



August 10, 2020

Steven Terner Mnuchin
Secretary of the Treasury
Internal Revenue Service
CC:PA:LPD:PR(REG-109755-19)
Room 203, Internal Revenue Service,
P.O. BOX 7604
Ben Franklin Station
Washington, DC 20044

Dear Secretary Mnuchin:

On behalf of the American College of Physicians (ACP), I am pleased to share our comments on the Department of The Treasury, Internal Revenue Service's notice of proposed regulations. This proposal relates to section 213 of the Internal Revenue Code (Code) regarding the treatment of amounts paid for certain medical care arrangements, including direct primary care arrangements, health care sharing ministries, and certain government-sponsored health care programs.

The American College of Physicians is the largest medical specialty organization and the second largest physician membership society in the United States. ACP members include 159,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. Internal medicine specialists treat many of the patients at greatest risk from COVID-19, including the elderly and patients with pre-existing conditions like diabetes, heart disease, and asthma.

Definition of Direct Primary Care Arrangement:

The proposed regulations define a "direct primary care arrangement" as a contract between an individual and one or more primary care physicians under which the physician or physicians agree to provide medical care (as defined in section 213(d)(1)(A)) for a fixed annual or periodic fee without billing a third party.

ACP agrees with this definition of DPC and recognizes that there are strengths of the DPC in its ability to leverage price transparency, improve timely access, and make participating clinicians fully accountable for cost. An advantage of the model is its degree of autonomy, flexibility, and direct relationship between the physician and patient, which allows the practice to scale out-of-pocket costs according to a patient's ability to pay. Yet, there are important patient access implications to consider related to affordability to patients and downsizing patient panels that must be considered in any models that replace billing of third party payers with direct billing of patients for a fixed annual or periodic fee. Many DPC practices have modest monthly capitation fees, particularly for low-income patients, to make them affordable and accessible for such patients. Of note, concierge practices, which tend to be associated with high fees, are distinct from DPC models, and may be less affordable for low-income

persons. Such issues are discussed in detail in *Assessing the Patient Care Implications of “Concierge” and Other Direct Patient Contracting Practices: A Policy Position Paper From the American College of Physicians*.¹ As noted in that paper, **ACP supports physician and patient choice of practice and delivery models that are accessible, ethical, and viable and that strengthen the patient–physician relationship.**

ACP supports the Institute of Medicine definition of primary care: the provision of integrated, accessible health care services by physicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. **Therefore, the College supports the proposed regulations definition a “primary care physician” as an individual who is a physician [as described in section 1861(r)(1) of the Social Security Act (SSA)] who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine.** Primary care physicians with the specialty designations of family medicine, internal medicine, geriatric medicine, and pediatric medicines, in collaboration with other clinicians on the clinical care team, are ideally suited to provide principal care and be a patient’s care coordinator – a personal physician, in the advanced medical home model. Internal medicine specialists, in particular, have unique training and skills to care for adult patients with more complex medical conditions. In some cases, an internal medical subspecialist working with his or her clinical care team can fulfill the role of personal physician particularly as it relates to chronic conditions under their care.

The College recognizes the important role that nurse practitioners and physician assistants play in meeting the current and growing demand for primary care as part of a dynamic clinical care team, especially in underserved areas, yet we strongly believe that patients should have access to a personal physician who is trained in the care of the “whole person” and has leadership responsibilities for a team of health professionals, consistent with the Joint Principles of the Patient-Centered Medical Home, and as discussed in ACP’s position paper, *Principles Supporting Dynamic Clinical Care Teams: An American College of Physicians Position Paper*.²

In this paper, ACP notes that the “purpose of licensure must be to ensure public health and safety. Licensure should be evidence-based. It should protect the public from receiving care from clinicians that is beyond their training, skills, clinical experience, and demonstrated competence; licensure should not restrict qualified clinicians from providing care that is commensurate with, but does not extend beyond, their training, skills, clinical experience, and demonstrated competence. Licensure should ensure that each member of the health care team practices within ethical standards as a condition of obtaining and maintaining their license. Licensure should ensure a level of consistency (minimum standards) in the credentialing of clinicians who provide health care services. Licensing bodies should recognize that the

¹ Doherty, R. *Assessing the Patient Care Implications of “Concierge” and Other Direct Patient Contracting Practices: A Policy Position Paper From the American College of Physicians*. 15 December 2015. <https://www.acpjournals.org/doi/10.7326/M15-0366?articleid=2468810>

² Doherty, R. Crowley, R. *Principles Supporting Dynamic Clinical Care Teams: An American College of Physicians Position Paper*. American College of Physicians. 5 November 2013. <https://www.acpjournals.org/doi/10.7326/0003-4819-159-9-201311050-00710>

skills, training, clinical experience, and demonstrated competencies of physicians, nurses, physician assistants, and other health professionals are not equal and not interchangeable.”

Further, the Treasury Department and the IRS understand that other types of medical arrangements between health practitioners and individuals exist that do not fall within the definition of direct primary care. ACP is also aware that such arrangements exist. As an example, physicians who practice in the specialty of obstetrics and gynecology may have direct payment arrangements with patients that bundle payment for maternity care and a few other select services. We believe such arrangements may be appropriate as long as they are held to the same criteria as for direct primary care contracts arrangements and the payments are for medical services provided.

Women’s health care transcends reproductive care and should address the broad spectrum of health concerns of adult women through their life cycle. Delivering primary care to women is one of the core competencies of internal medicine. Internists should minimize the fragmentation of women’s health care and maximize the opportunities for comprehensive primary and preventive care at each clinical encounter. All physicians delivering primary care to women should be competent to diagnose and manage the most common conditions in women presenting in the ambulatory setting.

Direct Primary Care Arrangements, Health Reimbursement Arrangements (HRAs), and HSAs:

ACP is concerned that high deductible health plans, to which Health Savings Accounts (HSA) must be connected, dissuade from seeking care. High-deductible health plans (HDHPs) should only be used to encourage use of high-value services. Further, consumer-directed health care plans, like HDHPs with certain HRAs and HSAs, can exist as an option as long as they are offered alongside comprehensive, low-deductible coverage. Such plans should make available advance refundable tax credits for lower income, uninsured Americans and expansion of existing public safety net programs for the poor.

ACP believes advance, refundable and sliding scale tax credits to purchase qualified health insurance in the individual insurance marketplaces should continue to be made available to uninsured or underinsured working Americans with incomes up to 400% of the federal poverty level. We believe that it may be appropriate to apply tax credits to the purchase of Health Savings Accounts with wrap-around catastrophic coverage in direct primary care and other direct payment models. The Department of Treasury should also consider working with Congress to enhance and expand eligibility of cost-sharing reductions and eliminate the 400% cap in current law to allow income adjusted subsidies to all persons as well as enhancing the amount of premium tax credits for all income levels.

The federal government and other groups should continue to monitor the use of HSAs, HDHPs and other consumer-directed health plans on access to health insurance for people with existing health problems and people with low and moderate incomes. The effect such plans have on the ability of vulnerable populations to obtain health insurance and access to health care services should also be monitored to ensure that such groups are not indirectly harmed. Elements to be especially monitored include: the problem of adverse selection; access to basic, preventive services; affordability of premiums; consumer and employer awareness and understanding of these savings options; and potential for consumers to save for future health care expenses.

HSAs should provide patients with incentives to select more cost-effective and higher-quality options. Since HSAs put patients in control of the limited resources that are available for their health care, it is

essential that patients be provided with the understandable information necessary for such decision-making. Patients must have ample health and health insurance literacy and access to understandable health care cost and quality information to make informed decisions. The literature shows that even when preventive services are exempt from cost sharing, patients may forgo such services because they are unaware that such services are free.

ACP is appreciative and encouraged by this request considering ways to help patients, physicians, and their teams especially during these difficult economic times. The hope any changes implemented will lay the necessary groundwork to explore additional policy solutions to continue to support our nation's clinicians and patients in the months and years to come. ACP offers our assistance toward these efforts. Please contact Brian Outland, PhD, Director, Regulatory Affairs, by phone at 202-261-4544 or email at boutland@acponline.org if you have questions or need additional information.

Sincerely,

A handwritten signature in black ink that reads "Jacqueline W. Fincher MD". The signature is written in a cursive, flowing style.

Jacqueline W. Fincher, MD, MACP

President