



August 10, 2020

The Honorable Charles P. Rettig  
Commissioner  
Internal Revenue Service  
1111 Constitution Avenue NW  
Washington, DC 20224

RE: REG-109755-19 (RIN: 1545-BP31)

Dear Commissioner Rettig:

We appreciate the Administration's efforts to encourage the Department of the Treasury to propose rules to treat expenses related to direct primary care (DPC) arrangements as eligible medical expenses under section 213(d) of the Internal Revenue Code, 26 USC (IRC) pursuant to Executive Order 13877 Improving Price and Quality Transparency to Put Patients First (EO). We have limited our comments in this document to DPC Agreements, our area of expertise.

We understand that the scope of the EO did not encompass changes to Section 223 (c) of the IRC outlining eligibility requirement for Health Savings Accounts (HSA). As the proposed rule (rule) points out, IRC Sec. 223 (c) states that to be eligible to establish and contribute to an HSA, an individual must be covered under a high deductible health plan (HDHP)—and while covered under an HDHP, may not be covered under any other health plan which is not an HDHP and which provides coverage for any benefit which is covered under the HDHP. But the rule appropriately forces IRS to make definitions of a DPC agreement bringing new interpretations or definitions coverage under 223 (c) into consideration.

Under the definitions proposed by IRS in the rule, a DPC agreement in its most common form today would amount to coverage like a "group health plan," insurance, or "other" coverage, making an individual ineligible to fund an HSA. Thus, the rule does not address the key regulatory barrier keeping individuals with HSAs from having a DPC arrangement. We believe this could be resolved by correcting the IRS interpretation of DPC arrangements in the rule.

This key issue for DPC agreements stems not from the lack of clarity around DPC in 213 (d) of the Internal Revenue Code (IRC), but from 223 (c) of the IRC, which is addressed in the rule defining HSA eligibility criteria:

- IRC 223 (c) states that to be eligible to establish and contribute to an HSA, an individual must be covered under an HDHP—and while covered under an HDHP, may not be covered under any other health plan which is not an HDHP and which provides coverage for any benefit which is covered under the HDHP.
- S. 2999, The Primary Care Enhancement Act creates an exception under 223 (c) to make a permanent change to the tax code which clarifies that a DPC arrangement is not to be considered insurance or other coverage that would make an individual ineligible to fund an HSA, and allow them to use funds from their HSA to pay fees for primary care services in an affordable DPC arrangement.

- While the legislation would fix this problem, we ask that IRS look more closely at the nature of DPC arrangements, which represent a new innovative way for patients to pay for primary care services and make appropriate changes in definitions.

First, we ask that IRS use current industry practice and define DPC agreements in the rule as contracts for payment for a high level of access to primary care services, which are already qualified expenses under 213 (d). Secondly, we ask IRS to acknowledge that these advanced primary care services offered in a DPC agreement are not an HDHP, and that they do not replicate the kind of coverage found in any HDHP today. Under this correct definition, a DPC agreement would not constitute coverage provided under any other health plan, nor would it provide coverage for any benefit which is already covered under the HDHP.

HSA eligibility rules under Sec. 223 (c) represent the most significant regulatory hurdle facing Americans with High Deductible Health Plans (HDHP) who need improved access to better primary care that DPC provides, and to the employers who wish to pay for DPC arrangements as a part of a modern health benefits package. The pandemic facing our nation which has stressed primary care to the brink, demands that we change this outdated and inappropriate regulatory hurdle.

We do appreciate clarification in the proposed rule that DPC arrangements providing a high level of access to quality affordable primary care are compatible with Health Reimbursement Arrangements (HRA) and Flexible Spending Accounts (FSA). However, we urge the IRS to read these comments, along with the comments of individuals, DPC practitioners, and employers who would all greatly benefit from regulatory flexibility on the HSA eligibility criteria. We believe there is a regulatory pathway to fix all these issues and it lies in finding the appropriate definition of a DPC agreement. The rule as proposed falls short of this mark.

**Definition of DPC:** The rule shows a fundamental lack of understanding of current state and federal laws (outside the tax code) defining what constitutes a direct primary care agreement. There are at least [30 state laws and regulations](#) defining DPC agreements as contracts for medical services, not insurance or group health plans, and as such are outside of state insurance regulations. Likewise, the regulations promulgated for Sec. 1301 (a) (3) of the Affordable Care Act (PL-111-148) by the U.S. Department of Health and Human Services (HHS) says that DPC practices are “providers, not insurance companies.” Treatment of Direct Primary Care Medical Homes, 77 Fed. Reg. 18423 (Mar. 27, 2012) states that a DPC arrangement is “an arrangement where a fee is paid by an individual, or on behalf of an individual, directly to a medical home for primary care services, consistent with the program established in Washington.” (WA 48.150 RCW).

The common definition for DPC agreements used by most state laws and the ACA are: 1. DPC agreements are for primary care medical services, and are not regulated as insurance; 2. Compensation for services provided in such agreements comes in the form of a periodic (usually monthly) fee from an individual, employer or other payer; 3. That no third parties are billed again for any medical services already provided under the terms of the agreement.

Primary care services as defined in the rule stemming from section 1833(x)(2)(B) of the SSA are appropriate.

**Scope of Practice:** The rule also requests comments on whether to “expand the definition of a direct primary care arrangement to include a contract between an individual and a nurse practitioner, clinical

nurse specialist, or physician assistant or other non-physician practitioners.” We would ask that the rule not address these as issues, which are already the subject of many state and federal laws in addition to primary care services as defined in section 1833(x)(2)(B) of the SSA. If state medical licensure, or government payers (e.g. CMS) permit non-physician practitioners to provide primary care services we see no reason why the IRS needs to limit or change these conditions strictly for the purposes of tax treatment of DPC agreements.

**Legislative Approach:** Realizing that changes to this or any section of the IRC are complex, we are very appreciative of the administration’s past support for legislative changes to these dated definitions of DPC arrangements under 223 (c) restrictions, currently found in S. 2999, the Primary Care Enhancement Act. In a Statement of Administration Policy on July 23, 2018, the administration supported H.R. 6311 (115<sup>th</sup>), which contained this proposal, calling it a “commonsense” health reform. The bipartisan bill passed the House of Representatives but did not pass the Senate before the session ended. We will continue to support legislative changes and would ask the IRS to provide appropriate technical assistance to Congress as the bill moves through the legislative process. It would be ideal that IRS apply the appropriate definition to DPC in such efforts.

**Regulatory Flexibility:** While working with Congress on a legislative solution, we have also worked closely with this administration, and previous administrations, providing ideas for some simple changes that might be made under current law with an appropriate understanding of the scope of DPC. It is more critical than ever to apply appropriate definitions of DPC agreements, taking into consideration the great public need for improved access to primary care and prioritizing personal health as an essential element in rebuilding the economy of our nation and security of the treasury itself. We note that Sec. 223 (c) uses section 213 (d) in making determinations of what is or is not insurance or medical care bringing Sec. 223 (c) into consideration for regulatory review or perhaps even simple changes in guidance. Timing is critical.

**Process and Timing:** The purpose of this rule is to seek stakeholder comment on a proposed set of regulations that would define DPC agreements, among other things. We understand that the Internal Revenue Service and the Treasury Department took time to conduct a long review (far more time than the EO anticipated) of DPC practices and current law under difficult circumstances which resulted in a significant delay of these proposed rules. Given the importance, in this time of pandemic, of making sure all Americans can engage a primary care provider of their choice virtually or in person, we respectfully request that the IRS expedite its review of the comments and engage directly and openly with stakeholders, such as DPC practices in making significant changes in direction before publishing a final rule.

Primary care in America is in crisis, and DPC providers have a solution in this new value-based delivery model that can improve care, save lives and replenish the primary care workforce in an economically sound model. A recent [Milliman Study](#) for the Society of Actuaries shows that enrollment in a DPC agreement is associated with a reduction in overall demand for health care services outside primary care. DPC patients generate as much as 19.90% lower claim costs for employers; and up to 40% fewer ER visits than those in traditional plans. Ninety nine percent of DPC practices surveyed were doing virtual consults via text/phone as a part of the membership fee two years prior to COVID-19, and 88% said they provided “telemedicine” benefits with expanded video or additional digital communications assets. We urge IRS to act in a timely fashion so that individuals with HDHP can take full benefit of the opportunity to have a personal relationship with a physician in this time of pandemic.

**HSA Eligibility and services offered under High Deductible Health Plans:** IRS has shown flexibility to make regulatory changes through published guidance evolving its interpretations of medical services under Sec. 223 (c) in the past. There is very recent history of such guidance. On March 20, 2020, IRS Notice 2020-15, “To facilitate the nation’s response to the 2019 Novel Coronavirus (COVID-19)” provided that “Until further guidance is issued, a health plan that otherwise satisfies the requirements to be a high deductible health plan (HDHP) under section 223(c)(2)(A) of the Internal Revenue Code (Code) will not fail to be an HDHP under section 223(c)(2)(A) merely because the health plan provides health benefits associated with testing for and treatment of COVID-19 without a deductible, or with a deductible below the minimum deductible (self only or family) for an HDHP. Therefore, an individual covered by the HDHP will not be disqualified from being an eligible individual under section 223(c)(1) who may make tax-favored contributions to a health savings account (HSA)... As a result, the individuals covered by such a plan will not fail to be eligible individuals under section 223(c)(1) merely because of the provision of those health benefits for testing and treatment of COVID-19.1Tax-favored contributions may also be made on behalf of eligible individuals by their employers.”

We also note that Section 3701 of the CARES Act (PL-116-136) creates a Sec 223 (C) exception available to telemedicine as part of the CARES Act, further showing Congressional intent to give IRS flexibility to make changes to HSA eligibility.

We appreciate the IRS and Treasury Department’s consideration of these comments and stand ready for further dialogue with the department to help improve this important proposal. Comments are made on behalf of the [Direct Primary Care Coalition](#) (DPCC) representing the founders of the DPC practice model, primary care physicians, healthcare associations, employers, and patients who support the advancement of state, federal, and private sector policies that bring patients and physicians together to promote better primary care through DPC. Today, over 1,200 DPC practices nationwide provide outstanding access to great primary care to over 300,000 American patients. The DPCC believes that Americans of all ages and incomes should have access to high functioning, affordable, comprehensive, accessible, personal primary care delivered by a trusted personal primary care physician who knows the patient, and therefore can be that patient’s guide through the often complicated and expensive healthcare system.

Sincerely,



Garrison Bliss, MD  
Chairman  
Direct Primary Care Coalition



Jay Keese  
Executive Director  
Direct Primary Care Coalition