AAFP

AMERICAN ACADEMY of FAMILY PHYSICIANS

July 15, 2026

The Honorable Rick Allen
Chairman
Subcommittee on Health, Employment, Labor, and Pensions
Committee on Education and the Workforce
U.S. House of Representatives
2176 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Mark DeSaulnier
Ranking Member
Subcommittee on Health, Employment, Labor, and Pensions
Committee on Education and the Workforce
U.S. House of Representatives
2176 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Allen and Ranking Member DeSaulnier:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 124,500 family physicians and medical students across the country, I write in response to your Subcommittee hearing on July 1, 2026, entitled, "Direct Contracting: A Prescription for Lower Health Care Costs" to share the experience of family physicians engaged in direct contracting models, including direct primary care, and related policy recommendations.

Insurance plan design has a significant impact on family physicians and their patients. Plan policies can create administrative burdens that make it difficult to provide care and excessive patient cost-sharing can prevent patients from seeking care or following physician recommendations. Given that 60 percent of individuals under age 65 receive insurance coverage through their employer, and two-thirds of patients covered by an employer plan are enrolled in self-funded employer plans, employer decisions regarding coverage and contracting are consequential for family physicians and the care they can provide to their patients.[i,ii]

Currently, self-funded employers face rising costs and limited control over negotiated rates. In a self-funded plan, employers typically rely on third-party administrators (TPAs) to negotiate rates with clinicians, design benefits, and process claims. Self-insured employers aim to minimize costs, but TPAs have less incentive to reduce claims spending when it's linked to their revenue. In fact, a recent study found that employers in self-funded plans often pay higher rates for health care services than those in fully insured plans.[iii] Moreover, recent lawsuits have highlighted common TPA practices that make it difficult for employers to comply with fiduciary requirements set forth in the Employee Retirement Income Security Act (ERISA).[iv] As a result, a growing number of employers are considering direct contracting strategies.

Direct contracting allows employers to contract directly with physician groups or health systems to provide health care services, including primary care, to employees and their families. The AAFP supports physician and patient choice to participate in any ethical care

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delivery or payment model, including direct contracting. **The AAFP believes that, when priced and contracted appropriately, direct contracting can enable physicians to spend more time with their patients and provide numerous benefits for employers, including reduced health care costs and increased employee satisfaction and productivity.** To that end, we offer the following feedback and recommendations for the Subcommittee's consideration to further enable patient-, physician-, and employer-friendly direct contracting, including:

- **Ensuring employers can make direct payment for direct primary care services arrangements fees on behalf of employees without affecting eligibility for health savings accounts;** and
- **Amending existing requirements that physicians who offer direct primary care services must opt out of the Medicare program entirely if they are seeing Medicare beneficiaries.**

Direct Primary Care (DPC) Models

Perhaps the fastest growing direct contracting model is direct primary care (DPC), which enables physicians to prioritize patient relationships, improve health outcomes, and lower overall health care costs. DPC is an innovative practice and payment model in which patients contract directly with their physician or medical practice for primary care services.

Under DPC models, patients (or employers) pay a flat monthly or annual fee in exchange for access to a defined set of primary care and related administrative services. DPC practices are structured around the patient-physician relationship and are designed to replace the traditional reliance on third-party insurance reimbursement for primary care services. In many cases, the DPC model allows physicians to offer enhanced access and more personalized care than is typically possible under a traditional fee-for-service system. These services may include same-day or real-time communication with a personal physician through advanced technology, extended appointment times, coordinated care management, and, in some cases, home-based medical visits. For example, the AAFP's 2024 DPC study found that 98 percent of DPC practices offer same-day appointments and phone/text consults, and over 80 percent provide nutritional counseling and weight management services as part of the membership fee.[v]

In addition to improving access to primary care and preventive services, DPC models increase physician satisfaction and reduce burnout. Among family physicians working in a DPC practice, 94 percent said they were satisfied with their overall practice, compared to 57 percent of those not in a DPC practice[vi]. Physicians working in a DPC practice were also more likely to indicate no level of burnout than those not working in a DPC practice (49 percent versus 14 percent, respectively).[vii] Administrative burden is a major driver of burnout; DPC models likely increase satisfaction by reducing administrative burden, allowing physicians to spend more providing care to patients.

Because of the many benefits to physicians and patients, an increasing number of family physicians are choosing to practice in the DPC model. As noted above, a growing number of employers are exploring direct primary care models to bolster employee access and utilization to high-value primary care and preventive services. Already, two-thirds of family physicians in DPC practices report they participate in employer-based contracts.[viii] While most (71 percent) of employer contracts for direct primary care offer the same bundle of services, over a quarter of employers have opted to customize their contract based on the needs of their employee population.[ix] Such customizations could include services tailored to the employee population, such as occupational health screenings specific to the industry or worksite urgent care clinics.

Remaining Barriers to DPC Expansion

The AAFP greatly appreciates that H.R. 1 eliminated the prohibition on using health savings account (HSA) funds to pay for a DPC arrangement. In response to this legislation, the Internal Revenue Service (IRS) issued Notice 2026-5, which clarifies that direct primary care services arrangements (DPCSAs) should not be treated as a health plan for the purposes of defining HSA eligibility. However, while the guidance resolves individual HSA use, it does not resolve whether employers may pay DPCSA fees on behalf of employees without jeopardizing HSA eligibility.

As the AAFP and others noted in a recent letter to the Department of the Treasury, we believe Congress intended to expand access to DPC not only for individuals, but to employers who want to offer DPC models to their employees. Unfortunately, the IRS has stated in Notice 2026-5 that employers may not pay the DPCSA periodic fee on behalf of employees enrolled in a high-deductible health plan (HDHP) paired with an HSA. This guidance is a barrier to employers who want to contract directly with family physicians to offer DPC care to their employees and their families.

Additionally, employer-sponsored arrangements provide the stability and scale DPC practices need to fund investments in service expansion to provide care for an entire workforce. For example, an employer may want a DPC practice to open an onsite worksite clinic or offer unique occupational screening services. If employees must enroll and pay individually, participation is less predictable, making it harder for DPC practices to make the upfront investments needed to open a worksite clinic or hire and train staff to provide unique services. **Therefore, we urge the Committee to work with the Department of the Treasury and the IRS to clarify that employers may pay DPCSA periodic fees on employees' behalf without affecting their HSA eligibility.**

Finally, while not squarely in the Subcommittee's jurisdiction, **we urge you to work with your colleagues at Energy and Commerce and Ways and Means to explore policy options to amend the current requirement that DPC physicians opt-out of the Medicare program entirely if they enter into a DPC arrangement with Medicare beneficiaries.** Currently, physicians who see Medicare beneficiaries as part of a DPC practice

can directly contract with those patients to provide services, but they must opt-out of the Medicare program entirely to do so. Importantly, the Centers for Medicare and Medicaid Services is explicit that opt-out is not selective.[x] This means that a physician cannot opt-out for some Medicare beneficiaries and remain participating for others – it's all or nothing. With the exception of emergency and urgent care services, opted-out physicians may not furnish any Medicare-covered services to any Medicare beneficiary, even beneficiaries who are not in a DPC contract.[xi] This restriction can leave access voids in communities where DPC family physicians also provide inpatient, skilled nursing facility, or other Medicare-covered services outside their DPC practice model. Expanding the exceptions allowed would permit opted-out physicians to care for Medicare beneficiaries who are not in a DPC contract, ensuring seniors can maintain access to necessary services within a community.

Thank you for considering these recommendations. The AAFP looks forward to working with the Subcommittee to advance policies that promote greater access to primary care through direct contracting models that benefit physicians, patients, and employers. Should you have any additional questions, please contact Julie Riley, Manager of Legislative Affairs, at jriley@aafp.org.

Sincerely,

Jen Brull, MD, FAAFP
American Academy of Family Physicians, Board Chair

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[i] Claxton, G., Rae, M., & Winger, A. (2026, April 17). *What are the recent trends in employer-based health coverage?* Peterson-KFF Health System Tracker. https://www.healthsystemtracker.org/chart-collection/trends-in-employer-based-health-coverage/

[ii] KFF. (2025, October 22). *2025 employer health benefits survey*. https://www.kff.org/health-costs/2025-employer-health-benefits-survey/

[iii] Sen, A. P., Chang, J. Y., & Hargraves, J. (2023). *Health care service price comparison suggests that employers lack leverage to negotiate lower prices*. *Health Affairs, 42*(7), 946–954. https://doi.org/10.1377/hlthaff.2023.00257

[iv] Monahan, C. (2023, March 24). *Questionable conduct: Allegations against insurers acting as third-party administrators*. Center on Health Insurance Reforms, Georgetown University McCourt School of Public Policy. https://chir.georgetown.edu/questionable-conduct-allegations-insurers-acting-third-party-administrators/

[v] American Academy of Family Physicians, "Data Brief: 2024 Direct Primary Care Study." Accessed June 29, 2026. Available online at: infographic_direct_primary_care_24_data_brief_750x1124_uaxw14.jpg (750×1124)

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[viii] Ibid.
[ix] Ibid.
[x] Centers for Medicare & Medicaid Services. (2026, March 4). *Manage your enrollment*. U.S. Department of Health and Human Services. https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/manage-your-enrollment
[xi] Electronic Code of Federal Regulations. (2026). *42 C.F.R. § 405.425 (Effects of opting-out of Medicare)*. U.S. Government Publishing Office. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-405/subpart-D/section-405.425