



DEPARTMENT OF TREASURY

Internal Revenue Service

26 CFR Part 1

[REG-109755-19]

RIN 1545-BP31

Certain Medical Care Arrangements

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking.

SUMMARY: This document contains proposed regulations relating to section 213 of the Internal Revenue Code (Code) regarding the treatment of amounts paid for certain medical care arrangements, including direct primary care arrangements, health care sharing ministries, and certain government-sponsored health care programs. The proposed regulations affect individuals who pay for these arrangements or programs and want to deduct the amounts paid as medical expenses under section 213.

DATES: Written or electronic comments and requests for a public hearing must be received by **[INSERT DATE 60 DAYS AFTER PUBLICATION OF THIS DOCUMENT IN THE FEDERAL REGISTER]**. Requests for a public hearing must be submitted as prescribed in the “**Comments and Requests for a Public Hearing**” section.

ADDRESSES: Commenters are strongly encouraged to submit public comments electronically. Submit electronic submissions via the Federal eRulemaking Portal at www.regulations.gov (indicate IRS and REG-109755-19) by following the online instructions for submitting comments. Once submitted to the Federal eRulemaking Portal, comments cannot be edited or withdrawn. The IRS expects to have limited

personnel available to process public comments that are submitted on paper through mail. Until further notice, any comments submitted on paper will be considered to the extent practicable. The Department of the Treasury (Treasury Department) and the Internal Revenue Service (IRS) will publish for public availability any comment submitted electronically, and to the extent practicable on paper, to its public docket.

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

FOR FURTHER INFORMATION CONTACT: Concerning the proposed regulations, call Richard C. Gano IV of the Office of Associate Chief Counsel (Income Tax and Accounting), (202) 317-7011 (not a toll-free call); concerning the preamble discussion of health reimbursement arrangements or health savings accounts, call William Fischer of the Office of Associate Chief Counsel (Employee Benefits, Exempt Organizations, and Employment Taxes), (202) 317-5500 (not a toll-free call); concerning the submission of comments and/or requests for public hearing, call Regina Johnson, (202) 317-5177 (not a toll-free call).

SUPPLEMENTARY INFORMATION:

Background

1. Executive Order 13877

On June 24, 2019, President Trump issued Executive Order 13877, “Improving Price and Quality Transparency in American Healthcare to Put Patients First” (84 FR 30849 (June 27, 2019)). The Executive Order states that it is the policy of the Federal Government to ensure that patients are engaged with their healthcare decisions and have the information requisite for choosing the healthcare they want and need. In

furtherance of that policy, section 6(b) of the Executive Order directs the Secretary of the Treasury, to the extent consistent with law, to “propose regulations to treat expenses related to certain types of arrangements, potentially including direct primary care arrangements and healthcare sharing ministries, as eligible medical expenses under Section 213(d)” of the Code. The proposed regulations have been developed in response to this Executive Order.

2. Deduction for Medical Expenses

Section 213(a) allows a deduction for expenses paid during the taxable year, not compensated for by insurance or otherwise, for medical care of the taxpayer, the taxpayer’s spouse, or the taxpayer’s dependent (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) of section 152), to the extent the expenses exceed 10 percent of adjusted gross income (AGI) (7.5 percent of AGI for a taxable year beginning before January 1, 2021).¹ A section 213 deduction is allowable only with respect to medical expenses actually paid during the taxable year, regardless of when the incident or event that occasioned the expenses occurred, and regardless of the method of accounting used by the taxpayer for filing income tax returns. Section 1.213-1(a)(1) of the Income Tax Regulations.

3. Definition of Medical Care under Section 213(d)(1)

For purposes of determining whether medical expenses are deductible under section 213, section 213(d)(1) defines “medical care” as amounts paid for (A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of

¹ Section 103 of the Taxpayer Certainty and Disaster Tax Relief Act of 2019, enacted as part of the Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, 133 Stat. 2534, Div. Q, Title I (2019)), amending section 213(f) to reduce the threshold for the deduction to 7.5 percent of AGI for tax years beginning before January 1, 2021.

affecting any structure or function of the body (referred to in this preamble as “medical care under section 213(d)(1)(A)”); (B) transportation primarily for and essential to obtaining medical care referred to in (A); (C) qualified long-term care services; or (D) insurance covering medical care and transportation as described in (A) and (B), respectively (referred to in this preamble as “medical insurance”), including supplementary medical insurance for the aged (Medicare Part B), and any qualified long-term care insurance contract. See also §1.213-1(e).

A. Medical Care under Section 213(d)(1)(A)

Deductions for amounts paid for medical care under section 213(d)(1)(A) are confined strictly to expenses incurred primarily for the prevention or alleviation of a physical or mental defect or illness and for operations or treatment affecting any portion of the body. Section 1.213-1(e)(1)(ii). Thus, payments for the following are payments for medical care under section 213(d)(1)(A): hospital services; nursing services; medical, laboratory, surgical, dental and other diagnostic and healing services; obstetrical expenses, expenses of therapy, and X-rays; prescribed drugs or insulin; and artificial teeth or limbs. Section 213(b) and §1.213-1(e)(1)(ii). However, an expenditure which is merely beneficial to the general health of an individual, such as an expenditure for a vacation, is not an expenditure for medical care. Section 1.213-1(e)(1)(ii). Amounts paid for illegal operations or treatments are not deductible. Id.

B. Medical Insurance under Section 213(d)(1)(D)

Expenditures for medical insurance described in section 213(d)(1)(D) are amounts paid for medical care only to the extent such amounts are paid for insurance covering the diagnosis, cure, mitigation, treatment, or prevention of disease; for the

purpose of affecting any structure or function of the body; or for transportation primarily for and essential to medical care. Section 1.213-1(e)(4)(i)(a). Amounts are considered payable for other than medical care under a contract if the contract provides for the waiver of premiums upon the occurrence of an event. Id. In the case of an insurance contract under which amounts are payable for other than medical care (as, for example, a policy providing an indemnity for loss of income or for loss of life, limb, or sight), (1) no amount may be treated as paid for medical insurance 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 treated as paid for medical insurance may not exceed such charge, and (3) no amount may be treated as paid for 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 (considering the relationship of the coverages under the contract together with all the facts and circumstances). Id.

In determining whether a contract constitutes an “insurance” contract for purposes of section 213, it is irrelevant whether the benefits are payable in cash or in services. Section 1.213-1(e)(4)(i)(a). For example, amounts paid for hospitalization insurance, for membership in an association furnishing cooperative or so-called free-choice medical service, or for group hospitalization and clinical care are payments for medical insurance. Id. In addition, premiums paid for Medicare Part B are amounts paid for medical insurance. Id.

Explanation of Provisions

In developing the proposed regulations, the Treasury Department and the IRS considered how to carry out the objectives of Executive Order 13877 in a way permitted by law and supported by sound policy. The Treasury Department and the IRS undertook a review of direct primary care arrangements and health care sharing ministries by meeting with practitioners and individuals who operate the arrangements to analyze the facts of those arrangements. After gathering information on those arrangements and considering the relevant legal authorities, the Treasury Department and the IRS propose that expenditures for direct primary care arrangements and health care sharing ministry memberships are amounts paid for medical care as defined in section 213(d), and that amounts paid for those arrangements may be deductible medical expenses under section 213(a). The proposed regulations also clarify that amounts paid for certain arrangements and programs, such as health maintenance organizations (HMO) and certain government-sponsored health care programs, are amounts paid for medical insurance under section 213(d)(1)(D).² These proposed regulations do not affect the tax treatment of any medical care arrangement that currently qualifies as medical care under section 213(d).

² The proposed regulations and this preamble do not address any issues under Title I of the Employee Retirement Income Security Act of 1974, as amended (ERISA) that are within the interpretive and regulatory jurisdiction of the U.S. Department of Labor. For example, the proposed regulations and this preamble do not address whether any particular arrangement or payment constitutes, or is part of, an employee welfare benefit plan within the meaning of ERISA section 3(1). Rather, the Department of Labor advised the Treasury Department and the IRS that an employer's funding of a benefit arrangement, in most circumstances, is sufficient to treat an arrangement that provides health benefits to employees as an ERISA-covered plan. Compare 29 CFR 2510.3-1(l), which provides a safe harbor from ERISA-coverage for certain reimbursements for non-group health insurance premiums solely for individual health insurance coverage as defined in 29 CFR 2590.701-2 that does not consist solely of excepted benefits as defined in 29 CFR 2590.732(c).

1. Definition of Direct Primary Care Arrangement

The proposed regulations define a “direct primary care 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. 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 (SSA)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine. The definition is adopted from paragraph (I) of the definition of “primary care practitioner” in section 1833(x)(2)(A)(i) of the SSA. The Treasury Department and the IRS request comments on the definition of primary care physician and on the definition of direct primary care arrangement.

The Treasury Department and the IRS also request comments on whether to expand the definition of a direct primary care arrangement to include a contract between an individual and a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5) of the SSA) who provides primary care services under the contract. The Treasury Department and the IRS request comments on how to define primary care services provided by a non-physician practitioner, including whether the definition of primary care services in section 1833(x)(2)(B) of the SSA is appropriate.

In addition, the Treasury Department and the IRS understand that other types of medical arrangements between health practitioners and individuals exist that do not fall within the definition of direct primary care. For example, an agreement between a

dentist and a patient to provide dental care, or an agreement between a physician and a patient to provide specialty care, would not be a direct primary care arrangement but nonetheless may be the provision of medical care under section 213(d). The Treasury Department and the IRS request comments on whether the final regulations should clarify the treatment of other types of arrangements that are similar to direct primary care arrangements but do not meet the definition in the proposed regulations.

2. Definition of Health Care Sharing Ministry

For the purposes of section 213, the proposed regulations define a health care sharing ministry as an organization: (1) which is described in section 501(c)(3) and is exempt from taxation under section 501(a); (2) 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; (3) members of which retain membership even after they develop a medical condition; (4) 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 (5) 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. This definition is from section 5000A(d)(2)(B)(ii), which provides that the individual shared responsibility payment (which is zero after December 31, 2018) does not apply to an individual who is a member of a health care sharing ministry. The Treasury Department and the IRS request comments on the definition of a health care sharing ministry.

3. Analysis of Medical Care under Section 213(d)(1)(A)

Direct primary care arrangements, as defined in the proposed regulations, may encompass a broad range of facts. Depending on the facts, a payment for a direct primary care arrangement may be a payment for medical care under section 213(d)(1)(A) or, as discussed below, may be a payment for medical insurance under section 213(d)(1)(D). For example, payments for a direct primary care arrangement that solely provides for an anticipated course of specified treatments of an identified condition, or solely provides for an annual physical examination, are payments for medical care under section 213(d)(1)(A). However, so long as a direct primary care arrangement meets the definition set forth in the proposed regulations, amounts paid for the arrangement will qualify as an expense for medical care under section 213(d), regardless of whether the arrangement is for medical care under section 213(d)(1)(A) or medical insurance under section 213(d)(1)(D).

Health care sharing ministries, unlike direct primary care arrangements, do not themselves provide any medical treatment or services that would qualify as medical care under section 213(d)(1)(A). Instead, membership in a health care sharing ministry entitles members to share their medical bills through the ministry and potentially receive payments from other members to help with their medical bills. The membership payments are not payments for medical care under section 213(d)(1)(A). However, as further explained below, these proposed regulations provide that amounts paid for membership in a health care sharing ministry may be payments for medical insurance under section 213(d)(1)(D).

4. Analysis of Medical Insurance under Section 213(d)(1)(D)

Section 213(d)(1)(D) does not define the term “insurance.” When a federal statute uses a term without an accompanying definition, the meaning of the term must be determined from the ordinary use of the term, in conjunction with any guidance found in the structure of the relevant statute and its legislative history. See Group Life & Health Insurance Co. v. Royal Drug. Co., 440 U.S. 205, 211 (1979).

The predecessor to section 213, section 23x, was originally enacted in 1942 and allowed a deduction for medical care expenses, including amounts paid for health insurance. Although the statutory language did not define “insurance” for purposes of the medical expense deduction, the legislative history specifically states that amounts paid for health insurance are included in the category of medical expenses, and that payments for “hospitalization insurance, or for membership in an association furnishing cooperative or so-called free-choice medical service, or group hospitalization and clinical care are intended, for purposes of this section, to be included as amounts which may be deducted.” This language from the legislative history was incorporated into the section 213 regulations in 1957 and remains unchanged. See §1.213-1(e)(4)(i)(a). Based on that legislative history, the Treasury Department and the IRS conclude that Congress intended that “insurance” for section 213 purposes be read broadly. Indeed, the Treasury Department and the IRS have interpreted “insurance” broadly over the years in guidance under section 213. See, e.g., Rev. Rul. 79-175, 1979-1 C.B. 117 (premiums paid for Medicare Part A coverage are amounts paid for medical insurance); Rev. Rul. 74-429, 1974-2 C.B. 83 (nonrefundable fixed amount paid by a taxpayer for an agreement with an optometrist to replace the taxpayer’s contact lenses for one year if they became lost or damaged is an amount paid for medical insurance); Rev. Rul. 68-

433, 1968-2 C.B. 110 (insurance premiums paid for a policy that provides only for reimbursement of the cost of prescription drugs are amounts paid for medical insurance). Further, IRS Publication 502 (Medical and Dental Expenses) states the long-standing IRS position that amounts paid for membership in an HMO are treated as medical insurance premiums.

The Treasury Department and the IRS also conclude that the general insurance principles used for subchapter L purposes are not controlling for purposes of determining whether payment for an arrangement is treated as an amount paid for medical insurance under section 213. Subchapter L does not define insurance. It provides a definition of the term “insurance company” for purposes of determining whether an entity is an insurance company for federal income tax purposes. However, there is no requirement in section 213 that amounts be paid to an insurance company to qualify as payments for medical insurance. Further, the legislative history of section 213 indicates that medical insurance is not limited to traditional health insurance provided by an insurance company. Thus, although payments to an insurance company for medical care may be amounts paid for medical insurance under section 213(d)(1)(D), amounts need not be paid to an insurance company to be payments for medical insurance under section 213.

As noted above, depending on the specific facts regarding an arrangement, a payment for a direct primary care arrangement may be a payment for medical care under section 213(d)(1)(A) or may be a payment for medical insurance under section 213(d)(1)(D). Regardless of the characterization of an arrangement as medical care under section 213(d)(1)(A) or medical insurance under section 213(d)(1)(D), an amount

paid for the arrangement will qualify as a medical expense under section 213.

However, the characterization of a direct primary care arrangement as medical insurance under section 213(d)(1)(D) has implications for purposes of the rules for health savings accounts (HSAs) under section 223. Specifically, as explained later in this preamble, if an individual enters into a direct primary care arrangement, the type of coverage provided by the arrangement will impact whether or not he or she is an eligible individual for purposes of section 223.

Under these proposed regulations, payments 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). The purpose of a health care sharing ministry is for members to share the burden of their medical expenses with other members. Members assist in the payment of other members' medical bills, and possibly receive reimbursement for their own medical bills in return. Whether this is done by making membership payments to the ministry or by sending the payments directly to other members, the substance of the transaction is the same. Similar to traditional medical insurance premiums, amounts paid for membership in a health care sharing ministry allow members who incur expenses for medical care under section 213(d)(1)(A) to submit claims for those expenses and potentially receive payments to help cover those expenses.

Accordingly, the proposed regulations provide that medical insurance under section 213(d)(1)(D) includes health care sharing ministries that share expenses for medical care under section 213(d)(1)(A). This proposal under section 213 has no bearing on whether a health care sharing ministry is considered an insurance company,

insurance service, or insurance organization (health insurance issuer) for other purposes of the Code, ERISA, the Public Health Service Act (PHS Act), or any other Federal or State law. In addition, the proposed regulations incorporate the long-standing position of the IRS treating amounts paid for membership in an HMO as medical insurance premiums for section 213 purposes. In contrast, amounts paid to an HMO or a provider to cover coinsurance, copayment, or deductible obligations under an HMO's terms are payments for medical care under section 213(d)(1)(A). Regardless of their classification, both HMO amounts paid are eligible for deduction as a medical expense under section 213(a).

Finally, the proposed regulations clarify that amounts paid for coverage under certain government-sponsored health care programs are treated as amounts paid for medical insurance under section 213(d)(1)(D). The proposed regulations incorporate the guidance in section 213(d)(1)(D) and Rev. Rul. 79-175, respectively, that Medicare Parts A and B are medical insurance, and clarify that Medicare Parts C and D are medical insurance, for purposes of section 213. The proposed regulations also provide that Medicaid, the Children's Health Insurance Program (CHIP), TRICARE, and certain veterans' health care programs are medical insurance under section 213(d)(1)(D). Thus, to the extent a particular government-sponsored health program requires individuals to pay premiums or enrollment fees for coverage under the program, those amounts are eligible for deduction as a medical expense under section 213. The Treasury Department and the IRS request comments on whether amounts paid for other government-sponsored health care programs should be treated as amounts paid

for medical insurance, and if so, which specific government-sponsored health care programs should be treated as medical insurance.

5. Direct Primary Care Arrangements, Health Reimbursement Arrangements (HRAs), and HSAs

A. Direct Primary Care Arrangements and HRAs

An HRA (other than a qualified small employer health reimbursement arrangement (QSEHRA)) is a type of account-based group health plan funded solely by employer contributions (with no salary reduction contributions or other contributions by employees) that reimburses an employee solely for medical care expenses incurred by the employee (and, at the discretion of the plan sponsor, the employee's family), up to a maximum dollar amount for a coverage period. See Notice 2002-45, 2002-2 C.B. 93 and Rev. Rul. 2002-41, 2002-2 C.B. 75. Because an HRA cannot by itself satisfy the prohibition on lifetime and annual dollar limits for group health plans under PHS Act section 2711 or the requirement to provide coverage for certain preventive services without cost sharing under PHS Act section 2713 (both of which are incorporated by reference in section 9815), unless an applicable exception applies, it must be integrated with coverage that otherwise satisfies those requirements. See §54.9815-2711. A QSEHRA is a type of HRA, except that it generally is not a group health plan and is subject to additional specific requirements, including the requirement that it may be provided only by an employer that is not an applicable large employer, as defined in

section 4980H(c)(2). See section 9831. Because QSEHRAs are generally not group health plans, there is no need for them to be integrated with other coverage.³

An HRA, including a QSEHRA, an HRA integrated with a traditional group health plan, an HRA integrated with individual health insurance coverage or Medicare (individual coverage HRA), or an excepted benefit HRA, generally may reimburse expenses for medical care, as defined under section 213(d). Thus, an HRA may provide reimbursements for direct primary care arrangement fees.

B. Direct Primary Care Arrangements and HSAs

Section 223 permits eligible individuals to establish and contribute to HSAs. In general, an HSA is a tax-exempt trust or custodial account established exclusively for the purpose of paying qualified medical expenses of the account beneficiary who, for the months for which contributions are made to an HSA, is covered under a high deductible health plan (HDHP). See section 223(d); Notice 2004-2, 2004-1 C.B. 269, Q&A 1. An eligible individual is, with respect to any month, any individual if (i) such individual is covered under an HDHP as of the first day of such month, and (ii) such individual is not, while covered under an HDHP, covered under any health plan which is not an HDHP, and which provides coverage for any benefit which is covered under the HDHP. See section 223(c)(1); Notice 2004-2, Q&A 2. An HDHP is a health plan that satisfies the minimum annual deductible requirement and maximum out-of-pocket expenses requirement under section 223(c)(2)(A), and meets certain other requirements. See section 223(c)(2); Notice 2004-2, Q&A 3.

³ However, under section 9831(d)(2)(B)(ii), a QSEHRA may only provide reimbursements to an eligible employee after the eligible employee provides proof of coverage, and consistent with section 106(g), the coverage must qualify as minimum essential coverage as defined in section 5000A(f).

Section 223(c)(1)(B) provides that, in addition to coverage under an HDHP, an eligible individual may have “disregarded coverage,” which includes only certain permitted insurance under section 223(c)(3), and coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, long-term care, or certain health flexible spending arrangements. Section 223(c)(3) provides that permitted insurance is insurance relating to liabilities incurred under worker’s compensation laws, tort liabilities, or liabilities relating to ownership or use of property, insurance for a specified disease or illness, and insurance paying a fixed amount per day (or other period) of hospitalization. In addition, section 223(c)(2)(C) provides that an HDHP may provide preventive care before the minimum annual deductible for an HDHP is met.

The legislative history to section 223 states that “[e]ligible individuals for HSAs are individuals who are covered by a high deductible health plan and no other health plan that is not a high deductible health plan.” H.R. Conf. Rep. No. 391, 108th Cong., 1st Sess. 841 (2003). The legislative history also states that, “[a]n individual with other coverage in addition to a high deductible health plan is still eligible for an HSA if such other coverage is certain permitted insurance or permitted coverage.” Id.

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. Redesignating 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. Redesignating 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 redesignated 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**].

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(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.

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