August 10, 2020

Charles Rettig, Commissioner
Internal Revenue Service
P.O. Box 7604, Ben Franklin Station
Washington, D.C. 20044

RE: Internal Revenue Service Proposed Rule on Certain Medical Care Arrangements (REG-109755-19)

Dear Commissioner Rettig:

Thank you for the opportunity to submit comments on the Internal Revenue Service Proposed Rule on Certain Medical Care Arrangements.

The undersigned organizations represent millions of patients facing serious, acute, and chronic health conditions across the country. Our organizations have a unique perspective on what patients need to prevent disease, cure illness, and manage chronic health conditions. Our diversity enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion. We urge the Department to make the best use of the knowledge and experience our patients and organizations offer in response to this proposed rule.

In 2017, our organizations agreed upon three overarching principles[1] to guide any work to reform and improve the nation's healthcare system. These principles state that: (1) healthcare

[1] Muscular Dystrophy Association website, "Healthcare reform principles." Available at: https://cqrcengage.com/mda/file/kSgnXK91pJZ/052820%20Healthcare%20Principles42logos.pdf

must be adequate, meaning healthcare coverage should cover treatments patients need, including the services in the essential health benefit package; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care. Enrollment should be easy to understand, and benefits should be clearly defined.

We are writing in response to the Internal Revenue Service proposed regulations that would treat payments made to health care sharing ministries (HCSMs) and to direct primary care arrangements (DPCAs) as medical expenses under section 213 of the Internal Revenue Code. This would grant the payments the same tax status as health insurance premiums so that they could be deducted as medical expenses from personal income taxes or reimbursed using funds from a health reimbursement arrangement (HRA). We strongly oppose giving tax breaks for membership in an HCSM; these entities do not provide the same guaranteed financial protection as health insurance, are exempted from providing a robust baseline of services akin to the essential health benefits package mandated by the ACA, and are not regulated as insurance by any state. We are similarly concerned that the proposed rule may encourage enrollment in DPCAs as a substitute for comprehensive coverage.

Health Care Sharing Ministries

HCSMs are not subject to any consumer protections. They typically exclude coverage for preventive care, including cancer screenings and immunizations, mental health services, and maintenance prescription drugs required for chronic conditions. Maternity coverage is only available to families that meet certain religious requirements and then is typically subject to a waiting period and dollar limits. Although HCSMs do not turn away people with pre-existing conditions, they are not mandated to provide coverage for services or care related to pre-existing conditions. For example, one HCSM won't cover any care related to cancer unless the member's doctor has declared them cured or cancer-free and the member has gone 5 years without any signs, symptoms, testing or treatment related to cancer. That means cancer survivors would have to forgo any testing that may be needed to monitor their care in order to qualify for submitting any future bills related to their cancer. Another HCSM doesn't cover costs associated with Type 1 diabetes and most exclude durable medical equipment, including diabetic test strips, from eligibility for reimbursement.

Even when services may be eligible for sharing under an HCSM's member guidelines, there is absolutely no guarantee that a member's costs will be covered. Unlike insurers, HCSMs provide members no written contract and assert that they assume no responsibility for paying their claims. Rather, these entities say that they facilitate voluntary payments between members. This is fundamentally different from insurance, where enrollees have a guarantee that costs associated with medically necessary care for covered benefits will be reimbursed according to a contract. If an insurer denies coverage, enrollees have a legal right to appeal the insurer's decision to an independent reviewer with medical expertise. In contrast, HCSM members may need to first demonstrate that they've applied for hospital-based charity care or authorized an

HCSM representative to negotiate with a provider to reduce the charges. Even then, the HCSM has full discretion to approve or deny the claim for payment and may limit payment based on available funds.[2]

Recent media attention has focused on Aliera, which left members across multiple states with unpaid claims.[3] In response, at least 7 states have taken action against Aliera (CA, CO, CT, MD, NH, TX and WA), and at least 3 more are investigating Aliera for operating as an unlicensed insurer (NY, NC, RI). But even longstanding HCSMs that tout their recognition under the ACA's definition have left members with unpaid bills.[4] HCSMs don't have to meet solvency standards, so members must just hope that funds will be available when they need help paying bills. Nor do HCSMs have to meet minimum loss ratio standards that guarantee that at least 80 percent of a member's monthly cost will go toward health care expenses rather than advertising, broker commissions and other administrative costs.

The proposed rule will contribute to consumer confusion: While they are not held to any particular standards, HCSMs have structured their features so that they closely resemble those of insurance, including cost-sharing requirements that function just like an insurance plan deductible, provider networks, coverage tiers based on metal levels, monthly costs that vary by age, and defined covered services. However, HCSMs have long argued, and assert repeatedly on their websites, that they are not health insurance and should not be regulated as such because they do not assume responsibility for paying claims.

Despite the fact that both the industry and the law do not recognize these plans as insurance, the proposed rule put forward by the IRS dismisses how HCSMs characterize their own activities and determines that the "substance" of what these entities do is sufficiently similar to traditional insurance that member payments are, for tax purposes, health insurance premiums. Perhaps sensing a problem for the very entities the rule is intended to benefit, the proposal immediately pivots and asserts that its analysis of HCSMs "has no bearing" on any other legal requirement that may or may not apply to HCSMs whatsoever. This blanket disclaimer notwithstanding, by conferring the same tax benefits afforded to health insurance premiums to

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[2] See, for example, Liberty HealthShare Sharing Guidelines, Effective February 1, 2019, accessed at https://libertyhealthshare.org/assets/public/2019-LHS-Guidelines.pdf; Medi-Share Guidelines, accessed at https://mychristiancare.org/medi-share/what-is-medishare/how-medi-share-works/medi-share-guidelines/; Christian Healthcare Ministries Guidelines accessed at https://www.chministries.org/media/1039/chmguidelines.pdf; and Samaritan Ministries for Health Care Sharing, Effective Jul. 2020, accessed at https://samaritanministries.org/uploads/documents/SMI-Guidelines-July2020_download.pdf

[3] Jenny Deam, "Buyer Beware: When religion, politics, health care and money collide," Houston Chronicle, July 2, 2019.

[4] Reed Abelson, "It Looks Like It's Health Insurance, But It's Not. 'Just Trust God,' Buyers Are Told," New York Times, Jan. 2, 2020. See also ACA claims at Medi-Share at https://www.medishare.com/about and Liberty HealthShare at https://libertyhealthshare.org/faq

HCSM payments, this proposed rule will further blur the lines between HCSMs and insurance, which unquestionably will make it harder for consumers to understand the benefits and risks of their coverage options.

The proposed rule will drive enrollment in non-comprehensive coverage: In order for HCSM fees to be eligible for the proposed tax benefits, the HCSM must meet a definition that is the same as the definition used in the Affordable Care Act's exemption from the individual mandate penalty for qualifying HCSM members. HCSMs, and brokers selling memberships on their behalf, are likely to use the federal recognition and tax benefits to market memberships and drive enrollment, just as some HCMS did in response to the ACA exemption. For example, some ministries used their recognition under the ACA to suggest legitimacy as a form of coverage, saying, for example, that the law included them as an "eligible" or "viable" health care option.[5]

The proposed rule will invite fraud: Recent stories of unpaid claims have prompted regulators in multiple states to take action, including issuing consumer warnings and imposing new requirements on brokers who sell HCSM plans.[6] Thirty states specifically exempt HCSMs from insurance regulation, but no state regulates them.[7] Given this regulatory vacuum, it is particularly concerning that the IRS is proposing tax benefits for HCSM enrollment fees, which is likely to give new life to fraudsters at a time when tens of millions of newly uninsured may be searching for coverage that advertises low upfront costs.[8]

For these reasons, we believe the proposed rule should not be finalized. In addition to not finalizing the rule, we believe the IRS and other agencies should take additional steps to improve transparency around HCSMs enforcement. The proposed rule defines HCSMs using the same definition as the ACA, yet the process for considering HCSMs for approval for the ACA exemption and the list of HCSMs that met the ACA criteria was never made public. Furthermore, the HCSM definition in the ACA has been shown to be meaningless. One HCSM established after enactment of the ACA – long after the ACA's requirement that HCSMs be in existence prior to 1999 – suggests that it meets the ACA definition.[9] If the rule is finalized, the IRS must implement a transparent process for considering HCSM requests for recognition,

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[5] See Christian Healthcare Ministries at https://chministries.org/resources/affordable-care-act/; Medi-Share at https://mychristiancare.org/medi-share/what-is-medishare/healthcare-reform/; and Samaritan Ministries at https://samaritanministries.org/about-us#sustainability

[6] Jenna Carlesso, "'I'm relying on prayer.' Complaints pile up against health care sharing ministries as state mounts a defense," Connecticut Mirror, Mar. 2, 2020. See also, J J. Volk, J. Giovannelli and C. Goe, "States Take Action on Health Care Sharing Ministries, But More Could Be Done to Protect Consumers," The Commonwealth Fund, Feb. 19, 2020.

[7] J. Volk, E. Curran and J. Giovannelli, "Health Care Sharing Ministries: What Are the Risks to Consumers and Insurance Markets?" The Commonwealth Fund, Aug. 8, 2018.

[8] J. Banthin et al, "Changes in Health Insurance Coverage Due to the COVID-19 Recession," The Urban Institute, Jul. 13, 2020.

[9] See Solidarity Healthshare at https://www.solidarityhealthshare.org/faq/transparency-and-accountability/how-does-solidarity-remain-accountable-to-its-members/

publish the list of approved HCSMs, and require HCSMs to annually demonstrate compliance with the definition and provide enrollment data and other information about their operations to assist in IRS oversight of tax filings.

Direct Primary Care Arrangements

As with fees paid to HCSMs, the proposed rule would allow fees paid to DPCAs to qualify as a medical expense that can be deducted from personal income taxes or be reimbursed from an HRA. About half the states exempt DPCAs from state insurance regulation.[10] Although DPCAs may be paired with comprehensive coverage – typically to provide enhanced primary care services to individuals who have coverage for specialty and other care outside the scope of the DPCA – they may be sold on their own, leaving individuals exposed to claims for care not covered under the DPCA. However, nothing in the proposed rule would require individuals to have comprehensive insurance coverage in order to be eligible for the tax benefits under section 213 of the Internal Revenue Code. We have concerns that providing for tax advantages to purchase a DPCA will drive enrollment in coverage that fails to provide adequate coverage and financial protection for chronic conditions. We therefore urge the IRS to require individuals to demonstrate they have other, comprehensive coverage in order to claim a tax deduction or reimbursement from an HRA for fees paid to a DPCA.

Thank you for the opportunity to comment on this proposed rule. Please contact Rachel Patterson at rpatterson@efa.org for any follow up.

Sincerely,

Alpha-1 Foundation
American Cancer Society Cancer Action Network
American Heart Association
American Lung Association
Arthritis Foundation
Chronic Disease Coalition
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Leukemia & Lymphoma Society
National Alliance on Mental Illness
National Health Council
National Hemophilia Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
Susan G. Komen
The AIDS Institute

[10] M. Kona, K. Lucia and S. Corlette, "Direct Primary Care Arrangements Raise Questions for State Insurance Regulators," The Commonwealth Fund, Oct. 22, 2018.