“Reducing Health Care Costs: Improving Affordability Through Innovation”

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INTRODUCTION

Chairman Alexander, Ranking Member Murray, and distinguished members of the HELP committee, I am Dr. Lee Gross, and I am a full-time practicing family physician from Southwest Florida. I appreciate this opportunity to testify how an emerging primary care practice model can use free-market principles to help simplify health care delivery, reduce the cost of care, lower barriers to access, reduce physician burnout and restore the patient as the central focus of our health care system. Direct Primary Care (DPC) physicians are strongly committed to working to fix our broken health care system to reduce complexity, improve value and patient health, and improve health care access regardless of a patient's pre-existing conditions or socioeconomic status.

PERSONAL BACKGROUND

I grew up in a rural community outside of Cleveland, Ohio. After college, I spent three years coordinating clinical trials for the Cleveland Clinic Foundation's cardiology program prior to attending medical school at Cleveland's Case Western Reserve University. Despite my extensive background in cardiology, the primary care field of family medicine that allowed me to care for the entire patient called to me during my training. I went on to complete a family medicine residency at University Hospitals of Cleveland, where I became a chief resident.

At the time of completing my residency, the Cleveland health care market was undergoing a major transformation with nonprofits University Hospitals (UH) and Cleveland Clinic Foundation (CCF) both in frenzied growth modes, acquiring medical practices and expanding their footprint across the entire regional landscape including my rural hometown. A graduating physician that wanted to stay in the Cleveland market had essentially 3 options: work for CCF; work for UH; or don't work. Not interested in the large corporate model of health care delivery, I left Cleveland and relocated with my family to Southwest Florida, where I have remained in private practice since 2002.

Having a primary care career in private practice has been a matter of survival of the fittest. My solo practice rapidly grew and within a few years, I was ready to bring on a partner, Dr. William Crouch. My practice was an early adopter of electronic health records (EHR), starting in 2003, because it made sense and helped us improve efficiency and workflow. As the government got into EHR regulation and certification, Washington regulations were now the driver of the EHR development, not the user experience. Our once affordable and helpful technology platform rapidly became an extremely costly, clunky and inefficient billing tool – a required burden that no longer had the ability to capture the nuances of the patient encounter.

As a Florida-based practice, we were very heavy in Medicare patients in our practice. Over the years, we seemed to play a continuous game of "whack-a-mole" with Medicare as CMS would change regulations that limited what services we could provide to our patients and cut off sources of practice

revenue. Every time Congress used the phrase “stamping out fraud and abuse”, came another several hundred pages of paperwork that we were required to complete and more staff were required to complete them.

The SGR payment adjustments became a constant source of fear, as half of our accounts receivables would often be uncertain due to Washington brinksmanship. We were a small business that had no way to keep our fiscal house in order because we had less and less control over what we spent our money on and no idea what our projected payments might be from Medicare. The SGR ordeal forced us to open a personal line of credit to make sure we could meet payroll the next time Washington froze Medicare claims processing. With Medicare patients comprising more than half our patients at the time, we were eventually forced to make the difficult decision to stop accepting new Medicare patients into the practice to minimize our exposure to the uncertainty.

Private practice consultants offered universal advice – see more patients. The 30-minute office visit for the complex patient became 15 minutes, then 7 minutes. Twenty-five patient visits per day became the new normal. Providing care to our patients in the hospital was no longer financially viable, as we needed to be in the office seeing more and more patients.

Through all of the complex regulatory changes in health care, two people have been forgotten -- the patient and the doctor. We have created a “system” of primary care delivery that is so complex, it would make Rube Goldberg proud. We have become a reactive delivery care model of “sick care” that only seems to work for the hospitals, pharmaceutical industry and 3rd party payers. It is driving even further consolidation by hospitals. It is reducing the physician workforce by forcing physicians to choose early retirement or leaving the profession entirely. It is leading to physician burnout and an epidemic of physician suicide.

It is in this context that we had our “epiphany” in 2009.

OUR EPIPHANY

Epiphany is a strange name for a medical company, but my partner, Dr. Crouch, and I had an epiphany. We were in the rat race of independent practice primary care, where you are trying to funnel the patients through as fast as possible, keeping office visits to seven minutes, fighting with insurance companies to get procedures and medications approved. It ended up feeling like we were treating the chart and the computer and the insurance company but not providing good medical care. We decided there had to be a better way to do this.

It was about that time when a patient made a staggering suggestion.

He owned an air-conditioning business, and all 10 of his employees were patients of our primary care practice. And his insurance rates continued to climb sky high.

He said, “Why am I paying my insurance company to pay you? Why don’t I just hire you directly to take care of my employees? I’ll take out a catastrophic insurance policy on them and, even if they hit their deductible every year and I have to pay it, I’d still come out ahead and so would they.” That was our epiphany, and the impetus for naming our practice Epiphany Health.

Why are we insuring primary care?

Why are we using an extremely expensive, extremely inefficient and incredibly impersonal insurance vehicle to finance the most basic aspect of health care delivery?

Why are we inserting so many barriers, financial or otherwise, between the doctor and the patient?

Our epiphany was that we are using health insurance wrong. We don’t expect our homeowner’s insurance to pay for blown light bulbs or routine maintenance. Imagine how complex and expensive it would be to purchase gasoline if we used our auto insurance to pay for fuel. This is what we expect from our health insurance, yet we are surprised that it is expensive, inefficient and impersonal. Our epiphany was that we should work towards making routine care affordable for everyone in a predictable, price transparent manner, without needing insurance. Let health insurance be true insurance -- a hedge against an unexpected catastrophic loss. Out of that epiphany, we created what was to become one of the nation’s pioneer **Direct Primary Care (DPC)** practices, Epiphany Health.

HOW IT WORKS

We ended up creating a membership based primary care program for our patients ages 5 and up. Instead of charging fee-for-service for things we do in our office, we charge a flat monthly membership fee, and then we don’t charge for anything that we do. That fee is $60 per month for adults, $25 for one child and $10 for each additional child. A family of four pays just $155 per month. Beyond that, we don’t charge for anything we do in the office. No copays. No deductibles. We don’t bill anything to any insurance company. It includes all necessary in-office testing and procedures such as EKG, holter monitors, strep testing, urine tests, blood thinner monitoring, minor surgical procedures, joint injections, abscess draining and more. The payment is made by automated electronic funds transfer, eliminating expensive labor-intensive invoicing and collections.

It is like Netflix for health care. After you pay your membership, you don’t have to pay for each episode of care. Patients consume what they need at no extra cost, including unlimited email, text, phone calls or technology visits. Our practice finances were stabilized by a steady revenue stream that no longer required converting every patient contact into an office visit in order to get paid.

We determined what services outside our office a primary care doctor needed to do his or her job, without relying on a 3rd party to finance it. We needed access to affordable labs, imaging services, physical therapy, specialty care, pharmaceuticals, and durable medical supplies. Our office supplies were already relatively inexpensive. Mostly, in primary care we are just selling time. Managed correctly, that can be affordable.

We reached out to other practitioners and almost took a Priceline.com approach. I said, "If you have a CT scan machine, and it's not running all day long, and I could send a cash-paying patient to fill an open slot, payable at the time of service, what would you sell us your CT scan for?" With the labs, I said, "if we send you 500 patients, instead of billing the patients individually or their insurance companies — where you'd have to track them down for their co-payments or deductibles and wait 6 months to get paid — what if I collected from the patient when I gave them the order and you sent me one bill and I paid it, what could you sell me your services for?" We ended up buying labs and imaging wholesale, and the prices we got were ridiculously low — pennies on the dollar. We had eliminated their largest expense – labor costs and time for the purpose of collecting money.

As a result, Epiphany patients pay $175 for a CT scan. If that procedure were performed in an emergency room, it could be billed at $10,000. With Epiphany, an MRI costs $225. An x-ray costs $25. Physical therapy costs $35 per session, which is less than most people pay with commercial health insurance, where the co-pay is about $50. Routine bloodwork costs our patients $45. One of our first patients with rheumatoid arthritis was quoted $1,800 for blood work. Using our pricing, her blood tests were purchased for under $100. The savings from one blood test alone nearly paid for 2 ½ years of her membership in our program.

As an example of the potential savings, I offer the following. In the figure below, I show the actual billed charges for a patient that went to the ER for abdominal pain. The total itemized bill came to just under $20,000. We have the ability to see patients urgently, because our schedules are not overly packed with patients. Actually, patients can often see us faster than they might be seen in the ER. Because we know the patients, we might eliminate the need for many of the ordered tests. Even so, we can also arrange for stat labs and imaging. Our actual cost for a patient without insurance for the exact same tests that the hospital billed $20,000 for is $301.29.

Hospital Charges vs. DPC Charges

Hospital Charges		Epiphany Charges
Service	Charge	Charge
Lab charges	$38.14	$8.00
Chemistry	$3524.14	$70.79
Hematology	$1,782.95	$15.00
Urology	$231.79	$4.50
Chest x-ray	$490.94	$18.00
CT scan	$10,955.13	$185
ER Level 4	$2,700.18	$0
TOTAL:	**$19,723.27**	**$301.29**

Of course, everyone knows that those services don't actually cost $20K, but most don't know that they can cost as little as $300. If the patient had no insurance or was with a self-funded health plan, they would have to negotiate the billed charges, maybe getting a 30-50% reduction payable over many years. If the patient had insurance, there would be a network discount applied, maybe discounted to $5,000. Often that $5,000 would be out-of-pocket due to deductibles.

What happens to that $15,000 "savings" for having insurance? In many cases, a percentage of that savings goes to the PPO for negotiating the discount. While one might think that a health plan is incentivized to find the best prices, they are often incentivized to find the highest charges with the biggest negotiated discount. In the end, it is the patient that bears the financial burden, especially those without insurance. In this example, the insured patient may pay $5,000 for $300 worth of medical care and pay a hefty insurance premium for that privilege. In either case, whether $5,000 or $20,000, the hospital is equally likely to not get paid and often both insured and uninsured patients declare bankruptcy. Timely and effective primary care access through DPC has great potential to reduce this financial impact.

DPC doctors have the ability to manage a myriad of chronic medical conditions such as diabetes, hypertension, heart disease or asthma. As long as it can be done within our four walls, there's no additional charge. Everything outside of our office, we offer complete price transparency. Most people nowadays have high-deductible health plans, and we are asking them to be cost-conscious consumers

while shopping in a supermarket that has no prices on it. We put prices on everything. We even have negotiated transparent bundled surgical prices for inpatient and outpatient surgeries in 2 local hospitals. As physicians, we take a Hippocratic Oath to do no harm. That oath should include doing no financial harm. This allows us to include cost and value in the conversation about the risks, benefits and alternatives of the patient's personal health care treatment approach.

In the 3rd party payment system of high volume care, primary care physicians are relegated to data entry clerks and referral agents. In this context, we do not adequately use the physician's skills. In a DPC model, because we don't have to bring the patient in for everything, it frees up our office time for more complex cases. Instead of 7 minute visits, a doctor may have 30-60 minutes to manage a complex illness. That allows family physicians to use the full-scope of their 22,000 hours of clinical training, rather than referring out patients simply due to lack of time. It also allows the practice to hire employees to provide patient care rather than paying employees to chase insurance requirements.

Doing primary care better prevents unnecessary downstream utilization, unnecessary referrals, unneeded consultations / tests / hospitalization / procedures / surgeries. Not through rationing, but through better care delivery and dedicating the right amount of resources to the right patient as determined by the doctor and the patient -- not an arbitrary third party. Unfortunately, commercial 3rd party payers are financially disincentivized from reducing downstream utilization and spending because their profits are tied by the Medical Loss Ratio (MLR) to a percentage of that spending. They must grow spending to grow profits.

Although Epiphany's clients include small businesses, the patients who really benefit are those who slipped through the cracks of the Affordable Care Act. We are capturing those people who go to insurance exchanges, and they see the price tags and know they want it, but can't afford it, even if they may get penalized. We are even getting referrals from the Affordable Care Act navigators; they're sending patients in our direction. We often receive referrals of new patients from the charity clinics, health departments and emergency rooms. We have become the safety net's safety net for chronic disease management.

Epiphany has remained one of the last independently owned and operated primary care practices in the region — one of the few that haven't been bought out by large corporations. Despite the "skyrocketing cost of health care", our prices remain lower today than they were on the day we launched in 2010. Additionally, our negotiated prices for medical services outside our practice have largely remain unchanged over the same time period. In fact, many have come down through increased volume and competition.

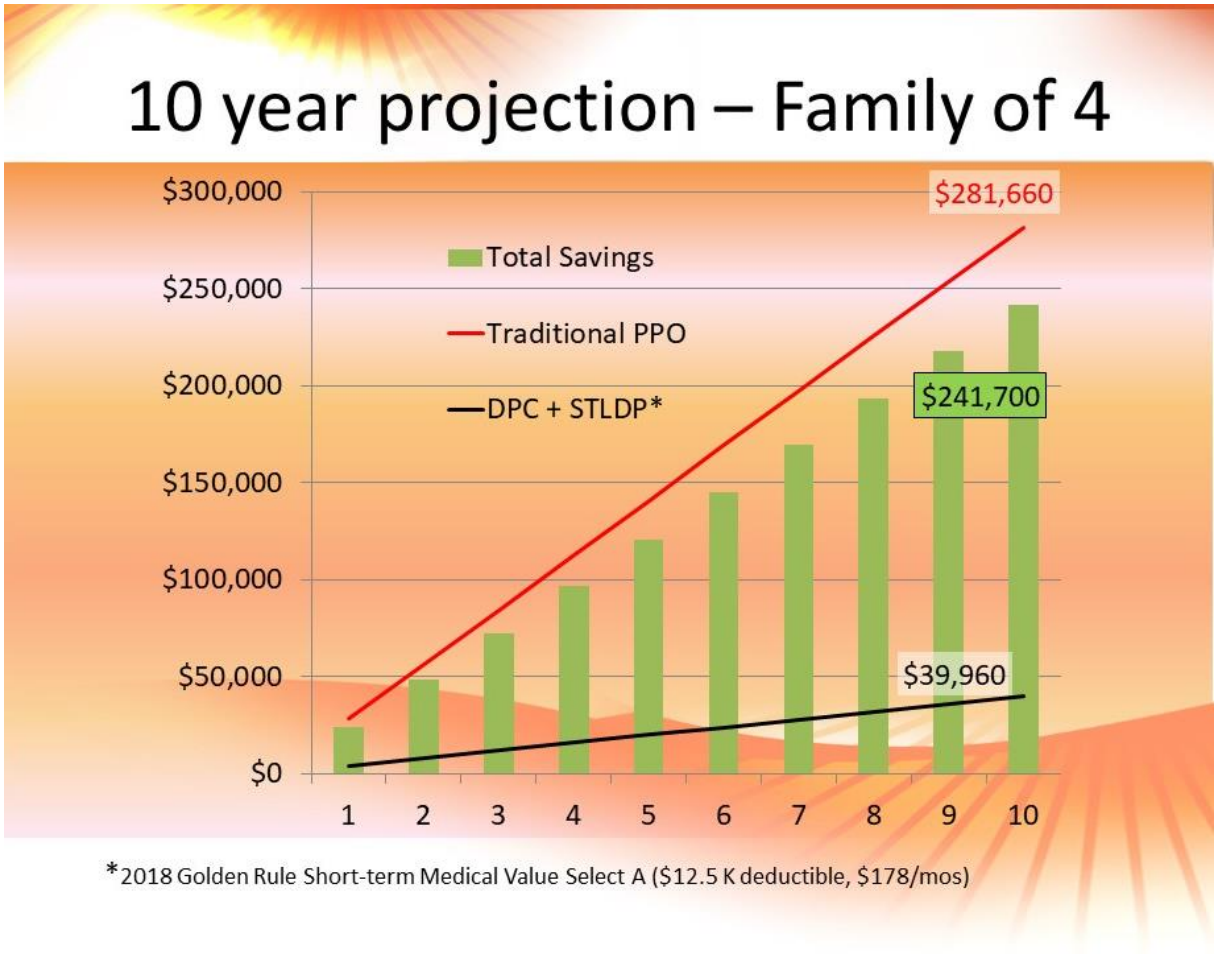
Patients without insurance sometimes drive hours to our practice. We see patients in our Southwest Florida practice from Miami, Orlando, and Naples. We have some that travel from out of state. They drive past nonprofit tertiary care facilities because they can afford what we are offering. One of our

patients came to us from the Caribbean island of Antigua for treatment of thyroid cancer. Her thyroid surgery would have cost her $100,000 without insurance in the islands. We cured her once-in-a-lifetime catastrophic event for just over $10,000, including surgery, staging, specialty consultation, imaging, medications and 6 months of medical care.

The majority of our patients do have insurance, and we encourage all of our patients to have coverage. However, most plans today have high deductibles to meet or large copays. While the ACA allows patients with pre-existing conditions to get coverage, our practice population is evidence that coverage is not health care. The high deductibles often keep patients from accessing the care they need to prevent those chronic conditions from becoming more severe out of fear for what it may cost them. Even a patient with a subsidized bronze plan may have a $7,000 out-of-pocket financial exposure. Those patients seek out our practice to care for their chronic medical conditions, because the cost is predictable and transparent. Complex problems are no longer needing to be cared for in a short office visit because of fear of another $50 copay or the uncertainty of an unmet deductible. In fact, patients frequently pay much less for care outside our office using our negotiated prices than they would if they used their insurance. Patients commonly share that their responsibility for tests or surgery with insurance is twice the cost of our pricing without insurance.

What are we insuring if using that insurance doubles the out-of-pocket cost to the patient on top of the insurance premiums?

According to the Milliman Medical Index, in 2018, the cost of health care for a typical American family of four covered by an average employer-sponsored preferred provider organization (PPO) plan is $28,166. Of that, the employee contribution is $12,378 per year, with $4,704 being for out-of-pocket costs paid when using health care services. Using these numbers, an employer sponsored PPO for a family of 4 will cost $281,660 over 10 years (see figure below). A membership in Epiphany Health Direct Primary Care plus an underwritten short-term limited duration plan would cost $39,960 over 10 years (assuming it were allowed to be renewed that long). The net difference is a $241,700 10-year potential savings for one family. To put that potential savings into perspective, the average total household debt in the US is under $135,000 for all age brackets, including a home mortgage. The potential savings is also 10-times what the same family of 4 is likely to take home from the recently passed tax cuts.



If the family became extremely ill and hit their deductible and maximum out of pocket every year for 10-years, it would still cost less than the PPO plan. The difference being that the PPO is loaded with built-in pre-paid benefits and no potential savings for services that are not needed or wanted. It is for this reason why our patients continually ask us how they can get affordable major medical plans to wrap around DPC. Of course, it is the fear of the $20,000 ER bill above that drives people to pay for an insurance product that may otherwise make no financial sense. And that patient from Antigua – her once in a lifetime catastrophic thyroid cancer was cured for less than the cost of one year of premium payments.

Using our program, we make routine and predictable care affordable. We also make unpredictable expenses affordable, even those once felt to be impossible to afford without insurance. We can't do anything for catastrophic illness, other than try to prevent it through good primary care and prevention. We are hopeful that Congress will pass legislation that will improve access to catastrophic only coverage. In the interim, we welcome the Administration's recent rule change expanding access to short-term medical plans. While far from perfect, they are an option that can bundle with a DPC

membership to provide an affordable combination of access to routine care / chronic disease management plus coverage for catastrophic illness.

A NATIONAL MOVEMENT

As it turns out, many practices around the country were having a similar epiphany at the same time. There were likely under a dozen practices developing a similar approach, now collectively referred to as **Direct Primary Care**. Practices in the state of Washington, Nevada, Virginia, North Carolina, Kansas, Pennsylvania and others began popping up and making waves. Some did not survive, while others thrive. Where there were likely less than a dozen DPC practices in 2010, there are estimated to be nearly 1,000 true DPC practices today. Most of that growth has been in the last 4 years, with an 800% growth in the number of DPC practices since 2014. Many of these practices can be found by going to www.dpcfrontier.com/mapper. These practices are now serving patients of all socioeconomic groups in rural, urban, suburban and inner-city settings in nearly every state. Some practices even include prenatal care and baby delivery in the membership.

DPC is frequently confused with "concierge medicine", which is often considered care for the affluent. DPC was born out of the concierge movement. While some may use the terms DPC and concierge interchangeably, DPC practices generally offer lower price points that most can afford. Much like airbags first appeared on luxury cars, they are now standard safety features on even the most affordable vehicles. The national average membership fee for a DPC practice is approximately $70. Concierge practices also often still bill 3rd parties on a fee-for-service basis in addition to the membership fee, where a DPC practice usually does not charge extra beyond the membership.

DPC is frequently accused of skimming the "worried well" and healthy from the system, while leaving the sick patients for insurers and the government to care for. As it turns out, DPC practices tend to attract the opposite. Patients that are healthy have little interest in paying a recurring monthly fee for a service that they will rarely use. DPC practices tend to attract those with chronic diseases that are finding it difficult to navigate within our broken health care system, often bringing with them problems that have been neglected for many years.

Because of the efficiency of the DPC practice delivery model, it is no wonder that businesses are seeking to work with DPC practices to keep their employees healthy, especially those with self-funded health plans. As our "epiphany" employer realized, DPC is an affordable vehicle for small business owners to provide employee access to medical care, even if they cannot afford health insurance coverage.

I presently serve as the President of Docs 4 Patient Care Foundation. D4PCF is a national leader in educating physicians on how to set up a DPC practice. Our grant-supported national conference curriculum has helped train hundreds of physicians from across the nation at little to no cost for the

physician attendee. We maintain a large video library of free content for those interested in learning more at www.d4pcfoundation.org. Our third annual DPC Nuts and Bolts conference, November 1-3 in Orlando, is on track to attract well over 300 attendees.

DPC doctors are a special breed of small business owners with an entrepreneurial spirit and huge heart. Unlike most competitive businesses, DPC practices are always willing to step up and help each other and help others. This was true in the case of Hurricane relief, where DPC docs started an effort that sent tens of millions of dollars in private medical supply donations to doctors in need, delivering medical supplies and medicines to damaged clinics in Texas, Puerto Rico and elsewhere. It was also true when several DPC practices in the Mid-Atlantic joined forces to pay off $1.4 million in patient accumulated medical debt.

REGULATORY RELIEF

There have been several hurdles along the way for the DPC movement. Some of those hurdles remain. Simply put, the best way for Congress to support the DPC movement in restoring the health care system is to let it happen and not try to force it or stop it. The movement is transforming the health care landscape in many good ways. It is a non-partisan movement, supported by all but those that continue to do well in our current broken system.

Some have argued that physicians that enter directly into a contract with a patient for a defined package of medical services should be regulated as risk bearing entities and treated as insurance companies. Twenty-five states have seen differently and passed legislation defining a direct contractual relationship between a doctor and a patient as being exempt from regulation as an insurance product. These relationships are already heavily regulated by state boards of medicine and also fall under the regulation of standard contract law. To date, no state has legislated a contrary position.

While there is presently a pilot program for DPC currently under consideration by Center for Medicare and Medicaid Innovation (CMMI), many members of the DPC community have expressed concerns during the recent RFI. To be clear, many Medicare beneficiaries are already members in DPC practices and Medicare is enjoying those savings. However, in order for a doctor to legally contract with a Medicare patient outside of the traditional fee-for-service structure, the doctor must opt-out of Medicare entirely. That greatly limits moonlighting opportunities which can be critical to the success of a physician starting a practice in this model. The DPC movement would be helped tremendously if CMS and Congress were to adopt rules and regulations that allow doctors to develop DPC practices without having to opt out of Medicare.

Many DPC practices dispense wholesale medications direct to their patients, resulting in tremendous savings and improved compliance. In the example provided below, courtesy of Plum Health DPC in Detroit, a patient could easily save hundreds of dollars every month just through direct dispensing of

generic medications. These savings alone often easily cover the DPC membership cost. While most states allow direct dispensing of medications by physicians, some states restrict the practice. Congress could improve affordability and access to medications by structuring incentives for states to allow physician direct dispensing of wholesale medications.

Which Pharmacies Have the **Best Rx Prices**?

To find out, Consumer Reports' secret shoppers called more than 150 drugstores across the U.S.—representing dozens of chain pharmacies, supermarket drugstores, and independent pharmacies—to compare prices for five commonly prescribed generic drugs. They included the diabetes drug pioglitazone (generic Actos, 30 mg); the painkiller celecoxib (generic Celebrex, 200 mg); the antidepressant duloxetine (generic Cymbalta, 20 mg); the cholesterol medication atorvastatin (generic Lipitor, 20 mg); and clopidogrel (generic Plavix, 75 mg), a blood thinner. The chart shows average discounted retail prices that pharmacies quoted for a one-month supply.

RETAILER	Pioglitazone *Actos*	Celecoxib *Celebrex*	Duloxetine *Cymbalta*	Atorvastatin *Lipitor*	Clopidogrel *Plavix*	TOTAL PRICE
Plum Health DPC	$4.30	$6.47	$7.04	$2.09	$4.28	$24.18
HealthWarehouse.com	$12	$22	$13	$10	$10	$66
Costco [1]	$16	$26	$35	$13	$16	$105
Independents [2]	$19 *$10–$493*	$34 *$11–$295*	$31 *$20–$267*	$15 *$8–$197*	$15 *$8–$260*	$107 *$69–$1,351*
Sam's Club [1]	$20	$38	$31	$20	$45	$153
Walmart	$132	$203	$123	$30	$30	$518
Kmart	$160	$185	$120	$35	$35	$535
Grocery Stores [3]	$113 *$10–$349*	$189 *$46–$250*	$170 *$13–$223*	$32 *$11–$71*	$36 *$7–$224*	$565 *$88–$1,117*
Walgreens	$167	$204	$251	$65	$65	$752
Rite Aid	$255	$194	$170	$128	$119	$866
CVS/Target	$270	$187	$195	$135	$141	$928

...the ranges across sampled stores. [3] Prices in italics are the ranges of the averages across sampled stores,

Direct Primary Care was included in Sec 1301(a)(3) of the Affordable Care Act as an acceptable minimum essential coverage that can be sold on the Exchanges when paired with appropriate wrap-around coverage. In 2014, Ranking Member Murray and colleagues sought clarification in a letter to then IRS Commissioner Koskinen about use of HSA dollars to pay for DPC memberships in support of a pioneer DPC practice in Washington state. Commissioner Koskinen's response letter established the IRS position that DPC was a health plan, contradictory to the ACA rules, not only disqualifying use of HSA dollars to pay for DPC memberships, but disqualifying DPC member patients from contributing to their HSA whatsoever. This single obstacle has served to greatly slow the uptake of DPC, particularly among the majority of Americans with an employer sponsored health plan. As a result, DPC is the only physician service in the country that is ineligible to accept HSA dollars for payment.

The US House of Representatives recently passed HR6199. Section 3 of that bill pertains to HSA use with DPC memberships. While we appreciate the importance of resolving this big issue, the language in the bill has some considerable flaws that make it less helpful, perhaps even harmful for the DPC movement at large. The original bill language introduced in Ways and Means contained a reference to a definition of primary care that was so narrow, likely less than one-third of primary care practices would meet the definition. Most importantly, the language would have unintentionally prevented DPC practices from including routine services such as women's wellness care in their memberships. Fortunately, that restrictive language was removed before passage by the House. However, after passage, Treasury felt that the change was a drafting error and advised reinserting the troublesome primary care definition reference.

Unfortunately, the bill fixes the wrong section of the Internal Revenue Code (IRC). The bill makes DPC an eligible health plan to use HSA dollars under IRC 223(d), instead of making it an eligible health care expense under IRC 213(d). By designating DPC as a health plan, it sets up conflict with the 25 states that have legislation declaring DPC is NOT a health plan. It also creates potential regulatory conflict in the remainder of states that do not have such legislative DPC clarification. It would be helpful if HR6199 or similar legislation was consistent with most opinion that DPC is not health insurance.

Despite DPC being the shining beacon for price transparency in American health care, the bill imposes the first-ever legislative cap on physician charges and potentially blocks DPC practices from accepting HSA dollars if they dispense medications. While we greatly hope to see this bill move forward in the US Senate, I welcome the opportunity to work with lawmakers to help make it a better bill, resolving the issues stated above.

CONCLUSION

Thank you for the opportunity to testify about the transformative potential of Direct Primary Care. This rapidly growing care delivery model has the ability to properly align the incentives of the doctor, patient and health care system in general. It eliminates third party intrusion into the private patient decisions and is a much needed change in providing critical access to all patients, regardless of insurance status or pre-existing conditions. I look forward to your questions and look forward to a continuing dialogue on regulatory and legislative changes to expand the positive impact and growth of Direct Primary Care.

Respectfully submitted,

Lee S. Gross, MD