



State of California  
Office of the Attorney General

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ATTORNEY GENERAL

August 10, 2020

*Via e-filing at [www.regulations.gov](http://www.regulations.gov)*

Secretary Steven Mnuchin  
U.S. Department of the Treasury  
Internal Revenue Service  
1111 Constitution Avenue NW  
Washington, DC 20224

RE: “Certain Medical Care Arrangements” RIN 1545–BP31; IRS REG–109755–19

Dear Secretary Mnuchin:

The undersigned State Attorneys General of California, Colorado, Connecticut, Delaware, Hawai‘i, Illinois, Iowa, Maine, Maryland, Michigan, Minnesota, Nevada, New Jersey, New Mexico, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, and New York (the States) submit these comments in opposition to: “Certain Medical Care Arrangements” (“Proposed Rule”). The Proposed Rule seeks to treat expenses for healthcare sharing ministries (HSMs) as deductible medical expenses under Section 213(d) of the Internal Revenue Code. HSMs do not provide comprehensive coverage and are not compliant with the Affordable Care Act (ACA), leaving consumers who purchase “coverage” from them without essential health benefits and lacking other critical protections, such as coverage for pre-existing conditions. As state Attorneys General, we have a duty to protect our residents by safeguarding their health and safety and for this reason we urge you to withdraw this Proposed Rule immediately.

The ACA is a landmark law that made affordable health coverage available to 20 million Americans and sharply reduced the number of Americans without health insurance. It was designed to create local, state-based markets presenting affordable insurance choices for consumers in order to “increase the number of Americans covered by health insurance and decrease the cost of health care.” *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 539 (2012) (*NFIB*). The Proposed Rule would undermine these reforms by incentivizing consumers to buy into HSMs, which contain none of the safeguards of traditional insurance. This incentive will not only cause harm to our residents—who will be left without coverage—it will inflict fiscal harm on the States and providers, leaving them to fill in the coverage gaps and cover the costs of uncompensated care. Especially in light of the coronavirus pandemic, which is leaving many unemployed and without coverage, incentivizing payments to HSMs will only accelerate medical debt and poor health outcomes during an international health crisis.



The Proposed Rule will also increase market segmentation, causing the broader insurance market to become smaller, sicker, and more expensive. Furthermore, HSMs are not traditional insurance and claim to be exempt from normal regulation. Thus, incentivizing enrollment could spur HSMs to ramp up fraudulent marketing practices and continue to elude enforcement by the States. At a minimum, the Proposed Rule is sure to increase consumer confusion. The Department of the Treasury and the Internal Revenue Service's failure to consider these issues constitutes arbitrary and capricious rulemaking. And defining payments to HSMs as payments for "medical insurance" is in excess of their statutory authority, flying in the face of the plain meaning of the term and the legislative history of these tax provisions.

**I. The Proposed Rule will increase consumer confusion and fraud in the healthcare marketplace.**

The Proposed Rule legitimizes HSMs as an alternative to traditional health insurance, further blurring the line between the two for consumers looking to purchase health coverage. Prior to the enactment of the ACA, HSMs filled a small niche in the healthcare market for people with shared religious beliefs.<sup>1</sup> They allowed members to pool money to help others in their community endure surprise financial burdens, like a medical emergency, with the idea that members should share each other's burdens.<sup>2</sup> When the ACA became law, it mandated health plans sold in the individual market provide ten essential health benefits, including coverage for preventive care, services for mental health and substance use disorders, and reproductive care.<sup>3</sup> In order to encourage consumers to purchase qualified health insurance, the ACA required those who did not do so to make a "shared responsibility payment" to the IRS. 26 U.S.C. § 5000A(b); *see also NFIB*, 567 U.S. at 563-564. The ACA added an exemption from that requirement for HSMs that met certain criteria.<sup>4</sup> As a result, rather than buying traditional health insurance, an individual could pay into an HSM and avoid the tax. California and some other states have adopted into law the same criteria.<sup>5</sup>

Since the enactment of the ACA, existing HSMs remained in place along with plans that offered leaner health insurance benefits, but several new companies entered the HSM market

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<sup>1</sup> See Stephanie Armour et al., *As Sharing Health-Care Costs Takes Off, States Warn: It Isn't Insurance*, Wall Street Journal (Jun. 10, 2019), <https://www.wsj.com/articles/groups-that-share-health-care-costs-are-drawing-more-members-and-scrutiny-11560177134>; *see also* JoAnn Volk et al., *Health Care Sharing Ministries: What Are the Risks to Consumers and Insurance Markets?*, Commonwealth Fund, Aug. 2018, [https://www.commonwealthfund.org/sites/default/files/2018-08/Volk\\_hlt\\_care\\_sharing\\_ministries.pdf](https://www.commonwealthfund.org/sites/default/files/2018-08/Volk_hlt_care_sharing_ministries.pdf).

<sup>2</sup> Armour, *supra* note 1.

<sup>3</sup> See 42 U.S.C. § 18022; *What Marketplace Health Insurance Plans Cover*, Healthcare.gov, <https://www.healthcare.gov/coverage/what-marketplace-plans-cover/> (last visited Jul. 24, 2020).

<sup>4</sup> 26 U.S.C. § 5000A(d)(2)(B)(ii)(I)-(V).

<sup>5</sup> See, e.g., Cal. Gov't Code § 100705(c)(2); D.C. Mun. Regs. tit. 26-A § 8901.1(f); 956 Mass. Code Regs. § 5.03(3)(d); N.J. Stat. Ann. § 54A:11-2; R.I. Gen. Laws § 44-30-101; Vt. Stat. Ann. tit. 33, § 1805.

intent on capitalizing on consumers seeking cheaper alternatives to ACA-compliant health insurance. HSM enrollment has since grown exponentially from approximately 100,000 members in 2010 to 1 million members in 2018.<sup>6</sup>

Modern HSMs have evolved to adopt many of the trappings of ACA-compliant health insurance, such as requiring payments resembling deductibles and monthly premiums, paying broker commissions, using provider networks, and offering tiered membership levels (some even mimicking the metal designations—bronze, silver, etc.—in advertisements); but they are not the same as ACA-compliant health insurance.<sup>7</sup> In fact, certain HSMs have long avoided state regulation by maintaining they are not health insurance companies.<sup>8</sup>

HSMs fall short of ACA-compliant health coverage in several significant respects, including the following:

- HSMs do not provide minimum essential coverage or coverage of essential health benefits (e.g., coverage for preventative care).<sup>9</sup>
- HSMs apply preexisting condition exclusions and sometimes refuse to accept individuals who are already sick. *Id.*
- HSMs have dollar limits per “incident,” generally ranging between \$125,000 and \$250,000. *Id.*
- HSMs usually exclude coverage for prescription drugs altogether. As such, HSMs do not cover medications for chronic illness, such as diabetes or high blood pressure. *Id.*

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<sup>6</sup> *Compare Sharing ministries offer alternative to health insurance*, Dallas Morning News (Dec. 28, 2010), <https://www.dallasnews.com/business/2010/12/28/sharing-ministries-offer-alternative-to-health-insurance/> with Christina Lechner Goe, *Non-ACA-Compliant Plans and the Risk of Market Segmentation*, National Association of Insurance Commissioners, Mar. 2018, at 20, [https://healthyfuturega.org/ghf\\_resource/non-aca-compliant-plans-risk-market-segmentation/](https://healthyfuturega.org/ghf_resource/non-aca-compliant-plans-risk-market-segmentation/); see also *Why the boom in ‘health caring ministries’ is worrying regulators*, Advisory Board (Jun. 19, 2019), <https://www.advisory.com/daily-briefing/2019/06/19/health-ministries> (Samaritan Ministries International reported that membership increased from 57,277 enrollees in 2011 to 269,809 in 2019).

<sup>7</sup> Volk et al., *supra* note 1.

<sup>8</sup> See generally *Lawsuit: Christian Health Care Ministry Was Deceptive*, Associated Press, Apr. 18, 2020, <https://www.usnews.com/news/best-states/missouri/articles/2020-04-18/lawsuit-christian-health-care-ministry-was-deceptive> (Alera affirms their programs “are absolutely not health insurance” and “[a]ny assertions to the contrary are simply incorrect.”); Armour et al., *supra* note 1 (“Because the ministries aren’t regulated by state insurance commissioners, consumers have little recourse.”).

<sup>9</sup> See Goe, *supra* note 6 at 20-22.

- HSMs are not subject to the laws governing claims review processes.<sup>10</sup>

HSMs often employ deceptive marketing tactics. The resulting harms are far from speculative. For example, a Connecticut man who developed a condition in which his brain tissue extended into the spinal canal was left on the hook for \$280,000 in medical bills after Alera and Unity HealthShare denied his claims, saying he had a preexisting condition.<sup>11</sup> He had signed up for the HSM after he had lost his job, and had even consulted with an insurance broker.<sup>12</sup> In another example, a Nebraska woman counted on an HSM to cover her medical costs during and after her pregnancy.<sup>13</sup> The HSM delayed certain payments for months—resulting in her being sent to collections—and did not pay other bills at all.<sup>14</sup> The consequences of medical debt are not limited to depleted savings. The ripple effects from damaged credit can result in long-term economic deprivation, bankruptcy, housing instability, and even homelessness.<sup>15</sup> The confusion HSMs cause by mimicking traditional health insurance is not without a human toll.<sup>16</sup>

More recently, HSMs have been accused of deploying aggressive marketing practices to enroll unwitting beneficiaries and increase profits.<sup>17</sup> Multiple states’ attorneys general and

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<sup>10</sup> See generally 42 U.S.C. § 300gg-19; 45 C.F.R. § 147.136 (requiring as a minimum the ERISA-based process in 29 C.F.R. § 2560.503-1); 42 C.F.R. § 438.406(b)(2)(ii) (Medicaid requires insurance carriers to have in place appeal and grievance processes); see also Cal. Health & Safety Code § 1367.01 (requirement that a covered insurer has a medical doctor who reviews treatment claim denials); Cal. Ins. Code § 10169 (detailed Independent Medical Review process afforded to insureds).

<sup>11</sup> Jenna Carleso, ‘I’m relying on prayer,’ C.T. Mirror (Mar. 2, 2020),

<https://ctmirror.org/2020/03/02/im-relying-on-prayer-complaints-pile-up-against-health-care-sharing-ministries-as-state-mounts-a-defense/>.

<sup>12</sup> *Id.*

<sup>13</sup> Helaine Olen, *Health-care sharing ministries promise relief from high insurance costs. But there’s a catch*, Washington Post (Nov. 25, 2019),

<https://www.washingtonpost.com/opinions/2019/11/25/health-care-sharing-ministries-promise-relief-high-insurance-costs-theres-catch/>.

<sup>14</sup> *Id.*

<sup>15</sup> See Karen Pollitz et al., *Medical Debt Among People With Health Insurance*, Kaiser Family Foundation (Jan. 7, 2014), <https://www.kff.org/report-section/medical-debt-among-people-with-health-insurance-consequences-of-medical-debt/>.

<sup>16</sup> See also Reed Abelson, *It Looks Like Health Insurance, but It’s Not*, N.Y. Times (Jan. 2, 2020), <https://www.nytimes.com/2020/01/02/health/christian-health-care-insurance.html>.

<sup>17</sup> For example, one HCSM’s website makes the following questionable claim: “Is Christian medical-sharing real health coverage? Although health sharing is not insurance it is recognized by the HHS as ‘coverage’ and is a legal alternative to health insurance. Although the current ACA Federal tax penalty is \$0, Obamacare as a law does still require individuals to have health ‘coverage’; but not health ‘insurance.’” See *Medical-Sharing Health Care FAQs*, Medical-Sharing.org, <https://www.medical->

departments of insurance have opened investigations into HSMs' fraudulent practices targeting consumers.<sup>18</sup> In May of 2018, the Washington State Office of the Insurance Commissioner issued cease and desist orders to marketing company Alera, and the cost sharing ministry it had partnered with, Trinity.<sup>19</sup> In July of 2019, the Texas Attorney General filed a lawsuit against

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[sharing.org/?gclid=EAIaIQobChMIIt8yC3Iy06AIVFYvICh1LgAgrEAAYAyAAEgKCRvD\\_BwE](https://www.sharepoint.com/:document?d=92454844-4444-4444-4444-444444444444&e=92454844-4444-4444-4444-444444444444&id=92454844-4444-4444-4444-444444444444&parent=92454844-4444-4444-4444-444444444444) (last visited Jul. 24, 2020).

<sup>18</sup> See, e.g., First Amended Petition, State of Texas v. Alera Healthcare (Jul. 11, 2019), <https://www.tdi.texas.gov/news/2019/documents/Alera-First-Amd-Petition-July-2019.pdf>; Reed Abelson, *New York State Investigates Christian Health Cost-Sharing Affiliate*, N.Y. Times (Jan. 8, 2020), <https://www.nytimes.com/2020/01/08/health/christian-health-insurance-subpoena.html> (identifying certain investigations); see also Cease and Desist Order (Alera), Colorado Division of Insurance (Aug. 12, 2019), <https://drive.google.com/file/d/148u0-QW0eRf0uaobl7TRGL01JLbvLf9j/view>; Cease and Desist Order (Trinity), Colorado Division of Insurance (Aug. 12, 2019), <https://drive.google.com/file/d/1ADpz74U03Gt-PQBhlgW-5dIN2F1javHm/view>; Cease and Desist Order, Connecticut Insurance Department (Dec. 2, 2019), [https://portal.ct.gov/-/media/CID/1\\_Orders/Order-MC-19-109.pdf](https://portal.ct.gov/-/media/CID/1_Orders/Order-MC-19-109.pdf); *Maryland Insurance Administration issues order revoking license of Alera Healthcare Inc.*, Maryland Insurance Administration (Feb. 27, 2020), <https://insurance.maryland.gov/Pages/newscenter/NewsDetails.aspx?NR=2020249>; Order to Show Cause (Alera), New Hampshire Insurance Department (Mar. 10, 2020), <https://www.nh.gov/insurance/legal/documents/show-cause-order-aliera-03-10-20.pdf>; Order to Show Cause (Trinity), New Hampshire Insurance Department (Mar. 10, 2020), <https://www.nh.gov/insurance/legal/documents/show-cause-order-trinity-03-10-20.pdf>; Cease and Desist Order 19-0251 (Alera), Washington Office of the Insurance Commissioner (May 13, 2019), <https://fortress.wa.gov/oic/consumertoolkit/Orders/OrderProfile.aspx?OrderNumber=VhHhNLG4TQG21%252BO9wXewdA%253D%253D>; Cease and Desist Order 19-0252 (Trinity), Washington Office of the Insurance Commissioner (May 13, 2019), <https://fortress.wa.gov/oic/consumertoolkit/Orders/OrderProfile.aspx?OrderNumber=fWchyRPh2egU8CEDFrkOSA%253D%253D>; *Consumer Alert: Health Care Sharing Ministries - Information You Should Know*, Nebraska Department of Insurance (Nov. 13, 2018), <https://doi.nebraska.gov/alert/consumer-alert-health-care-sharing-ministries-information-you-should-know>; Division of Insurance Warns Against Unlicensed Health Insurance Plans, Massachusetts Division of Insurance (Jun. 12, 2019), <https://www.mass.gov/news/division-of-insurance-warns-against-unlicensed-health-insurance-plans>.

<sup>19</sup> Order to Cease and Desist from the Washington State office of the Insurance Commissioner to Alera Healthcare, Inc., Order No. 19-0251, <https://www.insurance.wa.gov/sites/default/files/2019-08/1-19-0251-order-to-cess-and-desist-aliera-healthcare-inc-05-13-19.pdf>; Order to Cease and Desist from the Washington State office of the Insurance Commissioner to Trinity Healthshare, Inc., Order No. 19-0252, <https://www.insurance.wa.gov/sites/default/files/2019-08/1-19-0252-order-to-cess-and-desist-05-13-19.pdf>.

Aliera for engaging in the business of insurance without a license.<sup>20</sup> Several other states, including California, Colorado, Connecticut, and New Hampshire have issued cease and desist orders against Trinity and Aliera.<sup>21</sup> Aliera is arguing in virtually every one of these cases that states have no authority to regulate it because it is not “insurance.”<sup>22</sup> However, despite these recent efforts, HSMs remain largely unregulated under state and federal law.

The Proposed Rule will hamper the States’ ability to root out fraud and regulate insurance within their borders. Allowing tax deductions for payments made to HSMs—and defining payments for membership in HSMs as a payment for medical insurance—will further blur the line between HSMs and ACA-compliant health insurance. More people will sign up for HSMs believing they have obtained actual health coverage, but in fact be afforded none of the protections required of traditional insurance plans.<sup>23</sup> Enterprising HSMs focused on profit expansion will increase marketing and creative, fraudulent schemes may abound, forcing States to expend limited resources to protect its citizens. Healthcare literacy levels are already low, especially among lower income patients and racial and ethnic minorities.<sup>24</sup> The Proposed Rule will increase consumer confusion and fraud in a health insurance market that is already difficult to navigate.

## **II. The Proposed Rule will worsen market segmentation.**

The Proposed Rule, if promulgated, runs the risk of further segmenting the health insurance market. Market segmentation occurs when people who opt out of standard protections in ACA-compliant coverage “divert[] younger, healthier people to cheaper products that offer less coverage, leaving older, sicker people in health insurance markets that are still protected from health status discrimination.”<sup>25</sup> When enough people eschew ACA-compliant health plans

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<sup>20</sup> See *State files lawsuit against Aliera Healthcare*, Texas Department of Insurance (Jul. 19, 2019), <https://www.tdi.texas.gov/news/2019/tdi05172019-faq.html>.

<sup>21</sup> See, e.g., Cease and Desist from California Department of Insurance, In the Matter of Aliera Healthcare, Inc., File No. LA201900234, [http://www.insurance.ca.gov/0400-news/0100-press-releases/2020/upload/nr026AlieraCEASE\\_AND\\_DESIST.PDF](http://www.insurance.ca.gov/0400-news/0100-press-releases/2020/upload/nr026AlieraCEASE_AND_DESIST.PDF).

<sup>22</sup> See Reed Abelson, *Christian Health Sharing Group Is Target of Customer Lawsuits*, N.Y. Times (April 21, 2020), <https://www.nytimes.com/2020/04/21/health/christian-ministries-insurance-lawsuits.html>.

<sup>23</sup> See Katie Kieth, *New Proposed Rule On Health Care Sharing Ministries And Direct Primary Care*, Health Affairs (Jun. 11, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200611.714521/full/>.

<sup>24</sup> See Victor G. Villagra et al., Health Insurance Literacy: Disparities by Race, Ethnicity, and Language Preference, *Am. J. Managed Care*, Mar. 7, 2019, <https://www.ajmc.com/journals/issue/2019/2019-vol25-n3/health-insurance-literacy-disparities-by-race-ethnicity-and-language-preference>; Myles Ma, *Health Insurance Literacy Survey 2019*, Policy Genius (Oct. 29, 2019), <https://www.policygenius.com/blog/health-insurance-literacy-survey-2019/>.

<sup>25</sup> See Goe, *supra* note 6 at 4.

for alternatives like HSMs, the cost of premiums and cost-sharing for ACA-compliant coverage increases.<sup>26</sup> This results in costlier insurance for those in the traditional insurance marketplace, which leads to more and more beneficiaries abandoning ACA-compliant plans for cheaper alternatives.

Segmentation in the market not only creates more expensive insurance, it also has far-reaching implications for the ACA. The ACA emphasizes the need for health plans to cover preventative health and preexisting conditions.<sup>27</sup> HSMs do not provide coverage for either, whereas ACA-compliant plans must cover both.<sup>28</sup> The fewer people who have coverage for preventive healthcare and preexisting conditions, the less healthy the population pool. And when sick consumers reenter the traditional insurance market to get coverage for the conditions that are not covered by HSMs, prices will increase to accommodate the risk they add to the insurance pool.

It is axiomatic that when the number of uninsured individuals rise, uncompensated care costs rise as well. Each newly uninsured individual is associated with a \$900 increase in uncompensated care annually.<sup>29</sup> And that directly increases the amount of uncompensated care costs borne by state and local governments. Approximately 65 percent of uncompensated care costs are offset by government funds, and 36.5 percent of that pot of governmental funding comes from state and local governments (63.5% comes out of federal funds).<sup>30</sup> Therefore, state and local governments will collectively spend around \$214 more annually for each newly uninsured individual. Collectively, large numbers of newly uninsured and underinsured individuals will impose a serious financial strain on state and local government coffers.

### **III. The Proposed Rule is arbitrary and capricious rulemaking.**

The Department of the Treasury and IRS must engage in reasoned decision making in their rulemaking process. Failure to consider a major aspect of a problem is arbitrary and capricious rulemaking. *See Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins.*

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<sup>26</sup> The Proposed Rule only allows a deduction when medical expenses exceed 7.5% of AGI (10% after 2021), so it is unclear how widely the deduction will apply in practice. However, the incentive alone could be enough to push those already desiring cheaper health coverage to opt in favor of HCSMs.

<sup>27</sup> *See generally* 42 U.S.C. § 300gg-3; *see also* Goe, *supra* note 6 at 24.

<sup>28</sup> *See* 42 U.S.C. §§ 18022(b) (listing essential health benefits), 300gg-3 (preexisting conditions).

<sup>29</sup> *See* Dhruv Khullar et al., *Safety-Net Health Systems At Risk: Who Bears The Burden Of Uncompensated Care?*, Health Affairs (May 10, 2018),

<https://www.healthaffairs.org/doi/10.1377/hblog20180503.138516/full/>; *see also* Craig Garthwaite et al., *Hospitals as Insurers of Last Resort 2* (Nat'l Bureau of Econ. Research, Working Paper No. 21290, 2015), <https://www.nber.org/papers/w21290.pdf>.

<sup>30</sup> *See* Teresa A. Coughlin et al., *An Estimated \$84.9 Billion in Uncompensated Care was Provided in 2013*, Health Affairs at 811-13 (May 2014),

<https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2013.1068>.

*Co.*, 463 U.S. 29, 42–43 (1983). In spite of the known risks of consumer confusion and fraud and the risk of market segmentation and erosion of existing health insurance marketplaces, the Department of the Treasury and IRS do not consider these issues in the Proposed Rule at all. The Proposed Rule fails to discuss, much less quantify, the costs of these fundamental issues. In fact, the only mention of “costs” in the Proposed Rule concludes that there is nothing in it that “may result in expenditures by state, local, or tribal governments, or by the private sector in excess of [a \$100 million] threshold.” *See* 85 Fed. Reg. 35,398, 35,402 (June 10, 2020).

In the context of the coronavirus pandemic, this oversight is especially egregious. The public health crisis has caused millions of Americans to lose employment—and therefore lose health coverage. The federal government has refused to open up special enrollment periods for state health insurance exchanges on HealthCare.gov, thus increasing the likelihood that even more people will turn to HSMs believing they are purchasing some form of affordable health coverage.<sup>31</sup> And, as stated above, the costs of uncompensated care will place significant strain on states and localities working with budgets already strained by the pandemic. It is arbitrary and capricious rulemaking for the Department of the Treasury and IRS not to have analyzed and weighed these issues.

#### **IV. The Proposed Rule was promulgated in excess of statutory authority.**

The IRS seeks to broaden the term “insurance” as used in Section 213(d)(1)(D) to allow payments made to HSMs to be eligible medical expenses deductible under section 213(d) of the Internal Revenue Code. They do not have this authority under the Internal Revenue Code generally or the statutory text of Section 213. *See La. Pub. Serv. Comm’n v. FCC*, 476 U.S. 355, 374 (1986) (“[A]n agency literally has no power to act . . . unless and until Congress confers power upon it.”).

First, the Internal Revenue Code defines the term “insurance company” for purposes of federal taxation, as requiring the entity to, among other things, organize as an insurance company under the states in which it does business and provide non-voidable contracts in order to qualify. *See* 26 U.S.C. § 831. Ample evidence shows that HSMs do not do so. Indeed, the federal government has taxed insurance companies for nearly a century, and during that time has never held that HSMs are subject to insurance tax regulations. *See, e.g.*, 26 U.S.C. §§ 801–848; 26 C.F.R. § 1.801-1.<sup>32</sup> That practice—and Congress’s acquiescence in it—strongly supports the conclusion that HSMs should not be considered insurance for tax purposes.

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<sup>31</sup> *See* Press Release, California Attorney General’s Office (Jun. 22, 2020), <https://oag.ca.gov/news/press-releases/attorney-general-becerra-files-brief-challenging-trump-administration%E2%80%99s-refusal>.

<sup>32</sup> *See also* Steven Plitt et al., *Couch on Insurance* § 1:6 (3d ed. 2020) (“To determine whether an arrangement constitutes ‘insurance’ in its commonly accepted sense, as required to show that corporate taxpayer is an insurance company entitled to compute its taxable income using special insurance accounting rules, the Tax Court considers factors such as: (1) whether the insurer is organized, operated, and regulated as an insurance company by the states in which it does

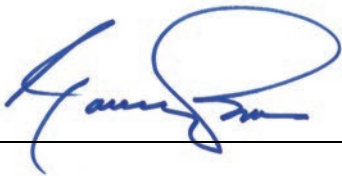


Second, the text of Section 213 leaves no room for HSMs to be included in this Internal Revenue Code definition of insurance. Definitions must “inexorably follow” from spare terms of the statute. *See New York v. United States Dep’t of Health & Human Servs.*, 414 F. Supp. 3d 475, 523 (S.D.N.Y. 2019) (holding that the definitions in HHS’s rule went beyond “expressing ‘what [the] statute has always meant’”) (quoting *Guedes v. Bureau of Alcohol, Tobacco, Firearms, and Explosives*, 920 F.3d 1, 19 (D.C. Cir. 2019)). Definitions follow from the statute where a regulatory definition “‘so closely track[s] the relevant statutory provisions as to make the rule virtually self-evident’ so as to ‘create[ ] no new rights or duties.’” *Id.* (quoting *Mejia-Ruiz v. INS*, 51 F.3d 358, 364 (2d Cir. 1995)). Here, nothing in the text of Section 213 permits expanding the term “insurance,” as used in the Internal Revenue Code, to include HSMs. Indeed, the Proposed Rule admits as much, noting that “the statutory language did not define ‘insurance’ for purposes of the medical expense deduction.” *See* 85 Fed. Reg. at 35,400. And while the Proposed Rule finds support for its conclusion in a single passage for a Senate Report from 1942, that legislative history cannot overcome the “language of the statute itself.” *Grp. Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 210-211 (1979).

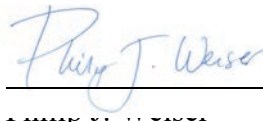
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In sum, the Department of the Treasury and IRS stepped far beyond their authority in dramatically expanding the meaning of the term “medical insurance” for tax purposes. By including payments for membership in HSMs as a medical insurance deduction, they will create additional confusion in the insurance marketplace, increase fraud in the healthcare marketplace, and generate market segmentation—all in contravention of the reforms established by the ACA and to the great detriment of the States and their residents. The Proposed Rule completely fails to consider, much less adequately weigh, these concerns. We respectfully request you withdraw the Proposed Rule.

Sincerely,



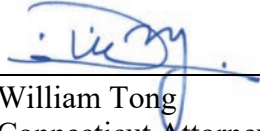
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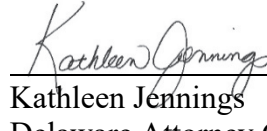
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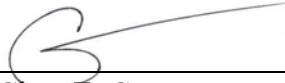
business; (2) whether the insurer is adequately capitalized; (3) whether the insurance policies are valid and binding; (4) whether the premiums are reasonable in relation to the risk of loss; and (5) whether premiums are duly paid and loss claims are duly satisfied.” (citing *R.V.I. Guar. Co., Ltd. & Subsidiaries v. C.I.R., Tax Ct. Rep.* (CCH) 60408, Tax Ct. Rep. Dec. (RIA) 145.9, 2015 WL 5729627 (T.C. 2015)).



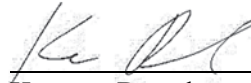
William Tong  
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Kathleen Jennings  
Delaware Attorney General



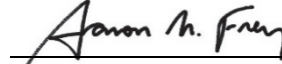
Clare E. Connors  
Hawai'i Attorney General



Kwame Raoul  
Illinois Attorney General



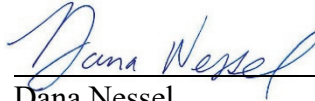
Tom Miller  
Iowa Attorney General



Aaron M. Frey  
Maine Attorney General



Brian E. Frosh  
Maryland Attorney General



Dana Nessel  
Michigan Attorney General



Keith Ellison  
Minnesota Attorney General



Aaron D. Ford  
Nevada Attorney General



Gurbir S. Grewal  
New Jersey Attorney General



Hector Balderas  
New Mexico Attorney General



Ellen F. Rosenblum  
Oregon Attorney General

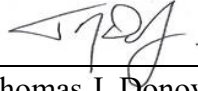


Josh Shapiro  
Pennsylvania Attorney General



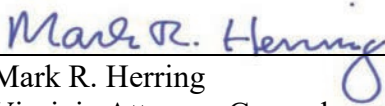
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Peter Neronha  
Rhode Island Attorney General



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Thomas J. Donovan, Jr.  
Vermont Attorney General



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Mark R. Herring  
Virginia Attorney General



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Letitia James  
New York Attorney General