Texas Public Policy Foundation

December 14, 2019

Dear Members of Congress:

We write to express concern regarding the Primary Care Enhancement Act of 2019 (HR 3708) that would impose price caps and detrimental exclusions on the most successful model extant in healthcare today that offers affordable care with no exclusions for those with chronic conditions. While we appreciate efforts to pass meaningful bi-partisan legislation clarifying the tax treatment of Direct Primary Care (DPC) periodic medical service fees, the recently introduced HR 3708 contains critical flaws identical to those in Section 3 of HR 6199 (2018) which failed during the 2018 legislative session. HR 3708 is a drastic departure from the original Primary Care Enhancement Act of 2017 (HR 365) that had broad bipartisan support and backing of the DPC community and patients alike.

MEDICATION EXCLUSION – HR 3708, SEC. 2(a), creating IRC § 223(c)(1)(D)(iii)(II):

This vaguely worded section establishes unreasonable bias against practices that offer in-house dispensing of medications. Physicians dispense prescription medications from their offices in 45 of the 50 states. Recent data suggest direct-to-consumer dispensing of generic medication could save billions of dollars annually. While Congress seeks affordable medication solutions, placing *any* restrictions on the most affordable medication solution available is a move in the wrong direction. The section mandates that vaccines be included in instances where clinics may want to charge separately. Conversely, physicians that administer medications for no additional cost within their membership will now be forced to charge separately.

CAP ON PATIENT USE OF HSA – HR 3708, SEC. 2(a), creating IRC § 223(c)(1)(D)(ii)(II):

This provision proposes a $150 cap on an individual's aggregate monthly DPC fees. DPC is one of the few working models of healthcare innovation in the country. It offers affordable care for patients, while exemplifying congressional priorities of price transparency and elimination of surprise medical bills. This provision creates the first federally legislated limitation on a patient's use of HSA dollars for medical care in U.S. history. This is harmful to patient choice and an affront to the transparency that Congress seeks. There is absolutely no reason to cap one of the only medical models that is actively lowering costs. This innovation should be fostered, not stifled by federal price controls of the most affordable healthcare solution in the country.

DEFINITION IN TAX CODE – HR 3708,SEC. 2(b), creating IRC § 223(d)(2)(C)(v):

We believe this bill proposes to fix the wrong section of tax code. Instead of simply defining DPC memberships as an eligible medical expense under §213(d) of the Internal Revenue Code (IRC), it erroneously categorizes DPC as one of the exempt forms of health insurance, listed under IRC § 223(d)(2)(C), that can be purchased with HSA funds. This provision sets up conflicts with half the states in the nation that have passed laws declaring that DPC is *not* health insurance. Additionally, it provides a legal foundation for hostile state insurance commissioners to regulate DPC as insurance in states without DPC protection. During a time where Congress is trying to put forth meaningful healthcare reform policy, contradicting state laws intended to improve healthcare access will not serve the best interests of states, patients, and constituents.

EXCLUSION OF SPECIALTIES – HR 3708, SEC. 2(a), creating IRC § 223(c)(1)(D)(ii)(I):

This provision appears to limit DPC agreements to practitioners who listed one of four primary specialty designations when they enrolled with Medicare: family medicine, internal medicine, geriatric medicine, or pediatric medicine. The vast majority of independent DPC physicians have opted out of Medicare, so it is unclear how they could comply with this requirement. Additionally, there are specialists now opening "direct care" offices. In particular, the state of Florida has passed legislation expanding their definition of DPC to all specialties.

CONTRADICTORY TREATMENT OF DPC AS NOT INSURANCE – HR 3708, SEC. 2(a), creating IRC § 223(c)(1)(D)(i):

DPC is not a health plan under existing law. The provision in HR 3708, Sec. 2(a), that creates IRC § 223(c)(1)(D)(i), codifies this position, removing any question of whether DPC is a disqualifying "second health plan" when combined with a qualified High Deductible Health Plan. It is contradictory then for the bill to later, at HR 3708, Sec. 2(b),define DPC, in IRC § 223(d)(2)(C), as a type of plan that can be purchased with HSA dollars. We reiterate our position that DPC is properly defined as medical care for which HSA dollars can be used, not a type of plan. Combined with the President's recent executive order directing the IRS to clarify DPC as an HSA eligible IRC § 213(d) medical expense, this single provision at HR 3708, Sec. 2(a), creating IRC §223(c)(1)(D)(i), which states that DPC is not a plan, could serve as a simple standalone solution.

CONCLUSION

Direct primary care (DPC) continues to grow and make positive strides in the delivery of healthcare throughout the nation even though this model has been erroneously considered a plan as interpreted by the Treasury Department. DPC does not accept risk and offers comprehensive primary care services. This model, unlike other healthcare services, does not qualify for use of Health Savings Accounts and would only need to be designated as a qualified medical expense under the law. HR 3708 would create too many unintended consequences and cause this innovative model to move in the wrong direction.

Yours respectfully,

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