

For hearing on Senate Bill 68, Tuesday March 17, 2015

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Key Points From Chapter 4 in my soon to be published book,

If You Really Want To Understand Health Care

At Issue: Should the licenses of Advance Practice Nurse Practitioners (A.P.N.P.) be expanded to allow care to patients without physician supervision and to what degree, in hopes of expanding access?

Although future changes in our health care system may alleviate this problem, there seems to be a need for a remedy at this time. **I suggest limiting A.P.N.P. non-physician supervised practice to non-procedural care for those who are not chronically ill and whose complaints are minor and immediate, including prescription refills**

However, mentioned in Senate Bill 68, is the provision for unsupervised care of chronically ill patients¹. I object to this for two reasons:

1) Patients with complicated chronic disease such as renal failure, inflammatory bowel disease, advanced C.O.P.D., multiple sclerosis and many others, require sound clinical judgment for management and prevention of progression whenever possible, which requires years of residency and frequently fellow-ship training.

¹ i.e. p.24 lines 19 & 20, p.25 line 17, & for controlled substances p.36, lines 12-17

Included in this category would be patients who need repeated prescriptions of controlled drugs for whatever reason.

2) There would be significant risk of legal action for non-physician supervised A. P. N. P. caring for seriously ill chronic disease patients whose disease progresses. Thus, regardless of their certifying authority, they would be under considerable legal risk for caring for these patients without the oversight of physicians.

Present reasons for this apparent primary care shortage include:

- A) As a result of our price fixed physician payment system (Medicare & Medicaid) primary care physicians are grossly underpaid, limiting their numbers despite an overall increase in physicians.
- B) Approximately 80% of health care is consumed by 10% of the population with chronic diseases, but with our price fixed system the sub-specialists with the advanced training to care for these patients are discouraged from providing their primary care.
- C) The ACA has created a marked increase in the demand for primary care services in the hope of decreasing costs without any evidence that it would do so.

However, we in Michigan have started to introduce market forces into health care because of Public Act 522, which will expedite improved primary care. From the Federal Government we need expanded Health Savings Accounts (HSAs) for all

These benefits are especially pronounced in patients afflicted with chronic conditions.

A recent study published in the American Journal of Managed Care found that a single collective DPC group was able to produce savings of \$120 million in just one year, averaging \$2,551 per patient.

Another study published in the British Medical Journal found DPC patients had 35 percent fewer hospitalizations, 65 percent fewer emergency department visits, and 82 percent fewer surgeries than similar populations.

In 2005, there were only 146 physicians in the U.S. utilizing this practice model. By 2010, that number had more than quintupled to 756. And in 2012, two years after the passage of the health overhaul, there were 4,400 physicians nationwide who chose DPC over the traditional insurance-payment model.

The growth between 2010 and 2012 is noteworthy because it shows physicians' growing frustration with the Affordable Care Act.

Every physician I know entered the field of medicine because they wanted to build healing relationships on a very human level and improve patients' health over time. That has become increasingly less possible under the act.

Removing insurers and government from the health care equation allows physicians to focus exclusively on the needs of their patients without having to consider external factors like whether certain policies cover certain treatments and so forth.

But despite these benefits of DPC, various federal policies are nonetheless restricting their expansion.

For instance: tax laws dealing with Health Savings Account (HSA) eligibility, lack of option to pay for DPC from HSAs, and potential conflicts with Medicare are hurdles that must be overcome.

There also remains abundant uncertainty with how DPC fits into the regulatory maze that is the Affordable Care Act, and as a result federal action is needed so that more physicians and businesses can participate.

Federal lawmakers should look to PA 522 as an example of how to clear confusion about the treatment of Direct Primary Care at the national level. Removing DPC from consideration as a health insurance product enables it to

continue evolving in ways that will lower costs, improve health outcomes, and — most importantly — return health care decisions to patients.

Dr. Kenneth Fisher, a nephrologist, is the president of the Michigan chapter of Docs4PatientCare.