Direct patient provider primary care practices

Annual report to the Legislature

Dec. 1, 2009

Washington State
Office of the
Insurance Commissioner

Mike Kreidler - Insurance Commissioner

www.insurance.wa.gov

Table of contents

Executive summary

In 2007, the Washington state Legislature enacted Engrossed Substitute House Bill 5958 - creating innovative primary health care delivery.

The legislation requires the insurance commissioner to report annually to the Legislature on direct health care practices, including but not limited to "participation trends, complaints received, voluntary data reported by the direct practices and any necessary modifications to this chapter." [1]

In a direct health care practice, a health care provider charges a patient a set fee for all primary care services provided in their office, regardless of the number of visits. Patients pay a monthly fee. No insurance plan is involved, although patients may have insurance coverage for more costly medical services. Direct practices are sometimes called retainer or concierge practices.

This initial report on direct patient-provider primary care practices analyzes three years of annual statements (2007, 2008, and 2009).

Participation trends:

- As of 2009, there were approximately 8,000 patients—less than one tenth of one percent of the total population—enrolled in a direct practice.
- Overall patient participation has nearly doubled from 4,708 in 2007 to 8,093 in 2009.
- The majority of enrollment growth was concentrated in two practices.
- The number of practices has remained stable with only one new entrant in August 2009.
- Three practices have more than one office.
- The number of providers has increased from 21.5 to 29.
- Greatest growth is in the $85-$135 monthly fee practices.
- Practices are located in only three counties: King (6), Snohomish (2) and Thurston (2) counties.

Complaints received: The insurance commissioner's Insurance Consumer Hotline has received no complaints regarding any of the 10 direct patient practices.

Voluntary data reported by direct practices: In anticipation of the 2012 study required by the new law, the insurance commissioner asked the practices to voluntarily submit additional data (see appendix A). While all of the registered

1 - RCW 48.150.100 (3)

practices responded to the mandatory questions, only half of the direct practices chose to report voluntary information. Some reported that they did not collect this information. Others did not respond to any of the questions.

Necessary modification to chapter: The insurance commissioner suggests four options for the Legislature to consider:

1. Strike the study requirement found in RCW 48.150.120.

2. Increase annual statement reporting requirements.

3. Wait and see.

4. Require direct practices to collect and report specific data to the Office of the Insurance Commissioner and provide compliance authority for practices that fail to comply with the reporting requirements.

Background

In 2007, the Washington state Legislature enacted a law to encourage innovative arrangements between patients and providers and to promote access to medical care for all citizens. Engrossed Substitute House Bill 5958, known as the direct patient-provider primary health care bill, identified direct practices as "a means of encouraging innovative arrangements between patients and providers and to help provide all citizens with a medical home."[2]

Prior to the passage of the 2007 law, the insurance commissioner determined that health care providers engaged in direct patient practices or retainer health care were subject to current state law governing health care service contractors.[3] However, due to the limited nature of the business model, the insurance commissioner recognized that imposing the full scope of regulation under this law was neither practical nor warranted.

The 2007 law permits direct practices to operate without having to meet the same responsibilities of insurers, health carriers, health care service contractors, or health maintenance organizations such as financial solvency, capital maintenance, market conduct, reserving, and filing requirements.

Additional public policy goals expressed in the intent section of the law:

- Create an innovative and affordable option for patients.
- Improve access to primary medical services.
- Reduce emergency room use for primary care purposes.[4]

The law specifically states that direct practices operated under the safe harbor created by Ch. 48.150 RCW are not insurers, health carriers, health care service contractors or health maintenance organizations as defined in Title 48 RCW.[5] As a result, the insurance commissioner has extremely limited regulatory authority over these practices. They are not subject to financial solvency or market conduct oversight and do not have to comply with the patient bill of rights, for example.

The only explicit regulatory role given to the insurance commissioner is the collection and reporting of certain information. Specifically, the insurance commissioner is required to file annual reports to the Legislature on the information submitted in annual statements and conduct a study of direct practices by Dec. 1, 2012.

2 - RCW 48.150.005

3 - RCW 48.44.010(3)

4 - RCW 48.150.005

5 - RCW 48.150.060

Annual reports

Each October 1, direct practices must submit annual statements to the Office of the Insurance Commissioner specifying the:

- Number of providers in each practice.
- Total number of patients being served.
- Average direct fee being charged and providers' names.
- Business address for each direct practice.

The Legislature did not give the insurance commissioner rule-making authority, but permitted him to instruct the practices on how to submit the statement, in what form and with what content. The first annual statements were received in October 2007.

The insurance commissioner is required to submit an annual report to the Legislature on direct practices including but not limited to:

- Participation trends.
- Complaints received.
- Voluntary data reported by the direct practices.
- Any necessary modifications to the chapter.

2012 study

In addition to the annual reports, the insurance commissioner is required to submit a study to the Legislature by Dec. 1, 2012 providing an analysis of whether direct patient practices:

- Improve or reduce access to primary health care services by recipients of Medicare and Medicaid, individuals with private health insurance, and the uninsured.
- Provide adequate protection for consumers from practice bankruptcy, practice decisions to drop participants, or health conditions not covered by direct practices.
- Increase premium costs for individuals who have coverage through traditional health insurance.
- Have an impact on a health carrier's ability to meet network adequacy standards set by the insurance commissioner or state health purchasing agencies.

- Cover a population that is different from individuals covered through traditional health insurance.[6]

Direct practices in Washington: A definition

Direct patient-provider primary care practices (direct practices) also are sometimes called retainer medicine or concierge medicine. Washington's legislative definition states that a direct practice:

- Charges patients monthly fees for access to service.
- Offers only primary care services.
- Enters into a written agreement with patients describing the services and fees.
- Does not bill insurance to pay for any of the patient's primary care services.

A direct practice is a model of care where physicians charge a pre-determined fixed monthly fee to patients for all primary care services provided in their offices, regardless of the number of visits. Primary care services are defined as routine health care services, including screening, assessment, diagnosis, and treatment for the purpose of promotion of health, and detection and management of disease or injury.[7]

These health care arrangements cannot market or sell to employer groups.

In 2009, the Legislature made minor modifications to the original legislation. The modifications allow direct practices to accept a direct fee paid by an employer on behalf of an employee who is a direct patient, but continue to prohibit employers from entering into coverage agreements with direct practices.

Physicians providing direct practice care describe their practices as caring for fewer patients than conventional practices, and allowing more time for patients during office visits to ask questions and doctors to explain medical care. Some direct practices offer additional services such as same-day appointments or extended business hours, home visits and physicians available for emergency calls on a 24-hour basis.

6 - RCW 48.150.120

7 - RCW 48.150.010 (7)

It also is important to understand what direct practices are not:

Comprehensive health care coverage – Direct practices are not "comprehensive coverage." Services covered under direct practice agreements cannot include services or supplies such as prescription drugs, hospitalization, major surgery, dialysis, high-level radiology, rehabilitation services, procedures requiring general anesthesia, or similar advanced procedures, services, or supplies.[8] In fact, direct practice agreements must contain the following disclaimer statement: "This agreement does not provide comprehensive health insurance coverage. It provides only the health care services specifically described."[9]

Access fee model – Some practices in Washington offer a variety of amenities in return for an "access fee." Most of these providers offer patients "improved access" through some type of same-day office visits, e-mail or telephone consultation, 24/7 contact by pager or cell phone, lifestyle planning, special tracking and follow-up, etc. These amenities are in addition to an underlying health care policy and can apply only to non-covered services.

Discount health plan – Discount health plans are membership organizations that charge a fee for a list of providers who offer discounted health care services or products.

Cash only practices or service – Cash only practices do not charge a monthly fee. These practices charge patients for non-emergency services on an as-needed basis. Many insurance plans reimburse for these as out-of-network providers.

2009 annual report

What the data shows

Direct practices began filing annual statements in October 2007. In August 2009, the insurance commissioner sent a data call survey to all direct practices reporting annually since enactment of the bill. The survey was designed to collect not only the mandatory information required in the annual statements, but also voluntary data necessary to conduct the analysis required for the 2012 study. (see Appendix B)

8 - RCW 48.150.010 (d)

9 - RCW 48.150.110(1).

Number of direct practices in Washington state

Listed below are the 10 direct practices filing annual statements with the insurance commissioner.

Required Data Reported by Annual Statement						
	Practice Name Location	Provider type	# of patients 2007	# of patients 2008	# of patients 2009	Average monthly fee
1	Anchor Medical Clinic Mukilteo	1 MD	192	207	208	$73
2	Bellevue Medical Partners Bellevue	2 MD	260	350	292	$135
3	CARE Medical Associates Bellevue	1 DO	266	252	252	$108
4	Direct CareMed Olympia	1 MD/2 ARNP	25	19	35	$49
5	Guardian Family Care, Mill Creek	2 MD	286	300	225	$100
6	King County P.H. D. #4/ Snoqualmie Valley Clinics • Fall City • North Bend	 1 DNP 1 PA-C			 5 19	 $30 $30
7	MD2 • Bellevue • Seattle	 2 MD 2 MD	 224 211	 223 213	 224 205	 $859 $844
8	Qliance Medical Group • Seattle • Kent	 7 MD/1ARNP 1 MD/1ARNP	131	1624	 2,292	$85
9	Seattle Medical Associates Seattle, WA	3 MD	2732	2686	3945	$75
10	Vantage Physicians Olympia, WA	1 MD	381	393	392	$73
TOTALS		29	4708	6258	8093	

Table 1. Summary of annual reports 2007-2009

The practices deliver care through 23 primary care physicians and six physician assistants. In 2009, 301 reported enrollees were children. Practices did not report the number of enrolled children until 2009.

We know that one practice (operated by Swedish in Ballard) is not included, as they have not yet filed their first annual statement.

Where direct practices are located and who participates

Direct practices remain concentrated in urban areas along the I-5 corridor with 90 percent of practices and 95 percent of patients located in Seattle, Bellevue or immediate surrounding areas.

Those practices charging less than $100 per month are the fastest growing segment.

Direct practices have increased by one new practice[10] since 2007. One practice opened an additional office.[11]

The majority of direct practices show that the number of patients receiving care has remained fairly consistent or that their practice is at capacity and not accepting new patients. Two practices - Qliance and Seattle Medical Associates - account for the doubling of overall enrollment.

With one exception,[12] the practices are exclusively direct patient-provider primary care practices.

Most patients remain with the practice for at least a year, although some report average enrollment of three-month's duration.

One physician relocated their practice from Seattle Medical Associates to Qliance in 2008, which accounts for much of the 2008 census shift for the $85-135 bracket that year.

Affordability of direct practices

A key assumption underlying the legislation was that direct practices could provide affordable access to primary services. This, in turn, would reduce pressure on the health care safety net or problems caused by a shortage of primary care physicians.

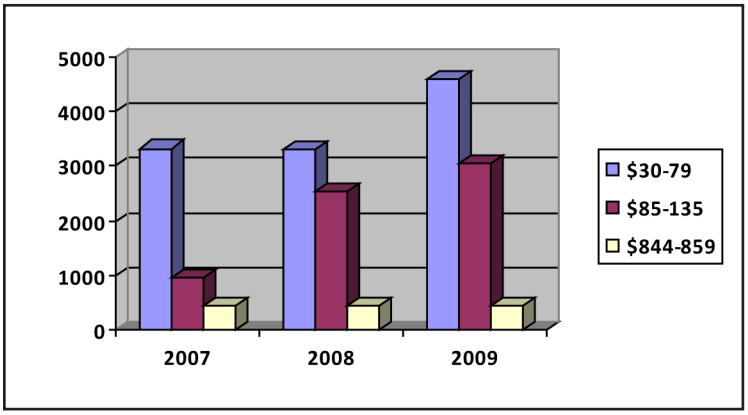


Table 2. Change in practice census over time, based on monthly fee.

10 - King County Public Hospital District#4/Snoqualmie Valley Clinics, established in August of 2009

11 - Qliance, Kent August 2009

12 - Direct CareMed, Olympia

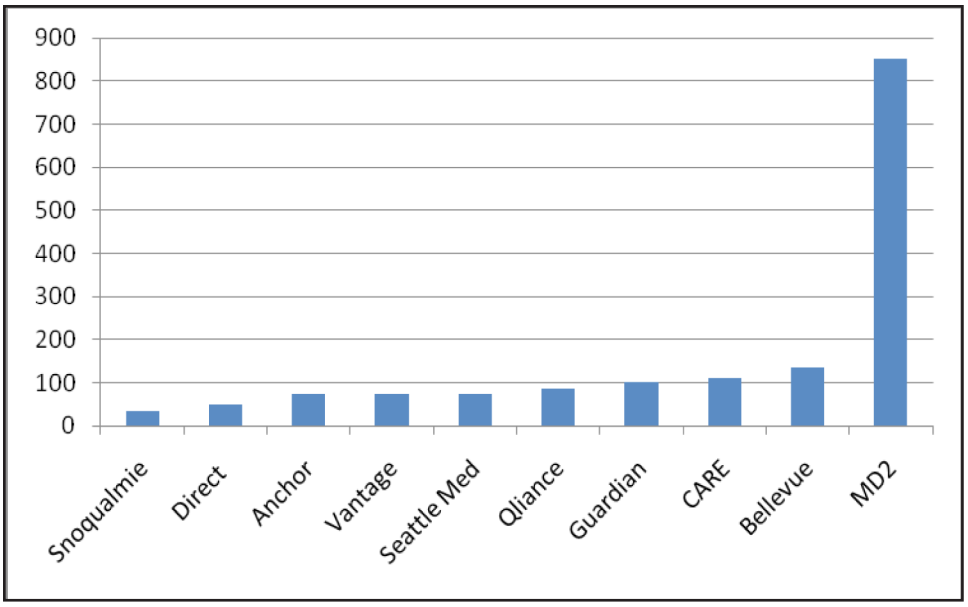


Table 3. Fee schedule by practice

Ninety percent of direct practices charge a fee of $135 or less (representing 95 percent of enrollees). Practices with lower monthly fees experienced the greatest growth during the reporting period.

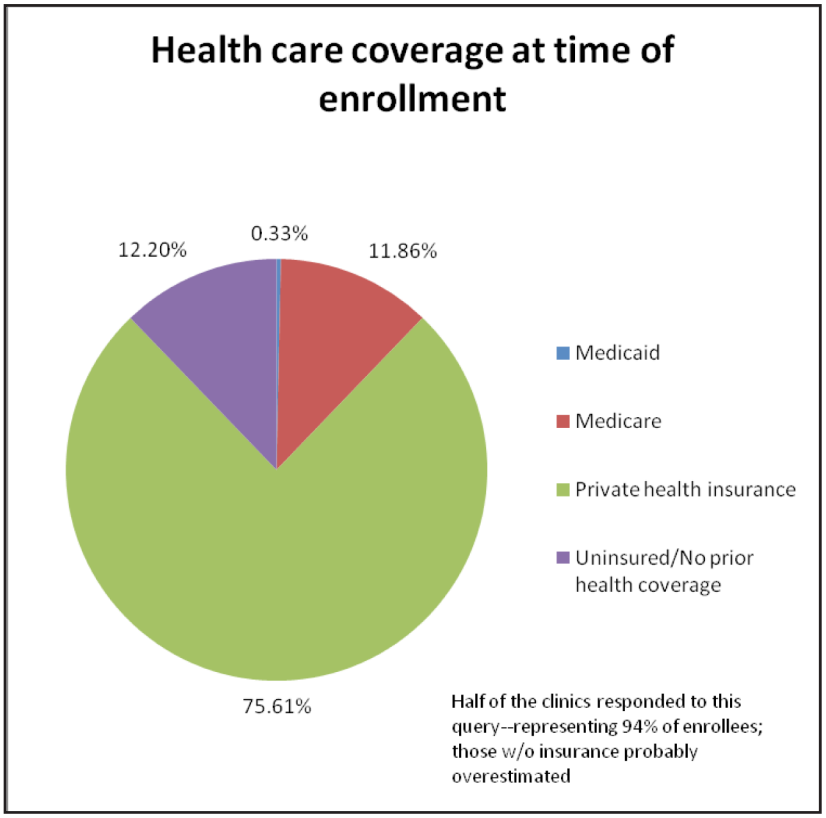
Impact on the uninsured

The survey asked direct practices if they collected information about other types of health coverage the patient has when they sign a direct practice agreement. Half (five) of the direct practices answered that they collect this information, three answered that they did not collect the information and two did not answer the question.

The collected data shows that:

- Eighty-eight percent of enrollees had some additional form of insurance coverage at the time they enrolled with the direct practice.
- The largest percentage of other type of health care coverage is private insurance (75.6 percent).

Because direct practices are barred by law from billing carriers for primary care services, if enrollees retained private insurance, the assumption made is that these patients are combining high-deductible plans with direct practice primary care. Direct practices themselves often recommend that their patients combine direct practice enrollment with a high-deductible insurance plan.



How direct practices evolved

Washington state is the birthplace of this health care delivery approach. The origins of this approach are often traced to MD2, which began in 1996. In the last 13 years:

- Both the American Medical Association and the American Academy of Family Physicians established ethical and practice guidelines for retainer practices.
- In 2003, the federal establishment of Health Savings Accounts (HSA) promotes consumer-directed medicine, which includes enrolling in direct practices.
- In 2003, the Society for Innovative Medical Practice Design formed, representing direct practice physicians (its initial name was the American Society of Concierge Physicians).
- In 2004, the federal Office of the Inspector General for the U.S. Department of Health and Human Services warned practices about "double dipping,"and began taking enforcement steps against physicians charging Medicare beneficiaries extra fees for already-covered services, such as coordination of care with other health care providers, preventive services and annual screening tests. The practices were referred to under various names: concierge, retainer, or platinum practices.
- In 2005, the U.S. Government Accountability Office issued the report "Physician Services: Concierge Care Characteristics and Considerations for Medicare."[13] At that time, there were 112 "concierge physicians" nationwide charging annual fees ranging from $60 to $15,000.
- In 2006, Washington's insurance commissioner determined that retainer practices are insurance. West Virginia's Commissioner made the same ruling that year.
- In 2007, Washington was the first state to define and regulate direct patient-primary care practices, ensuring that direct practice providers also do not bill insurance companies for services being provided to patients.

13 - GAO-05-929

How other states and the federal government regulate direct practices

Direct practices must carefully navigate a host of federal laws addressing anti-kickback, discrimination, Medicare fraud and patient privacy protections. Most state pronouncements on direct practice/retainer medicine/concierge medicine address two key issues important to Medicare:

1. That practices not bill insurers for services covered by a direct practice fee.

2. That dual practices (those with both insured and direct practice patients) do not discriminate against non-direct practice patients in terms of appointment timing and services offered.

When state insurance commissioners have evaluated direct practices, most have concluded, as Washington did, that the practices are transacting insurance. However, at present, only one state imposes insurer level financial requirements and operational standards on direct practices. California requires direct practices to comply with the Knox-Keen Act, the California law regulating health maintenance organizations.

West Virginia specifically created a pilot program of prepaid medical services, partly due to the state insurance commissioner's pronouncement that direct practice is insurance. The pilot expires in 2009.[14] In other states, such as Massachusetts, bills introduced to study concierge medicine have not passed the legislature.[15]

In 2009, Maryland's insurance commissioner began investigating whether concierge medicine practiced in that state violated the state's insurance law.[16]

A bill is pending in New York to pave the way for conciergists, and legislation is expected to be reintroduced in Indiana to do the same.

14 - W.Va.Code, H.B. 4021 (2006).

15 - See, Senate bill 1295 (2005).

16 - See, https://extranet.wnj.com/concierge/wnj%20site%20articles/maryland%20report.pdf

Recommendations for legislative modifications

Washington is at the forefront of national regulation of direct primary care practices. Since passage of the 2007 law, direct primary care practices have not gained significant market share, and are limited to three counties in the state.

Bearing this in mind, the insurance commissioner suggests four options for the Legislature to consider:

1. Strike the study requirement.

a. The study required under RCW 48.150.120 is very broad and unwieldy, especially given the limited amount of information that these practices are required to report. Current direct practices reporting requirements include only the data questions for the annual statement. This information is not extensive enough to capture the information needed to provide analysis of the questions required for the 2012 study.

b. Without the authority to instruct the practices on what data to collect and how to report it, the insurance commissioner will be extremely limited in his ability to produce a meaningful study without investing a tremendous amount of time and resources.

c. Given the scope of these practices and the fluidity of health care reform at the national level, any change in reporting requirements may result in administrative costs to collect data later made irrelevant because of reforms.

2. Increase annual statement reporting requirements.

a. Current information required for the annual statements is extremely limited. The annual statements reporting requirements could be enhanced to provide the Legislature with additional information without placing an undue burden on the practices. Examples of additional requirements include the voluntary questions used in the data call for this report.

3. Wait and see.

a. Make no changes and continue to monitor practices using annual statements and consumer complaints.

b. Write the 2012 report using available data.

4. Require direct practices to collect and report specific data necessary for the 2012 study to the insurance commissioner and provide him with compliance authority for practices failing to comply with the reporting requirements.

a. Our recent data call shows that direct practices do not collect patient data similarly or consistently.

b. In order for the insurance commissioner to provide analysis and answers to the policy questions identified by the statutory public policy statement and provide a study of direct practices that responds to the questions required by RCW 48.150.120, direct practices should be required to collect and provide specific information to the insurance commissioner. Examples of data needed for the 2012 report:

    i. Specific information about other types of insurance coverage.

    ii. Practices' accounting standards.

    iii. Patient health conditions not covered by direct practice and how they are treated.

    iv. How many direct practice patients used the emergency room and for what health conditions.

    v. Premium increases for direct patients with traditional health insurance.

    vi. Demographics of direct practice patients.

c. Under current law, the insurance commissioner has few regulatory tools to use with direct practices. He should be given authority to enforce the reporting requirements or sanction those who fail to register and report.

Given the current landscape, Commissioner Kreidler's preference is to combine options one and two – eliminate the 2012 study requirement and increase the information required for the annual statement. This would enable the Legislature to continue monitoring the growth and behavior of these practices without requiring significant new effort on the part of the practices or significant investment of resources by the agency.

Appendix A

MIKE KREIDLER
STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON
OFFICE OF
INSURANCE COMMISSIONER

P.O. BOX 40255
OLYMPIA, WA 98504-0255
Phone: (360) 725-7000

August 3, 2009

Dear Dr. XXXX:

I am writing to remind all innovative direct practices of the reporting requirements found in RCW 48.150.100.

Specifically, the statue states that:

> "(1) Direct practices must submit annual statements, beginning on October 1, 2007, to the office of [the] insurance commissioner specifying the number of provider in each practice, total number of patients being served, the average direct fee being charged, providers' names, and the business address for each direct practice." and,
>
> "(3) The commissioner shall report annually to the Legislature on direct practices including, but not limited to, participation trends, complaints received, voluntary data reported by the direct practices, and any necessary modifications to this chapter. The initial report shall be due December 1, 2009"

Additionally, RCW 48.150.120 requires the commissioner to submit a more in depth study by December 1, 2012 (http://apps.leg.wa.gov/RCW/default.aspx?Cite=48).

With the purpose of gathering information for the 2009 report and the 2012 study, we have added a series of questions to the annual report form. We are also requesting that you provide us with copies of your marketing material and direct practice agreement. The answers to the additional questions and submission of the materials are on a voluntary basis.

Please take a few moments to complete the report and return it no later than August 21, 2009. If you have other information that you think might help us with the study please feel free to include it.

Please respond in one of the following ways (in order of preference):

E-mail: Donna Dorris, Senior Health Policy Analyst at donnad@oic.wa.gov

FAX: (360) 586-3109 - Attention Donna Dorris, Senior Health Policy Analyst

Snail Mail: Donna Dorris
Senior Health Policy Analyst
Office of the Insurance Commissioner
PO Box 40255
Olympia, WA 98504-0255

If you have any questions, please feel free to contact either Donna (360-725-7040) or me.

Sincerely,

Mary Clogston
Deputy Commissioner
Policy and Legislative Affairs
360-352-4275

DD:mc
Encl.

DIRECT PRACTICE ANNUAL STATEMENT REPORT

Please provide the following information by clicking on the shaded boxes. The questions marked with an * symbol are required to be answered.

***Practice Name:** _____
***Address:**
_____

***List the name of the providers participating in direct practice care. _____**

Do any of these providers participate as a network provider in a health carrier's network?
Check one: ☐ Yes ☐ No

What percentage of your business is direct practice?
Check one: ☐ Yes ☐ Don't know _____ percent

Has the practice discontinued any patients?
Check one: ☐ Yes ☐ No
If yes, how many _____, and please check the reasons:
- ☐ The patient failed to pay the direct fee under the terms of the direct agreement.
- ☐ The patient performed an act that constitutes fraud.
- ☐ The patient repeatedly fails to comply with the recommended treatment plan.
- ☐ The patient is abusive and presents an emotional or physical danger to the staff or other patients of the direct practice.
- ☐ Other

Has your direct practice declined to accept any patients?
Check one: ☐ Yes ☐ No
If yes, how many _____, and please check the reasons:
- ☐ The practice has reached its maximum capacity.
- ☐ The patient's medical condition is such that the provider is unable to provide the appropriate level and type of health care services in the direct practice.
- ☐ Other

***How many direct practice patients are enrolled in your program? _____**
How many are children? _____ How many are adults? _____

(Please continue to page 2)

***What is your average monthly fee? _____**

***What is your average annual fee? _____**

Do you collect information about any other type of health coverage the patient has when they sign a direct practice agreement?
Check one: ☐ Yes ☐ No
If yes, what is the total number of patients with:

Medicaid _____
Medicare _____
Private health insurance _____
Uninsured/No prior health coverage _____

We also request that you include a copy of your direct practice agreement including your fee structure, disclosure statement, and any marketing materials you use with your completed Direct Practice Annual Statement Report form.

Please respond in one of the following ways (in order of preference):

E-mail: Donna Dorris, Senior Health Policy Analyst donnad@oic.wa.gov

FAX: (360) 586-3109 - Attention Donna Dorris, Senior Health Policy Analyst

Snail Mail: Donna Dorris
Senior Health Policy Analyst
Office of the Insurance Commissioner
PO Box 40258
Olympia, WA 98504-0258

If you have any questions regarding this survey please contact:

Donna Dorris
Senior Health Policy Analyst
Office of Insurance Commissioner

Phone: (360) 725-7040
FAX: (360) 586-3109
donnad@oic.wa.gov

Appendix B – Voluntary Information Reported[1]

	Anchor Medical Clinic	Bellevue Medical Partners LLC	CARE Medical Associates	Direct CareMed	Guardian Family Care, PLLC	King County Public Hospital District 4	MD2	Qliance Medical Group of WA	Seattle Medical Associates	Vantage Physicians
Do any providers in your practice participate as a network provider in a health carrier's network?	No	No	Yes	Yes	No	Yes	No	No	No	No
What percentage of your business is direct practice?	100%	100%	100%	2%	100%	Don't know	100%	100%	100%	100%
Has the practice discontinued any patients?[2]	Yes (18)	Yes (7)	Yes (2)	No	Yes (3)	New practice	Blank	Yes (438)	Yes (20)	Yes (18)
The patient failed to pay the direct fee under the terms of the direct agreement.	X	X	X		X			X	X	X
The patient performed an act that constitutes fraud?	X				X					X
Has your direct practice declined to accept any patients?	Yes	No	No	No	No	No	Yes	No	Yes	Yes
The practice has reached its maximum capacity.							X		X	
The patient's medical condition is such that the provider is unable to provide the appropriate level and type of health care services in the direct practice.	X									
Do you collect information about any other type of health coverage the patient has when they sign a direct practice agreement?[3]	Yes	Yes	No	No	No	New practice 8/01/09	Blank	Yes	Yes	Yes
Medicaid		7	1					11	4	2
Medicare		67	0					323	415	92
Private health insurance		83	289					1652	3446	251
Uninsured/No prior health coverage		51	2					743	80	47
What is the average length of enrollment?	New	One	One		One	One +years	Blank	One +years	Blank	One +years

(Footnotes)

1 If the question was not answered, the word blank is inserted into the chart.

2 The top two reasons out of five checked on the survey are contained in the chart.

3 These totals contain both active and non-active patients; non-active patients are not included in total enrollment numbers.