August 10, 2020

VIA Federal eRulemaking Portal at www.regulations.gov

Sunita Lough, Deputy Commissioner for Services and Enforcement
CC:PA:LPD:PR (REG-109755-19)
Room 5203
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Re: Notice of Proposed Rulemaking (IRS REG -109755-19)

Dear Deputy Commissioner Lough:

On behalf of our more than 53,000 Texas physicians and medical student members, the Texas Medical Association and the undersigned associations appreciate the opportunity to comment on the Internal Revenue Service's (IRS's) proposed rule relating to Section 213 of the Internal Revenue Code regarding the treatment of amounts paid for certain medical arrangements.

The agency's notice of proposed rulemaking, issued in response to President Trump's 2019 Executive Order 13877, ''Improving Price and Quality Transparency in American Healthcare to Put Patients First," shows positive intent overall. While some of the improvements will benefit patients, the physicians represented in these comments express strong concern about the potential harm that certain elements of this rule proposal may cause (as detailed in our specific comments, below).

As indicated in the preamble to the proposed rule, "The Executive Order (EO) states that it is the policy of the Federal Government to ensure that patients are engaged with their healthcare decisions and have the information requisite for choosing the healthcare they want and need."[1] The EO requests that the Secretary of the Treasury ''propose regulations to treat expenses related to certain types of arrangements, potentially including direct primary care arrangements and healthcare sharing ministries, as eligible medical expenses" for tax deduction purposes.[2]

Under Section 213(a) of the Internal Revenue Code, Congress allows for certain medical care expenses that are not reimbursed by insurance (or otherwise) to be tax-deductible. These are medical care expenses paid on behalf of a taxpayer, taxpayer's spouse, or taxpayer's dependents during the taxable year to the extent the expenses exceed 10% of adjusted gross income. For

[1] 85 *Fed. Reg.* 35398 (June 10, 2020).
[2] Executive Order 13877; *available at*: www.whitehouse.gov/presidential-actions/executive-order-improving-price-quality-transparency-american-healthcare-put-patients-first/.

deducibility purposes, "medical care" is defined under Section 213(d)(1) of the Internal Revenue Code as amounts paid for:

- The diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body (Section 213(d)(1)(A));
- Transportation primarily for and essential to obtaining this care (Section 213(d)(1)(B));
- Qualified long-term care services (Section 213(d)(1)(C)); or
- Insurance covering the above-described medical care and transportation (Section 213(d)(1)(D)).

The last category referenced above from Section 213(d)(1)(D) is referred to as "medical insurance" under the proposed rule and includes supplementary medical insurance for the aged (Medicare Part B) and any qualified long-term care insurance contract.

The goal of the proposed rule is to carry out EO 13877. To accomplish this, the agency proposes that payments for direct primary care (DPC) arrangements and health care sharing ministry (HSM) memberships are within the definition of payments for medical care under Section 213(d) and that they may be considered a deductible expense under Section 213(a).

While we support the proposal's intended inclusion of DPC payments as payments for medical care under Section 213(d)(1)(A) (and contend that all DPC arrangements should fall within Section 213(d)(1)(A)), we do not support the proposed rule's classification of DPC payments as insurance under Section 213(d)(1)(D) or as a health plan for health savings account (HSA) purposes under Section 223. We are also opposed to the proposed rule's characterization of HSMs as insurance for Section 213 purposes (as discussed more fully, below).

Medical insurance definition

In the rule preamble, the agency correctly notes that Section 213(d)(1)(D) of the Internal Revenue Code does not define the term "insurance" for purpose of the "medical care" expense deduction.[3] The agency also correctly notes that without a definition, a term should be given its ordinary meaning.[4] However, the agency then relies on the legislative history to create an expansive interpretation of the term that exceeds its ordinary meaning and encompasses both DPC and HSMs as categories of insurance for Section 213(d)(1)(D) purposes. This is an inappropriate use of the term "insurance." To the extent that the proposed expanded definition encompasses DPC and HSMs, it directly conflicts with state statutes that expressly state that DPC and HSMs are *not* insurance.

While states often call DPC payments for this innovative care delivery model medical "retainer fees," they do not consider these fees in any way to be insurance or payment for a prepaid health care plan. Texas law, for example, specifically states that "[a] physician providing direct primary care is not an insurer or health maintenance organization [HMO], and the physician is not subject to regulation by the Texas Department of Insurance for the direct primary care."[5] Unlike scenarios involving insurance companies or HMOs, these arrangements involve patients directly paying physicians for medical services.

Some may consider HSMs to be an innovative method to finance medical care expenses. However, no one (including HSMs) consider an HSM's offering to be insurance. There is no guarantee of

[3] 85 *Fed. Reg*. 35400.
[4] *Id.*
[5] Tex. Occ. Code § 162.253.

payment for medical services. Furthermore, HSMs do not receive, adjudicate, and pay claims as insurance plans do.

Considering that so many states have been able to agree on the fact that DPC and HSMs are not insurance, it is surprising that the IRS would make a contrary rule proposal in the context of tax deductions. We are, therefore, concerned about the potential unintended consequences of mischaracterizing DPC and HSMs as insurance.

The preamble to the rule proposal states the following with regard to HSMs:

> This proposal under section 213 has no bearing on whether a health care sharing ministry is considered an insurance company, insurance service or insurance organization (health insurance issuer) for other purpose of the Code, ERISA, the Public Health Service Act (PHS Act), or any other Federal or State law.[6]

However, this is a slippery slope, and if HSMs are considered insurance in this context, patients could be misled into believing HSMs are insurance under state law. This is precisely the misunderstanding the state legislatures have worked actively to avoid by requiring HSMs to, for example, include disclaimers on applications stating that "participation in the ministry or subscription to any of its documents should never be considered to be insurance."[7]

If an HSM pursues status as an insured entity, then we would strongly urge the IRS and other regulators to require them to meet the minimum standards for insurance and be regulated by state insurance agencies.

Further, we are particularly concerned with the IRS's categorization of DPC as insurance. This categorization is disconcerting for multiple reasons. First, as stated previously, many states expressly define DPC as not being insurance. Second, the IRS engages in faulty logic to assume that DPC is an insurance plan or even a "gap" plan similar to a Medigap policy. When the Affordable Care Act was created, it considered direct primary care to be separate from insurance, *not* insurance.[8] For the IRS to suddenly change definitions causes confusion and inconsistency for both state and federal governments, as well as physicians and patients. Third, there is no language similar to the above-referenced HSM language in the preamble stating that the proposal under Section 213 has no bearing on whether a DPC arrangement is considered an insurance company, insurance service, or insurance organization for the purposes of the code or any other state or federal law, which could potentially result in additional regulation. Fourth, state medical boards, not state insurance regulators, regulate physicians (and nothing the IRS does in this context should impact that regulatory framework). Fifth, the preamble expressly states the following negative impact of this proposal:

> [T]he characterization of a direct primary care arrangement as medical insurance under section 213(d)(1)(D) has implications for purpose 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.[9]

---

[6] 85 *Fed. Reg*. 35401

[7] Tex. Ins. Code §§1681.001 and 1681.002.

[8] 77 *Fed. Reg.* 18310, *available at*: www.govinfo.gov/content/pkg/FR-2012-03-27/pdf/2012-6125.pdf#page=2.

[9] 85 *Fed. Reg.* 35400.

Recommendation: The IRS should:

- **Either not adopt the proposed language in (4)(i)(A) or modify it to clarify that it does not consider DPCs or HSMs as payment for medical insurance under Section 213(d)(1)(D) of the Internal Revenue Code; and**
- **Expressly state that all amounts paid for DPCs arrangements fall within Section 213(d)(1)(A) of the Internal Revenue Code.**

DPC and primary care physician definitions

Next, the agency proposes to define DPC 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." This is an accurate depiction and understanding of DPC. The agencies have also chosen well to define a primary care physician according to the Social Security Act's Section 1861(r)(1). This allows patients to contract directly with physicians and access tax credit for DPC fees the way patients do in a traditional fee-for-service arrangement.

Recommendation: The IRS should adopt the definition of direct primary care arrangements, but expressly modify the provision to state that amounts paid for direct primary care arrangements qualify as expenses paid under section 213(d)(1)(A), as indicated, below:

> (v)(A) Direct primary care arrangements. Amounts paid for direct primary care arrangements are payments for medical care under section 213(d)(1)(A). [~~Expenses paid for medical care under section 213(d) include amounts paid for a direct primary care arrangement.~~] A "direct primary care arrangement" is 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. A "primary care physician" is an individual who is a physician (as described in section 1861(r)(1) of the Social Security Act) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine or pediatric medicine.

DPC and health reimbursement arrangements (HRA)

Health reimbursement arrangements are similar to health savings accounts. They are a fund of money to be used on qualified medical expenses. However, HRAs are solely funded by an employer, while an HSA can be funded by an individual and/or an employer. With an HRA, the employer controls what is a qualified expense and how much to pay for such expenses. Such arrangements can be used to purchase insurance and pay directly for medical expenses. We agree that HRA funds should be available to pay for DPC fees, but not for the rationale proposed herein, namely, that DPC arrangements are a form of insurance. As noted extensively throughout this document, DPC is *not* insurance but is a medical care expense. HRAs should be allowed to pay for this medical care expense.

Recommendation: The IRS should permit the use of HRAs to pay for DPC fees because DPC fees are medical care expenses. However, the agency should not classify the use of HRA funds as paying for insurance premiums when purchasing DPC services.

DPC and health savings accounts

HSAs are tax-exempt accounts that can be used to pay for qualified medical care expenses. To open an HSA, one must be enrolled in a high-deductible health plan (HDHP). If an individual does not have a HDHP, he or she is not allowed to contribute to an HSA. Additionally, for an individual to be eligible for an HSA, the individual must "not, while covered under an HDHP, [be] covered under any health plan which is not an HDHP, and which provides coverage for any benefit which is covered under the HDHP."[10]

Through the use of faulty logic, the IRS has chosen to classify many DPC arrangements as a health plan or insurance that provides coverage before the minimum annual deductible is met. As a result, the agency has stated that "therefore, an individual generally is not eligible to contribute to an HSA if that individual is covered by a direct primary care arrangement."[11] As stated previously, contracting with a physician for medical services is not insurance. Yet, because the proposed rule erroneously conflates medical services and insurance, the IRS has prohibited individuals from benefiting from the use of an HSA in these scenarios. The agency does provide a narrow exception to this rule. Specifically, the rule preamble states:

> However, in 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 an HSA.[12]

However, direct contracting is *not* typically for a specified treatment of an identified disease. Thus, this limited exception is insufficient. Further, the agency's statements that employers who pay for DPC for their employees in effect have purchased group health insurance does not align with all of our prior comments that DPC is not insurance. Again, Texas along with many other states, has made it clear through express statutory language that DPC is not insurance. Therefore, whether the employer or the individual pays for DPC, the IRS should not classify it as insurance or as a health plan for purposes of Section 213 or Section 223.

Recommendation: The agency should not classify DPC as insurance or a health plan for purposes of Section 213 or Section 223.

Health care sharing ministry definition

Next, the agency proposes to use the Internal Revenue Code Section 5000A(d)(2)(B)(ii) definition of HSMs for Section 213 tax deduction purposes. An HSMs must have the following components:

- It is described in Section 501(c)(3) and is exempt from taxation under Section 501(a).

[10] 85 *Fed. Reg*. 35401.
[11] 85 *Fed. Reg.* 35402.
[12] 85 *Fed. Reg*. 35402.

- Members share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the state in which a member resides or is employed.
- Members retain membership even after they develop a medical condition.
- It (or its predecessor) has been in existence at all times since Dec. 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least Dec. 31, 1999.
- It conducts an annual audit performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and made available to the public upon request.

As stated previously, HSMs are *not* insurance. Texas law even clearly states this in Insurance Code Section 1681.003: "[A] health care sharing ministry that acts in accordance with this chapter is not considered to be engaging in the business of insurance." As the Commonwealth Fund states, while HSMs "may provide value for some individuals" they "are not insurance and do not guarantee payment for claims."[13] Additionally, HSMs clearly state they do not offer insurance. As an example: "Trinity HealthShare programs are not insurance."[14]

HSMs present a radically different approach to financing health care. While some people have found these organizations to be helpful, others have found their coverage to be too narrow, including inadequate annual and/or lifetime limits. HSMs do not offer any guarantee of payment or coverage, despite an HSM participant having paid HSM fees. Washington state fined an HSM $150,000 for failing to act as a bona fide HSM under state law and failing to meet the requirements for an exemption from insurance regulation.[15] Other states, Texas included, are looking for ways to limit or prevent HSMs from selling shares. Without proper regulatory oversight and disclosures to consumers, patients may be misled into believing they have "insurance" coverage when they do not. Indeed, in Washington state, the Insurance Commissioner noted, "Many consumers here and in other parts of the country thought they were buying a health insurance plan, only to find out that pre-existing and chronic conditions weren't covered."[16] For the IRS to label HSMs as insurance may lead to more patients being harmed by this lack of coverage.

Recommendation: The IRS should not adopt the proposed rule language in (4)(i)(A)(2) regarding health care sharing ministries, which expressly states that amounts paid for membership in a HSM that shares expenses for medical care are payments for medical insurance under Section 213(d)(1)(D). As previously stated, HSMs are not insurance, and the IRS should not characterize them as insurance for the purpose of the instant rule proposal.

IRS questions

Comments on Proposed Expansion of DPC arrangements to include nonphysician providers (NPPs)

Texas physicians have concerns with the agency's proposal to expand DPC arrangements to include NPPs, given that in many states, including Texas, NPPs act under physician delegation and

---

[13] JoAnn Volk, Emily Curran, and Justin Giovanelli, Health Care Sharing Ministries: What are the Risks to Consumers and Insurance Market, Aug. 8, 2018; *available at*: www.commonwealthfund.org/publications/fund-reports/2018/aug/health-care-sharing-ministries.

[14] Trinity HealthShare, About Us; *available at*: www.trinityhealthshare.org/about/.

[15] *Office of the Insurance Commissioner, Washington State, Kreidler bans Trinity Healthshare, collects $150,000 fine, Dec. 30, 2019;available at: www.insurance.wa.gov/news/kreidler-bans-trinity-healthshare-collects-150000-fine.*

[16] *Id*.

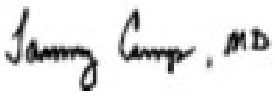
supervision when providing certain services. Furthermore, we note that any care offered by an NPP must comply with state scope of practice laws.

Comments on Other arrangements similar to DPC but that don't meet definition in this regulation
Texas physicians believe all physicians should have the freedom to contract directly with patients for medical care. Medical care expenses should qualify for tax deduction no matter if payment is made through a direct contracting arrangement or not. These expenses should qualify no matter if the medical care is provided by a primary care physician or a specialist.

Once again, we thank you for this opportunity to comment on the proposed rules. If you have any questions, please do not hesitate to contact the following TMA staff: Trina Bean, Director of Health Care Research and Data Analysis, at trina.bean@texmed.org or Kelly Walla, JD, LLM, Associate Vice President and Deputy General Counsel at kelly.walla@texmed.org.

Sincerely,

Diana L. Fite, MD
President
Texas Medical Association



Tammy Camp, MD
President, Texas Academy of Family Physicians

Amanda La Violette, MD, MPH
President, American College of Physicians Services, Texas Chapter