August 10, 2020

Submitted via www.regulations.gov

CC:PA:LPD:PR (REG-109755-19)
Room 5203
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Re: Proposed Regulations Regarding Certain Medical Care Arrangements (REG-109755-19)

Dear Sir or Madam,

We write on behalf of the American Benefits Council ("the Council") to provide comments in connection with the Certain Medical Care Arrangements proposed regulations ("proposed regulations") published in the Federal Register on June 10, 2020, by the U.S. Treasury Department and the Internal Revenue Service (IRS). The proposed regulations address the extent to which payments for various types of medical care arrangements constitute "medical care" under Section 213 of the Internal Revenue Code (Code), which is relevant to whether those amounts can be reimbursed by account-based health plans, among other things. While the proposed regulations address various medical care arrangements, the Council's comments focus on direct primary care (DPC) arrangements and the interaction of those arrangements with account-based health plans, as those are the most significant issues for Council members under the proposed regulations.

The Council is a Washington D.C.-based employee benefits public policy organization. The Council advocates for employers dedicated to the achievement of best-in-class solutions that protect and encourage the health and financial well-being of their workers, retirees and families. Council members include over 220 of the world's largest corporations and collectively either directly sponsor or administer health and retirement benefits for virtually all Americans covered by employer-sponsored plans.

More Americans are covered by employer-provided health care than any other source of health insurance. Due to their central role in providing health coverage, employers are constantly innovating to increase value and reduce health care costs in the health coverage they offer to many millions of Americans. These efforts emphasize high-value, lower-cost care and effective management of chronic conditions. As relevant to the proposed regulations, we have seen DPC arrangements become a meaningful part of these efforts for some employers.

The value of DPC arrangements relates to the importance of access to high-value primary care for individuals to manage chronic conditions and maintain general health, and, as a result, reduce health care costs.[1] Further, DPC arrangements often enable remote care, including telehealth, which, as we have learned most recently during the pandemic, can be an essential service.

As such, DPC arrangements can be a valuable option for many individuals. Of course individuals may choose to enroll in DPC arrangements on their own to supplement other coverage or on a stand-alone basis. However, it is also the case that a number of employers that offer traditional health coverage to their employees are paying some or all of the cost of a DPC arrangement, as a supplemental feature of the traditional coverage being offered. Employers do this in order to address various health care challenges, including limited availability of care in a geographic location, employee populations with a high incidence of chronic conditions and cost issues for lower-income employees. DPC arrangements have been a valued benefit by employees, including because they encourage long-term relationships with primary care providers and address behavioral health needs. In addition, these arrangements have the potential to lower health care costs.[2]

The Council appreciates the opportunity to comment on the proposed regulations and commends the Administration's efforts to support DPC arrangements. We also support the clarification in the proposed regulations that amounts paid for DPC arrangements may be reimbursed by health reimbursement arrangements (HRAs). This will enable individuals who have DPC arrangement coverage (generally in addition to other coverage with which the HRA is integrated) to seek reimbursement for the cost of the DPC arrangement, depending on the terms of the HRA.

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[1] See, e.g., The Twentieth Report of the Council on Graduate Medical Education on Advancing Primary Care, https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/graduate-medical-edu/reports/archive/2010.pdf.

[2] An unpublished study, based on one type of DPC arrangement for Medicare patients found that inpatient hospital admissions among a cohort of 1,176 Medicare enrollees over an 18-month period decreased by 50%, emergency department visits decreased by 20%, and the total medical spend declined by 12% — this despite the cohort being sicker than average Medicare patients. https://hbr.org/2017/10/the-innovation-health-care-really-needs-help-people-manage-their-own-health.

However, notwithstanding the proposed regulations, a significant impediment to the use of DPC arrangements remains in that Treasury and the IRS have taken the position that coverage by a DPC arrangement renders an individual ineligible for contributions to a health savings account (HSA). As explained below, Congress needs to address this issue to enable DPC arrangements to reach their potential to increase high-quality care and reduce health care costs. In addition, the Council's comments address a number of areas in which further clarity is needed on the interaction of DPC arrangements and account-based plans. The Council also provides comments on the definitions used in the proposed regulations.

DPC ARRANGEMENTS AND HSA ELIGIBILITY

Under Code Section 223, in order to be eligible to contribute to an HSA, an individual must be covered by a high deductible health plan (HDHP) and may not be covered by a "health plan" that is not an HDHP, unless the health plan provides only permitted insurance (e.g., worker's compensation or specific disease insurance), permitted coverage (e.g., dental and vision coverage) or preventive care. Although neither the Code nor guidance by Treasury and the IRS provide a specific definition for what "health plan" means in this context, Treasury and the IRS have interpreted the term to cover various health care arrangements in addition to traditional major medical coverage, such as health flexible spending arrangements (FSAs) and HRAs, unless they are designed specifically to cover only permitted benefits and preventive care.[3]

In the preamble to the proposed regulations, Treasury and the IRS state the following:

> The Treasury Department and the IRS understand that direct primary care arrangements typically provide for an array of primary care services and items, such as physical examinations, vaccinations, urgent care, laboratory testing, and the diagnosis and treatment of sickness or injuries. This type of DPC arrangement would constitute a health plan or insurance that provides coverage before the minimum annual deductible is met, and provides coverage that is not disregarded coverage or preventive care. Therefore, an individual generally is not eligible to contribute to an HSA if that individual is covered by a direct primary care arrangement.

The general inability of individuals to contribute to an HSA and have a DPC arrangement is a substantial issue that needs to be resolved. The effect of this interpretation is that employers that have had success in making DPC arrangements available in connection with the traditional health plans they offer are unable to extend the same benefits to their employees who are covered by an HSA-eligible HDHP. Also, employees who want to contribute to an HSA do not have the option to enroll in a DPC arrangement without regard to whether their employer has any involvement. The

[3] See Revenue Ruling 2004-45, 2004-1 IRB 971.

population of American workers eligible for coverage by an HDHP is substantial – Mercer's National Survey for 2019 shows that 59% of employers with over 500 employees offer an HDHP and over 67% of employers with over 200,000 employees offer an HDHP.[4] Moreover, the goal of both DPC arrangements and HSAs is to use market forces to reduce overall medical costs for the individual and in the aggregate. Those forces would be strengthened by the ability of individuals to use both arrangements, with day-to-day medical needs addressed in a cost-effective manner through a DPC arrangement and with the ability to save funds in an HSA for major medical issues.

Given the significant number of Americans enrolled in HSA-eligible HDHPs, in order for DPC arrangements to be a meaningful option for employees and employers, the HSA barrier needs to be removed. Accordingly, the Council is continuing our efforts to encourage Congress to address this issue, including by passing legislation along the lines of the Primary Care Enhancement Act of 2019 (H.R. 3708 and S. 2999). We also encourage Treasury and IRS to consider the extent to which they can utilize existing interpretative authority with respect to Code Section 223 to define a "health plan" to not encompass DPC arrangements. We also encourage the Administration to support legislative efforts to affirm the ability of individuals to be covered by a DPC arrangement and remain HSA-eligible.[5] With regard to these efforts, the Council stands ready to provide information and support.[6]

DEFINITIONS

The proposed regulations define a DPC arrangement 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." Treasury and the IRS specifically request comments on this definition.

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[4] https://www.mercer.us/what-we-do/health-and-benefits/strategy-and-transformation/mercer-national-survey-benefit-trends.html.

[5] We note that on-site clinics also increase access to primary care and management of chronic diseases, and, as such, the Council also supports legislative or regulatory changes that would allow individuals with access to primary care services and services to manage chronic conditions through free or low-cost on-site clinics to be eligible to contribute to an HSA. See https://www.americanbenefitscouncil.org/pub/?id=9DBEDD63-1866-DAAC-99FB-265ECC598AED.

[6] We note that in the proposed regulations the Treasury Department and the IRS also explain very limited circumstances in which a DPC arrangement does not undermine HSA eligibility, and we address that aspect of the rule later in this comment letter.

As noted above, in some cases, employers pay some or all of the cost of the DPC arrangement and this type of arrangement does not seem to be captured by the proposed definition. However, we see no substantive reason why the treatment of an arrangement where the employer partially subsidizes the cost should be different from the treatment of an arrangement where the individual is obligated to pay the whole cost. Accordingly, to align the definition with the ways that DPC arrangements are being provided in some cases, we request that Treasury and the IRS revise the definition to account for this set of facts.

In addition, the proposed regulations define a "primary care physician" as "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." Treasury and the IRS ask for comments as to whether the definition should be expanded to include a contract with a nurse practitioner, clinical nurse specialist or physician assistant. In order to provide flexibility and support for DPC arrangements, and to account for our understanding of how they are sometimes structured, we recommend that the definition be expanded to cover these additional non-physician practitioners.

Further regarding the definition of primary care physician, although we understand that the definition provided, which is limited to four specialty designations, is based on the Social Security Act, we also note that in some cases providers with other specialty designations also provide primary care services. This could occur in particular in areas where there may be a scarcity of more traditional primary care providers. For example, endocrinologists and obstetricians/gynecologists sometimes provide primary care, which in the latter case is treated as primary care under certain provisions of the Affordable Care Act.[7] As such, we recommend that Treasury and the IRS consider this as part of finalizing the definition of primary care physician and, as needed, retain the flexibility to expand the definition of primary care physician via the issuance of future subregulatory guidance as appropriate.

INTERACTION OF DPC ARRANGEMENTS AND ACCOUNT-BASED PLANS

Notwithstanding the above comments, the proposed regulations outline two circumstances in which an individual who is covered by a DPC arrangement would not be precluded from contributing to an HSA. In the first circumstance, the DPC arrangement solely provides coverage which otherwise doesn't preclude individuals from contributing to an HSA under the general statutory HSA rules, as explained earlier (i.e., disregarded coverage, disregarded insurance, preventive care). The second circumstance is when "an individual is covered by a direct primary care arrangement that does not provide coverage under a health plan or insurance (for example, the

[7] See Public Health Service Act Section 2719A(d).

arrangement solely provides for an anticipated course of specified treatments of an identified condition)."

We request that additional clarity be provided regarding the circumstances in which a DPC arrangement does not constitute a "health plan" or insurance, so that the HSA interaction rules can be applied with consistency and certainty. Although Treasury and the IRS explain the general concept – that is, that DPC arrangements are varied and in some limited cases they will not be considered to be a "health plan" or insurance – it is difficult to discern the HSA rule being applied that results in the provided example being permissible (i.e., an arrangement that solely provides for an anticipated course of specified treatments of an identified condition). We request that Treasury and the IRS explain why that type of an arrangement is not a "health plan" or insurance, including whether the answer is contingent on whether the arrangement is provided under a separate policy, certificate or contract of insurance and whether it is limited to one identified condition or whether it could include more than one identified condition.

More generally, we also request a clearer explanation of the rule that stakeholders may apply to determine if a DPC arrangement is considered a "health plan" for purposes of interaction with the HSA rules, including additional examples. For example, does the extent of employer involvement matter and does it matter if the employee pays the full cost? Does it matter if the DPC arrangement is considered insurance under state insurance law and does the extent of risk shifting come into play? The proposed regulations are not clear on the answers to these questions. As noted above, the interaction of DPC arrangements and HSAs is a significant issue and so clarity as to when an individual may have a DPC arrangement and contribute to an HSA under this rule is key, in particular because it is possible that a number of DPC arrangements may take many different forms, including in the extent of covered items and services, number of visits and whether there is risk shifting by the individual to the primary care provider. Without additional clarity, it will be very difficult to determine if a DPC arrangement is of the sort that does not constitute a "health plan" and, as a practical matter, stakeholders will be unable to apply the exception in any consistent manner. In the interest of consistency, predictability and fairness for taxpayers, we ask that additional clarity be provided.

Additional clarity is also needed regarding when a DPC arrangement constitutes "medical insurance" or non-insurance medical care because the status of a DPC arrangement as "medical insurance" affects whether the related costs may be reimbursable from certain medical savings accounts – specifically health FSAs, excepted benefit HRAs ("EBHRAs") and HSAs. This is because these medical savings accounts generally cannot reimburse health insurance premiums or amounts paid for health coverage.[8] Thus, it is imperative that individuals and employers be able to determine with certainty – and ideally with ease – whether a given DPC arrangement constitutes "medical insurance" or non-insurance medical care. Otherwise, the only course of

[8] See Proposed Treas. Reg. § 1.125-5(k)(4), Code Section 223(d)(2)(B), 26 CFR § 54.9831-1(c)(3)(viii)(C).

action for employers may be to include plan language that excludes DPC arrangements from the costs that are eligible for reimbursement from these account-based plans.

Such a result would surely be unfortunate as it could prevent employees (and their families) from accessing the high-quality, lower-cost care, that can be received from using DPC arrangements. As such, we request that Treasury and the IRS provide that amounts paid for DPC arrangements are not treated as amounts paid for "medical insurance" for purposes of the rules that determine which expenses may be reimbursed from health FSAs, EBHRAs and HSAs. Further, we ask that Treasury and the IRS provide that payments for DPC arrangements are treated as incurred on the date the amount is paid rather than on the date when actual medical services are received, which will allow reimbursement from an account-based plan at the time paid, rather than when medical care is actually provided.[9]

In addition, in the preamble to the proposed regulations, in explaining the types of DPC arrangements which do not preclude HSA eligibility, Treasury and the IRS state that "[i]f 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 a HSA." We request that Treasury and the IRS clarify this statement as well because this could be read to mean that, if an employer pays for the cost of the DPC arrangement, the individual is foreclosed from contributing to an HSA, even if the DPC arrangement is not a "health plan" or provides only permitted benefits or preventive care.

Such a result is not consistent with other HSA guidance. For example, in Revenue Ruling 2004-45, Treasury and the IRS clarified that an otherwise eligible individual remains an HSA-eligible individual if he or she is covered by a limited-purpose HRA, which is an HRA that pays or reimburses benefits for permitted benefits or preventive care only. Subsequently, Q&A-1 of Notice 2008-59[10] stated that a limited-purpose HRA that is also available to pay premiums for health coverage does not disqualify an otherwise eligible individual from contributing to an HSA, provided the individual does not use the HRA to (or otherwise) obtain coverage that is not HSA-compatible. As such, it should not be the case that, if an employer pays for all or part of the cost of a DPC arrangement, the individual is automatically rendered ineligible to contribute to an HSA – that determination should hinge on whether the DPC arrangement *itself* is of the *type* that renders the individual HSA-ineligible (e.g., because it offers benefits or coverage that is disqualifying of HSA eligibility). We request that the final regulations address this issue more clearly.

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[9] In general, subject to a special rule for health insurance premium reimbursements from HRAs as set forth in Notice 2020-33, health FSAs and HRAs may not reimburse medical care expenses incurred before the beginning of the plan year and medical care expenses are treated as incurred when the covered individual is provided the medical care that gives rise to the expense, not when the amount is billed or paid. However, the Treasury Department and the IRS have provided that certain medical care expenses are treated as incurred when paid (i.e., expenses for orthodontia). *See* Prop. Treas. Reg. § 125-5(k)(3)(i).

[10] *See* IRS Notice 2008–59, 2008–29 IRB 123.

STAND-ALONE DPC ARRANGEMENTS

As noted earlier, employers have had an interest, and some success, in offering DPC arrangements in connection with the traditional group health plans that they offer. We are aware that additional guidance would be needed from Treasury and the IRS, along with the Departments of Labor and Health and Human Services (collectively, "the departments"), to enable employers to offer DPC arrangements to employees on a stand-alone basis (i.e., to those who aren't enrolled in the employer's traditional group health plan).

Our understanding is that currently, offering stand-alone DPC arrangements is not a priority for employers but that may well change as the workforce changes and health care innovations develop. In order to facilitate this practice, however, enabling guidance would be needed addressing the interaction of these stand-alone arrangements with other federal rules, such as the Affordable Care Act's market reforms and eligibility for Code Section 36B premium tax credits, among others. We are continuing to monitor this issue and will follow up with the departments in the event additional guidance is needed. In the meantime, we are more than happy to discuss the related issues with the departments if that would be helpful.

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Thank you for the opportunity to comment on these proposed regulations. We appreciate the Administration's efforts to take steps to increase health care quality and reduce health care costs, as those are critical issues for Council members. More generally, we commend you for your efforts to address the pandemic and economic crisis and we understand the immense amount of work that Treasury and the IRS have been undertaking in response. We greatly appreciate your attention to these comments among the many other essential matters before you.

If you have any questions or would like to discuss these recommendations further, please contact us at (202) 289-6700.

Sincerely,

Ilyse Schuman
Senior Vice President, Health Policy