The Honorable _____

U.S. House

Dear Representative

My name is Dr. [DPC physician name] and I am a Direct Primary Care (DPC) physician practicing in our great state of [State]. The name and location of my practice is [name and address of DPC practice]. I am one of many DPC practices in our state providing patients affordable, attentive and accessible health care.

I am writing asking you to oppose HR 3708. The DPC community is hopeful for legislation which allows Health Savings Accounts (HSAs) to collaborate with DPC, which this bill purports to do. But there are too many concerning areas of this bill and we cannot support it as written. Our ask would be that the Primary Care Enhancement Act, as introduced in 2017 (H.R. 365), be used as the basis for any bill that seeks to give patients the ability to take advantage of the cost savings offered by both HSAs and DPC.

To ensure the continued the growth of independent DPC practices which are helping hundreds of thousands of patients across the country, I would greatly appreciate thoughtful review and consideration of the following areas.

The first issue listed is of utmost importance:

1. **As written, HR 3708 risks creating new obstacles to all patient and physician collaboration through DPC arrangements**. Specifically, although the language does state that DPC agreements must be *for* qualified medical expenses, the legislation fails to expressly define DPC arrangements *as* a qualified medical expense under IRC 213(d). Instead it designates DPC as "excepted coverage" under the provisions in IRC 223(d)(2)(C) that permit HSA payment for certain types of insurance. These may seem trivial distinctions, but they carry potentially significant policy consequences. **Correctly identifying DPC arrangements as medical care under IRC 213(d), and not as disregarded insurance under IRC 223(d), will avoid unnecessary conflicts with state laws exempting DPC from regulation as an insurance product, as well as curbing the potential application of any relevant federal insurance regulation to DPC. Making this change will better serve the Administration's goal of reducing regulatory burden, especially for the DPC practices operating as small businesses.**

To date, *27 states* have passed legislation defining Direct Primary Care and removing it from any insurance regulation. Five states have legislative efforts currently under-way.

2. **Independent DPC physicians often offer patients access to prescription drugs at wholesale cost resulting in substantial savings to patients**. While it appears that the language in the bill as written *might* preserve the ability of patients to obtain their prescriptions in this way, the wording is not sufficiently clear. A 2018 Yale study by Liu et al in the *Annals of Internal Medicine* reports a finding that DPC patients already know: bypassing insurance often results in lower drug costs. It is imperative to ensure that the bill language does indeed preserve this practice. In addition, allowing some medications to be included in DPC agreements would be welcome

flexibility. Striking the "services specifically excluded" provisions, or at least item (II), prescription drugs, would better serve patients. **Any pressure brought to bear that serves to unwind the predominance of PBM- and insurer-controlled prescription benefits will help achieve the mission of reducing drug costs for American patients.**

3. Another provision impeding **the goal of increasing patient options is the $150 aggregate cap on individuals' use of Direct Primary Care agreements that preserve HSA-eligibility.** This aggregate cap constrains any flexibility the bill might have for allowing agreements with non-primary care specialties, i.e. patients who enter into agreement with one DPC practice could enter into an agreement with a second or third physician only to the extent allowed by the amount remaining under the cap. Related provisions in the bill that require separate reporting of DPC fees to the IRS on employees' W2 forms will increase employer compliance expense and unnecessarily intrude into employee decisions about their benefits. Ideally the cap should be lifted and the W2 provisions removed. Alternately the bill could be changed to allow the use of after-tax dollars for the amount in excess of the cap. If a cap remains in the bill, at the very least, individuals exceeding the cap should not become disqualified from contributing to their HSA. This change could be facilitated by moving the cap out of the bill's definition of eligible DPC agreements.

4. **The provision of the bill limiting the types of specialties allowed to enter into an HSA-eligible direct care agreement harms patient options and restrains competition.** For instance, a patient might wish to enter an agreement with his or her endocrinologist for diabetes management care, which would likely be prohibited under the bill as presently written. The provision also potentially increases the regulatory role of HHS since the definition of eligible specialty is tied to Medicare's definition in Section 1833(x)(2)(A) of the Social Security Act. **A solution would require modifying or striking the citation to "1833(x)(2)(A)" and related accompanying language. An alternative, that would have minimal impact to the cost estimate, would be lifting the specialty restrictions for HSA-eligible agreements funded solely from an individual's HSA account or after tax dollars, not from other tax-advantaged sources like an employer or plan. HSA dollars are supposed to increase patient choice, not limit them**.

5. Another needed clarification relates to how physicians opted out of Medicare (as many DPC physicians are) or not otherwise enrolled will designate their specialty, since the specialty designation mentioned in 1833(x)(2)(A) appears tied to Medicare enrollment. **This bill should not require enrollment in any federal program**.

In summary, the best solution is to start over with the original language of the Primary Care Enhancement Act of 2017 (then known as H.R. 365). But if the House moves forward with H.R. 3708, the changes outlined above must be addressed, or the bill risks doing more harm than good to my patients, your constituents, and to all Direct Primary Care practices across the nation. Private, independent DPC offices must remain available to provide affordable high-level primary care to patients and the public.

Thank you for your time and consideration,

_____(signature)

_____(office address and contact info)

P.S. In case you're not already familiar with it, Direct Primary Care (DPC) is an innovative practice model that is growing across the nation as a grassroots approach to restore the patient-physician relationship by directly bringing patients and their primary care physicians together without the administrative burdens of a third party. Patients pay their physicians directly through an affordable monthly membership fee which provides value-added services such as improved access, longer visits, improved continuity of care and restored one-on-one relationships with their doctor. DPC offices can provide access to low cost medications, imaging and lab pricing that enables patients who are uninsured, underinsured, or patients with high deductible plans to get the treatment or workup they need.

If you are interested in talking more about Direct Primary Care, please feel free to contact me; you are always welcome to visit my office to see DPC in action.