# Joint Commission on Health Care

## Health Insurance Mandate Review - Assessment of Senate Bill 735 (2024)

Report to the Health Insurance Reform Commission pursuant to § 30-343

October 2025

**Statutory Mandate**

Section 30-343 of the *Code of Virginia* directs the Joint Commission on Health Care, together with the Bureau of Insurance of the State Corporation Commission, to assess the social and financial impact and medical efficacy of proposed mandated health insurance benefits and health or providers upon request of the Health Insurance Reform Commission established pursuant to Chapter 53 (§ 30-339 et seq.) of Title 30 of the *Code of Virginia*.


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## Contents

# Executive Summary: Health Insurance Mandate Review - Assessment of Senate Bill 735 (2024)

Senate Bill 735 (Sturtevant), introduced during the 2024 Session of the General Assembly, was referred to the Health Insurance Reform Commission (HIRC) for consideration by the Senate Committee on Commerce and Labor. On June 17, 2025, HIRC referred SB 735 to the Joint Commission on Health Care (JCHC) and the Bureau of Insurance (BOI) of the State Corporation Commission (SCC) for assessment pursuant to subsection C of § 30-343 of the *Code of Virginia.* This report presents the results of the JCHC's assessment.

## SB 735 would prohibit denial of coverage and higher cost-sharing requirements for services referred by DPC providers

SB 735 would prohibit a health carrier from (i) denying coverage for any health care service covered under an enrollee's health benefit plan or solely because the referral originated from a direct primary care (DPC) provider or (ii) imposing cost-sharing requirements for services for which a referral originated with a DPC provider that are greater than the applicable cost-sharing requirement that would apply to the same health care service if the service was referred by a participating provider. The bill also allows a health carrier to require a DPC provider who has referred a patient to a service for which reimbursement is sought to provide information to the carrier demonstrating that the provider has entered into a DPC agreement with the patient.

## DPC providers provide primary care services directly to patients outside of traditional health insurance networks

DPC is a health care delivery and payment model in which health care providers enter into agreements directly with patients for the delivery of health care services. DPC agreements must specify the type of health care services the provider will make available to the patient and the amount of the fee, which is intended to cover the cost of the services provided. DPC providers do not bill participating patients' health insurance carriers for services provided and generally do not participate in health carriers' provider networks.

## Health carriers do not deny claims or impose higher cost-sharing for services because of referral source so impact of SB 735 is likely minimal

Health carriers report that they do not specifically collect information tracking the number of referrals originating from DPC providers. Health carriers also report that they generally do not deny coverage or impose higher cost-sharing requirements for covered services provided to enrollees solely because the referral originated from a DPC provider. As a result, it is unlikely that enactment of SB 735 would have a significant impact on access to health care or the cost of health insurance coverage.

# Health Insurance Mandate Review – Assessment of Senate Bill 735 (2024)

Senate Bill 735, referred to the Health Insurance Reform Commission by the General Assembly during the 2024 Session, would prohibit a health carrier from denying coverage of any health care service covered under an enrollee's health benefit plan solely because the referral originated from a direct primary care (DPC) provider. The bill would also prohibit a health carrier from imposing cost-sharing requirements for services for which a referral originated with a DPC provider that are greater than the applicable cost-sharing requirement that would apply to the same health care service if the service was referred by a participating provider.[i] Generally, health carriers may deny coverage or impose higher cost-sharing requirements for services provided by health care providers who do not participate in the carrier's provider network. DPC providers generally do not participate in carriers' provider networks, though they may refer patients to other health care providers who do participate in carriers' provider networks. SB 735 would prohibit carriers from denying coverage or imposing higher cost-sharing requirements for a service provided by a provider who participates in the carrier's provider network solely on the grounds that the referral for such service was made by a DPC who does not participate in the carriers' provider network. SB 735 would permit a health carrier to require a DPC provider who referred a patient for a health care service for which reimbursement is sought from a carrier to provide information to the carrier demonstrating that the provider has entered into a DPC agreement with the patient, which may include a written attestation or copy of such agreement and may request any additional information to meet the requirements of the legislation.

## DPC model offers access to primary care services outside of traditional insurance-based systems

DPC is a health care delivery and payment model in which health care providers enter into agreements directly with patients for the delivery of health care services. The DPC model

[i] For the purposes of SB 735 (2024), a "carrier" is (i) any insurer proposing to issue individual or group accident or sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense incurred basis, (ii) any corporation providing individual or group accident or sickness subscription contracts, (iii) any health maintenance organization providing health care plans for health care services, (iv) any corporation offering prepaid dental or optometric service plans, or (v) any other person or organization that provides health benefit plans subject to state regulation, and includes an entity that arranges a provider panel for compensation. *Code of Virginia* § 38.2-3407.10

has emerged as an alternative approach to the organization and financing of primary health care services outside of traditional insurance-based systems. However, while the model has generally grown nationally and within Virginia, it remains a relatively small component of the primary care system with very limited oversight.

## DPC model emphasizes direct patient-to-provider relationships

DPC providers enter into agreements with patients for the delivery of health care services in exchange for a flat, recurring fee paid directly to the provider. DPC agreements must specify the type of health care services the provider will make available to the patient and the amount of the fee, which typically ranges from $50 to $100 per month for adults, often with lower rates for children. DPC providers generally offer a broad scope of outpatient primary care services, including preventive services, chronic disease management, basic mental health services, acute visits, basic laboratory services, and referral to specialty services when necessary. Fees paid pursuant to DPC agreements are intended to cover the full cost of the health care services offered, and DPC providers do not bill a patient's health insurance for services provided.

## Oversight of DPC arrangements in Virginia is limited

In 2017, the General Assembly adopted Senate Bill 800 and House Bill 2053, which specified that DPC arrangements do not constitute health insurance, established basic disclosure requirements for DPC agreements generally, and set out specific requirements applicable to DPC agreements between DPC providers and individuals employed by an employer who offers coverage of DPC services as a benefit of employment. Section 54.1-2998 of the *Code of Virginia*, added by the legislation, provides that when an employer enters into an agreement with a DPC provider for provision of primary care services for employees, the contract must include: a clear list of the services provided under the agreement; a statement that the scope of services is limited to the services described; notice that the DPC will not bill a health carrier for services covered under the DPC agreement; and notice that the patient must pay for all services provided by the DPC provider that are outside the scope of the agreement. The statute also requires that DPC agreements covered by an employer as a benefit of employment be agreed to by both the DPC provider and the covered individual, and that the DPC agreement includes a disclosure statement encouraging patients to obtain and maintain health insurance coverage for services not included by the DPC arrangement. While the *Code of Virginia* does establish basic requirements for certain DPC arrangements, Virginia does not provide any other oversight of DPC arrangements. As a result, little is known about the exact scope or content of DPC agreements, membership fees, or the types of services provided.

## Number of DPC providers practicing in Virginia is unknown

In Virginia, health care providers must be licensed by the appropriate health regulatory board within the Department of Health Professions. While licensed providers must provide

an address of record and providers licensed as medical doctors of medicine, osteopathy, or podiatry must provide information about the location of each practice setting in which they practice, Virginia does not differentiate between DPC arrangements and traditional primary care arrangements and health regulatory boards do not collect information about the type of practice with which a primary care provider is affiliated. As a result, information about the exact number or location of DPC providers in the state is not available. National estimates suggest that between 1,500 and 2,000 DPC providers are practicing across the nation, serving between 300,000 and 1.2 million patients, representing less than 1% of the U.S. population. Available estimates for Virginia indicate that there are between 50 and 80 active DPC practices in the state, serving between 10,000 and 48,000 patients statewide. DPC providers appear to be concentrated primarily in urban and suburban regions of the state such as Richmond, Northern Virginia, Hampton Roads, and Roanoke. Rural adoption remains limited, largely due to lower physician density and constraints on patient purchasing power. While the number of DPC providers in Virginia is growing, DPC arrangements remain a small component of the primary care delivery system in the Commonwealth.

### Federal policy changes may increase utilization of DPC arrangements in the future

Federal policy is also evolving to support adoption of the DPC model. Provisions of the One Big Beautiful Bill Act (OBBBA), effective January 1, 2026, permit individuals enrolled in high-deductible health plans to use Health Savings Account (HSA) funds to pay DPC membership fees. To qualify, DPC arrangements must charge no more than $150 per month for individual coverage or $300 per month for family coverage, with these amounts indexed for inflation. Additionally, the DPC arrangements must provide only primary care services and not include coverage for prescriptions (other than vaccines), services requiring general anesthesia, or laboratory services typically not provided in an ambulatory primary care setting. The federal provision also removes the previous disqualification for HSA contributions while participating in a DPC arrangement. These federal provisions may result in increased utilization of DPC arrangements in the future.

## DPC model may expand access to primary care but does not provide access to the full array of health care services

The DPC model is intended to increase access to timely primary health care services and improve health outcomes for participating patients, reducing utilization of costly downstream care. However, the model does not provide comprehensive coverage of the full array of health care services for participating patients and does not appear to improve access to primary care for all segments of the population. More research is required to fully understand the impact of the model on access to and the quality of health care services provided.

## DPC model may improve access to primary care services for some patients but does not provide access to the full array of health care services

The DPC model is designed to improve access to primary care services for patients participating in DPC arrangements. DPC providers generally maintain smaller patient panels than traditional primary care providers, with patient panels ranging from 200 to 600 patients per provider, compared to the 1,200 to 2,500 patients typical of the traditional model. This reduced patient load enables DPC providers to spend more time with each patient, with visits averaging 30 to 60 minutes for DPC providers compared to 15 to 20 minutes for traditional primary care providers. The DPC model also prioritizes easy and rapid access to care, including same-day or next-day appointments, direct 24/7 communication through phone, text, or email, and occasional home visits. The ease and rapidity of access to care for participating patients, combined with longer visit times, may allow patients to access more primary care services than patients who receive health care services in traditional primary care settings.

While DPC arrangements may improve access to primary care services for participating patients, DPC arrangements do not provide comprehensive coverage of the full array of health care services a patient may require. Specifically, DPC agreements do not cover emergency services, specialty services, or hospital-based care. Instead, patients must access and pay for these services in other ways. Because DPC arrangements do not provide access to the full array of health care services, the impact of the DPC model on overall access to care may be limited.

## DPC model may reduce financial barriers to primary care, but cost is not the primary motivation for patients

The DPC model was intended to make primary care services more affordable than traditional primary care services, providing access for patients who might otherwise avoid care due to financial barriers. Because DPC providers do not participate in health insurance, DPC arrangements can offer access to primary care for individuals without health care coverage. Primary care services offered through DPC agreements may also be more affordable than services available to patients with health insurance coverage through traditional primary care providers. While traditional primary care providers may bill a patient's health insurance provider for some portion of the cost of health care services provided, many patients are still required to pay out of pocket costs up to a set deductible amount, copayments, or coinsurance amounts. These cost-sharing requirements can be significant and the expense, combined with the lack of predictability in health care costs, may create financial barriers to care for some patients. DPC arrangements, which charge a flat fee for access to covered services, can be more predictable and more affordable for patients, potentially improving access to health care services.

While the DPC model was designed to reduce the cost of primary care services and expand access to primary care services, available information indicates that DPC patients are less

likely to face financial barriers to health care than patients utilizing traditional primary care providers and that financial considerations related to the cost of care may not be the primary factor motivating participation in DPC agreements. Patients in DPC arrangements must have the financial means to pay monthly membership fees. Additionally, because DPC agreements do not provide comprehensive coverage, patients must often maintain health insurance coverage to pay for emergency, specialty, hospital-based, and other health care services they may require. The cost of DPC arrangements combined with the cost of health insurance coverage for these services may make the DPC model most accessible to individuals who can accommodate the expense. Available evidence indicates that DPC patients tend to have higher household incomes than patients utilizing traditional primary care services. The promise of predictable costs, faster access to appointments, and longer, more personalized interactions with providers, rather than purely financial considerations related to the cost of care, tend to motivate these individuals to enter into DPC arrangements.

## The DPC model may improve health outcomes and reduce utilization of high-cost care

Smaller patient panel sizes, improved access to timely care, longer visit times, and enhanced continuity of care offered by DPC providers have been associated with decreased emergency department utilization and lower hospitalization rates. In one large-scale study, the DPC model reported a 50 percent reduction in emergency department visits and a reduction in specialist consultations, advanced radiologic testing, and surgical procedures compared to traditional primary care populations, while primary care visits more than doubled. Similarly, an employer-based study demonstrated a statistically significant 40.5 percent risk-adjusted reduction in emergency department usage and a 12.6 percent reduction in overall health care claim costs for DPC enrollees. However, overall evidence of the impact of DPC arrangements on patient health outcomes is limited and most published studies are observational or rely on self-reported outcomes, raising concerns about potential biases and variation between individual practices and settings. Additionally, because DPC patients are generally higher-income, insured individuals who tend to experience better health outcomes, these favorable population characteristics may contribute to the positive impacts reported for DPC arrangements.

## Patients and providers report high rates of satisfaction with DPC arrangements

Improved accessibility and affordability of health care services, longer visit times, and more personalized attention contribute to high patient satisfaction in DPC arrangements. Health care providers participating in DPC arrangements report higher professional satisfaction than their peers in traditional primary care practices. Specifically, DPC providers cite improved ability to provide quality care and reduced administrative burden due to the model's separation from traditional insurance billing as factors driving greater satisfaction.

Additionally, many DPC providers report reduced burnout and greater autonomy which may support physician retention and practice stability.

### Additional research is needed to fully understand the implications of the DPC model

DPC is an emerging health care delivery and payment model. While available evidence suggests DPC may improve some aspects of primary care access, patient health outcomes, and patient experience, the overall evidence base remains limited. More rigorous comparative research including long-term studies on populations served may be necessary to fully understand the impact of the DPC model on access to primary care and the quality of services provided. Addressing these gaps is critical for understanding the long-term patient- and population-level impacts of DPC arrangements, particularly with regard to health care access, equity, and broader health system utilization.

## Impact of requiring coverage for services referred by DPC providers is likely limited

SB 735 would prohibit a health carrier from denying coverage of any health care service covered under an enrollee's health benefit plan solely because the referral originated from a DPC provider or imposing higher cost-sharing requirements for services for which a referral originated with a DPC provider that are greater than the applicable cost-sharing requirement that would apply to the same health care service if the service was referred by a participating provider. Health carriers report that they do not collect information about referrals originating from DPC providers specifically and do not deny coverage or impose higher cost-sharing requirements solely because a referral originated from a DPC provider. As a result, it is unlikely that enactment of SB 735 would have a significant impact on access to health care or the cost of health insurance coverage.

### Health insurance carriers reimburse participating health care providers for services provided to covered patients

In Virginia, most health insurance is offered through Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). HMOs and PPOs are managed care arrangements that provide enrollees with access to health care services through networks of providers with whom the carrier has entered into contractual agreements. In both HMOs and PPOs, eligibility for and the amount of reimbursement for health care services provided to enrollees depend on the provider's network participation status.

HMOs operate under a "gatekeeper" model, requiring enrollees to designate a primary care provider within the HMO network. Referrals from that designated provider are generally necessary to access specialty services. Requiring referrals from a patient's designated primary care provider prior to accessing specialist or high-cost services allows HMOs to

limit unnecessary utilization of services, reduce duplication of services, and ensure that care pathways remain clinically appropriate and financially sustainable. This gatekeeping mechanism is also a primary factor enabling HMOs to offer relatively lower premiums compared to other plan types.

PPOs differ from HMOs in that they allow enrollees to access care from providers both within and outside the network, but typically at different cost-sharing levels. Section 38.2-3407 of the *Code of Virginia* requires PPOs to pay all claims for eligible services, regardless of whether providers are in-network or out-of-network. However, PPOs are permitted to establish different payment amounts for preferred (in-network) and non-preferred (out-of-network) providers, which affects the enrollee's out-of-pocket costs and the insurer's reimbursement rates.

Because DPC providers do not bill carriers for services provided to participating patients, most DPCs do not participate in carriers' provider networks. However, specialty and other health care providers to which DPC providers refer patients may participate in a carrier's provider network and, as a result, be eligible for coverage under the patient's health insurance plan.

## Health carriers in Virginia typically do not consider the source of a referral when determining eligibility for coverage

In response to a data request from the Bureau of Insurance (BOI), health carriers reported that they generally do not collect information about whether a referral for a covered health care service originated from a DPC provider. Carriers also reported that they did not typically consider whether a referral originated from a DPC provider when determining whether a service was eligible for coverage or the amount of cost-sharing required for a service and do not deny coverage or impose higher cost-sharing requirements solely because a referral originated from a DPC provider. As a result, enactment of SB 735 likely would not have a significant impact on access to health care or the cost of health insurance coverage in the Commonwealth.

## The state's actuarial analysis projects a modest fiscal impact

The Department of Human Resource Management's actuarial analysis estimates that SB 735 would result in a modest fiscal impact of approximately $104,000 annually to the state health insurance plan, with roughly half of this amount funded by the general fund. These projections indicate that the proposal is unlikely to materially affect premiums or the solvency of the plan. Current evidence does not suggest that insurer utilization rates or administrative costs would experience significant increases if SB 735 were enacted. Overall, the fiscal impact is limited, and the Department of Human Resource Management has not identified any downstream effects on utilization trends. State employee health insurance premiums are not expected to change as a result of adoption of SB 735, indicating that the financial risk to insurers under current actuarial assumptions is minimal.

## One state has adopted legislation prohibiting denial of coverage for referrals made by DPC providers

Use of the DPC model is expanding nationwide. DPC arrangements are available in all 50 states. As of 2025, 34 states, including Virginia, have enacted legislation explicitly clarifying that DPC arrangements do not constitute health insurance.

Only one state – Maine – has enacted legislation similar to SB 735. In 2017, Maine enacted legislation prohibiting health insurance carriers from denying payment for services solely because a referral was made by a DPC provider outside the carrier's network. Insurers must honor DPC-initiated referrals on the same terms as in-network primary care referrals, including applying equivalent deductibles, coinsurance, and copayments. Carriers may require documentation verifying the existence of a DPC service agreement between the patient and the provider. In 2019, the law was amended to clarify that carriers will only be required to honor referrals made by a DPC provider who has a contractual relationship with the enrollee.

# Appendix 1: Senate Bill 735 (2024)

## 2024 SESSION

**INTRODUCED**

24104904D

**SENATE BILL NO. 735**

Offered January 19, 2024

*A BILL to amend the Code of Virginia by adding a section numbered 38.2-3407.10:01, relating to health insurance; denial of referral by direct primary care provider prohibited.*

Patron—Sturtevant

Referred to Committee on Commerce and Labor

**Be it enacted by the General Assembly of Virginia:**

**1. That the Code of Virginia is amended by adding a section numbered 38.2-3407.10:01 as follows:**

***§ 38.2-3407.10:01. Denial of referral by a direct primary care provider prohibited.***

*A. As used in this section:*

*"Carrier" has the same meaning as provided in § 38.2-3407.10.*

*"Cost-sharing requirement" has the same meaning as provided in § 38.2-3438.*

*"Direct primary care provider" means a health care provider that has entered into an agreement with a patient, the patient's legal representative, or the patient's employer for ongoing primary care services in exchange for the payment of a monthly periodic fee.*

*"Enrollee" has the same meaning as provided in § 38.2-3407.10.*

*"Health benefit plan" has the same meaning as provided in § 38.2-3438.*

*"Participating provider" means a provider that has contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees.*

*B. No health carrier shall (i) deny payment for any health care service covered under an enrollee's health benefit plan based solely on the basis that such enrollee's referral was made by a direct primary care provider or (ii) impose a cost-sharing requirement greater than the applicable cost-sharing requirement that would apply to the same health care service if the service was referred by a participating provider.*

*C. A carrier may require a direct primary care provider to provide information demonstrating that such provider has entered into a direct primary care agreement with the enrollee, which may include a written attestation or copy of such agreement and may request any additional information to meet the requirements of this section.*