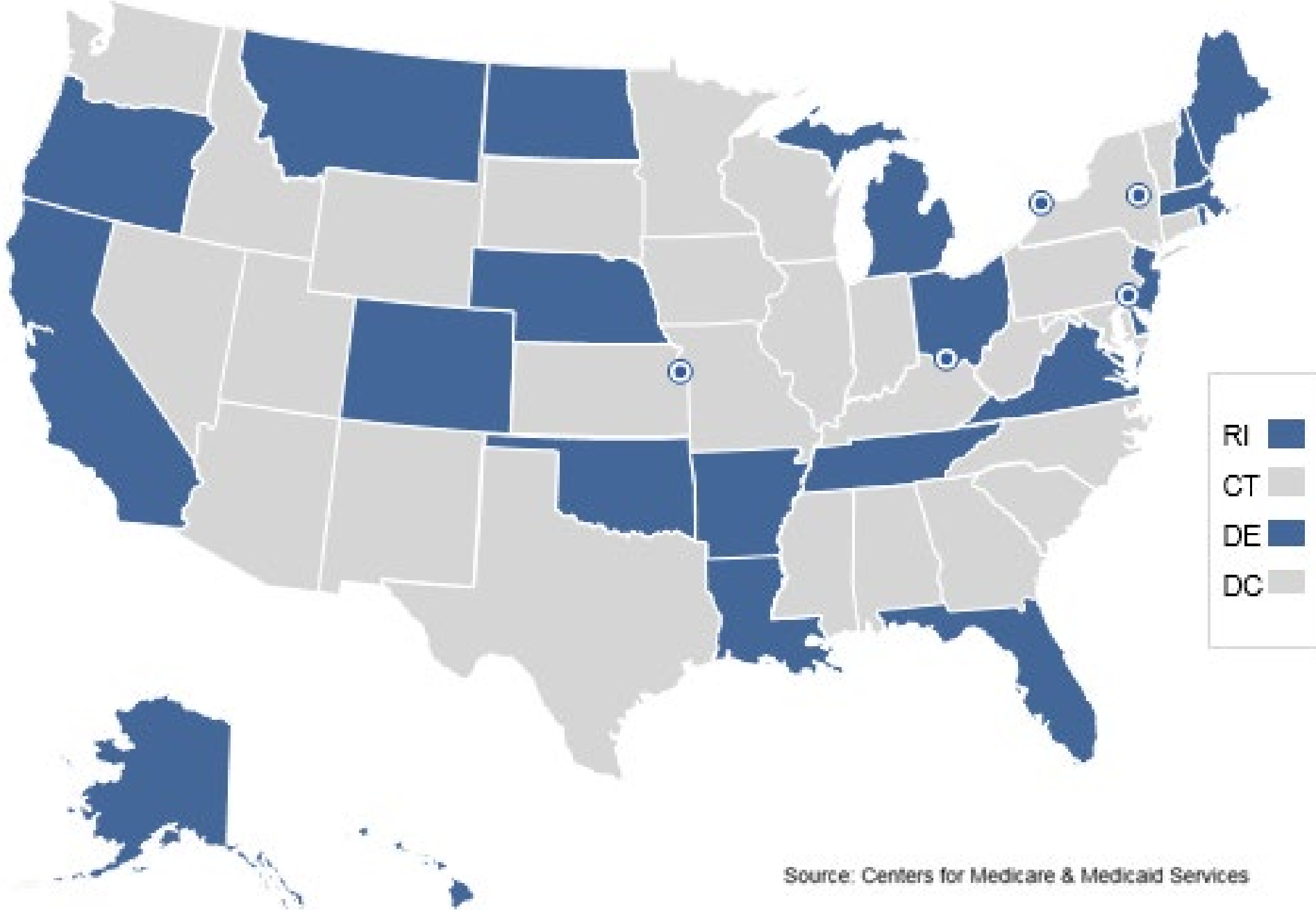
Primary Care First

“The general Primary Care First payment model option is designed for primary care practices with advanced primary care capabilities that are prepared to accept increased financial risk in exchange for flexibility and potential rewards based on practice performance.”

Primary Care First

- Geographic Limitations (next slide)
- Include primary care practitioners (IM, GP, Geriatrics, FM, Hospice/Palliative)
- Serve as a PCP for at least 125 attributed Medicare beneficiaries at a particular location
- Have primary care services account for at least 70% of the practices' collective billing based on revenue.
- Have experience with value-based payment arrangements or payments based on cost, quality, and/or utilization performance such as shared savings, performance-based incentive payments, and episode-based payments, and/or alternative to fee-for-service payments such as full or partial capitation.
- Use 2015 Edition **Certified Electronic Health Record Technology (CEHRT)**, support data exchange with other providers and health systems via **Application Programming Interface (API)**, and connect to their regional health information exchange (HIE).
- Attest via questions in the Practice Application to a limited set of advanced primary care delivery capabilities, such as **24/7 access to a practitioner or nurse call line and empanelment of patients to a practitioner or care team.**
- Can meet the requirements of the **Primary Care First Participation Agreement** (not available yet)





Source: Centers for Medicare & Medicaid Services



Primary Care First Application Process and Timeline

- Spring 2019 - CMS will release to practices a request for Application
- Summer 2019, practice applications will be due and solicitation of payers will take place.
- Fall and winter 2019, practices and payers will be selected.
- In January 2020, the Primary Care First model will launch and payments will begin in April 2020.



Primary Care First Payments

- Population rating determines PMPM amount
- Risk sharing expected
- \$50 per visit fee
- “Seriously Ill” payments are different
 - One-time payment for first visit with SIP patient: \$325 per beneficiary
 - Monthly SIP payments for up to 12 months: \$275 per beneficiary per month
 - Flat visit fees: \$50
 - Quality payment: up to \$50



Primary Care First – Seriously Ill Patients

CMS will attribute Seriously Ill Population (SIP) patients lacking a primary care practitioner or care coordination to Primary Care First practices that specifically opt to participate in this payment model option. Practices may limit their participation in Primary Care First to exclusively caring for SIP patients, but in order to do so, such practices must demonstrate in their applications that they have a network of relationships with other care organizations in the community to ensure that beneficiaries can access the care best suited to their longer-term needs.

Primary Care Plus Quality Markers

- CPC+ Patient Experience of Care Survey
- Diabetes: Hemoglobin A1c and Poor Control
- Controlling High Blood Pressure
- Care Plan
- Colorectal Cancer Screening



CMS “Direct Contracting”

- Professional PBP offers the lower risk-sharing arrangement—50% savings/losses—and provides Primary Care Capitation, a capitated, risk-adjusted monthly payment for enhanced primary care services.
- Global PBP offers the highest risk sharing arrangement—100% savings/losses—and provides two payment options: Primary Care Capitation (described above) or Total Care Capitation, capitated, risk-adjusted monthly payment for all services provided by DC Participants and preferred providers with whom the DCE has an agreement.
- Geographic PBP would offer a similar risk-arrangement as the Global PBP option as potential participants would assume responsibility for the total cost of care for all Medicare FFS beneficiaries in a defined target region.

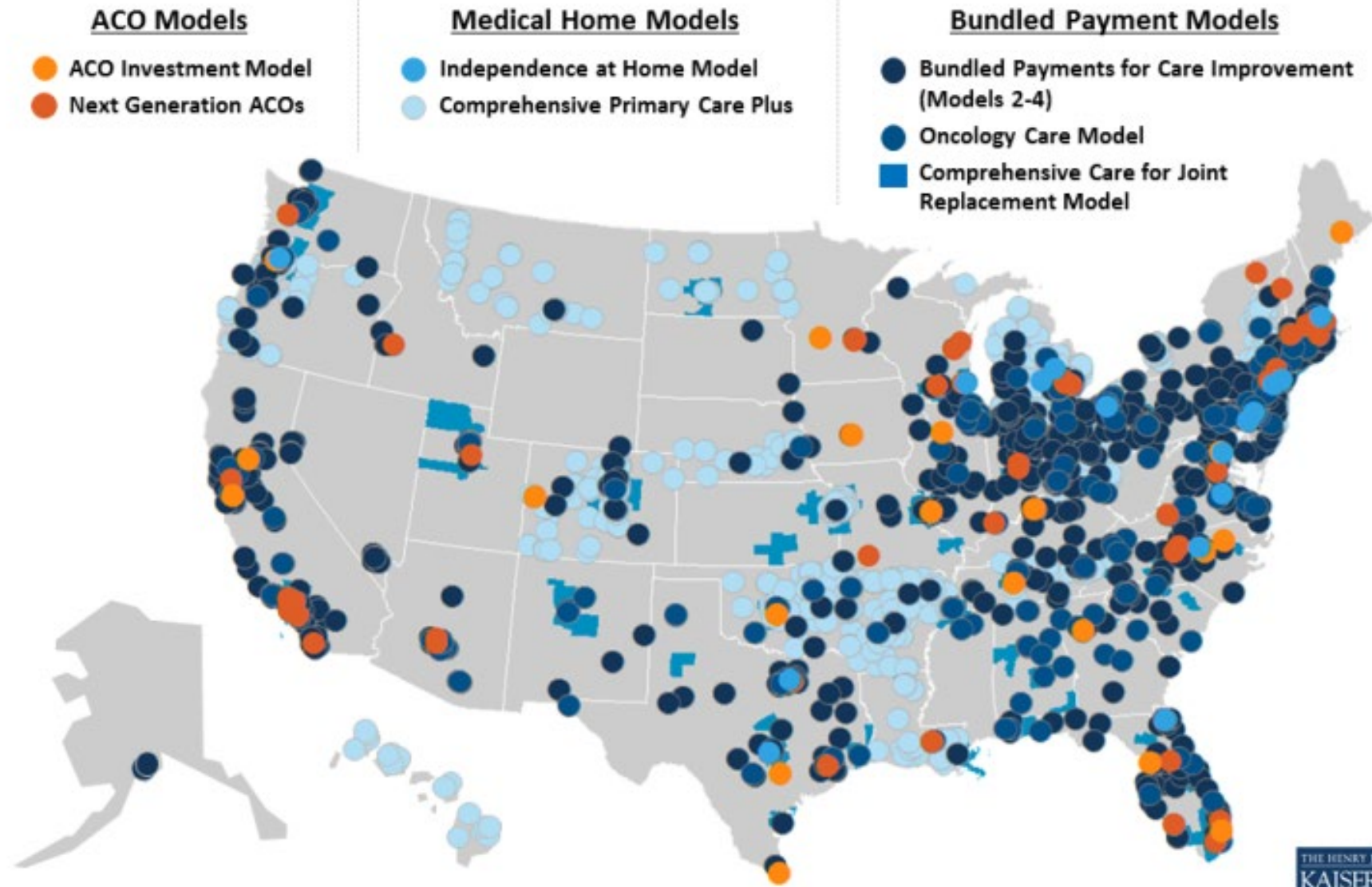


Model	Eligibility	Payment	Other Details
Primary Care First General or Seriously Ill Populations (SIP)	Minimum 125 attributed Medicare patients Primary care ≥ 70% practice revenue Can participate in one or both model options Located in one of 26 PCF regions SIP-only must have sufficient network to address complex health needs Claims based attribution with voluntary alignment opportunity	Three parts: 1. Prospective capitated payment 2. Flat fee for in-person visits 3. Bonus for quality + avoidance of admissions Bonuses can be up to 50% of practice revenue and losses up to 10% Specific PMPM and quality measures for SIP	Request for Application Spring 2019 January 2020: first cohort starts January 2021: likely second cohort
Direct Contracting Global or Professional	Contract with Direct Contracting Entity (DCE) Provider, payer, or other organization can be DCE At least 5,000 aligned Medicare lives Claims based or voluntary alignment (patients identify provider)	Population-Based payments (PBP) Professional PBP: Primary Care Capitation, 7% TCOC, 50% savings/losses Global PBP: Choice of Primary Care Capitation or Total Care Capitation, 100% savings/losses.	CMS will request Letter of Intent, then issue RFA Starts in 2020 with PY 0 Benchmark: Prospective blend of historical spending and adjusted MA regional expenditures Discount applied with potential quality bonus.
Direct Contracting Geographic	In each region: <ul style="list-style-type: none"> One or more DCEs DCEs responsible for all Medicare FFS spending Must have 75,000 Medicare beneficiaries 	Geographic PBP: Choice of Total Care Capitation or full risk with FFS claims Either choice has 100% risk for DCE	RFI comments due May 23, 2019 RFA likely Fall 2019 Proposed Benchmark: One year historical FFS spend in target region trended forward with negotiated discount



Figure 1

CMMI Payment and Delivery System Reform Models (2018)



Source: Map data downloaded February 8, 2018 from CMS, "Where Innovation is Happening."



- <https://www.kff.org/medicare/fact-sheet/what-is-cmmi-and-11-other-faqs-about-the-cms-innovation-center/>

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Recommendations

- Cannot participate if “Opted Out” of Medicare
- Primary Care First = Revised CPC+
 - No go, consider using simpler Medicare Chronic Care Management Codes
- Direct Contracting = Revised ACOs
 - No go, consider more DPC-like forms of capitation
 - PACE – Program for All Inclusive Care of the Elderly
 - Correctional Medicine

Choose Your Location Wisely

- Not all states are created equal
 - A helpful “not insurance” law (half of states)
 - Medication Dispensing freedom
 - Pathology restrictions (if procedure heavy)
 - Certificate of need (if purchasing diagnostics)
 - CPOM & Fee Splitting (if raising capital)
 - Other Random Hiccups
 - Labs (NY & NJ), Medicaid (CO & KY)



2019 DPC Defining “Not Insurance” Efforts

- Arizona revision (SB 1105 & HB 2113) – signed into law on 04/17/19
- Georgia – SB 18 – signed on 04/25/19
- Hawaii SB 232 – died in committee
- Maryland SB 0315 and HB 0315 – died in committee
- Minnesota SF 277 – passed the senate 67-0, currently in the house
- New Hampshire HB 508 – on the governor’s desk
- South Carolina SB 0445 – died this year
- Pennsylvania – discussions only, no bill launched
- Wisconsin – SB 28 and AB 26 – stuck in committee



2019 State DPC Pilot Program Discussions

- Indiana SB 470
- Missouri HB 233
- Minnesota HF 718
- **Oklahoma SB 386**
- Tennessee HB 0894 & SB 0696
- Virginia HB 2456



Michigan Medicaid Pilot

- Quarterly Performance Metrics Report
- Enrollees, DPC rate, claim volume and dollar value
- Per-Member-Per-Month “Actual Cost” = DPC fee + insurer allocated overhead
- “Total Health Care (THC) has partnered with Department of Health and Human Services (DHHS) and began accepting enrollments into the program on July 1, 2018. As of October 1, 2018 THC has 360 members enrolled in the Direct Primary Care Pilot. THC expects this number to grow over the next few months.”



Minnesota – HB 718

- “The commissioner shall pay health care providers directly to provide services for all medical assistance enrollees...”
- “The commissioner shall not renew the state’s contracts with managed care plans...”
- Primary care providers may be selected by the patient as their “case manager”

Minnesota – HB 718

- PCP Case managers “shall also receive a flat per-member, per-month fee for performing care coordination services. The **commissioner shall set case management fees to reflect the variation in time and services required for a primary care provider to coordinate care based on the complexity of a patient’s health needs and socioeconomic factors that lead to health disparities.**”
- “The primary care provider shall provide overall oversight of the enrollee's health and coordinate with any other case manager of the enrollee as well as **ensure 24-hour access to health care, emergency treatment, and referrals.**”



Minnesota – HB 718

- Price Setting
- Rules and prices vary commissioner
 - But managed care insurance is dead
- Patient is left out of monetary transaction
- PCP must ensure 24 hour access to emergency treatment?
 - Bizarre
 - Unlawful unless an HMO is established

Indiana Medicaid Pilot (SB 470)

- Arbitrary categories
- Price Fixing
- Formulary mandates
- Prior authorization mandates
- Lack of privacy
- Did not reference their own DPC law

Indiana Medicaid Pilot (SB 470)

- Pilot limitations

(400 patients in each category = 2,000 total)

2,000 x \$70 average PMPM = \$140,000 DPC spend

- (1) Childless Adults
- (2) Children
- (3) Parents
- (4) Medicare 65+
- (5) Medicare disability



Indiana Medicaid Pilot (SB 470)

- “In order to participate in the pilot program under this chapter as an eligible direct primary care services provider, an individual shall meet the following:
 - (1) Be licensed as a physician under IC 25-22.5 and practice primary care.
 - (2) **Charge an average monthly fee to a participant of not more than seventy dollars (\$70)** across all eligibility categories described in section 3(a) of this chapter, weighted by the population makeup of the pilot program.
 - (3) **Contract with the office** and not accept any other third party payments for providing health care services to a pilot program participant.
 - (4) Provide **only primary care services, including access to telemedicine and same day or next business day appointments.**”



Indiana Medicaid Pilot (SB 470)

- “A direct primary care services provider must do the following:
- (1) Refer pilot program participants needing nonprimary care services **only to nonprimary care services providers within the network of the** respective office or **managed care organization.**
- (2) For any pharmacy service not covered under the direct primary care services agreement between the direct primary care services provider and the participant, **authorize the use of a drug covered only under the formulary of the respective office or managed care organization.**
- (3) **Comply with any prior authorization requirement** set by the respective office or managed care organization.
- (4) Allow the **office to have access to the participant's medical records** for the sole purpose of aggregate data collection.”



Missouri Medicaid Pilot (HB 233)

- January 2020 to December 2025
- Three counties of various sizes selected
 - 260,000 to 300,000
 - 65,000 to 85,000
 - 17,000 to 19,000
- “The monthly direct primary care enrollment fee **shall not exceed a weighted average of seventy dollars per month** across all eligibility categories. The average shall be weighted by the population makeup of the pilot program.”



Missouri Medicaid Pilot (HB 233)

- The pilot program shall include enrollees from each of the following MO HealthNet eligibility categories:
 - (1) Childless adults;
 - (2) Children under seven years of age;
 - (3) Children seven years of age and older and under nineteen years of age;
 - (4) Parents;
 - (5) Elderly individuals; and
 - (6) Disabled individuals.

Missouri Medicaid Pilot (HB 233)

- “The managed care provider shall designate participating direct primary care providers as the managers for the pilot participant. As manager, **the direct primary care provider shall be authorized to provide the pilot participant with access to nonprimary care services in the managed care provider network.**”

Missouri Medicaid Pilot (HB 233)

“The managed care provider shall not stipulate any conditions upon a direct primary care provider that would alter the direct primary care service delivery model as a requirement for the direct primary care provider to receive the manager designation. The managed care provider shall not restrict or limit the patient’s choice of direct primary care provider and shall not require a direct primary care provider to have certain admitting privileges...”

“The managed care provider shall not be liable for increased costs resulting from the implementation of the pilot program”



Virginia Medicaid Pilot (HB 2456)

- Drafted HB 2456 to direct the “Department of Medical Assistance Services (the Department) shall prepare and submit to the Centers for Medicaid and Medicare Services an application for a waiver, pursuant to **§ 1115** of the Social Security Act, 42 U.S.C. § 1315, to allow the Commonwealth to implement a pilot project... provided that such regular monthly fees shall in no case exceed \$100 per month for each eligible recipient and \$125 per month per dual eligible recipient.” “The Director of the Department of Medical Assistance Services shall report to the Governor and the General Assembly on the status of the waiver application and implementation of the direct primary care pilot program by December 1, 2019.”



Virginia Medicaid Pilot (HB 2456)

- **Ceiling** (\$100/125)
- Section 1115 Waiver
- **Data tracked**
 - ER visits
 - Hospitalizations
 - Surgeries
 - Specialists
 - Advanced Radiology (carving out Dexa/Mammo)

Oklahoma DPC Medicaid Pilot (SB 386)

- The Oklahoma Health Care Authority, upon verification of a SoonerCare [Medicaid] member's execution of a direct primary care membership agreement... shall **reimburse the member** the expense of the monthly direct primary care membership fee **not to exceed \$25** per month for minors or **\$50 per month** for adults. A SoonerCare **member** receiving reimbursement pursuant to this subsection **shall immediately notify** the Authority upon termination of a direct primary care membership agreement. The **authority shall verify** each SoonerCare member's direct primary care membership on a quarterly basis. Such verification may include but not be limited to, review of the member's direct primary care membership invoice.



Oklahoma DPC Medicaid Pilot (SB 386)

- Voucher reimbursement floor (\$25 and \$50)
- Member must notify authority (rather than physician)
- Authority (Medicaid Dept) quarterly invoice verification requirements (rather than physician)
- No price fixing
- No requirement that the physician be enrolled in Medicaid, or even practicing in Oklahoma
- No new data specified – the department is already tracking downstream spending/claims



Tennessee State Employee Pilot (HB 0894 and SB 0696)

- The “department of finance and administration shall **study the feasibility** of adding direct primary care as a covered benefit under one (1) or more of the basic health plans approved by the state insurance committee for eligible state employees pursuant to...” “The study must be actuarially based and include an examination of any legal barriers, estimated cost savings, and benefits to patients/physicians/insurers.”



Nebraska State Employee Pilot (LB 1119)

- A direct primary care health plan means a health plan which includes **primary care services**..., **pharmaceutical care**..., and health care coverage for **medical specialists, hospitals, pharmacy**, and **other medical coverage** that the department deems appropriate.”

Nebraska State Employee Pilot (LB 1119)

- Five year effort – 2019 to 2023
- Providers receive a PMPM **from the state**
- Measuring Patient Engagement
 - HRA
 - Face-to-face visit
 - Preventive Care
 - Chronic Disease Management
- Report clinical & financial performance to the Governor / Legislature on Sept 1 of each year

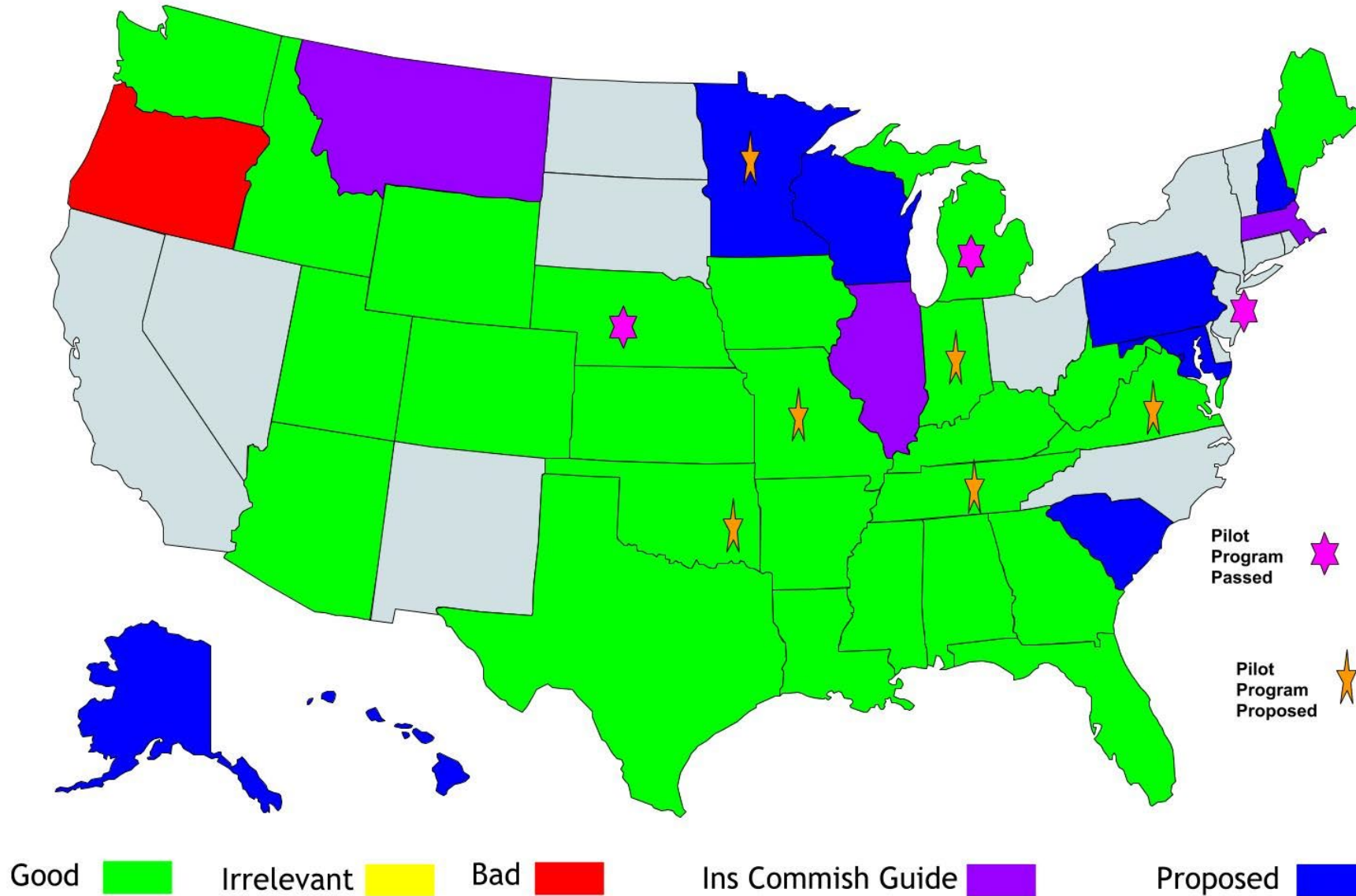


Pilot Summary

- YES!
 - Voucher reimbursement floor
 - Track downstream data
 - Enrollment = Agreement between patient / state
- NO!
 - Price ceilings (not paid by the patient)
 - Redefine DPC as an HMO
 - Use a managed care company
 - Reporting obligations or open records access



2019 DPC Laws + Pilots



Pilot Program Passed 
Pilot Program Proposed 

Good  Irrelevant  Bad  Ins Commish Guide  Proposed 

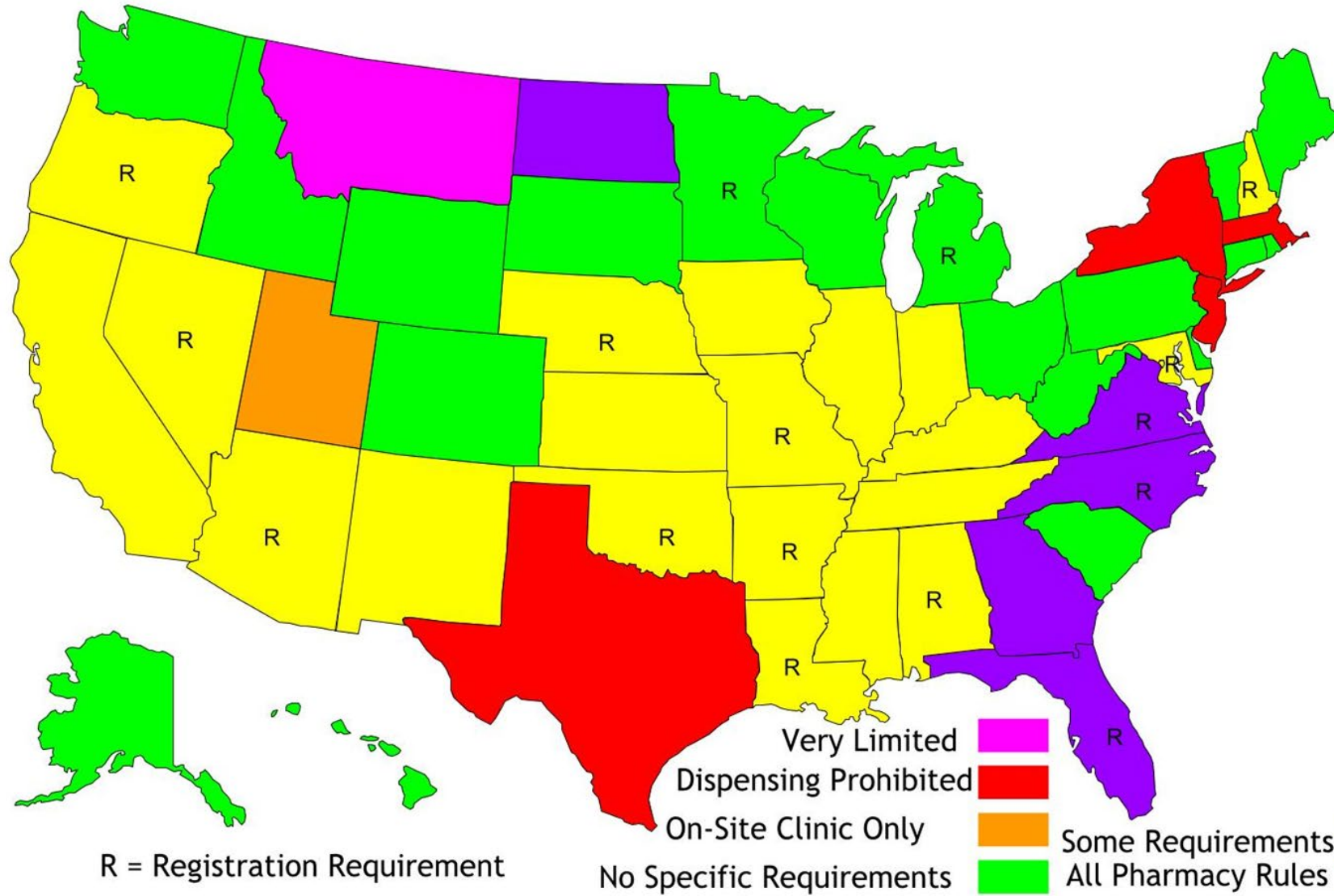


Texas HB 1622 – Dispensing Correction

- Permits non-controlled dispensing
- Some task delegation permitted to employees
- Must notify patient that traditional pharmacies are an option
- Register with BOTH the medical board and pharmacy board
 - No fee contemplated
 - Unclear which board has greater jurisdiction
- **Michael Garrett, MD & Kristin Held, MD v Texas State Board of Pharmacy & Texas Medical Board**
 - State constitutional law argument



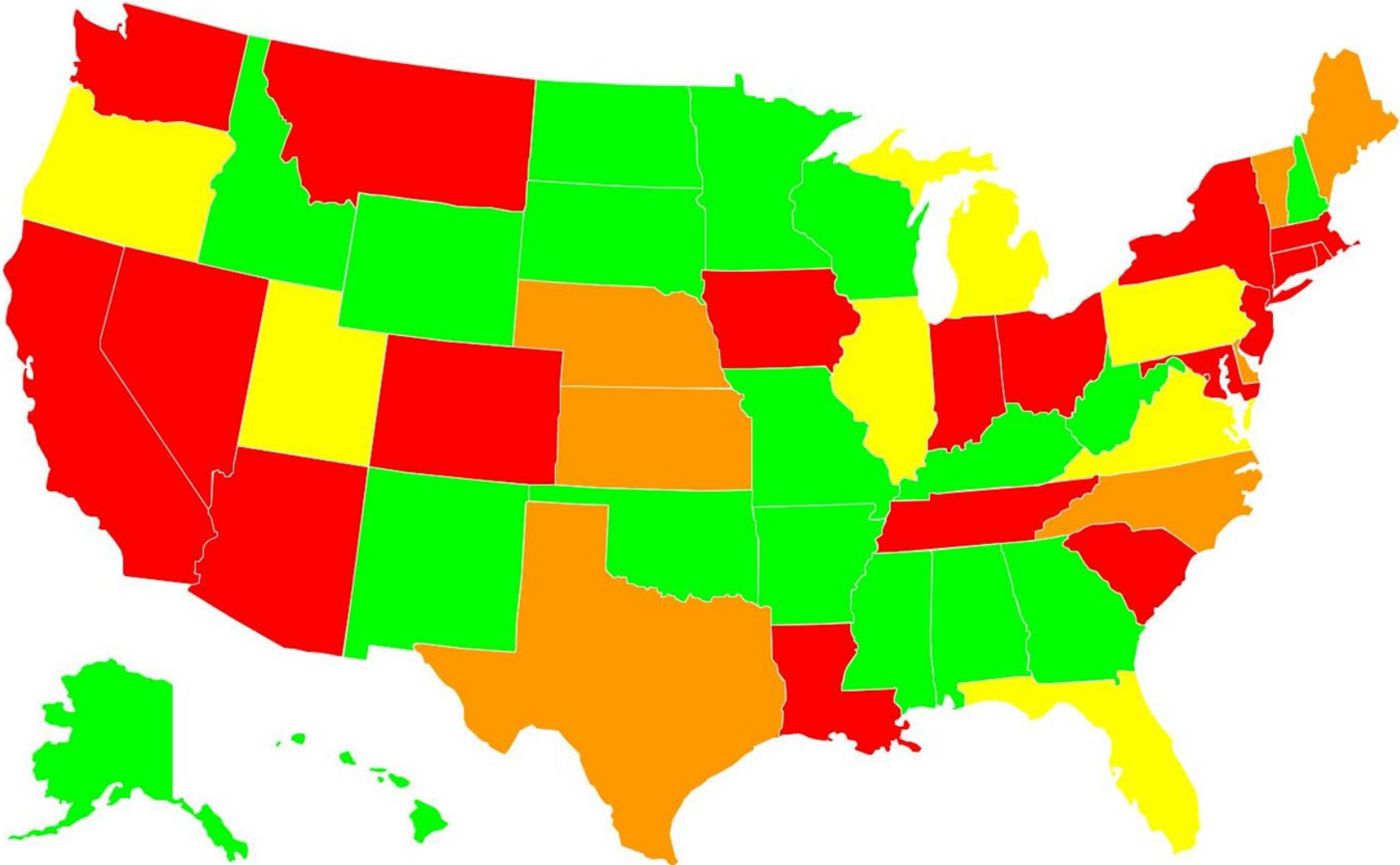
Physician Dispensing Regulations



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Pathology Direct Billing



Direct Billing (Red) Anti-Markup (Yellow) Disclosure (Orange) None (Green)



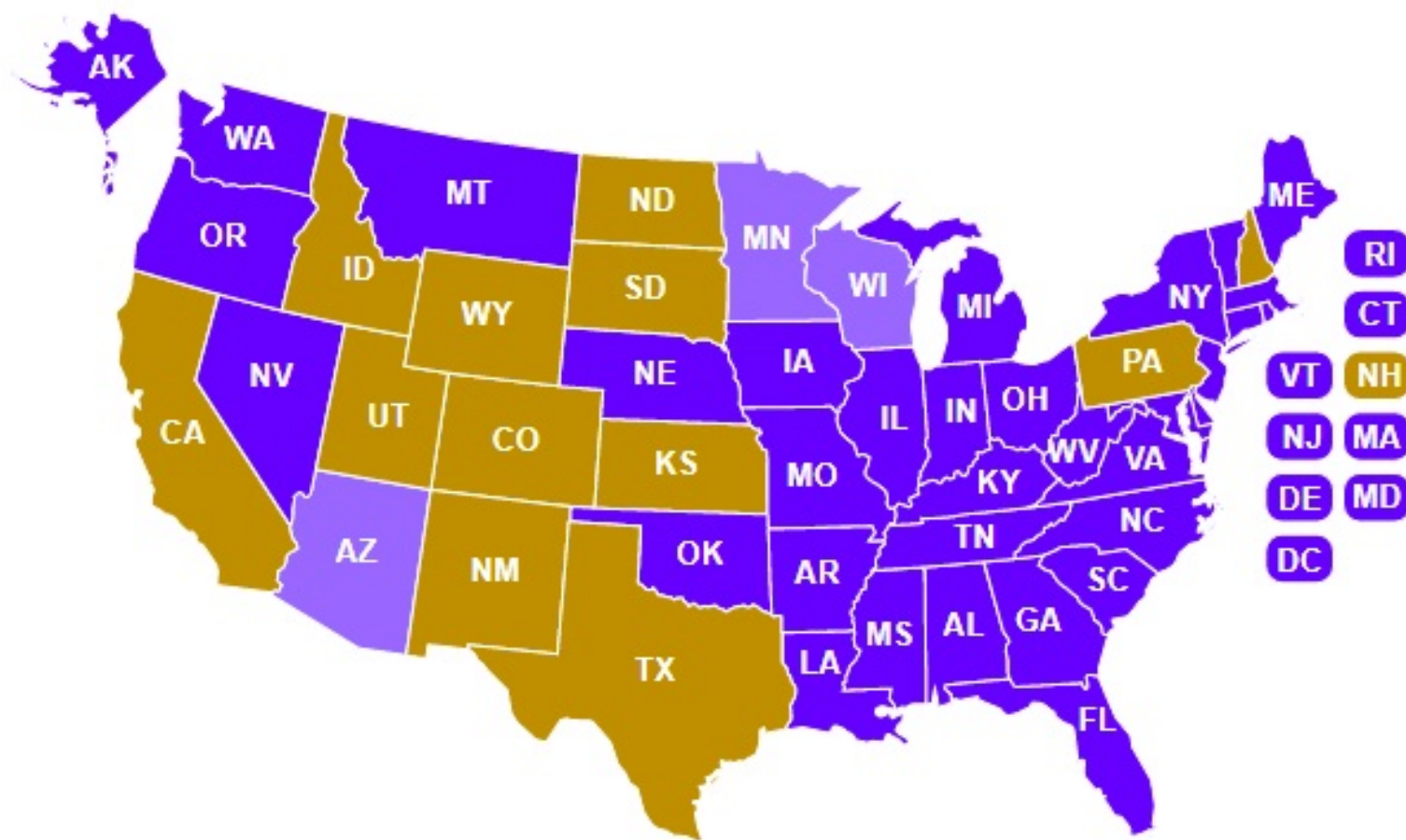
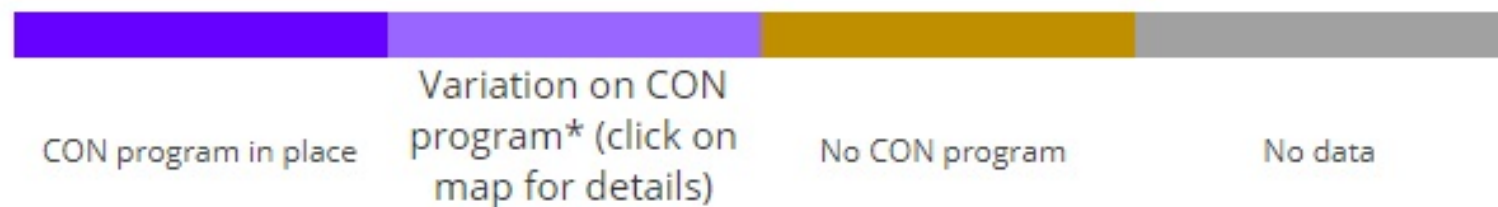
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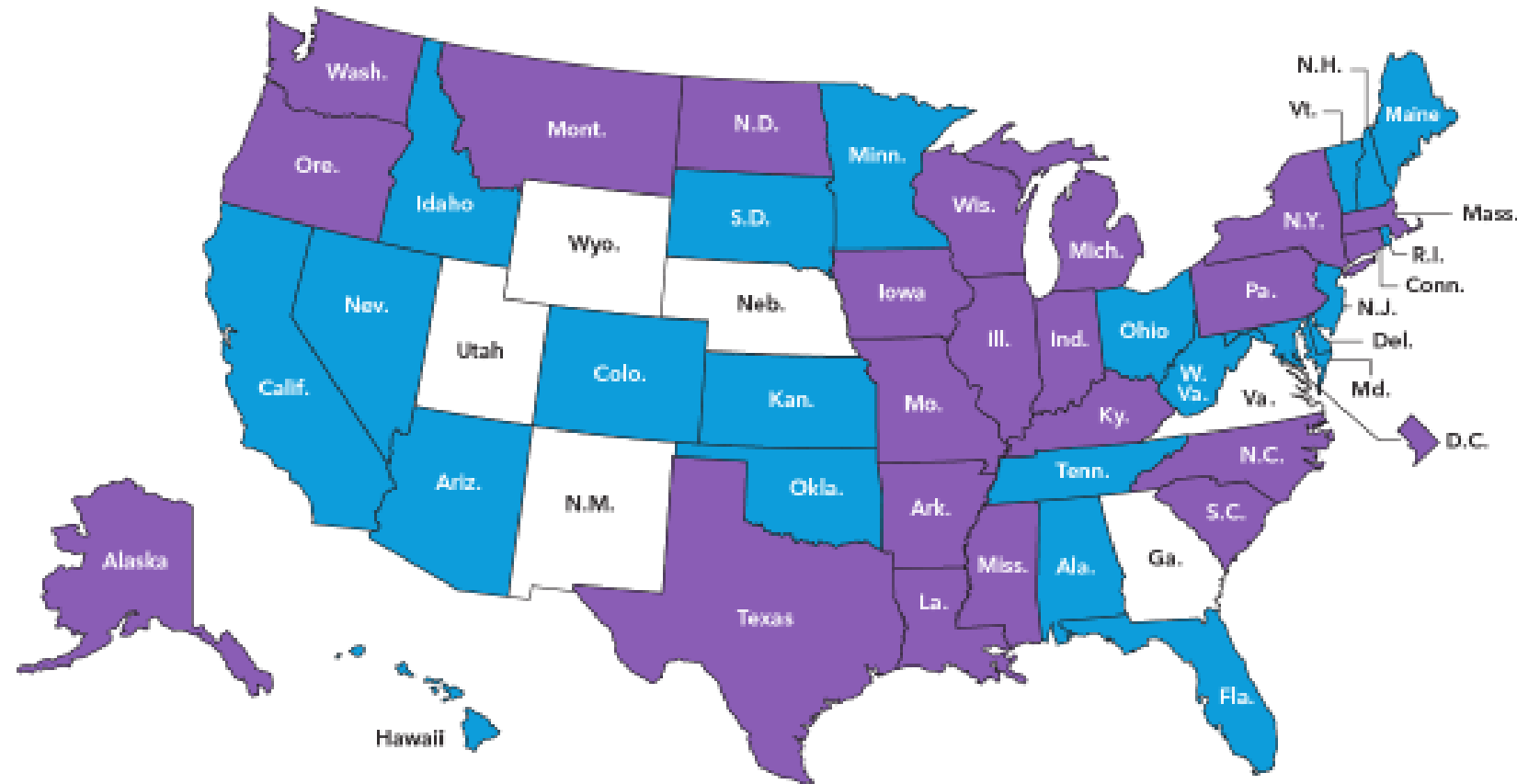
CERTIFICATE OF NEED STATE LAWS



Corporate Practice of Medicine Doctrine

■ State laws restrict corporate practice of medicine, dentistry, optometry, or chiropractic

■ State administrative or court decisions restrict corporate practice of medicine



Source: Bloomberg Law

Bloomberg Law



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“Not Insurance” Guidance Summary:

- Termination – without penalty or fee at any time
- Arrears – payment AFTER the service is delivered (or escrow)
- Scope description
- Fee description (monthly, enrollment, itemization)
- Caps: # of office visits & total panel size
- Promise to NOT bill insurance (no double dipping)
- Disclose this is NOT health insurance (both website & contract)
- Disclose this does NOT meet ACA requirements
- Disclose that you are out of network (especially with HMOs)
- Disclose your status with Medicare and Medicaid
- Do not compensate brokers to sell your DPC memberships
- Do not bundle: 1) labs, 2) meds, 3) radiology, or 4) consultations



Marketing Pitfalls

- Dirty Words
 - Unlimited
 - 24/7
 - Higher Quality
 - Covered
 - Utilization
- Marketer Fee Arrangements
 - Can implicate “Unlawful Fee Splitting”
 - Can implicate “Corporate Practice of Medicine”
- Ask about actual **DPC** Experience!
 - DPC ≠ Concierge
 - Use Free Resources first



What about Medicaid?

- Credentialing changed with the ACA
 - Ideally your state has “ordering and referring” (OPRA) only status
 - Watch out in KY and CO
 - State dependent inquiry, you may either
 - Fully enroll and still privately contract
 - Need to use OPRA status
 - Need to remain not enrolled (risking HMO issues)

Federal Health Savings Accounts

- Primary Care Enhancement Act
 - Address 223(c) “gap plan” problem
 - Address 213(d) “medical expense” problem
 - Move the monetary cap from the definition previously in 223(c) to the deduction in 213(d)
 - Ceiling becomes a floor
 - \$150 individual / \$300 family, indexed for inflation
 - Pursuing fast track options as a stand alone, bipartisan bill



Federal Health Savings Accounts

- Primary Care Enhancement Act (no # yet)
- Health Savings Account Act (HR 457)
 - 213(d) & 223(c)
- Health Savings Account Expansion Act of 2019 (HR 603)
 - 213(d) only, poorly drafted
- Health Savings Account Act of 2019 (SB 12)
 - 223(c) only
- Physician Pro Bono Care Act of 2019 (HR 856)
 - Tax deduction for DPC charity care and malpractice immunity for charity care
 - Same language also found in “Fair Care Act of 2019 (HR 1332)”



2019 Potpourri

- Med Mal Noneconomic Damages Caps
 - OK's invalidated – wide variance (see next slide)
- FTC Goes after Surescripts
 - Surescripts deployed exclusivity clauses, bundled discounts, and non-compete clauses to monopolize two "e-prescribing" markets: (i) routing of e-prescriptions to pharmacies, and (ii) determining patients' eligibility and benefits for prescription coverage.
- HIPAA Max Penalty Reduction
 - \$25,000 for no knowledge, \$100,000 for reasonable cause, \$250,000 for corrected willful neglect, and \$1,500,000 for uncorrected willful neglect.



Medical Malpractice Caps in the United States

Non-Economic Award Limits by State

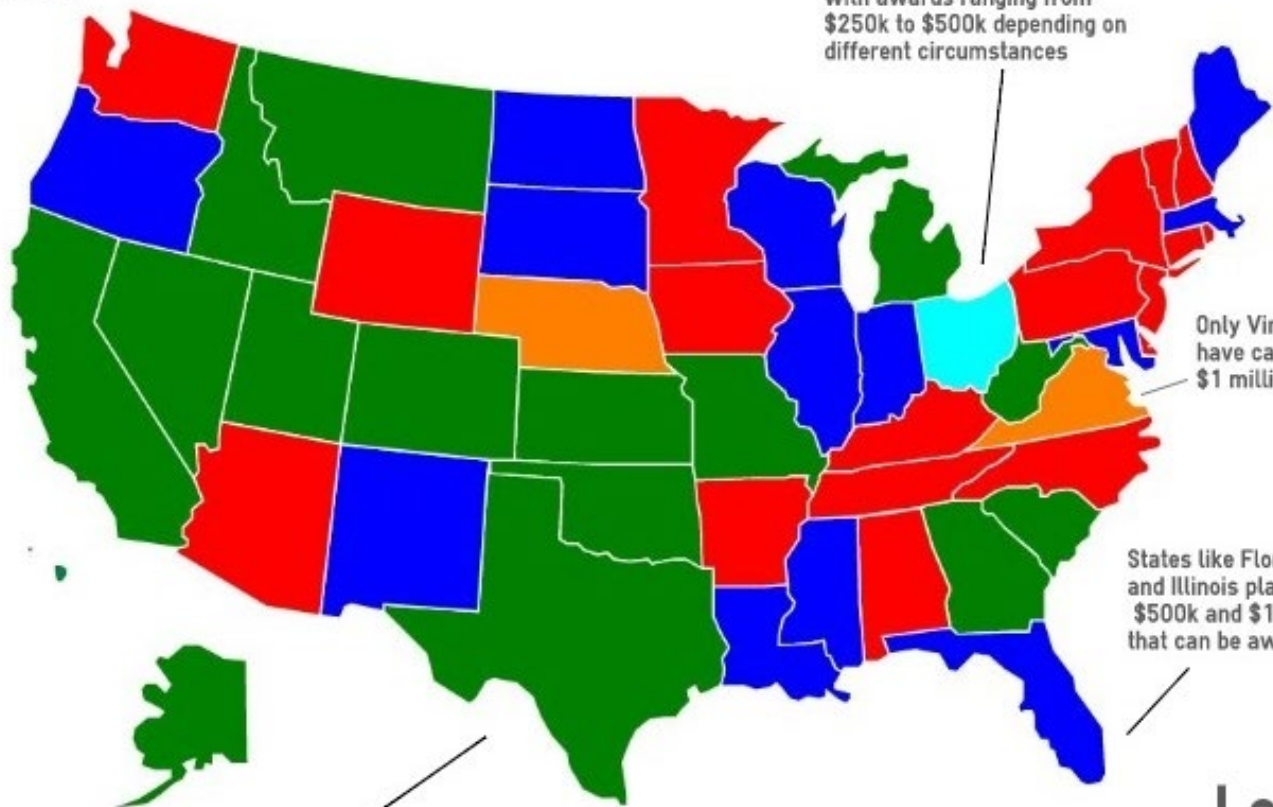
States like Washington, Arizona, North Carolina, and New York place no caps on the amount of non-economic damages you can be awarded by a court.

Ohio has a sliding scale, with awards ranging from \$250k to \$500k depending on different circumstances

Only Virginia and Nebraska have caps that exceed \$1 million.

States like Florida, Maine, Oregon, and Illinois place limits of between \$500k and \$1 million in damages that can be awarded.

States like Texas, California, Colorado, and Georgia have a limit of between \$250k and \$400k on damages that can be awarded.



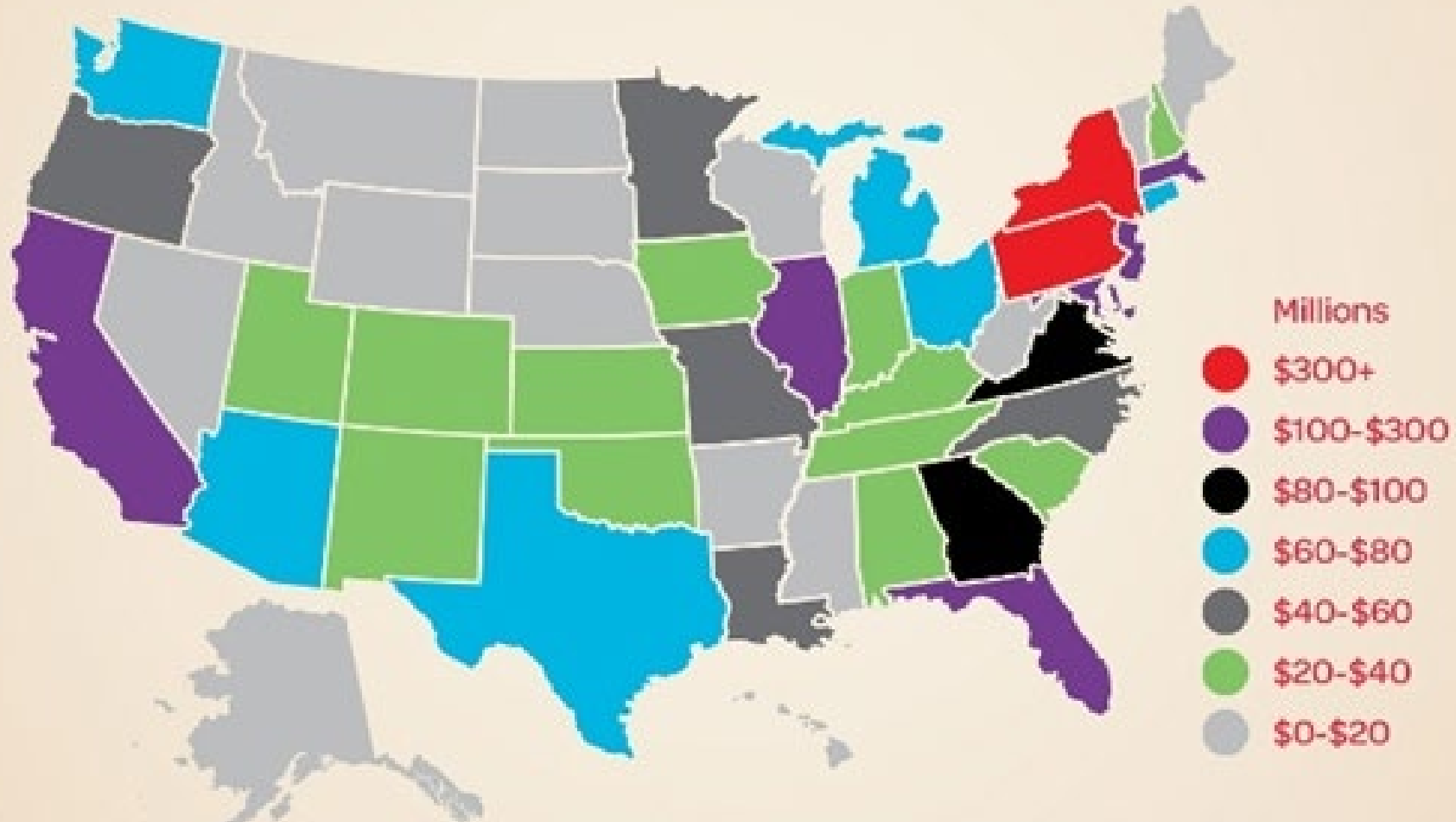
Legend

- RED: No Cap
- GREEN: \$250-\$400k
- BLUE: \$500k - \$1 mil
- ORANGE: \$1 million +

Infographic courtesy of Cuthbert Law Offices
Virginia Medical Malpractice Attorneys.
<http://www.cuthbertlaw.com>



2013 state medical malpractice payouts



Source: Jeremy Gower/Diederich Healthcare



Executive Order Glossary

- ERISA = Employee Retirement Income Security Act
- AHP = Association Health Plans
- MEWA = Multiple Employer Welfare Arrangement
- MEP = Multiple Employer Plan (aka MEWA)
- MET = Multiple Employer Trust (aka MEWA)
- HRA = Health Reimbursement Arrangement
- STLDI = Short Term Limited Duration Insurance
- DPC = Direct Primary Care
- DOL = Department of Labor
- HHS = Department of Health and Human Services



Executive Order Timeline

- 10/12/17 Trump Executive Order 13813
 - Secretaries (Treasury, Labor, HHS) to promote
 - HRAs (health reimbursement arrangements)
 - STDLIs (short-term limited duration insurance plans)
 - AHPs (association health plans)
- 06/19/18 DOL Released AHP Final Rule
- 08/03/18 Secs Released STLDI Final Rule
 - Litigation Pending (Assoc for Comm Aff Plans vs US)
- 10/22/18 Secs Released Proposed HRA
- 03/28/19 AHP Expansion Litigation Result Blocked
- 06/20/19 HRA Final Rule Released - Dept Treasury, Labor, HHS
- 06/24/19 Trump Price Transparency Executive Order
- 07/09/19 Texas v Azar (5th Cir ACA Unconstitutional) Oral Arguments (Standing)



AHP Litigation: State of NY v US DOL

- Eleven State AGs + DC have filed suit against DOL
- The new AHP regulations allow smaller employers and sole proprietors to shift into the "large group" insurance market and to evade the ACA protections for "small group" health plans. As a result, participants in AHPs will **not necessarily have access to all of the essential health benefits** (required only in "small group" plans) and will instead be provided stripped-down plans offering limited benefits.

State of NY v US DOL

- The Court concludes that “DOL has **failed to reasonably interpret the statute**. The Final Rule’s bona fide association standard **fails to establish meaningful limits on the types of associations that may qualify** to sponsor an ERISA plan, thereby violating Congress’s intent that only an employer association acting “in the interest of” its members falls within ERISA’s scope.”
- The Final Rule’s **working owner provision similarly exceeds ERISA’s scope** because it seeks to extend ERISA’s coverage to plans arising outside of any employment relationship.



State of New York v. U.S. Department of Labor, 18-cv-1747, U.S. District Court, District of Columbia

- State of NY Case vs DOL published on 03/28/19 (DC Federal Judge)
- Court objected to the new concept that a sole owner was both an employer and an employee (as being inconsistent with the original language in ERISA)
- This vacated the working owner's one man shop option. You now have to have an owner and at least two employees.
- The geography only standard has been struck down



What is a Health Reimbursement Account?

- A group health plan
- 1) funded SOLELY by employer contributions
- 2) that reimburses an employee SOLELY for section 213(d) medical expenses
- Tax favored
- Current law -
 - 1) No HRA integration with individual coverage
 - 2) Non-integrated plan = \$100/day per employee



HRA Expansion Implications

- Individual Coverage HRA
 - Reimbursing individual premiums now meets ACA employer mandate
- Excepted Benefit HRA
 - In addition to a Traditional Group Health Plan
 - Contribution limited to \$1,800
 - May use dollars to purchase STLDI plans (hopefully DPC focused)
- No Specific Changes to DPC tax debates
- HRAs define medical expenses using IRC 213(d)



Why do Employers like HRAs?

- Tax Avoidance
 - Excluded from employee income
 - No employment taxes apply
- Flexible Financing
 - No contribution limits
 - No Advanced Funding is needed
 - If funded, may follow employee to a new job IF the employer wants to design it this way

What about HRAs for < 50 FTE employers?

- QSEHRAs (21st Century CURES Act)
 - Already permitted to offer stand alone HRAs without facing the \$100 per day fine
 - Quiz question – why are these HRAs not already widely paired with DPC offerings?
- No changes here in proposed HRA changes
- Medicare? Tricare? Retiree-Only?
 - All three may also carry HRA accounts

Short-Term Limited Duration Insurance (STLDI) Plans

- Plan duration extended from 3 to 12 months
- Coverage may be renewed up to 36 months
 - After each 36 month period repeat underwriting is needed
- Short-term plans do not have to comply with the Affordable Care Act's (ACA's) market reforms (not MEC coverage, but in 2019 fine = \$0. Short-term insurers can:
 - charge higher premiums based on health status,
 - exclude coverage for preexisting conditions,
 - impose annual or lifetime limits,
 - opt not to cover entire categories of benefits (such as substance use disorder treatment or prescription drugs),
 - rescind coverage, and
 - require higher out-of-pocket cost-sharing than under the ACA.



STLDI Precautions

- Common Coverage Limitations (2018 KFF Study):
- 43% of the plans studied do not cover mental health services;
- 62% do not cover services for substance abuse treatment (including both alcohol and other drugs),
- 71% do not cover outpatient prescription drugs, and
- None of the plans studied cover maternity care.
- No cost sharing limits (ACA plans limited to \$7,350)
- No medical loss ratio rules
 - ACA plans must pay out 80% of premium revenue
 - STLDI plans typically pay out between 50-67% of premium



STLDI Plan Risk & Commission Variance

- Annual or Lifetime payment limits
- Pre-existing conditions excluded
- Prescription drugs can be excluded
- Specific conditions (beyond pre-existing) may be excluded
- Can be purchased anytime during the year
- Brokers get a higher commission – often 20% of the cost of the plan or more
- ACA subsidies do not apply to these plans
- They spent around 67% of premium on care
- Often priced around 20% of the cost of a bronze plan



STLDI Litigation (with those opposed listed)

- ASSOCIATION FOR COMMUNITY AFFILIATED PLANS et al v. UNITED STATES DEPARTMENT OF TREASURY et al (DC District Court) Civil Action No. 18-2133
- American Medical Association
- American College of Physicians
- American Osteopathic Association
- American Academy of Family Physicians
- American Academy of Pediatrics
- American College of Obstetricians & Gynecologists
- HIV Medicine Association, and
- Medical Society for the District of Columbia



Quick Review

- Does COBRA apply if the employer pays the monthly fee?
 - Yes – but you just have to give the patient the option to pay and stay in the practice
- Can a patient pay for DPC using their HSA, HRA, or FSA?
 - No – these all go back to section 213(d)
 - Short term solution – use cash pay fee for service
- How long can I have an STLDI plan?
 - Three years or more – likely need to repeat underwriting
- Can AHPs and MEWAs be formed across state lines?
 - Yes – but state specific insurance laws still apply, and some states want to outlaw these entities



Summary of Poorer Options

- AHPs
 - Too many requirements
 - Invalidated current “final rule” with litigation
- MEWAs
 - Inconsistent requirements
 - ERISA or not? State regulatory variance?
 - Un-litigated (thus unpredictable)& Untrustworthy
- STLDIs
 - Untrustworthy
 - Unlikely to survive current litigation

The Better Option: HRAs

- Expansion of QSEHRA is more likely to survive judicial scrutiny
 - Though rules not yet “finalized” or litigated
- Creative Funding Options
- Consistently applied across different states
- Naturally paired with DPC
- Natural Starting place
 - First advise employer to have an HRA
 - If favorable AHP or MEWA, fund it with an HRA



Price Transparency Executive Order

"Within 180 days of the date of [this order](#), the Secretary of the Treasury, **to the extent consistent with law**, shall propose regulations to treat expenses related to certain types of arrangements, **potentially including direct primary care arrangements and healthcare sharing ministries, as eligible medical expenses under section 213(d)** of title 26, United States Code."



Summary: WE ARE WINNING!

- State laws
 - 26 states with “not insurance” laws + NH + MN
 - 5 States with good guidance
 - State Employee & Medicaid Pilot Discussions
- Federal Discussions
 - Executive order – Waiting on Treasury to respond
 - Primary Care Enhancement Act
 - Chronic Care Management Codes 99490, 99491
- Growth – DPC Mapper Contains 1,091 Practices
 - Missing only Dakotas



Advocate!

DPC Action & Docs4PatientCare Foundation

DPC Alliance

DPC Coalition

DPC Nation

American Academy of Family Physicians

Association of American Physicians & Surgeons

American College of Osteopathic Family Physicians

Family Medicine Education Consortium

Free Market Medical Association



Upcoming Events

- Sept 16-17, 2019 DPC Coalition Meeting – Washington, DC
- Nov 14-16, 2019 DPC Nuts & Bolts to 4.0 – Orlando, FL



Questions?

Submit your questions to:

<https://aafp4.cnf.io>

Don't forget to evaluate
this session!

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