Doctors 4 Patients Care Foundation (D4PCF) appreciates the opportunity to comment on the proposed rule entitled “Health Reimbursement Arrangements and Other Account-Based Group Health Plans” (REG-136724-17).¹ D4CPF is a 501(c)(3) nonpartisan, nonprofit organization committed to unleashing human ingenuity in health care. D4CPF is the only health care policy think tank whose board is composed of practicing physicians who possess hands-on, practical knowledge of the American health care system.

We support the efforts of the Department of Treasury (DTR), Department of Labor (DOL), and Department of Health & Human Services (HHS) (together referred to as the Departments) to “expand opportunities for working men and women and their families to access affordable, quality healthcare….”² In pursuit of those goals, D4CPF recommends that the Departments clarify in the final rule that monthly fees for Direct Primary Care Medical Homes (DPCs) are qualified medical expenses as defined under Section 213(d)(1)(A) of the Internal Revenue Code of 1986, as amended (the “Code”). Such an interpretation would bring consistency to the Departments’ interpretation of DPCs and expand the availability of affordable and quality healthcare options to working Americans.

DPCs involve a fixed-fee arrangement between providers and consumers, where the patient pays a periodic fee in exchange for a defined number of visits as well as office-based procedures and treatments. It generally includes all office based professional services for the prevention and management of disease, including associated in-office testing, procedures, related supplies and office-administered medications. It also typically includes technology visits via email, texting or video. Despite the fact that such services fit within the definition of “medical care” expenses pursuant to Section 213(d) of the Code, there is uncertainty as to whether Health Reimbursement Arrangement (“HRA”) funds can be used to pay the monthly fee that individuals incur as part of a membership in a DCP.

² Id.
Inconsistent guidance from the IRS has limited access to DPCs.

The Patient Protection and Affordable Care Act of 2010 authorized Qualified Health Plans (QHPs) to offer DPCs as part of their plan offerings so long as the QHP complied with other applicable requirements for health insurance coverage.\(^3\) In the preamble to 2011 rulemaking, the HHS described a DPC as involving an “arrangement where a fee is paid by an individual, or on behalf of an individual, directly to a medical home for primary care services.”\(^4\) The HHS further described “primary care services” as routine health care services, including screening, assessment, diagnosis, and treatment for the purpose of promotion of health, and detection and management of disease or injury.\(^5\)

The Internal Revenue Service (IRS) has provided limited guidance on the tax treatment of DPCs, and in particular, has suggested that DPCs may not be used with Health Savings Accounts (HSAs).\(^6\) On June 17, 2014 Senators Patty Murray and Maria Cantwell and Congressman Jim McDermott wrote a letter (Congressional Letter) to then-IRS Commissioner John Koskinen requesting clarification on the issue of whether the agency considers DPCs to be second health plans that disqualify individuals from using HSA funds to offset DPC expenses.\(^7\) The Congressional Letter noted a statement from the preamble of the HHS proposed rule implementing DPCs that “direct primary care medical homes are not insurance.”\(^8\) Furthermore, the Congressional Letter requested that the Commissioner respond with how he may address the classification of DPC costs as qualified medical expenses under Section 213(d) of the Code. The Congressional Letter emphasized “paying for a primary care physician is ultimately one of the most important ‘qualified medical expenses’ that a patient with or without an HSA can make.”\(^9\)

On June 30, 2014, Commissioner John Koskinen responded to the Congressional Letter.\(^10\) Commissioner Koskinen stated that the IRS and Treasury Department were considering reviewing the rules regarding qualified medical expenses and that it would consider the Congressional Letter in promulgating the 2013-2014 Treasury and IRS Priority Guidance Plan. As to the issue of DPCs qualifying as second health plans, Commissioner Koskinen

\(^5\) Id.
\(^6\) As noted in footnote 12 below, there is uncertainty as to the treatment of DPC payments for both HSAs and HRAs, but this letter focuses upon HRAs as they are the subject of the proposed rulemaking.
\(^8\) Id.
\(^9\) Id. at 2.
\(^10\) Letter to The Honorable Patty Murray, (June 30, 2014), available at https://static1.squarespace.com/static/54c15fc5e4b06765d7d750d5/t/5b08549c8a922d37c7a169b4/1527272609141/06.30.14+Koskinen.pdf.
asserted that the “concept of a second plan under section 223(c)(1)(A)(ii) is not restricted to insurance,” and thus it was not necessary for DPCs to satisfy the traditional role of health insurance in order to be incompatible with HSAs.\textsuperscript{11}

The IRS, despite having multiple opportunities to do so, has never codified or issued any guidance apart from Commissioner Koskinen’s Letter to Sen. Patty Murray on the tax treatment of DPCs. Although 25 states have enacted legislation clarifying that DPCs are not health insurance, it is unclear at this time whether HRA funds can be used to offset DPC-related medical costs as qualified medical expenses under Section 213(d) of the Code. Accordingly, individuals have not been able to use HRA funds to offset the monthly fee that they incur as part of their membership in a DPC. We are concerned that the lack of additional guidance from the IRS over the years on the issue of DPCs has served to restrict access to a form of extremely affordable and convenient healthcare by preventing individuals from leveraging HRA funds to pay for their DPC-related expenses.

The Departments should appropriately interpret the costs associated with DPCs as qualified medical expenses under Section 213(d)(1)(A) of the Code.

As the Departments consider available options to expand access to affordable and quality healthcare for working Americans, we recommend that the Departments clarify in the final rule that the monthly fees associated with DPCs are qualified medical expenses which can be offset by HRA funds.\textsuperscript{12} As discussed in further detail below, the fees associated with DPCs comfortably fall within the definition of “medical care” as defined by Section 213(d)(1)(A) of the Code and its implementing regulations.

A. A DPC is not health insurance.

As a threshold matter, we note that DPCs are not health insurance. The underlying statutory language in the ACA clearly envisioned DPCs as something that would be \textit{paired} with QHPs, indicating that DPCs themselves are not health insurance. Indeed, DPCs offered by QHPs can be most appropriately viewed as an innovative method to deliver primary care, which itself is a component benefit offered by QHPs, but it is not the health insurance plan itself. For example, participation in a DPC does not constitute minimum essential coverage (MEC) because it only covers primary care and not the other basket of benefits essential to MEC.

\textsuperscript{11} Id.
\textsuperscript{12} We note that there is also the same ambiguity in the treatment of DPCs as they relate to Health Savings Accounts (“HSAs”), but we understand HSAs are outside the scope of this rulemaking.
HHS also recognized in rulemaking that the payments associated with DPCs involved payments to providers, not health insurance companies. Providers, unlike health insurance companies, are not typically licensed as risk-bearing entities and therefore they do not have the necessary infrastructure in place that define health insurance carriers, such as a risk-based financing system. Thus, DPC payments, which are made directly to the provider and do not involve third-party billing, cannot appropriately be characterized as payments similar to premiums or other risk-based financing mechanisms.

The preceding point is also critical to understanding why DPCs cannot be considered a “health plan” (even if they are not considered “health insurance”) as Commissioner Koskinen suggested in his response to the Congressional Letter. The IRS has never, in regulations or guidance, indicated that a “health plan” includes an arrangement that does not involve risk-based financing. In other words, risk-based financing is a core feature of a “plan” as commonly understood by the IRS, and DPCs do not involve such risk-based financing mechanisms. Additionally, we note that DPCs do not involve third-party billing, which is another key characteristic of “health plans” where a third entity assumes the obligation of payment for the covered individual. Therefore, because risk-based financing and third-party billing are key features of “health plans” as they have been commonly understood by the IRS, it would be inaccurate to characterize DPCs as “health plans” given that they lack these two key features.

B. The monthly costs associated with DPCs squarely fall within the definition of “medical care” expenses under Section 213(d)(1)(A) and implementing regulations.

“Medical care” expenses were understood by Congress to apply to a broad expenses for “the diagnosis cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.” The IRS’ implementing regulations reflect a similarly broad application of “medical care” expenses and includes expenses for:

- “hospital services, nursing services (including nurses' board where paid by the taxpayer), medical, laboratory, surgical, dental and other diagnostic and healing services, X-rays, medicine and drugs (as defined in subparagraph (2) of this paragraph, subject to the 1-percent limitation in paragraph (b) of this section), artificial teeth or limbs, and ambulance hire.”

Further, in its 2017 annual sub-regulatory guidance to individuals regarding its interpretation of “medical care” expenses, the IRS reaffirmed the broad definition of the term:

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15 26 C.F.R. § 1.213-1(e)(1)(ii).
“Medical expenses are the costs of diagnosis, cure mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body. These expenses include payments for legal medical services rendered by physicians, surgeons, dentists, and other medical practitioners. They include the costs of equipment, supplies, and diagnostic devices needed for these purposes.

Medical care expenses must be primarily to alleviate or prevent a physical or mental disability or illness. They don't include expenses that are merely beneficial to general health, such as vitamins or a vacation.”

In short, qualifying medical expenses under section 213(d) of the Code are confined strictly to expenses incurred primarily for the prevention or alleviation of a physical or mental defect or illness (or to prevent exacerbation of a chronic condition), such as special food that alleviates or treats an illness and is substantiated by a physician (and is not part of the normal nutritional needs of the taxpayer), or expenses paid for a weight-loss program to treat obesity and hypertension. Expenses that are merely beneficial to the general health of an individual is not an expense for medical care, such as participation in a weight reduction program to improve the taxpayer’s appearance, general health, and sense of well-being.

The fixed-fee that consumers pay under a DPC qualifies as a “medical care” expense because it is incurred “primarily for the prevention or alleviation of a physical or mental defect or illness.” As described above, DPCs involve a fixed-fee arrangement between providers and consumers, where the patient pays a periodic fee in exchange for a defined number of visits as well as office-based procedures and treatments. It generally includes all office based professional services for the prevention and management of disease, including associated in-office testing, procedures, related supplies and office-administered medications. It also typically includes technology visits via email, texting or video. The costs of these services are not remunerated by a third party.

Interpreting the periodic fees associated with DPCs as qualifying medical expenses is consistent with how the IRS has treated other types of fixed-fee arrangements. For instance, in Revenue Ruling 75-302, the IRS allowed a taxpayer to claim a deductible medical care expense under Section 213(d) of

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the Code for a lump-sum life-care fee paid to a retirement home in exchange for lifetime care.\textsuperscript{21} The IRS determined that:

\begin{quote}
\textit{“the [taxpayer’s] obligation to pay was incurred at the time payment was made in return for the retirement home's promise to provide lifetime care, and the payment was made in order to secure medical services despite the fact that the medical services were not to be performed until a future time if at all. Accordingly, the portion of the lump-sum life-care fee payment, made by the taxpayer pursuant to a contract, that was properly allocable to his medical care, is deductible as an expense for medical care in the year paid….\textquotedblright} \textsuperscript{22}
\end{quote}

As the Revenue Ruling 75-302 demonstrates, the IRS has recognized fixed-fee arrangements as medical care expenses. Consistent with prior reasoning, the Departments could clarify that the fixed-fees associated with DPCs also qualify as medical care expenses under Section 213(d) of the Code because they involve an obligation on part of the individual to pay a specified amount, which is a condition imposed by the DPC provider for its agreement to provide primary care services. Thus, the fixed-fee paid to the DPC provider would cover the provider’s costs in rendering the medically necessary items and services to the individual which, as described above, themselves plainly fall within the types of services and items recognized by the medical care provision.

\textbf{Issuing a clarification regarding the treatment of DPCs with respect to HRAs would be a logical outgrowth of the proposed rule.}

As described in further detail below, we believe that the Departments could issue a clarification that the costs associated with participation in DPCs may be offset by HRA funds in the final rule even though the Departments did not specifically propose the clarification in the proposed rule.

The APA requires an agency to provide published notice of its proposed rulemaking. In doing so, the agency’s notice must include “either the terms or substance of the proposed rule or a description of the subjects and issues involved.”\textsuperscript{23} That is, the agency must describe “the range of alternatives being considered with reasonable specificity.”\textsuperscript{24} “Otherwise, interested parties will

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\textsuperscript{21} Rev. Rul. 75-302, 1975-2 C.B. 86; \textit{see also} Rev. Rul. 76-481, 1976-2 C.B. 82. These revenue rulings were clarified by Rev. Rul. 93-72, 1993-2 CB 77 to limit the current year deductibility of payments for future medical expenses extending substantially beyond the year of payment to cases involving lifetime care; however the clarification relates to the timing of deducting future care payments rather than their status as a medical care expense.

\textsuperscript{22} \textit{Id.}

\textsuperscript{23} See 5 U.S.C. § 553(b)(3).

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not know what to comment on, and notice will not lead to better-informed agency decision-making.\textsuperscript{25}

The requirement is satisfied where an agency’s final rule is a “logical outgrowth” of its rulemaking proposal.\textsuperscript{26} A final rule is a “logical outgrowth” when stakeholders, “\textit{ex ante}, should have anticipated that such a requirement might be imposed.”\textsuperscript{27} When analyzing whether a final rule is a logical outgrowth of the proposed rule, courts apply the standard functionally by “asking whether the purposes of notice and comment have been adequately served...that is, whether a new round of notice and comment would provide the first opportunity for interested parties to offer comments that could persuade the agency to modify its rule.”\textsuperscript{28} In other words, “[t]he essential inquiry focuses on whether interested parties reasonably could have anticipated the final rulemaking from the draft [rule].”\textsuperscript{29}

Courts have found that “a final rule represents a logical outgrowth where the NPRM expressly asked for comments on a particular issue or otherwise made clear that the agency was contemplating a particular change.\textsuperscript{30} In the proposed rule, the Departments clearly indicated that they were seeking input on “expand[ing] opportunities for working men and women and their families to access affordable, quality healthcare....”\textsuperscript{31} Furthermore, the main purpose of the proposed rule was to explore how the Departments could leverage HRAs to promote innovation in the health care market. The clarification that we seek here, which is that the Departments clarify that HRA funds could be used to cover the costs associated with DPCs, closely aligns with these goals and therefore would represent a logical outgrowth of the proposed rule.

Conclusion

In summary, D4PCF recommends that the Departments clarify in the final rule that HRA funds may be used to offset the monthly fees associated with DPCs because such fees constitute qualified medical expenses under Section 203(d)(1)(A) of the Code. A clarification along these lines will enable more

\textsuperscript{26} See \textit{United Steelworkers of America v. Marshall}, 647 F.2d 1189, 1221 (D.C. Cir. 1980).
\textsuperscript{27} See \textit{Small Refiner Lead Phase-Down Task Force, supra} n. 24, 705 F.2d at 549.
\textsuperscript{28} See \textit{American Water Works Ass’n v. EPA}, 40 F.3d 1266 (D.C. Cir. 1994) (internal quotations and citations omitted).
\textsuperscript{29} See \textit{Anne Arundel County v. EPA}, 963 F.2d 412, 418 (D.C. Cir. 1992).
\textsuperscript{30} See \textit{International Union v. MSHA}, 626 F.3d 84 (D.C. Cir 2010) (concluding that the final rule was a logical outgrowth of the proposed rule because the agency identified a problem and solicited detailed comments on it); \textit{City of Portland v. EPA}, 507 F.3d 706 (D.C. Cir. 2007) (concluding that the final rule was a logical outgrowth despite the agency finalizing a very different policy than the one proposed); \textit{Natural Resources Defense Council, Inc. v. Thomas}, 838 F.2d 1224, 1241 (D.C. Cir. 1988). (concluding that the final rule was a logical outgrowth of the proposed rule while acknowledging that it was “dramatically different” from the proposed rule but sufficiently connected to the issues raised in the public comments).
\textsuperscript{31} 83 Fed. Reg. at 54420.
working Americans to access affordable health care, consistent with the purpose of the proposed rule.

We appreciate the Departments’ consideration of our recommendation and look forward to further dialogue as the Departments consider implementing the final rule.

Sincerely,

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