In Rev. Rul. 2004–38, 2004–1 C.B. 717, an individual was covered by a health plan that satisfied the requirements to be an HDHP under section 223(c)(2) (including the minimum annual deductible under section 223(c)(2)(A)), but the plan did not include coverage for prescription drugs. The individual was also covered by another plan (or rider) providing prescription drug benefits that required copays but was not subject to the minimum annual deductible under section 223(c)(2)(A). Rev. Rul. 2004–38 held that an individual covered by an HDHP that does not cover prescription drugs, and who is also covered by a separate plan (or rider) that provides prescription drug benefits before the minimum annual deductible is met, is not an eligible individual under section 223(c)(1)(A) and may not contribute to an HSA. Accordingly, if an individual has coverage that is not disregarded coverage or preventive care, and that provides benefits before the minimum annual deductible is met, the individual is not an eligible individual. *See also* Notice 2008–59, 2008–2 C.B. 123, Q&A 2 and 3.

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. However, in the limited circumstances in which an individual is covered by a direct primary care arrangement that does not provide coverage under a health plan or insurance (for example, the arrangement solely provides for an anticipated course of specified treatments of an identified condition) or solely provides for disregarded coverage or preventive care (for example, it solely provides for an annual physical examination), the individual would not be precluded from contributing to an HSA solely due to participation in the direct primary care arrangement. If 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.

6. Health Care Sharing Ministries, HRAs, and HSAs

Under the regulations authorizing individual coverage HRAs, health care sharing ministries cannot integrate with an individual coverage HRA. However, under these proposed regulations, an HRA, including an HRA integrated with a traditional group health plan, an individual coverage HRA, a QSEHRA, or an excepted benefit HRA, may reimburse payments for membership in a health care sharing ministry as a medical care expense under section 213(d). Because the proposed regulations provide that health care sharing ministries are medical insurance under section 213(d)(1)(D) that is not permitted insurance, membership in a health care sharing ministry would preclude an individual from contributing to an HSA.

Proposed Applicability Date

These regulations are proposed to apply for taxable years that begin on or after the date of publication of a Treasury decision adopting these rules as final regulations in the **Federal Register**.

Special Analyses

I. Regulatory Planning and Review

This regulation is subject to review under section 6 of Executive Order 12866 pursuant to the April 11, 2018, Memorandum of Agreement (''April 11, 2018 MOA'') between the Treasury Department and the Office of Management and Budget (''OMB'') regarding review of tax regulations. The Acting Administrator of the Office of Information and Regulatory Affairs (''OIRA''), OMB, has waived review of this proposed rule in accordance with section 6(a)(3)(A) of Executive Order 12866. OIRA will subsequently make a significance determination of the final rule under Executive Order 12866 pursuant to the terms of section 1 of the April 11, 2018 MOA.

II. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a final rule that includes any Federal mandate that may result in expenditures in any one year by a state, local, or tribal government, in the aggregate, or by the private sector, of $100 million (updated annually for inflation). This proposed rule does not include any Federal mandate that may result in expenditures by state, local, or tribal governments, or by the private sector in excess of that threshold.

III. Executive Order 13132: Federalism

Executive Order 13132 (entitled ''Federalism'') prohibits an agency from publishing any rule that has federalism implications if the rule either imposes substantial, direct compliance costs on state and local governments, and is not required by statute, or preempts state law, unless the agency meets the consultation and funding requirements of section 6 of the Executive Order. This proposed rule does not have federalism implications and does not impose substantial direct compliance costs on state and local governments or preempt state law within the meaning of the Executive Order.

IV. Regulatory Flexibility Act

Pursuant to the Regulatory Flexibility Act (5 U.S.C. chapter 6), it is hereby certified that these proposed regulations will not have a significant economic impact on a substantial number of small entities. The proposed regulations directly affect individuals and not entities. Accordingly, the proposed rule will not have a significant economic impact on a substantial number of small entities.

In accordance with section 7805(f), this notice of proposed rulemaking has been submitted to the Chief Counsel of the Office of Advocacy of the Small Business Administration for comment on its impact on small business.

Comments and Requests for a Public Hearing

Before these proposed regulations are adopted as final regulations, consideration will be given to comments that are submitted timely to the IRS as prescribed in this preamble in the **ADDRESSES** section. The Treasury Department and the IRS request comments on all aspects of the proposed regulations. Any electronic comments submitted, and to the extent practicable any paper comments submitted, will be made available at *www.regulations.gov* or upon request.

A public hearing will be scheduled if requested in writing by any person who timely submits electronic or written comments. Requests for a public hearing are also encouraged to be made electronically. If a public hearing is scheduled, notice of the date, time, and place for the public hearing will be published in the **Federal Register**. Announcement 2020–4, 2020–17 IRB 1, provides that until further notice, public hearings conducted by the IRS will be held telephonically. Any telephonic hearing will be made accessible to people with disabilities.

Statement of Availability of IRS Documents

IRS revenue procedures, revenue rulings, notices, and other guidance cited in this preamble are published in the Internal Revenue Bulletin and are available from the Superintendent of Documents, U.S. Government Publishing Office, Washington, DC 20402, or by visiting the IRS website at *http://www.irs.gov.*

Drafting Information

The principal author of these proposed regulations is Richard C. Gano IV of the Office of Associate Chief Counsel (Income Tax and Accounting). However, other personnel from the Treasury Department and the IRS participated in their development.

List of Subjects in 26 CFR Part 1

Income taxes, Reporting and recordkeeping requirements.

Proposed Amendments to the Regulations

Accordingly, 26 CFR part 1 is proposed to be amended as follows:

PART 1—INCOME TAXES

■ **Paragraph 1.** The authority citation for part 1 continues to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

■ **Par. 2.** Section 1.213–1 is amended by:

■ 1. Redesignating paragraphs (e)(1)(v) and (vi) as (e)(1)(vi) and (vii) respectively.

■ 2. Adding a new paragraph (e)(1)(v).

■ 3. Redesingnating newly redesignated paragraphs (e)(1)(vi)(*a*) through (*c*) as (e)(1)(vi)(A) through (C).

■ 4. Redesignating paragraphs (e)(4)(i)(*a*) and (*b*) as (e)(4)(i)(B) and (C) respectively.

■ 5. Adding a new paragraph (e)(4)(i)(A).

■ 6. Revising newly redesignated paragraph (e)(4)(i)(B).

■ 7. In newly redesignated paragraph (e)(4)(i)(C):

■ i. Adding a subject heading;

■ ii. Redsignating the introductory text as paragraph (e)(4)(i)(C)(*1*) introductory text and paragraphs (e)(4)(i)(C)(*1*) and (*2*) as paragraphs (e)(4)(i)(C)(*1*)(*i*) and (*ii*);

■ iii. Removing the words ''(a) of this subdivision'' and add in their place the words ''paragraphs (e)(4)(i)(A) and (B) of this section'' in newly redesignated paragraph (e)(4)(i)(C)(*1*) introductory text;

■ iv. Designating the undesignated paragraph following newly redsignated paragraph (e)(4)(i)(C)(*1*)(*ii*) as paragraph (e)(4)(i)(C)(*2*); and

■ v. Removing ''subdivision (*b*)'' and adding in its place ''paragraph (e)(4)(i)(C)'' in newly designated paragraph (e)(4)(i)(C)(*2*)

The additions and revision read as follows:

§ 1.213–1 Medical, dental, etc., expenses.

* * * * *

(e) * * *

(1) * * *

(v)(A) *Direct primary care arrangements.* Expenses paid for medical care under section 213(d) include amounts paid for a direct primary care arrangement. A ''direct primary care arrangement'' is 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. A ''primary care physician'' is 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.

(B) *Applicability date.* The rules of this paragraph (e)(1)(v) apply to taxable years ending on or after [the date of publication of the Treasury decision adopting these rules as final regulations in the **Federal Register**].

* * * * *

(4)(i)(A) *Medical insurance contracts and programs*—(*1*) *In general.* In determining whether a contract constitutes an ''insurance'' contract under section 213(d)(1)(D), it is irrelevant whether the benefits are payable in cash or in services. For example, amounts paid for hospitalization insurance, for membership in an association furnishing cooperative or so-called free-choice medical service, for group hospitalization and clinical care, or for membership in a health maintenance organization (HMO) are payments for medical insurance under section 213(d)(1)(D).

(*2*) *Health care sharing ministries.*— Amounts paid for membership in a health care sharing ministry that shares expenses for medical care, as defined in section 213(d)(1)(A), are payments for medical insurance under section 213(d)(1)(D). A health care sharing ministry is an organization:

(*i*) Which is described in section 501(c)(3) and is exempt from taxation under section 501(a);

(*ii*) Members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed;

(*iii*) Members of which retain membership even after they develop a medical condition;

(*iv*) Which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999; and

(*v*) Which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

(*3*) *Government-sponsored health care programs.* Amounts paid for coverage under government-sponsored health care programs may be amounts paid for medical insurance under section 213(d)(1)(D). Taxes imposed by any governmental unit that fund such a program, however, do not constitute amounts paid for medical insurance. The following government-sponsored health care programs are medical insurance under section 213(d)(1)(D):

(*i*) The Medicare program under Title XVIII of the Social Security Act (42 U.S.C. 1395c and following sections), including Parts A, B, C, and D;

(*ii*) Medicaid programs under title XIX of the Social Security Act (42 U.S.C. 1396 and following sections);

(*iii*) The Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act (42 U.S.C. 1397aa and following sections);

(*iv*) Medical coverage under chapter 55 of title 10, U.S.C., including coverage under the TRICARE program; and

(*v*) Veterans' health care programs under chapter 17 or 18 of Title 38 U.S.C.

(*4*) *Applicability date.* The rules of this paragraph (e)(4)(i)(*a*) apply to taxable years ending on or after [the date of publication of the Treasury decision adopting these rules as final regulations in the **Federal Register**].

(B) *Insurance contract covering more than medical care.* Amounts are paid for medical insurance under section 213(d)(1)(D) only to the extent that such amounts are paid for insurance covering expenses of medical care referred to in paragraph (e)(1) of this section or for any qualified long-term care insurance contract as defined in section 7702B(b). Amounts will be considered payable for other than medical insurance under a contract if the contract provides for the waiver of premiums upon the

occurrence of an event. In the case of an insurance contract under which amounts are payable for other than medical insurance (as, for example, a policy providing an indemnity for loss of income or for loss of life, limb, or sight)—

(*1*) No amount shall be treated as paid for medical insurance under section 213(d)(1)(D) unless the charge for such insurance is either separately stated in the contract or furnished to the policyholder by the insurer in a separate statement,

(*2*) The amount taken into account as the amount paid for such medical insurance shall not exceed such charge, and

(*3*) No amount shall be treated as paid for such medical insurance if the amount specified in the contract (or furnished to the policyholder by the insurer in a separate statement) as the charge for such insurance is unreasonably large in relation to the total charges under the contract. In determining whether a separately stated charge for insurance covering expenses of medical care is unreasonably large in relation to the total premium, the relationship of the coverage under the contract together with all of the facts and circumstances shall be considered.

(C) *Premiums paid after taxpayer attains the age of 65.* * * *

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Sunita Lough,

Deputy Commissioner for Services and Enforcement.

[FR Doc. 2020–12213 Filed 6–8–20; 4:15 pm]

BILLING CODE 4830–01–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 100

[Docket No. USCG–2020–0081]

RIN 1625–AA08

Special Local Regulation; Choptank River, Hambrooks Bay, Cambridge, MD

AGENCY: Coast Guard, DHS.

ACTION: Notice of proposed rulemaking; withdrawal.

SUMMARY: The Coast Guard is withdrawing its proposed rule concerning temporary special local regulations for certain waters of the Choptank River that was to have been in effect on July 25, 2020 and July 26, 2020 to provide for the safety of life on these navigable waters located at Cambridge, MD during a high-speed power boat racing event. The proposed rule is being withdrawn because it is no longer necessary. The event sponsor has cancelled the boat race.

DATES: The Coast Guard is withdrawing the proposed rule published May 6, 2020 (85 FR 26903) as of June 10, 2020.

ADDRESSES: To view the docket for this withdrawn rulemaking, go to *https://www.regulations.gov,* type USCG–2020–0081 in the ''SEARCH'' box and click ''SEARCH.'' Click on Open Docket Folder on the line associated with this rule.

FOR FURTHER INFORMATION CONTACT: If you have questions about this notice, call or email MST3 Courtney Perry, Sector Maryland-National Capital Region Waterways Management Division, U.S. Coast Guard; telephone (410) 576–2674, email *Courtney.E.Perry@uscg.mil*.

SUPPLEMENTARY INFORMATION:

Background

On May 6, 2020, we published a notice of proposed rulemaking entitled ''Special Local Regulation; Choptank River, Hambrooks Bay, Cambridge, MD'' in the **Federal Register** (85 FR 26903). The rulemaking concerned was proposing to establish temporary special local regulations for certain waters of the Choptank River in Cambridge, MD on July 25, 2020 and July 26, 2020. This action was necessary to provide for the safety of life on these waters during a high-speed power boat racing event. This rulemaking would have prohibited persons and vessels from entering the regulated area unless authorized by the Captain of the Port Maryland-National Capital Region or a designated representative.

Withdrawal

The proposed rule is being withdrawn due to a regulated area no longer being necessary following a cancellation of the high-speed power boat racing event by the event sponsor.

Authority

We are issuing this notice of withdrawal under the authority of 46 U.S.C. 70034.

Dated: June 5, 2020.

Joseph B. Loring,

Captain, U.S. Coast Guard, Captain of the Port Sector Maryland-National Capital Region.

[FR Doc. 2020–12581 Filed 6–9–20; 8:45 am]

BILLING CODE 9110–04–P

POSTAL SERVICE

39 CFR Part 551

Semipostal Stamp Program

AGENCY: Postal Service™.

ACTION: Proposed rule.

SUMMARY: This proposed rule would revise the provisions governing the Postal Service's discretionary Semipostal Stamp Program to provide more flexibility to the Postal Service to manage the program. Revisions include removing restrictions on the duration of sales of semipostal discretionary stamps and the number of discretionary semipostal stamps that may be offered at any one time.

DATES: Comments must be received on or before July 10, 2020.

ADDRESSES: Mail or deliver written comments to the Manager, Stamp Products & Exhibitions, U.S. Postal Service®, 475 L'Enfant Plaza SW, Room 3300, Washington, DC 20260. Email and faxed comments are not accepted. You may inspect and photocopy all written comments at the Stamp Products & Exhibitions office by appointment only between the hours of 9 a.m. and 4 p.m., Monday through Friday, by calling 202–268–7998 in advance.

FOR FURTHER INFORMATION CONTACT: Amity C. Kirby, Manager, Stamp Products & Exhibitions, 202–268–7998, *amity.c.kirby@usps.gov*.

SUPPLEMENTARY INFORMATION:

Background

The Semipostal Authorization Act, Public Law 106–253, grants the Postal Service discretionary authority to issue and sell semipostal stamps to advance such causes as it considers to be ''in the national public interest and appropriate.'' See 39 U.S.C. 416(b). On June 12, 2001, the Postal Service published a final rule establishing the regulations in 39 CFR part 551 for the discretionary Semipostal Stamp Program (66 FR 31826). Minor revisions were made to these regulations to implement Public Law 107–67, 115 Stat. 514 (2001), and to reflect minor organizational changes in the Postal Service (67 FR 5215 (February 5, 2002)). On February 19, 2004, the Postal Service published a final rule clarifying the cost-offset policy for semipostal stamps (69 FR 7688), and on February 9, 2005, the Postal Service also published an additional minor clarifying revision to these cost-offset regulations (70 FR 6764). On April 20, 2016, the Postal Service published a final rule removing certain restrictions on the commencement date for the