AMA
AMERICAN MEDICAL ASSOCIATION

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August 10, 2020

The Honorable Charles P. Rettig
Commissioner
Internal Revenue Service
1111 Constitution Avenue, NW
Washington, DC 20224

Re: Certain Medical Care Arrangements REG–109755–19 (RIN 1545–BP31); Notice of Proposed Rulemaking

Dear Commissioner Rettig:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to provide comments on the Internal Revenue Service's (IRS) proposed rule, "Certain Medical Care Arrangements," relating to section 213 of the Internal Revenue Code (IRC or Tax Code) regarding the treatment of amounts paid for certain medical care arrangements, including direct primary care (DPC) arrangements and health care sharing ministries (HCSM), as published in the June 10, 2020 *Federal Register*. The proposed regulation would define these fees or "shares" as payments for medical care or medical insurance, which would make them eligible for a tax deduction as qualified medical expenses, and would allow employers to reimburse employees for fees for DPC and HCSMs through a health reimbursement arrangement (HRA). **The AMA supports the IRS' proposed change to treat fees paid for DPC arrangements as eligible medical expenses under the Tax Code. However, the AMA urges the IRS to change its interpretation of section 223(c) of the IRC to allow the use of Health Savings Account (HSA) funds to pay for participation in DPC arrangements. In addition, the AMA does not support the proposed change to treat certain expenses of HCSMs as tax-advantaged health insurance products and urges the IRS not to finalize that proposal.**

Direct Primary Care Arrangements

DPC arrangements have been rising in popularity among primary care physicians. As of 2020, DPC laws have been passed in 32 states with pending legislation in 12 states. About half of states exempt DPC arrangements from state insurance laws and offer varying levels of consumer protection. According to the Direct Primary Care Coalition, almost 1,200 new DPC practices have emerged since 2009.

DPC is an alternative to the traditional fee-for-service primary care practice model. DPC practices offer patients the full range of comprehensive primary services, including routine care, regular checkups, preventive care, and care coordination and comprehensive care management in exchange for a flat, recurring retainer fee that is typically billed to patients on a monthly basis. This type of arrangement can benefit patients by providing savings and a greater degree of access to, and time with, physicians. Under such arrangements, a consumer pays a regular fee to have access to a primary care physician. However, the primary care physician usually does not accept insurance, and the arrangement does not include the coverage of prescription drugs, emergency care, hospitalization, or most other non-primary care-related

benefits. Patients enrolled in DPC practices, therefore, still need major medical insurance coverage to pay for these other expenses. DPC medical homes meeting certain federal standards can be used, pursuant to the Affordable Care Act (ACA), along with a qualified health plan.[1]

A DPC arrangement is defined under the proposed rule as "a contract between an individual and one or more primary care physicians where a physician agrees to provide medical care for a fixed annual or periodic fee without billing a third party." Moreover, the proposed rule defines a primary care physician as a physician with a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine. The IRS proposes that fees for direct primary care would be treated as qualified medical expenses and therefore deductible under the tax code if the arrangement meets the proposed rule's definition. Furthermore, under the proposed rule, an HRA could reimburse fees for direct primary care.

The AMA supports the proposed definition of a DPC arrangement. While the proposed definition of primary care physician is consistent with the definition under Medicare, the AMA supports adding obstetricians/gynecologists to the definition, as many women receive primary care from such specialists. We do not support extending the definition of a DPC arrangement to include a contract between an individual and a nurse practitioner, clinical nurse specialist, or physician assistant or other non-physician practitioners. While we recognize the important role of such practitioners in primary care as part of a physician-led team, they are already covered by numerous state and federal laws, in addition to primary care services as defined under Medicare, and do not need to be added to the tax code.

The proposed rule does not address the key regulatory barrier that prevents individuals with HSAs from participating in a DPC arrangement. Under section 223 of the IRC, individuals can contribute to an HSA coupled with a high-deductible health plan (HDHP). While those enrolled in a HDHP-HSA can be covered under additional types of coverage, the tax code limits this to specific coverage, e.g., dental or vision coverage, specified disease coverage, or worker's compensation coverage. IRC section 223(c) states that, to be eligible to establish and contribute to an HSA, an individual must be covered under an HDHP and, while covered under an HDHP, may not be covered under any other health plan that is not an HDHP and provides coverage for any benefit which is covered under the HDHP. Under previous interpretations of the IRC, patients with HSAs are prohibited from engaging in DPC arrangements with a family physician or other primary-care physician.

The AMA supports enabling patients to use HSAs to help pay for DPC arrangements and to enter DPC periodic-fee agreements without IRS interference or penalty. We urge the IRS to use its regulatory discretion to reconsider its previous interpretations of HSAs in relation to DPC arrangements, and issue guidance that clarifies that an individual with a DPC arrangement is eligible to fund an HSA and allow them to use funds from their HSA to pay fees for primary care services in a periodic fee-based DPC arrangement. Alternatively, the AMA urges the IRS to work with Congress to enact H.R. 3708/S. 2999, the "Primary Care Enhancement Act of 2019" (Blumenauer, D-OR/Cassidy, R-LA), which would allow the use of HSA funds to pay for participation in DPC arrangements.

[1] New Proposed Rule on Health Care Sharing Ministries And Direct Primary Care, Health Affairs Blog, June 11, 2020. DOI: 10.1377/hblog20200611.714521.

Health Care Sharing Ministries

HCSMs are arrangements in which members who follow a common set of religious or ethical beliefs agree to contribute regular payments to help pay the qualifying medical expenses of other members. They can look much like health insurance, but they are not. They do not guarantee to reimburse members for medical expenses and do not have to meet financial or other standards that ensure they can cover members' medical needs. Some of them can leave members vulnerable to unpaid medical bills.[2] States usually do not regulate them as insurers, meaning HCSMs are exempt from state health insurance consumer protections. Partly due to deceptive marketing and misleading plan features, state regulators have stepped up their scrutiny of HCSMs to warn consumers of their limits. As of February 2020, Colorado, Connecticut, New Hampshire, Texas, and Washington had taken legal action against one HCSM, Aliera. Meanwhile, the National Association of Insurance Commissioners and at least 15 states have issued consumer alerts warning of the risks posed by HCSMs.[3] The AMA has been working with the National Council of Insurance Legislators (NCOIL) to strengthen its current draft of the Health Care Sharing Ministry Registration Model Act to include greater transparency requirements and additional public disclosures.

Despites these concerns, the IRS proposes to treat "shares" of HCSMs as deductible qualified medical expenses under section 213(d) of the IRC. Shares for these ministries would qualify as payments for medical insurance. This is contrary to the position taken by the ministries themselves: according to the Alliance of Health Care Sharing Ministries, HCSMs are "not insurance." The AMA is concerned that granting HCSMs a tax status reserved for insurance raises questions about using federal funds to promote a coverage option that fails to provide consumers with adequate coverage and financial protection for health care expenses. The AMA does not support this proposed change and urges the IRS to withdraw it.

Thank you for considering our comments. If you have any questions, please contact Margaret Garikes, Vice President of Federal Affairs, at margaret.garikes@ama-assn.org or (202) 789-7409.

Sincerely,

James L. Madara, MD

[2] JoAnn Volk, Justin Giovannelli, and Christina L. Goe, "States Take Action on Health Care Sharing Ministries, But More Could Be Done to Protect Consumers," *To the Point* (blog), Commonwealth Fund, Feb. 18, 2020. https://doi.org/10.26099/qgkr-0384

[3] Ibid.