



DIRECT PRIMARY CARE

RECOMMENDATION

American Academy of Family Physicians (AAFP) [policy](#) supports physician and patient choice to provide and receive healthcare in any ethical healthcare delivery system model. This includes the Direct Primary Care (DPC) model. DPC is consistent with AAFP's advocacy for a blended payment model to pay family physicians and patient centered practice design.

An Alternative to Fee-for-Service

DPC provides family physicians and patients with an alternative to fee-for-service insurance. DPC typically works by charging patients a fixed periodic fee that offsets primary care service costs. DPC is designed to remove the financial barriers patients encounter in accessing routine primary care; including preventive, wellness, and chronic care services. DPC practices often suggest that patients acquire a high-deductible, wraparound insurance policy to cover subspecialty care, emergency room visits, and hospitalizations.

Federal Legislation Supporting DPC

In January 2017, U.S. Representatives Erik Paulsen and Earl Blumenauer introduced the *Primary Care Enhancement Act of 2017* ([HR 365](#)). In June 2017, U.S. Senators Bill Cassidy and Maria Cantwell introduced companion legislation ([S 1358](#)). The bill proposes to allow HSA enrollees to contract for services from a DPC practice and pay for it with their Health Savings Accounts. The AAFP submitted a [letter](#) in support of HR 365 and released a [statement](#) supporting the bill.

State Legislation Expanding Access and Alternatives for DPC

Laws in many states lack clear definitions of DPC terms, creating a varying patchwork of state-level regulation. This patchwork creates confusion for physicians and regulators on whether and how to conform DPC practices. DPC legislation commonly seeks to clarify that a DPC arrangement is not an insurance product and not subject to state insurance regulations. DPC creates an agreement for a defined set of services over time and thus, some state insurance regulators have interpreted DPC as a capitated risk arrangement. In traditional health insurance arrangements, one party assumes certain risks from another for compensation (the premium) and is obligated to pay the other party for covered health care services. A DPC agreement is not an insurance agreement as the principal benefit of DPC is limited to primary care. Even though DPC agreements cover the risk of assorted primary care complications, they usually contain an express provision for additional charges (based on actual expense incurred) and refunds—both of which are absent in insurance agreements.

As of October 2017, 23 states have enacted legislation supporting DPC and/or defining it as a medical service outside the scope of insurance regulation.^{i, ii} In the 2017 legislative session eight states enacted DPC legislation.

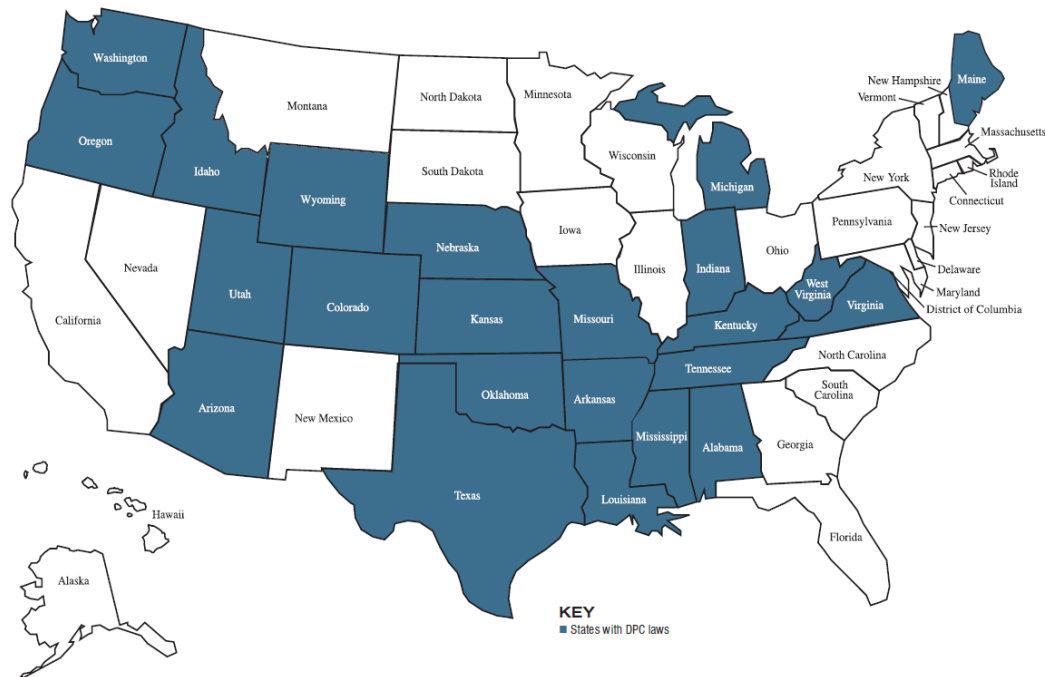
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2017 States with DPC Legislation



Many DPC proponents believe the Wyoming [statute](#) serves as a model to codify DPC due to its simplicity. Wyoming's law defines a DPC arrangement with minimal requirements and exempts DPC practices from insurance regulations. Proponents also point to the Oregon [statute](#) as state legislation to avoid. In Oregon, DPC practices must register with the state insurance department, which has expanded authority to regulate DPC practices. The Oregon statute does not exempt DPC practices from insurance regulations. West Virginia had similar legislation and imposed advertising restrictions, additional taxation, limits on DPC services, and an approval process for setting the periodic fee but the restrictive statute was modified during the 2017 legislative session.

New Jersey State Pilot: DPC Model of Health Care Finance and Delivery

In 2015, New Jersey began a voluntary pilot program "Direct Primary Care Medical Homes" for public employees, early retirees, and their families in non-HMO plans. The benefits available in the program provide participants with 24/7 access to a primary care physician while eliminating deductibles, copays, and coinsurance for primary care services. The pilot was developed by the joint labor-management design committees of the New Jersey School Employees Health Benefits Plan and the State Health Benefits Plan, with support from public employee unions and bipartisan elected state leaders. The pilot started on April 1, 2016, and after three years, the pilot will be evaluated by an independent group which will produce recommendations to expand DPC.ⁱⁱⁱ The New Jersey pilot will gather data on quality, cost, utilization, and outcomes to illustrate the impact of the DPC model on health care finance and delivery.

ⁱ Direct Primary Care Coalition. Direct Primary Care: An Alternative Payment Model. <http://www.dpcsummit.org>. Published January 28, 2016. Accessed October 14, 2016.

ⁱⁱ States with DPC Laws. DPC Frontier website. www.dpcfrontier.com/states. Accessed October 14, 2016.

ⁱⁱⁱ The Direct Primary Care Journal. New Jersey Pilot Project – Direct Primary Care Medical Homes. www.directprimarycarejournal.com/2015/10/11/new-jersey-pilot-project-direct-primary-care-medical-homes-voluntary. Published October 11, 2015. Accessed October 12, 2016.