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August 10, 2020

VIA ELECTRONIC SUBMISSION

Charles P. Rettig
Commissioner
Internal Revenue Service
Department of Treasury
Attention: REG-109755-19

Dear Commissioner Rettig,

On behalf of the American College of Osteopathic Family Physicians (ACOFP), we appreciate the opportunity to respond to the Internal Revenue Service (IRS) proposed rule entitled, *Certain Medical Care Arrangements* (REG-109755-19).

ACOFP is the professional organization representing more than 18,000 practicing osteopathic family physicians, residents, and students throughout the United States who are deeply committed to advancing our nation's health care system by improving health care delivery and outcomes and ensuring that patients receive high-quality care.

As an organization with many osteopathic family physicians in direct primary care (DPC) arrangements, we understand how these arrangements can improve patient care, limit administrative burden, and improve overall quality of life for both patients and physicians. While the proposed rule clarifies that DPCs are compatible with Health Reimbursement Arrangements (HRAs), the proposed rule does not address key issues related to Health Savings Accounts (HSAs). Specifically, we urge the agency not to classify most DPCs as a type of health insurance for HSA purposes.

Our full comments are detailed on the following pages. Thank you for the opportunity to share our feedback with you. Should you need any additional information or if you have any questions, please feel free to contact ACOFP at advocacy@acofp.org or (847) 952-5100.

Sincerely,

Robert C. DeLuca, DO, FACOFP *dist.*
ACOFP President

As physicians have been increasingly burdened with complex and time-consuming administrative requirements for payors, many have turned to DPCs. Unlike federal health programs, like Medicare or commercial insurance, DPC payment rules are simple for both patients and physicians. DPCs allow patients to pay a reoccurring (typically monthly) rate for primary care and preventative services from their primary care physician. This often is referred to as the "Netflix" payment model. Patients may see their primary care physician as often as they would like and will not receive an additional bill. These arrangements can also lead to greater health outcomes and reduced costs.[1] DPCs allow physicians to focus on providing care, rather than administrative requirements, and patients experience better health outcomes as a result.

The Trump Administration has recognized the value of DPCs and, in June 2019, issued an executive order entitled, *Improving Price and Quality Transparency in American Health to Put Patients First*. Section 6(b) of the order directed the Treasury Secretary to propose regulations on DPCs and health care sharing ministries. This proposed rule relates to section 213 of the Internal Revenue Code (IRC) regarding the tax treatment of amounts paid for DPCs and health care sharing ministries (HCSMs). While the agency provides clarity related to DPCs and HRAs, it incorrectly classifies DPCs as a type of gap plan that many confuse with health insurance, which has direct implications for the use of HSA funds. Below we provide comments on the incorrect classification of DPCs as gap plans and/or health insurance, the importance of physician-led care teams for purposes of DPCs, and other areas in which IRS requests comment.

1. DPCs should not be considered health insurance for purposes of HSAs.

We urge the IRS to not classify DPCs as a type of gap plan since this would effectively freeze a DPC patient's health savings account and prevent further contributions. Section 223 of the IRC permits eligible individuals to establish and contribute to HSAs, but the individual must be covered under a high deductible health plan (HDHP). While covered under a HDHP, an individual cannot be covered under any *other health plan* which is providing coverage for any benefit that is covered under the HDHP. By classifying most DPCs as gap plans, individuals would be in violation of section 223.

DPCs do not operate like typical health insurance plans and are not risk-bearing entities. Traditional health insurance is paid by a third party on behalf of the patient. On the other hand, a DPC arrangement is an agreement between the provider and patient for primary care services, and patients are expected to have coverage to account for catastrophic events or specialty care. Furthermore, the IRS has never formally defined "insurance" since states are the primary regulators of insurance. The Affordable Care Act has specifically stated that DPC memberships are not insurance, and the majority of individual states have passed laws clarifying that DPC practices are not selling insurance but merely primary care.

Under the proposed rule's classification of DPCs, nearly 23 million Americans with HSA-eligible HDHPs would be prohibited from continuing to contribute to their HSAs merely because they have started a membership at a DPC practice. We therefore urge the IRS to recognize the important role of DPCs in care delivery for both patients and physicians and not finalize its proposed classification of DPCs as a type of gap plan and/or health insurance.

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[1] Studies have shown that when patients increase utilization for primary care services, health care costs lower and fewer patients are hospitalized. See Reyan Ghany, *et al.*, High-Touch Care Leads to Better Outcomes and Lower Costs in a Senior Population. American Journal of Managed Care. (August 28, 2018) Available here: https://www.ajmc.com/view/hightouch-care-leads-to-better-outcomes-and-lower-costs-in-a-senior-population?&p=3

2. Physician-led care teams deliver the highest quality care.

The proposed rule solicits comments on whether the Department of Treasury should include services provided by non-physician practitioners in the definition of "primary care services." Although the goal of this proposed rule should be to ensure that there are fewer regulatory barriers to DPCs, we remind the agency that physician-led care teams are the gold standard for care delivery. Non-physician led care teams are not the equivalent.

Physicians have rigorous training requirements and deliver higher quality of care. The path to becoming a physician is long—typically requiring 11 to 14 years of education, testing, and training. In addition to a four-year undergraduate degree, physicians must successfully complete the Medical College Admission Test, complete hundreds of hours of lectures and training, and complete two years of rotation in a variety of care settings, including community hospitals, large medical centers, and physician offices. Students must have superb academic credentials, perform at a high level during clinical rotations, and excel at the training designed to ensure patients receive the highest quality care.

After successfully completing medical school, a student must then begin postgraduate residency, which includes thousands of hours of training over the course of three to seven years. During this time, physicians gain expertise and advanced clinical skills for a wide range of patient conditions to sharpen and perfect their practice. Additionally, a physician must pass rigorous examinations in order to receive their medical license, and once licensed, an overwhelming majority of physicians must participate in continuing medical education and complete comprehensive board certification examinations throughout their career.

A family physician will spend approximately 18,900 more hours on education and training than other mid-level health providers.[2] The education, training, and commitment to continued learning during a physician's career are representative of the significant and unmatched credentials of physicians and the profession's rigorous requirements that ensure patients obtain the highest quality health care.

Decades of evidence has shown that physicians are better positioned to deliver high quality care because of their demanding education and professional training requirements. We urge the Department of Treasury to recognize the training and quality differences between physicians and non-physician providers and not include the services of non-physician providers in the definition of primary care services.

3. Other Comment Areas

Medical Expenses Under 213(d)

The proposed rule appropriately clarifies that payments for a DPC may be a payment under section 213(d) for medical care, either as medical care or insurance. Specifically, the proposed rule clarifies that a payment for a DPC arrangement may be a payment for medical care under section 213(d)(1)(A) or a payment for medical insurance under section 213(d)(1)(D). Therefore, regardless of how a DPC is classified, an amount paid for a DPC will qualify as a medical expense under section

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[2] Primary Care Coalition. "Compare the Education Gaps Between Primary Care Physicians and Nurse Practitioners." Texas Academy of Family Physicians, Texas Pediatric Society, and the Texas Chapter of the American College of Physicians. Accessed August 3, 2020 at https://tafp.org/Media/Default/Downloads/advocacy/scope-education.pdf

213. Although this does not overcome the section 223 issues discussed above, we support this proposal because it is a step toward increasing access to DPC arrangements and provides much-needed relief to individuals with high medical expenses.

HRAs and DPC Arrangements

We support the agency's proposal that HRAs may provide reimbursements for DPC arrangement fees. We agree with the IRS' reasoning that since HRAs may reimburse expenses for medical care as defined by section 213(d), such funds should be allowed to be used for DPC fees. This policy will help improve access to DPCs for individuals with HRAs.

We also ask IRS to clarify that patients can use Flexible Spending Arrangements (FSA) funds to pay DPC arrangement fees. As you know, FSA funds may be used for qualified medical expenses in a health plan that would qualify for the medical expense deduction. Since DPCs are not health insurance and payments for DPCs qualify as medical expenses under this proposed rule, we urge the IRS to allow FSA funds to be used for DPC arrangement fees.

Health Care Sharing Ministries and DPCs

We applaud the proposed rule's treatment of HCSMs for purposes of HRAs and HSAs. We agree that individuals with an HSA or HRA should be able to use those funds for HCSMs. However, HCSMs and DPCs are distinct from each other and should not be conflated. We ask the IRS to clearly indicate to the public that they are two separate methods for paying for health care and future rulemaking should address each arrangement separately.

Conclusion

DPCs are intended to provide high-quality care for patients while allowing physicians to focus on care rather than administrative tasks. The federal government has the opportunity to expand DPCs and thereby improve health outcomes and drive efficiencies in the health sector. We believe that addressing our feedback to this proposed rule would help ensure that these goals are met. Thank you for your attention to and consideration of our comments.