DEPARTMENT OF TREASURY Internal Revenue Service 26 CFR Part 1 [REG-109755-19] RIN 1545-BP31 Certain Medical Care Arrangements (Proposed Rule)

Below are thoughts from Philip Eskew, DO, JD, MBA drafted on 06/09/20. Areas that are in green are helpful, red are harmful, blue are suggested wording additions, and highlighted areas are spots where the IRS has specifically requested commentary

The document opens in a fairly harmless manner, noting on page 6 that

> "After gathering information on those arrangements and considering the relevant legal authorities, the Treasury Department and the IRS propose that **expenditures for direct primary care arrangements** and health care sharing ministry memberships **are amounts paid for medical care as defined in section 213(d)**, and that amounts paid for those arrangements may be deductible medical expenses under section 213(a)."

On page 7 the definition leaves much to be desired. At a minimum I would recommend that we add the language below in blue. Highlighted areas are spots where the IRS is inviting formal comment. In this case I think we should pick our current favorite state DPC defining language. With the ACA the feds referenced Washington state's language. In this case we might ask them to reference Wyoming's language defining DPC.

> "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 on a fee for service basis. The proposed regulations define a "primary care physician" as an individual who is a physician (as described in section 1861(r)(1) of the Social Security Act (SSA)) or other provider who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, occupational medicine, preventive medicine, or pediatric medicine, . The definition is adopted from paragraph (I) of the definition of "primary care practitioner" in section 1833(x)(2)(A)(i) of the SSA."

> "The Treasury Department and the IRS request comments on the definition of primary care physician and on the definition of direct primary care arrangement."

Please see my thoughts above.

> "The Treasury Department and the IRS also request 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 (as those terms are defined in section 1861(aa)(5) of the SSA) who provides primary care services under the contract. The Treasury Department and the IRS request comments on how to define primary care services provided by a non-physician practitioner, including whether the definition of primary care services in section 1833(x)(2)(B) of the SSA is appropriate."

I doubt we need to say much here. I'm sure that the IRS has no rational basis for concluding that only care delivered by physicians would be taxed one way while care delivered by NPs is taxed another way. This is a distraction.

Page 8 contains another request for comment:

> "The Treasury Department and the IRS request comments on whether the final regulations should clarify the treatment of other types of arrangements that are similar to direct primary care arrangements but do not meet the definition in the proposed regulations."

This is a distraction as well. The IRS is too busy and needs to remain focused on providing a clean response to the DPC community.

The language on page 9 makes it clear that the IRS sees two possible outcomes. DPC payments are either made pursuant to a specific chronic condition with a specific expected course of treatment or they are for preventive visits only. This is NOT really a new interpretation. It is merely a restatement of an old and unhelpful interpretation. These old and narrow exceptions were not widely embraced for obvious reasons and they are not helpful to us now either.

> "Direct primary care arrangements, as defined in the proposed regulations, may encompass a broad range of facts. Depending on the facts, a payment for a direct primary care arrangement may be a payment for medical care under section 213(d)(1)(A) or, as discussed below, may be a payment for medical insurance under section 213(d)(1)(D). For example, payments for a direct primary care arrangement that solely provides for an anticipated course of specified treatments of an identified condition, or solely provides for an annual physical examination, are payments for medical care under section 213(d)(1)(A). However, so long as a direct primary care arrangement meets the definition set forth in the proposed regulations, amounts paid for the arrangement will qualify as an expense for medical care under section 213(d), **regardless of whether the arrangement is for medical care under section 213(d)(1)(A) or medical insurance under section 213(d)(1)(D)."**

Page 11-12 clarifies that while the IRS always had a lousy argument against DPC based on 213(d) they believe that they have a stronger argument with section 223. They seem to cede that no matter how things play out they will likely lose on 213(d), but that as long as we practice traditional DPC they see no way around the 223(c) problem.

> "As noted above, depending on the specific facts regarding an arrangement, a payment for a direct primary care arrangement may be a payment for medical care under section 213(d)(1)(A) or may be a payment for medical insurance under section 213(d)(1)(D). Regardless of the characterization of an arrangement as medical care under section 213(d)(1)(A) or medical insurance under section 213(d)(1)(D), an amount paid for the arrangement will qualify as a medical expense under section 213.
> However, the characterization of a direct primary care arrangement as medical insurance under section 213(d)(1)(D) has implications for purposes of the rules for health savings accounts (HSAs) under section 223. Specifically, as explained later in this preamble, if an individual enters into a direct primary care arrangement, the type of coverage provided by the arrangement will impact whether or not he or she is an eligible individual for purposes of section 223."

Page 15 goes on to clarify what I have already stated previously. HRAs are concerned only with section 213 and not 223. If the IRS is backing off the 213 argument, then there really is not much debate about HRAs (or FSAs – even though they failed to clarify this issue here) moving forward.

> "An HRA, including a QSEHRA, an HRA integrated with a traditional group health plan, an HRA integrated with individual health insurance coverage or Medicare (individual coverage HRA), or an excepted benefit HRA, generally may reimburse expenses for medical care, as defined under section 213(d). Thus, an HRA may provide reimbursements for direct primary care arrangement fees."

Page 17 clarifies that when DPC provides broad scope primary care not limited to the narrow "prevention only" category and not limited to a set of predefined and individually charged chronic conditions then the IRS envisions a clear 223 HSA eligibility problem. The last sentence below appears to discriminate against group health plans, but this is not the case. The IRS is simply stating that when DPC is paid for by an employer then it is considered part of a group health plan. Whether an employer pays the fee or the individual pays the fee ultimately does not change the 223 analysis from treasury.

> "Accordingly, if an individual has coverage that is not disregarded coverage or preventive care, and that provides benefits before the minimum annual deductible is met, the individual is not an eligible individual. The Treasury Department and the IRS understand that direct primary care arrangements typically provide for an array of primary care services and items, such as physical examinations, vaccinations, urgent care, laboratory testing, and the diagnosis and treatment of sickness or injuries. **This type of DPC arrangement would constitute a health plan or insurance that provides coverage before the minimum annual deductible is met, and provides coverage that is not disregarded coverage or preventive care. Therefore, an individual generally is not eligible to contribute to an HSA if that individual is covered by a direct primary care arrangement**. However, in the limited circumstances in which an individual is covered by a direct primary care arrangement that does not provide coverage under a health plan or insurance (for example, the arrangement solely provides for an anticipated course of specified treatments of an identified condition) or solely provides for disregarded coverage or preventive care (for example, it solely provides for an annual physical examination), the individual would not be precluded from contributing to an HSA solely due to participation in the direct primary care arrangement. **If the direct primary care arrangement fee is paid by an employer, that payment arrangement would be a group health plan and it (rather than the direct primary care arrangement), would disqualify the individual from contributing to a HSA."**

We should point out the current broad section 223 exception available to telemedicine as part of the CARES Act. This Section 3701 exception is worded in a broad manner and DPC arrangements could easily fit within it as well by contractually designating that the periodic fee only covers "telehealth and remote care services" and that any in person visits that are not for preventive purposes will result in a small per visit fee at the time of the visit.

SEC. 3701. EXEMPTION FOR TELEHEALTH SERVICES.
(a) In General.—Paragraph (2) of section 223(c) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

"(E) SAFE HARBOR FOR ABSENCE OF DEDUCTIBLE FOR TELEHEALTH.—In the case of plan years beginning on or before December 31, 2021, a plan **shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for telehealth and other remote care services**."

(b) Certain Coverage Disregarded.—Clause (ii) of section 223(c)(1)(B) of the Internal Revenue Code of 1986 is amended by striking "or long-term care" and inserting "long-term care, or (in the case of plan years beginning on or before December 31, 2021) telehealth and other remote care".

(c) Effective Date.—The amendments made by this section shall take effect on the date of the enactment of this Act.