

INTERNAL REVENUE BULLETIN



HIGHLIGHTS OF THIS ISSUE

Bulletin No. 2015-49
December 7, 2015

These synopses are intended only as aids to the reader in identifying the subject matter covered. They may not be relied upon as authoritative interpretations.

INCOME TAX

REG-134219-08, page 842.

This document contains proposed regulations relating to relief from joint and several liability under section 6015 of the Internal Revenue Code (Code).

Rev. Rul. 2015-25, page 695.

Federal rates; adjusted federal rates; adjusted federal long-term rate and the long-term exempt rate. For purposes of sections 382, 642, 1274, 1288, and other sections of the Code, tables set forth the rates for December 2015.

Rev. Rul. 2015-26, page 696.

The "base period T-bill rate" for the period ending September 30, 2015, is published as required by section 995(f) of the Code.

Rev. Proc. 2015-56, page 827.

Revenue Procedure 2015-56 provides guidance that taxpayers may use to determine whether costs paid or incurred to refresh or remodel a qualified retail or restaurant building are deductible under § 162(a), must be capitalized as improvements under § 263(a), or must be capitalized as property produced for use in the taxpayer's trade or business under § 263A.

Notice 2015-79, page 775.

This notice describes regulations that the Treasury Department and the IRS will issue to address certain transactions that are structured to avoid the purposes of section 7874 and certain post-inversion tax avoidance transactions.

EMPLOYEE PLANS

T.D. 9744, page 700.

This document contains final regulations concerning Public Health Services Act sections which are incorporated into section 9815 of the Internal Revenue Code by section 1563(f) of the Patient Protection and Affordable Care Act, regarding grandfathered health (PHS Act section 1251), the prohibition on preexisting condition exclusions (PHS Act section 2704), the prohibition on lifetime and annual dollar limits (PHS Act section 2711), the prohibition on rescissions (PHS Act section 2712), the extension of coverage of dependent children to age 26 (PHS Act section 2714), the patient protections (PHS Act section 2719A), and the provisions for internal claims and appeals and external review (PHS Act section 2719). The final rule was published jointly with the Departments of Labor and of Health and Human Services.

EXEMPT ORGANIZATIONS

Announcement 2015-32, page 841.

Serves notice to potential donors of organizations that have recently filed a timely declaratory judgment suit under section 7428 of the Code, challenging revocation of its status as an eligible donee under section 170(c)(2).

Announcement 2015-33, page 842.

Revocation of IRC 501(c)(3) Organizations for failure to meet the code section requirements. Contributions made to the organizations by individual donors are no longer deductible under IRC 170(b)(1)(A).

(Continued on the next page)

Notice 2015–81, page 784.

This notice advises how the Treasury Department and the Internal Revenue Service (IRS) intend to respond to comments by revising three provisions of the proposed regulations under § 529A of the Internal Revenue Code when those regulations are finalized. Specifically, commenters noted that the following three requirements for qualified Achieving Better Life Experience (ABLE) programs in the proposed regulations would create significant barriers to the establishment of such programs: (1) the requirement to establish safeguards to categorize distributions from ABLE accounts, (2) the requirement to request the taxpayer identification number (TIN) of each contributor to an ABLE account, and (3) the requirements for disability certifications, and in particular the requirement to process disability certifications with signed physicians' diagnoses.

ADMINISTRATIVE**Announcement 2015–31, page 841.**

This document contains corrections to Revenue Procedure 2015–51, as published on Monday, October 19, 2015 (I.R.B. 2015–42, 583). In particular, this announcement corrects certain specifications for checkboxes on Form W–2 and the address to send sample substitute forms to receive approval from the SSA.

Rev. Proc. 2015–55, page 788.

Pub. 1167, General Rules and Specifications for Substitute Forms and Schedules, provides guidelines and general requirements for the development, printing, and approval of substitute tax forms.

The IRS Mission

Provide America's taxpayers top-quality service by helping them understand and meet their tax responsibilities and enforce the law with integrity and fairness to all.

Introduction

The Internal Revenue Bulletin is the authoritative instrument of the Commissioner of Internal Revenue for announcing official rulings and procedures of the Internal Revenue Service and for publishing Treasury Decisions, Executive Orders, Tax Conventions, legislation, court decisions, and other items of general interest. It is published weekly.

It is the policy of the Service to publish in the Bulletin all substantive rulings necessary to promote a uniform application of the tax laws, including all rulings that supersede, revoke, modify, or amend any of those previously published in the Bulletin. All published rulings apply retroactively unless otherwise indicated. Procedures relating solely to matters of internal management are not published; however, statements of internal practices and procedures that affect the rights and duties of taxpayers are published.

Revenue rulings represent the conclusions of the Service on the application of the law to the pivotal facts stated in the revenue ruling. In those based on positions taken in rulings to taxpayers or technical advice to Service field offices, identifying details and information of a confidential nature are deleted to prevent unwarranted invasions of privacy and to comply with statutory requirements.

Rulings and procedures reported in the Bulletin do not have the force and effect of Treasury Department Regulations, but they may be used as precedents. Unpublished rulings will not be relied on, used, or cited as precedents by Service personnel in the disposition of other cases. In applying published rulings and procedures, the effect of subsequent legislation, regulations, court decisions, rulings, and procedures must be considered, and Service personnel and others concerned are cautioned

against reaching the same conclusions in other cases unless the facts and circumstances are substantially the same.

The Bulletin is divided into four parts as follows:

Part I.—1986 Code.

This part includes rulings and decisions based on provisions of the Internal Revenue Code of 1986.

Part II.—Treaties and Tax Legislation.

This part is divided into two subparts as follows: Subpart A, Tax Conventions and Other Related Items, and Subpart B, Legislation and Related Committee Reports.

Part III.—Administrative, Procedural, and Miscellaneous.

To the extent practicable, pertinent cross references to these subjects are contained in the other Parts and Subparts. Also included in this part are Bank Secrecy Act Administrative Rulings. Bank Secrecy Act Administrative Rulings are issued by the Department of the Treasury's Office of the Assistant Secretary (Enforcement).

Part IV.—Items of General Interest.

This part includes notices of proposed rulemakings, disbarment and suspension lists, and announcements.

The last Bulletin for each month includes a cumulative index for the matters published during the preceding months. These monthly indexes are cumulated on a semiannual basis, and are published in the last Bulletin of each semiannual period.

The contents of this publication are not copyrighted and may be reprinted freely. A citation of the Internal Revenue Bulletin as the source would be appropriate.

Part I. Rulings and Decisions Under the Internal Revenue Code of 1986

Section 1274.— Determination of Issue Price in the Case of Certain Debt Instruments Issued for Property

(Also Sections 42, 280G, 382, 412, 467, 468, 482, 483, 642, 807, 846, 1288, 7520, 7872.)

Rev. Rul. 2015-25

This revenue ruling provides various prescribed rates for federal income tax purposes for December 2015 (the current

month). Table 1 contains the short-term, mid-term, and long-term applicable federal rates (AFR) for the current month for purposes of section 1274(d) of the Internal Revenue Code. Table 2 contains the short-term, mid-term, and long-term adjusted applicable federal rates (adjusted AFR) for the current month for purposes of section 1288(b). Table 3 sets forth the adjusted federal long-term rate and the long-term tax-exempt rate described in section 382(f). Table 4 contains the appropriate percentages for determining the low-income housing credit described in section 42(b)(1) for buildings placed in ser-

vice during the current month. However, under section 42(b)(2), the applicable percentage for non-federally subsidized new buildings placed in service after July 30, 2008, with respect to housing credit dollar amount allocations made before January 1, 2015, shall not be less than 9%. Table 5 contains the federal rate for determining the present value of an annuity, an interest for life or for a term of years, or a remainder or a reversionary interest for purposes of section 7520. Finally, Table 6 contains the 2016 interest rate for purposes of sections 846 and 807.

REV. RUL. 2015-25 TABLE 1

Applicable Federal Rates (AFR) for December 2015

	<i>Annual</i>	<i>Period for Compounding Semiannual</i>	<i>Quarterly</i>	<i>Monthly</i>
		<i>Short-term</i>		
AFR	.56%	.56%	.56%	.56%
110% AFR	.62%	.62%	.62%	.62%
120% AFR	.67%	.67%	.67%	.67%
130% AFR	.73%	.73%	.73%	.73%
		<i>Mid-term</i>		
AFR	1.68%	1.67%	1.67%	1.66%
110% AFR	1.85%	1.84%	1.84%	1.83%
120% AFR	2.01%	2.00%	2.00%	1.99%
130% AFR	2.18%	2.17%	2.16%	2.16%
150% AFR	2.53%	2.51%	2.50%	2.50%
175% AFR	2.94%	2.92%	2.91%	2.90%
		<i>Long-term</i>		
AFR	2.61%	2.59%	2.58%	2.58%
110% AFR	2.87%	2.85%	2.84%	2.83%
120% AFR	3.13%	3.11%	3.10%	3.09%
130% AFR	3.40%	3.37%	3.36%	3.35%

REV. RUL. 2015-25 TABLE 2

Adjusted AFR for December 2015

	<i>Annual</i>	<i>Period for Compounding Semiannual</i>	<i>Quarterly</i>	<i>Monthly</i>
Short-term adjusted AFR	.48%	.48%	.48%	.48%
Mid-term adjusted AFR	1.38%	1.38%	1.38%	1.38%
Long-term adjusted AFR	2.61%	2.59%	2.58%	2.58%

REV. RUL. 2015–25 TABLE 3
Rates Under Section 382 for December 2015

Adjusted federal long-term rate for the current month	2.61%
Long-term tax-exempt rate for ownership changes during the current month (the highest of the adjusted federal long-term rates for the current month and the prior two months.)	2.61%

REV. RUL. 2015–25 TABLE 4
Appropriate Percentages Under Section 42(b)(1) for December 2015

Note: Under section 42(b)(2), the applicable percentage for non-federally subsidized new buildings placed in service after July 30, 2008, with respect to housing credit dollar amount allocations made before January 1, 2015 shall not be less than 9%.

Appropriate percentage for the 70% present value low-income housing credit	7.49%
Appropriate percentage for the 30% present value low-income housing credit	3.21%

REV. RUL. 2015–25 TABLE 5
Rate Under Section 7520 for December 2015

Applicable federal rate for determining the present value of an annuity, an interest for life or a term of years, or a remainder or reversionary interest	2.0%
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REV. RUL. 2015–25 TABLE 6
Rate Under Sections 846 and 807

Applicable rate of interest for 2016 for purposes of sections 846 and 807	1.56%
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Section 995.—Taxation of DISC Income to Shareholders

2015 Base Period T-Bill Rate. The “base period T-bill rate” for the period ending September 30, 2015, is published as required by section 995(f) of the Code.

Rev. Rul. 2015–26

Section 995(f)(1) of the Internal Revenue Code provides that a shareholder of a domestic international sales corporation (“DISC”) shall pay interest each taxable year in an amount equal to the product of the shareholder’s DISC-related deferred tax liability for the year (as defined in section 995(f)(2)) and the “base period T-bill rate.” Under section 995(f)(4), the base period T-bill rate is the annual rate of interest determined by the Secretary to be equivalent to the average of the 1-year constant maturity Treasury yields, as published by the Board of Governors of the Federal Reserve System, for the 1-year period ending on September 30 of the calendar year ending with (or the most recent

calendar year ending before) the close of the taxable year of the shareholder.

The base period T-bill rate for the period ending September 30, 2015, is 0.24 percent.

Pursuant to section 6622 of the Internal Revenue Code, interest must be compounded daily. The table below provides factors for compounding the 2015 base period T-bill rate daily for any number of days in the shareholder’s taxable year (including for a 52–53 week accounting period). To compute the amount of the interest charge for the shareholder’s taxable year, multiply the amount of the shareholder’s DISC-related deferred tax liability for that year by the base period T-bill rate factor corresponding to the number of days in the shareholder’s taxable year for which the interest charge is being computed. Generally, one would use the factor for 365 days. One would use a different factor only if the shareholder’s taxable year for which the interest charge is being determined is a short taxable year, if the shareholder uses a 52–53 week taxable year, or if the shareholder’s taxable year is a leap year.

For the base period T-bill rates for periods ending in prior years, see Rev. Rul. 2014–33, 2014–52 IRB 957; Rev. Rul. 2013–24, 2013–49 IRB 594; Rev. Rul. 2012–22, 2012–48 IRB 565; Rev. Rul. 2011–30, 2011–49 IRB 826; and Rev. Rul. 2010–28, 2010–49 IRB 804.

DRAFTING INFORMATION

The principal author of this revenue ruling is Joshua Simmons of the Office of Associate Chief Counsel (International). For further information regarding the revenue ruling, contact Anand Desai at (202) 317-6939 (not a toll-free number).

ANNUAL RATE, COM- POUNDED DAILY 0.24 PERCENT	
DAYS	FACTOR
1	.000006575
2	.000013151
3	.000019726
4	.000026302
5	.000032877

ANNUAL RATE, COM- POUNDED DAILY 0.24 PERCENT		ANNUAL RATE, COM- POUNDED DAILY 0.24 PERCENT		ANNUAL RATE, COM- POUNDED DAILY 0.24 PERCENT	
DAYS	FACTOR	DAYS	FACTOR	DAYS	FACTOR
6	.000039453	43	.000282779	80	.000526164
7	.000046028	44	.000289356		
8	.000052604	45	.000295933	81	.000532743
9	.000059180			82	.000539322
10	.000065755	46	.000302511	83	.000545901
		47	.000309088	84	.000552480
11	.000072331	48	.000315665	85	.000559058
12	.000078907	49	.000322243		
13	.000085483	50	.000328820	86	.000565638
14	.000092059			87	.000572217
15	.000098635	51	.000335398	88	.000578796
		52	.000341975	89	.000585375
16	.000105211	53	.000348553	90	.000591954
17	.000111787	54	.000355130		
18	.000118363	55	.000361708	91	.000598533
19	.000124939			92	.000605113
20	.000131515	56	.000368286	93	.000611692
		57	.000374864	94	.000618271
21	.000138091	58	.000381441	95	.000624851
22	.000144668	59	.000388019		
23	.000151244	60	.000394597	96	.000631430
24	.000157820			97	.000638010
25	.000164397	61	.000401175	98	.000644589
		62	.000407753	99	.000651169
26	.000170973	63	.000414331	100	.000657748
27	.000177549	64	.000420909		
28	.000184126	65	.000427487	101	.000664328
29	.000190702			102	.000670908
30	.000197279	66	.000434065	103	.000677487
		67	.000440644	104	.000684067
31	.000203856	68	.000447222	105	.000690647
32	.000210432	69	.000453800		
33	.000217009	70	.000460378	106	.000697227
34	.000223586			107	.000703807
35	.000230163	71	.000466957	108	.000710387
		72	.000473535	109	.000716967
36	.000236740	73	.000480114	110	.000723547
37	.000243316	74	.000486692		
38	.000249893	75	.000493271	111	.000730127
39	.000256470			112	.000736707
40	.000263047	76	.000499849	113	.000743287
		77	.000506428	114	.000749868
41	.000269624	78	.000513007	115	.000756448
42	.000276202	79	.000519585		

ANNUAL RATE, COM- POUNDED DAILY 0.24 PERCENT	
DAYS	FACTOR
116	.000763028
117	.000769609
118	.000776189
119	.000782769
120	.000789350
121	.000795930
122	.000802511
123	.000809092
124	.000815672
125	.000822253
126	.000828834
127	.000835415
128	.000841995
129	.000848576
130	.000855157
131	.000861738
132	.000868319
133	.000874900
134	.000881481
135	.000888062
136	.000894644
137	.000901225
138	.000907806
139	.000914387
140	.000920969
141	.000927550
142	.000934132
143	.000940713
144	.000947295
145	.000953876
146	.000960458
147	.000967039
148	.000973621
149	.000980203
150	.000986785
151	.000993367
152	.000999948

ANNUAL RATE, COM- POUNDED DAILY 0.24 PERCENT	
DAYS	FACTOR
153	.001006530
154	.001013112
155	.001019694
156	.001026276
157	.001032858
158	.001039441
159	.001046023
160	.001052605
161	.001059187
162	.001065770
163	.001072352
164	.001078934
165	.001085517
166	.001092099
167	.001098682
168	.001105264
169	.001111847
170	.001118430
171	.001125012
172	.001131595
173	.001138178
174	.001144761
175	.001151343
176	.001157926
177	.001164509
178	.001171092
179	.001177675
180	.001184258
181	.001190842
182	.001197425
183	.001204008
184	.001210591
185	.001217175
186	.001223758
187	.001230341
188	.001236925
189	.001243508

ANNUAL RATE, COM- POUNDED DAILY 0.24 PERCENT	
DAYS	FACTOR
190	.001250092
191	.001256675
192	.001263259
193	.001269842
194	.001276426
195	.001283010
196	.001289594
197	.001296178
198	.001302761
199	.001309345
200	.001315929
201	.001322513
202	.001329097
203	.001335681
204	.001342265
205	.001348850
206	.001355434
207	.001362018
208	.001368602
209	.001375187
210	.001381771
211	.001388356
212	.001394940
213	.001401525
214	.001408109
215	.001414694
216	.001421278
217	.001427863
218	.001434448
219	.001441033
220	.001447617
221	.001454202
222	.001460787
223	.001467372
224	.001473957
225	.001480542

ANNUAL RATE, COM- POUNDED DAILY 0.24 PERCENT		ANNUAL RATE, COM- POUNDED DAILY 0.24 PERCENT		ANNUAL RATE, COM- POUNDED DAILY 0.24 PERCENT	
DAYS	FACTOR	DAYS	FACTOR	DAYS	FACTOR
226	.001487127	263	.001730806	300	.001974543
227	.001493712	264	.001737392		
228	.001500297	265	.001743979	301	.001981131
229	.001506883			302	.001987720
230	.001513468	266	.001750566	303	.001994308
		267	.001757153	304	.002000897
231	.001520053	268	.001763740	305	.002007485
232	.001526639	269	.001770326		
233	.001533224	270	.001776913	306	.002014074
234	.001539809			307	.002020662
235	.001546395	271	.001783500	308	.002027251
		272	.001790088	309	.002033840
236	.001552980	273	.001796675	310	.002040428
237	.001559566	274	.001803262		
238	.001566151	275	.001809849	311	.002047017
239	.001572737			312	.002053606
240	.001579323	276	.001816436	313	.002060195
		277	.001823024	314	.002066784
241	.001585909	278	.001829611	315	.002073373
242	.001592494	279	.001836198		
243	.001599080	280	.001842786	316	.002079962
244	.001605666			317	.002086551
245	.001612252	281	.001849373	318	.002093140
		282	.001855961	319	.002099729
246	.001618838	283	.001862548	320	.002106318
247	.001625424	284	.001869136		
248	.001632010	285	.001875723	321	.002112907
249	.001638596			322	.002119496
250	.001645182	286	.001882311	323	.002126086
		287	.001888899	324	.002132675
251	.001651768	288	.001895487	325	.002139264
252	.001658354	289	.001902074		
253	.001664941	290	.001908662	326	.002145854
254	.001671527			327	.002152443
255	.001678113	291	.001915250	328	.002159033
		292	.001921838	329	.002165622
256	.001684700	293	.001928426	330	.002172212
257	.001691286	294	.001935014		
258	.001697873	295	.001941602	331	.002178801
259	.001704459			332	.002185391
260	.001711046	296	.001948190	333	.002191981
		297	.001954778	334	.002198570
261	.001717632	298	.001961367	335	.002205160
262	.001724219	299	.001967955		

**ANNUAL RATE, COM-
POUNDED DAILY
0.24 PERCENT**

DAYS	FACTOR
336	.002211750
337	.002218340
338	.002224930
339	.002231520
340	.002238110
341	.002244700
342	.002251290
343	.002257880
344	.002264470
345	.002271061
346	.002277651
347	.002284241
348	.002290832
349	.002297422
350	.002304012
351	.002310603
352	.002317193
353	.002323784
354	.002330375
355	.002336965
356	.002343556
357	.002350147
358	.002356738
359	.002363328
360	.002369919
361	.002376510
362	.002383101
363	.002389692
364	.002396283
365	.002402874
366	.002409466
367	.002416057
368	.002422648
369	.002429239
370	.002435831
371	.002442422

26 CFR 54.9801-2; 54.9801-3; 54.9815-1251;
54.9815-2704; 54.9815-2711; 54.9815.2712;
54.9815 2714; 54.9815.2719; 54.9815.2719A

T.D. 9744

DEPARTMENT OF THE TREASURY Internal Revenue Service 26 CFR Part 54

DEPARTMENT OF LABOR Employee Benefits Security Administration 29 CFR Part 2590

DEPARTMENT OF HEALTH AND HUMAN SERVICES 45 CFR Parts 144, 146 and 147 CMS-9993-F

Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections under the Affordable Care Act

AGENCIES: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Final rules.

SUMMARY: This document contains final regulations regarding grandfathered health plans, preexisting condition exclusions, lifetime and annual dollar limits on benefits, rescissions, coverage of dependent children to age 26, internal claims and appeal and external review processes, and patient protections under the Affordable Care Act. It finalizes changes to the proposed and interim final rules based on comments and incorporates subregulatory guidance issued since publication of the proposed and interim final rules.

DATES: *Effective date.* These final regulations are effective on January 19, 2016.

Applicability date. These final regulations apply to group health plans and health insurance issuers beginning on the first day of the first plan year (or, in the individual market, the first day of the first policy year) beginning on or after January 1, 2017. For information on requirements applicable prior to this date, see section II.I. of this preamble.

FOR FURTHER INFORMATION CONTACT: Elizabeth Schumacher or Amber Rivers, Employee Benefits Security Administration, Department of Labor, at (202) 693-8335; Karen Levin, Internal Revenue Service, Department of the Treasury, at (202) 927-9639; Cam Clemmons, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at (410) 786-1565.

Customer Service Information: Individuals interested in obtaining information from the Department of Labor concerning employment-based health coverage laws may call the EBSA Toll-Free Hotline at 1-866-444-EBSA (3272) or visit the Department of Labor’s web site (www.dol.gov/ebsa). Information from HHS on private health insurance coverage can be found on CMS’s web site (www.cms.gov/ccio), and information on health care reform can be found at www.HealthCare.gov.

SUPPLEMENTARY INFORMATION:

I. Background

The Patient Protection and Affordable Care Act, Pub. L. 111-148, was enacted on March 23, 2010; the Health Care and Education Reconciliation Act (the Reconciliation Act), Pub. L. 111-152, was enacted on March 30, 2010 (these are collectively known as the “Affordable Care Act”). The Affordable Care Act reorganizes, amends, and adds to the provisions of part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets. The term “group health plan” includes both insured and self-insured group

health plans.¹ The Affordable Care Act adds section 715(a)(1) to the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and make them applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated into the Code and ERISA are sections 2701 through 2728.

The Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (collectively, the Departments) have issued regulations implementing the revised PHS Act sections 2701 through 2719A in several phases.² Throughout 2010, the Departments issued interim final regulations (or temporary and proposed regulations),³ with requests for comment, implementing Affordable Care Act section 1251 (preservation of right to maintain existing coverage), and PHS Act sections 2704 (prohibition of preexisting condition exclusions), 2711 (prohibition on lifetime or annual limits), 2712 (prohibition on rescissions), 2714 (extension of dependent coverage), 2719 (internal claims and appeals and external review process), and 2719A (patient protections) (collectively, the 2010 interim final regulations). As discussed in more detail below, after consideration of comments⁴ in response to the 2010 interim final regulations, the Departments are issuing these final regulations.

II. Overview of the Final Regulations

A. Section 1251 of the Affordable Care Act, Preservation of Right to Maintain Existing Coverage (26 CFR 54.9815–1251, 29 CFR 2590.715–1251, and 45 CFR 147.140)

Section 1251 of the Affordable Care Act provides that certain group health plans and health insurance coverage existing as of March 23, 2010 (the date of enactment of the Affordable Care Act) (grandfathered health plans) are only subject to certain provisions of the Affordable Care Act (for as long as they maintain that status as grandfathered health plans under the applicable regulations).⁵ On June 17, 2010, the Departments issued interim final regulations implementing section 1251 and requesting comment.⁶ On November 17, 2010, the Departments issued an amendment to the interim final regulations to permit certain changes in policies, certificates, or contracts of insurance without loss of grandfathered status.⁷ Also in 2010, the Departments released Affordable Care Act Implementation Frequently Asked Questions (FAQs) Parts I, II, IV, V, and VI to answer questions related to maintaining a plan's status as a grandfathered health plan.⁸ After consideration of the comments and feedback received from stakeholders, the Departments are publishing these final regulations. As discussed in more detail below, these final regulations finalize the 2010 interim final regulations and amendment to the interim final regulations without substantial change and incor-

porate the clarifications issued thus far in subregulatory guidance.

1. Definition of Grandfathered Health Plan Coverage

Under the Affordable Care Act and paragraph (a)(1) of the interim final regulations implementing section 1251 of the Affordable Care Act, a group health plan or group or individual health insurance coverage is a grandfathered health plan with respect to individuals enrolled on March 23, 2010 (for as long as it maintains that status under the applicable regulations). The interim final regulations provided that a group health plan or coverage does not relinquish its grandfather status merely because one or more (or even all) individuals enrolled on March 23, 2010 cease to be covered, provided that the plan or group health insurance coverage has continuously covered at least one person (although not necessarily the same person) at all times since March 23, 2010. The interim final regulations also provided that the determination of grandfather status under the rules is made separately with respect to each benefit package made available under a group health plan or health insurance coverage.

Some commenters requested clarification with respect to the meaning of the term “benefit package” including requesting further guidance regarding what coverage option features constitute separate benefit packages. In response to the comments, the Departments issued Affordable Care Act Implementation FAQs Part II Q2 to further clarify the application of the

¹The term “group health plan” is used in title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, and is distinct from the term “health plan,” as used in other provisions of title I of the Affordable Care Act. The term “health plan” does not include self-insured group health plans.

²Note, however, that in sections under headings listing only two of the three Departments, the term “Departments” generally refers only to the two Departments listed in the heading.

³The Departments of Labor and HHS published their rules as interim final rules and are finalizing their interim final rules. The Department of the Treasury/Internal Revenue Service published temporary regulations and proposed regulations with the text of the temporary regulations serving as the text of the proposed regulations. The Department of the Treasury/Internal Revenue Service is finalizing its proposed rules.

⁴In response to the 2010 interim final regulations, the Departments received many comments that relate to early implementation issues, many of which were addressed through subregulatory guidance (addressed more fully below). While the Departments acknowledge and have reviewed the comments provided in response to the 2010 interim final regulations, to the extent the issues presented are now moot, such comments are not explicitly addressed below.

⁵For a list of the market reform provisions under title XXVII of the PHS Act, as added or amended by the Affordable Care Act and incorporated into ERISA and the Code, applicable to grandfathered health plans, visit <http://www.dol.gov/ebsa/pdf/grandfatherregtable.pdf>.

⁶75 FR 34538.

⁷75 FR 70114.

⁸See Affordable Care Act Implementation FAQs Part I, available at <http://www.dol.gov/ebsa/faqs/faq-aca.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html, Affordable Care Act Implementation FAQs Part II available at <http://www.dol.gov/ebsa/faqs/faq-aca2.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs2.html, Affordable Care Act Implementation FAQs Part IV, available at <http://www.dol.gov/ebsa/faqs/faq-aca4.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs4.html and Affordable Care Act Implementation FAQs Part V, available at <http://www.dol.gov/ebsa/faqs/faq-aca5.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html and Affordable Care Act Implementation FAQs Part VI, available at <http://www.dol.gov/ebsa/faqs/faq-aca6.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs6.html.

rules on a benefit-package-by-benefit-package basis.⁹ These final regulations continue to provide that the determination of grandfather status applies separately with respect to each benefit package and incorporate the clarifications issued in the FAQs. Therefore, as demonstrated by the example provided in the FAQs, if a group health plan offers three benefit package options – a PPO (preferred provider organization), a POS (point of service) arrangement, and an HMO (health maintenance organization) – the PPO, POS arrangement, and HMO are treated as separate benefit packages. Similarly, under these final regulations, if any benefit package ceases grandfather status, it will not affect the grandfather status of the other benefit packages.

2. Disclosure of Grandfather Status

Paragraph (a)(2) of the interim final regulations implementing section 1251 of the Affordable Care Act provided that to maintain status as a grandfathered health plan, a plan or health insurance coverage (1) must include a statement, in any plan materials provided to participants or beneficiaries (in the individual market, primary subscribers) describing the benefits provided under the plan or health insurance coverage, that the plan or health insurance coverage believes that it is a grandfathered health plan within the meaning of section 1251 of the Affordable Care Act and (2) must provide contact information for questions and complaints. The interim final regulations provided model language that can be used to satisfy this disclosure requirement.¹⁰

The Departments received several comments asking the Departments to require enhanced disclosure to participants that includes a more comprehensive explanation of grandfathered health plan status, information on the triggers that can result in a cessation of such status, a complete listing of the specific market reforms that are inapplicable to the plan by virtue of its status, and access to a formal pro-

cess for obtaining a determination on a plan's status from the appropriate government agency. Other commenters stated that including this disclosure requirement in consumer materials may be confusing to participants, may not have the intended benefit, and that it may be more appropriate to include the applicable consumer protections in the employer plan documents or insurance coverage documents. Additional commenters stated this requirement is unnecessary because ERISA's disclosure requirements are already sufficient to explain to participants the information they need about their plan (including which benefits are included or excluded), and that including information about what benefits they could have had if their employers chose to relinquish their grandfathered plan status is unnecessary.

In response to these comments the Departments issued Affordable Care Act Implementation FAQs Part IV Q1, in which the Departments clarified that a grandfathered health plan is not required to provide the disclosure statement every time it sends out a communication, such as an explanation of benefits (EOB), to a participant or beneficiary. Instead, a grandfathered health plan will comply with this disclosure requirement if it includes the model disclosure language provided in the Departments' interim final grandfather regulations (or a similar statement) whenever a summary of the benefits under the plan is provided to participants and beneficiaries. For example, many plans distribute summary plan descriptions upon initial eligibility to receive benefits under the plan or coverage, during an open enrollment period, or upon other opportunities to enroll in, renew, or change coverage. The FAQs also provided that, while it is not necessary to include the disclosure statement with each plan or issuer communication to participants and beneficiaries (such as an EOB), the Departments encourage plan sponsors and issuers to identify other communications in which disclosure of grandfather status would be appropriate and consistent with the goal of

providing participants and beneficiaries information necessary to understand and make informed choices regarding health coverage.¹¹

After consideration of the comments and feedback from stakeholders, the Departments retain the approach in the interim final regulations and subsequent subregulatory guidance because that approach provides consumers with information about the status of their plan or health insurance coverage, which assists them in identifying and enforcing their rights, without undue burden on plans and issuers. Therefore, these final regulations clarify that, to maintain status as a grandfathered health plan, a group health plan, or health insurance coverage, must include a statement that the plan or health insurance coverage believes it is a grandfathered health plan in any summary of benefits provided under the plan. It must also provide contact information for questions and complaints. These final regulations also retain the model disclosure language. Plans and issuers may (but are not required to) utilize the model disclosure language to satisfy this disclosure requirement. The Departments also note that the disclosure language is a model, and, thus, plans and issuers are permitted to include additional disclosure elements, such as the entire list of the market reform provisions that do not apply to grandfathered health plans.

3. Anti-abuse rules

The interim final regulations provided that a group health plan that provided coverage on March 23, 2010 generally is a grandfathered health plan with respect to new employees (whether newly hired or newly enrolled) and their families who enroll in the grandfathered health plan after March 23, 2010. The interim final regulations also provided two anti-abuse rules to curtail attempts to retain grandfather status by indirectly making changes that would otherwise result in a loss of grandfather status.

⁹See Affordable Care Act Implementation FAQs Part II, available at <http://www.dol.gov/ebsa/faqs/faq-aca2.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs2.html.

¹⁰29 CFR 2590.715-1251(a)(2)(ii); 45 CFR 147.140(a)(2)(ii).

¹¹See Affordable Care Act Implementation FAQs Part IV, available at <http://www.dol.gov/ebsa/faqs/faq-aca4.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs4.html.

The first anti-abuse rule provided that if the principal purpose of a merger, acquisition, or similar business restructuring is to cover new individuals under a grandfathered health plan, the plan ceases to be a grandfathered health plan. Under the second anti-abuse rule, the interim final regulations set forth specific criteria that, if met, would cause a plan that is transferring employees to relinquish its grandfather status. Specifically, the interim final regulations provided that a plan that is transferring employees would relinquish its grandfather status if, comparing the terms of the transferee plan with those of the transferor plan (as in effect on March 23, 2010) and treating the transferee plan as if it were an amendment of the transferor plan, such amendment would cause a loss of grandfather status and there was no bona fide employment-based reason to transfer the employees into the transferee plan. The second anti-abuse rule was designed to prevent a plan or issuer from circumventing the limits on changes that cause a plan or health insurance coverage to cease to be a grandfathered health plan. This rule was intended to address situations in which employees who previously were covered by a grandfathered health plan are transferred to another grandfathered health plan without any bona fide employment-based reason.

a. Bona fide employment-based reasons

The Departments received several comments regarding the anti-abuse provisions. Stakeholders requested that the Departments clarify what constitutes a bona fide employment-based reason that would prevent a plan that is transferring employees from relinquishing its grandfather status. In response, the Departments issued Affordable Care Act Implementation FAQs Part VI Q1, which provided several examples of the variety of circumstances that would constitute a bona fide employment-based reason to transfer em-

ployees. Examples of a bona fide employment-based reason include: when a benefit package is being eliminated because the issuer is exiting the market; when a benefit package is being eliminated because the issuer no longer offers the product to the employer; when low or declining participation by plan participants in the benefit package makes it impractical for the plan sponsor to continue to offer the benefit package; when a benefit package is eliminated from a multiemployer plan as agreed upon as part of the collective bargaining process; or when a benefit package is eliminated for any reason and multiple benefit packages covering a significant portion of other employees remain available to the employees being transferred.¹²

These final regulations include those examples of bona fide employment-based reasons. The Departments continue to interpret the term “bona fide employment-based reason” to embrace a variety of circumstances, and plans and issuers should evaluate all facts and circumstances carefully to determine whether a bona fide employment-based reason exists when considering transferring employees from one grandfathered health plan to another. The Departments may issue additional guidance if further questions regarding what constitutes a bona fide employment-based reason arise.

b. Clarification regarding multiemployer plans

Section 1251 of the Affordable Care Act, as well as the 2010 interim final regulations, permit a grandfathered group health plan to cover new employees without any effect on its status as a grandfathered plan. Several commenters requested that the Departments clarify in the final regulations whether a multiemployer plan may add new contributing employers to the plan without triggering a loss of grandfather status. These final regulations

clarify that the addition of a new contributing employer or new group of employees of an existing contributing employer to a grandfathered multiemployer health plan will not affect the plan’s grandfathered status, provided that the multiemployer plan has not made any other changes that would cause the plan to relinquish its grandfathered status.

4. Maintenance of Grandfather Status

The interim final regulations set forth rules for determining when changes to the terms of a plan or health insurance coverage cause the plan or coverage to cease to be a grandfathered health plan. Specifically, the interim final regulations outlined six changes to benefits, cost-sharing mechanisms, and contribution rates that will cause a plan or health insurance coverage to relinquish its grandfather status.¹³ Since the promulgation of the interim final regulations, questions have been brought to the Departments’ attention regarding other specific changes to a plan’s design and the impact of such changes on a plan’s grandfather status.

a. Elimination of all or substantially all benefits

The 2010 interim final regulations and these final regulations provide that the elimination of all or substantially all benefits to diagnose or treat a particular condition will cause a group health plan or health insurance coverage to relinquish its grandfathered status. One commenter requested that the Departments clarify what constitutes eliminating “substantially all benefits” to diagnose or treat a particular condition. As the interim final regulations stated, and these final regulations continue to provide, the elimination of benefits for any necessary element to diagnose or treat a condition is considered the elimination of all or substantially all benefits to diagnose or treat a particular condition. The

¹²See Affordable Care Act Implementation FAQs Part VI, available at <http://www.dol.gov/ebsa/faqs/faq-aca6.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs6.html.

¹³The six changes (measured from March 23, 2010) outlined in paragraph (g)(1) of the interim final regulations that are considered to change a health plan so significantly that they will cause a group health plan or health insurance coverage to relinquish grandfather status include the following: (1) the elimination of all or substantially all benefits to diagnose or treat a particular condition, (2) any increase in percentage cost-sharing requirements, (3) an increase in a deductible or out-of-pocket maximum by an amount that exceeds medical inflation plus 15 percentage points, (4) an increase in a copayment by an amount that exceeds medical inflation plus 15 percentage points (or, if greater, \$5 plus medical inflation), (5) a decrease in an employer’s contribution rate towards the cost of coverage by more than 5 percentage points, or (6) the imposition of annual dollar limits below the restricted annual dollar limits that were in effect prior to 2014 (note that for plan years (or policy years in the individual market) beginning on and after January 1, 2014, annual dollar limits on essential health benefits are prohibited, except for grandfathered individual health insurance coverage). See 26 CFR 54.9815-1251(g), 29 CFR 2590.715-1251(g), and 45 CFR 147.140(g).

Departments decline to establish a bright-line test establishing what constitutes “substantially all benefits” for purposes of these final regulations. Whether or not a plan has eliminated substantially all benefits to diagnose or treat a particular condition must be determined based on all the facts and circumstances, taking into account the items and services covered for a particular condition under the plan on March 23, 2010, as compared to the items and services covered at the time the plan makes the benefit change effective. The preamble to the 2010 interim final regulations provided two examples. First, if a plan or health insurance coverage eliminates all benefits for cystic fibrosis, the plan or coverage will lose its grandfathered status. Second, if a plan or insurance coverage provides benefits for a particular mental health condition, the treatment for which is a combination of counseling and prescription drugs, and subsequently eliminates benefits for counseling, the plan is treated as having eliminated all or substantially all benefits for that mental health condition and will as a result lose its grandfathered status. These final regulations continue to provide that the elimination of all or substantially all benefits to diagnose or treat a particular condition will cause a group health plan or health insurance coverage to relinquish its grandfathered status and contain an example.

b. Increase in fixed-amount copayments

The interim final regulations provided standards for when increases in fixed-amount copayments would cause a plan or coverage to relinquish its grandfather status. Under the interim final regulations, a plan or coverage ceases to be a grandfathered health plan if there is an increase since March 23, 2010 in a copayment that exceeds the greater of the maximum percentage increase¹⁴ or five dollars increased by medical inflation.¹⁵

With respect to grandfathered health plans that utilize multiple levels of copayments for different benefits under the plan, stakeholders sought clarification on what degree of change would cause a plan to relinquish its grandfather status. Specifically, stakeholders wanted to know whether raising the copayment level for a category of services by an amount that would otherwise trigger a loss of grandfather status would cause a loss of grandfather status if the plan retained the level of copayment on other categories of services. The Departments clarified in Affordable Care Act Implementation FAQs Part II Q4 that a change to a copayment level for a category of services that exceeds the standards set forth in the interim final regulations will cause a plan to relinquish its grandfather status, even if a plan retains the level of copayment for other categories of services.¹⁶ These final regulations retain this clarification, and continue to provide that each change in cost sharing must be separately evaluated under the standards set forth in the regulations. A plan or issuer may not exceed the standards set forth in these final regulations with respect to one level of copayment for a category of services, and retain its grandfather status by retaining the level of copayments for other categories of services.

c. Decrease in Contribution Rate by Employers and Employee Organization

The interim final regulations provided that a decrease in the employer contribution rate for coverage under a group health plan or group health insurance coverage beyond the permitted percentage would result in cessation of grandfather status. There are two rules related to decreases in employer contributions: one for a contribution based on the cost of coverage and one for a contribution based on a formula.

First, if the contribution rate is based on the cost of coverage, a group health plan or group health insurance coverage

ceases to be a grandfathered health plan if the employer or employee organization decreases its contribution rate towards the cost of any tier of coverage for any class of similarly situated individuals¹⁷ by more than 5 percentage points below the contribution rate on March 23, 2010. For this purpose, contribution rate is defined as the amount of contributions made by an employer or employee organization compared to the total cost of coverage, expressed as a percentage. The interim final regulations also provided that the total cost of coverage is determined in the same manner as the applicable premium is calculated under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) continuation provisions of section 604 of ERISA, section 4980B(f)(4) of the Code, and section 2204 of the PHS Act. In the case of a self-insured group health plan, contributions by an employer or employee organization are calculated by subtracting the employee contributions towards the total cost of coverage from the total cost of coverage.

Second, if the contribution rate is based on a formula, such as hours worked or tons of coal mined, a group health plan or group health insurance coverage ceases to be a grandfathered health plan if the employer or employee organization decreases its contribution rate towards the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percentage points below the contribution rate on March 23, 2010. These final regulations finalize these provisions without change but incorporate the additional clarifications issued in subregulatory guidance as discussed below.

The Departments received several comments relating to the employer contribution limitations. Some commenters stated that issuers do not always have the information needed to know whether (or when) an employer plan sponsor changes its rate of contribution towards the cost of group health plan coverage. In response to this issue, the Departments issued Afford-

¹⁴The interim final regulations defined the maximum percentage increase as medical inflation (from March 23, 2010) plus 15 percentage points. Medical inflation is defined in the interim final regulations by reference to the overall medical care component of the Consumer Price Index for All Urban Consumers, unadjusted (CPI), published by the Department of Labor. See 26 CFR 54.9815-1251(g)(3), 29 CFR 2590.715-1251(g)(3), and 45 CFR 147.140(g)(3).

¹⁵75 FR 35538, 34543 (June 17, 2010).

¹⁶See Affordable Care Act Implementation FAQs Part II, available at <http://www.dol.gov/ebsa/faqs/faq-aca2.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs2.html.

¹⁷Similarly situated individuals are described in the HIPAA nondiscrimination regulations at 26 CFR 54.9802-1(d), 29 CFR 2590.702(d), and 45 CFR 146.121(d).

able Care Act Implementation FAQs Part I Q2 and Q3 providing relief if issuers and employer plan sponsors or contributing employers and multiemployer plans take certain steps to communicate regarding changes to the contribution rate for purposes of determining grandfather status.¹⁸ These final regulations also provide relief to issuers, plan sponsors, employers, and plans that take certain steps to communicate changes in contribution rates. Specifically, these final regulations provide that an insured group health plan that is a grandfathered health plan will not relinquish its grandfather status immediately based on a change in the employer contribution rate if, upon renewal, an issuer requires a plan sponsor to make a representation regarding its contribution rate for the plan year covered by the renewal, as well as its contribution rate on March 23, 2010 (if the issuer does not already have it). Additionally, the issuer's policies, certificates, or contracts of insurance must disclose in a prominent and effective manner that plan sponsors are required to notify the issuer if the contribution rate changes at any point during the plan year. An insured grandfathered group health plan with a decrease in employer contributions relinquishes its grandfather status as of the earlier of the first date on which the issuer knows or reasonably should know that there has been at least a 5-percentage-point reduction or the first date on which the plan no longer qualifies for grandfathered status without regard to the 5-percentage-point reduction. Similarly, if multiemployer plans and contributing employers follow these steps, the plan will not relinquish its grandfather status unless or until the multiemployer plan knows or reasonably should know that the contribution rate has changed by at least the applicable 5-percentage point reduction or until the date the plan no longer qualifies for grandfathered status without regard to the 5-percentage point reduction. Moreover, nothing in the Af-

fordable Care Act or these regulations prevents a policy, certificate, or contract of insurance from requiring a plan sponsor to notify an issuer in advance (for example, 30 or 60 days in advance) of a change in their contribution rate.

The Departments also received comments on the application of this provision to multiemployer plans with unique contribution structures. It is common for multiemployer plans to have either a fixed-dollar employee contribution or no employee contribution towards the cost of coverage. In such cases, a contributing employer's contribution rate may change (for example, after making up a funding deficit in the prior year or to reflect a surplus) but the employee contribution amount is not affected. The Departments issued Affordable Care Act Implementation FAQs Part I Q4 clarifying that in this case, provided any changes in the coverage terms would not otherwise cause the plan to cease to be grandfathered and there continues to be no employee contribution or no increase in the fixed-dollar employee contribution towards the cost of coverage, the plan would not relinquish its grandfather status.¹⁹ These final regulations incorporate this clarification and apply the relief to all grandfathered group health plans. Therefore, under these final regulations a group health plan that requires either fixed-dollar employee contributions or no employee contributions will not cease to be a grandfathered health plan if the employer contribution rate changes so long as there continues to be no employee contributions or no increase in the fixed-dollar employee contributions towards the cost of coverage and there are no corresponding changes in coverage terms that would otherwise cause the plan to cease to be a grandfathered plan.

The Departments also received comments requesting clarification on the application of the rules where a group health plan includes multiple tiers of coverage. In response, the Departments issued Af-

fordable Care Act Implementation FAQs Part II Q3, explaining that the standards for employer contributions found in paragraph (g)(1)(v) of the interim final regulations on grandfathered health plans apply on a tier-by-tier basis.²⁰ These final regulations incorporate this guidance. Therefore, if a group health plan modifies the tiers of coverage it had on March 23, 2010 (for example, from self-only and family to a multi-tiered structure of self-only, self-plus-one, self-plus-two, and self-plus-three-or-more), the employer contribution for any new tier would be tested by comparison to the contribution rate for the corresponding tier on March 23, 2010. For example, if the employer contribution rate for family coverage was 50 percent on March 23, 2010, the employer contribution rate for any new tier of coverage other than self-only (i.e., self-plus-one, self-plus-two, self-plus-three or more) must be within 5 percentage points of 50 percent (i.e., at least 45 percent). If, however, the plan adds one or more new coverage tiers without eliminating or modifying any previous tiers and those new coverage tiers cover classes of individuals that were not covered previously under the plan, the new tiers would not be analyzed under the standards for changes in employer contributions. For example, if a plan with self-only as the sole coverage tier added a family coverage tier, the level of employer contributions toward the family coverage could not cause the plan to lose grandfather status.

The Departments also received comments asking for clarification on when a decrease in the employer contribution rate for coverage under a group health plan or group health insurance beyond the permitted percentage would result in cessation of grandfather status for a contribution based on a formula. In response, the Departments issued Affordable Care Act Implementation FAQs Part VI Q6.²¹ The FAQ provided an example under which a plan covers both retirees and active employees

¹⁸See Affordable Care Act Implementation FAQs Part I, available at <http://www.dol.gov/ebsa/faqs/faq-aca.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html.

¹⁹See Affordable Care Act Implementation FAQs Part I, available at <http://www.dol.gov/ebsa/faqs/faq-aca.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html.

²⁰See Affordable Care Act Implementation FAQs Part II, available at <http://www.dol.gov/ebsa/faqs/faq-aca2.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs2.html.

²¹See Affordable Care Act Implementation FAQs Part VI, available at <http://www.dol.gov/ebsa/faqs/faq-aca6.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs6.html.

and the employer that sponsors the plan contributes \$300 per year multiplied by the individual's years of service for the employer, capped at \$10,000 per year. In the example, the employer makes contributions based on a formula, and accordingly, the plan will cease to be a grandfathered health plan if the employer decreases its contribution rate towards the cost of coverage by more than five percent below the contribution rate on March 23, 2010. If the formula does not change, the employer is not considered to have reduced its contribution rate, regardless of any increase in the total cost of coverage. However, if the dollar amount that is multiplied by years of service decreases by more than five percent (or if the \$10,000 maximum employer contribution cap decreases by more than five percent), the plan will cease to be a grandfathered health plan. Although this example has not been added to the text of the final regulations, this guidance continues to apply.

d. Changes in annual limits

PHS Act section 2711, as added by the Affordable Care Act, generally prohibits lifetime and annual limits on the dollar amount of essential health benefits, as defined in section 1302(b) of the Affordable Care Act. Under PHS Act section 2711 and its implementing regulations, plans and issuers were generally prohibited from imposing lifetime limits on the dollar value of essential health benefits for plan years (in the individual market, policy years) beginning on or after September 23, 2010.

With respect to annual dollar limits, for plan or policy years beginning before January 1, 2014, plans and issuers were permitted to impose restricted annual dollar limits in accordance with the guidance set forth in the interim final regulations. For plans years beginning on or after January 1, 2014, plans and issuers generally are prohibited from imposing annual dollar limits on essential health benefits. However, grandfathered individual health in-

surance plans are not subject to the annual dollar limit prohibition. Accordingly, the final regulations retain the rules regarding loss of grandfathered status based on imposition of annual dollar limits to allow issuers of grandfathered individual health insurance coverage to analyze grandfathered status.

These final regulations, like the interim final regulations, address three different limit-related situations that would cause a plan or health insurance coverage to relinquish its grandfather status: (1) A plan or health insurance coverage that, on March 23, 2010, did not impose an overall annual or lifetime limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage imposes an overall annual limit on the dollar value of benefits; (2) A plan or health insurance coverage, that, on March 23, 2010, imposed an overall lifetime limit on the dollar value of all benefits but no overall annual limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage adopts an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010; and (3) A plan or health insurance coverage that, on March 23, 2010, imposed an overall annual limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage decreases the dollar value of the annual limit (regardless of whether the plan or health insurance coverage also imposed an overall lifetime limit on March 23, 2010 on the dollar value of all benefits).

e. Changes to fixed amount cost-sharing based on a formula

On December 22, 2010, the Departments issued Affordable Care Act Implementation FAQs Part V Q7 to provide clarification on the application of the thresholds under paragraph (g)(1) of the interim final regulations when a plan's terms include out-of-pocket spending limits that are based on a for-

mula.²² The Departments continue to interpret paragraph (g)(1) as clarified in the FAQ. Therefore, under these final regulations, if a plan or coverage has a fixed-amount cost-sharing requirement other than a copayment (for example, a deductible or out-of-pocket limit) that is based on a percentage-of-compensation formula, that cost-sharing arrangement will not cause the plan or coverage to cease to be a grandfathered health plan as long as the formula remains the same as that which was in effect on March 23, 2010. Accordingly, if the percentage-of-compensation formula for determining an out-of-pocket limit is unchanged and an employee's compensation increases, then the employee could face a higher out-of-pocket limit, but that change would not cause the plan to relinquish grandfather status.

f. Grandfather status and wellness programs

Under PHS Act section 2705, ERISA section 702, and Code section 9802 and the Departments' implementing regulations, group health plans and health insurance issuers in the group and individual market are prohibited from discriminating against participants, beneficiaries, and individuals in eligibility, benefits, or premiums based on a health factor.²³ For group health plans and group health insurance coverage, an exception to this general prohibition allows premium discounts, rebates, or modification of otherwise applicable cost sharing (including copayments, deductibles, or coinsurance) in return for adherence to certain programs of health promotion and disease prevention, commonly referred to as wellness programs.

Many stakeholders requested clarification with respect to how changes to contribution rates and cost-sharing mechanisms in the context of a wellness program would impact a plan's grandfather status. In light of these questions, the Departments issued Affordable Care Act Implementation FAQs Part II Q5, which stated that while group health plans may

²²See Affordable Care Act Implementation FAQs Part V and Mental Health Parity Implementation, available at <http://www.dol.gov/ebsa/faqs/faq-aca5.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html.

²³The statute and its implementing regulations set forth eight health status-related factors, which the final regulations on Nondiscrimination and Wellness Programs in Health Coverage in the Group Market refer to as "health factors" for simplicity. 71 FR 75014, 75016 (Dec. 13, 2006) Under the statute and the regulations, the eight health factors are health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability. Id. In the Departments' view, "[t]hese terms are largely overlapping and, in combination, include any factor related to an individual's health." 66 FR 1378, 1379 (Jan. 8, 2001).

continue to provide incentives for wellness by providing premium discounts or additional benefits to reward healthy behaviors by participants and beneficiaries, penalties (such as cost-sharing surcharges) may implicate the standards outlined in paragraph (g)(1) of the grandfather interim final regulations and should be examined carefully.²⁴ If additional questions arise regarding the interaction of wellness programs and these requirements, the Departments may issue additional subregulatory guidance.

g. Changes to multi-tiered prescription drug formularies

In Affordable Care Act Implementation FAQs Part VI Q2, the Departments addressed questions related to certain changes to the level of cost sharing for brand-name prescription drugs. Stakeholders requested that the Departments clarify whether changes to cost sharing for brand-name prescription drugs would cause a plan to relinquish its grandfather status in instances where a plan classifies and determines cost sharing for prescription drugs based on the availability of a generic alternative, and a generic drug becomes available and is added to the formulary. The Departments stated that if a drug was classified in a tier as a brand name drug with no generic available, and a generic alternative for the drug becomes available and is added to the formulary, moving the brand-name drug to a higher tier would not cause the plan or coverage to relinquish grandfather status.²⁵ These final regulations adopt this rule that such changes will not result in a loss of grandfather status.

h. Grandfather status and certain changes in individual policies

Some individual health insurance policies in place on March 23, 2010 included a feature that allowed a policyholder to elect an option under which the individual would pay a reduced premium in exchange for higher cost sharing. The Departments received comments asking whether individuals enrolled in these policies as of March 23, 2010 could make such an election after March 23, 2010 without affecting the policy's grandfather status, even if the increase in cost sharing would exceed the limits set forth under the interim final regulations. In response, the Departments issued Affordable Care Act Implementation FAQs Part IV Q2, which stated that, as long as the policyholder had such option under the insurance policy that was in place on March 23, 2010, he or she could exercise the option after March 23, 2010 without affecting grandfather status, even if as a result of electing this option the individual's cost sharing would increase by an amount that exceeds the limits established under the interim final regulations.²⁶ The Departments maintain this approach in these final regulations.

i. Clarifications on timing of the loss of grandfather status

Since the promulgation of the 2010 interim final regulations, questions have arisen regarding whether or not a plan ceases to be a grandfathered health plan immediately after making a change that triggers a loss of grandfathered status, and whether or not there is an opportunity to cure a loss of grandfather status following a change made inadvertently or otherwise that triggers a loss of grandfather status. Several commenters have requested clarification

on when the plan or coverage ceases to be a grandfathered health plan if it makes an amendment to plan terms that trigger loss of grandfather status in the middle of the plan year. The Departments issued Affordable Care Act Implementation FAQs Part VI Q4 and Q5 addressing timing of the loss of grandfather status with respect to mid-year plan amendments that exceed the thresholds described in the interim final regulations.²⁷ These final regulations adopt the clarification outlined in the FAQs that a plan or coverage will cease to be a grandfathered health plan when an amendment to plan terms that exceeds the thresholds described in paragraph (g)(1) of these final regulations becomes effective – regardless of when the amendment is adopted. Once grandfather status is lost there is no opportunity to cure the loss of grandfather status. A reversal after the effective date will not allow the plan or coverage to regain grandfather status. If a plan sponsor wishes to avoid relinquishing grandfathered status in the middle of a plan year, any changes that will cause a plan or coverage to relinquish grandfather status should not be effective before the first day of a plan year that begins after the change is adopted.

B. PHS Act Section 2704, Prohibition of Preexisting Condition Exclusions (26 CFR 54.9815–2704, 29 CFR 2590.715–2704, 45 CFR 147.108)

PHS Act section 2704, added by the Affordable Care Act, amends the HIPAA²⁸ rules relating to preexisting condition exclusions to provide that a group health plan and a health insurance issuer offering group or individual health insurance coverage generally may not impose any preexisting condition exclusions.²⁹ HIPAA, as well as PHS Act section 2704

²⁴See Affordable Care Act Implementation FAQs Part II, available at <http://www.dol.gov/ebsa/faqs/faq-aca2.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs2.html.

²⁵Affordable Care Act Implementation FAQs Part VI, available at <http://www.dol.gov/ebsa/faqs/faq-aca6.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs6.html.

²⁶See Affordable Care Act Implementation FAQs Part IV, available at <http://www.dol.gov/ebsa/faqs/faq-aca4.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs4.html.

²⁷See Affordable Care Act Implementation FAQs Part VI, available at <http://www.dol.gov/ebsa/faqs/faq-aca6.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs6.html.

²⁸HIPAA is the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191).

²⁹The HIPAA rules (that were in effect prior to the effective date of these amendments) applied only to group health plans and group health insurance coverage, and permitted limited exclusions of coverage based on a preexisting condition under certain circumstances. Section 2704 prohibits any preexisting condition exclusion from being imposed by group health plans or group health insurance coverage and extends this protection to non-grandfathered individual health insurance coverage but this prohibition does not apply to grandfathered individual health insurance coverage.

and its implementing regulations, define a preexisting condition exclusion as a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, regardless of whether any medical advice, diagnosis, care, or treatment was recommended or received before that date. PHS Act section 2704,³⁰ which became effective for enrollees who are under 19 years of age for plan years (in the individual market, policy years) beginning on or after September 23, 2010, and effective for adults for plan years (in the individual market, policy years) beginning on or after January 1, 2014, prohibits preexisting condition exclusions for both group health plans and group or individual health insurance coverage (except for grandfathered individual health insurance). On June 28, 2010, the Departments issued interim final regulations implementing PHS Act section 2704 and requesting comment.³¹ After issuance of regulations in 2010, the Departments also released Affordable Care Act Implementation FAQs Part V, Q6³² to provide additional clarification on the prohibition of preexisting condition exclusions. These final regulations finalize the 2010 interim final regulations without substantial change and incorporate the clarifications issued to date in subregulatory guidance.

1. Allowable Exclusion of Benefits

Prior to implementation of PHS Act section 2704, HIPAA rules limiting preexisting condition exclusions provided that a plan's or issuer's exclusion of benefits for a condition regardless of when the condition arose relative to the effective date of coverage is not a preexisting condition exclusion. With respect to such exclusions, the 2010 interim final regulations did not change this approach under HIPAA.³³

Several commenters requested that the final regulations reiterate this rule. Other commenters requested that all exclusions of specific conditions be prohibited regardless of whether the exclusion relates to when the condition arose. Another commenter wrote that restrictions on benefits concerning rehabilitation services and devices should be considered a form of preexisting condition exclusion and not be allowed.

Similar to the interim final regulations, these final regulations retain the approach set forth under HIPAA relating to exclusions for a specific benefit. More specifically, these final regulations continue to provide that a plan's or issuer's exclusion of benefits for a condition from the plan or policy regardless of when the condition arose relative to the effective date of coverage is not a preexisting condition exclusion. Other requirements of Federal or State law, however, may prohibit certain benefit exclusions, including the essential health benefits requirements applicable in the individual and small group health insurance markets at 45 CFR 156.110 *et seq.*

2. Enrollment Period

The 2010 interim final regulations did not impose any requirement on plans to provide for an open enrollment period. One commenter requested that the regulations clarify that issuers in the individual market may restrict enrollment of children under age 19 to specified open enrollment periods, consistent with guidance issued by HHS.³⁴ Another commenter requested that the regulations specify that after the initial enrollment period, health insurance issuers must make open enrollment periods available to families at least once a year during a standardized time period for at least 90 days and that insurers should fully advertise the availability. Another commenter stated that having at least one

issuer that offers open enrollment at any time during the year, without a penalty for deferral, will be an economic incentive to defer the purchase of insurance which may encourage adverse selection and subsequently, higher claim costs. Additional commenters requested continuous open enrollment for children with preexisting conditions, clarification of whether guaranteed issue will be available only during open enrollment or all 12 months of the year, and that families be given the opportunity to enroll their children when certain life events occur. These final regulations do not adopt these suggestions. The provisions of the Affordable Care Act related to guaranteed availability of coverage, including open and special enrollment periods, are implemented in regulations issued by HHS under section 2702 of the PHS Act and are outside the scope of this rulemaking. Additionally, while HIPAA generally permits plans and issuers to treat participants and beneficiaries with adverse health factors more favorably, such as providing a longer open enrollment period, nothing in these regulations requires plans and issuers to do so.

3. Premiums

Commenters raised concerns about increasing premiums related to the prohibition on preexisting condition exclusions. Effective for plan years (or, in the individual market, policy years) beginning on or after January 1, 2014, section 2701 of the PHS Act and section 1312(c) of the Affordable Care Act govern the premium rates charged by an issuer for non-grandfathered health insurance coverage in the individual and small group markets, and section 2794 of the PHS Act provides for the annual review of unreasonable increases in premiums for health insurance coverage in the individual and small group markets. These provisions are im-

³⁰Before the amendments made by the Affordable Care Act, PHS Act section 2701(b)(1) was the applicable provision concerning preexisting condition exclusions; after the amendments made by the Affordable Care Act, PHS Act section 2704(b)(1) is the applicable provision. See also ERISA section 701(b)(1) and Code section 9801(b)(1).

³¹75 FR 37188 (June 28, 2010).

³²See Affordable Care Act Implementation FAQs Part V, available at <http://www.dol.gov/ebsa/faqs/faq-aca5.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html.

³³The rule is illustrated with examples in the HIPAA regulations on preexisting condition exclusions. See Examples 6, 7, and 8 in 26 CFR 54.9801-3(a)(2), 29 CFR 2590.701-3(a)(2), 45 CFR 146.111(a)(2).

³⁴Center for Consumer Information & Insurance Oversight, Questions and Answers on Enrollment of Children Under 19 Under the New Policy That Prohibits Pre-Existing Condition Exclusions, available at <https://www.cms.gov/CCIIO/Resources/Files/factsheet.html>.

plemented in regulations issued by HHS³⁵ and are outside the scope of this rulemaking. However, the rating rules under PHS Act section 2701 prohibit variations in premiums based on a child's health status.

4. Allowable Screenings to Determine Eligibility for Alternative Coverage in the Individual Market

Subsequent to the promulgation of the interim final regulations, questions arose regarding whether it would be permissible under the rules implementing PHS Act section 2704 for issuers in the individual market to screen certain applicants for eligibility for alternative coverage before issuing a child-only policy. Specifically, States expressed an interest in permitting such screenings. In response to these concerns, the Departments issued Affordable Care Act Implementation FAQs Part V, Q6, which provided that under certain circumstances, States can permit issuers in the individual market to screen applicants for eligibility for alternative coverage options before offering a child-only policy if (1) the practice is permitted under State law; (2) the screening applies to all child-only applicants, regardless of health status; and (3) the alternative coverage options include options for which healthy children would potentially be eligible, such as the Children's Health Insurance Program (CHIP) and group health insurance.³⁶ Screenings may not be limited to programs targeted to individuals with a preexisting condition, such as a State high risk pool. Note that Medicaid policy, under 42 U.S.C. 1396a (25)(G), prohibits participating States from allowing health insurance issuers to consider whether an individual is eligible for, or is provided medical assistance under, Medicaid in

making enrollment decisions. Furthermore, issuers may not implement a screening process that by its operation significantly delays enrollment or artificially engineers eligibility of a child for a program targeted to individuals with a preexisting condition. Additionally, the screening process may not be applied to offers of dependent coverage for children. The FAQ provided that States are encouraged to require issuers that screen for other coverage to enroll and provide coverage to the applicant effective on the first date that the child-only policy would have been effective had the applicant not been screened for an alternative coverage option. It also provided that States are encouraged to impose a reasonable time limit, such as 30 days, at which time the issuer would have to enroll the child regardless of pending applications for other coverage. Subsequent to the issuance of the FAQ, the guaranteed availability requirements in section 2702 of the PHS Act took effect, similarly precluding an issuer from denying coverage. This screening, as permitted under State law, will continue to be allowed under these final regulations, consistent with both section 2704 and guaranteed availability obligations under section 2702.

C. PHS Act Section 2711, Prohibition on Lifetime and Annual Limits (26 CFR 54.9815-2711, 29 CFR 2590.715-2711, 45 CFR 147.126)

PHS Act section 2711, as added by the Affordable Care Act, generally prohibits annual and lifetime dollar limits on essential health benefits, as defined in section 1302(b) of the Affordable Care Act. With respect to annual dollar limits, PHS Act section 2711(a)(2) provided that for plan

years beginning before January 1, 2014, restricted annual dollar limits were allowed. On June 28, 2010, the Departments issued interim final regulations implementing PHS Act section 2711 and requested comment.³⁷ After issuance of the 2010 interim final regulations, the Departments also released Affordable Care Act Implementation FAQs Parts IV, XI, XV, XXII, as well as Technical Release 2013-03, to address various requests for clarifications under PHS Act section 2711.³⁸ These final regulations adopt the 2010 interim final regulations without substantial change and incorporate certain pertinent clarifications issued thus far in subregulatory guidance.

1. Definition of Essential Health Benefits

On February 25, 2013, HHS issued final regulations addressing essential health benefits (EHB) under Affordable Care Act section 1302.³⁹ Among other things, HHS regulations defined EHB based on a State-specific benchmark plan and required each State to select a benchmark plan from among several options.⁴⁰ While self-insured, large group market, and grandfathered health plans are not required to offer EHB, PHS Act section 2711 prohibits such plans from imposing annual and lifetime dollar limits on covered benefits that fall within the definition of EHB. In the interim final regulations, the Departments said that "[f]or plan years (in the individual market, policy years) beginning before the issuance of regulations defining 'essential health benefits,' for purposes of enforcement, the Departments will take into account good faith efforts to comply with a reasonable interpretation of the term 'essential health benefits.'"

³⁵See 45 CFR 147.102, 154.101 et. seq., and 156.80.

³⁶See Affordable Care Act Implementation FAQs Part V, available at <http://www.dol.gov/ebsa/faqs/faq-aca5.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html.

³⁷75 FR 37188 (June 28, 2010).

³⁸Affordable Care Act Implementation FAQs Parts IV, XI, XV, XXII, available at <http://www.dol.gov/ebsa/faqs/faq-aca4.html>, <http://www.dol.gov/ebsa/faqs/faq-aca11.html>, <http://www.dol.gov/ebsa/faqs/faq-aca15.html>, and <http://www.dol.gov/ebsa/faqs/faq-aca22.html>, or https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs4.html, https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html, https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html and <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-XXII-FINAL.pdf>; Technical Release 2013-03, available at <http://www.dol.gov/ebsa/newsroom/tr13-03.html>. See footnote 51 for a list of additional items of guidance under PHS Act section 2711.

³⁹78 FR 12834.

⁴⁰The benchmark plans from which a State could choose are: (1) the largest plan by enrollment in any of the three largest products in the State's small group market; (2) any of the largest three State employee health benefit plans options by enrollment; (3) any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment; or (4) the largest insured commercial HMO in the State. 45 CFR 156.100. The EHB-benchmark plan serves as a reference plan, reflecting both the scope of services and limits offered by a typical employer plan in each State. The term "base-benchmark plan" in 45 CFR 156.100 is distinct from the term "EHB-benchmark plan" as defined in 45 CFR 156.20.

In a 2012 FAQ, HHS stated that the Departments would consider a self-insured group health plan, a large group market health plan, or a grandfathered group health plan to have used a permissible definition of EHB under section 1302(b) of the Affordable Care Act if the definition was one of the potential EHB base-benchmark plans that, at the time, States could have chosen from as the standard for EHB in their State.⁴¹ At the time, this list of potential EHB-benchmark plans included over 510 EHB base-benchmark plans that were authorized by the Secretary for a State or the District of Columbia⁴² to select, as each State and the District of Columbia has a choice of ten possible benchmark plans. All of these potential plans were “authorized” in the sense that they were potential EHB benchmark plans that could be selected by a State or the District of Columbia under the EHB regulations. This approach was intended to provide plans and issuers not subject to the EHB rules with flexibility to define what constitutes EHB under their respective plan for purposes of the limits in PHS Act section 2711. Since that time, each State and the District of Columbia has selected or defaulted to a single EHB-benchmark option, and that is the only benchmark plan “authorized” to be used for defining EHB in that State or the District of Columbia.

Given the enforcement challenges for Federal and State regulators and difficulties for participants, beneficiaries, and enrollees in ascertaining what benefits under their respective plans constitute EHB posed by a choice of over 500 plans, the Departments are codifying their interpretation that a “reasonable interpretation of the term ‘essential health benefits’” includes only those EHB base-benchmarks that, in fact, have been selected, whether by active State selection or by default to be the EHB base-benchmark plan for a State, rather than all plans that are potentially authorized.

In addition to the foregoing base-benchmark plans, there are three base-benchmark plan options not currently among those a State or the District of Columbia has either selected or had assigned by default that the Departments believe should also continue to be made available for plans and issuers not subject to EHB requirements. These three plan options are the current base-benchmark plan options under the Federal Employees Health Benefit Program (FEHBP) specified at 45 CFR 156.100(a)(3) (the three largest FEHBP plans available to all Federal employees nationally). These base-benchmark plan options are unique among base-benchmark plans in that they are available nationally, and thus can be utilized to determine what benefits would be categorized as EHBs for those employers who provide health coverage to employees throughout the United States and are not situated only in a single State.

Thus, under these final regulations, group health plans (and health insurance coverage offered in connection with such plans) and grandfathered individual market coverage that are not required to provide EHB may select among any of the 51 EHB base-benchmark plans identified under 45 CFR 156.100 and selected by a State or the District of Columbia and the FEHBP base-benchmark plan, as applicable for plan years beginning on or after January 1, 2017, for purposes of determining which benefits cannot be subject to annual and lifetime dollar limits. The current list of the 51 proposed EHB base-benchmark plans selected by the States for 2017 can be found at <https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html>. HHS anticipates publishing the final list later this month.

2. Out-of-network benefits

The Departments have been asked whether the scope of the prohibition on lifetime and annual dollar limits in PHS

Act section 2711 applies only to in-network benefits as opposed to both in-network and out-of-network benefits. The statute and interim final regulations made no distinction between in-network or out-of-network benefits. Therefore, lifetime and annual dollar limits on essential health benefits are generally prohibited, regardless of whether such benefits are provided on an in-network or out-of-network basis. These final regulations incorporate this clarification.

3. End of Waiver Program

Under PHS Act section 2711, for plan years beginning before January 1, 2014, the Departments were given authority to define restricted annual dollar limits to ensure that access to needed services was made available with minimal impact on premiums. As noted in the preamble to the 2010 interim final regulations, in order to mitigate the potential for premium increases for all plans and policies, while at the same time ensuring access to EHB, the interim final regulations adopted a three-year phased approach for restricted annual dollar limits, with the dollar limit increasing for each year of the three year period. Annual dollar limits, including restricted annual dollar limits, are not allowed for plan years (in the individual market, policy years) beginning on or after January 1, 2014, except for grandfathered individual health insurance coverage.

Some previously widely available low-cost coverage was designed with low maximum benefits and did not meet the phased in restricted annual dollar limits, such as stand-alone health reimbursement arrangements (HRAs)⁴³ and so-called “mini med” plans. In order to ensure that individuals with such limited coverage would not be denied access to needed services or experience more than a minimal impact on premiums, the interim final regulations also provided for HHS to establish a program under which the re-

⁴¹See Q10 of Frequently Asked Questions on Essential Health Benefits Bulletin, available at <https://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf>.

⁴²Initially, issuers in the territories were subject to the EHB requirement and also had potential benchmarks to choose from under the EHB regulations. A change in the interpretation of the statute resulted in issuers in the territories being exempt from the EHB rules. See Letter to Gary R. Francis, Commissioner, Office of Lieutenant Governor, Virgin Islands, dated July 16, 2014, available at <https://www.cms.gov/CCIIO/Resources/Letters/Downloads/letter-to-Francis.pdf>.

⁴³An HRA is an arrangement that is funded solely by an employer and that reimburses an employee for medical care expenses (as defined under Code section 213(d)) incurred by the employee, or his spouse, dependents, and any children who, as of the end of the taxable year, have not attained age 27, up to a maximum dollar amount for a coverage period. IRS Notice 2002-45, 2002-02 CB 93; Revenue Ruling 2002-41, 2002-2 CB 75. This reimbursement is excludable from the employee’s income. Amounts that remain at the end of the year generally can be used to reimburse expenses incurred in later years. HRAs generally are considered to be group health plans within the meaning of Code section 9832(a), section 733(a) of ERISA, and section 2791(a) of the PHS Act and are subject to the rules applicable to group health plans.

stricted annual dollar limit requirements would be waived if compliance with the limits would result in a significant decrease in access to benefits or a significant increase in premiums.⁴⁴ However, this waiver program was only available for the period during which the statute authorized restricted annual dollar limits, that is, plan years (in the individual market, policy years) beginning before January 1, 2014. Consequently such waivers are no longer available and the waiver program rules are not incorporated in these final regulations.

4. HRAs and other account based plans

In general, HRAs and other account-based group health plans are subject to the annual dollar limit prohibition under PHS Act section 2711 (annual dollar limit prohibition)⁴⁵ and will fail to comply with this prohibition because these arrangements impose an annual limit on the amount of expenses the arrangement will reimburse. However, special rules apply to certain types of account-based plans under which the HRA or other account-based health plan either is not subject to the annual dollar limit prohibition, or is considered to comply with the annual dollar limit prohibition if it is “integrated” with another group health plan that complies with the annual dollar limit prohibition.

The preamble to the interim final regulations noted that the annual dollar limit prohibition applies differently to certain account-based plans that are subject to other rules that limit the benefits available under those plans.⁴⁶ In particular, under the 2010 interim final regulations and these final regulations, certain health Flexible Spending Arrangements (health FSAs)⁴⁷ are not subject to the PHS Act section 2711 annual dollar limit prohibition because health FSAs are subject to specific limits under section 9005 of the Affordable Care Act. In addition, as noted in the preamble to the 2010 interim final regulations, the annual dollar limit prohibition does not apply to Archer Medical Savings Accounts (Archer MSAs) under section 220 of the Code and Health Savings Accounts (HSAs) under section 223 of the Code, because both types of plans are subject to specific statutory provisions that require that the contributions be limited.

These final regulations contain a clarification regarding the application of the annual dollar limit prohibition to health FSAs. Question and Answer 8 of DOL Technical Release 2013–03⁴⁸ and IRS Notice 2013–54⁴⁹ clarified that the annual dollar limit prohibition applies to a health FSA that is not offered through a Code section 125 plan. That is because the exemption for health FSAs from the annual

dollar limit prohibition is intended to apply only to health FSAs that are subject to the separate annual limitation under Code section 125(i), and health FSAs that are not offered through a Code section 125 plan are not subject to that separate statutory limit. The prior guidance provided that this clarification was intended to apply beginning September 13, 2013 and the guidance noted that the Departments intended to amend the annual dollar limit prohibition regulations to conform to the Q&A. These final regulations include this amendment.

Other types of account-based plans, such as HRAs and employer payment plans,⁵⁰ are not exempt from the annual dollar limit prohibition. However, the preamble to the interim final regulations and subsequently issued subregulatory guidance⁵¹ interpreting these rules included a number of rules regarding the application of the annual dollar limit prohibition to these types of arrangements. In particular, this guidance provides that if an HRA is “integrated” with other group health plan coverage, and the other group health plan coverage complies with the requirements of PHS Act section 2711, the combined arrangement satisfies the requirements even though the HRA imposes a dollar limit.⁵² The basic principles for when an HRA is considered integrated with other group health plan coverage have been set

⁴⁴Guidance regarding the annual dollar limit waiver program was issued at <https://www.cms.gov/ccio/resources/Regulations-and-Guidance/index.html#AnnualLimits>.

⁴⁵In accordance with Code section 9831(a)(2) and ERISA section 732(a), the market reforms, including PHS Act section 2711, do not apply to a group health plan that has fewer than two participants who are current employees on the first day of the plan year, and, in accordance with Code section 9831(b), ERISA section 732(b), and PHS Act sections 2722(b) and 2763, the market reforms, including PHS Act section 2711, also do not apply to a group health plan in relation to its provision of excepted benefits described in Code section 9832(c), ERISA section 733(c) and PHS Act section 2791(c).

⁴⁶See 75 FR 37188, 37190 (June 28, 2010).

⁴⁷In general, a health FSA is a benefit designed to reimburse employees for medical care expenses (as defined in Code section 213(d), other than premiums) incurred by the employee, or the employee’s spouse, dependents, and any children who, as of the end of the taxable year, have not attained age 27. See Employee Benefits—Cafeteria Plans, 72 FR 43938, 43957 (August 6, 2007) (proposed regulations; to be codified, in part, once final, at 26 CFR 1.125-5); Code section 105(b) and 106(c). Contributions to a health FSA offered through a cafeteria plan satisfying the requirements of Code section 125 do not result in gross income to the employee. Code section 125(a).

⁴⁸Technical Release 2013-03, available at www.dol.gov/ebsa/pdf/tr13-03.pdf.

⁴⁹2013–40 IRB 287.

⁵⁰An employer payment plan is a group health plan under which an employer reimburses an employee for some or all of the premium expenses incurred for an individual health insurance policy, such as a reimbursement arrangement described in Revenue Ruling 61–146, 1961–2 CB 25, or arrangements under which the employer uses its funds to directly pay the premium for an individual health insurance policy covering the employee.

⁵¹Five items of guidance have been issued on this topic: (1) Affordable Care Act Implementation FAQs Part XI, available at (<http://www.dol.gov/ebsa/faqs/faq-aca11.html>) or http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html; (2) IRS Notice 2013-54 and DOL Technical Release 2013-03, issued on September 13, 2013; (3) IRS FAQ on Employer Healthcare Arrangements available at <http://www.irs.gov/Affordable-Care-Act/Employer-Health-Care-Arrangements>; (4) Affordable Care Act Implementation FAQs Part XXII, available at <http://www.dol.gov/ebsa/faqs/faq-aca22.html> or <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-XXII-FINAL.pdf>; and (5) IRS Notice 2015–17, issued on February 18, 2015. See also 75 FR 37188 (June 28, 2010). This guidance, much of which is not directly addressed in these final regulations, continues to be in effect.

⁵²Issues also arise for account-based group health plans under PHS Act section 2713, which requires non-grandfathered group health plans (or health insurance issuers offering group health insurance plans) to provide certain preventive services without imposing any cost-sharing requirements for these services. The Departments have issued guidance providing that, similar to the analysis of the annual dollar limit prohibition, an HRA that is integrated with a group health plan will comply with the preventive services requirements if the group health plan with which the HRA is integrated complies with the preventive services requirements. Also, a group health plan, including an HRA, used to purchase coverage on the individual market is not integrated with that individual market coverage for purposes of the preventive services requirements and therefore will fail to comply with the preventive services requirements because an HRA or similar arrangement does not provide preventive services without cost-sharing in all instances. See DOL Technical Release 2013–03 and IRS Notice 2013–54.

forth in various forms of subregulatory guidance and have been included in these final regulations.

These final regulations clarify the scope of arrangements, in addition to HRAs, that can be integrated with other group health plan coverage by defining and referring to “account-based plans.” Account-based plans are employer-provided group health plans that provide reimbursements of medical expenses other than individual market policy premiums, with the reimbursement subject to a maximum fixed dollar amount for a period. Examples of account-based plans include health FSAs and medical reimbursement plans that are not HRAs, in addition to HRAs. Account-based plans that do not qualify as excepted benefits⁵³ generally are subject to the market reforms (except that health FSAs offered through a Code section 125 plan are not subject to the annual dollar limit prohibition), including the preventive services requirements under PHS Act section 2713. If the other group health plan coverage with which an account-based plan is integrated complies with the requirements under PHS Act sections 2711 and 2713, the account-based plan also complies with those requirements because, in that case, the combined benefit satisfies those requirements.⁵⁴

The Departments’ prior guidance regarding when an HRA is considered integrated with another group health plan provides two methods for integration, each of which has been added to the final regulations and extended to other account-based plans. In addition to various other requirements, each integration method requires that under the terms of the HRA or other account-based plan, (1) an employee (or former employee) must be permitted to permanently opt out of and waive future reimbursements from the account-based plan at least annually, and (2) upon termi-

nation of employment either remaining funds are forfeited or the employee is allowed to opt out of and waive future reimbursements under the account-based plan.

Stakeholders have requested clarification regarding whether for this purpose a forfeiture of amounts or a waiver of reimbursements under an HRA includes an otherwise permanent forfeiture or waiver, if the amounts will be reinstated or the waiver will be discontinued upon a fixed date or death. The Departments interpret the prior guidance to provide, and the final regulations clarify, that forfeiture or waiver occurs even if the forfeited amounts or waived reimbursements may be reinstated upon a fixed date, a participant’s death, or the earlier of the two events (the reinstatement event). For this purpose, an HRA is considered forfeited or waived prior to a reinstatement event only if the participant’s election to forfeit or waive is irrevocable, meaning that, beginning on the effective date of the election, the participant and the participant’s beneficiaries have no access to amounts credited to the HRA until the reinstatement event.⁵⁵ This means that the HRA may not be used to reimburse or pay medical expenses incurred during the period after the forfeiture or waiver and prior to reinstatement. An HRA need not provide for reinstatement of forfeited amounts or waived reimbursements to be integrated with a non-HRA group health plan. The final regulations reflect this clarification, and this clarification applies for integration of HRAs as well as other account-based plans, as defined in the regulations.

The Departments’ prior guidance regarding integration of an HRA or other account-based plan with another group health plan further provides that integration requires, among other requirements, that the plan sponsor offering the HRA or

other account-based plan also offer to the employee another group health plan (other than the HRA or other account-based plan). On February 18, 2015, Treasury and IRS issued Notice 2015–17, which, in Q&A3, provided for integration of a premium reimbursement arrangement for an employee’s Medicare part B or D premiums for purposes of the annual dollar limit prohibition and the preventive services requirements under PHS Act section 2713 if the arrangement meets certain conditions and the employer offers the employee another group health plan.⁵⁶ However, Notice 2015–17 provided that the premium reimbursement arrangement for an employee’s Medicare part B or D premiums could not be integrated with Medicare coverage to satisfy the market reforms because Medicare coverage is not a group health plan. In response to this prior guidance, stakeholders have indicated that employers with fewer than 20 employees are unable to meet the integration test set out in Notice 2015–17 for Medicare part B or D premium reimbursement arrangements. That is because these employers that offer group health plan coverage are not required by the applicable Medicare secondary payer rules to offer group health plan coverage to their employees who are eligible for Medicare coverage, and some issuers of insurance for group health plans do not allow these smaller employers to offer group health plan coverage to their employees who are eligible for Medicare coverage. In response to these concerns, these regulations now provide a special rule for employers with fewer than 20 employees that are not required to offer their group health plan coverage to employees who are eligible for Medicare coverage, and that offer group health plan coverage to their employees who are not eligible for Medicare, but not to their employees who are eligible for Medicare coverage.

⁵³Health FSAs will be considered to provide only excepted benefits if the employer also makes available group health plan coverage that is not limited to excepted benefits and the health FSA is structured so that the maximum benefit payable to any participant cannot exceed two times the participant’s salary reduction election for the health FSA for the year (or, if greater, cannot exceed \$500 plus the amount of the participant’s salary reduction election). See 26 CFR 54.9831–1(c)(3)(v), 29 CFR 2590.732(c)(3)(v), and 45 CFR 146.145(c)(3)(v).

⁵⁴See Affordable Care Act Implementation FAQs Part XIX, available at <http://www.dol.gov/ebsa/faqs/faq-aca19.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs19.html.

⁵⁵During a period in which an HRA has been forfeited or waived prior to a reinstatement event, the participant is considered not covered by the HRA. For a former employee (such as a retiree), an individual’s right to have a forfeited or waived HRA reinstated upon a reinstatement event will not prevent the individual from receiving the premium tax credit under § 36B during the period after forfeiture or waiver and prior to reinstatement, if the individual is otherwise eligible for a premium tax credit. See 26 CFR § 1.36B–2(c)(3)(i), proposed § 1.36B–2(c)(3)(iv).

⁵⁶Notice 2015–17 provides special rules for integration of Medicare Part B and D premium reimbursement arrangements and TRICARE-related HRAs with other group health plans, along with various other related pieces of guidance. That guidance continues to apply but is not repeated in these final regulations.

For these employers, a premium reimbursement arrangement for Medicare part B or D premiums may be integrated with Medicare (and deemed to satisfy) the annual dollar limit prohibition and the preventive services requirements under PHS Act section 2713 if the employees who are not offered the other group health plan coverage would be eligible for that group health plan but for their eligibility for Medicare. These employers may use either of the non-Medicare specific integration tests, as applicable, for account-based plans for employees who are not eligible for Medicare.

Although in certain circumstances HRAs and other account-based plans may be integrated with another group health plan to satisfy the annual dollar limit prohibition, these final regulations incorporate the general rule set forth in prior subregulatory guidance clarifying that an HRA and other account-based plans may not be integrated with individual market coverage, and therefore an HRA or other account-based plan used to reimburse premiums for the individual market coverage fails to comply with PHS Act section 2711.

These final regulations, however, do not incorporate all of the other subregulatory guidance concerning the application of the Affordable Care Act to HRAs and other account-based plans. It has come to the Departments' attention that there are a wide variety of account-based products being marketed, often with subtle but insubstantial differences, in an attempt to circumvent the guidance set forth by the Departments on the application of the annual dollar limit prohibition and the preventive services requirements to account-based plans. The Departments intend to continue to address these specific instances of noncompliance. The subregulatory guidance not specifically addressed in these final regulations continues to apply and the Departments will continue to address additional situations as necessary.

D. PHS Act Section 2712, Prohibition on Rescissions (26 CFR 54.9815–2712, 29 CFR 2590.715–2712, 45 CFR 147.128)

PHS Act section 2712, as added by the Affordable Care Act, provides that a group health plan or health insurance issuer offering group or individual health insurance coverage must not rescind coverage unless a covered individual commits fraud or makes an intentional misrepresentation of material fact. This standard applies to all rescissions, whether in the group or individual insurance market, or self-insured coverage. These rules also apply regardless of any contestability period of the plan or issuer. On June 28, 2010, the Departments issued interim final regulations implementing PHS Act section 2712.⁵⁷ The interim final regulations included several clarifications regarding the standards for rescission, including that the rules of PHS Act section 2712 apply whether the coverage is rescinded for an individual or a group. The Departments also issued Affordable Care Act Implementation FAQs Part II Q7, which clarified when retroactive terminations in the 'normal course of business' would not be considered rescissions.⁵⁸ These final regulations finalize the 2010 interim final regulations without substantial change and incorporate the clarifications issued thus far in subregulatory guidance.

1. Definition of rescission

Under the interim final regulations and these final regulations, a rescission is a cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats an insurance policy as void from the time of an individual's or group's enrollment is a rescission, whether the cancellation is a result of the issuer subsequently determining that a valid insurance contract does not exist or the insurance contract was entered into despite its noncompliance with applicable law. As another example, a cancellation that voids benefits paid up to a year before

the cancellation is also a rescission. However, a cancellation or discontinuance of coverage is not a rescission if it has only prospective effect or to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. Other provisions of Federal and State law limit the grounds for prospective cancellations of coverage, including PHS Act section 2703 regarding guaranteed renewability of coverage and PHS Act section 2705 regarding non-discrimination in rules for eligibility (or continued eligibility) based on health status.

Under PHS Act section 2712, rescission is not prohibited if a covered individual commits fraud or makes an intentional misrepresentation of material fact. Some commenters recommended that the Departments define the term "material fact." These final regulations decline this suggestion. However, the Departments have addressed whether providing false or inaccurate information concerning tobacco use is considered a misrepresentation of material fact for this purpose. HHS published final regulations under PHS Act section 2701 (regarding fair health insurance premiums) on February 13, 2013.⁵⁹ In the preamble to those regulations, HHS stated that, with respect to an individual who is found to have reported false or inaccurate information about their tobacco use, the individual may be charged the appropriate premium that should have been paid retroactive to the beginning of the plan year. However, as stated in the preamble, the "remedy of recoupment renders any misrepresentation with regard to tobacco use no longer a 'material' fact for purposes of rescission under PHS Act section 2712 and its implementing regulations," and therefore, coverage cannot be rescinded on such basis. The Departments may provide further guidance regarding the definition of a "material fact" for purposes of rescission under PHS Act section 2712 if additional questions arise.

⁵⁷75 FR 37188 (June 28, 2010).

⁵⁸Affordable Care Act Implementation FAQs Part II, available at <http://www.dol.gov/ebsa/faqs/faq-aca2.html> or https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs2.html.

⁵⁹78 FR 13406, 13414 (February 13, 2013).

2. Scope and Application

The statutory prohibition related to rescissions is not limited to rescissions based on prior medical history, rather it precludes plans and issuers from rescinding coverage under any circumstances except as provided in the statute and regulations. For example, coverage cannot be rescinded because an individual makes a mistake on an insurance application or enrollment form. An example in both the interim final regulations and in these final regulations clarifies that some plan errors (such as mistakenly covering a part-time employee for a period of time under a plan that only covers full-time employees) may be cancelled prospectively once identified, but not retroactively rescinded unless there was fraud or intentional misrepresentation of a material fact by the employee.

The Departments received comments on the interim final regulations stating that some employers' human resource departments may reconcile lists of eligible individuals with their plan or issuer via data feed only once per month, and that routine enrollment adjustments in the normal course of business should not be considered a rescission.

In response to these comments, the Departments issued an FAQ concerning rescissions on October 8, 2010.⁶⁰ The FAQ stated that if a plan covers only active employees (subject to the COBRA continuation of coverage provisions) and an employee pays no premiums for coverage after termination of employment, the Departments do not consider the retroactive elimination of coverage back to the date of termination of employment, due to delay in administrative record-keeping, to be a rescission. Similarly, if a plan does not cover ex-spouses and the plan is not notified of a divorce (subject to the COBRA continuation coverage provisions), and the full COBRA premium is not paid by the employee or ex-spouse for coverage, the Departments do not consider a plan's termination of coverage retroactive to the divorce to be a rescission.⁶¹

3. Termination of Coverage Initiated by Participant, Beneficiary, or Enrollee

The Departments have been asked whether the rescission rules prohibit a plan or issuer from retroactively terminating coverage at the request of a participant, beneficiary, or enrollee. In the Departments' view, the statutory provision was enacted by Congress to protect individuals against potential abuses by group health plans and health insurance issuers; it was not intended to prevent individuals from exercising their rights and privileges under the terms of the plan or coverage in accordance with applicable State law, where they are acting voluntarily and without coercion by the plan or issuer. Moreover, HHS regulations at 45 CFR 155.430, which govern termination of enrollment in the Exchange, permit enrollees and the Exchange to initiate a retroactive termination of enrollment in a QHP through the Exchange, including instances where the enrollee has the right to terminate coverage under applicable State law (such as State "free look" cancellations laws).⁶² For these reasons, the Departments clarify in these final regulations that a retroactive cancellation or discontinuance of coverage is not a rescission if (1) it is initiated by the individual (or by the individual's authorized representative) and the employer, sponsor, plan, or issuer does not, directly or indirectly, take action to influence the individual's decision to cancel or discontinue coverage retroactively, or otherwise take any adverse action or retaliate against, interfere with, coerce, intimidate, or threaten the individual; or (2) it is initiated by the Exchange pursuant to 45 CFR 155.430 (other than under paragraph (b)(2)(iii)). The Departments may issue additional subregulatory guidance if abusive situations or questions arise.

4. Interaction with Internal Appeals and External Review

Commenters requested that these final regulations provide that individuals have

the right to appeal a rescission to an independent third party. PHS Act section 2719 and its implementing regulations address internal claims and appeals and external review of adverse benefit determinations. Under the Department of Labor's claims procedure regulation at 29 CFR 2560.503-1 (the DOL claims procedure regulation), adverse benefit determinations eligible for internal claims and appeals processes generally include denial, reduction, termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including a denial, reduction, termination, or failure to make a payment based on the imposition of a pre-existing condition exclusion, a source of injury exclusion, or other limitation on covered benefits. The Departments' regulations under PHS Act section 2719 broaden the definition of "adverse benefit determination" to include rescissions of coverage. Therefore, rescissions of coverage are also eligible for internal claims and appeals and external review for non-grandfathered health plans, whether or not the rescission has an adverse effect on any particular benefit at the time of an appeal. The regulations under PHS Act section 2719 also contain provisions requiring coverage to remain effective pending the outcome of an internal appeal.

5. Interaction with COBRA Continuation Coverage

COBRA provides for a temporary continuation of group health coverage that would otherwise be lost due to certain life events. COBRA requires group health plans to offer continuation coverage to covered employees, former employees, spouses, former spouses, and dependent children when group health coverage would be terminated due to the following: the death of a covered employee; termination or reduction in the hours of a covered employee's employment for reasons other than gross misconduct; a covered employee's becoming entitled to Medicare; divorce or legal separation of a covered employee and spouse; and a child's

⁶⁰Affordable Care Act Implementation FAQs Part II, Q7 at <http://www.dol.gov/ebsa/pdf/faq-aca2.pdf> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs2.html.

⁶¹In such situations, COBRA may require coverage to be offered for up to 36 months if the COBRA applicable premium is paid by the qualified beneficiary.

⁶²State "free look" cancellation laws are laws permitting an individual to cancel coverage within a certain time period, even following the effectuation of the enrollment.

loss of dependent status (and therefore coverage) under the plan.

COBRA sets forth rules for how and when continuation coverage must be offered and provided, how employees and their families may elect continuation coverage, and what circumstances justify terminating continuation coverage. COBRA allows plans to continue coverage during an initial 60-day election period and allows plans to continue providing coverage during the 30-day grace periods for each premium payment. If a qualified beneficiary fails to pay for coverage during the initial election period, or fails to pay in full before the end of a grace period, continuation coverage may be terminated retroactively under COBRA.

Several commenters sought clarification about the interaction of the COBRA continuation provisions with the prohibition against rescissions. The Departments clarify that the regulatory exception to the prohibition on rescission for failure to timely pay required premiums or contributions toward the cost of coverage also includes failure to timely pay required premiums towards the cost of COBRA continuation coverage. Accordingly, if a group health plan requires the payment of a COBRA premium to continue coverage after a qualifying event and that premium is not paid by the applicable deadline, the prohibition on rescission is not violated if the plan retroactively terminates coverage due to a failure to elect and pay for COBRA continuation coverage.

6. Notice of Rescission

Consistent with PHS Act section 2712, under the interim final regulations and these final regulations, a plan or issuer must provide at least 30 calendar days advance written notice to each participant (in the individual market, primary subscriber) who would be affected before coverage may be rescinded (where per-

mitted). This provides individuals time to appeal the decision or enroll into new coverage. This notice is required regardless of whether it is a rescission of group or individual coverage; or whether, in the case of group coverage, the coverage is insured or self-insured, or the rescission applies to an entire group or only to an individual within the group.

Some commenters recommended the 30-day notice of rescission be coordinated with the rules for providing notices of adverse benefit determinations under the Departments' internal appeals and external review regulations under PHS Act section 2719. Other commenters made specific suggestions regarding the content of the notice, such as that the notice indicate the basis for the rescission and include an explanation of the remedies available to the individual.

Under PHS Act section 2719, the interim final regulations, and these final regulations, a plan or issuer must provide notice to individuals, in a culturally and linguistically appropriate manner, of the reason or reasons for an adverse benefit determination or final internal adverse benefit determination (including a rescission of coverage) and a description of available internal appeals and external review processes, including information on how to initiate an appeal. The Departments encourage plans and issuers to coordinate notices related to rescissions and appeal procedures to the extent possible.

E. PHS Act section 2714, Coverage of Dependents to Age 26 (26 CFR 54.9815-2714, 29 CFR 2590.715-2714, 45 CFR 147.120)

PHS Act section 2714, as added by the Affordable Care Act, provides that a group health plan or a health insurance issuer offering group or individual health insurance coverage that makes available dependent coverage⁶³ of children must

make such coverage available for children until attainment of 26 years of age.⁶⁴ On May 13, 2010, the Departments issued interim final regulations implementing PHS Act section 2714 and requesting comment.⁶⁵ After issuance of the 2010 interim final regulations, the Departments released Affordable Care Act Implementation FAQs Parts I and V to address various requests for clarifications under PHS Act section 2714.⁶⁶ These final regulations adopt the 2010 interim final regulations without substantial change and incorporate the clarifications issued thus far in subregulatory guidance.

1. Restrictions on Plan Definition of Dependent

a. Definition of Dependent – Based on Relationship Between Child and Participant

PHS Act section 2714 provides that the “Secretary shall promulgate regulations to define the dependents to which coverage shall be made available” under the dependent coverage provision. The 2010 interim final regulations provided that with respect to a child who has not attained age 26, a plan or issuer may not define dependent for purposes of eligibility for dependent coverage of children other than in terms of a relationship between a child and the participant. For example, a plan or issuer may not deny or restrict coverage for a child who has not attained age 26 based on the child’s financial dependency (upon the participant or any other person), residency with the participant or with any other person, student status, employment, or any combination of those factors. Additional examples of factors that cannot be used for defining dependent for purposes of eligibility (or continued eligibility) in-

⁶³For purposes of these final regulations, dependent coverage means coverage of any individual under the terms of a group health plan, or group or individual health insurance coverage, because of the relationship to a participant (in the individual market, primary subscriber).

⁶⁴Under section 1004(d) of the Reconciliation Act and IRS Notice 2010-38, 2010-20 IRB 682, released on April 27, 2010, employers may exclude from the employee’s income the value of any employer-provided health coverage for an employee’s child for the entire taxable year the child turns 26 if the coverage continues until the end of that taxable year. This means that if a child turns 26 in March, but stays on the plan past December 31st (the end of most individual’s taxable year), the health benefits up to December 31st can be excluded from the employee’s income.

⁶⁵See 75 FR 27122 (May 13, 2010).

⁶⁶Affordable Care Act Implementation FAQs Part I, Q&A-14, available at <http://www.dol.gov/ebsa/faqs/faq-aca.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html and Affordable Care Act Implementation FAQs Part 5 and Mental Health Parity Implementation, Q&A 5, available at <http://www.dol.gov/ebsa/faqs/faq-aca5.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html and <http://www.dol.gov/ebsa/faqs/faq-aca5.html>.

clude eligibility for other coverage⁶⁷ and marital status of a dependent child.⁶⁸ Because the statute does not distinguish between coverage for minor children and coverage for adult children under age 26, these factors also may not be used to determine eligibility for dependent coverage of minor children.

It has come to the Departments' attention that certain plans that utilize an HMO design impose restrictions on eligibility that require participants and beneficiaries to work, live or reside in the HMO service area. While these provisions on their face appear to be generally applicable, the overwhelming impact of such provisions affects dependent children, who would otherwise be required to be covered pursuant to PHS Act section 2714. For example, a plan that utilizes an HMO design that requires participants and beneficiaries to work, live or reside in the service area would not permit a dependent child covered under the parent's plan to continue to be eligible for the plan if the dependent child moves out of the HMO's service area to attend college. Under the same plan, however, most employees and their spouses would work, live or reside in the service area.

These final regulations provide that, to the extent such restrictions are applicable to dependent children up to age 26, eligibility restrictions under a plan or coverage that require individuals to work, live or reside in a service area violate PHS Act section 2714. (This rule does not relate to the extent to which a plan must cover participants or provide services outside of its service area). While eligibility provisions of general applicability are usually outside the scope of PHS Act section 2714, due to the disproportion-

ate effect on dependent children, these final regulations do not permit eligibility provisions under a plan or coverage based on service area, to the extent such restrictions are applicable to dependent children up to age 26, even if such restrictions are intended to apply generally to all participants and beneficiaries under the plan.

b. Definition of Child

PHS Act section 2714 does not require a plan to provide dependent coverage of children but instead provides that if a plan does provide dependent coverage of children it must continue to make such coverage available until the child turns age 26.⁶⁹ Neither PHS Act section 2714 nor the interim final regulations defined the term child for purpose of the dependent coverage provision.⁷⁰

In response to comments requesting guidance on the definition of the term child and questions from stakeholders, the Departments released an FAQ⁷¹ stating that a group health plan or issuer will not fail to satisfy the dependent coverage provision merely because it conditions health coverage on support, residency, or other dependency factors for individuals under age 26 who are not described in section 152(f)(1) of the Code. For an individual not described in section 152(f)(1), such as a grandchild or niece, a plan may impose additional conditions on eligibility for health coverage, such as a condition that the individual be a dependent for income tax purposes. The FAQ also provided that a plan or issuer does not fail to satisfy the requirements of PHS Act section 2714 or its implementing regulations because the plan limits health coverage for children

until the child turns 26 to only those children who are described in section 152(f)(1) of the Code. These final regulations incorporate the clarifications provided in the FAQ.

Some commenters requested that the Departments interpret PHS Act section 2714 to apply to grandchildren. The statute and the 2010 interim final regulations provided that nothing in PHS Act section 2714 requires a plan or issuer to make available coverage for a child of a child receiving dependent coverage. Because the statute specifically provides that plans and issuers are not required to make coverage available to grandchildren, these final regulations do not adopt this suggestion.

2. Uniformity Irrespective of Age

The 2010 interim final regulations provided that the terms of the plan or health insurance coverage providing dependent coverage of children cannot vary based on the age of a child, except for children age 26 or older. The 2010 interim final regulations contained examples illustrating that age-based surcharges violate the uniformity requirement but that cost of coverage increases for tiers with more covered individuals do not violate this requirement because such an increase applies without regard to the age of any child. The 2010 interim final regulations also contained an example demonstrating that a plan that limits the benefit packages offered based on the age of dependent children violates the uniformity requirement. These final regulations retain these examples.

⁶⁷See section II.H.1. of this preamble, entitled "Special Rule Relating to Dependent Coverage of Children to Age 26 for Grandfathered Group Health Plans," for discussion of an out-of-date special rule for grandfathered plans regarding adult children eligible for other coverage.

⁶⁸The Affordable Care Act, as originally enacted, required plans and issuers to make dependent coverage available only to a child "who is not married." This language was struck by section 2301(b) of the Reconciliation Act. Accordingly, under the interim final regulations and these final regulations, plans and issuers may not limit dependent coverage of children based on whether a child is married (however, a plan or issuer is not required under the final regulations to cover the spouse of an eligible child).

⁶⁹In general, under section 4980H of the Code, certain employers (applicable large employers) must either offer health coverage to their full-time employees (and their dependents) or potentially pay an assessable payment if at least one full-time employee receives a premium tax credit for purchasing individual coverage on an Affordable Insurance Exchange. For purposes of section 4980H, the term dependent means "a child (as defined in section 152(f)(1) of the Code but excluding a stepson, stepdaughter or an eligible foster child (and excluding any individual who is excluded from the definition of dependent under section 152 of the Code by operation of section 152(b)(3) of the Code)) of an employee who has not attained age 26. A child attains age 26 on the 26th anniversary of the date the child was born. A child is a dependent for purposes of section 4980H for the entire calendar month during which he or she attains age 26. Absent knowledge to the contrary, applicable large employer members may rely on an employee's representation about that employee's children and the ages of those children. The term dependent does not include the spouse of an employee." See 26 CFR 54.4980H-1(a)(12). Under section 152(f)(1) of the Code a child means an individual who is (i) a son, daughter, stepson, or stepdaughter of the taxpayer (including a legally adopted child or an individual lawfully placed for adoption with the taxpayer) or (ii) an eligible foster child of the taxpayer.

⁷⁰Under section 1004(d) of the Reconciliation Act and IRS Notice 2010-38, child means child as defined in section 152(f)(1) of the Code.

⁷¹Affordable Care Act Implementation FAQs Part I, Q&A 14 (released on September 20, 2010), available at <http://www.dol.gov/ebsa/faqs/faq-aca.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html.

Following the 2010 interim final regulations, the Departments issued an FAQ⁷² that addressed an arrangement under which a group health plan charges a copayment for physician visits that do not constitute preventive services to individuals age 19 and over, including employees, spouses, and dependent children, but waives the copayment for children under age 19. The FAQ clarifies that the Departments do not consider such an arrangement to violate the dependent coverage provision. This arrangement is permissible under the dependent coverage provision because, while the dependent coverage provision prohibits distinctions based upon age in dependent coverage of children under age 26, it does not prohibit distinctions based upon age that apply to all coverage under the plan, including coverage for employees and spouses as well as dependent children. In this situation, the copayments charged to dependent children are the same as those charged to employees and spouses. (However, with respect to individual and small group plans required to provide essential health benefits, distinctions based on age may be considered discriminatory under HHS regulations regarding essential health benefits.⁷³) The final regulations reflect the clarification contained in this FAQ.

F. PHS Act Section 2719, Internal Claims and Appeals and External Review (26 CFR 54.9815–2719, 29 CFR 2590.715–2719, 45 CFR 147.136)

PHS Act section 2719, as added by the Affordable Care Act, applies to group health plans that are not grandfathered health plans and health insurance issuers offering non-grandfathered coverage in the group and individual markets, and sets forth standards for plans and issuers regarding both internal claims and appeals and external review. With respect to internal claims and appeals processes for group health plans and health insurance issuers offering group health insurance coverage, PHS Act section 2719 provides that a non-grandfathered group health

plan or health insurance issuer offering non-grandfathered group coverage must initially incorporate the internal claims and appeals processes set forth in regulations promulgated by the Department of Labor (DOL) at 29 CFR 2560.503–1 (the DOL claims procedure regulation) and update such processes in accordance with standards established by the Secretary of Labor. Similarly, with respect to internal claims and appeals processes for individual health insurance coverage, issuers must initially incorporate the internal claims and appeals processes set forth in applicable State law and update such processes in accordance with standards established by the Secretary of HHS. With respect to external review, PHS Act section 2719 provides for either a State external review process or a Federal external review process.

The following list identifies certain regulations and subregulatory guidance that the Departments have issued to implement these requirements:

- Interim final regulations on July 23, 2010, at 75 FR 43329, implementing the internal claims and appeals and external review process requirements of PHS Act section 2719;
- Technical Release 2010 – 01, on August 23, 2010, setting forth interim procedures for Federal External Review;
- Technical Guidance, on August 26, 2010, setting forth interim procedures for Federal External Review for health insurance issuers in the group and individual markets under the Patient Protection and Affordable Care Act;
- Affordable Care Act Implementation FAQs part I, on September 20, 2010, providing guidance on outstanding questions regarding the internal claims and appeals and external review process requirements of PHS Act section 2719;
- Technical Release 2010 – 02, on September 20, 2010, establishing an enforcement grace period with respect to some of the internal claims and appeals standards set forth in the interim final regulations;
- Technical Release 2011 – 01, on March 18, 2011, extending the enforcement grace period set forth in Technical Release 2010 – 02;
- Technical Release 2011 – 02, on June 22, 2011, setting forth interim standards for a State-administered external review process authorized under section 2719(b)(2) of the PHS Act and paragraph (d) of the interim final regulations;
- Amendments to the interim final regulations on June 24, 2011, at 76 FR 37207, with respect to the internal claims and appeals and external review provisions of PHS Act section 2719 in response to comments received regarding the interim final regulations; and
- Technical Release 2013 – 01, on March 15, 2013, extending the interim standards for a State-administered external review process authorized under section 2719(b)(2) of the PHS Act and paragraph (d) of the interim final regulations set forth in Technical Release 2011 – 02.

After consideration of the comments and feedback received from stakeholders, the Departments are publishing these final regulations. These final regulations adopt the interim final regulations, as previously amended, without substantial change. These final regulations also codify some of the enforcement safe harbors, transition relief, and clarifications set forth through subregulatory guidance. Contemporaneous with the issuance of these final regulations, the Department of Labor is issuing a proposed regulation to amend the DOL claims procedure regulations under 29 CFR 2560.503–1, as applied to plans providing disability benefits. The amendment would revise and strengthen the current DOL claims procedure regulations regarding claims and appeals applicable to plans providing disability benefits primarily by adopting the protections and standards for internal claims and appeals applicable to group health plans under PHS Act section 2719 and these final regulations.

⁷²Affordable Care Act Implementation Part V and Mental Health Parity Implementation FAQs, Q&A 5 (released on December 22, 2010), available at <http://www.dol.gov/ebsa/faqs/faq-aca5.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html.

⁷³See 45 CFR 156.125.

1. Internal Claims and Appeals

In addition to the requirement in PHS Act section 2719(a) that plans and issuers must initially incorporate the internal claims and appeals processes set forth in the DOL claims procedure regulation, the interim final regulations, as amended, provide further standards for compliance with the internal claims and appeals requirements of PHS Act 2719.⁷⁴ Specifically, under these requirements, in addition to complying with the internal claims and appeals processes set forth in the DOL claims procedure regulation, plans and issuers are required to comply with the following standards: (1) The scope of adverse benefit determinations eligible for internal claims and appeals includes a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time); (2) A plan or issuer must notify a claimant of a benefit determination (whether adverse or not) with respect to a claim involving urgent care as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the receipt of the claim by the plan or issuer; (3) Clarifications with respect to full and fair review, such that plans and issuers are clearly required to provide the claimant (free of charge) with new or additional evidence considered, relied upon, or generated by (or at the direction of) the plan or issuer in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the claimant to respond to such new evidence or rationale; (4) Clarifications regarding conflicts of interest, such that decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to an individual, such as a claims adjudicator or medical expert, must not be based upon the likelihood that the individual will support the denial of benefits; (5) Notices must be provided in a culturally and linguistically appropriate manner, as required by the statute, and as set forth in paragraph (e) of the interim final regulations, as amended; (6) Notices to claimants must provide additional content, in-

cluding that any notice of adverse benefit determination or final internal adverse benefit determination must include information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; and (7) With the exception of de minimis violations under specified circumstances, if a plan or issuer fails to adhere to all the requirements of the interim final regulations, as amended, the claimant is deemed to have exhausted the plan's or issuer's internal claims and appeals process, and the claimant may initiate any available external review process or remedies available under ERISA or under State law.

To address certain relevant differences in the group and individual markets the interim final regulations, as amended, provided that health insurance issuers offering individual coverage must comply with three additional requirements for internal claims and appeals processes. First, initial eligibility determinations in the individual market must be included within the scope of claims eligible for internal appeals. Second, health insurance issuers offering individual coverage are only permitted to have one level of internal appeal. Third, health insurance issuers offering individual coverage must maintain records of all claims and notices associated with the internal claims and appeals process for six years. The issuer must make such records available for examination by the claimant or State, or Federal oversight agency upon request.

These final regulations generally incorporate the standards of the interim final regulations, as amended, and the Departments' associated guidance, without major change.

a. Full and fair review

The interim final regulations provided that plans and issuers must provide the claimant (free of charge) with new or additional evidence considered, relied upon,

or generated by (or at the direction of) the plan or issuer in connection with the claim, as well as any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of the final adverse benefit determination is required to be provided under the DOL claims procedure regulations. Since the issuance of the interim final regulations and subsequent subregulatory guidance, stakeholders have requested additional clarification regarding how to provide a full and fair review in accordance with the requirements set forth in the regulations.

Commenters requested additional guidance related to the timing and amount of information required to be provided in order to satisfy this requirement. Specifically, individuals asked whether such information actually must be provided automatically to participants and whether or not it would be sufficient to send participants a notice informing them of the availability of new or additional evidence or rationale. The Departments retain the requirement that plans and issuers provide the new or additional evidence or rationale automatically. In the Departments' view, fundamental fairness requires that participants and beneficiaries have an opportunity to rebut or respond to any new or additional evidence upon which a plan or issuer may rely. Therefore, plans and issuers that wish to rely on any new or additional evidence or rationale in making a benefit determination must send such new or additional evidence or rationale to participants as soon as it becomes available to the plan or issuer.

In order to comply with this requirement, a plan or issuer must send the new or additional evidence or rationale to the participant. Merely sending a notice informing participants of the availability of such information fails to satisfy this requirement. To address the narrow circumstance raised by some comments that the new or additional information could be first received so late that it would be impossible to provide it, these final regulations provide that if the new or additional evidence is received so late that it would

⁷⁴The statute requires the Secretary of Health and Human Services to set forth processes for internal claims and appeals in the individual market. Under the interim final regulations, the Secretary of Health and Human Services has determined that a health insurance issuer offering individual health insurance coverage must generally comply with all the requirements for the internal claims and appeals process that apply to group health coverage. Also, see 45 CFR 147.136 for additional requirements for coverage in the individual market.

be impossible to provide it to the claimant in time for the claimant to have a reasonable opportunity to respond, the period for providing a notice of final internal adverse benefit determination is tolled until such time as the claimant has a reasonable opportunity to respond. After the claimant responds, or has a reasonable opportunity to respond but fails to do so, the plan or issuer must notify the claimant of the benefit determination as soon as a plan or issuer acting in a reasonable and prompt fashion can provide the notice, taking into account the medical exigencies.

2. Culturally and linguistically appropriate standard (CLAS)

PHS Act section 2719 requires group health plans and health insurance issuers to provide relevant notices in a culturally and linguistically appropriate manner. The interim final regulations, as amended, set forth a requirement to provide notices in a non-English language if at least a specified percentage of residents in a county are literate only in the same non-English language. Specifically, with respect to group health plans and health insurance issuers offering group or individual health insurance coverage, the interim final regulations established that the threshold percentage of people who are literate only in the same non-English language is set at ten percent or more of the population residing in the claimant's county, as determined in guidance based on American Community Survey data published by the United States Census Bureau. Furthermore, the interim final regulations, as amended, required that each notice sent by a plan or issuer to an address in a county that meets this threshold include a one-sentence statement in the relevant non-English language about the availability of language services. In addition, under the interim final regulations, as amended, plans and issuers must provide a customer assistance process (such as a telephone hotline) with oral language services in the non-English language and provide written notices in the non-English language upon request.

In response to the culturally and linguistically appropriate standards (CLAS) set forth in the amendments to the interim final regulations described in the prior paragraph, the Departments received many comments from various stakeholders. Some commenters requested that the Departments incorporate the prior proposed CLAS (rather than the amended CLAS) into these final regulations, citing that the prior standard was less costly for plans and issuers than was stated in the proposed regulations. Other commenters requested that the threshold percentage that triggers the CLAS requirements be reduced to a lower percentage to capture a greater number of counties. Other stakeholders supported the CLAS requirements as set forth in the amendments to the interim final regulations. Stakeholders that support the amended CLAS reiterated prior comments that the Departments received that opposed the “tagging and tracking” requirement.⁷⁵

In light of all the comments received, these final regulations retain the CLAS requirements as set forth in the amendment to the interim final regulations. The Departments believe that the CLAS requirements appropriately balance the objective of protecting consumers by providing understandable notices to individuals who speak primary languages other than English with the goal of imposing reasonable language access requirements on plans and issuers. Furthermore, the Departments note that nothing in these regulations should be construed as limiting an individual's rights under Federal or State civil rights statutes, such as section 1557 of the Affordable Care Act and Title VI of the Civil Rights Act of 1964 (Title VI) which prohibits covered entities, including issuers participating in Medicare Advantage, from discriminating on the basis of race, color, or national origin. To ensure non-discrimination on the basis of national origin under Title VI, recipients are required to take reasonable steps to ensure meaningful access to their programs and activities by limited English proficient persons. (For more information, see, “Guidance to Federal Financial Assistance Recipients Regarding Title VI

Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons,” available at <http://www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html>.)

3. Extension of the Transition Period for State External Review Processes

PHS Act section 2719(b) requires that a non-grandfathered group health plan that is not a self-insured plan that is not subject to State insurance regulations and a health insurance issuer offering non-grandfathered group or individual health insurance coverage comply with an applicable State external review process if that process includes, at a minimum, the consumer protections set forth in the Uniform Health Carrier External Review Model Act issued by the National Association of Insurance Commissioners (the NAIC Uniform Model Act). Paragraph (c)(2) of the 2010 interim final regulations under PHS Act section 2719, as amended, sets forth the minimum consumer protection standards that a State external review process must include to qualify as an applicable State external review process under PHS Act section 2719(b)(1) (NAIC-parallel external review process).

Under PHS Act section 2719(b)(2), if a State's external review process does not meet the minimum consumer protection standards set forth in the NAIC Uniform Model Act (or if a plan is self-insured and not subject to State insurance regulation), group health plans and health insurance issuers in the group and individual markets in that State are required to implement an effective external review process that meets minimum standards established by the Secretary of HHS through guidance. These standards must be similar to the standards established under PHS Act section 2719(b)(1) and must meet the requirements set forth in paragraph (d) of the 2010 interim final regulations, as amended.

In June 2011, the Departments amended the July 2010 interim final regulations and announced that plans and issuers could continue to participate in a State external review process that met Federal standards that were

⁷⁵Under the interim final regulations, the CLAS standard included a “tagging and tracking requirement” which required plans and issuers, to the extent individuals request a document in a non-English language, to “tag” and “track” such request so that any future notices would be provided automatically in the non-English language.

NAIC-similar for a limited time (the NAIC-similar external review process), in anticipation that such an allowance would reduce market disruption during a transition period. Contemporaneous with the June 2011 amendment, the Departments issued guidance which, among other things, established the NAIC-similar external review process.

The Departments recognize that many States have done considerable work to bring their external review laws and processes into compliance with the NAIC Uniform Model Act and, because of those efforts, the Departments have extended the transition periods to allow States more time to meet the NAIC-parallel external review process standards. States continue to make changes to their laws through what have often proven to be complex and time consuming processes, often involving legislative changes; and it is apparent that more time is needed for some States to achieve NAIC-parallel external review processes. Therefore, the Departments are extending the NAIC-similar external review process transition period so that the last day of the transition period is December 31, 2017. Through December 31, 2017, an applicable State external review process applicable to a health insurance issuer or group health plan may be considered to meet the minimum standards of paragraph (c)(2), if it meets the temporary standards established by the Secretary in guidance for a process similar to the NAIC Uniform Model Act. During this transition period, the NAIC-similar external review process will continue to apply⁷⁶ for non-grandfathered group health plans and issuers of non-grandfathered group or individual coverage in the State.⁷⁷ This modification seeks to minimize cost and confusion for participants and enrollees, issuers, and plans alike. Furthermore, the extension will provide States that are currently in the process of making changes to external review laws time to implement NAIC-parallel external review processes. The Departments will continue to work with health insurance issuers, States, and other stakeholders to assist them in coming into compliance

with the law. Once this transition period has ended, plans and issuers in a State that has not implemented the NAIC-parallel external review process will be required to comply with a Federal external review process.

4. Federal External Review

PHS Act section 2719(b)(2) provides that plans and issuers in States without an external review process that meets the requirements of PHS Act section 2719(b)(1) or that are self-insured plans not subject to State insurance regulation shall implement an effective external review process that meets minimum standards established by the Secretary of HHS through guidance and that is similar to a State external review process described in PHS Act section 2719(b)(1). The interim final regulations reiterated this statutory requirement, and also provided additional standards, including that the Federal external review process, like the State external review process, will provide for expedited external review and additional consumer protections with respect to external review for claims involving experimental or investigational treatment. The interim final regulations also set forth the scope of claims eligible for review under the Federal external review process. The interim final regulations also established the procedural standards that apply to claimants, plans, and issuers under this Federal external review process, as well as the substantive standards under this process. These final regulations incorporate both the procedural and substantive standards established in the interim final regulations and subsequent subregulatory guidance without substantial change and with minor clarifications.

a. Scope of Federal External Review Process

The 2010 interim final regulations set forth the original scope of claims eligible for external review under the Federal external review process. Specifically, any

adverse benefit determination (including final internal adverse benefit determination) could be reviewed unless it related to a participant's or beneficiary's failure to meet the requirements for eligibility under the terms of a group health plan (for example, worker classification and similar issues were not within the scope of the Federal external review process). After considering comments received in response to the 2010 interim final regulations, the Departments suspended the original rule and temporarily narrowed its scope. The amended scope limited the Federal external review process to claims that involve (1) medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and (2) a rescission of coverage (whether or not the rescission has any effect on any particular benefit at the time). The amendments also provided two examples of claims involving medical judgment.

The Departments received mixed comments in response to the revised scope of Federal external review in the 2011 amendment to the July 2010 interim final regulations. Generally, comments supported narrowing the scope to decisions based on medical judgment and suggested permanently adopting the standards in the 2011 amendment. However, there were also commenters that objected to limiting the scope and favored the original scope as stated in the July 2010 interim final regulations. Some of these commenters stated that the description of medical judgment was ambiguous and that it was unclear how to determine whether a claim involved "medical judgment." Other commenters disagreed with the description of medical judgment, finding either the explanation was too vague or that certain information in the examples did not fall within what was normally considered medical judgment.

⁷⁶If a State enacts an NAIC-parallel law prior to January 1, 2018, coverage subject to that State law will be required to comply with the provisions of that State law, in accordance with ERISA section 731 and PHS Act section 2719 and 2724.

⁷⁷See Technical Release 2011-02, Guidance on External Review for Group Health Plans and Health Insurance Issuers Offering Group and Individual Health Coverage, and Guidance for States on State External Review Processes, June 22, 2011. The temporary standards were extended in March 15, 2013 in Technical Release 2013-01, Extension of the Transition Period for the Temporary NAIC-Similar State External Review Process under the Affordable Care Act.

Additionally, the Departments received comments requesting more clarity around the treatment of coding issues under the amended scope of Federal external review. The Departments recognize that there may be instances when a patient may have a procedure performed that is similar to another and a coding issue impacts whether coverage is provided. For example, a patient may need a stoma revision, and recent significant weight loss necessitates a procedure to remove the patient's excess skin and tissue prior to addressing the stoma. However, the skin removal procedure may be coded as a cosmetic surgery, such as an abdominoplasty or "tummy tuck", instead of as a panniculectomy, and is therefore not covered. In this case both procedures involve the removal of skin from the abdomen, but one procedure is an excluded cosmetic surgery while the other is covered so long as certain medical criteria are met. This dispute would likely be resolved via an internal appeal, but in the event that the initial decision to deny coverage was affirmed on an internal appeal, the claimant could have the claim reviewed in a Federal external review process. Medical judgment is necessary to determine whether the correct code was used in the patient's case. To the extent that a coding error such as this one involves medical judgment, the claim is within the scope of Federal external review under the July 2010 interim final regulations, as amended.

After consideration of comments, these final regulations make permanent the scope for Federal external review as set out in the 2011 amendments to the July 2010 interim final regulations, to include only an adverse benefit determination that involves medical judgment as determined by the external reviewer, or a rescission of coverage. The interim final regulations included a non-exhaustive list of adverse benefit determinations that involve medical judgment. The final regulations add two items to the list of adverse benefit determinations that involve medical judgment:

(1) a plan's or issuer's determination of whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program, and (2) a plan's or issuer's determination of whether a plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act and its implementing regulations, which generally require, among other things, parity in the application of medical management techniques. Both of these clarifications were included in preambles to regulations issued previously by the Departments.⁷⁸

b. Federal External Review Process for Self-Insured Group Health Plans

The preamble to the 2010 interim final regulations stated that the Departments will address in sub-regulatory guidance how non-grandfathered self-insured group health plans may comply with the requirements of the new Federal external review process. The Department of Labor issued Technical Releases 2010-01 and 2011-02 regarding procedures for Federal external review.⁷⁹ The technical releases set forth these procedures for non-grandfathered self-insured group health plans not subject to a State external review process. Technical Release 2011-02 also provided non-grandfathered health insurance issuers subject to a Federally-administered external review process⁸⁰ and all non-grandfathered self-insured, non-Federal governmental plans with the option of using the external review process set out in Technical Release 2010-01.

In general, under these procedures, a group health plan must first allow a claimant to file a request for Federal external review with the plan. The group health plan must then complete a preliminary review of the request within five business days following the date of receipt of the external review request. Within one business day after completion of the preliminary review, the plan must issue a notification

in writing to the claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and current contact information, including the phone number for the Employee Benefits Security Administration (toll free number 866-444-EBSA (3272)). Upon its determination that a request is eligible for external review, the group health plan must then assign an independent review organization (IRO), accredited by URAC or by a similar nationally-recognized accrediting organization, to conduct the external review. The IRO must timely notify the claimant in writing of the external review and provide the claimant 10 business days to submit additional information that the IRO must consider. The group health plan must provide the IRO with any documents and information used in making the original determination within five business days after the date of the assignment and the IRO must forward any information submitted by the claimant to the group health plan within one business day after receipt of the information. The IRO must review all information and documents timely received and must provide written notice of the final external review decision to the claimant and the group health plan within 45 days after the request for the external review. After the final external review decision, the IRO must maintain records of all associated claims and notices for six years. If the IRO has decided to reverse the original determination, then, upon receipt of the IRO's notice of this decision, the group health plan must immediately provide coverage or payment for the claim.

The technical releases also provided that a group health plan must allow a claimant to make a request for expedited external review for benefit determinations involving a medical condition for which the timeframe for completion of an expedited internal appeal or standard external review under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize

⁷⁸See 78 FR 33158, 33164 (June 3, 2013); see also 78 FR 68240, 68247-8 (November 13, 2013).

⁷⁹See Technical Release 2010-01, available at: <http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-01.pdf> and Technical Release 2011-02, available at: <http://www.dol.gov/ebsa/pdf/tr11-02.pdf>.

⁸⁰Where a State's external review process does not meet the Federal consumer protection standards, issuers and self-insured non-Federal governmental plans may choose to utilize either the Federal IRO external review process or an HHS-administered Federal external review process in which a designated Federal contractor will perform all functions of the external review.

the claimant's ability to regain maximum function. The IRO must provide a notice of the final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for expedited review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the plan.

These final regulations incorporate the guidance in Technical Releases 2010–01 and 2011–02 without substantial change. These final regulations also continue to permit non-grandfathered self-insured plans to comply with the external review process outlined in these final regulations or a State external review process if the State chooses to expand access to their State external review process to plans that are not subject to the applicable State laws.

Furthermore, these final regulations continue to provide issuers subject to a Federally-administered external review process and all self-insured, non-Federal governmental plans with the option of electing the private accredited IRO process for external review described in these final regulations or the Federally-administered external review process, which is administered by HHS (also referred to as the HHS-administered external review process).

Similar to the technical releases, these final regulations continue to provide that group health plans must assign an IRO that is accredited by URAC or by similar nationally-recognized accrediting organization to conduct the external review. Moreover, the plan must take action to protect against bias and to ensure independence. Accordingly, plans must contract with at least three IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits. (Of course, plans also

may not terminate an IRO's contract in retaliation for granting claims.) For issuers and all self-insured, non-Federal governmental plans participating in the HHS-administered external review process, the requirement to take action to protect against bias and to ensure independence is satisfied without contracting with three IROs for assignment and rotating the claims assignments among them. Under the HHS-administered external review process, there are other unique factors that ensure independence and the absence of bias such as HHS oversight and lack of privity of contract between the issuer or self-insured non-Federal governmental plan and the IRO.

After issuance of the interim final regulations and technical releases, the Departments received questions relating to self-insured group health plans contracting directly with IROs. While such a group health plan must designate an IRO to conduct any external review, neither the interim final regulations nor the technical releases require a plan to contract directly with any IRO. As clarified in the FAQs about the Affordable Care Act implementation, issued on September 20, 2010, where a self-insured plan contracts with a third party administrator that, in turn, contracts with an IRO, the standards of the technical release can be satisfied in the same manner as if the plan had contracted directly. Such a contract does not automatically relieve the plan from responsibility if there is a failure to provide an individual with external review and fiduciaries of plans that are subject to ERISA have a duty to monitor the service providers to the plan. Furthermore, plans may contract with an IRO in another State, as these final regulations do not require the plan to be located in the same State as the IRO. If additional questions arise regarding the IRO external review process, the Departments may issue additional sub-regulatory guidance.

c. Filing Fees for External Review

The Departments also received comments related to the standard allowing consumers to be charged a filing fee when

requesting external review. While the original 2004 NAIC model upon which the 2010 interim final regulations was based expressly permitted imposition of a nominal filing fee for a claimant requesting an external review, and a small number of States have adopted this approach, the 2010 NAIC model did not address this topic. Commenters on the 2010 interim final regulations indicated that the ability to charge a filing fee should be prohibited because such fees may dissuade consumers from filing an appeal, even in cases where the fee is not a financial hardship for the consumer.

The Departments find the change in the NAIC model to be important and are concerned that any fee may impose a financial hardship on some claimants or discourage them from seeking external review. Therefore, these final regulations generally prohibit the imposition of filing fees for external review on claimants. However, the Departments recognize that several States' external review processes currently applicable to group and individual coverage permit nominal filing fees. Therefore, in determining whether a State external review process provides the claimants with minimum consumer protections, these final regulations do not invalidate existing State external review processes because they permit a nominal filing fee, consistent with the 2004 NAIC model.⁸¹ Therefore, plans and coverage subject to such laws may continue to impose nominal fees for as long as such laws continue to apply. For this purpose, consistent with the interim final regulations, to be considered nominal, the filing fee must not exceed \$25, must be refunded to the claimant if the adverse benefit determination (or final internal adverse benefit determination) is reversed through external review, must be waived if payment of the fee would impose an undue financial hardship, and the annual limit on filing fees for any claimant within a single plan year must not exceed \$75. All other plans and coverage must pay the full cost of the IRO for conducting the external review, without imposing any nominal filing fee.

⁸¹Twelve States expressly authorize nominal fees: Connecticut, Hawaii, Kentucky, Massachusetts, Minnesota, New Jersey, New York, North Dakota, Rhode Island, South Dakota, Vermont, and Wyoming.

G. PHS Act Section 2719A, Patient Protections (26 CFR 54.9815–2719A, 29 CFR 2590.715–2719A, 45 CFR 147.138)

PHS Act section 2719A, as added by the Affordable Care Act provides, with respect to a non-grandfathered group health plan or health insurance issuer offering non-grandfathered group or individual health insurance coverage, rules regarding the designation of primary care providers, if a plan or issuer requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider. In addition, the statute provides requirements relating to benefits for emergency services. On June 28, 2010, the Departments issued interim final regulations implementing PHS Act section 2719A.⁸² The Departments also released Affordable Care Act Implementation FAQs Part I Q15 to address an issue with respect to emergency services.⁸³ These regulations adopt the 2010 interim final regulations without substantial change and incorporate the clarification issued in subregulatory guidance.

1. Choice of Healthcare Professional

The interim final regulations and these final regulations state that if a plan or issuer requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer must permit each participant, beneficiary, and enrollee to designate any primary care provider who is available to accept the participant, beneficiary, or enrollee and who participates in the network of the plan or issuer.

Commenters recommended clarifying that in instances where a participant, beneficiary, or enrollee is incapacitated, a family member may select the primary care provider on their behalf. Under existing State and Federal law, including ERISA, a duly authorized representative is permitted to act on behalf of a participant or beneficiary for all purposes, including the designation of a primary care provider as provided under these final regulations. The final regulations regarding

the designation of a primary care provider do not include any new text to address cases of incapacity. However, as with all of the market reform provisions, a duly authorized representative may act on behalf of a participant or beneficiary to the extent permitted under other applicable Federal and State law.

Commenters recommended that participants, beneficiaries, and enrollees be allowed to designate a provider of any specialty or licensure as their primary care provider to improve access to care. For example, commenters recommended that enrollees have the option of designating a nurse practitioner as their primary care provider. The Departments do not define primary care provider for purposes of these final regulations. The classification of who is considered a primary care provider is determined under the terms of the plan or coverage and in accordance with applicable State law.

If a plan or issuer requires or provides for the designation of a participating primary care provider for a child by a participant, beneficiary, or enrollee, the plan or issuer must permit the designation of a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if the provider participates in the network of the plan or issuer and is available to accept the child. The general terms of the plan or health insurance coverage regarding pediatric care otherwise are unaffected, including any exclusion with respect to coverage of pediatric care.

Some commenters recommended that participants, beneficiaries, or enrollees have the option to designate physicians of various pediatric sub-specialties as the child's primary care provider to improve access to specialty care without prior authorization from a primary care coordinator. For example, commenters suggested that a pediatric cancer patient with a serious chronic condition should have the option of designating a pediatric oncologist that can provide cancer treatment as well as other routine treatment as the child's primary care provider. The Departments interpret this provision to mean that if a

plan or issuer requires or provides for the designation of a participating primary care provider for a child by a participant, beneficiary, or enrollee, the plan or issuer must permit the designation of any physician (allopathic or osteopathic) who specializes in pediatrics, including pediatric subspecialties, based on the scope of that provider's license under applicable State law. The designated provider must also participate in the plan network and be available to accept the child. These final regulations incorporate this clarification.

The interim final regulations also established requirements for a plan or issuer that provides coverage for obstetrical or gynecological care and requires the designation of an in-network primary care provider. Specifically, the plan or issuer may not require authorization or referral by the plan, issuer, or any person (including a primary care provider) for a female participant, beneficiary, or enrollee who seeks obstetrical or gynecological care provided by an in-network health care professional who specializes in obstetrics or gynecology. Plans and issuers must also treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, by the professional who specializes in obstetrics or gynecology as the authorization of the primary care provider. For this purpose, a health care professional specializing in obstetrics or gynecology is any individual who is authorized under applicable State law to provide obstetrical or gynecological care, and is not limited to a physician.

Commenters sought clarification that women of all ages may receive obstetrical and gynecological care without prior authorization or referral by the plan, issuer, or any person (including a primary care provider), noting that the statutory provision contains no restrictions based on the age of a participant, beneficiary or enrollee. The Departments agree that all women regardless of age are ensured direct access to obstetrical and gynecological care under this provision.

Since the promulgation of the interim final regulations, it has come to the De-

⁸²75 FR 37188 (June 28, 2010).

⁸³Affordable Care Act Implementation FAQs Part I, Q&A-15, available at <http://www.dol.gov/ebsa/faqs/faq-aca.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html.

partments' attention that some plans and issuers utilize plan designs where the delivery of care is coordinated through medical groups within the network based on the geographic location of the participant and the provider. Specifically, the Departments have encountered plan provisions in insured group health plan coverage that require participants to designate a primary care provider but restrict a participant's choice of provider based on the distance that the participant lives or works from the provider. Stakeholders requested that the Departments clarify in the final regulations that the choice of healthcare professional provision does not prohibit the application of such geographical limitations with respect to the selection of primary care providers. Stakeholders highlighted that prohibiting such geographical limitations would fundamentally disrupt these plan designs, as well as the underlying negotiated capitation arrangements (where payment is rendered on a per person rather than per service basis). Stakeholders also noted that the underlying provider contracts do not permit providers to accept participants that are not within the specified geographic limit, and, accordingly, such limitations should not violate these provisions of the regulations, as the providers are not available to accept such participants, based on the terms of the plan, and as required by the regulations.

The Departments recognize the importance of allowing plans and issuers the flexibility to deliver care in a cost-effective and efficient manner. Accordingly, these final regulations include a codification of the Departments' interpretation that plans and issuers are not prohibited under PHS Act section 2719A from applying reasonable and appropriate geographic limitations with respect to which participating primary care providers are considered available for purposes of selection as primary care providers, in accordance with the terms of the plan, the underlying provider contracts, and applicable State law. The Departments may provide additional guidance if questions persist or if the Departments become aware of geographic limitations that un-

duly restrict a participant's choice of provider.

2. Emergency Services

a. Additional administrative requirements

Under the interim final regulations and these final regulations, if a group health plan or issuer provides any benefits with respect to services in the emergency department of a hospital, then the plan or issuer must provide coverage for emergency services without the individual or the health care provider having to obtain prior authorization (even if the emergency services are provided out of network). For a plan or health insurance coverage with a network of providers that provide benefits for emergency services, the plan or issuer may not impose any administrative requirement or limitation on benefits for out-of-network emergency services that is more restrictive than the requirements or limitations that apply to in-network emergency services.

b. Out-of-network cost-sharing requirements

Cost-sharing requirements expressed as a copayment amount or coinsurance rate imposed for out-of-network emergency services cannot exceed the cost-sharing requirements that would be imposed if the services were provided in-network. The preamble to the interim final regulations explained that out-of-network providers may bill patients for the difference between the providers' billed charges and the amount collected from the plan or issuer and the amount collected from the patient in the form of a copayment or coinsurance amount (referred to as balance billing⁸⁴). Section 1302(c)(3)(B) of the Affordable Care Act excludes such balance billing amounts from the definition of cost sharing, and the requirement in section 2719A(b)(1)(C)(ii)(II) that cost sharing for out-of-network services be limited to that imposed in network only applies to cost sharing expressed as a copayment amount or coinsurance rate. Because the statute nei-

ther requires plans or issuers to cover balance billing amounts, nor prohibits balance billing, even where the protections in the statute apply, patients may still be subject to balance billing. In the preamble to the interim final regulations under PHS Act section 2719A, the Departments explained that it would defeat the purpose of the protections in the statute if a plan or issuer paid an unreasonably low amount to a provider, even while limiting the coinsurance or copayment associated with that amount to in-network amounts.⁸⁵

To avoid the circumvention of the protections of PHS Act section 2719A, the Departments determined it necessary that a reasonable amount be paid before a patient becomes responsible for a balance billing amount. Therefore, as provided in the interim final regulations and these final regulations, a plan or issuer must pay a reasonable amount for emergency services by some objective standard. Specifically, a plan or issuer satisfies the copayment or coinsurance limitations in the statute if it provides benefits for out-of-network emergency services (prior to imposing in-network cost sharing) in an amount at least equal the greatest of: (1) the median amount negotiated with in-network providers for the emergency service; (2) the amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount); or (3) the amount that would be paid under Medicare for the emergency service (minimum payment standards). The interim final regulations under PHS Act section 2719 clarified that the cost-sharing requirements create a minimum payment requirement. The cost-sharing requirements do not prohibit a group health plan or health insurance from providing benefits with respect to an emergency service that are greater than the amounts specified in the regulations.

Some commenters expressed concern about the level of payment for out-of-network emergency services and urged the Departments to require plans and issuers to use a transparent database to determine out-of-network amounts. The De-

⁸⁴See Uniform Glossary of Health Coverage and Medical Terms at <http://www.dol.gov/ebsa/pdf/sbcuniformglossaryproposed.pdf> and <https://www.cms.gov/apps/glossary>.

⁸⁵75 FR 37188, 37194 (June 28, 2010).

partments believe that this concern is addressed by our requirement that the amount be the greatest of the three amounts specified in paragraphs (b)(3)(i)(A), (b)(3)(i)(B), and (b)(3)(i)(C) of this section (which are adjusted for in-network cost-sharing requirements).

c. Clarifications regarding balance billing

Some commenters sought clarification about the interaction of the minimum payment standards under the interim final regulations and State laws that prohibit balance billing for emergency services. Balance billing generally is the practice of billing by a provider that is not a preferred provider for the difference between the charge of a provider that is not a preferred provider and the allowed amount under the plan or coverage. Some stakeholders expressed their opposition to the use of balance billing because it creates a substantial financial burden and may discourage a participant, beneficiary, or enrollee from obtaining the care needed in an emergency situation. Other stakeholders suggested that plans and issuers should be required to negotiate contracts with hospitals and facility-based providers that avoid balance billing. However, the statute does not require plans or issuers to cover balance billed amounts, nor does it prohibit balance billing. Even where the protections in the statute apply, a participant, beneficiary, or enrollee may be subject to balance billing. In the future, the Departments will consider ways to prevent providers from billing a participant, beneficiary, or enrollee for emergency services from out-of-network providers at in-network hospitals and facilities. States may also consider ways to prevent balance billing in these circumstances.

The minimum payment standards are designed to reduce potential amounts of balance billing to patients. Stakeholders commented that in circumstances where patients will not be balance billed (because balance billing is prohibited or be-

cause the issuer, rather than the patient, is required to cover the balance bill), the minimum payment standards are not necessary. In response to these comments, the Departments issued an FAQ⁸⁶ stating that the minimum payment standards set forth in the interim final regulations were developed to protect patients from being financially penalized for obtaining emergency services on an out-of-network basis. If State law prohibits balance billing, plans and issuers are not required to satisfy the payment minimum set forth in the regulations. Similarly, if a plan or issuer is contractually responsible for any amounts balanced billed by an out-of-network emergency services provider, the plan or issuer is not required to satisfy the payment minimum. In both situations, however, a plan or issuer may not impose any copayment or coinsurance requirement for out-of-network emergency services that is higher than the copayment or coinsurance requirement that would apply if the services were provided in-network. In addition, a plan or issuer must provide an enrollee or beneficiary adequate and prominent notice of their lack of financial responsibility with respect to amounts balance billed in order to prevent inadvertent payment by an enrollee or beneficiary. These final regulations incorporate this clarification. The regulations do not preempt existing State consumer protection laws and do not prohibit States from enacting new laws with respect to balance billing that would provide consumer protections at least as strong as the Federal statute.

In response to the interim final regulations, commenters also requested that the Departments require plans and issuers to inform a participant, beneficiary, or enrollee using clear and understandable language of the consequences of using out-of-network emergency services, including the possibility of balance billing. Another commenter stated that the summary plan description (SPD) provides sufficient information to meet the notice requirements. The Departments agree that plans and issuers must disclose the terms of the coverage as part of plan documents and are

not adding a new notice requirement at this time.

d. Definition of emergency services

In applying the rules relating to emergency services, the terms emergency medical condition, emergency services, and stabilize have the meaning given to those terms under the Emergency Medical Treatment and Labor Act (EMTALA), section 1867 of the Social Security Act. Under EMTALA, the term emergency services includes (1) “an appropriate medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to determine whether an emergency medical condition exists”; and (2) “such further medical examination and such treatment as may be required to stabilize the medical condition.”⁸⁷

Some commenters recommended that the Departments define “emergency services” such that an enrollee or beneficiary may only receive emergency benefits if an enrollee or beneficiary seeks treatment within 24 hours of the onset of an emergency. These final regulations decline to adopt this comment. The term “emergency services” as defined by the interim final regulations and these final regulations is based on the statutory definition, which does not specify parameters with respect to time. Accordingly, a plan or issuer cannot set a time limit within which to seek emergency services and must provide coverage for any emergency services that meet the definition of emergency services under EMTALA.

Some commenters requested clarification as to whether air ambulance transport and other emergency transportation is within the scope of the term “emergency services.” The Departments decline to provide a rule addressing this issue. These final regulations continue to provide that the terms emergency medical condition, emergency services, and stabilize have the meaning given to those terms under

⁸⁶See Affordable Care Act Implementation FAQ Part I Q15 at <http://www.dol.gov/ebsa/faqs/faq-aca.html> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html.

⁸⁷42 U.S.C. 1395dd(a)–(b).

EMTALA, section 1867 of the Social Security Act.⁸⁸

H. Provisions No Longer Applicable

1. Special Rule Relating to Dependent Coverage of Children to Age 26 for Grandfathered Group Health Plans

The dependent coverage provision of PHS Act section 2714 applies to all group health plans and health insurance issuers offering group or individual health insurance coverage for plan years (in the individual market, policy years) beginning on or after September 23, 2010, whether or not the plan or health insurance coverage qualifies as a grandfathered health plan. However, consistent with section 2714 of the PHS Act, for plan years beginning before January 1, 2014, the 2010 interim final regulations provided that a grandfathered health plan that is a group health plan that makes available dependent coverage of children may exclude from coverage an adult child who has not attained age 26 if the child is eligible to enroll in an employer-sponsored health plan (as defined in section 5000A(f)(2) of the Code) other than a group health plan of a parent. Because this special rule for grandfathered group health plans no longer applies, it is not incorporated into these final regulations.

2. Transitional Rules for Individuals Whose Coverage Ended by Reason of Reaching a Dependent Eligibility Threshold

The 2010 interim final regulations implementing PHS Act section 2714 provided transitional relief for a child whose coverage ended, or who was denied coverage (or was not eligible for coverage) under a group health plan or health insurance coverage because, under the terms of the plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26. The 2010 interim final regulations also required a plan or issuer to give such a child a special enrollment opportunity, which was required to be provided (including written

notice) not later than the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010. Because the transitional rule no longer applies, it is not incorporated into these final regulations.

3. Restricted Annual Limits and Transitional Rules for Individuals Whose Coverage or Benefits Ended by Reason of Reaching a Lifetime Dollar Limit

PHS Act section 2711 and its implementing interim final regulations generally prohibited lifetime or annual limits on the dollar value of EHBs (as defined in section 1302(b) of the Affordable Care Act). With respect to annual dollar limits, the statute and the interim final regulations allowed the imposition of “restricted annual limits” with respect to EHBs for plan years (in the individual market, policy years) beginning before January 1, 2014. The interim final regulations adopted a three-year phased approach to restricted annual limits. As set forth in the interim final regulations, the restricted annual limits on the dollar value of EHBs could not be lower than:

- For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011, \$750,000;
- For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012, \$1.25 million; and
- For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014, \$2 million.

With respect to plan or policy years beginning on or after January 1, 2014, no annual dollar limits are permitted on essential health benefits except in the case of grandfathered individual market coverage.

The interim final regulations also provided transitional rules for individuals who reached a lifetime dollar limit under a group health plan or health insurance coverage prior to the applicability date of the interim final regulations. The regulations required a plan or issuer to provide an individual whose coverage ended due to

reaching a lifetime dollar limit with an enrollment opportunity (including written notice) that continues for at least 30 days. The notice and enrollment opportunity was required to be provided not later than the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010. Because the provisions regarding restricted annual dollar limits and the transitional rules regarding lifetime dollar limits no longer apply, they are not incorporated into these final regulations.

I. Applicability

1. General applicability

These final regulations apply to group health plans and health insurance issuers beginning on the first day of the first plan year (or, in the individual market, the first day of the first policy year) beginning on or after January 1, 2017. Until these final regulations become applicable, plans and issuers are required to continue to comply with the corresponding interim final regulations at 29 CFR part 2590, contained in the 29 CFR, parts 1927 to end, edition revised as of July 1, 2015, and 45 CFR parts 144, 146, and 147, contained in the 45 CFR, parts 1 to 199, edition revised as of October 1, 2015. In accordance with section 7805(e)(2) of the Code, the corresponding temporary regulations promulgated by the Department of the Treasury are inapplicable. Under section 104 of the Health Insurance Portability and Accountability Act (HIPAA), enacted on August 21, 1996, and subsequent amendments, the Departments must coordinate policies with respect to parallel provisions of ERISA, the PHS Act, and the Code (shared provisions). The Departments operate under a Memorandum of Understanding⁸⁹ implementing HIPAA section 104 which provides that the shared provisions must be administered so as to have the same effect at all times and the Departments must coordinate policies relating to enforcing the shared provisions in order to avoid duplication of enforcement efforts and to assign priorities in enforce-

⁸⁸For a more detailed discussion of definitions and requirements under EMTALA, see CMS State Operations Manual, Appendix V, pg. 33–41, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf.

⁸⁹See 64 FR 70164 (December 15, 1999).

ment. Therefore, until these final regulations promulgated by the Department of the Treasury become applicable, compliance with corresponding interim final regulations at 29 CFR part 2590, contained in the 29 CFR, parts 1927 to end, edition revised as of July 1, 2015 shall satisfy corresponding requirements of the Code.

Section 1251 of the Affordable Care Act provides that grandfathered health plans are subject to only certain provisions of the Affordable Care Act. The final regulations under PHS Act section 2719, Internal Claims and Appeals and External Review (26 CFR 54.9815–2719, 29 CFR 2590.715–2719, 45 CFR 147.136) and PHS Act Section 2719A, Patient Protections (26 CFR 54.9815–2719A, 29 CFR 2590.715–2719A, 45 CFR 147.138) do not apply to grandfathered health plans. Final regulations under PHS Act section 2704, Prohibition of Preexisting Condition Exclusions (26 CFR 54.9815–2704, 29 CFR 2590.715–2704, 45 CFR 147.108); PHS Act section 2711, Prohibition on Lifetime and Annual Limits (26 CFR 54.9815–2711, 29 CFR 2590.715–2711, 45 CFR 147.126); PHS Act section 2712, Prohibition on Rescissions (26 CFR 54.9815–2712, 29 CFR 2590.715–2712, 45 CFR 147.128); and PHS Act section 2714, Coverage of Dependents to Age 26 (26 CFR 54.9815–2714, 29 CFR 2590.715–2714, 45 CFR 147.120) apply to grandfathered health plans, except the prohibition of preexisting condition exclusions and prohibition on annual dollar limits do not apply to grandfathered health plans that are individual health insurance coverage. For a list of the market reform provisions under title XXVII of the PHS Act, as added or amended by the Affordable Care Act and incorporated into ERISA and the Code, applicable to grandfathered health plans, visit <http://www.dol.gov/ebsa/pdf/grandfatherregtable.pdf>.

2. Expatriate plans

On December 16, 2014, Congress enacted the Expatriate Health Coverage Clarification Act of 2014 (EHCCA) as part of the Consolidated and Further Con-

tinuing Appropriations Act, 2015, Division M, Public Law 113–235. The EHCCA provides that the market reform requirements of the Affordable Care Act generally do not apply to expatriate health plans, expatriate health insurance issuers with respect to expatriate health plans, and employers in their capacity as plan sponsors of expatriate health plans. However, the plans, coverage, sponsors and issuers must still satisfy provisions of the PHS Act, ERISA and the Code that would otherwise apply if not for the enactment of the Affordable Care Act. The EHCCA exception from the market reform requirements applies to expatriate health plans that are issued or renewed on or after July 1, 2015.

Treasury and IRS issued Notice 2015–43, 2015–29 I.R.B. 73, to provide interim guidance on the EHCCA. The notice provides that until the issuance of further guidance and except as otherwise provided in the notice, issuers, employers, and plan sponsors generally may apply the requirements of EHCCA using a reasonable good faith interpretation of the statute. The notice also provides that until further guidance is issued, using the definition of expatriate health plan provided in Affordable Care Act Implementation FAQs⁹⁰ is treated as a reasonable good faith interpretation of the statute. As explained in the notice, the Departments intend to publish proposed regulations implementing and providing guidance on the EHCCA. Consequently, these final regulations do not address the application to expatriate health plans of the Affordable Care Act provisions under which these final regulations are promulgated.

III. Economic Impact Analysis —Departments of Labor and Health and Human Services

Executive Orders 12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic,

environmental, public health and safety effects; distributive impacts; and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility.

Under Executive Order 12866 (58 FR 51735), “significant” regulatory actions are subject to review by the Office of Management and Budget (OMB). Section 3(f) of the Executive Order defines a “significant regulatory action” as an action that is likely to result in a rule (1) having an annual effect on the economy of \$100 million or more in any one year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as “economically significant”); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in the Executive Order. These final regulations have been designated “significant regulatory actions” under section 3(f) of Executive Order 12866. Accordingly, the regulations have been reviewed by the Office of Management and Budget.

A regulatory impact analysis must be prepared for major rules with economically significant effects (\$100 million or more in any one year). The Departments have concluded that these final regulations would have economic impacts of \$100 million or more in at least one year, thus meeting the definition of an “economically significant rule” under Executive Order 12866. Therefore, consistent with Executive Orders 12866 and 13563, the Departments have provided an assessment of the potential benefits and the costs associated with these final regulations.

The Departments expect these final regulations, when compared with the interim final regulations, to have marginal

⁹⁰See FAQs about Affordable Care Act Implementation (Part XIII), Q&A–1, available at <http://www.dol.gov/ebsa/pdf/faq-aca13.pdf> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/ACA_implementation_faqs13.html. See also FAQs about Affordable Care Act Implementation (Part XVIII), Q&A–6 and Q&A–7, available at <http://www.dol.gov/ebsa/pdf/faq-aca18.pdf> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/ACA_implementation_faqs18.html.

benefits and costs. This is because they primarily provide clarifications of the previous interim final regulations issued in 2010 and 2011 and incorporate subregu-

latory guidance, including frequently asked questions and safe harbors issued by the Departments. The Departments do not have sufficient data to quantify these

costs and benefits, but they are qualitatively discussed throughout the remainder of this section and summarized in the Accounting Table.

<i>Table 1.—Accounting Table</i>				
Category	Estimate	Year Dollar	Discount Rate	Period Covered
Benefits- Qualitative	These final regulations help ensure the protections and benefits intended by Congress. Many of these benefits have a distributional component, and promote equity, in the sense that they will benefit those who are especially vulnerable as a result of health problems and financial status. Other benefits include increased access to care and to information needed to protect consumer's rights. These final regulations also lead to improved health outcomes for patients and increase certainty for issuers, plans and consumers by providing clarifications and guidance.			
Costs				
Annualized Monetized (\$millions/year)	\$169.9	2015	7%	2016–2025
	\$169.9	2015	3%	2016–2025
Qualitative	The Departments have quantified where possible the costs associated with these final regulations. These costs include burden that will be incurred to prepare and distribute required disclosures and notices, and to bring plan and issuers' policies and procedures into compliance with the new requirements. The Departments have not been able to quantify cost related to increased access to care. To the extent these patient protections increase access to health care services, increased health care utilization and costs could result.			
Transfers				
Annualized Monetized (\$millions/year)	\$53.5	2015	7%	2016–2025
	\$53.5	2015	3%	2016–2025
Qualitative	Due to the risk pooling nature of health insurance these patient protections and other requirements create a transfer from those paying premiums to those individuals and families now obtaining increased protections, coverage and services.			

1. Need for Regulatory Action

a. Preservation of Right to Maintain Existing Coverage

Section 1251 of the Affordable Care Act provides that grandfathered health plans are subject only to certain provisions of the Affordable Care Act. The statute, however, is silent regarding changes plan sponsors and issuers can make to plans and health insurance coverage while retaining grandfather status.

These final regulations are necessary in order to provide rules that group health plans and health insurance issuers can use to determine which changes they can make to the terms of the plan or health insurance coverage while retaining their grandfather status, thus exempting them from certain provisions of the Affordable Care Act and fulfilling a goal of the leg-

islation, which is to allow those that like their coverage to keep it. These final regulations are designed to allow individuals to keep the coverage they had on March 23, 2010 (the date of enactment of the Affordable Care Act) to reduce short term disruptions in the market, and to ease the transition required by the market reforms.

In drafting this rule, the Departments attempted to balance a number of competing interests. For example, the Departments sought to provide adequate flexibility to group health plans and issuers to ease transition and mitigate potential premium increases while avoiding excessive flexibility that would unduly delay implementation of critical consumer protections in the Affordable Care Act. In addition, the Departments recognized that many group health plans and issuers make changes to the terms of plans or health insurance coverage on an

annual basis: Premiums fluctuate, provider networks and drug formularies change, employer and employee contributions and cost-sharing change, and covered items and services may vary. Without some ability to make some adjustments while retaining grandfather status, the ability of individuals to maintain their current coverage would be frustrated, because most plans or health insurance coverage would quickly cease to be regarded as the same group health plan or health insurance coverage in existence on March 23, 2010. At the same time, allowing unfettered changes while retaining grandfather status would also be inconsistent with Congress's intent to provide a transition to the Affordable Care Act market reforms.

These final regulations regarding grandfather health plans are designed, among other things, to take into account reasonable changes routinely made by plan sponsors or

issuers without the plan or health insurance coverage relinquishing its grandfather status. Thus, for example, these final regulations generally permit plans and issuers to make voluntary changes to increase benefits, to conform to required legal changes, and to voluntarily adopt other consumer protections in the Affordable Care Act without relinquishing grandfather status.

b. Prohibition of Preexisting Condition Exclusions

Section 2704 of the PHS Act, as added by the Affordable Care Act, generally prohibits group health plans and health insurance issuers offering group or individual health insurance coverage from imposing any preexisting condition exclusion.

Studies estimate that preexisting conditions affect approximately 129 million Americans⁹¹ which includes a broad range of conditions, from heart disease – affecting an estimated 85.6 million American adults (with more than 1 in 3 having one or more types of cardiovascular disease⁹²) – to cancer – which in 2012 affected an estimated 14 million Americans and will affect an estimated 1.7 million additional people in 2015⁹³ – to relatively minor conditions like hay fever, asthma, or previous sports injuries.⁹⁴ Denials of benefits or coverage based on a preexisting condition previously made adequate health insurance unavailable to millions of Americans. Before enactment of the Affordable Care Act, in 45 States, health insurance issuers in the individual market could deny coverage, charge higher premiums, and/or deny benefits for a preexisting condition.⁹⁵

These regulations finalize interim final regulations which were necessary to implement this statutory provision which Congress enacted to help ensure that quality health coverage is available to more Americans without the imposition of a preexisting condition exclusion.

c. Lifetime and Annual Limits

Section 2711 of the PHS Act, as added to the Affordable Care Act, generally pro-

hibits group health plans and health insurance issuers offering group or individual health insurance coverage from imposing annual and lifetime limits on the dollar value of essential health benefits.

These protections ensure that patients are not confronted with devastating healthcare costs because they have exhausted their health coverage when faced with a serious medical condition.

These regulations finalize interim final regulations that were necessary to implement the statutory provisions with respect to annual and lifetime limits that Congress enacted to help ensure that more Americans with chronic, long-term, and/or expensive illnesses have access to quality health coverage.

d. Prohibition on Rescissions

Section 2712 of the PHS Act, as added by the Affordable Care Act, prohibits group health plans and health insurance issuers offering group or individual health insurance coverage from rescinding coverage except in the case of fraud or intentional misrepresentation of material fact.

Prior to the Affordable Care Act, thousands of Americans lost health coverage each year due to rescission. When a coverage rescission occurs, an individual's health coverage is retroactively cancelled, which means that the insurance company is no longer responsible for medical care claims that had previously been accepted and paid. Rescissions can result in significant financial hardship for affected individuals, because, in most cases, the individuals have accumulated significant medical expenses.

These final regulations implement the statutory provision enacted by Congress to protect the most vulnerable Americans, those that incur substantial medical expenses due to a serious medical condition, from financial devastation by ensuring that such individuals do not unjustly lose health coverage by rescission.

e. Coverage of Dependents to Age 26

PHS Act section 2714, as added by the Affordable Care Act, requires group health plans and health insurance issuers offering group or individual health insurance coverage that make dependent coverage available for children to continue to make coverage available to such children until the attainment of age 26. With respect to a child receiving dependent coverage, coverage does not have to be extended to a child or children of the child or a spouse of the child. Furthermore these final regulations clarify that for an individual not described in Code section 152(f)(1), such as a grandchild or niece, a plan may impose additional conditions on eligibility for health coverage, such as a condition that the individual be a dependent for income tax purposes, and the final regulations also clarify that distinctions based upon age that apply generally to all individuals covered under the plan (employees, spouses, dependent children) are not prohibited. These regulations finalize the interim final regulations, which were necessary to implement the statute.

f. Internal Claims and Appeals and External Review

Before the enactment of the Affordable Care Act, health plan sponsors and issuers were not uniformly required to implement claims and appeals processes. For example, ERISA-covered group health plan sponsors were required to implement internal claims and appeal processes that complied with the DOL claims procedure regulation,⁹⁶ while group health plans that were not covered by ERISA, such as plans sponsored by State and local governments were not. Health insurance issuers offering coverage in the individual insurance market were required to comply with various applicable State internal appeals laws but were not required to comply with the DOL claims procedure regulation.

⁹¹ASPE. At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans: 129 Million People Could Be Denied Affordable Coverage Without Health Reform, 2011.

⁹²Mozzafarian, D., et al. Heart Disease and Stroke Statistics – 2015 Update: A Report From the American Heart Association. *Circulation*. 2015; 131(4):e29–322

⁹³National Cancer Institute: Surveillance, Epidemiology, and End Results Program (SEER) Stat Fact Sheet: All Cancer Types. <http://seer.cancer.gov/statfacts/html/all.html>.

⁹⁴Pollitz, K., et al. How Accessible is Individual Health Insurance for Consumers in Less than Perfect Health? Kaiser Family Foundation, June 2001.

⁹⁵Levitt, L., et al. How Buying Insurance Will Change Under Obamacare. Kaiser Family Foundation, September 2013.

⁹⁶29 CFR 2560.503–1

With respect to external appeal processes, before the enactment of the Affordable Care Act, sponsors of fully insured ERISA-covered group health plans, fully-insured State and local governmental plans, and fully-insured church plans were required to comply with State external review laws, while self-insured ERISA-covered group health plans were not subject to such laws due to ERISA preemption. In the individual health insurance market, issuers in States with external review laws were required to comply with such laws. However, uniform external review standards did not apply, because State external review laws vary from State-to-State. Moreover, at least six States did not have external review laws when the Affordable Care Act was enacted; therefore, prior to the Affordable Care Act, issuers in those States were not required to implement an external review process.

Under this regulatory system, inconsistent claims and appeals processes applied to plan sponsors and issuers and a patchwork of consumer protections were provided to participants, beneficiaries, and enrollees. The applicable processes and protections depended on several factors including whether (1) plans were subject to ERISA, (2) benefits were self-funded or financed by the purchase of an insurance policy, (3) issuers were subject to State internal claims and appeals laws, and (4) issuers were subject to State external review laws, and if so, the scope of such laws (such as, whether the laws only apply to one segment of the health insurance market, *e.g.*, managed care or HMO coverage). These uneven protections created an appearance of unfairness, increased cost for issuers and plans operating in multiple States, and may have led to confusion among consumers about their rights.

Congress enacted PHS Act section 2719 to ensure that plans and issuers implemented more uniform internal and external claims and appeals processes and to set a minimum standard of consumer protections that are available to participants, beneficiaries, and enrollees. These final regulations are necessary to provide rules that plan sponsors and issuers can use to implement effective internal and external claims and appeals processes that meet the requirements of PHS Act section 2719.

These changes do not add any incremental costs to those associated with the 2010 interim final rules, because they simply incorporate sub-regulatory guidance that was already issued.

g. Patient Protections

Section 2719A of the PHS Act, as added by the Affordable Care Act, requires group health plans and health insurance issuers offering group or individual health insurance coverage to ensure choice of healthcare professionals (including pediatricians, obstetricians, and gynecologists) and greater access to benefits for emergency services. Provider choice is a strong predictor of patient trust in a provider, and patient-provider trust can increase health promotion and therapeutic effects.⁹⁷ Studies have found that patients tend to experience better quality health-care if they have long-term relationships with their healthcare provider.⁹⁸

The emergency care provisions of PHS Act section 2719A require (1) non-grandfathered group health plans and health insurance issuers that cover emergency services to cover such services without prior authorization and without regard to whether the health care provider furnishing the services is a participating network provider, and (2) copayments and coinsurance for out-of-network emergency care do not exceed the cost-sharing

requirements that would have been imposed if the services were provided in-network. These provisions will help to ensure that patients receive covered emergency care when they need it, especially in situations where prior authorization cannot be obtained due to exigent circumstances or an in-network provider is not available to provide the services. They also will protect patients from the substantial financial burden that can be imposed when differing copayment or coinsurance arrangements apply to in-network and out-of-network emergency care.

These regulations finalize the interim final regulations that were necessary to implement the statutory provision enacted by Congress to provide these essential patient protections.

A. Section 1251 of the Affordable Care Act, Preservation of Right to Maintain Existing Coverage (26 CFR 54.9815-1251, 29 CFR 2590.715-1251, 45 CFR 147.140)

1. Affected Entities and Individuals

The Departments estimate that there are 2.3 million ERISA-covered plans with an estimated 66 million policy holders and 130.2 million participants and beneficiaries in those plans.⁹⁹ Similarly, the Departments estimate that there are 128,400 State and local governmental health plans¹⁰⁰ with an estimated 21.1 million policy holders and 41.1 million participants and beneficiaries in those plans.¹⁰¹

The 2014 Employer Health Benefits Survey reports that 37 percent of firms offer health benefits that have at least one health plan that is a grandfathered plan, and 26 percent of employees are enrolled in grandfathered plans.¹⁰² Using the above estimates, there are 851,000 (2.3 million ERISA-covered plans* 0.37) ERISA-covered plans with 17.2 million policy holders (66 million policy holders

⁹⁷Piette, John, *et al.*, "The Role of Patient-Physician Trust in Moderating Medication Nonadherence Due to Cost Pressures." *Archives of Internal Medicine* 165, August (2005) and Roberts, Kathleen J., "Physician-Patient Relationships, Patient Satisfaction, and Antiretroviral Medication Adherence Among HIV-Infected Adults Attending a Public Health Clinic." *AIDS Patient Care and STDs* 16.1 (2002).

⁹⁸Blewett, Lynn, *et al.*, "When a Usual Source of Care and Usual Provider Matter: Adult Prevention and Screening Services." *Journal of General Internal Medicine* 23.9 (2008).

⁹⁹EBSA estimates based on the 2014 Medical Expenditure Survey – Insurance Component.

¹⁰⁰The estimate of the total number of State and local governmental plans is based on the 2012 Census of Government.

¹⁰¹Health Insurance Coverage Bulletin: Abstract of Auxiliary Data for the March 2014 Annual Social and Economic Supplement to the Current Population Survey, Table 3C <http://www.dol.gov/ebsa/pdf/coveragebulletin2014.pdf>.

¹⁰²Kaiser Family Foundation, "2014 Employer Health Benefits Survey." <http://kff.org/health-costs/report/2014-employer-health-benefits-survey/>.

*0.26) and 33.9 million participants and beneficiaries (130.2 million participants and beneficiaries * 0.26). There are approximately 47,500 grandfathered State and local governmental health plans (0.37*128,400 plans¹⁰³) with approximately 5.5 million policyholders (21.1 million policy holders *0.26) and 10.7 million participants and beneficiaries (41.1 million participants and beneficiaries * 0.26).

There were an estimated 1.4 million policies with grandfathered coverage during 2013 with 2.2 million enrollees.¹⁰⁴

2. Discussion of Economic Impacts of Retaining or Relinquishing Grandfather Status

The economic effects of these final regulations will depend on decisions by plan sponsors and issuers, as well as by those covered under these plans and health insurance coverage.

For a plan sponsor or issuer, the potential economic impact of the application of the provisions in the Affordable Care Act may be one consideration in making its decisions. To determine the value of retaining a health plan's grandfather status, each plan sponsor or issuer must determine whether the rules applicable to grandfathered health plans are more or less favorable than the rules applicable to non-grandfathered health plans. This determination will depend on such factors as the respective prices of grandfathered and non-grandfathered health plans, as well as the preferences of grandfathered health plans' covered populations and their willingness to pay for benefits and patient protections available under non-grandfathered health plans. In making its decision whether to maintain grandfather status, a plan sponsor or issuer is also likely to consider the market segment (because different rules apply to the large and small group market segments), and the utilization pattern of its covered population. Those costs and benefits of the various provisions of the Affordable Care Act and their interaction with the coverages' grandfathered status

have been discussed in the impact analysis of those individual requirements and are not repeated here.

3. Impacts on the Individual Market

The market for individual insurance is significantly different than that for group coverage. As discussed in previous interim final regulations issued in 2010 and 2011, for many, the market is transitional, providing a bridge between other types of coverage. One study found a high percentage of individual insurance policies began and ended with employer-sponsored coverage.¹⁰⁵ More importantly, coverage on particular policies tends to be for short periods of time. As such, high turnover rates are likely the chief source of changes in grandfather status. Reliable data are scant, so there is no ability to update estimates as to how many people in the individual market are in non-grandfathered plans today.

1. Disclosure of Grandfather Status and Document Retention

To maintain grandfathered health plan status under these final regulations, a plan or issuer must maintain records that document the plan or policy terms in connection with the coverage in effect on March 23, 2010, and any other documents necessary to verify, explain or clarify its status as a grandfathered health plan, disclose its status as a grandfathered health plan, and if switching issuers and intending to maintain its status as a grandfathered plan, it must provide to the new health insurance issuer with documentation of plan terms under the prior health coverage sufficient for it to determine whether a change causing a cessation of grandfathered health plan status has occurred.

The Departments estimate that the total cost for these requirements will be \$1.8 million annually. For a detailed discussion of the grandfathered health plan document retention and disclosure requirements, see

the Paperwork Reduction Act section later in this preamble.

B. PHS Act Section 2704, Prohibition of Preexisting Condition Exclusions (26 CFR 54.9815–2704, 29 CFR 2590.715–2704, 45 CFR 147.108)

1. Affected Entities and Individuals

In the individual market, those applying for insurance will no longer face exclusions or denials of coverage based on a preexisting condition while those covered by non-grandfathered individual coverage with a rider or exclusion period will gain coverage for any preexisting condition otherwise covered by the plan. In the group market, participants and beneficiaries that have experienced a lapse in coverage will no longer face up to a twelve-month exclusion for preexisting conditions.

There are two main categories of people who have most likely been directly affected by this provision: First, those who had a preexisting condition and who were uninsured; second, those who were covered by grandfathered individual policies containing riders excluding coverage for a preexisting condition or have an exclusion period. It is difficult to estimate precisely how many uninsured individuals had a preexisting condition as of when this provision went into effect, as information on whether individuals have a preexisting condition for the purpose of obtaining health insurance is not collected in any major population based survey and can include conditions from hay fever to HIV/AIDS, all which could result in a denial of coverage.¹⁰⁶ The Departments find it difficult to estimate the number of individuals that will be uniquely affected by these final regulations due to the interactions with other provisions of the Affordable Care Act; however, estimates indicate that 50–129 million non-elderly individuals with a preexisting condition, 25 million uninsured individuals – including the 3.7 million adults that fall into the “coverage gap” in States without Medic-

¹⁰³The estimate of the total number of State and local governmental plans is based on the 2012 Census of Government.

¹⁰⁴Based on data from the McKinsey Center for US Health System Reform and Medical Loss Ratio submissions for 2013 reporting year.

¹⁰⁵Adele M. Kirk. The Individual Insurance Market: A Building Block for Health Care Reform? *Health Care Financing Organization Research Synthesis*. May 2008.

¹⁰⁶Levitt, L., et al. How Buying Insurance Will Change Under Obamacare. *Kaiser Family Foundation*, September 2013.

aid expansion, and the estimated 66.6–82 million with ESI with preexisting conditions could benefit from these final regulations.¹⁰⁷

2. Benefits

These final regulations will expand and improve coverage for those Americans with preexisting conditions; those currently diagnosed, undiagnosed, or who will develop conditions as they age. This will likely increase access to health care, improve health outcomes, and reduce family financial strain and “job lock.”

For many years insurance providers/issuers maintained risk pools that are equal to that of the general population, using various methodologies;¹⁰⁸ often to the detriment of those most in need. Passage of the Affordable Care Act on March 23, 2010, provided millions of Americans with a way to obtain, re-obtain, or keep their affordable health coverage without the fear of losing or not having it when they are at their most vulnerable.

Prior to enactment of the Affordable Care Act, an estimated 50–52 million non-elderly people lacked insurance and 50–129 million were diagnosed with a preexisting condition.¹⁰⁹ Numerous studies show that uninsured adults and children are 3 to 6 times more likely to go without or postpone receiving needed care, experience higher delays and incidences of unmet needs, have higher incidences in avoidable hospital stays, and

have a higher risk of death after an accident or when hospitalized.¹¹⁰ This provision benefits and protects the millions of non-elderly persons who currently have a preexisting condition and those that will develop some condition as they age – in one study of those reporting good or excellent health, 15–30 percent will develop a preexisting condition in the next eight years¹¹¹ – by providing them a means to obtain or keep health coverage. Without the protections of these final regulations, many more Americans could be faced with the fear and anxiety of trying to obtain health coverage or faced with insufficient coverage due to preexisting conditions.

As discussed previously, those with preexisting condition exclusions or those that were uninsured could have found themselves being charged 2.5 times more prior to the Affordable Care Act.¹¹² The higher cost faced by those with preexisting conditions, whether uninsured or containing riders, could have led families to encounter financial hardships, crisis, and emotional stress.

Reports show that those lacking coverage are more likely to have trouble paying bills while being more likely to take on additional credit card debt and spend down family assets and savings, often resulting in the loss of their homes and personal bankruptcy: In 1981 the foreclosure rate reported to be associated with medical issues was only 8 percent; by

2007 this rate had increased to 62.1 percent of all personal bankruptcies, and 49 percent of foreclosures.¹¹³ These higher rates can in turn lead to many health care organizations providing uncompensated care: in 2008, the uninsured received \$116 billion worth of hospital care – the primary source of which was federal funding.¹¹⁴ In addition to their advantages with regard to access to care, health, and well-being these final regulations are likely to lower families’ out-of-pocket health care spending and the level of uncompensated care; thus benefiting State and Federal governments and, by extension, taxpayers.

Finally, these final regulations may reduce instances of “job lock”- situations in which workers are unable to change jobs due to concerns regarding health insurance coverage for them and/or their dependents. Due to the limitations and exclusions in individual health coverage, many people were forced into a position where they chose to remain in a job out of fear of losing their existing coverage or chose a job with sponsored coverage over a higher wage position.¹¹⁵ Job lock leads to a number of labor market distortions resulting in workers in jobs that are a “poor fit,” with reduced satisfaction or skills that are not properly utilized, affecting their ability to start new businesses, retire, or reduce their work load.¹¹⁶ One study indicates that 35 percent of those surveyed worried they will have to forego

¹⁰⁷ASPE. At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans: 129 Million People Could Be Denied Affordable Coverage Without Health Reform, 2011 and Artiga, S. *et al.* The Impact of the Coverage Gap in States not Expanding Medicaid by Race and Ethnicity. *The Kaiser Family Foundation*, April 2015.

¹⁰⁸Claxton, G. and Lundy, J. How Health Care Coverage Works: A Primer 2008 Update. *The Kaiser Family Foundation*, April 2008.

¹⁰⁹ASPE. At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans: 129 Million People Could Be Denied Affordable Coverage Without Health Reform, 2011; Collins, S., *et al.* Help is on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief – Findings from The Commonwealth Fund Biennial Health Insurance Survey of 2010. *The Commonwealth Fund*. 2011. Studies utilized 2008 MEPS data and The Commonwealth Biennial Health Insurance Survey of 2010 and prior years to estimate the numbers of individuals with preexisting conditions.

¹¹⁰Collins, S., *et al.* Help is on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief – Findings from The Commonwealth Fund Biennial Health Insurance Survey of 2010. *The Commonwealth Fund*. 2011; Callahan, S., *et al.* Access to Health Care for Young Adults With Disabling Chronic Conditions. *Arch Pediatr Adolesc Med*. 2006;160:178–182; and Bernstein, J., *et al.* Issue Brief: How Does Insurance Coverage Improve Health Outcomes? *Mathematica Policy Research, Inc.* 2010:1.

¹¹¹Bailey, K. Worry No More: Americans with Pre-Existing Conditions Are Protected by the Health Care Law, *Families USA*; 2012 and ASPE. At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans: 129 Million People Could Be Denied Affordable Coverage Without Health Reform, 2011.

¹¹²Bailey, K. Worry No More: Americans with Pre-Existing Conditions Are Protected by the Health Care Law, *Families USA*; 2012 and Anderson, G. From ‘Soak The Rich’ To ‘Soak The Poor’: Recent Trends In Hospital Pricing. *Health Affairs*; 2007; 26(3), pp. 780–789.

¹¹³Himmelstein, D. *et al.* Medical Bankruptcy in the United States, 2007: Results of a National Study. *Am Jour of Med*. 2009; 122(8), pp. 741–746; Robertson, T., *et al.* “Get sick, get out: the medical causes of home mortgage foreclosures.” *Health Matrix: Journal of Law-Medicine*. 2008; 18(65), pp 65–105; Fact Sheet. Key Facts about the Uninsured Population. *The Kaiser Family Foundation*. October 2014; see also <https://www.medicare.gov/your-medicare-costs/help-paying-costs/medicaid/medicaid.html>.

¹¹⁴Stoll, K. and Bailey, K. Hidden Health Tax: Americans Pay a Premium. *Families USA*, 2009 and Coughlin, T. *et al.* Uncompensated Care for Uninsured in 2013: A detailed Examination. *The Kaiser Family Foundation*, 2014.

¹¹⁵GAO, Private Health Insurance: Estimates of Individuals with Preexisting Conditions Range from 36 million to 122 million, GAO–12–439, 2012.

¹¹⁶Baker, D. Job Lock and Employer – Provided Health Insurance: Evidence from the Literature. *Public Policy Institute*. 2015;1–35; ASPE. At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans: 129 Million People Could Be Denied Affordable Coverage Without Health Reform, 2011; Fact Sheet. Key Facts about the Uninsured Population. *The Kaiser Family Foundation*. October 2014.

job opportunities or forego retirement to maintain coverage.¹¹⁷

Under the Affordable Care Act, the interim final regulations, and these final regulations, someone currently insured through the group market with less than 18 months of continuous coverage may be more willing to leave their job and become a self-employed entrepreneur if they or their dependents have a preexisting condition – resulting in potentially 2–4 million more self-employed individuals.¹¹⁸ Similarly, even a worker with more than 18 months of continuous coverage who is already protected by HIPAA may be more likely to consider switching firms and changing policies because they will not have to worry that a preexisting condition could be excluded for up to 12 months.¹¹⁹ While the total reduction in job-lock may be small, the impact on those families with members that have preexisting conditions may be significant.

Executive Order 12866 requires agencies to take account of “distributive impacts” and “equity.” Requiring health plans and issuers to provide coverage to adults and children with preexisting conditions will result in a small increase in premium for relatively healthy adults and children, and a large increase in health and financial security for individuals with preexisting conditions. This transfer is a meaningful increase in equity, and is a benefit of this final regulation.

3. Costs and Transfers

Although those that have preexisting condition exclusions have higher health care costs than healthier individuals, among individuals with preexisting conditions, those who are uninsured have expenditures that are somewhat lower than the average insured individual.¹²⁰ It is expected that when those individuals who are uninsured or have policies with preexisting condition exclusions gain coverage,

there will be additional demand for and utilization of services, leading to a transfer from out-of-pocket spending to spending covered by insurance, which will partially be mitigated by a reduction in cost-shifting of uncompensated care to the insured population as coverage expands.

In evaluating the impact of this provision, it is important to remember that the full net effects of this provision cannot be estimated because of its interactions with other provisions in the Affordable Care Act. For example, under the current guaranteed availability and renewability protections in the individual market, children and young adults with a preexisting condition are now generally able to obtain and maintain coverage on a parental plan, where he or she can potentially stay on that plan until age 26. As another example, the Affordable Care Act requires that non-grandfathered health plans provide recommended preventive services at no cost-sharing. This will amplify the benefits of coverage for newly insured individuals with preexisting conditions. Moreover, the expansion of the preexisting condition exclusion policy occurred at the same time as other policies were implemented, such as the individual responsibility and premium tax credit provisions. Therefore, the Departments cannot provide a more precise estimation of either the benefits or the costs and transfers of this provision.

C. PHS Act Section 2711, Prohibition on Lifetime and Annual Limits (26 CFR 54.9815–2711, 29 CFR 2590.715–2711, 45 CFR 147.126)

1. Affected Entities and Individuals

Prior to the passage of the Affordable Care Act, both the incidence and amount of lifetime limits varied by market and plan type (e.g., HMO, PPO, POS). In the RIA for the interim final regulations, it was estimated that only 8 percent of large employers, 14 percent of small employers

and 19 percent of individual market policies imposed an annual limit at that time and thus would have been directly impacted by the interim final regulations, which were phased in.

Fear and anxiety about reaching annual or lifetime limits on coverage was a major concern among Americans who have health insurance, although while such limits were relatively common in health insurance, the numbers of people expected to exceed either an annual or lifetime limit was quite low.

2. Benefits

As discussed in the RIA for the interim final regulations, annual and lifetime limits function as caps on how much a group health plan or insurance company will spend on medical care for a given insured individual over the course of a year, or the individual’s lifetime. Once a person reaches this limit or cap, the person is essentially uninsured: he or she must pay the remaining cost of medical care out-of-pocket. These limits particularly affect people with high-cost conditions,¹²¹ which typically are very serious and can lead to financial hardship. Prohibiting lifetime limits and annual limits will benefit families and individuals experiencing financial burdens due to exceeding the benefit limits of their insurance policy. By ensuring and continuing coverage, the regulations also reduce uncompensated care, which would otherwise increase premiums of the insured population through cost-shifting.

These provisions will also improve access to care. Reaching a limit could interrupt or cause the termination of needed treatment, leading to worsening of medical conditions. The removal and restriction of benefit limits helps ensure continuity of care and the elimination of the extra costs that arise when an untreated or undertreated condition leads to the need for even more costly treatment, that could

¹¹⁷Altman, D. Pre-X Redux. *The Kaiser Family Foundation*, June 2013.

¹¹⁸Baker, D. Job Lock and Employer – Provided Health Insurance: Evidence from the Literature. *Public Policy Institute*. 2015;1–35.

¹¹⁹Foronstin, P. Health Insurance Portability and Job Lock: Findings from the 1998 Health Confidence Survey. *Employee Benefit Research Institute Notes*. 1998: 19(8), pp. 4–6.

¹²⁰Coughlin, T. *et al.* Uncompensated Care for Uninsured in 2013: A Detailed Examination. *The Kaiser Family Foundation*, 2014; GAO, Private Health Insurance: Estimates of Individuals with Preexisting Conditions Range from 36 million to 122 million, GAO–12–439, 2012.

¹²¹A December 2014 study by Milliman “2014 U.S. organ and tissue transplant cost estimates and discussion” found that the average 2014 billed charges related to a heart transplant is \$1,242,200, a liver transplant averaged \$739,100, while a heart-lung transplant averaged \$2,313,600.

have been prevented if no loss of coverage had occurred. By ensuring continuation of coverage, the regulations benefit the health and the economic well-being of participants, beneficiaries, and enrollees.

Executive Order 12866 explicitly requires agencies to take account of “distributive impacts” and “equity,” and these considerations help to motivate the relevant statutory provisions and the interim final regulations and these regulations. Prohibiting lifetime and annual limits assures that insurance will perform the function for which it was designed—namely, protecting health and financial wellbeing for those most in need of care. This represents a meaningful improvement in equity, which is a benefit associated with the regulations.

3. Costs and Transfers

As discussed in the regulatory impact analysis for the interim final regulations, extending health insurance coverage for individuals who would otherwise hit a lifetime or annual limit will increase the demand for and utilization of health care services, thereby generating additional costs to the system. The three year phase-in of the elimination of annual limits and the immediate elimination of lifetime limits increased the actuarial value of the insurance coverage for affected plans and policies if no other changes were made to the plan or policy. Issuers and plans in the group market may have chosen to make changes to the plan or policy to maintain the pre-regulation actuarial value of the plan or policy, such as changing their provider networks or copayments in some manner. To the extent that higher premiums (or other plan or policy changes) are passed on to all employees, there is an explicit transfer from workers who would not incur high medical costs to those who do incur high medical costs. If, instead, the employers do not pass on the higher costs of insurance coverage to their workers, this can result in lower profits or higher prices for the employer’s goods or services. In the individual market, when policies were individually underwritten

with no rating bands in the majority of States, the Departments expected the added premium cost or other benefit changes to be largely borne by the individual policyholder. With the market reforms in place, along with single risk pool requirements, issuers can spread the increased costs across the entire individual market, leading to a transfer from those who do not incur high medical costs to those who do incur such costs. However, as with the group market, such a transfer was expected to be modest, given the small numbers of people who were expected to exceed their benefit limits. The Departments previously estimated that the transfer would be three-quarters of a percent or less for lifetime limits and one-tenth of a percent or less for annual limits, under a situation of pure community rating where all the costs get spread across the insured population. This impact does not apply to grandfathered individual market plans.

It is worth noting that these transfers are expected to have been significantly mitigated by the associated expansion of coverage created by the interim final regulations and other regulations implementing the Affordable Care Act. The Departments expect that, as a result of the gradual elimination of annual limits and the immediate elimination of lifetime limits, fewer people have been left without protection against high medical costs. This results in fewer individuals spending down resources and enrolling in Medicaid or receiving other State and locally funded medical support. Such an effect will likely be amplified due to the high-cost nature of people who exceed benefit limits.

D. PHS Act Section 2712, Prohibition on Rescissions (26 CFR 54.9815–2712, 29 CFR 2590.715–2712, 45 CFR 147.128)

1. Affected Entities and Individuals

PHS Act Section 2712 and these final regulations create a statutory Federal standard and enforcement power in the group

and individual markets where it did not exist. Prior to this provision taking effect, varying Federal common laws existed for ERISA plans. State rules pertaining to rescission have been found to be preempted by ERISA by five circuit courts (5th, 6th, 7th, 9th and 11th as of 2008).

The Affordable Care Act and its implementing regulations should have a large effect on reducing the number of rescissions for two reasons. First, the Affordable Care Act raised the standard governing when coverage may be rescinded. Group health plans and health insurance issuers may now only rescind coverage based on fraud or intentional misrepresentation of a material fact which is a higher standard than most State laws required previously. Second, the interaction of these regulations with PHS Act sections 2704, prohibition of preexisting condition exclusions, and sections 2705, prohibiting discrimination against individual participants and beneficiaries based on health status, could significantly reduce the number of policies rescinded. Previously, the issues surrounding the reporting of preexisting conditions to issuers and an individual’s health status were primary causes of rescissions. With the main source of rescissions removed there would be a significant drop in rescissions even without these regulations.

The Departments assume that these final regulations will have their largest impact on the individual insurance market, because group health coverage rarely is rescinded.¹²² By creating a new Federal standard governing when policies can be rescinded, the Departments expect these final regulations to potentially affect the approximately 6.7 million non-elderly individual health insurance policies covering 10.9 million policy holders and their dependents in the individual health insurance market.¹²³ In addition, approximately 430 health insurance issuers offering coverage in the individual health insurance market who currently could rescind health insurance coverage are expected to be affected.¹²⁴ That said, the actual incidence of individuals who are subject to rescissions each year is likely to

¹²²This statement is based on the Departments’ conversations with industry experts.

¹²³2013 filings of the Medical Loss Ratio Report found at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio.html>.

¹²⁴2013 filings of the Medical Loss Ratio Report.

be small. The NAIC Regulatory Framework Task Force collected data on 52 companies covering the period 2004–2008, and found that rescissions averaged 1.46 per thousand policies in force.¹²⁵ These pre-Affordable Care Act estimates are believed to be a significant overstatement of rescissions occurring now, however no new data is available. Using this estimate implies that when combined with the current numbers of policy holders in the individual market there could be approximately 9,900 rescissions per year.

2. Benefits

Because there is little pre-Affordable Care Act data available and no publicly available post-Affordable Care Act data, the Departments find it difficult to estimate the benefits associated with this provision. However, the Departments believe that the benefits of this provision would accrue to those individuals who without these regulations would have their policies rescinded.

As noted, Executive Order 12866 requires consideration of “distributive impacts” and “equity.” To the extent that rescissions are arbitrary, or targeted at those most ill, and revoke the insurance that enrollees paid for and expected to cover the cost of expensive illnesses and conditions, preventing rescissions would prevent inequity and greatly increase health and economic well-being. Consumers would have greater confidence that purchasing insurance would be worthwhile, and policies would represent better value for money.

Individuals who otherwise would have had their policies rescinded are now able to retain their coverage; the maintenance of such coverage through severe illness helps to prevent financial hardship for the enrollee and their family, creating a substantial financial benefit.¹²⁶

As discussed previously, uninsured individuals are less likely to receive needed care when they become ill, resulting in the

worsening of their condition. The lack of insurance can lead to lost workplace productivity and additional mortality and morbidity. Additionally, this provision protects those individuals currently receiving treatment for a condition by eliminating the potential interruptions or terminations in care resulting from rescissions, resulting in higher losses in productivity.¹²⁷ Thus, this rule would contribute to increased worker productivity by reducing the burden associated with the loss of insurance coverage, and the concomitant financial and emotional stress.

3. Costs and Transfers

As with the benefits, the costs and transfers of these regulations are similar to those of the interim final regulations. The prohibition of rescissions except in cases of fraud or intentional misrepresentation of material fact could lead insurers to spend more resources checking applications before issuing policies than they did before the Affordable Care Act, which would increase administrative costs. However, under the final regulations, these costs could be partially offset by decreased costs associated with reduced post-claims underwriting.

To the extent that continuing coverage for these generally high-cost populations leads to additional demand for and utilization of health care services, there will be additional costs generated in the health care system. However, given the relatively low rate of rescissions (approximately 0.15 percent of individual policies in force) and the relative nature of those individuals who generally have policies rescinded (who would have difficulty going without treatment), the Departments estimate that these additional costs would be small.

For those policies or plans that are rescinded, the requirement for an advance notice prior to such a rescission imposes a total hour burden of approximately 250

hours and a cost burden of approximate \$3,900. These costs are discussed in more detail in the Paperwork Reduction Act section later in this preamble.

A transfer likely will occur within the individual health insurance market from policyholders whose policies would not have been rescinded before the Affordable Care Act to some of those whose policies that would have been rescinded before the Affordable Care Act, depending on the market and the rules which apply to it. This transfer could result from higher overall premiums insurers will charge to recoup the costs associated with the health care costs of those individuals with chronic or serious conditions whose policies could previously be rescinded (the precise change in premiums depending on the competitive conditions in specific insurance markets). This transfer across the market would benefit those individuals with substantially higher medical costs, due to chronic or severe conditions, and would be attributable to insurers covering those costs associated with such individuals.

E. PHS Act Section 2714, Coverage of Dependents to Age 26 (26 CFR 54.9815–2714, 29 CFR 2590.715–2714, 45 CFR 147.120)

1. Affected Entities and Individuals

Prior to implementation of the Affordable Care Act there were an estimated 6.6 million uninsured young adults age 19–26; with an estimated 3.3 million having parents with ESI and an additional 2.7 million with individual coverage, all of whom could potentially have been affected.¹²⁸ Implementation of this provision allowed 13.7 million young adults to either stay on or join their parents’ health plans (from November 2010 until November 2011).¹²⁹ There was a rapid response to changes in the regulations leading to large number of employers enrolling

¹²⁵NAIC Rescission Data Call, December 17, 2009, p.1.

¹²⁶Girion, Lisa “Health Net Ordered to Pay \$9 million after Canceling Cancer Patient’s Policy,” *Los Angeles Times* (2008), available at: <http://www.latimes.com/business/la-fi-insure23feb23,1,5039339.story>.

¹²⁷Collins et al. “Gaps in Health Insurance: An All American Problem” *Commonwealth Fund* (2006), available http://www.commonwealthfund.org/usr_doc/Collins_gapshtlins_920.pdf.

¹²⁸Collins, S. and Nicholson, J. Rite of Passage: Young Adults and the Affordable Care Act of 2010. *The Commonwealth Fund*. May 2010.

¹²⁹Collins, S. et al. Young, Uninsured and in Debt: Why Young Adults Lack Health Insurance and How the Affordable Care Act is Helping. *The Commonwealth Fund*. June 2012.

young adults¹³⁰, with thirteen percent of small firms and 70 percent of large firms enrolling at least one young adult – small employers on average enrolled two young adults while large employers enrolled on average 492 young adults.¹³¹

Studies have shown that 2.3 million young adults were able to gain coverage since implementation of the Affordable Care Act and this provision in 2010 through the start of the open enrollment period in October 2013.¹³² The number of affected young adults has continued to increase as more employers began covering young adult dependents and those on individual grandfathered plans began changing policies to include dependents up to age 26. This has resulted in an additional 3.4 million young adults gaining coverage since October 2013, resulting in a total of an estimated 5.7 million gaining coverage from 2010 through March 2015.¹³³

2. Benefits

The benefits of these final regulations are expected to outweigh the costs to the regulated community. As of March 2015, an estimated 5.7 million additional young adults are now covered by their parents' health plans due to the implementation of this provision.¹³⁴ Expanding coverage options for the 19–26 year old population has resulted in a decline in the number of uninsured young adults, declining to an uninsured rate of 26.7 percent in the third quarter of 2013 (before the start of the October 2013 open enrollment period).¹³⁵

Uninsured young adults are less likely to have access to care and thus delay

seeking needed care¹³⁶, leading to higher costs when care is received. Further, expanded coverage provides young adults with security and protection from the financial consequences of serious medical emergencies. Recent studies have found that due to the implementation of this provision there has been a decline in the number of young adults facing higher out-of-pocket expenses (greater than \$1,500);¹³⁷ benefiting them when many young adults are currently facing elevated debt burdens and low wages.¹³⁸

Additionally, expanding coverage to those aged 19–26 should decrease the cost-shifting of uncompensated care onto those with coverage (including \$147 million from emergency department care),¹³⁹ increase the receipt of preventive health care and provide more timely access to high quality care, resulting in a healthier population. In particular, children with chronic conditions or other serious health issues will be able to continue coverage through a parent's plan until age 26.

Extending dependent coverage of children to age 26 will also permit greater job mobility for this population as their health coverage will no longer be tied to their jobs, thus reducing the potential of “job lock”,¹⁴⁰ or student status.

3. Costs and Transfers

Estimates for the incremental annual premium costs for the newly covered individuals were developed in the interim final regulations; estimating that for those enrolling in their parents' ESI, the expected annual premium cost would lead to an expected increase of 0.7 percent in 2011, 1.0 percent in 2012, and 1.0 percent

in 2013. A recent study carried out by Depew and Bailey found that the requirement dependent coverage provision led to a 2.5–2.8 percent increase in premiums for plans that cover children, and that employers did not pass on the entire premium increase to employees in the form of higher required plan contributions.¹⁴¹ To the extent that some of these increases are passed on to workers in the form of higher premiums for all workers purchasing family policies or in the form of lower wages for all workers, there will be a transfer from workers who do not have newly covered dependents to those who do. To the extent that these higher premiums result in lower profits or higher prices for the employer's product, the higher premiums will result in a transfer either from stockholders or consumers to workers who have newly covered dependents.

In addition, to the extent these final regulations result in a decrease in the number of uninsured, the Departments expect a reduction in uncompensated care, and a reduction in liability for those who fund uncompensated care, including public programs (primarily Medicaid and State and local general revenue support for public hospitals), as well as the portion of uncompensated care that is paid for by shifting costs from private payers. Such effects would lead to lower premiums for the insured population, both with or without newly covered children.

For the number of young adults enrolling in their parents' non-group (individual) insurance policy, the Departments estimated that, to a large extent, premiums in the individual market will be borne by the parents who are purchasing the coverage. If, instead, these costs are distributed

¹³⁰Cantor, J. *et al.* Early Impact of the Affordable Care Act on Health Insurance Coverage of Young Adults. *Health Services Research*, 47:5 (2012):pp. 1773–1790.

¹³¹Claxton, G. *et al.* Employer Health Benefits: 2011 Annual Survey. *Kaiser Family Foundation and Health Research & Education Trust*. 2011

¹³²ASPE *Data Point*, Health Insurance Coverage and the Affordable Care Act, September 2015.

¹³³ASPE. Health Insurance Coverage and the Affordable Care Act. May 2015 at http://aspe.hhs.gov/sites/default/files/pdf/83966/ib_uninsured_change.pdf

¹³⁴*Id.*

¹³⁵*Ibid* and Sommers, B. Number of Young Adults Gaining Insurance Due to the Affordable Care Act Now Tops 3 Million. *ASPE Issue Brief*, June 2012

¹³⁶Newacheck, P. *et al.* Health Insurance and Access to Primary Care for Children. *N Engl J Med*. 338:8 (1998) and Sommers, B. *et al.* The Affordable Care Act Has Led To Significant Gains in Health Insurance and Access to Care for Young Adults. *Health Affairs*, 32:1 (2013):pp. 165–174

¹³⁷Busch, S. *et al.* ACA Dependent Coverage Provision Reduced High Out-Of-Pocket Health Care Spending For Young Adults. *Health Affairs*, 33:8 (2014): pp. 1361–1366 and Mulcahy, A. *et al.* Insurance Coverage of Emergency Care for Young Adults under Health Reform. *N Engl J Med*. 368:22 (2013)

¹³⁸Chua, K-P. and Sommers, B. Changes in Health and Medical Spending Among Young Adults Under Health Reform. *JAMA*, 311:23 (2014)

¹³⁹Mulcahy, A. *et al.* Insurance Coverage of Emergency Care for Young Adults under Health Reform. *N Engl J Med*. 368:22 (2013)

¹⁴⁰Sommers, B. *et al.* The Affordable Care Act Has Led To Significant Gains in Health Insurance and Access to Care for Young Adults. *Health Affairs*, 32:1 (2013):pp. 165–174

¹⁴¹Depew, B. and Bailey, J. Did the Affordable Care Act's dependent coverage mandate increase premiums? *Journal of Health Economics*, 41 (2015):pp. 1–14

over the entire individual market (as would be the case in a pure community rated market), the Departments estimated in the interim final regulations that the individual premiums would rise 0.7 percent in 2011, 1.0 percent in 2012, and 1.2 percent in 2013. However, the Departments expected the actual increase across the entire individual market, if any, to be much smaller than these estimates, because they expected the costs to be largely borne by the subscribers who are directly affected rather than distributed across the entire individual market.

F. PHS Act Section 2719, Internal Claims and Appeals and External Review (26 CFR 54.9815–2719, 29 CFR 2590.715–2719, 45 CFR 147.136)

1. Estimated Number of Affected Entities

These provisions are applicable to non-grandfathered health plans and coverage. Using the estimates from the discussion of affected entities for the grandfathering provisions discussed in paragraph III.C, there are 96.3 million individuals covered by non-grandfathered ERISA-covered health plans, 30.4 million individuals covered by non-grandfathered State and local health plans, and 8.7 million individuals in non-grandfathered health coverage in the individual market.

Not all potentially affected individuals will be affected equally by these final regulations. Sponsors of ERISA-covered group health plans were required to implement an internal appeals process that complied with the DOL claims procedure regulation before the Affordable Care Act's enactment, and the Departments also understand that many non-Federal governmental plans and church plans that are not subject to ERISA had implemented internal claims and appeals processes that comply with the DOL claims procedure regulation. Therefore, participants and beneficiaries covered by such plans only will be affected by the internal claims and appeals standards that are provided by the Secretary of Labor in paragraph (b)(2)(ii) of these final regulations under PHS Act section 2719.

These final regulations will have the largest impact on individuals covered in the individual health insurance market, because with the issuance of the interim final regulation, these issuers were required to comply with the DOL claims procedure regulation for internal claims and appeals as well as the additional standards added by the Secretary of the Department of Health and Human Services in paragraph (b)(3) of these final regulations that are in some cases more protective than the ERISA standard.

On the external appeals side, before the enactment of the Affordable Care Act, issuers offering coverage in the group and individual health insurance market were already required to comply with State external review laws. At that time, all States except Alabama, Mississippi, Nebraska, North Dakota, South Dakota, and Wyoming had external review laws, and thirteen States had external review laws that apply only to certain market segments (for example, managed care or HMOs). Currently, all States except, Alabama, Alaska, Florida, Georgia, Pennsylvania, and Wisconsin have State external review laws that satisfy the requirement to provide a NAIC-similar or NAIC-parallel external review process. These six States that do not meet the requirements, must use the HHS-administered process or must contract with accredited independent review organizations to review external appeals on their behalf until they meet the requirements.¹⁴²

Individuals participating in ERISA-covered self-insured group health plans will be among those most affected by the external review requirements contained in these final regulations, because the preemption provisions of ERISA prevent a State's external review process from applying directly to an ERISA-covered self-insured plan. These plans will now be required to comply with the Federal external review process set forth under paragraph (d) of these final regulations.

In summary, the number of affected individuals depends on several factors, including whether (i) a health plan retains its grandfather status, (ii) the plan is subject to ERISA, (iii) benefits provided under the plan are self-funded or financed by

the purchase of an insurance policy, (iii) the applicable State has enacted an internal claims and appeals law, and (iv) the applicable State has enacted an external review law, and if so the scope of such law, and (v) the number of new plans and enrollees in such plans.

The following, is a summary of the benefits and costs as discussed in the interim final regulations and that are still applicable to these final regulations.

2. Benefits

Because of data limitations and a lack of effective measures, the Departments did not attempt to quantify the expected benefits. Nonetheless, the Departments were able to identify several of the interim final regulation's major economic benefits.

The interim final regulations and these final regulations will help transform the current, highly variable health claims and appeals process into a more uniform and structured process. This will:

- improve the extent to which employee benefit plans provide benefits consistent with the established terms of the plan;
- ensure greater certainty and consistency in the handling of benefit claims and appeals and improved access to information about the manner in which claims and appeals are adjudicated;
- increase efficiency in the operation of employee benefit plans and health care delivery as well as health insurance and labor markets;
- increase efficiency of health plans by enhancing their transparency and fostering participants' confidence in the plan's fairness;
- reduce delays and inappropriate denials;
- reduce the levels of error in the system and improve health outcomes;
- improve health care, health plan quality, and insurance market efficiency by serving as a communication channel, providing feedback from participants, beneficiaries, and providers to plans about quality issues; and

¹⁴²Affordable Care Act: Working with States to Protect Consumers, available at https://www.cms.gov/CCIIO/Resources/Files/external_appeals.html.

- enhance some insurers' and group health plans' abilities to effectively control costs by limiting access to inappropriate care.

3. Costs and Transfers

The Departments have quantified the primary source of costs associated with these final regulations that will be incurred to (i) administer and conduct the internal and external review process, and (ii) prepare and distribute required disclosures and notices. These costs and the methodology used to estimate them are discussed under the Paperwork Reduction Act section. The total cost related to the information collections is \$160.1 million annually.

a. Additional Requirements for Group Health Plans.

Paragraph (b)(2)(i) of these final regulations imposes additional requirements to the DOL claims procedure regulation that must be satisfied by group health plans and issuers offering group and individual coverage in the individual and group health insurance markets. The Departments believe that the additional requirements have modest costs associated with them, because they merely clarify provisions of the DOL claims procedure regulation.

As discussed in the impact analysis for the interim final regulations the Departments were not able to estimate the costs for some of the requirements, namely for: the definition of adverse determination, expedited notification of benefit determination involving urgent care, eliminating conflicts of interest, and deemed exhaustion of internal process. The Departments were able to quantify the costs for Full and fair review and Enhanced notice with culturally and linguistically appropriate notices. These costs are included in the Paperwork Reduction Act Section.

b. Additional Requirements for Issuers in the Individual Insurance Market.

To address certain relevant differences in the group and individual markets,

health insurance issuers offering individual health insurance coverage must comply with three additional requirements. First, these final regulations expand the scope of the group health coverage internal claims and appeals process to cover initial eligibility determinations.

This protection is important since eligibility determinations in the individual market are frequently based on the health status of the applicant, including preexisting conditions. The Departments do not have sufficient data to quantify the costs associated with this requirement.

Second, although the DOL claims procedure regulation permits group health plans to have a second level of internal appeals, these final regulations require health insurance issuers offering individual health insurance coverage to have only one level of internal appeals. This allows the claimant to seek either external review or judicial review immediately after an adverse determination is upheld in the first level of internal appeals. The Departments have factored this cost into their estimate of the cost for issuers offering coverage in the individual market to comply with this requirement.

Finally, these final regulations require health insurance issuers offering individual health insurance coverage to maintain records of all claims and notices associated with their internal claims and appeals processes. An issuer must make such records available for examination upon request. Accordingly, a claimant or State or Federal agency official generally would be able to request and receive such documents free of charge. The Departments believe that minimal costs are associated with this requirement, because most issuers retain the required information in the normal course of their business operations.

c. External Appeals.

The analysis of the cost associated with implementing an external review process under the interim final regulations and

these final regulations focuses on the cost incurred by the following three groups that were not required to implement an external review process before the enactment of the Affordable Care Act: plans and participants in ERISA-covered self-insured plans; plans and participants in States with no external review laws; and plans and participants in States that have State laws only covering specific market segment (usually HMOs or managed care coverage).

The Departments estimate that there are approximately 78.7 million participants in self-insured ERISA-covered plans and approximately 15.5 million participants in self-insured State and local governmental plans. In the States which currently have no external review laws or whose laws do not meet the federal minimum requirements¹⁴³ there are an estimated 13.8 million participants (8.1 million participants in ERISA-covered plans, 3.7 million participants in governmental plans and 2 million individual covered by policies in the individual market). These estimates lead to a total of 108 million participants, however, only the 80.0 million participants in non-grandfathered plans will be required to be covered by the external review requirement.

The Departments assume that there are an estimated 1.3 external appeals for every 10,000 participants¹⁴⁴, and that there will be approximately 10,400 external appeals annually. As required by these final regulations or applicable State law, plans or issuers are required to pay for most of the cost of the external review while claimants may be charged a nominal filing fee in States that authorized such fees as of November 18, 2015. One study found that the average cost of a review was approximately \$665¹⁴⁵. The average cost per appeal in the HHS-administered External Review Program is approximately \$625 for a standard case and \$825 for an expedited case.¹⁴⁶

The actual cost per review will vary by State and type of review (standard or expedited). Lacking data on the percent of

¹⁴³These states are Alabama, Alaska, Florida, Georgia, Pennsylvania, and Wisconsin. See Affordable Care Act: Working with States to Protect Consumers, available at https://www.cms.gov/CCIIO/Resources/Files/external_appeals.html

¹⁴⁴AHIP Center for Policy and Research, "An Update on State External Review Programs, 2006," July 2008.

¹⁴⁵North Carolina Department of Insurance "Healthcare Review Program: Annual Report," 2013 Table 4. <http://www.ncdoi.com/smart/Documents/ExternalReviewReport16.pdf>

¹⁴⁶The HHS-administered External Review Program is approximately \$625 for a standard case and \$825 for an expedited case.

appeals that are expedited, but with the majority of appeals being standard appeals, the higher cost per appeal of \$665 for a standard appeal is used as an estimate for all appeals. These estimates lead to an estimated cost of the external review of \$6.9 million (10,400 reviews * \$665) annually.

On average, about 40 percent of denials are reversed on external appeal.¹⁴⁷ An estimate of the dollar amount per claim reversed is \$12,500.¹⁴⁸ This leads to \$53.5 million in additional claims being reversed by the external review process annually. While this amount is a cost to plans, it represents a payment of benefits that should have previously been paid to participants, but was denied. Part of this amount is a transfer from plans and issuers to those now receiving payment for denied benefits. Part of the amount could also be a cost if the reversal leads to services and hence resources being utilized now that had been denied previously. The Departments are not able to distinguish between the two types but believe that most reversals are associated with a transfer.

These final regulations also require claimants to receive a notice informing them of the outcome of an appeal and/or external review. The independent review organization that conducts the external review is required to prepare the notice; therefore, the cost of preparing and delivering this notice is included in the fee paid them by the insurer to conduct the review.

4. Summary

These final rules extend the protections of the DOL claims procedure regulation to non-Federal governmental plans, and the market for individual coverage. Additional protections are added that cover these two markets and in addition to the market for ERISA-covered plans. These final regulations also extend the requirement to provide an independent external review. The Departments estimate that the total costs for these final regulations is

\$169.9 million annually with a transfer from the plan and its participants to those whose claims are reversed of \$53.5 million annually.

G. PHS Act Section 2719A, Patient Protections (26 CFR 54.9815–2719A, 29 CFR 2590.715–2719A, 45 CFR 147.138)

1. Designation of Primary Care Provider

The statute, the interim final regulations and these final regulations provide that if a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer must permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept the participant, beneficiary, or enrollee based on his or her geographic location.

a. Affected Entities and Individuals

Choice or assignment of a primary care provider is typically required by Health Maintenance Organizations (HMOs) and Point of Service plans (POS). Recent data suggest that there are 316,000 HMOs in the United States, accounting for more than 11.3 million enrollees with ESI. There are also 558,000 POS plans accounting for almost 7 million enrollees with ESI. The individual market includes 130,700 HMO policies.¹⁴⁹ Similar data do not exist for POS policies in the individual market.

This provision only applies to non-grandfathered health plans. However, due to the lack of data on HMO and POS enrollees by type of market, and the inability to predict new plans that may enter those markets, the Departments are unable to predict the number enrollees and plans that would be affected by this provision. Moreover, there is no data on the number of plans that auto-assigned patients to primary care physicians and did not already

allow patients to make the final provider choice, as this would be the population to benefit maximally from the interim final rules and these regulations. From conversations with industry experts the Departments expect, however, that this number would be very small, and therefore the benefits and costs of this provision would be small as well.

b. Benefits, Costs, and Transfers

As discussed in the RIA for the interim final regulations, provider choice allows patients to take into account factors they may value when choosing their provider, such as provider credentials, office hours and location, advice from professionals, and information on the experience of other patients. Provider choice is a strong predictor of patient trust in their provider, which could lead to decreased likelihood of malpractice claims, improved medication adherence and also improves health outcomes.

Although difficult to estimate given the data limitations described, the costs for this provision are likely to be minimal. As noted in the RIA for the interim final regulations, when enrollees like their providers, they are more likely to maintain appointments and comply with treatment, both of which could induce demand for services, but these services could then in turn reduce costs associated with treating more advanced conditions. However, the number of affected entities from this provision is very small, leading to small additional costs. There will likely be negligible transfers due to this provision given no changes in coverage or cost-sharing.

2. Designation of Pediatrician as Primary Care Provider

If a plan or issuer requires or provides for the designation of a participating primary care provider for a child by a participant, beneficiary, or enrollee, the plan or issuer must permit the designation of a physician (allopathic or osteopathic) who specializes in pediatrics, including pediat-

¹⁴⁷Of the 105 cases fully reviewed in the HHS-administered external review process so far, 28 have been overturned and 25 have been partially overturned.

¹⁴⁸North Carolina Department of Insurance "Healthcare Review Program: Annual Report," 2013. <http://www.ncdoi.com/smart/Documents/ExternalReviewReport16.pdf>

¹⁴⁹Data for the group market (plan and participant counts) were calculated using the 2012 MEPS, 2012 Census of Government, 2014 Current Population Survey, and 2014 Kaiser/HRET Survey of Employer Sponsored Health Benefits. Data for the individual market were calculated using AHIP "Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability and Benefits," Table 10 and Medical Loss Ratio submissions for 2013 reporting year.

ric subspecialties (based on the scope of that provider's license under applicable State law), as the child's primary care provider if the provider participates in the network of the plan or issuer and is available to accept the child. The general terms of the plan or health insurance coverage regarding pediatric care otherwise are unaffected, including any exclusions with respect to coverage of pediatric care.

a. Affected Entities and Individuals

Due to lack of data on enrollment in managed care organizations by age, as well as lack of data on HMO and POS enrollees by type of market, and the inability to predict new plans that may enter those markets, the Departments are unable to predict the number of enrollees and plans that would be affected by these provisions. As a reference, there are an estimated 5.6 million individuals under age 19 with ESI who are in an HMO plan.¹⁵⁰

b. Benefits, Costs, and Transfers

By expanding participating primary care provider options for children to include pediatricians, this provision benefits individuals who are making decisions about care for their children. As discussed in the previous section, research indicates that when doctors and patients have a strong, trusting relationship, patients often have improved medication adherence, health promotion, and other beneficial health outcomes.

In addition, allowing enrollees to select a physician specializing in pediatrics as their children's primary care provider has removed any referral related delays for individuals in plans that required referrals to pediatricians and did not allow physicians specializing in pediatrics to serve as primary care providers. The American Academy of Pediatrics (AAP) strongly supports the idea that the choice of primary care clinicians for children should include pediatricians.¹⁵¹ Regular pediatric care, including care by physicians specializing in pediatrics, can improve child

health outcomes and avert preventable health care costs.

Giving enrollees in covered plans (that require the designation of a primary care provider) the ability to select a participating pediatrician as the child's primary care provider benefits those individuals who would not otherwise have been given this choice. Again, the extent of these benefits will depend on the number of enrollees with children that are covered by plans that do not allow the selection of a pediatrician as the primary care provider, which industry experts suggest would be small.

Although difficult to estimate given the data limitations described, the costs for this provision are likely to be small. Giving enrollees a greater choice of primary care providers by allowing them to select participating physicians who specialize in pediatrics as their child's primary care provider could lead to increased health care costs by increasing the take-up of primary care services, assuming they would not have utilized appropriate services as frequently if they had not been given this choice.

Any transfers associated with the interim final regulations and these final regulations are expected to be minimal. To the extent that pediatricians acting as primary care providers would receive higher payment rates for services provided than would other primary care physicians, there may be some transfer of wealth from policy holders of non-grandfathered group plans to those enrollees that choose the former providers. However, the Departments do not believe that this is likely given the similarity in income for primary care providers that care for children.

3. Patient Access to Obstetrical and Gynecological Care

The statute, the interim final regulations and these final regulations also provide rules for a group health plan, or a health insurance issuer offering group or individual health insurance coverage, that provides coverage for obstetrical or gynecological care and requires the designation of an in-network primary care provider. Specifically, the plan or issuer may not require authorization or referral by the plan, issuer, or any person (including a primary care provider) for a female participant, beneficiary, or enrollee who seeks obstetrical or gynecological care provided by an in-network health care professional who specializes in obstetrics or gynecology (OB/GYN). These plans and issuers must also treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, by the OB/GYN as the authorization of the primary care provider. For this purpose, an OB/GYN is any individual who is authorized under applicable State law to provide obstetrical or gynecological care, and is not limited to a physician.

Requiring referrals or authorizations to OB/GYNs is typically required by HMOs and POS plans.

This provision applies to non-grandfathered health plans. However, due to the lack of data on HMO and POS enrollees by type of market, and the inability to predict new plans that may enter those markets, the Departments are unable to predict the number enrollees and plans that would be affected by this provision. As a reference, there are an estimated 7.3 million females between ages 21 to 65 with ESI who are in HMO plans.¹⁵²

a. Affected Entities and Individuals

Requiring referrals or authorizations to OB/GYNs is typically required by HMOs and POS plans.

This provision applies to non-grandfathered health plans. However, due to the lack of data on HMO and POS enrollees by type of market, and the inability to predict new plans that may enter those markets, the Departments are unable to predict the number enrollees and plans that would be affected by this provision. As a reference, there are an estimated 7.3 million females between ages 21 to 65 with ESI who are in HMO plans.¹⁵²

b. Benefits, Costs, and Transfers

This provision gives women in covered plans easier access to their OB/GYNs, where they can receive preventive services such as pelvic and breast exams, without the added time, expense, and inconvenience of needing permission first from their primary care providers. Moreover, this provision may also save time and reduce administrative burden since participating OB/GYNs do not need to get an authorization from a primary care provider.

¹⁵⁰Estimate based on data from the 2012 MEPS, 2012 Census of Government, 2014 Current Population Survey, and 2014 Kaiser/HRET Survey of Employer Sponsored Health Benefits.

¹⁵¹See AAP Policy Statement, "Guiding Principles for Managed Care Arrangements for the Health Care of Newborns, Infants, Children, Adolescents, and Young Adults", available at: <http://pediatrics.aappublications.org/content/132/5/e1452.full.pdf+html>.

¹⁵²Estimate based on data from the 2012 MEPS, 2012 Census of Government, 2014 Current Population Survey, and 2014 Kaiser/HRET Survey of Employer Sponsored Health Benefits.

vider to provide care and order obstetrical and gynecological items and services. To the extent that primary care providers spend less time seeing women who need a referral to an OB/GYN, access to primary care providers will be improved. To the extent that the items and services are critical and would have been delayed while getting an authorization from the primary care provider, this provision will improve the treatment and health outcomes of female patients. Access to such care can have substantial benefits in women's lives.

To the extent that direct access to OB/GYN services results in increased utilization of recommended and appropriate care, this provision may result in benefits associated with improved health status for the women affected. Potential cost savings also exist since women in affected plans will not need to visit their primary care provider in order to get a referral for routine obstetrical and gynecological care, items, and services, thereby reducing unnecessary time and administrative burden, and decreasing the number of office visits paid by her and by her health plan.

One potential area of additional costs associated with this provision would be induced demand, as women who no longer need a referral to see an OB/GYN may be more likely to receive preventive screenings and other care. Data is limited to provide an estimate of this induced demand, but the Departments believe it to be small.

To the extent this provision results in a shift in services to higher cost providers, it will result in a transfer of wealth from enrollees in non-grandfathered group plans to those individuals using the services affected. However, such an effect is expected to be small.

4. Emergency Services

PHS Act section 2719A, the interim final regulations, and these final regulations provide that a group health plan and a health insurance issuer covering emergency services must do so without the individual or the health care provider having to obtain prior authorization (even if the emergency services are provided out-of-network). For a plan or health insurance coverage with a network of providers

that provide benefits for emergency services, the plan or issuer may not impose any administrative requirement or limitation on benefits for out-of-network emergency services that is more restrictive than the requirements or limitations that apply to in-network emergency services.

Finally, the interim final regulations and these final regulations provide that cost-sharing requirements expressed as a copayment amount or coinsurance rate imposed for out-of-network emergency services cannot exceed the cost-sharing requirements that would be imposed if the services were provided in-network. The regulations also provide that a plan or health insurance issuer provide benefits for out-of-network emergency services (prior to imposing in-network cost sharing) in an amount at least equal the greatest of: (1) the median amount negotiated with in-network providers for the emergency service; (2) the amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount); or (3) the amount that would be paid under Medicare for the emergency service. In applying the rules relating to emergency services, the statute and the regulations define the terms emergency medical condition, emergency services, and stabilize. These terms are defined generally in accordance with their meaning under Emergency Medical Treatment and Labor Act (EMTALA), section 1867 of the Social Security Act.

The statute and the regulations relating to emergency services do not apply to grandfathered health plans; however, other Federal or State laws related to emergency services may apply regardless of grandfather status.

a. Affected Entities and Individuals

The interim final regulations and these regulations directly affect out-of-pocket expenditures for individuals enrolled in non-grandfathered private health plans (group or individual) whose copayment or coinsurance arrangements for emergency services differ between in-network and out-of-network providers. These regulations may also require some health plans to change the amount they pay to out-of-

network providers compared to their pre-Affordable Care Act contractual arrangements. There are no available data, however, that allow for national estimates of the number of plans (or number of enrollees in plans) that have different payment arrangements for out-of-network than in-network providers, or differences between in- and out-of-network copayment and coinsurance arrangements, in order to more precisely estimate the number of enrollees affected.

Prior to the issuance of the interim final regulations, the Departments conducted an informal survey of benefits plans for large insurers in order to assess the landscape with regard to copayment and coinsurance for emergency department services, but found that a variety of arrangements existed in the marketplace prior to the issuance of the interim final regulations. Many of the large insurers maintained identical copayment and/or coinsurance arrangements between in- and out-of-network providers. Others had differing arrangements based on copayments, coinsurance rates, or a combination of the two. While useful for examining the types of arrangement that exist in the market place, these data do not contain enrollment information and therefore cannot be used to make impact estimates.

It was estimated in the interim final regulations that a maximum of 2.1 to 4.2 million individuals would be potentially affected by differing out-of-pocket requirements. Based on an informal survey, some proportion, possibly a large portion, of these individuals were covered by plans that had identical in- and out-of-network requirements. Therefore, the number of individuals affected by this regulatory provision was expected to be smaller.

b. Benefits, Costs, and Transfers

Insurers maintained differing copayment and coinsurance arrangements between in- and out-of-network providers as a cost containment mechanism. Implementing reduced cost sharing for the use of in-network providers provides financial incentive for enrollees to use these providers, with whom plans often have lower-cost contractual arrangements. In emergency situations, however, the choice of an in-network provider may not be

available — for example, when a patient is some distance from his or her local provider networks or when an ambulance transports a patient to the nearest hospital which may not have contractual arrangements with the person's insurer. In these situations, the differing copayment or co-insurance arrangements could place a substantial financial burden on the patient. This provision eliminates this disparity in out-of-pocket burden for enrollees, leading to potentially substantial financial benefit.

The regulations also provide for potentially higher payments to out-of-network providers, if usual customary rates or Medicare rates are higher than median in-network rates. This can have a direct economic benefit to providers and patients, as the remaining differential between provider charge and plan payment will be smaller, leading to a smaller balance-bill for patients.

To the extent that expectations about such financial burden with out-of-network emergency department usage would cause individuals to delay or avoid seeking necessary medical treatment when they cannot access a network provider, this provision may result in more timely use of necessary medical care. It may therefore result in health and economic benefits associated with improved health status; and fewer complications and hospitalizations due to delayed and possibly reduced mortality. The Departments expect that this effect would be small, however, because insured individuals are less likely to delay care in emergency situations.

The economic costs associated with the emergency services provisions are likely to be minimal. These costs will occur to the extent that any lower cost-sharing will induce new utilization of out-of-network emergency services. Given the nature of these services as emergency services, this effect is likely to be small for insured individuals. In addition, the demand for emergency services in truly emergency situations can result in health care cost savings and population health improvements due to the timely treatment of conditions that could otherwise rapidly worsen.

As discussed in the RIA for the interim final regulations, the emergency services provisions are likely to result in some transfers from the general membership of non-grandfathered group health plans that have differing copayment and coinsurance arrangements to those policy holders that use the out-of-network emergency services. The precise amount of the transfer which would occur through an increase in premiums is impossible to quantify due to lack of data, but only applies to non-grandfathered health plans.

5. Application to Grandfathered Plans

The provisions relating to certain patient protections do not apply to grandfathered health plans. However, other Federal or State laws related to these patient protections may apply regardless of grandfather status.

6. Patient Protection Disclosure Requirement

When applicable, it is important that individuals enrolled in a plan or health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires participants or subscribers to designate a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization.

Accordingly, as was provided in the interim final regulations, these final regulations require such plans and issuers to provide a notice to participants (in the individual market, primary subscribers) of these rights when applicable. Model language is provided in these regulations. The notice must be provided whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage, or in the individual market, provides a primary subscriber with a policy, certificate, or contract of health insurance.

The Departments estimate that the cost to plans and insurance issuers to prepare and distribute the disclosure is \$940,000 in 2015. For a discussion of the Patient Protection Disclosure Requirement, see

the Paperwork Reduction Act section later in this preamble.

IV. Paperwork Reduction Act

A. Departments of Labor and the Treasury

These final regulations contain a notice of grandfather status and third party disclosure, rescissions notice, and patient protection disclosures requirement for issuers and notice requirements related to internal claims and appeals and external review that are information collection requests (ICRs) subject to the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3506(c)(2)(A)).

In accordance with the requirements of the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3506(c)(2)), the Departments submitted an ICR to OMB in accordance with 44 U.S.C. 3507(d), contemporaneously with the publication of the interim final regulations, for OMB's review under the emergency PRA Procedures.¹⁵³ OMB subsequently approved the ICRs. Contemporaneously with the publications of the emergency ICRs, the Departments published a separate **Federal Register** notice informing the public that it intended to request OMB to extend the approval for three years and soliciting comments on the ICRs. OMB approved the ICR extensions.

No public comments were received in response to the ICRs contained in the interim final regulations that specifically addressed the paperwork burden analysis of the information collections. The comments that were submitted contained information relevant to the costs and administrative burdens attendant to the proposals. The Departments took into account the public comments when analyzing the economic impact of the proposals, and developing the revised paperwork burden analysis, which is summarized in the following sections.

A copy of the ICRs may be obtained by contacting the following PRA addressee or at <http://www.RegInfo.gov>. PRA ADDRESSEE: G. Christopher Cosby, Office of Policy and Research, U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue,

¹⁵³ 5 CFR 1320.13

NW, Room N-5718, Washington, DC 20210. Telephone: (202) 693-8410; Fax: (202) 219-4745. These are not toll-free numbers. E-mail: ebsa.opr@dol.gov.

1. ICR Regarding Affordable Care Act Notice of Grandfather Status and Third Party Disclosure

As discussed earlier in this preamble, to maintain grandfathered health plan status under these final regulations, a plan or issuer must maintain records that document the plan or policy terms in connection with the coverage in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as a grandfathered health plan, disclose its status as a grandfathered health plan, and if switching issuers and intending to maintain its status as a grandfathered plan it must provide to the new health insurance issuer documentation of plan terms under the prior health coverage sufficient for it to determine whether a change causing a cessation of grandfathered health plan status has occurred.

a. Grandfathered Health Plan Disclosure

The final regulations provide that the plan or issuer of a grandfathered plan must disclose to participants and beneficiaries its status as a grandfathered health plan. Model language is provided by the Departments. Using data from the 2014 Employer Health Benefits Survey it is estimated that 37 percent of plans are grandfathered plans and 26 percent of employees in ERISA-covered plans are in a grandfathered plans.¹⁵⁴

The Departments estimate that there are 850,700 (2.3 million ERISA-covered plans * 0.37) ERISA-covered plans¹⁵⁵ – with an estimated 17.2 million policy holders (66 million policy holders * 0.26) – that will need to include the notice in plan documents.¹⁵⁶ After plans satisfied the grandfathered health plan disclosure

requirement in 2011, any additional burden should be de minimis if a plan wants to maintain its grandfathered status in future years. The Departments also expect the cost of removing the notice from plan documents as plans relinquish their grandfathered status to be de minimis and therefore it is not estimated. Based on the foregoing, the Departments estimate that plans will incur no additional burden to maintain or remove the notice from plan documents. The Departments estimate that the notice will require one-half of a page and five cents per page printing and material cost will be incurred, and 38 percent of the notices will be delivered electronically. This results in a total cost burden of approximately \$266,000 ($\0.05 per page * $1/2$ pages per notice * 17.2 million notices * 0.62).

b. Record Keeping Requirement

Plans were required to maintain records documenting the terms of the plan or health insurance coverage in connection with the coverage in effect on March 23, 2010.

The Departments assume that most of the documents required to be retained to satisfy the recordkeeping requirement of these final regulations are already retained by plans for tax purposes, to satisfy ERISA's record retention and statute of limitations requirements, and for other business reasons. The Departments estimated this as a one-time cost incurred in 2011, because after the first year, the Departments anticipate that any future costs to retain the records will be de minimis.

c. Documentation of Plan Terms

These final regulations contain a disclosure requirement that requires that a group health plan that is changing health insurance coverage to provide to the succeeding health insurance issuer (and the

succeeding health insurance issuer must require) documentation of plan terms (including benefits, cost sharing, employer contributions, and annual limits) under the prior health insurance coverage sufficient to make a determination whether the standards of paragraph (g)(1) under the Affordable Care Act section 1251 regulations are exceeded. The number of plans that might be effected (133,200) is estimated by multiplying the number of grandfathered plans (850,700) by the percent of plans shopping for a new carrier (58 percent) and the number of plans shopping for a new carrier that switched (27 percent). Each of these plans would need to transmit to the carrier documentation of plan terms (including benefits, cost sharing, employer contributions, and annual limits) under the prior health insurance coverage sufficient to make a determination whether the standards of paragraph (g)(1) of the final regulations under Affordable Care Act section 1251 are exceeded. It is estimated that the electronic transmission of the already retained documents would require 2 minutes of a clerical staff's time with a labor rate of \$30.42 per hour.¹⁵⁷ These estimate result in an hour burden of 4,440 hours ($133,200 * 2/60$) with an equivalent cost of \$135,100 ($133,200 * 2/60 * \30.42). Each of these plans would need to transmit to the carrier documentation of plan terms. If half of the plans transmit the required documents electronically then 66,600 plans will be sent via mail resulting in a materials and postage costs of \$467,600 ($(66,600 * (90 \text{ pages} * 5 \text{ cents per page} + \$2.52 \text{ postage}))$).

The Departments note that persons are not required to respond to, and generally are not subject to any penalty for failing to comply with an ICR unless the ICR has a valid OMB control number.

The paperwork burden estimates are summarized as follows:

Type of Review: Revision.

¹⁵⁴Kaiser Family Foundation, "2014 Employer Health Benefits Survey." <http://kff.org/health-costs/report/2014-employer-health-benefits-survey/>.

¹⁵⁵EBSA estimates based on the 2014 Medical Expenditure Survey - Insurance Component.

¹⁵⁶Health Insurance Coverage Bulletin: Abstract of Auxiliary Data for the March 2014 Annual Social and Economic Supplement to the Current Population Survey, Table 3C.

¹⁵⁷The Department's estimated 2015 hourly labor rates include wages, other benefits, and overhead are calculated as follows: mean wage from the 2013 National Occupational Employment Survey (April 2014, Bureau of Labor Statistics <http://www.bls.gov/news.release/pdf/ocwage.pdf>); wages as a percent of total compensation from the Employer Cost for Employee Compensation (June 2014, Bureau of Labor Statistics <http://www.bls.gov/news.release/ceec.t02.htm>); overhead as a multiple of compensation is assumed to be 25 percent of total compensation for paraprofessionals, 20 percent of compensation for clerical, and 35 percent of compensation for professional; annual inflation assumed to be 2.3 percent annual growth of total labor cost since 2013 (Employment Costs Index data for private industry, September 2014 <http://www.bls.gov/news.release/eci.nr0.htm>). Secretaries, Except Legal, Medical, and Executive (43-6014): $\$16.35(2013 \text{ BLS Wage rate})/0.675(\text{ECEC ratio}) * 1.2(\text{Overhead Load Factor}) * 1.023(\text{Inflation rate})^2(\text{Inflated 2 years from base year}) = \30.42

Agency: Employee Benefit Security Administration, Department of Labor; Internal Revenue Service, U.S. Department of the Treasury.

Title: Disclosure and Recordkeeping Requirements for Grandfathered Plans under the Affordable Care Act

OMB Control Number: 1210-0140; 1545-2178

Affected Public: Business or other for-profit; not-for-profit institutions.

Total Respondents: 850,700

Total Responses: 18,143,923

Frequency of Response: Occasionally.

Estimated Total Annual Burden Hours (three year average): 2,200 (Employee Benefits Security Administration); 2,200 (Internal Revenue Service).

Estimated Total Annual Cost Burden (three year average): \$366,800 (Employee Benefits Security Administration); \$366,800 (Internal Revenue Service).

2. ICR Regarding Affordable Care Act Notice Relating to Rescissions

As discussed earlier in this preamble, PHS Act Section 2712 and these final regulations provide rules regarding rescissions for group health plans and health insurance issuers that offer group or individual health insurance coverage. A plan or issuer must not rescind coverage under the plan, policy, certificate, or contract of insurance except in the case of fraud or intentional misrepresentation of a material fact. These final regulations provide that a group health plan or a health insurance issuer offering group health insurance coverage must provide at least 30 calendar days advance notice to an individual before coverage may be rescinded. This rescission notice requirement is an information collection request (ICR) subject to the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3506(c)(2)(A)).

The Departments assume that rescissions are rare in the group market and that small group health plans are affected by rescissions. The Departments are not

aware of a data source on the number of group plans whose policy is rescinded; therefore, the Departments assume that 100 small group health plan policies are rescinded in a year. The Departments estimate that there is an average of 15.33 participants in small, insured plans.¹⁵⁸ Based on these numbers the Departments estimate that approximately 100 policies are rescinded during a year, which would result in 1,533 notices being sent to affected participants with 38 percent transmitted electronically and 62 percent mailed. The Departments estimate that 15 minutes of legal professional time at \$129.94 per hour would be required by the insurers of the 100 plans to prepare the notice and one minute per notice of clerical professional time at \$30.42 per hour would be required to distribute the paper notices. The Departments believe the costs of electronic transmission would be de minimis. This results in an hour burden of approximately 41 hours with an equivalent cost of approximately \$3,700.¹⁵⁹

The Departments estimate that the cost burden associated with distributing the paper notices via mail will be approximately \$500. This results from distributing 950 paper notices at a cost of \$0.54 per notice.¹⁶⁰

These paperwork burden estimates are summarized as follows:

Type of Review: Revision of existing collection.

Agencies: Employee Benefits Security Administration, Department of Labor; Internal Revenue Service, U.S. Department of the Treasury.

Title: Required Notice of Rescission of Coverage under the Patient Protection and Affordable Care Act Disclosures.

OMB Number: 1210-0141; 1545-2180.

Affected Public: Business or other for-profit; not-for-profit institutions.

Total Respondents: 100.

Total Responses: 1,533.

Frequency of Response: Occasionally.

Estimated Total Annual Burden Hours: 20.5 hours (Employee Benefits Security Administration); 20.5 hours (Internal Revenue Service).

Estimated Total Annual Burden Cost: \$250 (Employee Benefits Security Administration); \$250 (Internal Revenue Service).

3. ICR Regarding Affordable Care Act Patient Protection Disclosure Requirement

a. Patient Protection Disclosure

As discussed earlier in this preamble, PHS Act section 2719A imposes, with respect to a group health plan, or group or individual health insurance coverage, a set of three requirements relating to the choice of health care professionals. When applicable, it is important that individuals enrolled in a plan or health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires participants or subscribers to designate a primary care physician; (2) obtain obstetrical or gynecological care without prior authorization; or (3) coverage of emergency services. Accordingly, these final regulations require such plans and issuers to provide a notice to participants (in the individual market, primary subscriber) of these rights when applicable. Model language is provided in these final regulations. The notice must be provided whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage, or in the individual market, provides a primary subscriber with a policy, certificate, or contract of health insurance. The Affordable Care Act patient protection disclosure requirement is an ICR subject to the PRA.

In order to satisfy these final regulations' patient protection disclosure requirement, the Departments estimate that 41,000 ERISA-covered plans will need to

¹⁵⁸U.S. Department of Labor, EBSA calculations using the March 2014 Current Population Survey Annual Social and Economic Supplement and the 2012 Medical Expenditure Panel Survey.

¹⁵⁹The Department's estimated 2015 hourly labor rates include wages, other benefits, and overhead are calculated as follows: mean wage from the 2013 National Occupational Employment Survey (April 2014, Bureau of Labor Statistics <http://www.bls.gov/news.release/pdf/ocwage.pdf>); wages as a percent of total compensation from the Employer Cost for Employee Compensation (June 2014, Bureau of Labor Statistics <http://www.bls.gov/news.release/eccec.t02.htm>); overhead as a multiple of compensation is assumed to be 25 percent of total compensation for paraprofessionals, 20 percent of compensation for clerical, and 35 percent of compensation for professional; annual inflation assumed to be 2.3 percent annual growth of total labor cost since 2013 (Employment Costs Index data for private industry, September 2014 <http://www.bls.gov/news.release/eci.nr0.htm>).

¹⁶⁰This estimate is based on an average document size of one page, \$.05 cents per page material and printing costs, and \$.49 postage costs.

notify an estimated 693,000 policy holders annually of their plans policy in regards to designating a primary care physician and for obstetrical or gynecological visits.¹⁶¹ The Departments believe that plans would only incur costs associated with this notice during the first year after relinquishing grandfather status. In subsequent years, this notice would remain unchanged and its costs are factored into the burden estimates associated with the Summary Plan Description information collection request (OMB Control Number 1210-0039).

The following estimates are based on the assumption that five percent of group health plans will relinquish grandfathered health plan status annually. Because the final regulations provide model language for this purpose, the Departments estimate that five minutes of clerical time (with a labor rate of \$30.42/hour) will be required to incorporate the required language into the plan document and ten minutes of a human resource professional's time (with a labor rate of \$110.30/hour) will be required to review the modified language. Therefore, the Departments estimate that plans relinquishing grandfathered health plan status will incur an annual hour burden of 10,000 hours with an equivalent cost of \$866,000.¹⁶²

The Departments assume that only printing and material costs are associated with the disclosure requirement, because the final regulations provide model language that can be incorporated into existing plan documents, such as an SPD. The Departments estimate that the notice will require one-half of a page, five cents per page printing and material cost will be incurred, and 38 percent of the notices will be delivered electronically at de minimis cost. This results in a cost burden of \$11,000.¹⁶³

b. Out-of-Network Emergency Services Disclosure

The final regulations require that a plan or issuer may not impose any copayment or coinsurance requirement for out-of-network emergency services that is more restrictive than the copayment or coinsurance requirement that would apply if the services were provided in network. If State law prohibits balance billing, or a plan or issuer is contractually responsible for any amounts balanced billed by an out-of-network emergency services provider, the plan or issuer must provide an enrollee or beneficiary adequate and prominent notice of their lack of financial responsibility with respect to amounts balanced billed in order to prevent inadvertent payment by an enrollee or beneficiary. This information should already be routinely included in the Explanation of Benefit documents sent by plans and issuers to enrollees and beneficiaries. Therefore, in accordance with the implementing regulations of the PRA at 5 CFR 1320.3(b)(2), we believe this is a usual and customary business practice. Plans and issuers routinely provide enrollees and beneficiaries with the Explanation of Benefit documents.

The Departments note that persons are not required to respond to, and generally are not subject to any penalty for failing to comply with, an ICR unless the ICR has a valid OMB control number. These paper-work burden estimates are summarized as follows:

Type of Review: Revision of an existing collection.

Agencies: Employee Benefits Security Administration, Department of Labor; Internal Revenue Service, U.S. Department of Treasury.

Title: Disclosure Requirement for Patient Protections under the Affordable Care Act.

OMB Number: 1210-0142; 1545-2181.

Affected Public: Business or other for profit; not-for-profit institutions.

Total Respondents: 41,000.

Total Responses: 693,000.

Frequency of Response: One time.

Estimated Total Annual Burden Hours: 5,000 (Employee Benefits Security Administration); 5,000 (Internal Revenue Service).

Estimated Total Annual Burden Cost: \$5,500 (Employee Benefits Security Administration); \$5,500 (Internal Revenue Service).

4. ICR Regarding Affordable Care Act Internal Claims and Appeals and External Review

PHS Act section 2719 and these final regulations, require that group health plans and health insurance issuers offering group health insurance coverage must comply with the internal claims and appeals processes set forth in 29 CFR 2560.503-1 (the DOL claims procedure regulation) and update such processes in accordance with standards established by the Secretary of Labor in paragraph (b)(2)(ii) of the regulations under PHS Act section 2719.

The burden to comply with the DOL claims procedure regulations is accounted for under OMB control number 1210-0053, therefore it is not included here.

Paragraph (b)(2)(ii)(C) of the final regulations under PHS Act section 2719 adds an additional requirement that non-grandfathered ERISA-covered group health plans provide to the claimant, free of charge, any new or additional evidence considered to be relied upon, or generated by the plan or issuer in connection with the claim. The related hour burden is 1,100 hours and the related cost burden is \$1.1 million.

The June 2011 amendment to the interim final regulations required that plans

¹⁶¹The Departments' estimate of the number of ERISA-covered health plans was obtained from the 2014 Medical Expenditure Survey - Insurance Component and the number of policy holders was obtained from the Health Insurance Coverage Bulletin: Abstract of Auxiliary Data for the March 2014 Annual Social and Economic Supplement to the Current Population Survey, Table 3C <http://www.dol.gov/ebsa/pdf/coveragebulletin2014.pdf>. Information on HMO and POS plans and enrollment in such plans was obtained from the Kaiser/HRET Survey of Employer Sponsored Health Benefits, 2014. The Department assumes that five percent of group health plans will relinquish grandfathered health plan status annually.

¹⁶²The Department's estimated 2015 hourly labor rates include wages, other benefits, and overhead are calculated as follows: mean wage from the 2013 National Occupational Employment Survey (April 2014, Bureau of Labor Statistics <http://www.bls.gov/news.release/pdf/ocwage.pdf>); wages as a percent of total compensation from the Employer Cost for Employee Compensation (June 2014, Bureau of Labor Statistics <http://www.bls.gov/news.release/eccec.t02.htm>); overhead as a multiple of compensation is assumed to be 25 percent of total compensation for paraprofessionals, 20 percent of compensation for clerical, and 35 percent of compensation for professional; annual inflation assumed to be 2.3 percent annual growth of total labor cost since 2013 (Employment Costs Index data for private industry, September 2014 <http://www.bls.gov/news.release/eci.nr0.htm>).

¹⁶³This estimate is based on an average document size of ½ page, \$.05 cents per page material and printing costs, and \$0.49 postage costs for paper notices and de minimis costs for electronically distributed notices. The Departments assume 62 percent of notices will be on paper and 38 percent will be distributed electronically.

and issuers must provide participants and beneficiaries who reside in a county where ten percent or more of the population residing in the county is literate only in the same non-English language with a one-sentence statement in all notices written in the applicable non-English language about the availability of language services. In addition to including the statement, plans and issuers are required to provide a customer assistance process (such as a telephone hotline) with oral language services in the non-English language and provide written notices in the non-English language upon request. Providing notice of the services and the translation services is estimated to have a cost burden of \$1 million annually.

Also, PHS Act section 2719 and these final regulations provide that group health plans and issuers offering group health insurance coverage must comply either with a State external review process or a Federal review process. Plans and issuers must provide to those conducting the external reviews required documents. There is an estimated 8,400 external appeals conducted annually. The related hour burden is 3,500 hours with an equivalent cost of \$193,700 and a cost burden of \$80,000 annually.

In total, the hour burden associated with claims, appeals, and external review is approximately 4,500 hours at an equivalent cost of \$244,800 annually. Because the burden is shared equally between the Department of Labor and the Department of the Treasury, each Department's share is 2,300 hours at an equivalent cost of \$122,400 annually.

In total, the cost burden is approximately \$2.2 million annually. Because the burden is shared equally between the Department of Labor and the Department of the Treasury, each Department's share is \$1.1 million annually.

The Departments note that persons are not required to respond to, and generally are not subject to any penalty for failing to comply with, an ICR unless the ICR has a valid OMB control number.

The paperwork burden estimates are summarized as follows:

Type of Review: Revision.

Agency: Employee Benefit Security Administration, Department of Labor; Internal Revenue Service, U.S. Department of the Treasury.

Title: Affordable Care Act Internal Claims and Appeals and External Review Disclosures for Non-Grandfathered Plans.

OMB Control Number: 1210-0144; 1545-2182

Affected Public: Business or other for-profit; not-for-profit institutions.

Total Respondents: 1,769,264

Total Responses: 275,430

Frequency of Response: Occasionally.

Estimated Total Annual Burden Hours (three year average): 2,300 (Employee Benefits Security Administration); 2,300 (Internal Revenue Service).

Estimated Total Annual Cost Burden (three year average): \$1,143,000 (Employee Benefits Security Administration); \$1,143,000 (Internal Revenue Service).

B. Department of Health and Human Services

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the Federal Register and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. These final regulations contain ICRs that are subject to review by OMB. A description of these provisions is given in the following paragraphs with an estimate of the annual burden, summarized below in the Table below. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the af-

fected public, including automated collection techniques.

As discussed above in the Department of Labor and Department of the Treasury PRA section, these final regulations contain a notice of grandfather status, rescissions notice, and patient protection disclosures requirement for issuers, and notice requirements related to internal claims and appeals and external review. These requirements are ICRs under the Paperwork Reduction Act. Each of these requirements is discussed in detail in the following sections. Estimated hourly labor rates are calculated using data from the 2013 National Occupational Employment Survey.¹⁶⁴

1. ICRs Regarding Affordable Care Act Notice of Grandfather Status (§§ 147.140(a)(2), 147.140(a)(3)(i), 147.140(a)(3)(ii))

a. Grandfathered Health Plan Disclosure

The final regulations provide model language for the grandfathered health plan disclosure that can be incorporated into existing plan documents. After plans first satisfied the grandfathered health plan disclosure requirement in 2011, any additional burden is expected to be negligible if a plan wants to maintain its grandfathered status in future years. It is also expected that the cost of removing the notice from plan documents as plans relinquish their grandfathered status would be minimal and therefore it is not estimated.

Issuers and multi-employer plans must also add a prominent disclosure in their group policies, certificates, or contracts of insurance that plan sponsors are required to notify the issuer if the contribution rate changes at any point during the plan year. This only affects issuers of fully insured group health plans and multi-employer plans and after this requirement is first satisfied, any additional burden in future years is expected to be negligible and is therefore not estimated.

Grandfathered plans will incur printing and material costs associated with the disclosure requirements. It is estimated that there will be approximately 47,500 grand-

¹⁶⁴2013 National Occupational Employment Survey, April 2014, Bureau of Labor Statistics, <http://www.bls.gov/news.release/pdf/ocwage.pdf>.

fathered State and local governmental health plans with approximately 5.5 million policyholders¹⁶⁵ and approximately 1.4 million policyholders in the individual market with grandfathered coverage¹⁶⁶ issued by 430 issuers during 2015. Therefore, grandfathered plans and issuers in the individual markets will need to send approximately 6.9 million disclosures notifying plan participants and beneficiaries of their plans' status as a grandfathered health plan. We anticipate that the notice will require one-half of a page and five cents per page printing and material cost will be incurred. We also assume that 38 percent of the notices will be delivered electronically. This results in a total annual cost burden of approximately \$106,000. The number of notices and cost burden are likely to be lower in subsequent years as more plans relinquish their grandfathered status. In the absence of data regarding how many plans will retain grandfathered status in subsequent years, we consider this estimate to be the upper limit for the number of notices and cost burden in future years.

b. Recordkeeping Requirement

It is assumed that most of the documents required to be retained to satisfy the recordkeeping requirement of these final regulations are already retained by plans for tax purposes, to satisfy ERISA's record retention and statute of limitations requirements, and for other business reasons. It was previously estimated that after the one-time cost related to record keeping requirement was incurred in 2011, costs in subsequent years will be negligible and, therefore, not estimated.

c. Grandfathered Plan Change in Carrier Disclosure

A group health plan that is changing health insurance issuers must provide to the succeeding health insurance issuer (and the succeeding health insurance issuer must require) documentation of plan terms (including benefits, cost sharing,

employer contributions, and annual limits) under the prior health insurance coverage sufficient to make a determination whether the standards of § 147.140(g)(1) are exceeded.

The number of plans that might change carriers and thus be affected (7,400) is estimated by multiplying the estimated number of grandfathered plans (47,500) by the percent of plans shopping for a new carrier (58 percent) and the number of plans shopping for a new carrier that switched (27 percent).¹⁶⁷

Each employer will require about 2 minutes of clerical labor (at an hourly cost of approximately \$30) to send the information required for the disclosure (which is already retained under the recordkeeping requirement) electronically to the succeeding issuer. The total annual labor burden for all employers is estimated to be approximately 248 hours with an equivalent annual cost of approximately \$7,500. The cost of transmitting the information electronically to the succeeding issuer is negligible and, therefore, not estimated. The number of disclosures and cost burden may be lower in subsequent years as more plans relinquish their grandfathered status. In the absence of data regarding how many plans will retain grandfathered status in subsequent years, we consider this estimate to be the upper limit for the burden in future years.

2. ICR Regarding Affordable Care Act Notice Relating to Rescissions (§ 147.128(a)(1))

This analysis assumes that rescissions only occur in the individual health insurance market, because rescissions in the group market are rare. It is estimated that there are approximately 430 issuers issuing 6.77 million policies in the individual market during a year. A report on rescissions found that 0.15 percent of policies were rescinded during the 2004 to 2008 time period. Based on these numbers, it is estimated that approximately 10,200 policies are rescinded during a year, which would result in approximately 10,200 no-

tices being sent to affected policyholders, with 38 percent transmitted electronically and 62 percent mailed. It is estimated that each issuer will require 15 minutes of legal professional time (at approximately \$129.94 per hour) to prepare the notice and one minute per notice of clerical professional time (at approximately \$30.42 per hour) to distribute the notice to each policyholder. Assuming that the cost of electronic distribution is minimal, this results in an annual hour burden of approximately 212 hours with an equivalent annual cost of approximately \$17,160.

Issuers will incur cost to print and send the notices. We assume that the notice will require one page printing and material cost will be \$0.05 per page, mailing cost will be \$0.49 per notice, and 38 percent of the notices will be delivered electronically at minimal cost. Therefore, it is estimated that the cost burden associated with mailing the notices to approximately 6,300 affected policy holders will be approximately \$3,400.

3. ICR Regarding Affordable Care Act Patient Protection Disclosure Requirement (§ 147.138(a)(4))

b. Patient Protection Disclosure

In order to satisfy the patient protection disclosure requirement, State and local government plans and issuers in individual markets will need to notify policy holders of their plans policy in regards to designating a primary care physician and for obstetrical or gynecological visits and will incur a one-time burden and cost to incorporate the notice into plan documents. State and local government plans that are currently not grandfathered and issuers in the individual market have already incurred the one-time cost to prepare and incorporate this notice in their existing plan documents. Only State and local government plans and individual market plans that relinquish their grandfathered status in subsequent years will become subject to this notice requirement

¹⁶⁵The Department lacks data on the number of State and local plans that are grandfathered plans. The Kaiser "Employer Health Benefits Survey" has estimates for private employer plans. Those estimates are used here as a proxy. They report that 37 percent of plans are grandfather plans and 26 percent of covered employees are in those plans. <http://kff.org/health-costs/report/2014-employer-health-benefits-survey/>.

¹⁶⁶Estimate based on data from the McKinsey Center for US Health System Reform and Medical Loss Ratio submissions for 2013 reporting year.

¹⁶⁷See Section 14. <http://kff.org/health-costs/report/2014-employer-health-benefits-survey/>.

and incur the one-time costs to prepare the notice.

There are an estimated 128,400 non-federal governmental plans and 430 health insurance issuers in the individual market. We estimate that five percent of non-federal governmental plans will relinquish their grandfathered status annually over the next three years and will therefore incur one-time costs to prepare the notice. Health insurance issuers in the individual market will also have five percent of their policies relinquish grandfathered status annually over the next three years. Data obtained from the 2014 Kaiser/HRET Survey of Employer Sponsored Health Benefits finds that 13 percent of plans have an HMO option and that 23 percent of plans offer a POS option. Thus, approximately 2,740 plans and issuers will produce notices each year.¹⁶⁸ While not all HMO and POS options require the designation of a primary care physician or a prior authorization or referral before a woman can visit an OB/GYN, the Department is unable to estimate this number. Therefore, this estimate should be considered an overestimate of the number of affected entities.

Each of these 2,740 plans and issuers will require a compensation and benefits manager to spend 10 minutes individualizing the model notice to fit the plan's specifications at an hourly rate of \$110.30. This results in approximately 457 hours of burden at an equivalent cost of \$50,400. Each plan will also require clerical staff to spend 5 minutes adding the notice to the plan's documents at an hourly rate of \$30.42. This results in approximately 228 hours of burden at an equivalent cost of \$7,000. The total annual burden associated with this requirement is 685 hours at an equivalent cost of \$57,000.

The Department assumes that only printing and material costs are associated with the disclosure requirement, because the final regulations provide model language that can be incorporated into existing plan documents. The Department estimates that the notice will require one-half of a page, five cents per page printing

and material cost will be incurred, and 38 percent of the notices will be delivered electronically.

It is estimated that there are 27.9 million non-federal government plan policyholders and individual policyholders. As stated in the previous section, it is estimated that 5 percent of plans will relinquish their grandfathered status annually in the next three years. Data obtained from the 2014 Kaiser/HRET Survey of Employer Sponsored Health Benefits finds that 13 percent of covered workers in Government plans have an HMO option and that 8 percent of covered workers have a POS option. Data obtained from AHIP in 2009 finds that 1.93 percent of individual policyholders have an HMO options. Thus, it is estimated that plans will produce 228,000 notices each year, 38 percent of which will be sent electronically.¹⁶⁹ This results in a cost burden of approximately \$3,500.¹⁷⁰

c. Out-of-Network Emergency Services Disclosure

The final regulations require that a plan or issuer may not impose any copayment or coinsurance requirement for out-of-network emergency services that is more restrictive than the copayment or coinsurance requirement that would apply if the services were provided in network. If State law prohibits balance billing, or a plan or issuer is contractually responsible for any amounts balanced billed by an out-of-network emergency services provider, the a plan or issuer must provide an enrollee or beneficiary adequate and prominent notice of their lack of financial responsibility with respect to amounts balanced billed in order to prevent inadvertent payment by an enrollee or beneficiary. This information should already be routinely included in the Explanation of Benefit documents sent by plans and issuers to enrollees and beneficiaries. Therefore, in accordance with the implementing regulations of the PRA at 5 CFR 1320.3(b)(2), we believe this is a usual and customary business practice. Plans

and issues routinely provide enrollees and beneficiaries with the Explanation of Benefit documents.

4. ICRs Regarding Affordable Care Act Internal Claims and Appeals and External Review (§§ 14.136 (b)(2)(ii), 147.136 (b)(2)(ii)(C), 147.136 (b)(3)(ii), 147.136 (b)(3)(ii)(C))

Paragraph (b)(2)(ii)(C) of the final regulations implementing PHS Act section 2719 provides that non-grandfathered ERISA-covered group health plans provide to the claimant, free of charge, any new or additional evidence considered relied upon, or generated by the plan or issuer in connection with the claim. The related hour burden is 773,800 hours and the related cost burden is \$115.2 million.

The June 2011 amendment to the interim final regulations under PHS Act section 2719 required that plans and issuers must provide participants and beneficiaries who reside in a county where ten percent or more of the population residing in the county is literate only in the same non-English language with a one-sentence statement in all notices written in the applicable non-English language, about the availability of language services. In addition to including the statement, plans and issuers are required to provide a customer assistance process (such as a telephone hotline) with oral language services in the non-English language and provide written notices in the non-English language upon request. Providing notice of the services and the translation services is estimated to have a cost burden of \$633,000 annually.

Also, PHS Act section 2719 and the final regulations provide that group health plans and issuers offering group health insurance coverage must comply either with a State external review process or a Federal review process. Plans and issuers must provide to those conducting the external reviews required documents. There is an estimated 2,100 external appeals conducted annually. The related hour bur-

¹⁶⁸128,400 Governmental plans x 5% newly non-grandfathered plans x (13% HMOs + 23% POSs) + 430 issuers = approximately 2,700 affected plans and issuers.

¹⁶⁹[21.1 million Government policyholders x 5% newly non-grandfathered plans x (13% in HMOs + 8% in POSs)] + [6.77 million individual policy holders x 5% newly non-grandfathered plans x 1.93% in HMOs] = approximately 228,000 notices.

¹⁷⁰\$0.05 per page*1/2 pages per notice * 228,000 notices*62% = approximately \$3,500

den is 150 hours with an equivalent cost of \$4,600 and a cost burden of \$5,400 annually.

In total, the burden associated with claims, appeals, and external review is approximately 774,000 hours at an equivalent cost of \$41,601,000 annually. The

cost burden associated with claims, appeals, language translation, and external review is approximately \$115.8 million annually.

Table 2.—Annual Reporting, Recordkeeping and Disclosure Burden (HHS)

	OMB Control No.	Number of Respondents	Responses	Total Annual Burden (Hours)	Total Labor Cost of Report- ing (\$)	Total Capital/ Maintenance Costs (\$)	Total Costs (\$)
Grandfathered Plans Disclosure (§ 147.140(a)(2))	0938–1093	47,932	6,850,695	0	\$0	\$106,186	\$106,186
Grandfathered Plans Change in Carrier Disclosure (§ 147.140(a)(3)(i))	0938–1093	7,440	7,440	248	\$7,544	\$0	\$7,544
Rescissions Notice (§ 147.128(a)(1))	0938–1094	430	10,200	212	\$17,160	\$3,400	\$20,560
Patient Protection Disclosures (§ 147.138(a) (4))	0938–1094	2,741	228,086	685	\$57,341	\$3,535	\$60,876
Claims and Appeals External Review ((§§ 147.136 (b)(2)(ii), 147.136 (b)(2)(ii)(C), 147.136 (b)(3)(ii), 147.136 (b)(3)(ii)(C))	0938–1098	95,500	399,151,000	773,996	\$41,601,000	\$115,827,000	\$157,428,000
Total		154,043	406,247,421	775,141			\$157,623,166

V. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 *et seq.*) and which are likely to have a significant economic impact on a substantial number of small entities.

The RFA generally defines a “small entity” as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA) (13 CFR 121.201) pursuant to the Small Business Act (15 U.S.C. 631 *et seq.*), (2) a nonprofit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000. (States and individuals are not included in the definition of “small entity.”) The Departments use as their measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 to 5 percent.

As discussed in detail in the “Need for Regulatory Action” section of this Regulatory Impact Analysis, these regulations are necessary to implement the following provisions: Affordable Care Act section 1251 (preservation of right to maintain existing coverage), and PHS Act sections 2704 (prohibition of preexisting condition exclusions), 2711 (no lifetime or annual limits), 2712 (prohibition on certain rescissions), 2714 (extension of dependent coverage), 2719 (internal appeals and external review process), and 2719A (patient protections). In response to the 2010 interim final regulations, the Departments received many comments that relate to early implementation issues and addressed many of these issues through sub-regulatory guidance. The Departments also held meetings with stakeholders, including small entities affected by the rules. After consideration of comments and stakeholder input received in response to the interim final regulations, the Departments are issuing these final regulations.

The Regulatory Flexibility Act requires agencies to assess and consider the direct economic impacts that regulations impose on small entities. The primary economic effects of these final regulations are indirect, because they result in transfers between individuals covered by health insurance. While these transfers could be significant, they do not impose direct effects on the regulated small entities for purposes of the RFA.

Most of the direct effects of the final regulations are associated with their disclosure requirements. As discussed below and in the Paperwork Reduction Act section above, these disclosure requirements do not have a significant economic impact. Therefore, pursuant to section 605(b) of the RFA, the Departments hereby certify that these final regulations are not likely to have a significant economic impact on a substantial number of small entities. The Departments’ basis for this determination and their estimate of small entities affected by these final regulations is discussed below.

A. Affected Small Entities

There are several different types of small entities affected by these final regulations. For issuers and third party administrators, a small business is one that has total premium revenue of \$38.5 million or less. The Departments continue to consider a small plan to be an employee benefit plan with fewer than 100 participants.¹⁷¹ Further, while some large employers may have small plans, in general small employers maintain most small plans. Thus, the Departments believe that assessing the impact of this final rule on small plans is an appropriate substitute for evaluating the effect on small entities. The definition of small entity considered appropriate for this purpose differs, however, from a definition of small business that is based on size standards promulgated by the Small Business Administration (SBA) (13 CFR 121.201) pursuant to the Small Business Act (15 U.S.C. 631 et seq.).

Based on data from MLR annual report submissions for the 2013 MLR reporting year, approximately 141 out of 500 issuers of health insurance coverage nationwide had total premium revenue of \$38.5 million or less.¹⁷² This estimate may overstate the actual number of small health insurance companies that may be affected, since 77 percent of these small companies belong to larger holding groups, and many if not all of these small companies are likely to have non-health lines of business that would result in their revenues exceeding \$38.5 million.

As discussed previously in the RIA, there are an estimated 2.3 million ERISA-covered plans and 128,400 State and local governmental health plans that may have experienced an increase in costs related to the provisions of these final rules. Ninety-seven percent of these plans are provided by small entities and have incurred costs related to the provisions of these final regulations.

B. Direct Impacts of Final Rules on Small Entities

1. Affordable Care Act Section 1251, Preservation of Right to Maintain Existing Coverage (26 CFR 54.9815–1251, 29 CFR 2590.715–1251, 45 CFR 147.140)

The direct impacts of this provision on affected small entities are primarily associated with notices requirements. Specifically, the final regulations require affected plans to maintain records documenting the terms of the plan in effect on March 23, 2010, and any other documents that are necessary to verify, explain or clarify status as a grandfathered health plan (the “recordkeeping requirement”). The plan must make such records available for examination upon request by participants, beneficiaries, individual policy subscribers, or a State or Federal agency official. The Departments believe this requirement imposes a minimal burden on small entities, because they should maintain such records in the usual and customary course of their business operations following standard business procedures.

To maintain status as a grandfathered health plan, a plan or health insurance coverage must include a statement that the plan or coverage believes it is a grandfathered health plan within the meaning of section 1251 of the Patient Protection and Affordable Care Act and must provide contact information for questions and complaints, in any summary of benefits provided under the plan to consumers. The Departments believe the costs associated with this disclosure are minimal, because a model statement is provided in the final rule and that statement can be provided in any summary of benefits that already is being provided to consumers.

Finally, if a grandfathered group health plan switches issuers and intends to maintain its status as a grandfathered plan, it must provide to the new health insurance issuer with documentation of plan terms under the prior health coverage sufficient for it to determine whether a change causing a cessation of grandfathered health plan status has occurred. This requirement

also imposes a minimal burden on affected small entities, because the documents should be maintained in the ordinary course of the plan’s business operations, and the only additional cost would be incurred to prepare the documentation for mailing and associated material and printing cost, which are estimated to total approximately \$8.

1. PHS Act Section 2704, Prohibition of Preexisting Condition Exclusions (26 CFR 54.9815–2704, 29 CFR 2590.715–2704, 45 CFR 147.108)

The direct impacts of this rule on the regulated small entities is limited as the removal of preexisting condition exclusions primarily operates through the pricing of insurance products, which are paid by plan participants. Small businesses will be impacted when they pay for part of the health insurance premium. The Departments have not been able to estimate this effect separately from the effect on premiums brought about by the other the Affordable Care Act changes.

2. PHS Act Section 2711, Prohibition on Lifetime and Annual Limits (26 CFR 54.9815–2711, 29 CFR 2590.715–2711, 45 CFR 147.126)

The direct impacts of this rule on the regulated small entities were primarily limited to an initial notice sent shortly after the issuance of the interim final regulations requiring plans to notify participants that had lost coverage due to reaching the lifetime limit of the new coverage option. This notice requirement is no longer in effect as the statute now bans all annual and life time limits, so there are no individuals losing coverage that need to be notified. To the extent premiums increase and employers contribute part of the premiums, or plans are self-insured with payments from the employers general assets there could be direct effects on employers, but for most employers those effects are small.

¹⁷¹The basis for this definition is found in section 104(a)(2) of ERISA, which permits the Secretary of Labor to prescribe simplified annual reports for pension plans that cover fewer than 100 participants.

¹⁷²U. S. Small Business Administration, “Table of Small Business Size Standards Matched to North American Industry Classification System Codes”, July 14, 2014.

3. PHS Act Section 2712, Prohibition on Rescissions (26 CFR 54.9815–2712, 29 CFR 2590.715–2712, 45 CFR 147.128)

PHS Act Section 2712 and the final regulations prohibit group health plans and health insurance issuers that offer group or individual health insurance coverage generally from rescinding coverage under the plan, policy, certificate, or contract of insurance from the individual covered under the plan or coverage unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. The final regulations provide that a group health plan or a health insurance issuer offering group health insurance coverage must provide at least 30 days advance notice to an individual before coverage may be rescinded. The Departments believe that rescissions are rare in the group market and that small group health plans are affected by rescissions more than large group health plans.

The Departments estimate¹⁷³ that 15 minutes of legal professional time at \$129.94 per hour¹⁷⁴ would be required by the insurers of the policies to prepare the notice, and one minute per notice of clerical professional time at \$30.42 per hour¹⁷⁵ would be required to distribute the paper notices. The Departments believe the costs of electronic transmission would be de minimis. This leads to an estimate of less than \$40 per rescission notice, which the Departments do not believe is significant.

4. PHS Act Section 2714, Coverage of Dependents to Age 26 (26 CFR 54.9815–2714, 29 CFR 2590.715–2714, 45 CFR 147.120)

The direct impacts of this rule on the regulated small entities were primarily

limited to an initial notice sent shortly after the issuance of the interim final regulations requiring plans to notify participants of the new coverage option. To the extent premiums increase and employers contribute part of the premiums, or plans are self-insured with payments from the employers general assets there could be direct effects on employers, but for most employers those effects are small.

5. PHS Act Section 2719, Internal Claims and Appeals and External Review (26 CFR 54.9815–2719, 29 CFR 2590.715–2719, 45 CFR 147.136)

Not all potentially affected individuals will be affected equally by these final regulations. Sponsors of ERISA-covered group health plans were required to implement an internal appeals process that complied with the DOL claims procedure regulation before the Affordable Care Act's enactment, and the Departments also understand that many non-Federal governmental plans and church plans that are not subject to ERISA implement internal claims and appeals processes that comply with the DOL claims procedure regulation.

These final regulations will have the largest impact on individuals covered in the individual health insurance market, because with the issuance of the final regulation, these issuers were required to comply with the DOL claims procedure regulation for internal claims and appeals as well as the additional standards added by the Secretary of the Department of Health and Human Services in paragraph (b)(3) of the final regulations under PHS Act section 2719 that are in some cases more protective than the ERISA standard.

Using estimates calculated for the Payroll Reduction Act it is estimated that there will be an average costs of 40 cents per notice that is required to be

sent related to the internal claims and appeals.

On the external appeals side, before the enactment of the Affordable Care Act, issuers offering coverage in the group and individual health insurance market were already required to comply with State external review laws. At that time, all States except Alabama, Mississippi, Nebraska, North Dakota, South Dakota, and Wyoming had external review laws, and thirteen States had external review laws that apply only to certain market segments (for example, managed care or HMOs). Currently, all States except, Alabama, Alaska, Florida, Georgia, Pennsylvania, and Wisconsin have State external review laws that satisfy these requirements. These six states that do not meet the requirements, must use the HHS administered process or must contract with accredited independent review organizations to review external appeals on their behalf.¹⁷⁶

Individuals participating in ERISA-covered self-insured group health plans will be among those most affected by the external review requirements contained in these final regulations, because the preemption provisions of ERISA prevent a State's external review process from applying directly to an ERISA-covered self-insured plan. These plans will now be required to comply with the Federal external review process set forth in these final regulations.

As discussed in the Regulatory Impact Section above an estimate for the average cost for an external appeal is \$665. This cost would be incurred by plans or issuers. It is also estimated above that there is on average only 1.3 external appeals per 10,000 covered lives. The Departments believe such costs are minimal for purpose of the RFA, because most small entities will have no external appeals in a given year.

¹⁷³The Department's estimated 2015 hourly labor rates include wages, other benefits, and overhead are calculated as follows: mean wage from the 2013 National Occupational Employment Survey (April 2014, Bureau of Labor Statistics <http://www.bls.gov/news.release/pdf/ocwage.pdf>); wages as a percent of total compensation from the Employer Cost for Employee Compensation (June 2014, Bureau of Labor Statistics <http://www.bls.gov/news.release/eccec.t02.htm>); overhead as a multiple of compensation is assumed to be 25 percent of total compensation for paraprofessionals, 20 percent of compensation for clerical, and 35 percent of compensation for professional; annual inflation assumed to be 2.3 percent annual growth of total labor cost since 2013 (Employment Costs Index data for private industry, September 2014 <http://www.bls.gov/news.release/eci.nr0.htm>).

¹⁷⁴Legal Professional (23-1011): \$63.46(2013 BLS Wage rate) /0.69(ECEC ratio) *1.35(Overhead Load Factor) *1.023(Inflation rate) ²(Inflated 2 years from base year) = \$129.94

¹⁷⁵Secretaries, Except Legal, Medical, and Executive (43-6014): \$16.35(2013 BLS Wage rate)/0.675(ECEC ratio) *1.2(Overhead Load Factor) *1.023(Inflation rate) ²(Inflated 2 years from base year) = \$30.42

¹⁷⁶https://www.cms.gov/CCHIO/Resources/Files/external_appeals.html

6. PHS Act Section 2719A, Patient Protections (26 CFR 54.9815–2719A, 29 CFR 2590.715–2719A, 45 CFR 147.138)

PHS Act section 2719A imposes, with respect to a group health plan, or group or individual health insurance coverage, a set of three requirements relating to the choice of health care professionals. When applicable, it is important that individuals enrolled in a plan or health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires participants or subscribers to designate a primary care physician; (2) obtain obstetrical or gynecological care without prior authorization; or (3) coverage of emergency services. Accordingly, these final regulations require such plans and issuers to provide a notice to participants (in the individual market, primary subscriber) of these rights when applicable. Model language is provided in these final regulations. The notice must be provided whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage, or in the individual market, provides a primary subscriber with a policy, certificate, or contract of health insurance.

The Departments assume that this provision will primarily affect Health Maintenance Organizations and Point-of-Service type arrangements. The Department believes that insignificant costs are associated with this notice, because a model notice is provided in the final rule, and it can be distributed with existing plan documents.

The Departments estimate that each plan or issuer would require a compensation and benefits manager¹⁷⁷ to spend 10 minutes individualizing the model notice provided by the Departments to fit the plan's specifications at an hourly rate of \$110.30.¹⁷⁸ This results in a cost of approximately \$21 in the first year. The cost per participant to receive the notice would be less than five cents per paper notice as

the notice would be included in existing documents.

VI. Unfunded Mandates Reform Act—Department of Labor and Department of Health and Human Services

Section 202 of the Unfunded Mandates Reform Act (UMRA) of 1995 requires that agencies assess anticipated costs and benefits before issuing any final rule that includes a Federal mandate that could result in expenditure in any one year by State, local or Tribal governments, in the aggregate, or by the private sector, of \$100 million in 1995 dollars updated annually for inflation. In 2015, that threshold level is approximately \$144 million. These final regulations include a Federal mandate that may result in expenditures by State, local, or Tribal governments. Specifically, these final regulations include requirements regarding minimum consumer protection standards that a State external review process must include to qualify as an applicable State external review process under PHS Act section 2719(b)(1). However, we conclude that these costs would not exceed the \$144 million threshold. Thus, the Departments of Labor and HHS conclude that these final regulations would not impose an unfunded mandate on State, local or Tribal governments or the private sector. Regardless, consistent with the policy embodied in UMRA, the final requirements described in this notice of final rulemaking has been designed to be the least burdensome alternative for State, Local and Tribal governments, and the private sector while achieving the objectives of the Affordable Care Act.

VII. Federalism Statement—Department of Labor and Department of Health and Human Services

Executive Order 13132 outlines fundamental principles of federalism, and requires the adherence to specific criteria by

Federal agencies in the process of their formulation and implementation of policies that have “substantial direct effects” on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have federalism implications must consult with State and local officials and describe the extent of their consultation and the nature of the concerns of State and local officials in the preamble to the regulation.

In the Departments of Labor's and HHS' view, these final regulations have federalism implications because they would have direct effects on the States, the relationship between the national government and the States, or on the distribution of power and responsibilities among various levels of government. Under these final regulations, group health plans and health insurance issuers offering group or individual health insurance coverage, including non-federal governmental plans as defined in section 2791 of the PHS Act, would be required to follow the Federal standards developed under Affordable Care Act section 1251 and PHS Act sections 2704, 2711, 2712, 2714, 2719 and 2719A, as added by the Affordable Care Act. However, in the Departments' view, the federalism implications of these final regulations are substantially mitigated because, with respect to health insurance issuers, the Departments expect that the majority of States will enact laws or take other appropriate action resulting in their meeting or exceeding the Federal standards.

In general, through section 514, ERISA supersedes State laws to the extent that they relate to any covered employee benefit plan, and preserves State laws that regulate insurance, banking, or securities. While ERISA prohibits States from regulating a plan as an insurance or investment company or bank, the preemption provisions of section 731 of ERISA and section

¹⁷⁷The Department's estimated 2015 hourly labor rates include wages, other benefits, and overhead are calculated as follows: mean wage from the 2013 National Occupational Employment Survey (April 2014, Bureau of Labor Statistics <http://www.bls.gov/news.release/pdf/ocwage.pdf>); wages as a percent of total compensation from the Employer Cost for Employee Compensation (June 2014, Bureau of Labor Statistics <http://www.bls.gov/news.release/ceec.t02.htm>); overhead as a multiple of compensation is assumed to be 25 percent of total compensation for paraprofessionals, 20 percent of compensation for clerical, and 35 percent of compensation for professional; annual inflation assumed to be 2.3 percent annual growth of total labor cost since 2013 (Employment Costs Index data for private industry, September 2014 <http://www.bls.gov/news.release/eci.nr0.htm>).

¹⁷⁸Compensation and Benefits Manager (11-3041): \$53.87/(2013 BLS Wage rate) /0.69(ECEC ratio) *1.35(Overhead Load Factor) *1.023(Inflation rate) ²(Inflated 2 years from base year) = \$110.30

2724 of the PHS Act (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the requirements in title XX-VII of the PHS Act (including those added by the Affordable Care Act) are not to be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with individual or group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of a Federal standard. The conference report accompanying HIPAA indicates that this is intended to be the “narrowest” preemption of State laws (See House Conf. Rep. No. 104-736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018).

States may continue to apply State law requirements except to the extent that such requirements prevent the application of the Affordable Care Act requirements that are the subject of this rulemaking. Accordingly, States have significant latitude to impose requirements on health insurance issuers that are more restrictive than the Federal law.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit the policy making discretion of the States, the Departments of Labor and HHS have engaged in efforts to consult with and work cooperatively with affected States, including consulting with, and attending conferences of, the National Association of Insurance Commissioners and consulting with State insurance officials on an individual basis. It is expected that the Departments of Labor and HHS will act in a similar fashion in enforcing the Affordable Care Act.

Throughout the process of developing these final regulations, to the extent feasible within the applicable preemption provisions, the Departments of Labor and HHS have attempted to balance the States’ interests in regulating health insurance issuers, and Congress’ intent to provide uniform minimum protections to consumers in every State. By doing so, it is the Departments of Labor’s and HHS’ view that they have complied with the requirements of Executive Order 13132.

Pursuant to the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to this final rule, the Departments certify that the Employee Benefits Security Administration and the Centers for Medicare & Medicaid Services have complied with the requirements of Executive Order 13132 for the attached final rules in a meaningful and timely manner.

VIII. Special Analyses – Department of the Treasury

Certain IRS regulations, including this one, are exempt from the requirements of Executive Order 12866, as supplemented and reaffirmed by Executive Order 13563. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these final regulations. For a discussion of the impact of this final rule on small entities, please see section V.B. of this preamble. Pursuant to section 7805(f) of the Code, this notice of final rulemaking has been submitted to the Small Business Administration for comment on its impact on small business.

IX. Congressional Review Act

These final regulations are subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*), which specifies that before a rule can take effect, the Federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information, and has been transmitted to Congress and the Comptroller General for review.

X. Statutory Authority

The Department of the Treasury final regulations are adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

The Department of Labor final regulations are adopted pursuant to the authority contained in 29 U.S.C. 1135, and 1191c; Secretary of Labor’s Order 1–2011, 77 FR 1088 (Jan. 9, 2012).

The Department of Health and Human Services final regulations are adopted pursuant to the authority contained in sections 2701 through 2763, 2791, and 2792 of the PHS Act (42 USC 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

* * * * *

John Dalrymple
*Deputy Commissioner for
Services and Enforcement
Internal Revenue Service.*

Approved: October 27, 2015

Mark J. Mazur
*Assistant Secretary
of the Treasury (Tax Policy).*

Signed this 6th day of November 2015.

Phyllis C. Borzi,
*Assistant Secretary Employee
Benefits Security Administration
Department of Labor*

Dated: October 15, 2015

Andrew M. Slavitt,
*Acting Administrator Centers for
Medicare & Medicaid Services*

Approved: October 22, 2015

Sylvia M. Burwell,
*Secretary Department of
Health and Human Services*

(Filed by the Office of the Federal Register on July 13, 2015, 8:45 a.m., and published in the issue of the Federal Register for July 14, 2015, 80 F.R. 40661)

DEPARTMENT OF THE TREASURY

Internal Revenue Service 26 CFR Chapter I

For the reasons stated in the preamble, the Internal Revenue Service amends Part 54 as set forth below:

PART 54—PENSION EXCISE TAXES

Paragraph 1. The authority citation for part 54 is amended by adding entries for §§ 54.9815–1251, 54.9815–2704, 54.9815–

2711, 54.9815–2712, 54.9815–2714, 54.9815–2719, and 54.9815–2719A in numerical order to read in part as follows:

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

Section 54.9815–1251 also issued under 26 U.S.C. 9833.

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Section 54.9815–2704 also issued under 26 U.S.C. 9833.

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Section 54.9815–2711 also issued under 26 U.S.C. 9833.

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Section 54.9815–2712 also issued under 26 U.S.C. 9833.

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Section 54.9815–2714 also issued under 26 U.S.C. 9833.

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Section 54.9815–2719 also issued under 26 U.S.C. 9833.

Section 54.9815–2719A also issued under 26 U.S.C. 9833.

Par.2. Section 54.9801–2 is amended by revising the introductory text and the definition of “preexisting condition exclusion” to read as follows:

§ 54.9801–2 Definitions.

Unless otherwise provided, the definitions in this section govern in applying the provisions of sections 9801 through 9815 and 9831 through 9833.

* * * * *

Preexisting condition exclusion means a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan or group or individual health insurance coverage (or other coverage provided to Federally eligible individuals pursuant to 45 CFR part 148), whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual’s health status before the individual’s effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan, or group or individual health insurance coverage (or other coverage pro-

vided to Federally eligible individuals pursuant to 45 CFR part 148), such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

* * * * *

Par.3. Section 54.9801–3 is amended by revising the section heading and paragraph (a)(1) to read as follows:

§ 54.9801–3 Limitations on preexisting condition exclusion period.

(a) *Preexisting condition exclusion defined*—(1) A *preexisting condition exclusion* means a *preexisting condition exclusion* within the meaning of § 54.9801–2.

* * * * *

Par.4. Section 54.9815–1251 is added to read as follows:

§ 54.9815–1251 Preservation of right to maintain existing coverage.

(a) *Definition of grandfathered health plan coverage*—(1) *In general*—(i) *Grandfathered health plan coverage* means coverage provided by a group health plan, or a health insurance issuer, in which an individual was enrolled on March 23, 2010 (for as long as it maintains that status under the rules of this section). A group health plan or group health insurance coverage does not cease to be grandfathered health plan coverage merely because one or more (or even all) individuals enrolled on March 23, 2010 cease to be covered, provided that the plan or group health insurance coverage has continuously covered someone since March 23, 2010 (not necessarily the same person, but at all times at least one person). In addition, subject to the limitation set forth in paragraph (a)(1)(ii) of this section, a group health plan (and any health insurance coverage offered in connection with the group health plan) does not cease to be a grandfathered health plan merely because the plan (or its sponsor) enters into a new policy, certificate, or contract of insurance after March 23, 2010 (for example, a plan enters into a contract with a new issuer or a new policy is issued with an existing issuer). For purposes of this section, a plan or health insurance coverage that provides grandfathered

health plan coverage is referred to as a grandfathered health plan. The rules of this section apply separately to each benefit package made available under a group health plan or health insurance coverage. Accordingly, if any benefit package relinquishes grandfather status, it will not affect the grandfather status of the other benefit packages.

(ii) *Changes in group health insurance coverage*. Subject to paragraphs (f) and (g)(2) of this section, if a group health plan (including a group health plan that was self-insured on March 23, 2010) or its sponsor enters into a new policy, certificate, or contract of insurance after March 23, 2010 that is effective before November 15, 2010, then the plan ceases to be a grandfathered health plan.

(2) *Disclosure of grandfather status*—(i) To maintain status as a grandfathered health plan, a plan or health insurance coverage must include a statement that the plan or coverage believes it is a grandfathered health plan within the meaning of section 1251 of the Patient Protection and Affordable Care Act, and must provide contact information for questions and complaints, in any summary of benefits provided under the plan.

(ii) The following model language can be used to satisfy this disclosure requirement:

This [group health plan or health insurance issuer] believes this [plan or coverage] is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or

www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.]

(3)(i) *Documentation of plan or policy terms on March 23, 2010.* To maintain status as a grandfathered health plan, a group health plan, or group health insurance coverage, must, for as long as the plan or health insurance coverage takes the position that it is a grandfathered health plan –

(A) Maintain records documenting the terms of the plan or health insurance coverage in connection with the coverage in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as a grandfathered health plan; and

(B) Make such records available for examination upon request.

(ii) *Change in group health insurance coverage.* To maintain status as a grandfathered health plan, a group health plan that enters into a new policy, certificate, or contract of insurance must provide to the new health insurance issuer (and the new health insurance issuer must require) documentation of plan terms (including benefits, cost sharing, employer contributions, and annual dollar limits) under the prior health coverage sufficient to determine whether a change causing a cessation of grandfathered health plan status under paragraph (g)(1) of this section has occurred.

(4) *Family members enrolling after March 23, 2010.* With respect to an individual who is enrolled in a group health plan or health insurance coverage on March 23, 2010, grandfathered health plan coverage includes coverage of family members of the individual who enroll after March 23, 2010 in the grandfathered health plan coverage of the individual.

(b) *Allowance for new employees to join current plan—* (1) *In general.* Subject to paragraph (b)(2) of this section, a group health plan (including health insurance coverage provided in connection with the group health plan) that provided coverage on March 23, 2010 and has retained its status as a grandfathered health plan (consistent with the rules of this section, in-

cluding paragraph (g) of this section) is grandfathered health plan coverage for new employees (whether newly hired or newly enrolled) and their families enrolling in the plan after March 23, 2010. Further, the addition of a new contributing employer or new group of employees of an existing contributing employer to a grandfathered multiemployer health plan will not affect the plan's grandfather status.

(2) *Anti-abuse rules—* (i) *Mergers and acquisitions.* If the principal purpose of a merger, acquisition, or similar business restructuring is to cover new individuals under a grandfathered health plan, the plan ceases to be a grandfathered health plan.

(ii) *Change in plan eligibility.* A group health plan or health insurance coverage (including a benefit package under a group health plan) ceases to be a grandfathered health plan if—

(A) Employees are transferred into the plan or health insurance coverage (the transferee plan) from a plan or health insurance coverage under which the employees were covered on March 23, 2010 (the transferor plan);

(B) Comparing the terms of the transferee plan with those of the transferor plan (as in effect on March 23, 2010) and treating the transferee plan as if it were an amendment of the transferor plan would cause a loss of grandfather status under the provisions of paragraph (g)(1) of this section; and

(C) There was no bona fide employment-based reason to transfer the employees into the transferee plan. For this purpose, changing the terms or cost of coverage is not a bona fide employment-based reason.

(iii) *Illustrative list of bona fide employment-based reasons.* For purposes of paragraph (b)(2)(ii)(C) of this section, bona fide employment-based reasons include –

(A) When a benefit package is being eliminated because the issuer is exiting the market;

(B) When a benefit package is being eliminated because the issuer no longer offers the product to the employer;

(C) When low or declining participation by plan participants in the benefit package makes it impractical for the plan

sponsor to continue to offer the benefit package;

(D) When a benefit package is eliminated from a multiemployer plan as agreed upon as part of the collective bargaining process; or

(E) When a benefit package is eliminated for any reason and multiple benefit packages covering a significant portion of other employees remain available to the employees being transferred.

(3) *Examples.* The rules of this paragraph (b) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan offers two benefit packages on March 23, 2010, Options *F* and *G*. During a subsequent open enrollment period, some of the employees enrolled in Option *F* on March 23, 2010 switch to Option *G*.

(ii) *Conclusion.* In this *Example 1*, the group health coverage provided under Option *G* remains a grandfathered health plan under the rules of paragraph (b)(1) of this section because employees previously enrolled in Option *F* are allowed to enroll in Option *G* as new employees.

Example 2. (i) *Facts.* A group health plan offers two benefit packages on March 23, 2010, Options *H* and *I*. On March 23, 2010, Option *H* provides coverage only for employees in one manufacturing plant. Subsequently, the plant is closed, and some employees in the closed plant are moved to another plant. The employer eliminates Option *H* and the employees that are moved are transferred to Option *I*. If instead of transferring employees from Option *H* to Option *I*, Option *H* was amended to match the terms of Option *I*, then Option *H* would cease to be a grandfathered health plan.

(ii) *Conclusion.* In this *Example 2*, the plan has a bona fide employment-based reason to transfer employees from Option *H* to Option *I*. Therefore, Option *I* does not cease to be a grandfathered health plan.

(c) *General grandfathering rule—* (1) Except as provided in paragraphs (d) and (e) of this section, subtitles A and C of title I of the Patient Protection and Affordable Care Act (and the amendments made by those subtitles, and the incorporation of those amendments into ERISA section 715 and Internal Revenue Code section 9815) do not apply to grandfathered health plan coverage. Accordingly, the provisions of PHS Act sections 2701, 2702, 2703, 2705, 2706, 2707, 2709 (relating to coverage for individuals participating in approved clinical trials, as added by section 10103 of the Patient Protection and Affordable Care Act), 2713, 2715A, 2716, 2717, 2719, and 2719A, as added or amended by the Patient Protection and Affordable Care Act, do not apply to grandfathered health plans. (In addition,

see 45 CFR 147.140(c), which provides that the provisions of PHS Act section 2704, and PHS Act section 2711 insofar as it relates to annual dollar limits, do not apply to grandfathered health plans that are individual health insurance coverage.)

(2) To the extent not inconsistent with the rules applicable to a grandfathered health plan, a grandfathered health plan must comply with the requirements of the PHS Act, ERISA, and the Internal Revenue Code applicable prior to the changes enacted by the Patient Protection and Affordable Care Act.

(d) *Provisions applicable to all grandfathered health plans.* The provisions of PHS Act section 2711 insofar as it relates to lifetime dollar limits, and the provisions of PHS Act sections 2712, 2714, 2715, and 2718, apply to grandfathered health plans for plan years beginning on or after September 23, 2010. The provisions of PHS Act section 2708 apply to grandfathered health plans for plan years beginning on or after January 1, 2014.

(e) *Applicability of PHS Act sections 2704, 2711, and 2714 to grandfathered group health plans and group health insurance coverage*—(1) The provisions of PHS Act section 2704 as it applies with respect to enrollees who are under 19 years of age, and the provisions of PHS Act section 2711 insofar as it relates to annual dollar limits, apply to grandfathered health plans that are group health plans (including group health insurance coverage) for plan years beginning on or after September 23, 2010. The provisions of PHS Act section 2704 apply generally to grandfathered health plans that are group health plans (including group health insurance coverage) for plan years beginning on or after January 1, 2014.

(2) For plan years beginning before January 1, 2014, the provisions of PHS Act section 2714 apply in the case of an adult child with respect to a grandfathered health plan that is a group health plan only if the adult child is not eligible to enroll in an eligible employer-sponsored health plan (as defined in section 5000A(f)(2) of the Internal Revenue Code) other than a grandfathered health plan of a parent. For plan years beginning on or after January 1, 2014, the provisions of PHS Act section 2714 apply with respect to a grandfathered health plan that is a group health

plan without regard to whether an adult child is eligible to enroll in any other coverage.

(f) *Effect on collectively bargained plans—In general.* In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before March 23, 2010, the coverage is grandfathered health plan coverage at least until the date on which the last of the collective bargaining agreements relating to the coverage that was in effect on March 23, 2010 terminates. Any coverage amendment made pursuant to a collective bargaining agreement relating to the coverage that amends the coverage solely to conform to any requirement added by subtitles A and C of title I of the Patient Protection and Affordable Care Act (and the amendments made by those subtitles, and the incorporation of those amendments into ERISA section 715 and Internal Revenue Code section 9815) is not treated as a termination of the collective bargaining agreement. After the date on which the last of the collective bargaining agreements relating to the coverage that was in effect on March 23, 2010 terminates, the determination of whether health insurance coverage maintained pursuant to a collective bargaining agreement is grandfathered health plan coverage is made under the rules of this section other than this paragraph (f) (comparing the terms of the health insurance coverage after the date the last collective bargaining agreement terminates with the terms of the health insurance coverage that were in effect on March 23, 2010).

(g) *Maintenance of grandfather status*—(1) *Changes causing cessation of grandfather status.* Subject to paragraph (g)(2) of this section, the rules of this paragraph (g)(1) describe situations in which a group health plan or health insurance coverage ceases to be a grandfathered health plan. A plan or coverage will cease to be a grandfathered health plan when an amendment to plan terms that results in a change described in this paragraph (g)(1) becomes effective, regardless of when the amendment was adopted. Once grandfather status is lost, it cannot be regained.

(i) *Elimination of benefits.* The elimination of all or substantially all benefits to diagnose or treat a particular condition causes a group health plan or health insurance coverage to cease to be a grandfathered health plan. For this purpose, the elimination of benefits for any necessary element to diagnose or treat a condition is considered the elimination of all or substantially all benefits to diagnose or treat a particular condition. Whether or not a plan or coverage has eliminated substantially all benefits to diagnose or treat a particular condition must be determined based on all the facts and circumstances, taking into account the items and services provided for a particular condition under the plan on March 23, 2010, as compared to the benefits offered at the time the plan or coverage makes the benefit change effective.

(ii) *Increase in percentage cost-sharing requirement.* Any increase, measured from March 23, 2010, in a percentage cost-sharing requirement (such as an individual's coinsurance requirement) causes a group health plan or health insurance coverage to cease to be a grandfathered health plan.

(iii) *Increase in a fixed-amount cost-sharing requirement other than a copayment.* Any increase in a fixed-amount cost-sharing requirement other than a copayment (for example, deductible or out-of-pocket limit), determined as of the effective date of the increase, causes a group health plan or health insurance coverage to cease to be a grandfathered health plan, if the total percentage increase in the cost-sharing requirement measured from March 23, 2010 exceeds the maximum percentage increase (as defined in paragraph (g)(3)(ii) of this section).

(iv) *Increase in a fixed-amount copayment.* Any increase in a fixed-amount copayment, determined as of the effective date of the increase, and determined for each copayment level if a plan has different copayment levels for different categories of services, causes a group health plan or health insurance coverage to cease to be a grandfathered health plan, if the total increase in the copayment measured from March 23, 2010 exceeds the greater of:

(A) An amount equal to \$5 increased by medical inflation, as defined in para-

graph (g)(3)(i) of this section (that is, \$5 times medical inflation, plus \$5), or

(B) The maximum percentage increase (as defined in paragraph (g)(3)(ii) of this section), determined by expressing the total increase in the copayment as a percentage.

(v) *Decrease in contribution rate by employers and employee organizations—*

(A) *Contribution rate based on cost of coverage.* A group health plan or group health insurance coverage ceases to be a grandfathered health plan if the employer or employee organization decreases its contribution rate based on cost of coverage (as defined in paragraph (g)(3)(iii)(A) of this section) towards the cost of any tier of coverage for any class of similarly situated individuals (as described in § 54.9802(d)) by more than 5 percentage points below the contribution rate for the coverage period that includes March 23, 2010.

(B) *Contribution rate based on a formula.* A group health plan or group health insurance coverage ceases to be a grandfathered health plan if the employer or employee organization decreases its contribution rate based on a formula (as defined in paragraph (g)(3)(iii)(B) of this section) towards the cost of any tier of coverage for any class of similarly situated individuals (as described in § 54.9802(d)) by more than 5 percent below the contribution rate for the coverage period that includes March 23, 2010.

(C) *Special rules regarding decreases in contribution rates.* An insured group health plan (or a multiemployer plan) that is a grandfathered health plan will not cease to be a grandfathered health plan based on a change in the employer contribution rate unless the issuer (or multiemployer plan) knows, or should know, of the change, provided:

(I) Upon renewal (or, in the case of a multiemployer plan, before the start of a new plan year), the issuer (or multiemployer plan) requires relevant employers, employee organizations, or plan sponsors, as applicable, to make a representation regarding its contribution rate for the plan year covered by the renewal, as well as its contribution rate on March 23, 2010 (if the issuer, or multiemployer plan, does not already have it); and

(2) The relevant policies, certificates, contracts of insurance, or plan documents disclose in a prominent and effective manner that employers, employee organizations, or plan sponsors, as applicable, are required to notify the issuer (or multiemployer plan) if the contribution rate changes at any point during the plan year.

(D) *Application to plans with multi-tiered coverage structures.* The standards for employer contributions in this paragraph (g)(1)(v) apply on a tier-by-tier basis. Therefore, if a group health plan modifies the tiers of coverage it had on March 23, 2010 (for example, from self-only and family to a multi-tiered structure of self-only, self-plus-one, self-plus-two, and self-plus-three-or-more), the employer contribution for any new tier would be tested by comparison to the contribution rate for the corresponding tier on March 23, 2010. For example, if the employer contribution rate for family coverage was 50 percent on March 23, 2010, the employer contribution rate for any new tier of coverage other than self-only (i.e., self-plus-one, self-plus-two, self-plus-three or more) must be within 5 percentage points of 50 percent (i.e., at least 45 percent). If, however, the plan adds one or more new coverage tiers without eliminating or modifying any previous tiers and those new coverage tiers cover classes of individuals that were not covered previously under the plan, the new tiers would not be analyzed under the standards for changes in employer contributions. For example, if a plan with self-only as the sole coverage tier added a family coverage tier, the level of employer contributions toward the family coverage would not cause the plan to lose grandfather status.

(E) *Group health plans with fixed-dollar employee contributions or no employee contributions.* A group health plan that requires either fixed-dollar employee contributions or no employee contributions will not cease to be a grandfathered health plan solely because the employer contribution rate changes so long as there continues to be no employee contributions or no increase in the fixed-dollar employee contributions towards the cost of coverage.

(vi) *Changes in annual limits—(A) Addition of an annual limit.* A group health plan, or group health insurance coverage,

that, on March 23, 2010, did not impose an overall annual or lifetime limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage imposes an overall annual limit on the dollar value of benefits. (But see § 54.9815–2711, which prohibits all annual dollar limits on essential health benefits for plan years beginning on or after January 1, 2014).

(B) *Decrease in limit for a plan or coverage with only a lifetime limit.* A group health plan, or group health insurance coverage, that, on March 23, 2010, imposed an overall lifetime limit on the dollar value of all benefits but no overall annual limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage adopts an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010. (But see § 54.9815–2711, which prohibits all annual dollar limits on essential health benefits for plan years beginning on or after January 1, 2014).

(C) *Decrease in limit for a plan or coverage with an annual limit.* A group health plan, or group health insurance coverage, that, on March 23, 2010, imposed an overall annual limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage decreases the dollar value of the annual limit (regardless of whether the plan or health insurance coverage also imposed an overall lifetime limit on March 23, 2010 on the dollar value of all benefits). (But see § 54.9815–2711, which prohibits all annual dollar limits on essential health benefits for plan years beginning on or after January 1, 2014).

(2) *Transitional rules—(i) Changes made prior to March 23, 2010.* If a group health plan or health insurance issuer makes the following changes to the terms of the plan or health insurance coverage, the changes are considered part of the terms of the plan or health insurance coverage on March 23, 2010 even though they were not effective at that time and such changes do not cause a plan or health insurance coverage to cease to be a grandfathered health plan:

(A) Changes effective after March 23, 2010 pursuant to a legally binding con-

tract entered into on or before March 23, 2010;

(B) Changes effective after March 23, 2010 pursuant to a filing on or before March 23, 2010 with a State insurance department; or

(C) Changes effective after March 23, 2010 pursuant to written amendments to a plan that were adopted on or before March 23, 2010.

(ii) *Changes made after March 23, 2010 and adopted prior to issuance of regulations.* If, after March 23, 2010, a group health plan or health insurance issuer makes changes to the terms of the plan or health insurance coverage and the changes are adopted prior to June 14, 2010, the changes will not cause the plan or health insurance coverage to cease to be a grandfathered health plan if the changes are revoked or modified effective as of the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010, and the terms of the plan or health insurance coverage on that date, as modified, would not cause the plan or coverage to cease to be a grandfathered health plan under the rules of this section, including paragraph (g)(1) of this section. For this purpose, changes will be considered to have been adopted prior to June 14, 2010 if:

(A) The changes are effective before that date;

(B) The changes are effective on or after that date pursuant to a legally binding contract entered into before that date;

(C) The changes are effective on or after that date pursuant to a filing before that date with a State insurance department; or

(D) The changes are effective on or after that date pursuant to written amendments to a plan that were adopted before that date.

(3) *Definitions*—(i) *Medical inflation defined.* For purposes of this paragraph (g), the term *medical inflation* means the increase since March 2010 in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted) published by the Department of Labor using the 1982 – 1984 base of 100. For this purpose, the increase in the overall medical care component is computed by subtracting 387.142 (the overall medical care compo-

nent of the CPI-U (unadjusted) published by the Department of Labor for March 2010, using the 1982 – 1984 base of 100) from the index amount for any month in the 12 months before the new change is to take effect and then dividing that amount by 387.142.

(ii) *Maximum percentage increase defined.* For purposes of this paragraph (g), the term *maximum percentage increase* means medical inflation (as defined in paragraph (g)(3)(i) of this section), expressed as a percentage, plus 15 percentage points.

(iii) *Contribution rate defined.* For purposes of paragraph (g)(1)(v) of this section:

(A) *Contribution rate based on cost of coverage.* The term *contribution rate based on cost of coverage* means the amount of contributions made by an employer or employee organization compared to the total cost of coverage, expressed as a percentage. The total cost of coverage is determined in the same manner as the applicable premium is calculated under the COBRA continuation provisions of section 604 of ERISA, section 4980B(f)(4) of the Internal Revenue Code, and section 2204 of the PHS Act. In the case of a self-insured plan, contributions by an employer or employee organization are equal to the total cost of coverage minus the employee contributions towards the total cost of coverage.

(B) *Contribution rate based on a formula.* The term *contribution rate based on a formula* means, for plans that, on March 23, 2010, made contributions based on a formula (such as hours worked or tons of coal mined), the formula.

(4) *Examples.* The rules of this paragraph (g) are illustrated by the following examples:

Example 1. (i) *Facts.* On March 23, 2010, a grandfathered health plan has a coinsurance requirement of 20% for inpatient surgery. The plan is subsequently amended to increase the coinsurance requirement to 25%.

(ii) *Conclusion.* In this *Example 1*, the increase in the coinsurance requirement from 20% to 25% causes the plan to cease to be a grandfathered health plan.

Example 2. (i) *Facts.* Before March 23, 2010, the terms of a group health plan provide benefits for a particular mental health condition, the treatment for which is a combination of counseling and prescription drugs. Subsequently, the plan eliminates benefits for counseling.

(ii) *Conclusion.* In this *Example 2*, the plan ceases to be a grandfathered health plan because counseling is an element that is necessary to treat the condition. Thus the plan is considered to have eliminated substantially all benefits for the treatment of the condition.

Example 3. (i) *Facts.* On March 23, 2010, a grandfathered health plan has a copayment requirement of \$30 per office visit for specialists. The plan is subsequently amended to increase the copayment requirement to \$40. Within the 12-month period before the \$40 copayment takes effect, the greatest value of the overall medical care component of the CPI-U (unadjusted) is 475.

(ii) *Conclusion.* In this *Example 3*, the increase in the copayment from \$30 to \$40, expressed as a percentage, is 33.33% ($40 - 30 = 10$; $10 \div 30 = 0.3333$; $0.3333 = 33.33\%$). Medical inflation (as defined in paragraph (g)(3)(i) of this section) from March 2010 is 0.2269 ($475 - 387.142 = 87.858$; $87.858 \div 387.142 = 0.2269$). The maximum percentage increase permitted is 37.69% ($0.2269 = 22.69\%$; $22.69\% + 15\% = 37.69\%$). Because 33.33% does not exceed 37.69%, the change in the copayment requirement at that time does not cause the plan to cease to be a grandfathered health plan.

Example 4. (i) *Facts.* Same facts as *Example 3*, except the grandfathered health plan subsequently increases the \$40 copayment requirement to \$45 for a later plan year. Within the 12-month period before the \$45 copayment takes effect, the greatest value of the overall medical care component of the CPI-U (unadjusted) is 485.

(ii) *Conclusion.* In this *Example 4*, the increase in the copayment from \$30 (the copayment that was in effect on March 23, 2010) to \$45, expressed as a percentage, is 50% ($45 - 30 = 15$; $15 \div 30 = 0.5$; $0.5 = 50\%$). Medical inflation (as defined in paragraph (g)(3)(i) of this section) from March 2010 is 0.2527 ($485 - 387.142 = 97.858$; $97.858 \div 387.142 = 0.2527$). The increase that would cause a plan to cease to be a grandfathered health plan under paragraph (g)(1)(iv) of this section is the greater of the maximum percentage increase of 40.27% ($0.2527 = 25.27\%$; $25.27\% + 15\% = 40.27\%$), or \$6.26 ($\$5 \times 0.2527 = \1.26 ; $\$1.26 + \$5 = \$6.26$). Because 50% exceeds 40.27% and \$15 exceeds \$6.26, the change in the copayment requirement at that time causes the plan to cease to be a grandfathered health plan.

Example 5. (i) *Facts.* On March 23, 2010, a grandfathered health plan has a copayment of \$10 per office visit for primary care providers. The plan is subsequently amended to increase the copayment requirement to \$15. Within the 12-month period before the \$15 copayment takes effect, the greatest value of the overall medical care component of the CPI-U (unadjusted) is 415.

(ii) *Conclusion.* In this *Example 5*, the increase in the copayment, expressed as a percentage, is 50% ($15 - 10 = 5$; $5 \div 10 = 0.5$; $0.5 = 50\%$). Medical inflation (as defined in paragraph (g)(3) of this section) from March 2010 is 0.0720 ($415.0 - 387.142 = 27.858$; $27.858 \div 387.142 = 0.0720$). The increase that would cause a plan to cease to be a grandfathered health plan under paragraph (g)(1)(iv) of this section is the greater of the maximum percentage increase of 22.20% ($0.0720 = 7.20\%$; $7.20\% + 15\% = 22.20\%$), or \$5.36 ($\$5 \times 0.0720 = \0.36 ; $\$0.36 +$

\$5 = \$5.36). The \$5 increase in copayment in this *Example 5* would not cause the plan to cease to be a grandfathered health plan pursuant to paragraph (g)(1)(iv) of this section, which would permit an increase in the copayment of up to \$5.36.

Example 6. (i) *Facts.* The same facts as *Example 5*, except on March 23, 2010, the grandfathered health plan has no copayment (\$0) for office visits for primary care providers. The plan is subsequently amended to increase the copayment requirement to \$5.

(ii) *Conclusion.* In this *Example 6*, medical inflation (as defined in paragraph (g)(3)(i) of this section) from March 2010 is $0.0720 (415.0 - 387.142 = 27.858; 27.858 \div 387.142 = 0.0720)$. The increase that would cause a plan to cease to be a grandfathered health plan under paragraph (g)(1)(iv)(A) of this section is \$5.36 ($\$5 \times 0.0720 = \$0.36; \$0.36 + \$5 = \5.36). The \$5 increase in copayment in this *Example 6* is less than the amount calculated pursuant to paragraph (g)(1)(iv)(A) of this section of \$5.36. Thus, the \$5 increase in copayment does not cause the plan to cease to be a grandfathered health plan.

Example 7. (i) *Facts.* On March 23, 2010, a self-insured group health plan provides two tiers of coverage — self-only and family. The employer contributes 80% of the total cost of coverage for self-only and 60% of the total cost of coverage for family. Subsequently, the employer reduces the contribution to 50% for family coverage, but keeps the same contribution rate for self-only coverage.

(ii) *Conclusion.* In this *Example 7*, the decrease of 10 percentage points for family coverage in the contribution rate based on cost of coverage causes the plan to cease to be a grandfathered health plan. The fact that the contribution rate for self-only coverage remains the same does not change the result.

Example 8. (i) *Facts.* On March 23, 2010, a self-insured grandfathered health plan has a COBRA premium for the 2010 plan year of \$5000 for self-only coverage and \$12,000 for family coverage. The required employee contribution for the coverage is \$1000 for self-only coverage and \$4000 for family coverage. Thus, the contribution rate based on cost of coverage for 2010 is 80% ($(\$5000 - \$1000)/\$5000$) for self-only coverage and 67% ($(\$12,000 - \$4000)/\$12,000$) for family coverage. For a subsequent plan year, the COBRA premium is \$6000 for self-only coverage and \$15,000 for family coverage. The employee contributions for that plan year are \$1200 for self-only coverage and \$5000 for family coverage. Thus, the contribution rate based on cost of coverage is 80% ($(\$6000 - \$1200)/\$6000$) for self-only coverage and 67% ($(\$15,000 - \$5000)/\$15,000$) for family coverage.

(ii) *Conclusion.* In this *Example 8*, because there is no change in the contribution rate based on cost of coverage, the plan retains its status as a grandfathered health plan. The result would be the same if all or part of the employee contribution was made pre-tax through a cafeteria plan under section 125 of the Internal Revenue Code.

Example 9. (i) *Facts.* A group health plan not maintained pursuant to a collective bargaining agreement offers three benefit packages on March 23, 2010. Option *F* is a self-insured option. Options *G* and *H* are insured options. Beginning July 1, 2013,

the plan increases coinsurance under Option *H* from 10% to 15%.

(ii) *Conclusion.* In this *Example 9*, the coverage under Option *H* is not grandfathered health plan coverage as of July 1, 2013, consistent with the rule in paragraph (g)(1)(ii) of this section. Whether the coverage under Options *F* and *G* is grandfathered health plan coverage is determined separately under the rules of this paragraph (g).

§ 54.9815–1251T [Removed]

Par. 5. Section 54.9815–1251T is removed.

Par.6. Section 54.9815–2704 is added to read as follows:

§ 54.9815–2704 Prohibition of preexisting condition exclusions.

(a) *No preexisting condition exclusions.* A group health plan, or a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion (as defined in § 54.9801–2).

(b) *Examples.* The rules of paragraph (a) of this section are illustrated by the following examples (for additional examples illustrating the definition of a preexisting condition exclusion, see § 54.9801–3(a)(2)):

Example 1. (i) *Facts.* A group health plan provides benefits solely through an insurance policy offered by Issuer *P*. At the expiration of the policy, the plan switches coverage to a policy offered by Issuer *N*. *N*'s policy excludes benefits for oral surgery required as a result of a traumatic injury if the injury occurred before the effective date of coverage under the policy.

(ii) *Conclusion.* In this *Example 1*, the exclusion of benefits for oral surgery required as a result of a traumatic injury if the injury occurred before the effective date of coverage is a preexisting condition exclusion because it operates to exclude benefits for a condition based on the fact that the condition was present before the effective date of coverage under the policy. Therefore, such an exclusion is prohibited.

Example 2. (i) *Facts.* Individual *C* applies for individual health insurance coverage with Issuer *M*. *M* denies *C*'s application for coverage because a pre-enrollment physical revealed that *C* has type 2 diabetes.

(ii) *Conclusion.* See *Example 2* in 45 CFR 147.108(a)(2) for a conclusion that *M*'s denial of *C*'s application for coverage is a preexisting condition exclusion because a denial of an application for coverage based on the fact that a condition was present before the date of denial is an exclusion of benefits based on a preexisting condition. Therefore, such an exclusion is prohibited.

(c) *Applicability date.* The provisions of this section are applicable to group health plans and health insurance issuers

for plan years beginning on or after January 1, 2017. Until the applicability date for this regulation, plans and issuers are required to continue to comply with the interim final regulations promulgated by the Department of Labor at 29 CFR part 2590, contained in the 29 CFR, parts 1927 to end, edition revised as of July 1, 2015.

§ 54.9815–2704T [Removed]

Par. 7. Section 54.9815–2704T is removed.

Par.8. Section 54.9815–2711 is added to read as follows:

§ 54.9815–2711 No lifetime or annual limits.

(a) *Prohibition—(1) Lifetime limits.* Except as provided in paragraph (b) of this section, a group health plan, or a health insurance issuer offering group health insurance coverage, may not establish any lifetime limit on the dollar amount of essential health benefits for any individual, whether provided in-network or out-of-network.

(2) *Annual limits—(i) General rule.* Except as provided in paragraphs (a)(2)(ii) and (b) of this section, a group health plan, or a health insurance issuer offering group health insurance coverage, may not establish any annual limit on the dollar amount of essential health benefits for any individual, whether provided in-network or out-of-network.

(ii) *Exception for health flexible spending arrangements.* A health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code) offered through a cafeteria plan pursuant to section 125 of the Internal Revenue Code is not subject to the requirement in paragraph (a)(2)(i) of this section.

(b) *Construction—(1) Permissible limits on specific covered benefits.* The rules of this section do not prevent a group health plan, or a health insurance issuer offering group health insurance coverage, from placing annual or lifetime dollar limits with respect to any individual on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted under applicable Federal or State law. (The scope of

essential health benefits is addressed in paragraph (c) of this section).

(2) *Condition-based exclusions.* The rules of this section do not prevent a group health plan, or a health insurance issuer offering group health insurance coverage, from excluding all benefits for a condition. However, if any benefits are provided for a condition, then the requirements of this section apply. Other requirements of Federal or State law may require coverage of certain benefits.

(c) *Definition of essential health benefits.* The term “essential health benefits” means essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations. For this purpose, a group health plan or a health insurance issuer that is not required to provide essential health benefits under section 1302(b) must define “essential health benefits” in a manner consistent with one of the three Federal Employees Health Benefit Program (FEHBP) options as defined by 45 CFR 156.100(a)(3) or one of the base-benchmark plans selected by a State or applied by default pursuant to 45 CFR 156.100.

(d) *Special rule for health reimbursement arrangements (HRAs) and other account-based plans—* (1) *In general.* If an HRA or other account-based plan is integrated with other coverage under a group health plan and the other group health plan coverage alone satisfies the requirements in paragraph (a)(2) of this section, the fact that the benefits under the HRA or other account-based plan are limited does not mean that the HRA or other account-based plan fails to meet the requirements of paragraph (a)(2) of this section. Similarly, if an HRA or other account-based plan is integrated with other coverage under a group health plan and the other group health plan coverage alone satisfies the requirements in PHS Act section 2713 and section 54.9815–2713(a)(1), the HRA or other account-based plan will not fail to meet the requirements of PHS Act section 2713 and § 54.9815–2713(a)(1).

(2) *Integration requirements.* An HRA or other account-based plan is integrated with a group health plan for purposes of paragraph (a)(2) of this section if it meets the requirements under either the integra-

tion method set forth in paragraph (d)(2)(i) of this section or the integration method set forth in paragraph (d)(2)(ii) of this section. Integration does not require that the HRA (or other account-based plan) and the group health plan with which it is integrated share the same plan sponsor, the same plan document, or governing instruments, or file a single Form 5500, if applicable. The term “excepted benefits” is used throughout the integration methods; for a definition of the term “excepted benefits” see Code section 9832(c), ERISA section 733(c), and PHS Act section 2791(c).

(i) *Integration Method: Minimum value not required.* An HRA or other account-based plan is integrated with another group health plan for purposes of this paragraph if:

(A) The plan sponsor offers a group health plan (other than the HRA or other account-based plan) to the employee that does not consist solely of excepted benefits;

(B) The employee receiving the HRA or other account-based plan is actually enrolled in a group health plan (other than the HRA or other account-based plan) that does not consist solely of excepted benefits, regardless of whether the plan is offered by the same plan sponsor (referred to as non-HRA group coverage);

(C) The HRA or other account-based plan is available only to employees who are enrolled in non-HRA group coverage, regardless of whether the non-HRA group coverage is offered by the plan sponsor of the HRA or other account-based plan (for example, the HRA may be offered only to employees who do not enroll in an employer’s group health plan but are enrolled in other non-HRA group coverage, such as a group health plan maintained by the employer of the employee’s spouse);

(D) The benefits under the HRA or other account-based plan are limited to reimbursement of one or more of the following—co-payments, co-insurance, deductibles, and premiums under the non-HRA group coverage, as well as medical care (as defined under section 213(d) of the Code) that does not constitute essential health benefits as defined in paragraph (c) of this section; and

(E) Under the terms of the HRA or other account-based plan, an employee (or

former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based plan at least annually and, upon termination of employment, either the remaining amounts in the HRA or other account-based plan are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based plan.

(ii) *Integration Method: Minimum value required.* An HRA or other account-based plan is integrated with another group health plan for purposes of this paragraph if:

(A) The plan sponsor offers a group health plan (other than the HRA or other account-based plan) to the employee that provides minimum value pursuant to Code section 36B(c)(2)(C)(ii) (and its implementing regulations and applicable guidance);

(B) The employee receiving the HRA or other account-based plan is actually enrolled in a group health plan that provides minimum value pursuant to section 36B(c)(2)(C)(ii) of the Code (and applicable guidance), regardless of whether the plan is offered by the plan sponsor of the HRA or other account-based plan (referred to as non-HRA MV group coverage);

(C) The HRA or other account-based plan is available only to employees who are actually enrolled in non-HRA MV group coverage, regardless of whether the non-HRA MV group coverage is offered by the plan sponsor of the HRA or other account-based plan (for example, the HRA may be offered only to employees who do not enroll in an employer’s group health plan but are enrolled in other non-HRA MV group coverage, such as a group health plan maintained by an employer of the employee’s spouse); and

(D) Under the terms of the HRA or other account-based plan, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based plan at least annually, and, upon termination of employment, either the remaining amounts in the HRA or other account-based plan are forfeited or the employee is permitted to permanently opt out of and waive future reimburse-

ments from the HRA or other account-based plan.

(3) *Forfeiture.* For purpose of integration under paragraphs (d)(2)(i)(E) and (d)(2)(ii)(D) of this section, forfeiture or waiver occurs even if the forfeited or waived amounts may be reinstated upon a fixed date, a participant's death, or the earlier of the two events (the reinstatement event). For this purpose coverage under an HRA or other account-based plan is considered forfeited or waived prior to a reinstatement event only if the participant's election to forfeit or waive is irrevocable, meaning that, beginning on the effective date of the election and through the date of the reinstatement event, the participant and the participant's beneficiaries have no access to amounts credited to the HRA or other account-based plan. This means that upon and after reinstatement, the reinstated amounts under the HRA or other account-based plan may not be used to reimburse or pay medical expenses incurred during the period after forfeiture and prior to reinstatement.

(4) *No integration with individual market coverage.* A group health plan, including an HRA or other account-based plan, used to purchase coverage on the individual market is not integrated with that individual market coverage for purposes of paragraph (a)(2) of this section (or for purposes of the requirements of PHS Act section 2713).

(5) *Integration with Medicare parts B and D.* For employers that are not required to offer their non-HRA group health plan coverage to employees who are Medicare beneficiaries, an HRA or other account-based plan that may be used to reimburse premiums under Medicare part B or D may be integrated with Medicare (and deemed to comply with PHS Act sections 2711 and 2713) if the following requirements are satisfied with respect to employees who would be eligible for the employer's non-HRA group health plan but for their eligibility for Medicare (and the integration rules under paragraphs (d)(2)(i) and (ii) of this section continue to apply to employees who are not eligible for Medicare):

(i) The plan sponsor offers a group health plan (other than the HRA or other account-based plan and that does not con-

sist solely of excepted benefits) to employees who are not eligible for Medicare;

(ii) The employee receiving the HRA or other account-based plan is actually enrolled Medicare part B or D;

(iii) The HRA or other account-based plan is available only to employees who are enrolled in Medicare part B or D; and

(iv) The HRA or other account-based plan complies with paragraphs (d)(2)(i)(E) and (d)(2)(ii)(D) of this section.

(6) *Account-based plan.* An account-based plan for purposes of this section is an employer-provided group health plan that provides reimbursements of medical expenses other than individual market policy premiums with the reimbursement subject to a maximum fixed dollar amount for a period. An HRA is a type of account-based plan.

(e) *Applicability date.* The provisions of this section are applicable to group health plans and health insurance issuers for plan years beginning on or after January 1, 2017. Until the applicability date for this regulation, plans and issuers are required to continue to comply with the interim final regulations promulgated by the Department of Labor at 29 CFR part 2590, contained in the 29 CFR, parts 1927 to end, edition revised as of July 1, 2015.

§ 54.9815–2711T [Removed]

Par. 9. Section 54.9815–2711T is removed.

Par.10. Section 54.9815–2712 is added to read as follows:

§ 54.9815–2712 Rules regarding rescissions.

(a) *Prohibition on rescissions*—(1) A group health plan, or a health insurance issuer offering group health insurance coverage, must not rescind coverage under the plan, or under the policy, certificate, or contract of insurance, with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the plan or coverage, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation

of material fact, as prohibited by the terms of the plan or coverage. A group health plan, or a health insurance issuer offering group health insurance coverage, must provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded under this paragraph (a)(1), regardless of whether the coverage is insured or self-insured, or whether the rescission applies to an entire group or only to an individual within the group. (The rules of this paragraph (a)(1) apply regardless of any contestability period that may otherwise apply.)

(2) For purposes of this section, a rescission is a cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats a policy as void from the time of the individual's or group's enrollment is a rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a rescission for this purpose. A cancellation or discontinuance of coverage is not a rescission if –

(i) The cancellation or discontinuance of coverage has only a prospective effect;

(ii) The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions (including COBRA premiums) towards the cost of coverage;

(iii) The cancellation or discontinuance of coverage is initiated by the individual (or by the individual's authorized representative) and the sponsor, employer, plan, or issuer does not, directly or indirectly, take action to influence the individual's decision to cancel or discontinue coverage retroactively or otherwise take any adverse action or retaliate against, interfere with, coerce, intimidate, or threaten the individual; or

(iv) The cancellation or discontinuance of coverage is initiated by the Exchange pursuant to 45 CFR 155.430 (other than under paragraph (b)(2)(iii)).

(3) The rules of this paragraph (a) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual A seeks enrollment in an insured group health plan. The plan terms permit rescission of coverage with respect to an individual if the individual engages in fraud or makes an intentional misrepresentation of a material fact. The plan requires A to complete a questionnaire

regarding A's prior medical history, which affects setting the group rate by the health insurance issuer. The questionnaire complies with the other requirements of this part. The questionnaire includes the following question: "Is there anything else relevant to your health that we should know?" A inadvertently fails to list that A visited a psychologist on two occasions, six years previously. A is later diagnosed with breast cancer and seeks benefits under the plan. On or around the same time, the issuer receives information about A's visits to the psychologist, which was not disclosed in the questionnaire.

(ii) *Conclusion.* In this *Example 1*, the plan cannot rescind A's coverage because A's failure to disclose the visits to the psychologist was inadvertent. Therefore, it was not fraudulent or an intentional misrepresentation of material fact.

Example 2. (i) *Facts.* An employer sponsors a group health plan that provides coverage for employees who work at least 30 hours per week. Individual B has coverage under the plan as a full-time employee. The employer reassigns B to a part-time position. Under the terms of the plan, B is no longer eligible for coverage. The plan mistakenly continues to provide health coverage, collecting premiums from B and paying claims submitted by B. After a routine audit, the plan discovers that B no longer works at least 30 hours per week. The plan rescinds B's coverage effective as of the date that B changed from a full-time employee to a part-time employee.

(ii) *Conclusion.* In this *Example 2*, the plan cannot rescind B's coverage because there was no fraud or an intentional misrepresentation of material fact. The plan may cancel coverage for B prospectively, subject to other applicable Federal and State laws.

(b) *Compliance with other requirements.* Other requirements of Federal or State law may apply in connection with a rescission of coverage.

(c) *Applicability date.* The provisions of this section are applicable to group health plans and health insurance issuers for plan years beginning on or after January 1, 2017. Until the applicability date for this regulation, plans and issuers are required to continue to comply with the interim final regulations promulgated by the Department of Labor at 29 CFR part 2590, contained in the 29 CFR, parts 1927 to end, edition revised as of July 1, 2015.

§ 54.9815–2712T [Removed]

Par. 11. Section 54.9815–2712T is removed.

Par.12. Section 54.9815–2714 is added to read as follows:

§ 54.9815–2714 Eligibility of children until at least age 26.

(a) *In general*—(1) A group health plan, or a health insurance issuer offering group health insurance coverage, that

makes available dependent coverage of children must make such coverage available for children until attainment of 26 years of age.

(2) The rule of this paragraph (a) is illustrated by the following example:

Example. (i) *Facts.* For the plan year beginning January 1, 2011, a group health plan provides health coverage for employees, employees' spouses, and employees' children until the child turns 26. On the birthday of a child of an employee, July 17, 2011, the child turns 26. The last day the plan covers the child is July 16, 2011.

(ii) *Conclusion.* In this *Example*, the plan satisfies the requirement of this paragraph (a) with respect to the child.

(b) *Restrictions on plan definition of dependent* – (1) *In general.* With respect to a child who has not attained age 26, a plan or issuer may not define dependent for purposes of eligibility for dependent coverage of children other than in terms of a relationship between a child and the participant. Thus, for example, a plan or issuer may not deny or restrict dependent coverage for a child who has not attained age 26 based on the presence or absence of the child's financial dependency (upon the participant or any other person); residency with the participant or with any other person; whether the child lives, works, or resides in an HMO's service area or other network service area; marital status; student status; employment; eligibility for other coverage; or any combination of those factors. (Other requirements of Federal or State law, including section 609 of ERISA or section 1908 of the Social Security Act, may require coverage of certain children.)

(2) *Construction.* A plan or issuer will not fail to satisfy the requirements of this section if the plan or issuer limits dependent child coverage to children under age 26 who are described in section 152(f)(1). For an individual not described in section 152(f)(1), such as a grandchild or niece, a plan may impose additional conditions on eligibility for dependent child health coverage, such as a condition that the individual be a dependent for income tax purposes.

(c) *Coverage of grandchildren not required.* Nothing in this section requires a plan or issuer to make coverage available for the child of a child receiving dependent coverage.

(d) *Uniformity irrespective of age.* The terms of the plan or health insurance cov-

erage providing dependent coverage of children cannot vary based on age (except for children who are age 26 or older).

(e) *Examples.* The rules of paragraph (d) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan offers a choice of self-only or family health coverage. Dependent coverage is provided under family health coverage for children of participants who have not attained age 26. The plan imposes an additional premium surcharge for children who are older than age 18.

(ii) *Conclusion.* In this *Example 1*, the plan violates the requirement of paragraph (d) of this section because the plan varies the terms for dependent coverage of children based on age.

Example 2. (i) *Facts.* A group health plan offers a choice among the following tiers of health coverage: self-only, self-plus-one, self-plus-two, and self-plus-three-or-more. The cost of coverage increases based on the number of covered individuals. The plan provides dependent coverage of children who have not attained age 26.

(ii) *Conclusion.* In this *Example 2*, the plan does not violate the requirement of paragraph (d) of this section that the terms of dependent coverage for children not vary based on age. Although the cost of coverage increases for tiers with more covered individuals, the increase applies without regard to the age of any child.

Example 3. (i) *Facts.* A group health plan offers two benefit packages — an HMO option and an indemnity option. Dependent coverage is provided for children of participants who have not attained age 26. The plan limits children who are older than age 18 to the HMO option.

(ii) *Conclusion.* In this *Example 3*, the plan violates the requirement of paragraph (d) of this section because the plan, by limiting children who are older than age 18 to the HMO option, varies the terms for dependent coverage of children based on age.

Example 4. (i) *Facts.* A group health plan sponsored by a large employer normally charges a copayment for physician visits that do not constitute preventive services. The plan charges this copayment to individuals age 19 and over, including employees, spouses, and dependent children, but waives it for those under age 19.

(ii) *Conclusion.* In this *Example 4*, the plan does not violate the requirement of paragraph (d) of this section that the terms of dependent coverage for children not vary based on age. While the requirement of paragraph (d) of this section generally prohibits distinctions based upon age in dependent coverage of children, it does not prohibit distinctions based upon age that apply to all coverage under the plan, including coverage for employees and spouses as well as dependent children. In this *Example 4*, the copayments charged to dependent children are the same as those charged to employees and spouses. Accordingly, the arrangement described in this *Example 4* (including waiver, for individuals under age 19, of the generally applicable copayment) does not violate the requirement of paragraph (d) of this section.

(f) *Applicability date.* The provisions of this section are applicable to group health plans and health insurance issuers for plan years beginning on or after January 1, 2017. Until the applicability date for this regulation, plans and issuers are required to continue to comply with the interim final regulations promulgated by the Department of Labor at 29 CFR part 2590, contained in the 29 CFR, parts 1927 to end, edition revised as of July 1, 2015.

§ 54.9815–2714T [Removed]

Par. 13. Section 54.9815–2714T is removed.

Par.14. Section 54.9815–2719 is added to read as follows:

§ 54.9815–2719 Internal claims and appeals and external review processes

(a) *Scope and definitions*—(1) *Scope.* This section sets forth requirements with respect to internal claims and appeals and external review processes for group health plans and health insurance issuers that are not grandfathered health plans under § 54.9815–1251. Paragraph (b) of this section provides requirements for internal claims and appeals processes. Paragraph (c) of this section sets forth rules governing the applicability of State external review processes. Paragraph (d) of this section sets forth a Federal external review process for plans and issuers not subject to an applicable State external review process. Paragraph (e) of this section prescribes requirements for ensuring that notices required to be provided under this section are provided in a culturally and linguistically appropriate manner. Paragraph (f) of this section describes the authority of the Secretary to deem certain external review processes in existence on March 23, 2010 as in compliance with paragraph (c) or (d) of this section.

(2) *Definitions.* For purposes of this section, the following definitions apply –

(i) *Adverse benefit determination.* An *adverse benefit determination* means an adverse benefit determination as defined in 29 CFR 2560.503–1, as well as any rescission of coverage, as described in § 54.9815–2712(a)(2) (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time).

(ii) *Appeal (or internal appeal).* An *appeal* or *internal appeal* means review by a plan or issuer of an adverse benefit determination, as required in paragraph (b) of this section.

(iii) *Claimant.* *Claimant* means an individual who makes a claim under this section. For purposes of this section, references to claimant include a claimant’s authorized representative.

(iv) *External review.* *External review* means a review of an adverse benefit determination (including a final internal adverse benefit determination) conducted pursuant to an applicable State external review process described in paragraph (c) of this section or the Federal external review process of paragraph (d) of this section.

(v) *Final internal adverse benefit determination.* A *final internal adverse benefit determination* means an adverse benefit determination that has been upheld by a plan or issuer at the completion of the internal appeals process applicable under paragraph (b) of this section (or an adverse benefit determination with respect to which the internal appeals process has been exhausted under the deemed exhaustion rules of paragraph (b)(2)(ii)(F) of this section).

(vi) *Final external review decision.* A *final external review decision* means a determination by an independent review organization at the conclusion of an external review.

(vii) *Independent review organization (or IRO).* An *independent review organization* (or *IRO*) means an entity that conducts independent external reviews of adverse benefit determinations and final internal adverse benefit determinations pursuant to paragraph (c) or (d) of this section.

(viii) *NAIC Uniform Model Act.* The *NAIC Uniform Model Act* means the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners in place on July 23, 2010.

(b) *Internal claims and appeals process*—(1) *In general.* A group health plan and a health insurance issuer offering group health insurance coverage must implement an effective internal claims and appeals process, as described in this paragraph (b).

(2) *Requirements for group health plans and group health insurance issuers.* A group health plan and a health insurance issuer offering group health insurance coverage must comply with all the requirements of this paragraph (b)(2). In the case of health insurance coverage offered in connection with a group health plan, if either the plan or the issuer complies with the internal claims and appeals process of this paragraph (b)(2), then the obligation to comply with this paragraph (b)(2) is satisfied for both the plan and the issuer with respect to the health insurance coverage.

(i) *Minimum internal claims and appeals standards.* A group health plan and a health insurance issuer offering group health insurance coverage must comply with all the requirements applicable to group health plans under 29 CFR 2560.503–1, except to the extent those requirements are modified by paragraph (b)(2)(ii) of this section. Accordingly, under this paragraph (b), with respect to health insurance coverage offered in connection with a group health plan, the group health insurance issuer is subject to the requirements in 29 CFR 2560.503–1 to the same extent as the group health plan.

(ii) *Additional standards.* In addition to the requirements in paragraph (b)(2)(i) of this section, the internal claims and appeals processes of a group health plan and a health insurance issuer offering group health insurance coverage must meet the requirements of this paragraph (b)(2)(ii).

(A) *Clarification of meaning of adverse benefit determination.* For purposes of this paragraph (b)(2), an “adverse benefit determination” includes an adverse benefit determination as defined in paragraph (a)(2)(i) of this section. Accordingly, in complying with 29 CFR 2560.503–1, as well as the other provisions of this paragraph (b)(2), a plan or issuer must treat a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at that time) as an adverse benefit determination. (Rescissions of coverage are subject to the requirements of § 54.9815–2712.)

(B) *Expedited notification of benefit determinations involving urgent care.* The requirements of 29 CFR 2560.503–

1(f)(2)(i) (which generally provide, among other things, in the case of urgent care claims for notification of the plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the receipt of the claim) continue to apply to the plan and issuer. For purposes of this paragraph (b)(2)(ii)(B), a claim involving urgent care has the meaning given in 29 CFR 2560.503-1(m)(1), as determined by the attending provider, and the plan or issuer shall defer to such determination of the attending provider.

(C) *Full and fair review.* A plan and issuer must allow a claimant to review the claim file and to present evidence and testimony as part of the internal claims and appeals process. Specifically, in addition to complying with the requirements of 29 CFR 2560.503-1(h)(2) —

(I) The plan or issuer must provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan or issuer (or at the direction of the plan or issuer) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided under 29 CFR 2560.503-1(i) to give the claimant a reasonable opportunity to respond prior to that date; and

(2) Before the plan or issuer can issue a final internal adverse benefit determination based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided under 29 CFR 2560.503-1(i) to give the claimant a reasonable opportunity to respond prior to that date. Notwithstanding the rules of 29 CFR 2560.503-1(i), if the new or additional evidence is received so late that it would be impossible to provide it to the claimant in time for the claimant to have a reasonable opportunity to respond, the period for providing a notice of final internal adverse benefit determination is tolled until such time as the claimant has a reasonable opportunity to respond. After the claimant responds, or has a reasonable opportunity to respond

but fails to do so, the plan administrator shall notify the claimant of the plan's benefit determination as soon as a plan acting in a reasonable and prompt fashion can provide the notice, taking into account the medical exigencies.

(D) *Avoiding conflicts of interest.* In addition to the requirements of 29 CFR 2560.503-1(b) and (h) regarding full and fair review, the plan and issuer must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

(E) *Notice.* A plan and issuer must provide notice to individuals, in a culturally and linguistically appropriate manner (as described in paragraph (e) of this section) that complies with the requirements of 29 CFR 2560.503-1(g) and (j). The plan and issuer must also comply with the additional requirements of this paragraph (b)(2)(ii)(E).

(I) The plan and issuer must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

(2) The plan and issuer must provide to participants and beneficiaries, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination or final internal adverse benefit determination. The plan or issuer must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal under this paragraph (b) or an external review under paragraphs (c) and (d) of this section.

(3) The plan and issuer must ensure that the reason or reasons for the adverse benefit determination or final internal adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the plan's or issuer's standard, if any, that was used in denying the claim. In the case of a notice of final internal adverse benefit determination, this description must include a discussion of the decision.

(4) The plan and issuer must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

(5) The plan and issuer must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and appeals and external review processes.

(F) *Deemed exhaustion of internal claims and appeals processes* — (I) In the case of a plan or issuer that fails to strictly adhere to all the requirements of this paragraph (b)(2) with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process of this paragraph (b), except as provided in paragraph (b)(2)(ii)(F)(2) of this section. Accordingly the claimant may initiate an external review under paragraph (c) or (d) of this section, as applicable. The claimant is also entitled to pursue any available remedies under section 502(a) of ERISA or under State law, as applicable, on the basis that the plan or issuer has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

(2) Notwithstanding paragraph (b)(2)(ii)(F)(I) of this section, the internal claims and appeals process of this paragraph (b) will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the plan or issuer demonstrates that the viola-

tion was for good cause or due to matters beyond the control of the plan or issuer and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the plan or issuer. The claimant may request a written explanation of the violation from the plan or issuer, and the plan or issuer must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process of this paragraph (b) to be deemed exhausted. If an external reviewer or a court rejects the claimant's request for immediate review under paragraph (b)(2)(ii)(F)(1) of this section on the basis that the plan met the standards for the exception under this paragraph (b)(2)(ii)(F)(2), the claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the plan shall provide the claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon claimant's receipt of such notice.

(iii) *Requirement to provide continued coverage pending the outcome of an appeal.* A plan and issuer subject to the requirements of this paragraph (b)(2) are required to provide continued coverage pending the outcome of an appeal. For this purpose, the plan and issuer must comply with the requirements of 29 CFR 2560.503-1(f)(2)(ii), which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

(c) *State standards for external review*—(1) *In general.* (i) If a State external review process that applies to and is binding on a health insurance issuer offering group health insurance coverage includes at a minimum the consumer protections in the NAIC Uniform Model Act, then the issuer must comply with the applicable State external review process and is not required to comply with the Federal

external review process of paragraph (d) of this section. In such a case, to the extent that benefits under a group health plan are provided through health insurance coverage, the group health plan is not required to comply with either this paragraph (c) or the Federal external review process of paragraph (d) of this section.

(ii) To the extent that a group health plan provides benefits other than through health insurance coverage (that is, the plan is self-insured) and is subject to a State external review process that applies to and is binding on the plan (for example, is not preempted by ERISA) and the State external review process includes at a minimum the consumer protections in the NAIC Uniform Model Act, then the plan must comply with the applicable State external review process and is not required to comply with the Federal external review process of paragraph (d) of this section. Where a self-insured plan is not subject to an applicable State external review process, but the State has chosen to expand access to its process for plans that are not subject to the applicable State laws, the plan may choose to comply with either the applicable State external review process or the Federal external review process of paragraph (d) of this section.

(iii) If a plan or issuer is not required under paragraph (c)(1)(i) or (c)(1)(ii) of this section to comply with the requirements of this paragraph (c), then the plan or issuer must comply with the Federal external review process of paragraph (d) of this section, except to the extent, in the case of a plan, the plan is not required under paragraph (c)(1)(i) of this section to comply with paragraph (d) of this section.

(2) *Minimum standards for State external review processes.* An applicable State external review process must meet all the minimum consumer protections in this paragraph (c)(2). The Department of Health and Human Services will determine whether State external review processes meet these requirements.

(i) The State process must provide for the external review of adverse benefit determinations (including final internal adverse benefit determinations) by issuers (or, if applicable, plans) that are based on the issuer's (or plan's) requirements for medical necessity, appropriateness, health

care setting, level of care, or effectiveness of a covered benefit.

(ii) The State process must require issuers (or, if applicable, plans) to provide effective written notice to claimants of their rights in connection with an external review for an adverse benefit determination.

(iii) To the extent the State process requires exhaustion of an internal claims and appeals process, exhaustion must be unnecessary where the issuer (or, if applicable, the plan) has waived the requirement; the issuer (or the plan) is considered to have exhausted the internal claims and appeals process under applicable law (including by failing to comply with any of the requirements for the internal appeal process, as outlined in paragraph (b)(2) of this section); or the claimant has applied for expedited external review at the same time as applying for an expedited internal appeal.

(iv) The State process provides that the issuer (or, if applicable, the plan) against which a request for external review is filed must pay the cost of the IRO for conducting the external review. Notwithstanding this requirement, a State external review process that expressly authorizes, as of November 18, 2015, a nominal filing fee may continue to permit such fees. For this purpose, to be considered nominal, a filing fee must not exceed \$25; it must be refunded to the claimant if the adverse benefit determination (or final internal adverse benefit determination) is reversed through external review; it must be waived if payment of the fee would impose an undue financial hardship; and the annual limit on filing fees for any claimant within a single plan year must not exceed \$75.

(v) The State process may not impose a restriction on the minimum dollar amount of a claim for it to be eligible for external review. Thus, the process may not impose, for example, a \$500 minimum claims threshold.

(vi) The State process must allow at least four months after the receipt of a notice of an adverse benefit determination or final internal adverse benefit determination for a request for an external review to be filed.

(vii) The State process must provide that IROs will be assigned on a random

basis or another method of assignment that assures the independence and impartiality of the assignment process (such as rotational assignment) by a State or independent entity, and in no event selected by the issuer, plan, or the individual.

(viii) The State process must provide for maintenance of a list of approved IROs qualified to conduct the external review based on the nature of the health care service that is the subject of the review. The State process must provide for approval only of IROs that are accredited by a nationally recognized private accrediting organization.

(ix) The State process must provide that any approved IRO has no conflicts of interest that will influence its independence. Thus, the IRO may not own or control, or be owned or controlled by a health insurance issuer, a group health plan, the sponsor of a group health plan, a trade association of plans or issuers, or a trade association of health care providers. The State process must further provide that the IRO and the clinical reviewer assigned to conduct an external review may not have a material professional, familial, or financial conflict of interest with the issuer or plan that is the subject of the external review; the claimant (and any related parties to the claimant) whose treatment is the subject of the external review; any officer, director, or management employee of the issuer; the plan administrator, plan fiduciaries, or plan employees; the health care provider, the health care provider's group, or practice association recommending the treatment that is subject to the external review; the facility at which the recommended treatment would be provided; or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended.

(x) The State process allows the claimant at least five business days to submit to the IRO in writing additional information that the IRO must consider when conducting the external review, and it requires that the claimant is notified of the right to do so. The process must also require that any additional information submitted by the claimant to the IRO must be forwarded to the issuer (or, if applicable, the plan) within one business day of receipt by the IRO.

(xi) The State process must provide that the decision is binding on the plan or issuer, as well as the claimant except to the extent the other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the plan or issuer from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits. For this purpose, the plan or issuer must provide benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the plan or issuer intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

(xii) The State process must require, for standard external review, that the IRO provide written notice to the issuer (or, if applicable, the plan) and the claimant of its decision to uphold or reverse the adverse benefit determination (or final internal adverse benefit determination) within no more than 45 days after the receipt of the request for external review by the IRO.

(xiii) The State process must provide for an expedited external review if the adverse benefit determination (or final internal adverse benefit determination) concerns an admission, availability of care, continued stay, or health care service for which the claimant received emergency services, but has not been discharged from a facility; or involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the claimant or jeopardize the claimant's ability to regain maximum function. As expeditiously as possible but within no more than 72 hours after the receipt of the request for expedited external review by the IRO, the IRO must make its decision to uphold or reverse the adverse benefit determination (or final internal adverse benefit determination) and notify the claimant and the issuer (or, if applicable, the plan) of the determination. If the notice is not in writing, the IRO must provide written confirmation of the decision within 48 hours after the date of the notice of the decision.

(xiv) The State process must require that issuers (or, if applicable, plans) include a description of the external review process in or attached to the summary plan description, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to participants, beneficiaries, or enrollees, substantially similar to what is set forth in section 17 of the NAIC Uniform Model Act.

(xv) The State process must require that IROs maintain written records and make them available upon request to the State, substantially similar to what is set forth in section 15 of the NAIC Uniform Model Act.

(xvi) The State process follows procedures for external review of adverse benefit determinations (or final internal adverse benefit determinations) involving experimental or investigational treatment, substantially similar to what is set forth in section 10 of the NAIC Uniform Model Act.

(3) *Transition period for external review processes*—(i) Through December 31, 2017, an applicable State external review process applicable to a health insurance issuer or group health plan is considered to meet the requirements of PHS Act section 2719(b). Accordingly, through December 31, 2017, an applicable State external review process will be considered binding on the issuer or plan (in lieu of the requirements of the Federal external review process). If there is no applicable State external review process, the issuer or plan is required to comply with the requirements of the Federal external review process in paragraph (d) of this section.

(ii) An applicable State external review process must apply for final internal adverse benefit determinations (or, in the case of simultaneous internal appeal and external review, adverse benefit determinations) provided on or after January 1, 2018. The Federal external review process will apply to such internal adverse benefit determinations unless the Department of Health and Human Services determines that a State law meets all the minimum standards of paragraph (c)(2) of this section. Through December 31, 2017, a State external review process applicable to a health insurance issuer or group health plan may be considered to meet the min-

imum standards of paragraph (c)(2) of this section, if it meets the temporary standards established by the Secretary in guidance for a process similar to the NAIC Uniform Model Act.

(d) *Federal external review process.* A plan or issuer not subject to an applicable State external review process under paragraph (c) of this section must provide an effective Federal external review process in accordance with this paragraph (d) (except to the extent, in the case of a plan, the plan is described in paragraph (c)(1)(i) of this section as not having to comply with this paragraph (d)). In the case of health insurance coverage offered in connection with a group health plan, if either the plan or the issuer complies with the Federal external review process of this paragraph (d), then the obligation to comply with this paragraph (d) is satisfied for both the plan and the issuer with respect to the health insurance coverage. A Multi State Plan or MSP, as defined by 45 CFR 800.20, must provide an effective Federal external review process in accordance with this paragraph (d). In such circumstances, the requirement to provide external review under this paragraph (d) is satisfied when a Multi State Plan or MSP complies with standards established by the Office of Personnel Management.

(1) *Scope —(i) In general.* The Federal external review process established pursuant to this paragraph (d) applies to the following:

(A) An adverse benefit determination (including a final internal adverse benefit determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is experimental or investigational; its determination whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; or its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer. (A

denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan or health insurance coverage is not eligible for the Federal external review process under this paragraph (d)); and

(B) A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

(ii) *Examples.* The rules of paragraph (d)(1)(i) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan provides coverage for 30 physical therapy visits generally. After the 30th visit, coverage is provided only if the service is preauthorized pursuant to an approved treatment plan that takes into account medical necessity using the plan's definition of the term. Individual A seeks coverage for a 31st physical therapy visit. A's health care provider submits a treatment plan for approval, but it is not approved by the plan, so coverage for the 31st visit is not preauthorized. With respect to the 31st visit, A receives a notice of final internal adverse benefit determination stating that the maximum visit limit is exceeded.

(ii) *Conclusion.* In this *Example 1*, the plan's denial of benefits is based on medical necessity and involves medical judgment. Accordingly, the claim is eligible for external review under paragraph (d)(1)(i) of this section. Moreover, the plan's notification of final internal adverse benefit determination is inadequate under paragraphs (b)(2)(i) and (b)(2)(ii)(E)(3) of this section because it fails to make clear that the plan will pay for more than 30 visits if the service is preauthorized pursuant to an approved treatment plan that takes into account medical necessity using the plan's definition of the term. Accordingly, the notice of final internal adverse benefit determination should refer to the plan provision governing the 31st visit and should describe the plan's standard for medical necessity, as well as how the treatment fails to meet the plan's standard.

Example 2. (i) *Facts.* A group health plan does not provide coverage for services provided out of network, unless the service cannot effectively be provided in network. Individual B seeks coverage for a specialized medical procedure from an out-of-network provider because B believes that the procedure cannot be effectively provided in network. B receives a notice of final internal adverse benefit determination stating that the claim is denied because the provider is out-of-network.

(ii) *Conclusion.* In this *Example 2*, the plan's denial of benefits is based on whether a service can effectively be provided in network and, therefore, involves medical judgment. Accordingly, the claim is eligible for external review under paragraph (d)(1)(i) of this section. Moreover, the plan's notice of final internal adverse benefit determination is inadequate under paragraphs (b)(2)(i) and (b)(2)(ii)(E)(3) of this section because the plan does provide benefits for services on an out-of-network

basis if the services cannot effectively be provided in network. Accordingly, the notice of final internal adverse benefit determination is required to refer to the exception to the out-of-network exclusion and should describe the plan's standards for determining effectiveness of services, as well as how services available to the claimant within the plan's network meet the plan's standard for effectiveness of services.

(2) *External review process standards.* The Federal external review process established pursuant to this paragraph (d) is considered similar to the process set forth in the NAIC Uniform Model Act and, therefore satisfies the requirements of paragraph (d)(2), if such process provides the following.

(i) *Request for external review.* A group health plan or health insurance issuer must allow a claimant to file a request for an external review with the plan or issuer if the request is filed within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

(ii) *Preliminary review — (A) In general.* Within five business days following the date of receipt of the external review request, the group health plan or health insurance issuer must complete a preliminary review of the request to determine whether:

(1) The claimant is or was covered under the plan or coverage at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan or coverage at the time the health care item or service was provided;

(2) The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the group health plan or health insurance coverage (e.g., worker classification or similar determination);

(3) The claimant has exhausted the plan's or issuer's internal appeal process unless the claimant is not required to exhaust the internal appeals process under paragraph (b)(1) of this section; and

(4) The claimant has provided all the information and forms required to process an external review.

(B) Within one business day after completion of the preliminary review, the plan or issuer must issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and current contact information, including the phone number, for the Employee Benefits Security Administration. If the request is not complete, such notification must describe the information or materials needed to make the request complete, and the plan or issuer must allow a claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

(iii) *Referral to Independent Review Organization* — (A) *In general.* The group health plan or health insurance issuer must assign an IRO that is accredited by URAC or by similar nationally-recognized accrediting organization to conduct the external review. The IRO referral process must provide for the following:

(1) The plan or issuer must ensure that the IRO process is not biased and ensures independence;

(2) The plan or issuer must contract with at least three (3) IROs for assignments under the plan or coverage and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection); and

(3) The IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

(4) The IRO process may not impose any costs, including filing fees, on the claimant requesting the external review.

(B) *IRO contracts.* A group health plan or health insurance issuer must include the following standards in the contract between the plan or issuer and the IRO:

(1) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the plan or coverage.

(2) The assigned IRO will timely notify a claimant in writing whether the request is eligible for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO, within ten business days following the date of receipt of the notice, additional information. This additional information must be considered by the IRO when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

(3) Within five business days after the date of assignment of the IRO, the plan or issuer must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the plan or issuer to timely provide the documents and information must not delay the conduct of the external review. If the plan or issuer fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the plan.

(4) Upon receipt of any information submitted by the claimant, the assigned IRO must within one business day forward the information to the plan or issuer. Upon receipt of any such information, the plan or issuer may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the plan or issuer must not delay the external review. The external review may be terminated as a result of the reconsideration only if the plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned

IRO must terminate the external review upon receipt of the notice from the plan or issuer.

(5) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the plan's or issuer's internal claims and appeals process applicable under paragraph (b). In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(i) The claimant's medical records;

(ii) The attending health care professional's recommendation;

(iii) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;

(iv) The terms of the claimant's plan or coverage to ensure that the IRO's decision is not contrary to the terms of the plan or coverage, unless the terms are inconsistent with applicable law;

(v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(vi) Any applicable clinical review criteria developed and used by the plan or issuer, unless the criteria are inconsistent with the terms of the plan or coverage or with applicable law; and

(vii) To the extent the final IRO decision maker is different from the IRO's clinical reviewer, the opinion of such clinical reviewer, after considering information described in this notice, to the extent the information or documents are available and the clinical reviewer or reviewers consider such information or documents appropriate.

(6) The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of the final external review decision to the claimant and the plan or issuer.

(7) The assigned IRO's written notice of the final external review decision must contain the following:

(i) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the plan's or issuer's denial);

(ii) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(iii) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(iv) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(v) A statement that the IRO's determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or health insurance issuer or to the claimant, or to the extent the health plan or health insurance issuer voluntarily makes payment on the claim or otherwise provides benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits;

(vi) A statement that judicial review may be available to the claimant; and

(vii) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

(viii) After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the claimant, plan, issuer, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

(iv) *Reversal of plan's or issuer's decision.* Upon receipt of a notice of a final

external review decision reversing the adverse benefit determination or final adverse benefit determination, the plan or issuer immediately must provide coverage or payment (including immediately authorizing care or immediately paying benefits) for the claim.

(3) *Expedited external review.* A group health plan or health insurance issuer must comply with the following standards with respect to an expedited external review:

(i) *Request for external review.* A group health plan or health insurance issuer must allow a claimant to make a request for an expedited external review with the plan or issuer at the time the claimant receives:

(A) An adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under paragraph (b) of this section would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or

(B) A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from the facility.

(ii) *Preliminary review.* Immediately upon receipt of the request for expedited external review, the plan or issuer must determine whether the request meets the reviewability requirements set forth in paragraph (d)(2)(ii) of this section for standard external review. The plan or issuer must immediately send a notice that meets the requirements set forth in paragraph (d)(2)(ii)(B) for standard review to the claimant of its eligibility determination.

(iii) *Referral to independent review organization.* (A) Upon a determination that a request is eligible for expedited external

review following the preliminary review, the plan or issuer will assign an IRO pursuant to the requirements set forth in paragraph (d)(2)(iii) of this section for standard review. The plan or issuer must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

(B) The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the plan's or issuer's internal claims and appeals process.

(iv) *Notice of final external review decision.* The plan's or issuer's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in paragraph (d)(2)(iii)(B) of this section, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the plan or issuer.

(4) *Alternative, Federally-administered external review process.* Insured coverage not subject to an applicable State external review process under paragraph (c) of this section may elect to use either the Federal external review process, as set forth under paragraph (d) of this section or the Federally-administered external review process, as set forth by HHS in guidance. In such circumstances, the requirement to provide external review under this paragraph (d) is satisfied.

(e) *Form and manner of notice* — (1) *In general.* For purposes of this section, a group health plan and a health insurance issuer offering group health insurance coverage are considered to provide relevant notices in a culturally and linguisti-

cally appropriate manner if the plan or issuer meets all the requirements of paragraph (e)(2) of this section with respect to the applicable non-English languages described in paragraph (e)(3) of this section.

(2) *Requirements.* (i) The plan or issuer must provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language;

(ii) The plan or issuer must provide, upon request, a notice in any applicable non-English language; and

(iii) The plan or issuer must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the plan or issuer.

(3) *Applicable non-English language.* With respect to an address in any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.

(f) *Secretarial authority.* The Secretary may determine that the external review process of a group health plan or health insurance issuer, in operation as of March 23, 2010, is considered in compliance with the applicable process established under paragraph (c) or (d) of this section if it substantially meets the requirements of paragraph (c) or (d) of this section, as applicable.

(g) *Applicability date.* The provisions of this section are applicable to group health plans and health insurance issuers for plan years beginning on or after January 1, 2017. Until the applicability date for this regulation, plans and issuers are required to continue to comply with the interim final regulations promulgated by the Department of Labor at 29 CFR part 2590, contained in the 29 CFR, parts 1927 to end, edition revised as of July 1, 2015.

Par.15. Section 54.9815–2719A is added to read as follows:

§ 54.9815–2719A Patient protections.

(a) *Choice of health care professional* – (1) *Designation of primary care provider*—(i) *In general.* If a group health plan, or a health insurance issuer offering group health insurance coverage, requires or provides for designation by a participant or beneficiary of a participating primary care provider, then the plan or issuer must permit each participant or beneficiary to designate any participating primary care provider who is available to accept the participant or beneficiary. In such a case, the plan or issuer must comply with the rules of paragraph (a)(4) of this section by informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider.

(ii) *Construction.* Nothing in paragraph (a)(1)(i) of this section is to be construed to prohibit the application of reasonable and appropriate geographic limitations with respect to the selection of primary care providers, in accordance with the terms of the plan or coverage, the underlying provider contracts, and applicable State law.

(iii) *Example.* The rules of this paragraph (a)(1) are illustrated by the following example:

Example. (i) *Facts.* A group health plan requires individuals covered under the plan to designate a primary care provider. The plan permits each individual to designate any primary care provider participating in the plan's network who is available to accept the individual as the individual's primary care provider. If an individual has not designated a primary care provider, the plan designates one until one has been designated by the individual. The plan provides a notice that satisfies the requirements of paragraph (a)(4) of this section regarding the ability to designate a primary care provider.

(ii) *Conclusion.* In this *Example*, the plan has satisfied the requirements of paragraph (a) of this section.

(2) *Designation of pediatrician as primary care provider*—(i) *In general.* If a group health plan, or a health insurance issuer offering group health insurance coverage, requires or provides for the designation of a participating primary care provider for a child by a participant or beneficiary, the plan or issuer must permit the participant or beneficiary to designate a physician (allopathic or osteopathic) who specializes in pediatrics (including pediatric subspecialties, based on the

scope of that provider's license under applicable State law) as the child's primary care provider if the provider participates in the network of the plan or issuer and is available to accept the child. In such a case, the plan or issuer must comply with the rules of paragraph (a)(4) of this section by informing each participant of the terms of the plan or health insurance coverage regarding designation of a pediatrician as the child's primary care provider.

(ii) *Construction.* Nothing in paragraph (a)(2)(i) of this section is to be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

(iii) *Examples.* The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan's HMO designates for each participant a physician who specializes in internal medicine to serve as the primary care provider for the participant and any beneficiaries. Participant *A* requests that Pediatrician *B* be designated as the primary care provider for *A*'s child. *B* is a participating provider in the HMO's network and is available to accept the child.

(ii) *Conclusion.* In this *Example 1*, the HMO must permit *A*'s designation of *B* as the primary care provider for *A*'s child in order to comply with the requirements of this paragraph (a)(2).

Example 2. (i) *Facts.* Same facts as *Example 1*, except that *A* takes *A*'s child to *B* for treatment of the child's severe shellfish allergies. *B* wishes to refer *A*'s child to an allergist for treatment. The HMO, however, does not provide coverage for treatment of food allergies, nor does it have an allergist participating in its network, and it therefore refuses to authorize the referral.

(ii) *Conclusion.* In this *Example 2*, the HMO has not violated the requirements of this paragraph (a)(2) because the exclusion of treatment for food allergies is in accordance with the terms of *A*'s coverage.

(3) *Patient access to obstetrical and gynecological care*—(i) *General rights*—(A) *Direct access.* A group health plan, or a health insurance issuer offering group health insurance coverage, described in paragraph (a)(3)(ii) of this section may not require authorization or referral by the plan, issuer, or any person (including a primary care provider) in the case of a female participant or beneficiary who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. In such a case, the plan or issuer must comply with the rules of paragraph (a)(4) of this section by informing each participant that the

plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology. The plan or issuer may require such a professional to agree to otherwise adhere to the plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer. For purposes of this paragraph (a)(3), a health care professional who specializes in obstetrics or gynecology is any individual (including a person other than a physician) who is authorized under applicable State law to provide obstetrical or gynecological care.

(B) *Obstetrical and gynecological care.* A group health plan or health insurance issuer described in paragraph (a)(3)(ii) of this section must treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under paragraph (a)(3)(i)(A) of this section, by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

(ii) *Application of paragraph.* A group health plan, or a health insurance issuer offering group health insurance coverage, is described in this paragraph (a)(3) if the plan or issuer—

(A) Provides coverage for obstetrical or gynecological care; and

(B) Requires the designation by a participant or beneficiary of a participating primary care provider.

(iii) *Construction.* Nothing in paragraph (a)(3)(i) of this section is to be construed to—

(A) Waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(B) Preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

(iv) *Examples.* The rules of this paragraph (a)(3) are illustrated by the following examples:

Example 1. (i) Facts. A group health plan requires each participant to designate a physician to serve as the primary care provider for the participant and the participant's family. Participant A, a female, requests a gynecological exam with Physician B, an in-network physician specializing in gynecological care. The group health plan requires prior authorization from A's designated primary care provider for the gynecological exam.

(ii) *Conclusion.* In this *Example 1*, the group health plan has violated the requirements of this paragraph (a)(3) because the plan requires prior authorization from A's primary care provider prior to obtaining gynecological services.

Example 2. (i) Facts. Same facts as *Example 1* except that A seeks gynecological services from C, an out-of-network provider.

(ii) *Conclusion.* In this *Example 2*, the group health plan has not violated the requirements of this paragraph (a)(3) by requiring prior authorization because C is not a participating health care provider.

Example 3. (i) Facts. Same facts as *Example 1* except that the group health plan only requires B to inform A's designated primary care physician of treatment decisions.

(ii) *Conclusion.* In this *Example 3*, the group health plan has not violated the requirements of this paragraph (a)(3) because A has direct access to B without prior authorization. The fact that the group health plan requires notification of treatment decisions to the designated primary care physician does not violate this paragraph (a)(3).

Example 4. (i) Facts. A group health plan requires each participant to designate a physician to serve as the primary care provider for the participant and the participant's family. The group health plan requires prior authorization before providing benefits for uterine fibroid embolization.

(ii) *Conclusion.* In this *Example 4*, the plan requirement for prior authorization before providing benefits for uterine fibroid embolization does not violate the requirements of this paragraph (a)(3) because, though the prior authorization requirement applies to obstetrical services, it does not restrict access to any providers specializing in obstetrics or gynecology.

(4) *Notice of right to designate a primary care provider—(i) In general.* If a group health plan or health insurance issuer requires the designation by a participant or beneficiary of a primary care provider, the plan or issuer must provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider and of the rights —

(A) Under paragraph (a)(1)(i) of this section, that any participating primary care provider who is available to accept the participant or beneficiary can be designated;

(B) Under paragraph (a)(2)(i) of this section, with respect to a child, that any participating physician who specializes in pediatrics can be designated as the primary care provider; and

(C) Under paragraph (a)(3)(i) of this section, that the plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology.

(ii) *Timing.* The notice described in paragraph (a)(4)(i) of this section must be included whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage.

(iii) *Model language.* The following model language can be used to satisfy the notice requirement described in paragraph (a)(4)(i) of this section:

(A) For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

[Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information].

(B) For plans and issuers that require or allow for the designation of a primary care provider for a child, add:

For children, you may designate a pediatrician as the primary care provider.

(C) For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply

with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information].

(b) *Coverage of emergency services—*

(1) *Scope.* If a group health plan, or a health insurance issuer offering group health insurance coverage, provides any benefits with respect to services in an emergency department of a hospital, the plan or issuer must cover emergency services (as defined in paragraph (b)(4)(ii) of this section) consistent with the rules of this paragraph (b).

(2) *General rules.* A plan or issuer subject to the requirements of this paragraph (b) must provide coverage for emergency services in the following manner –

(i) Without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis;

(ii) Without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect to the services;

(iii) If the emergency services are provided out of network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers;

(iv) If the emergency services are provided out of network, by complying with the cost-sharing requirements of paragraph (b)(3) of this section; and

(v) Without regard to any other term or condition of the coverage, other than –

(A) The exclusion of or coordination of benefits;

(B) An affiliation or waiting period permitted under part 7 of ERISA, part A of title XXVII of the PHS Act, or chapter 100 of the Internal Revenue Code; or

(C) Applicable cost sharing.

(3) *Cost-sharing requirements – (i) Copayments and coinsurance.* Any cost-sharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a participant or beneficiary for out-of-network emergency services cannot exceed the cost-sharing requirement imposed with re-

spect to a participant or beneficiary if the services were provided in-network. However, a participant or beneficiary may be required to pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network provider charges over the amount the plan or issuer is required to pay under this paragraph (b)(3)(i). A group health plan or health insurance issuer complies with the requirements of this paragraph (b)(3) if it provides benefits with respect to an emergency service in an amount at least equal to the greatest of the three amounts specified in paragraphs (b)(3)(i)(A), (B), and (C) of this section (which are adjusted for in-network cost-sharing requirements).

(A) The amount negotiated with in-network providers for the emergency service furnished, excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary. If there is more than one amount negotiated with in-network providers for the emergency service, the amount described under this paragraph (b)(3)(i)(A) is the median of these amounts, excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary. In determining the median described in the preceding sentence, the amount negotiated with each in-network provider is treated as a separate amount (even if the same amount is paid to more than one provider). If there is no per-service amount negotiated with in-network providers (such as under a capitation or other similar payment arrangement), the amount under this paragraph (b)(3)(i)(A) is disregarded.

(B) The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount), excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary. The amount in this paragraph (b)(3)(i)(B) is determined without reduction for out-of-network cost sharing that generally applies under the plan or health insurance coverage with respect to out-of-network services. Thus, for example, if a plan generally pays 70 percent of the usual,

customary, and reasonable amount for out-of-network services, the amount in this paragraph (b)(3)(i)(B) for an emergency service is the total (that is, 100 percent) of the usual, customary, and reasonable amount for the service, not reduced by the 30 percent coinsurance that would generally apply to out-of-network services (but reduced by the in-network copayment or coinsurance that the individual would be responsible for if the emergency service had been provided in-network).

(C) The amount that would be paid under Medicare (part A or part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq.*) for the emergency service, excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary.

(ii) *Other cost sharing.* Any cost-sharing requirement other than a copayment or coinsurance requirement (such as a deductible or out-of-pocket maximum) may be imposed with respect to emergency services provided out of network if the cost-sharing requirement generally applies to out-of-network benefits. A deductible may be imposed with respect to out-of-network emergency services only as part of a deductible that generally applies to out-of-network benefits. If an out-of-pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum must apply to out-of-network emergency services.

(iii) *Special rules regarding out-of-network minimum payment standards –*

(A) The minimum payment standards set forth under paragraph (b)(3) of this section do not apply in cases where State law prohibits a participant or beneficiary from being required to pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network provider charges over the amount the plan or issuer provides in benefits, or where a group health plan or health insurance issuer is contractually responsible for such amounts. Nonetheless, in such cases, a plan or issuer may not impose any copayment or coinsurance requirement for out-of-network emergency services that is higher than the copayment or coinsurance requirement that would apply if the services were provided in network.

(B) A group health plan and health insurance issuer must provide a participant or beneficiary adequate and prominent notice of their lack of financial responsibility with respect to the amounts described under this paragraph (b)(3)(iii), to prevent inadvertent payment by the participant or beneficiary.

(iv) *Examples.* The rules of this paragraph (b)(3) are illustrated by the following examples. In all of these examples, the group health plan covers benefits with respect to emergency services.

Example 1. (i) *Facts.* A group health plan imposes a 25% coinsurance responsibility on individuals who are furnished emergency services, whether provided in network or out of network. If a covered individual notifies the plan within two business days after the day an individual receives treatment in an emergency department, the plan reduces the coinsurance rate to 15%.

(ii) *Conclusion.* In this *Example 1*, the requirement to notify the plan in order to receive a reduction in the coinsurance rate does not violate the requirement that the plan cover emergency services without the need for any prior authorization determination. This is the result even if the plan required that it be notified before or at the time of receiving services at the emergency department in order to receive a reduction in the coinsurance rate.

Example 2. (i) *Facts.* A group health plan imposes a \$60 copayment on emergency services without preauthorization, whether provided in network or out of network. If emergency services are preauthorized, the plan waives the copayment, even if it later determines the medical condition was not an emergency medical condition.

(ii) *Conclusion.* In this *Example 2*, by requiring an individual to pay more for emergency services if the individual does not obtain prior authorization, the plan violates the requirement that the plan cover emergency services without the need for any prior authorization determination. (By contrast, if, to have the copayment waived, the plan merely required that it be notified rather than a prior authorization, then the plan would not violate the requirement that the plan cover emergency services without the need for any prior authorization determination.)

Example 3. (i) *Facts.* A group health plan covers individuals who receive emergency services with respect to an emergency medical condition from an out-of-network provider. The plan has agreements with in-network providers with respect to a certain emergency service. Each provider has agreed to provide the service for a certain amount. Among all the providers for the service: one has agreed to accept \$85, two have agreed to accept \$100, two have agreed to accept \$110, three have agreed to accept \$120, and one has agreed to accept \$150. Under the agreement, the plan agrees to pay the providers 80% of the agreed amount, with the individual receiving the service responsible for the remaining 20%.

(ii) *Conclusion.* In this *Example 3*, the values taken into account in determining the median are \$85, \$100, \$100, \$110, \$110, \$120, \$120, \$120, and \$150. Therefore, the median amount among those

agreed to for the emergency service is \$110, and the amount under paragraph (b)(3)(i)(A) of this section is 80% of \$110 (\$88).

Example 4. (i) *Facts.* Same facts as *Example 3*. Subsequently, the plan adds another provider to its network, who has agreed to accept \$150 for the emergency service.

(ii) *Conclusion.* In this *Example 4*, the median amount among those agreed to for the emergency service is \$115. (Because there is no one middle amount, the median is the average of the two middle amounts, \$110 and \$120.) Accordingly, the amount under paragraph (b)(3)(i)(A) of this section is 80% of \$115 (\$92).

Example 5. (i) *Facts.* Same facts as *Example 4*. An individual covered by the plan receives the emergency service from an out-of-network provider, who charges \$125 for the service. With respect to services provided by out-of-network providers generally, the plan reimburses covered individuals 50% of the reasonable amount charged by the provider for medical services. For this purpose, the reasonable amount for any service is based on information on charges by all providers collected by a third party, on a zip code by zip code basis, with the plan treating charges at a specified percentile as reasonable. For the emergency service received by the individual, the reasonable amount calculated using this method is \$116. The amount that would be paid under Medicare for the emergency service, excluding any copayment or coinsurance for the service, is \$80.

(ii) *Conclusion.* In this *Example 5*, the plan is responsible for paying \$92.80, 80% of \$116. The median amount among those agreed to for the emergency service is \$115 and the amount the plan would pay is \$92 (80% of \$115); the amount calculated using the same method the plan uses to determine payments for out-of-network services — \$116 — excluding the in-network 20% coinsurance, is \$92.80; and the Medicare payment is \$80. Thus, the greatest amount is \$92.80. The individual is responsible for the remaining \$32.20 charged by the out-of-network provider.

Example 6. (i) *Facts.* Same facts as *Example 5*. The group health plan generally imposes a \$250 deductible for in-network health care. With respect to all health care provided by out-of-network providers, the plan imposes a \$500 deductible. (Covered in-network claims are credited against the deductible.) The individual has incurred and submitted \$260 of covered claims prior to receiving the emergency service out of network.

(ii) *Conclusion.* In this *Example 6*, the plan is not responsible for paying anything with respect to the emergency service furnished by the out-of-network provider because the covered individual has not satisfied the higher deductible that applies generally to all health care provided out of network. However, the amount the individual is required to pay is credited against the deductible.

(4) *Definitions.* The definitions in this paragraph (b)(4) govern in applying the provisions of this paragraph (b).

(i) *Emergency medical condition.* The term *emergency medical condition* means a medical condition manifesting itself by acute symptoms of sufficient severity (in-

cluding severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). (In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.)

(ii) *Emergency services.* The term *emergency services* means, with respect to an emergency medical condition —

(A) A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

(B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

(iii) *Stabilize.* The term *to stabilize*, with respect to an emergency medical condition (as defined in paragraph (b)(4)(i) of this section) has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(c) *Applicability date.* The provisions of this section are applicable to group health plans and health insurance issuers for plan years beginning on or after January 1, 2017. Until the applicability date for this regulation, plans and issuers are required to continue to comply with the interim final regulations promulgated by the Department of Labor at 29 CFR part 2590, contained in the 29 CFR, parts 1927 to end, edition revised as of July 1, 2015.

§ 54.9815–2719AT [Removed]

Par. 16. Section 54.9815–2719AT is removed.

§ 54.9815–2719T [Removed]

Par. 17. Section 54.9815–2719T is removed.

Section 42.—Low-Income Housing Credit

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of December 2015. See Rev. Rul. 2015–25, page 695.

Section 280G.—Golden Parachute Payments

Federal short-term, mid-term, and long-term rates are set forth for the month of December 2015. See Rev. Rul. 2015–25, page 695.

Section 382.—Limitation on Net Operating Loss Carryforwards and Certain Built-In Losses Following Ownership Change

The adjusted applicable federal long-term rate is set forth for the month of December 2015. See Rev. Rul. 2015–25, page 695.

Section 412.—Minimum Funding Standards

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of December 2015. See Rev. Rul. 2015–25, page 695.

Section 467.—Certain Payments for the Use of Property or Services

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of December 2015. See Rev. Rul. 2015–25, page 695.

Section 468.—Special Rules for Mining and Solid Waste Reclamation and Closing Costs

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of December 2015. See Rev. Rul. 2015–25, page 695.

Section 482.—Allocation of Income and Deductions Among Taxpayers

Federal short-term, mid-term, and long-term rates are set forth for the month of December 2015. See Rev. Rul. 2015–25, page 695.

Section 483.—Interest on Certain Deferred Payments

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of December 2015. See Rev. Rul. 2015–25, page 695.

Section 642.—Special Rules for Credits and Deductions

Federal short-term, mid-term, and long-term rates are set forth for the month of December 2015. See Rev. Rul. 2015–25, page 695.

Section 807.—Rules for Certain Reserves

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of December 2015. See Rev. Rul. 2015–25, page 695.

Section 846.—Discounted Unpaid Losses Defined

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of December 2015. See Rev. Rul. 2015–25, page 695.

Section 1288.—Treatment of Original Issue Discount on Tax-Exempt Obligations

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of December 2015. See Rev. Rul. 2015–25, page 695.

Section 7520.—Valuation Tables

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of December 2015. See Rev. Rul. 2015–25, page 695.

Section 7872.—Treatment of Loans With Below-Market Interest Rates

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of December 2015. See Rev. Rul. 2015–25, page 695.

Part III. Administrative, Procedural, and Miscellaneous

Additional Rules Regarding Inversions and Related Transactions

Notice 2015-79

SECTION 1. OVERVIEW

On September 22, 2014, the Department of the Treasury (Treasury Department) and the Internal Revenue Service (IRS) issued Notice 2014-52, 2014-42 IRB 712. Notice 2014-52 announced that the Treasury Department and the IRS intend to issue regulations that will address certain transactions that are structured to avoid the purposes of sections 7874 and 367 of the Internal Revenue Code (Code), as well as certain post-inversion tax avoidance transactions. Notice 2014-52 also announced that the Treasury Department and the IRS expect to issue additional guidance to further limit (i) inversion transactions that are contrary to the purposes of section 7874 and (ii) the benefits of post-inversion tax avoidance transactions. This notice announces some of the additional guidance referred to in Notice 2014-52.

Section 2 of this notice describes regulations that the Treasury Department and the IRS intend to issue that will address transactions that are structured to avoid the purposes of section 7874 by (i) requiring the foreign acquiring corporation to be subject to tax as a resident of the relevant foreign country in order to have substantial business activities in the relevant foreign country; (ii) disregarding certain stock of the foreign acquiring corporation in “third-country” transactions; and (iii) clarifying the definition of nonqualified property for purposes of disregarding certain stock of the foreign acquiring corporation.

Section 3 of this notice describes regulations that the Treasury Department and the IRS intend to issue that will address certain post-inversion tax avoidance transactions by (i) defining inversion gain for purposes of section 7874 to include certain income or gain recognized by an expatriated entity from an indirect transfer or license of property and providing for aggregate treatment of certain transfers or

licenses of property by foreign partnerships for purposes of determining inversion gain; and (ii) requiring an exchanging shareholder to recognize all of the gain realized upon an exchange of stock of a controlled foreign corporation (as defined in section 957) (CFC), without regard to the amount of the CFC’s undistributed earnings and profits, if the transaction terminates the status of the foreign subsidiary as a CFC or substantially dilutes the interest of a United States shareholder (as defined in section 951(b)) (U.S. shareholder) in the CFC.

Section 4 of this notice describes corrections and clarifications that the Treasury Department and the IRS intend to make with respect to certain rules announced in Notice 2014-52.

Section 5 of this notice provides the effective dates of the regulations described in this notice, and section 6 of this notice requests comments and provides contact information.

SECTION 2. REGULATIONS TO ADDRESS TRANSACTIONS CONTRARY TO THE PURPOSES OF SECTION 7874

.01 Section 7874 Background

Under section 7874(a)(2)(B), a foreign corporation (foreign acquiring corporation) generally is treated as a surrogate foreign corporation if, pursuant to a plan (or a series of related transactions), three conditions are satisfied. First, the foreign acquiring corporation completes, after March 4, 2003, the direct or indirect acquisition of substantially all of the properties held directly or indirectly by a domestic corporation (acquisition). Second, after the acquisition, at least 60 percent of the stock (by vote or value) of the foreign acquiring corporation is held by former shareholders of the domestic corporation by reason of holding stock in the domestic corporation (at times this notice refers to such percentage as the “ownership percentage,” and the fraction used to calculate such percentage as the “ownership fraction”). And third, after the acquisition, the expanded affiliated group that includes the foreign acquiring corporation (EAG) does not have substantial business activi-

ties in the foreign country in which, or under the law of which, the foreign acquiring corporation is created or organized (relevant foreign country) when compared to the total business activities of the EAG. Similar provisions apply if a foreign acquiring corporation acquires substantially all of the properties constituting a trade or business of a domestic partnership. The domestic corporation or the domestic partnership described in this paragraph is referred to in this notice at times as the “domestic entity.” For purposes of this notice, a reference to a domestic corporation, a domestic partnership, or a domestic entity includes a successor, and the term “EAG” has the meaning provided in § 1.7874-3(d)(4).

The tax treatment of an acquisition in which the EAG does not have substantial business activities in the relevant foreign country varies depending on the level of owner continuity. If the ownership percentage is at least 80, the foreign acquiring corporation is treated as a domestic corporation for all purposes of the Code pursuant to section 7874(b). If, instead, the ownership percentage is at least 60 but less than 80 (in which case the acquisition is referred to in this notice as an “inversion transaction”), the foreign acquiring corporation is respected as a foreign corporation, but the domestic entity and certain related U.S. persons are treated as expatriated entities under section 7874(a)(2)(A). In the case of an inversion transaction, section 7874(a)(1) and (e) prevent the use of certain tax attributes to reduce the U.S. tax owed with respect to certain income or gain (referred to as “inversion gain”) recognized by an expatriated entity with respect to certain transfers or licenses of property that occur as part of, or after, the inversion transaction. See section 3.01(a) of this notice for additional discussion of the taxation of inversion gain.

Under section 7874(c)(4), a transfer of properties or liabilities (including by contribution or distribution) is disregarded if the transfer is part of a plan a principal purpose of which is to avoid the purposes of section 7874.

Section 7874(c)(6) grants the Secretary authority to prescribe regulations as may

be appropriate to determine whether a corporation is a surrogate foreign corporation, including regulations to treat stock as not stock. In addition, section 7874(g) grants the Secretary authority to provide regulations necessary to carry out section 7874, including regulations adjusting the application of section 7874 as necessary to prevent the avoidance of the purposes of section 7874, including the avoidance of such purposes through (i) the use of related persons, pass-through or other non-corporate entities, or other intermediaries, or (ii) transactions designed to have persons cease to be (or not become) members of EAGs or related persons.

Congress enacted section 7874 because it believed that “inversion transactions resulting in a minimal presence in a foreign country of incorporation are a means of avoiding U.S. tax and should be curtailed.” S. Rep. No. 192, 108th Cong., 1st Sess. 142 (Nov. 7, 2003) (Senate Report); Joint Committee on Taxation, General Explanation of Tax Legislation Enacted in the 108th Congress (JCS-5-05) 343 (May 31, 2005) (JCT Explanation). Congress expressed particular concern about how inversion transactions “permit corporations and other entities to continue to conduct business in the same manner as they did prior to the inversion, but with the result that the inverted entity avoids U.S. tax on foreign operations and may engage in earnings stripping techniques to avoid U.S. tax on domestic operations.” Senate Report at 142; JCT Explanation at 343.

.02 Transactions at Issue and Regulations to be Issued

(a) Substantial Business Activities of a Foreign Acquiring Corporation that is not Subject to Tax as a Resident of the Relevant Foreign Country

The Treasury Department and the IRS are aware of transactions in which the taxpayer asserts that the EAG has substantial business activities in the relevant foreign country (that is, the foreign country in which, or under the law of which, the foreign acquiring corporation is created or organized) when compared to the EAG’s total business activities, but the foreign acquiring corporation is not subject to income taxation in the relevant foreign country as a resident. This could occur,

for example, if the relevant foreign country determines the tax residency of an entity based on criteria other than the place of creation or formation, such as the location in which the entity is managed or controlled. If the foreign acquiring corporation is managed and controlled in a third country, the foreign acquiring corporation may not be subject to tax as a resident of the relevant foreign country (or, in some cases, of any foreign country). Alternatively, the foreign acquiring corporation may not be subject to tax as a resident of the relevant foreign country because of disparate entity classification rules in the United States and the relevant foreign country. For example, the foreign acquiring corporation may be treated as a corporation for U.S. tax purposes under the entity classification regulations promulgated under section 7701 (including by reason of a “check-the-box” election), but as a fiscally transparent entity under the tax law of the relevant foreign country. In such a case, the foreign acquiring corporation would not be subject to tax as a resident of the relevant foreign country.

The Treasury Department and the IRS have determined that the policy underlying the exception to section 7874 when there are substantial business activities in the relevant foreign country is premised on the foreign acquiring corporation being subject to tax as a resident of the relevant foreign country. For this purpose, the statute’s reference to country of creation or organization reflects the U.S. standard for determining tax residency. However, the U.S. standard for determining tax residency does not always align with foreign countries’ standards. Allowing the exception to apply when the foreign acquiring corporation is not subject to tax as a resident of the relevant foreign country effectively permits an EAG to replace its U.S. tax residence with tax residence in any other country (or, in certain cases, in no other country), without regard to the location of any substantial business activities conducted by the EAG. The Treasury Department and the IRS believe that this result is contrary to the policy underlying the substantial business activities test.

Accordingly, the Treasury Department and the IRS intend to issue regulations under section 7874 to provide that an EAG cannot have substantial business ac-

tivities in the relevant foreign country when compared to the EAG’s total business activities unless the foreign acquiring corporation is subject to tax as a resident of the relevant foreign country.

(b) Third-Country Transactions

The Treasury Department and the IRS are aware that certain acquisitions in which a domestic entity combines with an existing foreign corporation are structured by establishing a new foreign parent corporation for the combined group with a tax residence that is different from that of the existing foreign corporation. In other words, the parent corporation of the combined group will be a tax resident of a “third country.” In such transactions, the stock or assets of the existing foreign corporation are acquired by the new third-country parent, and the shareholders of the existing foreign corporation receive more than 20 percent of the stock of the new third-country parent. Similarly, the stock or assets of the domestic entity are acquired by the new third-country parent, and the shareholders of the domestic entity receive less than 80 percent of the stock of the new third-country parent.

In enacting section 7874, Congress believed that certain transactions in which a U.S. parent corporation is replaced with a new foreign parent corporation have little or no non-tax effect or purpose and should be disregarded for U.S. tax purposes, while in other cases such transactions may have sufficient non-tax effect and purpose to be respected, but warrant that any applicable corporate-level “toll charges” for establishing the inverted structure not be offset by tax attributes such as net operating losses or foreign tax credits. See Senate Report at 142, 143; JCT Explanation at 343. The Treasury Department and the IRS have considered whether certain stock issued in an acquisition structured with a third-country parent should be disregarded pursuant to the authority under sections 7874(c)(6) and (g) in order to effectuate this general purpose. In particular, the Treasury Department and the IRS are concerned that a decision to locate the tax residence of a new foreign parent corporation outside of both the United States and the jurisdiction in which the existing foreign corporation is tax resident gener-

ally is driven by tax planning, including the facilitation of U.S. tax avoidance following the acquisition. For example, the third country may have a more favorable income tax treaty with the United States than the country in which the existing foreign corporation is tax resident, with the result that U.S. withholding taxes on dividends, interest, and royalties paid by the domestic entity may be reduced or eliminated. The third country may also have a more favorable tax system than the country in which the existing foreign parent corporation is tax resident, including a less restrictive regime for controlled foreign corporations than the country in which the existing foreign corporation is tax resident. Thus, a third-country parent typically is chosen to facilitate the use of low- or no-taxed entities to erode the U.S. tax base following the acquisition.

The Senate Report and the JCT Explanation indicate that the 80-percent threshold under section 7874(b) for treating a foreign acquiring corporation as a domestic corporation reflects an assumption that, when the existing foreign corporation's shareholders will own more than 20 percent of the interests in the combined group, there is a sufficient likelihood of a non-tax business purpose for replacing the U.S. parent with a foreign parent to warrant respecting the new foreign parent. However, the Treasury Department and the IRS have concluded that, when a domestic entity combines with an existing foreign corporation by establishing a new parent for the combined group that is tax resident in a third country, the likelihood that there is a sufficient non-tax business purpose for replacing the U.S. parent with a foreign parent is significantly lower than Congress assumed in establishing the 80-percent threshold.

The Treasury Department and the IRS have accordingly determined that, in certain circumstances, the use of a third-country parent is contrary to the policy underlying the 80-percent threshold of section 7874(b) and is an appropriate circumstance for the exercise of regulatory authority under sections 7874(c)(6) and (g). The Treasury Department and the IRS therefore intend to issue regulations under sections 7874(c)(6) and (g) to address these transactions by disregarding certain stock of a foreign acquiring corporation

that is issued to the shareholders of the existing foreign corporation for purposes of determining whether the 80-percent threshold is met. The regulations will apply to an acquisition that satisfies four requirements.

First, in a transaction related to the acquisition (referred to in this notice as the "foreign target acquisition"), the foreign acquiring corporation directly or indirectly acquires substantially all of the properties held directly or indirectly by another foreign corporation (foreign target corporation). For purposes of determining if there is a foreign target acquisition with respect to a foreign corporation, the principles of section 7874(a)(2)(B)(i) (defining an acquisition) and § 1.7874-2(c) (regarding acquisitions of properties of a domestic entity and stock of a foreign corporation) apply with the following modifications: (i) the principles of § 1.7874-2(c)(1) (providing rules for determining whether there is an indirect acquisition of properties of a domestic entity) shall be applied by substituting the term "foreign target" for "domestic" wherever it appears, and (ii) the principles of § 1.7874-2(c)(2) (regarding acquisitions of stock of a foreign corporation that owns a domestic corporation or partnership) shall be applied by substituting the term "domestic" for "foreign" and the term "foreign" for "domestic" wherever such terms appear. Furthermore, except as provided in this paragraph, if there is a foreign target acquisition of a foreign corporation (upper-tier foreign corporation) that owns directly stock of another foreign corporation (lower-tier foreign corporation), for purposes of this section 2.02(b) there is not also a foreign target acquisition with respect to the lower-tier foreign corporation (or any foreign corporation owned directly or indirectly by the lower-tier foreign corporation). However, if the upper-tier foreign corporation acquired the stock of the lower-tier foreign corporation in a transaction related to the acquisition, then there would also be a foreign target acquisition with respect to the lower-tier foreign corporation (which would be treated as an upper-tier foreign corporation for purposes of further applying the rules of this paragraph).

Second, the gross value of all property directly or indirectly acquired by the for-

eign acquiring corporation in the foreign target acquisition exceeds 60 percent of the gross value of all foreign group property (as defined in section 2.01(b) of Notice 2014-52), but, for this purpose, gross value shall not include any property that is foreign group nonqualified property (as defined in section 2.01(b) of Notice 2014-52, but taking into account the corrections to the definition of foreign group nonqualified property described in section 4.01(b) of this notice).

Third, the tax residence of the foreign acquiring corporation is not the same as that of the foreign target corporation, as determined before the foreign target acquisition and any transaction related to the foreign target acquisition. A change in the location of the management and control of a foreign target corporation is treated as a transaction for this purpose.

Fourth, not taking into account the rules announced in this section 2.02(b), the ownership percentage is at least 60 but less than 80.

When these four requirements are satisfied, the regulations will provide that stock of the foreign acquiring corporation that otherwise would be included in the denominator of the ownership fraction will be excluded from the denominator to the extent the stock is held by former owners of the foreign target corporation by reason of holding stock in the foreign target corporation (based on the principles of section 7874(a)(2)(B)(ii)).

If, in one or more transactions related to the acquisition described in section 7874(a)(2)(B)(i), the foreign acquiring corporation directly or indirectly acquires multiple foreign target corporations that are tax residents of the same foreign country, then, for purposes of applying the regulations described in this section 2.02(b), all such transactions that otherwise would separately qualify as a foreign target acquisition will be treated as a single foreign target acquisition and those foreign target corporations will be treated as a single entity.

The following examples illustrate the regulations described in this section 2.02(b):

Example 1. (i) Facts. FA, a newly formed foreign corporation that is a tax resident of Country Y, acquires all the stock of DT, a domestic corporation that is wholly owned by Individual A, solely in exchange for 65 shares of newly issued FA stock

(DT acquisition). In a transaction related to the DT acquisition, FA acquires all the stock of FT, a foreign corporation that is a tax resident of Country X and wholly owned by Individual B, solely in exchange for the remaining 35 shares of newly issued FA stock (FT acquisition).

(ii) *Analysis.* A portion of the FA stock is excluded from the denominator of the ownership fraction because the DT acquisition satisfies the four requirements set forth in section 2.02(b) of this notice. The first requirement is satisfied because under the principles of section 7874(a)(2)(B)(i) and § 1.7874-2(c) (as modified by section 2.02(b) of this notice), FA is treated as acquiring 100 percent of the properties held by FT as a result of the FT acquisition. Therefore, the FT acquisition is a foreign target acquisition with respect to FT. The second requirement (that the gross value of all property directly or indirectly acquired in the FT acquisition exceeds 60 percent of the gross value of all foreign group property) is also satisfied because the foreign group property is comprised solely of the property acquired in the FT acquisition. The third requirement is satisfied because the foreign country in which FA is a tax resident (Country Y) is not the foreign country in which FT is a tax resident (Country X). Finally, the fourth requirement is satisfied because, absent the rules described in section 2.02(b) of this notice, the ownership fraction would be 65/100 and the ownership percentage would be 65. Accordingly, section 2.02(b) of this notice excludes from the denominator of the ownership fraction the 35 shares of FA stock held by the former shareholder of FT by reason of holding stock in FT. As a result, the ownership fraction is 65/65 and the ownership percentage is 100. The result would be the same if FA instead had directly acquired all of the properties held by FT in exchange for FA stock, for example, in a transaction that would qualify for U.S. income tax purposes as an asset reorganization under section 368.

Example 2. (i) Facts. The facts are the same as in Example 1 except that, before the FT acquisition, but in a transaction related to the FT acquisition, FT reincorporates in Country Y and, consequently, becomes a tax resident of Country Y.

(ii) *Analysis.* The analysis is the same as in Example 1 with respect to the first, second, and fourth requirements set forth in section 2.02(b) of this notice. The third requirement is applied by comparing the foreign country in which FA is a tax resident, which is Country Y, to the country in which FT was a tax resident prior to the FT acquisition and any transaction related to the FT acquisition, which is Country X. As a result, the third requirement is also satisfied because FA and FT are not tax residents of the same country for this purpose. Accordingly, section 2.02(b) of this notice excludes from the denominator of the ownership fraction the 35 shares of FA stock held by the former shareholder of FT by reason of holding stock in FT. Consequently, the ownership fraction is 65/65 and the ownership percentage is 100.

.03 Clarification of Regulations under § 1.7874-4T That Disregard Certain Stock Transferred in Exchange for Nonqualified Property

(a) Background

Under section 7874(c)(2)(B) (statutory public offering rule), stock of the foreign acquiring corporation that is sold in a public offering related to the acquisition is excluded from the denominator of the ownership fraction. Section 1.7874-4T modifies the statutory public offering rule. Specifically, § 1.7874-4T(b) provides that, subject to a de minimis exception, “disqualified stock” is not included in the denominator of the ownership fraction. Disqualified stock generally includes stock of the foreign acquiring corporation that is transferred in exchange for “nonqualified property” when that exchange is related to the acquisition. Section 1.7874-4T(i)(7) provides that the term nonqualified property means: (i) cash or cash equivalents, (ii) marketable securities, (iii) certain obligations (for example, obligations owed by members of the EAG that includes the foreign acquiring corporation), or (iv) any other property acquired in a transaction (or series of transactions) related to the acquisition with a principal purpose of avoiding the purposes of section 7874. Section 1.7874-4T(i)(6) provides that, for this purpose, the term marketable securities has the meaning set forth in section 453(f)(2), except that the term does not include stock of a corporation or an interest in a partnership that becomes a member of the expanded affiliated group that includes the foreign acquiring corporation in a transaction (or series of transactions) related to the acquisition, unless a principal purpose for acquiring such stock or partnership interest is to avoid the purposes of section 7874. This notice refers at times to the property described in clauses (i), (ii), and (iii) of this paragraph collectively as “specified nonqualified property” and to the property described in clause (iv) as “avoidance property.”

Example 2 of § 1.7874-4T(j) illustrates a transfer of stock of the foreign acquiring corporation in exchange for avoidance property. In this example, PRS, a partnership with individual partners,

transfers marketable securities to FT, a newly formed foreign corporation, in exchange solely for all of the FT stock. PRS then transfers the FT stock to FA, a newly formed foreign corporation, in exchange solely for 25 shares of FA stock. Individual A, who is unrelated to PRS, transfers all of the stock of DT, a domestic corporation of which Individual A is the sole shareholder, to FA in exchange solely for 75 shares of FA stock. The facts of the example state that FA acquires the FT stock with a principal purpose of avoiding the purposes of section 7874. Accordingly, the example concludes that the FT stock is nonqualified property, and, therefore, that the 25 shares of FA stock transferred to PRS in exchange for the FT stock are disqualified stock and are not included in the denominator of the ownership fraction.

(b) Transactions at Issue and Regulations to be Issued

The Treasury Department and the IRS are concerned that some taxpayers may be narrowly interpreting the definition of avoidance property. In particular, taxpayers may be asserting that avoidance property is limited to property, such as stock, that is used to indirectly transfer specified nonqualified property to the foreign acquiring corporation, as in the transaction described in Example 2 of § 1.7874-4T(j).

This interpretation of § 1.7874-4T is inconsistent with both the plain language and purpose of the regulation. In addition, section 7874(c)(4) separately provides that a transfer of properties or liabilities is disregarded if the transfer is part of a plan a principal purpose of which is to avoid the purposes of section 7874. Accordingly, the Treasury Department and the IRS intend to issue regulations that will clarify § 1.7874-4T to provide that avoidance property means any property (other than specified nonqualified property) acquired with a principal purpose of avoiding the purposes of section 7874, regardless of whether the transaction involves an indirect transfer of specified nonqualified property. Furthermore, the regulations will remove the phrase “in a transaction (or series of transactions) related to the acquisition” from the defini-

tion of avoidance property. The inclusion of that phrase in the definition is redundant with language contained in the operative rule in § 1.7874-4T(c)(1) for identifying disqualified stock, which itself requires, in relevant part, that there be an exchange of nonqualified property for stock of the foreign acquiring corporation in a transaction that is related to the acquisition. The regulations also will remove the phrase “unless a principal purpose for acquiring such stock or partnership interest is to avoid the purposes of section 7874” from the definition of marketable securities. The inclusion of that phrase in the definition is redundant with the rule for avoidance property, because if stock of a corporation or a partnership interest described in section 453(f)(2) does not constitute marketable securities due to the corporation or partnership becoming a member of the EAG, the stock or partnership interest is not specified nonqualified property and, therefore, may be avoidance property under § 1.7874-4T(i)(7)(iv).

In addition, Example 1 and Example 2 of § 1.7874-4T(j) (which illustrate transfers of stock of the foreign acquiring corporation in exchange for marketable securities and avoidance property, respectively) will be clarified to include a reference to section 7874(c)(4). Finally, in light of section 2.02(b) of this notice, which applies to certain third-country transactions, all the examples described in § 1.7874-4T(j) will be modified to provide that, unless otherwise indicated, FA, FMS, FS, and FT are tax residents of the same foreign country.

The following example illustrates the clarification described in this section 2.03(b):

Example. (i) *Facts.* DT is a publicly traded domestic corporation. PRS is a foreign partnership that is unrelated to DT. PRS transfers certain business assets (PRS properties) to FA, a newly formed foreign corporation, in exchange solely for 25 shares of FA stock. The shareholders of DT transfer all of their DT stock to FA in exchange solely for the remaining 75 shares of FA stock. None of the PRS properties is specified nonqualified property, but FA acquires the PRS properties with a principal purpose of avoiding the purposes of section 7874.

(ii) *Analysis.* Under § 1.7874-4T(i)(7)(iv), the PRS properties transferred to FA are nonqualified property, because FA acquires the PRS properties in a transaction related to the DT acquisition with a principal purpose of avoiding the purposes of section 7874. Accordingly, the 25 shares of FA stock trans-

ferred by FA to PRS in exchange for the PRS properties are disqualified stock described in § 1.7874-4T(c)(1)(i). Section 1.7874-4T(c)(2) does not apply to reduce the amount of disqualified stock described in § 1.7874-4T(c)(1)(i) because the transfer of FA stock in exchange for the PRS properties increases the fair market value of FA's assets by the fair market value of the PRS properties. Accordingly, pursuant to § 1.7874-4T(b), the 25 shares of FA stock transferred to PRS in exchange for the PRS properties are not included in the denominator of the ownership fraction. Furthermore, even in the absence of § 1.7874-4T(i)(7)(iv), the transfer of the PRS properties to FA would be disregarded pursuant to section 7874(c)(4). Therefore, the only FA stock included in the ownership fraction is the FA stock transferred to DT's former shareholders in exchange for their DT stock, and that FA stock is included in both the numerator and the denominator of the ownership fraction. Thus, the ownership fraction is 75/75.

SECTION 3. REGULATIONS TO ADDRESS POST-INVERSION TAX AVOIDANCE TRANSACTIONS

.01 Regulations under Section 7874 Defining Inversion Gain

(a) Background

If an acquisition is an inversion transaction, section 7874(a)(1) requires that the taxable income of an “expatriated entity” for any taxable year that includes any portion of the “applicable period” be no less than the “inversion gain” of the entity for the taxable year. Section 7874(a)(2)(A) provides that the term “expatriated entity” means a domestic corporation or a domestic partnership referred to in section 7874(a)(2)(B)(i) (which describes the acquisition) or any U.S. person that is related (within the meaning of section 267(b) or 707(b)(1)) to such domestic corporation or domestic partnership. Section 7874(d)(1) defines the term “applicable period” as the period beginning on the first date properties are acquired as part of the acquisition, and ending on the date that is 10 years after the last date properties are acquired as part of the acquisition. In addition, section 7874(d)(2) provides that the term “inversion gain” means:

The income or gain recognized by reason of the transfer during the applicable period of stock or other properties by an expatriated entity, and any income received or accrued during the applicable period by reason of a license of any property by an expatriated entity—

(A) as part of the acquisition described in subsection (a)(2)(B)(i), or

(B) after such acquisition if the transfer or license is to a foreign related person.

Subparagraph (B), however, does not apply to property described in section 1221(a)(1) (generally, property that is inventory) in the hands of the expatriated entity.

Section 7874(d)(3) provides that the term “foreign related person” means, with respect to any expatriated entity, a foreign person that is (i) related (within the meaning of section 267(b) or 707(b)(1)) to the entity, or (ii) under the same common control (within the meaning of section 482) as the entity.

Finally, section 7874(e)(2)(A) provides that, in the case of an expatriated entity that is a partnership, section 7874(a)(1) shall apply at the partner rather than the partnership level.

Section 7874(a)(1), together with section 7874(e)(1) (which prevents the use of certain credits to offset U.S. tax on inversion gain), ensure that an expatriated entity generally pays current U.S. tax with respect to inversion gain. These rules are intended to ensure that an appropriate “toll charge” is paid on transactions that accompany or follow an inversion transaction and are designed to “remove income from foreign operations from the U.S. taxing jurisdiction.” See H.R. Rep. No. 755, 108th Cong., 2nd Sess. 568, 574 (2004) (Conf. Rep.); JCT Explanation at 342, 345.

(b) Transactions at Issue and Regulations to be Issued

The Treasury Department and the IRS are concerned that certain indirect transfers of stock or other property by an expatriated entity (rather than direct transfers by the expatriated entity itself) may have the effect of removing foreign operations from U.S. taxing jurisdiction while avoiding current U.S. tax, contrary to the policy underlying sections 7874(a)(1) and (e)(1). This is because under current law the income is not inversion gain and therefore could be offset by tax attributes. For example, following an inversion transaction, an expatriated entity that wholly owns a CFC could cause the CFC to transfer property (including stock of a lower-

tier CFC) to a specified related person (as defined in section 3.02(e)(i) of Notice 2014–52) in a fully taxable transaction. Gain from the transfer may be subpart F income of the transferor CFC and, as a result, the expatriated entity may have an income inclusion under section 951(a)(1)(A) attributable to the transfer. However, such an inclusion is not inversion gain under current law, and therefore the expatriated entity's income can be offset by tax attributes (such as net operating losses). Similar concerns arise in connection with a license of property by a CFC of an expatriated entity to a specified related person.

The Treasury Department and the IRS have determined that it is inconsistent with the purposes of sections 7874(a)(1) and (e) to exclude from the definition of inversion gain income or gain recognized by an expatriated entity from an indirect transfer or license of property in circumstances analogous to those set forth in sections 7874(d)(2)(A) and (B). Accordingly, the Treasury Department and the IRS intend to issue regulations under section 7874(g) that will provide that inversion gain includes income or gain recognized by an expatriated entity from an indirect transfer or license of property, such as an expatriated entity's section 951(a)(1)(A) gross income inclusions taken into account during the applicable period that are attributable to a transfer of stock or other properties or a license of property, either (i) as part of the acquisition, or (ii) after such acquisition if the transfer or license is to a specified related person. However, clause (ii) of the preceding sentence will not apply to property described in section 1221(a)(1) in the hands of the CFC.

In addition, the Treasury Department and the IRS intend to issue regulations that will provide that, if a partnership that is a foreign related person transfers or licenses property, a partner of the partnership shall be treated as having transferred or licensed its proportionate share of that property, as determined under the rules and principles of sections 701 through 777, for purposes of determining inversion gain.

The following example illustrates the regulations described in this section 3.01(b):

Example. (i) *Facts.* On July 1, 2016, FA, a foreign corporation, acquires all the stock of DT, a domestic corporation, in an inversion transaction. When the inversion transaction occurred, DT wholly owned FS, a foreign corporation that is a CFC. During the applicable period, FS sells to FA property that is not described in section 1221(a)(1) in the hands of FS. Under section 951(a)(1)(A), DT has a \$100x gross income inclusion that is attributable to FS's sale of the property.

(ii) *Analysis.* Pursuant to section 7874(a)(2)(A), DT is an expatriated entity. Under section 3.01(b) of this notice, DT's \$100x gross income inclusion under section 951(a)(1)(A) is inversion gain, because it is taken into account during the applicable period and is attributable to a transfer of property after the inversion transaction to a specified related person (FA). Sections 7874(a)(1) and (e) therefore prevent the use of certain tax attributes (such as net operating losses) to reduce the U.S. tax owed with respect to DT's \$100x gross income inclusion under section 951(a)(1)(A).

.02 Regulations under Section 367(b) Regarding Certain Exchanges of Stock of an Expatriated Foreign Subsidiary

(a) Background

Section 367(b)(1) provides that, in the case of an exchange described in section 332, 351, 354, 355, 356, or 361 in connection with which there is no transfer of property described in section 367(a)(1), a foreign corporation shall be considered to be a corporation except to the extent provided in regulations prescribed by the Secretary which are necessary or appropriate to prevent the avoidance of Federal income taxes. Section 367(b)(2) provides that the regulations prescribed pursuant to section 367(b)(1) shall include (but shall not be limited to) regulations dealing with the sale or exchange of stock or securities in a foreign corporation by a United States person, including regulations providing the circumstances under which gain is recognized or deferred, amounts are included in gross income as a dividend, adjustments are made to earnings and profits, or adjustments are made to the basis of stock or securities.

In general, current regulations under § 1.367(b)–4(b), without regard to the regulations described in Notice 2014–52, require a shareholder that exchanges stock of a foreign corporation in an exchange subject to section 367(b) to include in income as a deemed dividend the section 1248 amount (as defined in § 1.367(b)–2(c)(1)) with respect to the stock ex-

changed if the exchange results in either a loss of CFC status of the foreign corporation whose stock is exchanged or a loss of section 1248 shareholder status of the exchanging shareholder (or of a shareholder of the exchanging shareholder when there is an exchange of stock of a lower-tier CFC). See § 1.367(b)–4(b)(1)(i)(A) and (B), which describe an exchanging shareholder subject to these regulations and the conditions under which an income inclusion is required, respectively.

Notice 2014–52 announced that the regulations under § 1.367(b)–4(b) would be amended to require an income inclusion in certain nonrecognition transactions that occur after an inversion transaction and that dilute the interest of a U.S. shareholder in a CFC, because such transactions could allow the U.S. shareholder to avoid tax on the CFC's earnings and profits. Specifically, subject to a de minimis rule, section 3.02(e)(ii) of Notice 2014–52 provides that an exchanging shareholder described in § 1.367(b)–4(b)(1)(i)(A) will be required to include in income as a deemed dividend the section 1248 amount with respect to stock of an expatriated foreign subsidiary that is exchanged in a specified exchange during the applicable period, without regard to whether any condition of § 1.367(b)–4(b)(1)(i)(B) is satisfied. The terms “expatriated foreign subsidiary” and “specified exchange” are defined in sections 3.01(b) and 3.02(e)(ii), respectively, of Notice 2014–52.

(b) Transactions at Issue and Regulations to be Issued

The Treasury Department and the IRS are concerned that certain nonrecognition transactions that dilute a U.S. shareholder's ownership of an expatriated foreign subsidiary may allow the U.S. shareholder to avoid U.S. tax on unrealized appreciation in property held by the expatriated foreign subsidiary at the time of the exchange. This could occur when the amount of realized gain in the stock of the expatriated foreign subsidiary that is exchanged in the specified exchange exceeds the earnings and profits attributable to such stock for purposes of section 1248. For example, at the time of the exchange, the expatriated foreign subsidiary could

hold valuable self-developed intangible property that has not yet been brought to market and therefore has not generated any significant earnings and profits. Any unrealized appreciation in the intangible property, when recognized by the expatriated foreign subsidiary after the exchange, would create earnings and profits that are attributable to gain that economically had accrued at the time of the exchange.

The Treasury Department and the IRS have determined that net unrealized built-in gain in property held by an expatriated foreign subsidiary at the time of the exchange gives rise to the same policy concerns that arise with respect to earnings and profits of the expatriated foreign subsidiary that exist at the time of the exchange. Therefore, to prevent the avoidance of U.S. tax on such net unrealized gain, it is appropriate to require the exchanging shareholder to recognize all of the gain in the stock of the expatriated foreign subsidiary that is exchanged, without regard to the amount of the expatriated foreign subsidiary's undistributed earnings and profits. Accordingly, the Treasury Department and the IRS intend to amend the regulations under section 367(b) to provide that, if an exchanging shareholder would be required under the rules announced in section 3.02(e)(ii) of Notice 2014-52 to include in income as a deemed dividend the section 1248 amount (if any) with respect to stock of an expatriated foreign subsidiary, the exchanging shareholder also must recognize all realized gain with respect to such stock, after taking into account any increase in basis resulting from a deemed dividend with respect to the exchange provided in § 1.367(b)-2(e)(3)(ii). For this purpose, the amount of realized gain that would be recognized is reduced by the amount of gain recognized under other applicable provisions of the Code, such as section 356.

Furthermore, a conforming change will be made to the regulations described in section 3.02(e)(i) of Notice 2014-52, which will recharacterize under section 7701(l) certain transfers of "specified stock" (as defined in section 3.02(e)(i) of Notice 2014-52), subject to the exceptions described in section 3.02(e)(i)(C) of Notice 2014-52. Specifically, the first exception described in section 3.02(e)(i)(C)

applies either when a transfer of specified stock gives rise to a deemed dividend to the exchanging shareholder under § 1.367(b)-4 (including by reason of the regulations described in section 3.02(e)(ii) of Notice 2014-52), or when the exchanging shareholder is required to recognize and include in income all of the gain in the specified stock. Consistent with the modification described in this section 3.02(b), when the regulations described in Notice 2014-52 are issued, the first exception described in section 3.02(e)(i)(C) will be modified to be applicable only if, as a result of the transfer, all the gain in the specified stock is recognized. See section 4.03 of this notice for additional discussion of the application of this notice and Notice 2014-52 to transfers of specified stock.

The following example illustrates the regulations described in this section 3.02(b):

Example 1. (i) *Facts.* FA, a foreign corporation, wholly owns DT, a domestic corporation, which in turn, wholly owns FT, a foreign corporation that is a CFC. FA wholly owns FS, a foreign corporation. FA acquired all the stock of DT in an inversion transaction that was completed on July 1, 2016. Accordingly, DT is a domestic entity, FT is an expatriated foreign subsidiary, and FA and FS are each a specified related person with respect to FT. During the applicable period, DT transfers to FS all of the stock of FT solely in exchange for FS voting stock representing 60% of the outstanding stock of FS, pursuant to a reorganization described in section 368(a)(1)(B). Immediately before the exchange, FT is a CFC in which DT is a section 1248 shareholder. Immediately after the exchange, FS and FT are CFCs in which DT is a section 1248 shareholder. At the time of the exchange, the FT stock owned by DT has a fair market value of \$150x and a tax basis of \$50x (such that the FT stock has a built-in gain of \$100x). In addition, the earnings and profits of FT attributable to DT's FT stock is \$60x and therefore the section 1248 amount with respect to the FT stock is \$60x (the lesser of the \$60x of earnings and profits attributable to the FT stock and the \$100x gain in the FT stock).

(ii) *Analysis.* Under § 1.367(b)-4(b)(1)(i), as modified by the regulations described in section 3.02(e)(ii) of Notice 2014-52, DT must include in income as a deemed dividend \$60x, the section 1248 amount with respect to its FT stock. Because DT is required to include in income as a deemed dividend the section 1248 amount, if any, with respect to its FT stock under section 3.02(e)(ii) of Notice 2014-52, the rules in section 3.02(b) of this notice apply. As a result, DT must also recognize all realized gain with respect to its FT stock after taking into account the \$60x increase in basis in the FT stock under § 1.367(b)-2(e)(3)(ii), or \$40x (\$150x - (\$50x + \$60x)). If instead the section 1248 amount with respect to the FT stock were zero (because, for

example, FT had no earnings and profits), DT would recognize all \$100x of realized gain with respect to its FT stock.

SECTION 4. CORRECTIONS AND CLARIFYING CHANGES TO CERTAIN RULES IN NOTICE 2014-52

.01 Regulations under Section 7874 to Disregard Certain Stock Attributable to Passive Assets

(a) Background

Notice 2014-52 announced that the Treasury Department and the IRS intend to issue regulations under section 7874(c)(6) that will exclude from the denominator of the ownership fraction certain stock of a foreign acquiring corporation that is attributable to passive assets. Specifically, section 2.01(b) of Notice 2014-52 provides that a portion of the stock of a foreign acquiring corporation will be excluded from the denominator of the ownership fraction when more than 50 percent of the gross value of all "foreign group property" is "foreign group non-qualified property." For this purpose, section 2.01(b) of Notice 2014-52 provides the general rule that foreign group non-qualified property is foreign group property (as defined in section 2.01(b) of Notice 2014-52) that is described in § 1.7874-4T(i)(7), other than property that gives rise to income described in section 1297(b)(2)(A) (PFIC banking exception) or section 954(h) or (i) (subpart F exceptions for qualified banking or financing income and for qualified insurance income, respectively, determined by substituting the term "foreign corporation" for the term "controlled foreign corporation"). In addition, a special rule treats certain property (referred to as "substitute property") that would not be foreign group nonqualified property under the general rule as foreign group nonqualified property if, in a transaction related to the acquisition, such property is acquired in exchange for other property that would be foreign group nonqualified property under the general rule.

(b) Modification of the General Definition of Foreign Group Nonqualified Property

(i) Exclusion for property that gives rise to income described in section 1297(b)(2)(B)

Notice 2014–52 did not exclude property that gives rise to income described in section 1297(b)(2)(B) (PFIC insurance exception) from the general definition of foreign group nonqualified property. Commenters have noted that certain insurance companies may not be able to satisfy the requirements of the subpart F exception for qualified insurance income under section 954(i), which is a narrower provision than section 1297(b)(2)(B). The Treasury Department and the IRS have determined that the rule described in Notice 2014–52 with respect to insurance companies can lead to inappropriate results in certain cases. Accordingly, the regulations described in section 2.01(b) of Notice 2014–52 will provide that property that gives rise to income described in the PFIC insurance exception will be excluded from the general definition of foreign group nonqualified property, but such property will be subject to the special rule for substitute property. Nevertheless, the Treasury Department and the IRS have significant concerns about certain corporations that do not conduct a bona fide active insurance business or whose investment assets exceed the amount necessary to meet their obligations under insurance and annuity contracts, but that nonetheless take the position that they earn income described in section 1297(b)(2)(B) with respect to all of their activities and investment assets. In this regard, on April 24, 2015, proposed regulations under § 1.1297–4 were published in the *Federal Register* (REG–108214–15) to provide guidance on when a foreign insurance company’s income is excluded from the definition of passive income under the PFIC insurance exception. In the preamble to those proposed regulations, the Treasury Department and the IRS requested comments on appropriate methodologies for determining the extent to which assets are held to meet obligations under insurance and annuity contracts. Accordingly, the Treasury Department and the IRS expect to issue separate guid-

ance under section 1297(b)(2)(B) to prevent companies from inappropriately applying the PFIC insurance exception.

(ii) Exclusion of property held by certain domestic corporations

Commenters have noted that the general definition of foreign group nonqualified property in Notice 2014–52 includes certain property held by domestic corporations engaged in the active conduct of a banking or insurance business. This could occur, for example, if a foreign acquiring corporation held all the stock of a domestic corporation prior to an acquisition. The Treasury Department and the IRS have determined that this definition may lead to inappropriate results in certain cases. Consequently, the regulations described in section 2.01(b) of Notice 2014–52 will provide that the general definition of foreign group nonqualified property does not include property held by a domestic corporation that is subject to tax as an insurance company under subchapter L, provided that the property is required to support, or is substantially related to, the active conduct of an insurance business. Furthermore, the regulations will provide that the general definition of foreign group nonqualified property does not include property held by a domestic corporation if that property gives rise to income described in section 954(h), determined by substituting the term “domestic corporation” for the term “controlled foreign corporation” and without regard to the phrase “located in a country other than the United States” in section 954(h)(3)(A)(ii)(I) and without regard to any inference that the tests in section 954(h) should be calculated or determined without taking into account transactions with customers located in the United States. In these cases, however, the special rule for substitute property will apply.

.02 Regulations under Section 7874 to Disregard Certain Distributions by the Domestic Entity

(a) Background

Notice 2014–52 announced that the Treasury Department and the IRS intend to issue regulations under section 7874 that disregard certain distributions made

by a domestic entity before being acquired by a foreign acquiring corporation. Specifically, section 2.02(b) of Notice 2014–52 provides that non-ordinary course distributions (as defined in section 2.02(b) of Notice 2014–52) made by a domestic entity (including a predecessor) during the 36-month period ending on the acquisition date (within the meaning of § 1.7874–3T(d)(1)) are disregarded for purposes of section 7874.

(b) Addition of a De Minimis Exception

Commenters have noted that the rules announced in section 2.02(b) of Notice 2014–52 could cause section 7874 to apply to an acquisition even though the former owners of the domestic entity actually own no, or only a de minimis amount of, stock in the foreign acquiring corporation after the acquisition. In general, this could occur when stock of the foreign acquiring corporation is disregarded for purposes of section 7874. For example, assume that, pursuant to a plan to purchase the stock of a domestic corporation, which made a non-ordinary course distribution, the purchaser forms a newly formed foreign acquiring corporation with cash and the foreign acquiring corporation uses the cash to purchase the stock of the domestic corporation. In applying the ownership percentage, the stock held by the shareholders of the foreign acquiring corporation is disregarded under § 1.7874–4T(b) (which disregards certain stock of the foreign acquiring corporation received in exchange for nonqualified property). This result is similar to a result that could occur under § 1.7874–4T(b), absent the de minimis exception provided in § 1.7874–4T(d)(1), when the former shareholders of the domestic entity in fact acquire a small interest in the foreign acquiring corporation by reason of having held an interest in the domestic entity. The Treasury Department and the IRS have determined that the policy reasons for providing the de minimis exception in § 1.7874–4T are equally applicable to the regulations described in section 2.02(b) of Notice 2014–52.

Accordingly, the Treasury Department and the IRS intend to include in the regulations described in section 2.02(b) of Notice 2014–52 a de minimis exception that will implement this policy. This ex-

ception will apply to an acquisition that meets two requirements. First, the ownership percentage, determined without regard to the application of § 1.7874-4T(b) and the rules announced in sections 2.01(b) and 2.02(b) of Notice 2014-52, must be less than five (by vote and value). Second, after the acquisition and all transactions related to the acquisition are completed, former shareholders (within the meaning of § 1.7874-2(b)(2)) or former partners (within the meaning of § 1.7874-2(b)(3)), as applicable, of the domestic entity, in the aggregate, must own (applying the attribution rules of section 318(a) with the modifications described in section 304(c)(3)(B)) less than five percent (by vote and value) of the stock of (or a partnership interest in) any member of the EAG that includes the foreign acquiring corporation. If these two requirements are satisfied, the rules announced in section 2.02(b) of Notice 2014-52 will not apply to the acquisition and, as a result, no distributions will be treated as non-ordinary course distributions that are disregarded under those rules. However, any distributions that are part of a plan a principal purpose of which is to avoid the purposes of section 7874 will be disregarded under section 7874(c)(4).

.03 Regulations to Address Transactions to De-Control or Significantly Dilute Ownership of Certain CFCs

(a) Background

Notice 2014-52 announced that the Treasury Department and the IRS intend to issue regulations under section 7701(l) that will recharacterize certain post-inversion transactions that otherwise would de-control or significantly dilute a U.S. shareholder's ownership of a CFC that is an expatriated foreign subsidiary. The general rule in section 3.02(e)(i) of Notice 2014-52 provides that a specified transaction completed during the applicable period is recharacterized under section 7701(l) in the manner described in section 3.02(e)(i)(A) of Notice 2014-52. For this purpose, a specified transaction is a transaction in which stock in an expatriated foreign subsidiary, referred to as "specified stock," is transferred (including by issuance) to a specified related person. The term "expatriated foreign subsidiary"

is defined in section 3.01(b) of Notice 2014-52, and the terms "specified transaction," "specified stock," and "specified related party" are defined in section 3.02(e)(i) of Notice 2014-52.

This general rule is subject to two exceptions described in section 3.02(e)(i)(C) of Notice 2014-52. The first exception is discussed in section 3.02(b) of this notice. The second exception (small dilution exception) applies if (i) the expatriated foreign subsidiary is a CFC immediately after the specified transaction and all related transactions and (ii) the amount of stock (by value) in the expatriated foreign subsidiary (and any lower-tier expatriated foreign subsidiary) that is owned, in the aggregate, directly or indirectly by the section 958(a) U.S. shareholders (as defined in section 3.02(e)(i)(A) of Notice 2014-52) of the expatriated foreign subsidiary immediately before the specified transaction and any transactions related to the specified transaction does not decrease by more than 10 percent as a result of the specified transaction and any related transactions.

Example 1 of section 3.02(e)(iii) of Notice 2014-52 illustrates a specified transaction in which neither exception applies and therefore the transaction is recharacterized in the manner described in section 3.02(e)(i)(A) of Notice 2014-52. In the example, FA is a foreign corporation that wholly owns DT, a domestic corporation acquired by FA in an inversion transaction completed on January 1, 2015. In addition, DT wholly owns FT, a foreign corporation that is a CFC and an expatriated foreign subsidiary, and FA wholly owns FS, a foreign corporation that is a specified related person with respect to FT. Shortly after the inversion transaction, FA acquires \$10x of FT stock from FT, representing 60 percent of total voting power and value of the stock of FT, in exchange for \$10x of cash.

The example states that FA's acquisition of the FT stock from FT is a specified transaction that must be recharacterized. The small dilution exception is not applicable because the amount of FT stock (by value) that is owned (within the meaning of section 958(a)), in the aggregate, by DT before the specified transaction decreases by more than 10 percent (in fact, by 60 percent, from 100 percent to 40 percent) as a result of the specified transaction.

(b) Clarifying Change to Small Dilution Exception

The Treasury Department and the IRS are concerned that some taxpayers may be inappropriately interpreting the small dilution exception. In particular, some taxpayers may be comparing the value of the stock of an expatriated foreign subsidiary owned by a section 958(a) U.S. shareholder immediately before a specified transaction with the value of the stock owned by the section 958(a) U.S. shareholder immediately after the specified transaction, rather than comparing the percentage of the stock owned (by value) by the section 958(a) U.S. shareholder before and after the specified transaction. This interpretation is plainly inconsistent with the purpose of the rules described in section 3.02(e)(i) of Notice 2014-52 and the small dilution exception, as well as the analysis in Example 1 of section 3.02(e)(iii) of Notice 2014-52. Accordingly, the regulations will clarify the application of the small dilution exception by substituting the phrase "the percentage of stock (by value)" for the phrase "the amount of stock (by value)." A similar clarification will be made to the exception described in section 3.02(e)(ii) of Notice 2014-52 (relating to the circumstances in which an exchanging shareholder is required under section 367(b) to include in income as a deemed dividend the section 1248 amount with respect to stock exchanged in a specified exchange).

SECTION 5. EFFECTIVE DATES

Except as provided in this section 5, the regulations described in section 2.02(a) (which requires the foreign acquiring corporation to be subject to tax as a resident of the relevant foreign country in order to have substantial business activities in the relevant foreign country), section 2.02(b) (which disregards certain stock of the foreign acquiring corporation in third-country transactions), section 2.03(b) (which clarifies the definition of nonqualified property in § 1.7874-4T), section 4.01(b) (which modifies the definition of foreign group nonqualified property in Notice 2014-52), and section 4.02(b) (which provides a de minimis exception to the rules announced in Notice 2014-52 regarding certain distributions of

a domestic entity that are disregarded) will apply to acquisitions completed on or after November 19, 2015. In addition, except as provided in this section 5, the regulations described in: (i) section 3.01(b) (which provides that inversion gain includes certain income or gain recognized by an expatriated entity from an indirect transfer or license of property and provides aggregate treatment for certain foreign partnerships for purposes of determining inversion gain) will apply to transfers or licenses of property occurring on or after November 19, 2015, but only if the inversion transaction is completed on or after September 22, 2014; (ii) section 3.02(b) (which requires the recognition of realized stock gain in certain specified exchanges) will apply to specified exchanges occurring on or after November 19, 2015, but only if the inversion transaction is completed on or after September 22, 2014; and (iii) section 4.03 (which clarifies certain exceptions to the rules announced in Notice 2014–52 regarding transactions to de-control or significantly dilute CFCs) will apply to specified transactions and specified exchanges completed on or after November 19, 2015, but only if the inversion transaction is completed on or after September 22, 2014.

Taxpayers may elect to apply the rules in sections 4.01(b) of this notice (which modifies the definition of foreign group nonqualified property in Notice 2014–52) and 4.02(b) of this notice (which provides a de minimis exception to the rules announced in Notice 2014–52 regarding certain distributions of a domestic entity that are disregarded) to acquisitions completed before November 19, 2015.

No inference is intended regarding the treatment under current law of the transactions described in this notice. The IRS may challenge such transactions under applicable Code provisions or judicial doctrines.

SECTION 6. REQUEST FOR COMMENTS AND CONTACT INFORMATION

The Treasury Department and the IRS expect to issue additional guidance to fur-

ther limit (i) inversion transactions that are contrary to the purposes of section 7874 and (ii) the benefits of post-inversion tax avoidance transactions. In particular, as described in section 5 of Notice 2014–52, the Treasury Department and the IRS continue to consider guidance to address strategies that avoid U.S. tax on U.S. operations by shifting or “stripping” U.S.-source earnings to lower-tax jurisdictions, including through intercompany debt. Accordingly, the Treasury Department and the IRS reiterate the requests for comments made in Notice 2014–52.

Written comments may be submitted to the Office of Associate Chief Counsel (International), Attention: David A. Levine and Shane M. McCarrick, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington, DC 20224. Alternatively, taxpayers may submit comments electronically to notice.comments@irs.counsel.treas.gov. Comments will be available for public inspection and copying.

The principal authors of this notice are Mr. Levine and Mr. McCarrick of the Office of Associate Chief Counsel (International). However, other personnel from the Treasury Department and the IRS participated in its development. For further information regarding this notice, contact Mr. Levine or Mr. McCarrick at (202) 317-6934 (not a toll-free number).

Section 529A INTERIM GUIDANCE REGARDING CERTAIN PROVISIONS OF PROPOSED REGULATIONS RELATING TO QUALIFIED ABLE PROGRAMS

Notice 2015–81

I. PURPOSE AND OVERVIEW

This notice advises how the Treasury Department and the Internal Revenue Service (IRS) intend to respond to comments by revising three provisions of the proposed regulations under § 529A of the

Internal Revenue Code when those regulations are finalized. Specifically, commenters noted that the following three requirements for qualified Achieving a Better Life Experience (ABLE) programs in the proposed regulations would create significant barriers to the establishment of such programs: (1) the requirement to establish safeguards to categorize distributions from ABLE accounts, (2) the requirement to request the taxpayer identification number (TIN) of each contributor to an ABLE account, and (3) the requirements for disability certifications, and in particular the requirement to process disability certifications with signed physicians’ diagnoses.

II. BACKGROUND

The Stephen Beck, Jr., Achieving a Better Life Experience Act of 2014 (ABLE Act) was enacted on December 19, 2014, as part of The Tax Increase Prevention Act of 2014 (P.L. 113–295). The ABLE Act added § 529A to the Code. Section 529A allows a State (or State agency or instrumentality) to establish and maintain a tax-advantaged savings program under which contributions may be made to an account (an ABLE account) for the purpose of providing for the qualified disability expenses of the designated beneficiary of the account. The designated beneficiary generally must be a resident of that State who has a disability that commenced before the designated beneficiary’s 26th birthday and who meets the statutory eligibility requirements. In general, neither the ABLE account nor distributions from the account are treated as income or resources of a designated beneficiary who is an eligible individual in determining that designated beneficiary’s qualification for federal benefits.¹ The undistributed income earned in an ABLE account is not taxable and distributions made from an ABLE account for qualified disability expenses of the designated beneficiary are not included in the designated beneficiary’s gross income for federal income tax purposes. However, the earnings portion of distributions from an ABLE

¹While section 103 of the ABLE Act (not a tax provision) generally provides that a designated beneficiary’s ABLE account is disregarded in determining the designated beneficiary’s eligibility under certain federal means-tested programs, there are two exceptions. In the case of the Supplemental Security Income program under title XVI of the Social Security Act, distributions for certain housing expenses are not disregarded and the balance (including earnings) in an ABLE account is considered a resource of the designated beneficiary to the extent that balance exceeds \$100,000. Section 103 also addresses the impact of an excess balance on the designated beneficiary’s eligibility under the Supplemental Security Income program and Medicaid.

account in excess of qualified disability expenses generally is includible in the gross income of the designated beneficiary.

The Treasury Department and the IRS released proposed regulations concerning qualified ABLE programs on June 19, 2015, which were published in the Federal Register on June 22, 2015 (80 Fed. Reg. 35602). Although the comments received to date generally have been positive regarding most aspects of the proposed regulations, commenters raised concerns that the provisions in the proposed regulations requiring a qualified ABLE program to establish safeguards to categorize distributions, collect taxpayer identification numbers (TINs) from contributors, and process disability certifications with signed physicians' diagnoses, if unchanged in the final regulations, would impose substantial administrative and cost burdens on the States administering qualified ABLE programs. States indicated that these burdens were sufficiently significant that they were encountering substantial hurdles in moving forward with creating their ABLE programs because they did not know if the final regulations would resolve their concerns regarding these requirements. Several commenters requested that the Treasury Department and the IRS issue interim guidance on these three requirements in order to facilitate the establishment of qualified ABLE programs by the States.

III. DISTRIBUTIONS FOR QUALIFIED DISABILITY EXPENSES

Consistent with § 529A(e)(5), § 1.529A-1(b)(16) of the proposed regulations defines the term "qualified disability expenses" as expenses incurred that relate to the blindness or disability of the designated beneficiary of an ABLE account and that are for the benefit of the designated beneficiary in maintaining or improving his or her health, independence, or quality of life. As stated in the preamble to the proposed regulations, the Treasury Department and the IRS recognize that this term should be broadly construed to permit the inclusion of basic living expenses and should not be limited to expenses for items for which there is a medical necessity or which provide no benefit to others in addition to the benefit

to the eligible individual. Section 1.529A-2(h)(1) of the proposed regulations provides that a qualified ABLE program must establish safeguards to allow the ABLE program to distinguish between distributions used to pay for qualified disability expenses and other distributions, and to permit the identification of amounts distributed for housing expenses as defined for purposes of the Supplemental Security Income program of the Social Security Administration.

Commenters noted that, because the identification of housing expenses is relevant only for purposes of determining eligibility for certain Social Security benefits and has no relevance for federal income tax purposes, any reference to classifying distributions as housing expenses should be eliminated from the regulations. The Treasury Department and the IRS agree, and the final regulations will not require a qualified ABLE program to identify or record whether distributions were made for housing expenses.

Commenters also expressed concerns regarding the requirement that a qualified ABLE program establish safeguards to distinguish between distributions for qualified disability expenses and other distributions. Commenters emphasized that requiring a qualified ABLE program to determine how a distribution will be used prior to making the distribution would be unduly burdensome for both the program and the designated beneficiary and explained that the particular use of a distribution might not be known when the distribution is made. The commenters recommended that any requirement or suggestion that qualified ABLE programs will have to classify distributions should be eliminated from the regulations.

Consistent with the reporting requirements in § 1.529A-6 of the proposed regulations, which require that qualified ABLE programs report only aggregate distributions and distinguish such distributions as basis, earnings, or returned contributions, the Treasury Department and the IRS confirm that the final regulations will not require, for any federal income tax purpose, a qualified ABLE program to establish safeguards to distinguish between distributions used for the payment of qualified disability expenses and other distributions. The designated bene-

ficiary, however, will have to categorize distributions in order to properly determine the designated beneficiary's federal income tax obligations.

IV. REPORTING REQUIREMENTS REGARDING CONTRIBUTORS

Consistent with §§ 529A(b)(2)(B) and (b)(6), §§ 1.529A-2(g)(2) and (3) of the proposed regulations provide that a qualified ABLE program must provide that no contribution to an ABLE account will be accepted to the extent that such contribution exceeds certain stated limits. Specifically, the total contributions (whether from the designated beneficiary or one or more other persons) to the designated beneficiary's ABLE account made during the designated beneficiary's taxable year must not exceed the amount in effect under § 2503(b) (the annual gift tax exclusion amount) for the calendar year in which the designated beneficiary's taxable year begins. In addition, the aggregate amount of contributions to an ABLE account must not exceed the limit established by the State under § 529(b)(6) (the limit on contributions to a qualified tuition program). If an excess contribution under § 1.529A-2(g)(2) or an excess aggregate contribution under § 1.529A-2(g)(3) is allocated to or deposited into the ABLE account of a designated beneficiary, § 1.529A-2(g)(4) of the proposed regulations requires the qualified ABLE program to return that excess contribution or excess aggregate contribution (with any net income attributable to it, as determined under the applicable rules) to the person who made that contribution. Because the income earned on that excess contribution or excess aggregate contribution (if any) will be taxable to that contributor, § 1.529A-6(d) of the proposed regulations requires a qualified ABLE program to request the TIN for each contributor to the ABLE account at the time a contribution is made if the program does not already have a record of that person's correct TIN.

One commenter suggested that excess contributions instead could be required to be paid to the designated beneficiary so there would be no need for a qualified ABLE program to procure a contributor's TIN. The Treasury Department and the IRS do not agree with this suggestion be-

cause the designated beneficiary's receipt of such an excess amount could put the designated beneficiary at risk of being disqualified for his or her federal benefits that are income or resource based, a result that would be inconsistent with the purposes of the statute.

Commenters are concerned about the substantial burdens imposed on qualified ABLE programs if they must request the TIN of every contributor (if the program does not already have a record of that person's correct TIN) at the time a contribution is made. Commenters explained that it is likely that contributions will come from multiple sources and will be made in a variety of ways (payroll deduction, check, debit, automated clearing house (ACH) transfers, or others), making it difficult as a practical matter to obtain the TIN of the contributor. Commenters also stated that some contributors, especially those making small gifts, may be reluctant to make a contribution if a TIN were required to be provided. Further, several commenters indicated that systems would be used that would ensure that qualified ABLE programs do not accept contributions that would exceed applicable limits.

As an alternative, commenters suggested that a contributor's TIN be required to be collected only by those qualified ABLE programs that do not have systems in place to prevent the acceptance and/or deposit to the ABLE account of a particular designated beneficiary of an excess contribution or excess aggregate contribution. The commenters expect that most qualified ABLE programs will adopt the infrastructure currently utilized by State § 529 qualified tuition programs either to reject such excess contributions or to escrow and immediately refund the excess contributions. Other commenters recommend that the obligation to request a contributor's TIN should only arise in the unlikely circumstance in which an excess contribution or excess aggregate contribution has been deposited into an individual's ABLE account and has accrued earnings or losses. One commenter suggested eliminating the TIN requirement altogether while another suggested the collection of TINs should be required only in the case of contributions over a specified dollar amount.

In consideration of these comments, the Treasury Department and the IRS believe that a modification to § 1.529A-6(d) of the proposed regulations is appropriate. Consequently, it is anticipated that the final regulations will eliminate the requirement to request the TIN of each contributor at the time a contribution is made (if the program does not already have a record of that person's correct TIN) if the qualified ABLE program has a system in place to identify and reject excess contributions and excess aggregate contributions before they are deposited into an ABLE account. However, in the event an excess contribution or excess aggregate contribution is deposited into an ABLE account, the qualified ABLE program will be required to request the TIN of the contributor making the excess contribution or excess aggregate contribution.

V. ELIGIBLE INDIVIDUAL, FILING OF DISABILITY CERTIFICATION AND PHYSICIAN DIAGNOSIS

Consistent with § 529A(e)(1), § 1.529A-2(d)(1) of the proposed regulations provides that a qualified ABLE program must specify the documentation that an individual must furnish, both at the time an ABLE account is established for the designated beneficiary of that account and thereafter, to ensure that the designated beneficiary of the ABLE account is, and continues to be, an eligible individual. One way to qualify as an eligible individual under § 529A(e)(1) is to have a disability certification filed with the Secretary of the Treasury. Under the proposed regulations, a disability certification is deemed to be filed with the Secretary once the qualified ABLE program has received the disability certification or a disability certification is deemed to have been received under the rules of the qualified ABLE program, which information the qualified ABLE program must file with the IRS in accordance with the filing requirements under § 1.529A-5(c)(2)(iv). Section 529A(e)(2)(A) defines a disability certification as "a certification to the satisfaction of the Secretary" by the individual or the parent or guardian of the individual that (i) certifies that the individual meets the disability standard and (ii) includes a copy of the individual's diagnosis signed by a licensed physician. Section

1.529A-2(e) defines the disability certification to include the required certifications and a copy of the signed diagnosis, but also provides for certain conditions to be deemed to meet the requirements of filing a disability certification.

States and potential qualified ABLE program administrators expressed concerns about their responsibilities and potential liabilities for receiving and safeguarding medical information contained in a signed diagnosis, particularly when they do not anticipate having any expertise or ability to evaluate that medical information. The commenters emphasized that qualified ABLE programs would incur unmanageable costs and burdens in trying to comply with applicable laws imposing system and other requirements on those in possession of medical records, as well as in implementing systems to receive and store paper documentation. The commenters also expressed the concern that, if these costs and burdens cannot be minimized, some States may not proceed with the implementation of qualified ABLE programs for their residents. The commenters recommended that a qualified ABLE program be permitted to open an ABLE account on the basis of a certification by the person opening the ABLE account, signed under penalties of perjury, that the individual has a condition that meets all of the required elements to qualify as an eligible individual and that a diagnosis signed by a physician regarding the relevant impairment or impairments has been obtained.

After consideration of these comments, the Treasury Department and the IRS have concluded that a certification under penalties of perjury that the individual (or the individual's agent under a power of attorney or a parent or legal guardian of the individual) has the signed physician's diagnosis, and that the signed diagnosis will be retained and provided to the ABLE program or the IRS upon request, is adequate to satisfy the Secretary with regard to the requirements of §§ 529A(e)(1)(B) and 529A(e)(2)(A) pertaining to the filing of a disability certification. Accordingly, the Treasury Department and the IRS intend, in the final regulations, to permit such a certification of eligibility for purposes of satisfying the requirement for filing a disability certification. The Trea-

sury Department and the IRS anticipate that the final regulations will contain further details with regard to the information required to be included in the certification, annual recertifications, and annual reporting. Based on the comments received, the required information is likely to include the statutory basis for the individual's eligibility (blindness or disability under title II or XVI of the Social Security Act, or a disability certification); confirmation that the blindness or disability occurred before age 26; the existence of an impairment that satisfies the required level of marked and severe functional limitations, if necessary for eligibility; and, if necessary for eligibility, confirmation of receipt of a written diagnosis relating to the disability, the name and address of the diagnosing physician, the date of the diagnosis, and identification of the applicable diagnostic

code from those listed on Form 5498-QA. The final regulations may also provide that the certification may include information provided by the physician as to the categorization of the disability that could determine, under the particular State's program, the appropriate frequency of required recertifications.

VI. RELIANCE

The Treasury Department and the IRS intend that the final regulations, when issued, will address the three identified issues in the manner indicated in this notice. Pending the issuance of final regulations, taxpayers may rely on the guidance contained in this notice. In particular, if a certification used to open a qualified ABLE account before the issuance of final regulations is consistent with the discussion in section V of this notice but does

not contain other information required by the final regulations, the account will not lose its qualification as an ABLE account solely for that reason. To the extent that additional information is required by the final regulations, the final regulations will provide a transition period to facilitate compliance with the additional requirements.

VII. DRAFTING INFORMATION

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Note. This revenue procedure will be reproduced as the next revision of IRS Publication 1167, General Rules and Specifications for Substitute Forms and Schedules.

Rev. Proc. 2015-55

TABLE OF CONTENTS

Part 1 – INTRODUCTION TO SUBSTITUTE FORMS	789
Section 1.1 – Overview of Revenue Procedure 2015-55	789
Section 1.2 – IRS Contacts	790
Section 1.3 – What’s New	791
Section 1.4 – Definitions	791
Section 1.5 – Agreement	792
Part 2 – GENERAL GUIDELINES FOR SUBMISSIONS AND APPROVALS	793
Section 2.1 – General Specifications for Approval	793
Section 2.2 – Highlights of Permitted Changes and Requirements	795
Section 2.3 – Vouchers	795
Section 2.4 – Restrictions on Changes	797
Section 2.5 – Guidelines for Obtaining IRS Approval	798
Section 2.6 – Office of Management and Budget (OMB) Requirements for All Substitute Forms	801
Part 3 – PHYSICAL ASPECTS AND REQUIREMENTS	801
Section 3.1 – General Guidelines for Substitute Forms	801
Section 3.2 – Paper	803
Section 3.3 – Printing	804
Section 3.4 – Margins	805
Section 3.5 – Examples of Approved Formats	806
Section 3.6 – Miscellaneous Information for Substitute Forms	806
Part 4 – ADDITIONAL RESOURCES	807
Section 4.1 – Guidance From Other Revenue Procedures	807
Section 4.2 – Electronic Tax Products	807
Section 4.3 – System Requirements and Ordering Forms and Instructions	1158
Part 5 – REQUIREMENTS FOR SPECIFIC TAX RETURNS	807
Section 5.1 – Tax Returns (Forms 1040, 1040A, 1120, etc.)	807
Section 5.2 – Changes Permitted to Graphics (Forms 1040A and 1040)	808
Section 5.3 – Changes Permitted to Form 1040A Graphics	810
Section 5.4 – Changes Permitted to Form 1040 Graphics	810
Part 6 – FORMAT AND CONTENT OF SUBSTITUTE RETURNS	811
Section 6.1 – Acceptable Formats for Substitute Forms and Schedules	811
Section 6.2 – Additional Instructions for All Forms	812
Part 7 – MISCELLANEOUS FORMS AND PROGRAMS	814
Section 7.1 – Specifications for Substitute Schedules K-1	814
Section 7.2 – Guidelines for Substitute Forms 8655	819
Part 8 – ADDITIONAL INFORMATION	819
Section 8.1 – Forms for Electronically Filed Returns	819
Section 8.2 – Effect on Other Documents	820

Part 1 Introduction to Substitute Forms

Section 1.1 – Overview of Revenue Procedure 2015–55

1.1.1 Purpose

The purpose of this revenue procedure is to provide guidelines and general requirements for the development, printing, and approval of substitute tax forms. Approval will be based on these guidelines. After review and approval, submitted forms will be accepted as substitutes for official IRS forms.

1.1.2 Unique Forms

Certain unique specialized forms require the use of other additional publications to supplement this publication. See *Part 4*.

1.1.3 Scope

The IRS accepts quality substitute tax forms that are consistent with the official forms and have no adverse impact on our processing. The IRS Substitute Forms Unit administers the formal acceptance and processing of these forms nationwide. While this program deals with paper documents, it also reviews for approval other processing and filing forms such as those used in electronic filing.

Only those substitute forms that comply fully with these requirements are acceptable. This revenue procedure is updated as required to reflect pertinent tax year form changes and to meet processing and/or legislative requirements.

1.1.4 Forms Covered by This Revenue Procedure

The following types of forms are covered by this revenue procedure:

- IRS tax forms and their related schedules,
 - Worksheets as they appear in instruction packages,
 - Applications for permission to file returns electronically and forms used as required documentation for electronically filed returns,
 - Powers of Attorney,
 - Over-the-counter estimated tax payment vouchers, and
 - Forms and schedules relating to partnerships, exempt organizations, and employee plans.
-

1.1.5 Forms Not Covered by This Revenue Procedure

The following types of forms are not covered by this revenue procedure.

- W–2 and W–3 (see Pub. 1141 for information on these forms).
- W–2c and W–3c (see Pub. 1223 for information on these forms).
- 941, Schedule B (Form 941), Schedule D (Form 941), and Schedule R (Form 941) (see Pub. 4436 for information on these forms).
- 1096, 1097–BTC, 1098 series, 1099 series, 3921, 3922, 5498 series, W–2G, 1042–S, and 8935 (see Pub. 1179 for information on these forms).
- 1095–A, 1094–B, 1095–B, 1094–C, and 1095–C (see Pub. 5223 for information on these forms).
- 8027 (see Pub. 1239 for information on this form).
- Forms 1040–ES (OCR) and 1041–ES (OCR), which may not be reproduced.
- Forms 5500 (for more information on these forms, see the Department of Labor website at www.efast.dol.gov).
- Forms 5300, 5307, 8717, and 8905, bar-coded forms requiring separate approval.
- Forms used internally by the IRS.
- State tax forms.
- Forms developed outside the IRS.

**1.1.6
Other Information Not
Covered by This Revenue
Procedure**

The following information is not covered by this revenue procedure.

- Requests for information or documentation initiated by the IRS.
- General Instructions and Specific Instructions (these are not reviewed by the Substitute Forms Program Unit).

Section 1.2 – IRS Contacts

**1.2.1
Where To Send Substitute
Forms**

Send your substitute forms for approval to the following offices (do not send forms with taxpayer data):

Form	Office and Address
5500	Check EFAST2 information at the Department of Labor’s website at www.efast.dol.gov
5300, 5307, 8717, and 8905	Sandra.K.Barnes@irs.gov
Software developer vouchers (see <i>Sections 2.3.7 – 2.3.9</i>)	Internal Revenue Service Attn: Doris Bethea 5000 Ellin Road, C5–226 Lanham, MD 20706 Doris.E.Bethea@irs.gov
Software developers and form producers must mail Forms 1094–B, 1095–B, 1094–C, and 1095–C for testing (for more information, see Pub. 5223)	scrips@irs.gov
All others covered by this publication	Internal Revenue Service Attn: Substitute Forms Program SE:W:CAR:MP:P:TP 5000 Ellin Road, C6–440 Lanham, MD 20706

For questions about:

- Forms W–2 and W–3, refer to Pub. 1141, General Rules and Specifications for Substitute Forms W–2 and W–3.
- Forms W–2c and W–3c, refer to Pub. 1223, General Rules and Specifications for Substitute Forms W–2c and S–3c.
- Form 941 and Schedules B, D, and R, refer to Pub. 4436, General Rules and Specifications for Substitute Form 941, Schedule B (Form 941), Schedule D (Form 941), and Schedule R (Form 941).
- Forms 1096, 1097–BTC, 1098, 1099, 3921, 3022, 5498, W–2G, and 1042–S, refer to Pub. 1179, General Rules and Specifications for Substitute Forms 1096, 1098, 1099, 5498, and Certain Other Information Returns.
- For Forms 1095–A, 1094–B, 1095–B, 1094–C, and 1095–C, refer to Pub. 5223, General Rules & Specifications for Affordable Care Act Substitute Forms 1095–A, 1094–B, 1095–B, 1094–C, and 1095–C.
- Form 8027, refer to Pub. 1239, Specifications for Filing Form 8027, Employer’s Annual Information Return of Tip Income and Allocated Tips, Electronically.

Section 1.3 – What’s New

1.3.1 What’s New

The following changes have been made to this year’s revenue procedure.

- **.01 Editorial Changes.** We made editorial changes throughout and redundancies were eliminated as much as possible.
 - **.02 Publication 5223.** Information about ACA forms has been included in this publication. For further information about ACA forms, see Pub. 5223, General Rules & Specifications for Affordable Care Act Substitute Forms 1095–A, 1094–B, 1095–B, 1094–C, and 1095–C.
-

Section 1.4 – Definitions

1.4.1 Substitute Form

A tax form (or related schedule) that differs in any way from the official version and is intended to replace the form that is printed and distributed by the IRS. This term also covers those approved substitute forms exhibited in this revenue procedure.

1.4.2 Printed/ Preprinted Form

A form produced using conventional printing processes, or a printed form which has been reproduced by photocopying or a similar process.

1.4.3 Preprinted Pin- Fed Form

A printed form that has marginal perforations for use with automated and high-speed printing equipment.

1.4.4 Computer Prepared Substitute Form

A preprinted form in which the taxpayer’s tax entry information has been inserted by a computer, computer printer, or other computer-type equipment.

1.4.5 Computer Generated Substitute Tax Return or Form

A tax return or form that is entirely designed and printed using a computer printer on plain white paper. This return or form must conform to the physical layout of the corresponding IRS form, although the typeface may differ. The text should match the text on the officially printed form as closely as possible. Condensed text and abbreviations will be considered on a case-by-case basis. **Exception.** All jurats (perjury statements) must be reproduced verbatim.

1.4.6 Manually Prepared Form

A preprinted reproduced form in which the taxpayer’s tax entry information is entered by an individual using a pen, pencil, typewriter, or other non-automated equipment.

1.4.7 Graphics

Parts of a printed tax form that are not tax amount entries or required text. Examples of graphics are line numbers, captions, shadings, special indicators, borders, rules, and strokes created by typesetting, photographs, photocomposition, etc.

1.4.8 Acceptable Reproduced Form

A legible photocopy or an exact replica of an original form.

**1.4.9
Supporting Statement
(Supplemental Schedule)**

A document providing detailed information to support a line entry on an official or approved substitute form and filed with (attached to) a tax return. **Note.** A supporting statement is not a tax form and does not take the place of an official form.

**1.4.10
Specific Form Terms**

The following specific terms are used throughout this revenue procedure in reference to all substitute forms: format, sequence, line reference, item caption, and data entry field.

**1.4.11
Format**

The overall physical arrangement and general layout of a substitute form.

**1.4.12
Sequence**

Sequence is an integral part of the total format requirement. The substitute form should show the same numeric and logical placement order of data, as shown on the official form.

**1.4.13
Line Reference**

The line numbers, letters, or alphanumerics used to identify each captioned line on an official form. These line references are printed to the immediate left of each caption and/or data entry field.

**1.4.14
Item Caption**

The text on each line of a form, which identifies the data required.

**1.4.15
Data Entry Field**

Designated areas for the entry of data such as dollar amounts, quantities, responses, and checkboxes.

**1.4.16
Advance Draft**

A draft version of a new or revised form may be posted to the IRS website (www.irs.gov/ap/picklist/list/draftTaxForms.html) for information purposes. Substitute forms may be submitted based on these advance drafts, but any submitter that receives forms approval based on these early drafts is responsible for monitoring and revising forms to mirror any revisions in the final forms provided by the IRS.

**1.4.17
Approval**

Generally, approval could be in writing or assumed after 20 business days from our receipt for forms that have not been substantially changed by the IRS. This does not apply to newly created or substantially revised IRS forms. However, the Substitute Forms Unit reserves the right to notify vendors of any inaccuracies even after 20 business days have lapsed.

Section 1.5 – Agreement

**1.5.1
Important Stipulation of
This Revenue Procedure**

Any person or company who uses substitute forms and makes all or part of the changes specified in this revenue procedure agrees to the following stipulations.

- The IRS presumes that any required changes are made in accordance with these procedures and will not be disruptive to the processing of the tax return.
- Should any of the changes be disruptive to the IRS's processing of the tax return, the person or company agrees to accept the determination of the IRS as to whether the form may continue to be filed.
- The person or company agrees to work with the IRS in correcting noted deficiencies. Notification of deficiencies may be made by any combination of letter, email, or phone contact and may include the request for the re-submission of unacceptable forms.

1.5.2 Response Policy and Stipulations

The Substitute Forms Unit (the Unit) will email confirmation of receipt of your forms submission, if possible. Even if you do not receive emailed confirmation of receipt, you will receive an emailed “submission receipt,” which will provide feedback on your submission. If the Unit anticipates problems in completing the review of your submission within the 20 business day period, the Unit will send an interim email notifying you of the extended period for review.

Once the substitute forms have been approved by the Substitute Forms Unit, you can release them after the final versions of the forms have been issued by the IRS. Before releasing the forms, you are responsible for updating forms approved as draft and for making form changes we requested.

The policy has the following stipulations.

- This 20-day policy applies to electronic submissions only. It does not apply to substitute forms submitted for approval by paper.
- The policy applies to submissions of 15 (optimal) or fewer items and submissions containing 75 pages or less. Submissions of more than 15 items may require additional review time.
- If you send a large number of submissions within a short period of time, processing may be delayed.
- Delays in processing could occur if the Unit finds significant errors in your submission or has experienced an increase in submissions. The Unit will send you an interim email in this case.
- Any anticipated problems in processing your submission within the 20-day period will generate an interim email on or about the 15th business day.
- If any significant inaccuracies are discovered after the 20-day period, the Unit reserves the right to inform you and will require that changes be made to correct the inaccuracies.
- The policy does not apply to substantially revised forms or to new forms created by the IRS for which you have already made an initial submission.

Part 2 General Guidelines for Submissions and Approvals

Section 2.1 – General Specifications for Approval

2.1.1 Overview

If you produce any substitute tax forms that fully comply or follow the changes specifically outlined by the Substitute Forms Unit, then you can generate your own substitute forms without further approval. If your changes are more extensive, you must get IRS approval before using substitute forms. More extensive changes include the use of a different typeface, font size, data entry font size and type layout, and the condensing of line item descriptions to save space.

Note. The 20-day turnaround policy may not apply to extensive changes.

2.1.2 Email Submissions

The Substitute Forms Program accepts substitute forms submissions via email. The email address is *substituteforms@irs.gov*. Please include the term “PDF Submissions” on the subject line. Follow these guidelines.

- Your submission should include all the forms you wish to submit in one attached PDF file. **Do not email each form individually. Do not attach each individual form to an email.**
- The emailed submission should include a maximum of 3 PDFs to include: a check sheet, a cover letter or accompanying statement, and a single PDF that includes all of the forms listed on your check sheet, cover letter, or accompanying statement.
- A submission should contain a maximum of 15 forms.
- An approval check sheet listing the forms you are submitting should always be included in the PDF file along with the forms. Excluding the check sheet can slow the reviewing process down, which can result in a delayed response to your submission. See a sample check sheet in Exhibit D.
- Optimize PDF files before submitting.
- The maximum allowable email attachment is 2.5 megabytes.
- The Substitute Forms Unit accepts zip files.
- To alleviate delays during the peak time of September through December, submit advance draft forms as early as possible.

If the guidelines are not followed, you may need to resubmit.

Emailing PDF submissions will not expedite review and approval. Submitting your substitute forms package via email is the preferred and suggested method for submitting forms for review. If, for some reason, you are not able to email your submission(s), you can mail your submission(s) to: Internal Revenue Service

Attn: Substitute Forms Program
SE:W:CAR:MP:P:TP
5000 Ellin Road, C6-440
Lanham, MD 20706

2.1.3 Expediting the Process

Follow these basic guidelines for expediting the process:

- Always include a check sheet for the Substitute Forms Unit's response.
- Include an accompanying statement identifying most, if not all, of the deviations your substitute forms may include which the official IRS version of the form does not.
- Follow the guidance in this publication for general substitute form guidelines. Follow the guidance in specialized publications produced by the Substitute Forms Unit for other specific forms.
- To spread out the workload, send in draft versions of substitute forms when they are posted. **Note.** Be sure to make any changes to approved drafts before releasing final versions.

2.1.4 Schedules

Schedules are considered to be an integral part of a complete tax return. A schedule may be included as part of a form or printed separately.

2.1.5 Examples of Schedules That Must Be Submitted with the Return

Form 706, United States Estate (and Generation-Skipping Transfer) Tax Return, is an example of this situation. Its Schedules A through U have pages numbered as part of the basic return. For Form 706 to be considered for approval, the entire form, including Schedules A through PC, must be submitted.

2.1.6 Examples of Schedules That Can Be Submitted Separately

However, Schedules C, D, E, and Form 1040 are examples of schedules that can be submitted separately. Although printed by the IRS as a supplement to Form 1040, none of these schedules are required to be filed with Form 1040. These schedules may be separated from Form 1040 and submitted as substitute forms.

2.1.7
Use and Distribution of
Unapproved Forms

The IRS is continuing a program to identify and contact tax return preparers, forms developers, and software publishers who use or distribute unapproved forms that do not conform to this revenue procedure. The use of unapproved forms hinders the processing of the returns.

Section 2.2 – Highlights of Permitted Changes and Requirements

2.2.1
Methods of Reproducing
Internal Revenue Service
Forms

There are methods of reproducing IRS printed tax forms suitable for use as substitutes without prior approval:

- You can photocopy most tax forms and use them instead of the official ones. The entire substitute form, including entries, must be legible.
- You can reproduce any current tax form as cut sheets, snap sets, and marginally punched, pin-fed forms as long as you use an official IRS version as the master copy.
- You can reproduce a form that requires a signature as a valid substitute form. Many tax forms (including returns) have a taxpayer signature requirement as part of the form layout. The jurat/perjury statement/signature line areas must be retained and worded exactly as on the official form. The requirement for a signature, by itself, does not prohibit a tax form from being properly computer generated.

Section 2.3 – Vouchers

2.3.1
Overview

All payment vouchers (Forms 940–V, 941–V, 943–V, 945–V, 1040–ES, 1040–V, 1041–V, and 2290–V) must be reproduced in conjunction with their forms. Substitute vouchers must be the same size as the officially printed vouchers. Vouchers that are prepared for printing on a laser printer may include a scan line.

2.3.2
Scan Line
Specifications

	NNNNNNNNNAA	XXXX	NN	N	NNNNNN	NNN	
Item:	A	B	C	D	E	F	G
A.	Social Security Number/Employer Identification Number (SSN/EIN) has 9 numeric (N) spaces.						
B.	Check Digits have 2 alpha (A) spaces.						
C.	Name Control has 4 alphanumeric (X) spaces.						
D.	Master File Tax (MFT) Code has 2 numeric (N) spaces (see below).						
E.	Taxpayer Identification Number (TIN) Type has 1 numeric (N) space (see below).						
F.	Tax Period has 6 numeric (N) spaces in year/month format (YYYYMM).						
G.	Transaction Code has 3 numeric (N) spaces.						

2.3.3
MFT Code

Code Number for Forms:

- 1040 (family) – 30,
- 940 – 10,
- 941 – 01,
- 943 – 11,
- 944 – 14,
- 945 – 16,
- 1041–V – 05,
- 2290 – 60, and
- 4868 – 30.

2.3.4 TIN Type

Type Number for:

- Form 1040 (family), 4868 – 0, and
 - Forms 940, 941, 943, 944, 945, 1041–V, and 2290 – 2.
-

2.3.5 Voucher Size

The voucher size must be exactly 8.0" x 3.25" (Forms 1040–ES and 1041–ES must be 7.625" x 3.0"). The document scan line must be vertically positioned 0.25 inches from the bottom of the scan line to the bottom of the voucher. The last character on the right of the scan line must be placed 3.5 inches from the right leading edge of the document. The minimum required horizontal clear space between characters is .014 inches. The line to be scanned must have a clear band 0.25 inches in height from top to bottom of the scan line, and from border to border of the document. "Clear band" means no printing except for dropout ink.

2.3.6 Print and Paper Weight

Vouchers must be imaged in black ink using OCR A, OCR B, or Courier 10. These fonts may not be mixed in the scan line. The horizontal character pitch is 10 CPI. The preferred paper weight is 20 to 24 pound OCR bond.

2.3.7 Specifications for Software Developers

Certain vouchers may be reproduced for use in the IRS lockbox system. These include the 1040–V, 1040–ES, 1041–V, the 940 family, and 2290 vouchers. Software developers must follow these specific guidelines to produce scannable vouchers strictly for lockbox purposes. Also see *Exhibit C*:

- The total depth must be 3.25 inches.
- The scan line must be .5 inches from the bottom edge and 1.75 inches from the left edge of the voucher and left-justified.
- Software developers vouchers must be 8.5 inches wide (instead of 8 inches with a cut line). Therefore, no vertical cut line is required.
- Scan line positioning must be exact.
- Do not use the over-the-counter format voucher and add the scan line to it.
- All scanned data must be in 12-point OCR A font.
- The 4-digit NACTP ID code should be placed under the payment indicator arrow.
- Windowed envelopes must not display the scan line in order to avoid disclosure and privacy issues.

Note. All software developers must ensure that their software uses OCR A font so taxpayers will be able to print the vouchers in the correct font.

2.3.8 Specific Line Positions

Follow these line specifications for entering taxpayer data in the lockbox vouchers.

Line Specifications for Taxpayer Data:	Start Row	Start Column	Width	End Column
Taxpayer Name	56	6	36	41
Taxpayer Address, Apt.	57	6	36	41
Taxpayer City, State, ZIP	58	6	36	41
Foreign Country Name	59	6	36	41
Foreign Province/ Country	60	6	17	22
Foreign Postal Code	60	26	16	41
Line Specifications for Mail To Data:				
Mail Name	56	43	38	80
Mail Address	57	43	38	80
Mail City, State, ZIP	58	43	38	80
Line Specifications for: Scan Line	63	26	n/a	n/a

2.3.9 How to Get Approval

To receive approval, please send in 25 voucher samples yearly for each form type or scenarios, by December 12, 2016, for testing to the following address.

Internal Revenue Service
Attn: Doris Bethea, C5-226
5000 Ellin Road
Lanham, MD 20706

For further information, contact Doris Bethea, Doris.E.Bethea@irs.gov, at 240-613-5922.

Section 2.4 – Restrictions on Changes

2.4.1 What You Cannot Do to Forms Suitable for Substitute Tax Forms

You cannot, without prior IRS approval, change any IRS tax form or use your own (non-approved) versions including graphics, unless specifically permitted by this revenue procedure. See *Sections 2.5.7 to 2.5.11*.

You cannot adjust any of the graphics on Forms 1040, 1040A, and 1040EZ (except in those areas specified in *Part 5* of this revenue procedure) without prior approval from the IRS Substitute Forms Unit.

You cannot re-arrange or re-distribute data entry fields, and/or allow data entry fields to flow from one page onto the next (i.e., each page of a substitute form must contain the exact number of data entry fields as there are on the official IRS form). The order and flow of information on the substitute form must be identical to the IRS version of the form. Some reproduced substitute recipient statements can be in different formation, provided that the information required by the regulations is supplied to the recipient. Publications for specific substitute forms will state these allowances.

Note. The 20-day turnaround policy may not apply to extensive changes.

Section 2.5 – Guidelines for Obtaining IRS Approval

2.5.1 Basic Requirements

Preparers who submit substitute privately designed, privately printed, computer-generated, or computer-prepared tax forms must develop these substitutes using the guidelines established in this part. These forms, unless there is an exception outlined by the revenue procedure, must be approved by the IRS before being filed.

2.5.2 Conditional Approval Based on Advanced Drafts

The IRS cannot grant final approval of your substitute form until the official form has been published. However, the IRS posts advance draft forms on its website at: www.irs.gov/app/picklist/list/draftTaxForms.html.

We encourage submission of proposed substitutes of these advance draft forms and will grant conditional approval based solely on these early drafts. These advance drafts are subject to significant change before forms are finalized. If these advance drafts are used as the basis for your substitute forms, you will be responsible for subsequently updating your final forms to agree with the final official version. These revisions need not be resubmitted for further approval.

Note. Approval of forms based on advance drafts will not be granted after the final version of an official form is published.

2.5.3 Submission Procedures

Follow these general guidelines when submitting substitute forms for approval.

- Any alteration of forms must be within the limits acceptable to the IRS. It is possible that, from one filing period to another, a change in law or a change in internal need (processing, audit, compliance, etc.) may change the allowable limits for the alteration of the official form.
 - When approval of any substitute form (other than those exceptions specified in *Part 1, Section 1.2 – IRS Contacts*) is requested, a sample of the proposed substitute form should be emailed for consideration to the Substitute Forms Unit at the address shown in *Section 1.2.1*.
 - Schedules and forms (for example, Forms 3468, 4136, etc.) that can be used with more than one type of return (for example, 1040, 1041, 1120, etc.) should be submitted only once for approval, regardless of the number of different tax returns with which they may be associated. Also, all pages of multi-page forms or returns should be submitted in the same package.
-

2.5.4 Approving Offices

Because only the Substitute Forms Unit is authorized to approve substitute forms, unnecessary delays may occur if forms are sent to the wrong office. You may receive an interim letter about the delay. The Substitute Forms Unit may then coordinate the response with the originator responsible for revising that particular form. Such coordination may include allowing the originator to officially approve the form. No IRS office is authorized to allow deviations from this revenue procedure.

2.5.5 IRS Review of Software Programs, etc.

The IRS does not review or approve the logic of specific software programs, nor does the IRS confirm the calculations on the forms produced by these programs. The accuracy of the program remains the responsibility of the software package developer, distributor, or user.

The Substitute Forms Unit is primarily concerned with the pre-filing quality review of the final forms that are expected to be processed by IRS field offices. For this purpose, you should submit forms without including any taxpayer information such as names, addresses, monetary amounts, etc.

If the software used is programmed to produce copies with populated fields only, then you must use dummy information. This will allow the Unit to review and provide feedback or approval. Vendors should use “0” for all number values and “X” for any information that requires alpha characters.

**2.5.6
When To Send Proposed
Substitutes**

Proposed substitutes, which are required to be submitted per this revenue procedure, should be sent as much in advance of the filing period as possible. This is to allow adequate time for analysis and response.

**2.5.7
Accompanying Statement**

When submitting sample substitutes, you should include an accompanying statement that lists each form number and its changes from the official form (position, arrangement, appearance, line numbers, additions, deletions, etc.). With each of the items you should include a detailed reason for the change.

When requesting approval, please include a check sheet. Check sheets expedite the approval process. The check sheet may look like the example in *Exhibit D* displayed in the back of this procedure or may be one of your own design. Please include your email address on the check sheet. If the Unit will need to fax the check sheet, the number will be requested at that time.

**2.5.8
Approval/Non- Approval
Notice**

The Substitute Forms Unit will email the check sheet or an approval letter to the originator, unless:

- The requester has asked for a faxed response or for a formal letter, or
- Significant corrections to the submitted forms are required.

Notice of approval may impose qualifications before using the substitutes. Notices of unapproved forms may specify the changes required for approval and require re-submission of the form(s) in question. When appropriate, you will be contacted by telephone.

**2.5.9
Duration of Approval**

Most signature tax returns and many of their schedules and related forms have the tax (liability) year printed in the upper right corner. Approvals for these annual forms are usually good for one calendar year (January through December of the year of filing). Quarterly tax forms in the 94X series and Form 720 require approval for any quarter in which the form has been revised.

Because changes are usually made to an annual form every year, each new filing season generally requires a new submission of a substitute form. Very rarely is updating the preprinted year the only change made to an annual form. However, if no significant content, formatting, or layout changes were made to a tax form, then review and approval received for the prior tax year can be carried over into the current tax year.

**2.5.10
Limited Continued Use of
an Approved Change**

Limited changes approved for one tax year may be allowed for the same form in the following tax year. Examples are the use of abbreviated words, revised form spacing, compressed text lines, and shortened captions, etc., which do not change the integrity of lines or text on the official forms.

If substantial changes are made to the form, new substitutes must be submitted for approval. If only minor editorial changes are made to the form, it is not subject to review. It is the responsibility of each vendor who has been granted permission to use substitute forms to monitor and revise forms to mirror any revisions to official forms made by the Service. If there are any questions, please contact the Substitute Forms Unit.

2.5.11 When Approval Is Not Required

If you received approval for a specific change on a form last year, you may make the same change this year if the item is still present on the official form:

- The new substitute form does not have to be submitted to the IRS and approval based on that change is not required.
- However, the new substitute form must conform to the official current year IRS form in other respects: date, Office of Management and Budget (OMB) approval number, attachment sequence number, Paperwork Reduction Act Notice statement, arrangement, item caption, line number, line reference, data sequence, etc.
- The new substitute form must also comply with changes to the guidelines in this revenue procedure. The procedure may have eliminated, added to, or otherwise changed the guideline(s) that affected the change approved in the prior year.
- An approved change is authorized only for the period from a prior tax year substitute form to a current tax year substitute form.

Exception. Forms with temporary, limited, or interim approvals (or with approvals that state a change is not allowed in any other tax year) are subject to review in subsequent years.

2.5.12 Continuous-Use Forms

Forms without preprinted tax years are called “continuous-use” forms. Continuous-use forms are revised when a legislative change affects the form or a change will facilitate processing. These forms frequently have revision dates that are valid for longer than one year.

2.5.13 Required Copies

Generally, you must send us one copy of each form being submitted for approval. However, if you are producing forms for different computer systems (for example, Microsoft compatible vs. Apple) or different types of printers and these forms differ **significantly** in appearance, submit one copy for each type of system or printer.

2.5.14 Requestor’s Responsibility

Following receipt of an initial approval for a substitute forms package or a software output program to print substitute forms, it is the responsibility of the originator (designer or distributor) to provide client firms or individuals with forms that meet the IRS’s requirements for continuing acceptability. Examples of this responsibility include:

- Using the prescribed print paper, font size, legibility, state tax data deletion, etc., and
 - Informing all users of substitute forms of the legal requirements of the Paperwork Reduction Act Notice, which is generally found in the instructions for the official IRS forms.
-

2.5.15 Source Code

The Substitute Forms Unit will assign a unique source code to each firm that submits substitute paper forms for approval. This source code will be a permanent identifier that must be used on every submission by a particular firm.

The source code consists of three alpha characters and should generally be printed under or to the left of the “Paperwork Reduction Act” statement. Vendors must ensure that the source code is not printed too close to or within the left ½ inch margin to avoid the source code from being cut off during printing.

Section 2.6 – Office of Management and Budget (OMB) Requirements for All Substitute Forms

2.6.1 OMB Requirements for All Substitute Forms

There are legal requirements of the Paperwork Reduction Act of 1995 (the Act). Public Law 104–13 requires the following.

- OMB approves all IRS tax forms that are subject to the Act.
 - Each IRS form contains (in the upper right corner) the OMB number, if assigned.
 - Each IRS form (or its instructions) states why the IRS needs the information, how it will be used, and whether or not the information is required to be furnished to the IRS.
- This information must be provided to every user of official or substitute IRS forms or instructions.
-

2.6.2 Application of the Paperwork Reduction Act

On forms that have been assigned OMB numbers:

- All substitute forms must contain in the upper right corner the OMB number that is on the official form, and
 - The required format is: OMB No. 1545-XXXX (Preferred) or OMB # 1545-XXXX (Acceptable).
-

2.6.3 Required Explanation to Users

You must inform the users of your substitute forms of the IRS use and collection requirements stated in the instructions for official IRS forms.

- If you provide your users or customers with the official IRS instructions, each form must retain either the Paperwork Reduction Act Notice (or Disclosure, Privacy Act, and Paperwork Reduction Act Notice), or a reference to it as the IRS does on the official forms (usually in the lower left corner of the forms).
- This notice reads, in part, “We ask for tax return information to carry out the tax laws of the United States...”

Note. If no IRS instructions are provided to users of your forms, the exact text of the Paperwork Reduction Act Notice (or Disclosure, Privacy Act, and Paperwork Reduction Act Notice) must be furnished separately or on the form.

2.6.4 Finding the OMB Number and Paperwork Reduction Act Notice

The OMB number and the Paperwork Reduction Act Notice, or references to it, may be found printed on an official form (or its instructions). The number and the notice are included on the official paper format and in other formats produced by the IRS.

Part 3 Physical Aspects and Requirements

Section 3.1 – General Guidelines for Substitute Forms

3.1.1 General Information

The official form is the standard. Because a substitute form is a variation from the official form, you should know the requirements of the official form for the year of use before you modify it to meet your needs. To obtain the most frequently used tax forms, visit www.irs.gov/orderforms.

3.1.2 Design

Each form must follow the design of the official form as to format arrangement, item caption, line numbers, line references, and sequence.

3.1.3 State Tax Information Prohibited

Generally, state tax information must not appear on the federal tax return, associated form, or schedule that is filed with the IRS. Exceptions occur when amounts are claimed on, or required by, the federal return (for example, state and local income taxes, on Schedule A of Form 1040).

3.1.4 Vertical Alignment of Amount Fields

IF a form is to be...	THEN...
Manually prepared	<ol style="list-style-type: none">1. The entry column must have a vertical line or some type of indicator in the amount field to separate dollars from cents.2. The cents column must be at least ³ 10" wide.
Computer generated	<ol style="list-style-type: none">1. Vertically align the amount entry fields where possible.2. Use one of the following amount formats:<ol style="list-style-type: none">a) 0,000,000, orb) 0,000,000.00.
Computer prepared	<ol style="list-style-type: none">1. You may remove the vertical line in the amount field that separates dollars from cents.2. Use one of the following amount formats:<ol style="list-style-type: none">a) 0,000,000, orb) 0,000,000.00.

3.1.5 Attachment Sequence Number

Many individual income tax forms have a required "attachment sequence number" located just below the year designation in the upper right corner of the form. The IRS uses this number to indicate the order in which forms are to be attached to the tax return for processing. Some of the attachment sequence numbers may change from year to year.

The following applies to computer-prepared forms.

- The sequence number may be printed in no less than 12-point boldface type and centered below the form's year designation.
 - The sequence number may also be placed following the year designation for the tax form and separated with an asterisk.
 - The actual number may be printed without labeling it the "Attachment Sequence Number."
-

3.1.6 Assembly of Forms

When developing software or forms for use by others, please inform your customers/clients that the order in which the forms are arranged may affect the processing of the package. A return must be arranged in the order indicated below.

IF the form is...	THEN the sequence is...
1040	<ul style="list-style-type: none"> ● Form 1040, and ● Schedules and forms in attachment sequence number order.
Any other tax return (Form 1120, 1120S, 1065, 1041, etc.)	<ul style="list-style-type: none"> ● The tax returns, ● Directly associated schedules (Schedule D, etc.), ● Directly associated forms, ● Additional schedules in alphabetical order, and ● Additional forms in numerical order.

Supporting statements should then follow in the same sequence as the forms they support. Additional information required should be attached last.

In this way, the forms are received in the order in which they must be processed. If you do not send returns to the IRS in order, processing may be delayed.

3.1.7 Paid Preparer's Information and Signature Area

On Forms 1040EZ, 1040A, 1040, and 1120, etc., the "Paid Preparer Use Only" area may not be rearranged or relocated. You may, however, add three extra lines to the paid preparer's address area without prior approval. This applies to other tax forms as well.

3.1.8 Some Common Reasons for Requiring Changes to Substitute Forms

Some reasons that substitute form submissions may require changes include the following.

- Failing to preprint certain amounts in entry spaces. Shading areas incorrectly.
- Failing to include a reference to the location of the Paperwork Reduction
- Act Notice.
- Not including parentheses for losses.
- Not including "Attach Statement" when appropriate.
- Including line references or entry spaces that do not match the official form.
- Printing text that is different from the official form.
- Altering the jurat (perjury statement).

Section 3.2 – Paper

3.2.1 Paper Content

The paper must be:

- Chemical wood writing paper that is equal to or better than the quality used for the official form,
- At least 18 pound (17" x 22", 500 sheets), or
- At least 50 pound offset book (25" x 38", 500 sheets).

3.2.2 Paper with Chemical Transfer Properties

There are several kinds of paper prohibited for substitute forms. These are:

1. Carbon-bonded paper, and
2. Chemical transfer paper except when the following specifications are met:
 - a. Each ply within the chemical transfer set of forms must be labeled, and
 - b. Only the top ply (ply one and white in color), the one that contains chemical on the back only (coated back), may be filed with the IRS.

3.2.3 Example

A set containing three plies would be constructed as follows: ply one (coated back), “Federal Return, File with IRS”; ply two (coated front and back), “Taxpayer’s copy”; and ply three (coated front), “Preparer’s copy.”

The file designation, “Federal Return, File with IRS” for ply one, must be printed in the bottom right margin (just below the last line of the form) in 12-point boldface type.

It is not mandatory, but recommended, that the file designation “Federal Return, File with IRS” be printed in a contrasting ink for visual emphasis.

3.2.4 Paper and Ink Color

It is preferred that the color and opacity of paper substantially duplicates that of the original form. This means that your substitute must be printed in black ink and may be on white or on the colored paper the IRS form is printed on. Forms 1040A and 1040 substitute reproductions may be in black ink without the colored shading. The only exception to this rule is Form 1041–ES, which should be printed with a PMS 100 yellow shading in the color screened area. This is necessary to assist us in expeditiously separating this form from the very similar Form 1040–ES.

3.2.5 Page Size

Substitute or reproduced forms and computer-prepared/-generated substitutes may be the same size as the official form or they may be the standard commercial size (8½" x 11"). The thickness of the stock cannot be less than .003 inches.

Section 3.3 – Printing

3.3.1 Printing Medium

The private printing of all substitute tax forms must be by conventional printing processes, photocopying, computer graphics, or similar reproduction processes.

3.3.2 Legibility

All forms must have a high standard of legibility as to printing, reproduction, and fill-in matter. Entries of taxpayer data may be no smaller than eight points. The IRS reserves the right to reject those with poor legibility. The ink and printing method used must ensure that no part of a form (including text, graphics, data entries, etc.) develops “smears” or similar quality deterioration. This standard must be followed for any subsequent copies or reproductions made from an approved master substitute form, either during preparation or during IRS processing.

3.3.3 Type Font

Many federal tax forms are printed using “Helvetica” as the basic type font. It is preferred that you use this type font when composing substitute forms.

3.3.4 Print Spacing

Substitute forms should be printed using a 6 lines/inch vertical print option. They should also be printed horizontally in 10 pitch pica (that is, 10 print characters per inch) or 12 pitch elite (that is, 12 print positions per inch).

3.3.5 Image Size

The image size of a printed substitute form should be as close as possible to that of the official form. You may omit any text on both computer-prepared and computer-generated forms that is solely instructional.

**3.3.6
Title Area Changes**

To allow a large top margin for marginal printing and more lines per page, the title line(s) for all substitute forms (not including the form's year designation and sequence number, when present), may be photographically reduced by 40 percent or reset as one line of type. When reset as one line, the type size may be no smaller than 14-point. You may omit "Department of the Treasury—Internal Revenue Service" and all reference to instructions in the form's title area.

**3.3.7
Remove Government
Printing Office Symbol and
IRS Catalog Number**

When privately printing substitute tax forms, the Government Printing Office (GPO) symbol and/or jacket number must be removed. In the same place using the same type size, print the Employer Identification Number (EIN) of the printer or designer or the IRS assigned source code. (We prefer this last number be printed in the lower left area of the first page of each form.) Also, remove the IRS Catalog Number (Cat. No.) and the recycle symbol if the substitute is not produced on recycled paper.

**3.3.8
Printing on One Side of
Paper**

Even though the IRS uses both sides of the paper for printing official paper forms or schedules, the IRS will accept your forms if only one side of the paper is used.

**3.3.9
Photocopy Equipment**

The IRS does not undertake to approve or disapprove the specific equipment or process used in reproducing official forms. Photocopies of forms must be entirely legible and satisfy the conditions stated in this and other revenue procedures.

**3.3.10
Reproductions**

Reproductions of official forms and substitute forms that do not meet the requirements of this revenue procedure may not be filed instead of the official forms. Illegible photocopies are subject to being returned to the filer for re-submission of legible copies.

**3.3.11
Removal of Instructions**

Generally, you may remove references to instructions. No prior approval is needed. However, in some instances, you may be requested to include references to instructions.

Exception. The words "For Paperwork Reduction Act Notice, see instructions" must be retained, or a similar statement indicating the location of the Notice, must be provided on each form.

Section 3.4 – Margins

**3.4.1
Margin Size**

The format of a reproduced tax form when printed on the page must have margins on all sides at least as large as the margins on the official form. This allows room for IRS employees to make necessary entries on the form during processing.

A 4½-inch to 4¼-inch margin must be maintained across the top, bottom, and both sides of all substitute forms.

- The marginal, perforated strips containing pin-fed holes must be removed from all forms prior to filing with the IRS.

3.4.2 Marginal Printing

Prior approval is not required for the marginal printing allowed when printed on an official form or on a photocopy of an official form.

- With the exception of the actual tax forms (for example, Forms 1040, 1040A, 1040EZ, 1120, 940, 941, etc.), you may print in the left vertical margin and in the left half of the bottom margin.
 - Printing is never allowed in the top right margin of the tax form (for example, Forms 1040, 1040A, 1040EZ, 1120, 940, 941, etc.). The Service uses this area to imprint a Document Locator Number for each return. There are no exceptions to this requirement.
-

Section 3.5 – Examples of Approved Formats

3.5.1 Examples of Approved Formats From the Exhibits

Two sets of exhibits (*Exhibits A–1 and 2; B–1 and 2*) at the end of this revenue procedure are examples of how these guidelines may be used. Vertical spacing is six (6) lines to the inch. A combination of upper-case and lower-case print font is acceptable in producing substitute forms.

The same logic may be applied to any IRS form that is normally reproducible as a substitute form, with the exception of the tax return forms as discussed elsewhere.

Note. These exhibits may be from a prior year and are not to be used as current substitute forms.

Section 3.6 – Miscellaneous Information for Substitute Forms

3.6.1 Filing Substitute Forms

To be acceptable for filing, a substitute form must print out in a format that will allow the filer to follow the same instructions that accompany official forms. The form must be legible, must be on the appropriately sized paper, and must include a jurat (perjury statement) where one appears on the published form.

3.6.2 Caution to Software Publishers

The IRS has received returns produced by software packages with approved output where either the form heading was altered or the lines were spaced irregularly. This produces an illegible or unrecognizable return or a return with the wrong number of pages. We realize that many of these problems are caused by individual printer differences but they may delay input of return data and, in some cases, generate correspondence to the taxpayer. Therefore, in the instructions to the purchasers of your product, both individual and professional, please stress that their returns will be processed more efficiently if they are properly formatted. This includes:

- Having the correct form numbers, six-digit form identifying numbers, and titles at the top of the return, and
 - Submitting the same number of pages as if the form were an official IRS form with the line items on the proper pages.
-

3.6.3 Caution to Producers of Software Packages

If you are producing a software package that generates name and address data onto the tax return, do not under any circumstances program either the IRS preprinted check digits or a practitioner derived name control to appear on any return prepared and filed with the IRS.

3.6.4 Programming to Print Forms

Whenever applicable:

- Use only the following label information format for single filers: JOHN Q. DOE 000 OAK DRIVE HOMETOWN, STATE 00000
- Use only the following information for joint filers: JOHN Q. DOE MARY Q. DOE 000 OAK DRIVE HOMETOWN, STATE 00000

Part 4 Additional Resources

Section 4.1 – Guidance From Other Revenue Procedures

4.1.1 General

The IRS publications listed below provide guidance for substitute tax forms not covered in this revenue procedure. These publications are available on the IRS website. Identify the requested document by the IRS publication number.

- Pub. 1141, General Rules and Specifications for Substitute Forms W-2 and W-3.
- Pub. 1179, Rules and Specifications for Substitute Forms 1096, 1098, 1099, 5498, W-2G, and 1042-S.
- Pub. 1223, General Rules and Specifications for Substitute Forms W-2c and W-3c.
- Pub. 4436, General Rules and Specifications for Substitute Form 941, Schedule B (Form 941), Schedule D (Form 941), and Schedule R (Form 941).
- Pub. 5223, General Rules and Specifications for Affordable Care Act Substitute Forms 1095-A, 1094-B, 1095-B, 1094-C, and 1095-C.

Section 4.2 – Electronic Tax Products

4.2.1 The IRS Website

Copies of tax forms, their instructions, publications, fillable forms, and prior year forms and publications, may be found on the IRS website at www.irs.gov/formspubs.

Draft forms and instructions may be found at www.irs.gov/draftforms.

Other tax-related information may be found at www.irs.gov.

4.2.2 System Requirements and Ordering Forms and Instructions

For system requirements, contact the National Technical Information Service (NTIS) at www.ntis.gov. Prices are subject to change.

You can order IRS forms and other tax material at IRS.gov. Click on the *Forms and Pubs* link and then the *Order Forms and Pubs* link.

Part 5 Requirements for Specific Tax Returns

Section 5.1 – Tax Returns (Forms 1040, 1040A, 1120, etc.)

5.1.1 Acceptable Forms

Tax forms (such as Forms 1040, 1040A, and 1120) require a signature and establish tax liability. Computer-generated versions are acceptable under the following conditions.

- These substitute forms must be printed on plain white paper. Substitute forms must conform to the physical layout of the corresponding IRS form although the typeface may differ. The text should match the text on the officially published form as closely as possible. Condensed text and abbreviations will be considered on a case-by-case basis. **Caution.** All jurats (perjury statements) must be reproduced verbatim. No text can be added, deleted, or changed in meaning.
- Various computer graphic print media such as laser printing, inkjet printing, etc., may be used to produce the substitute forms.
- The substitute form must be the same number of pages and contain the same line text as the official form.
- All substitute forms must be submitted for approval prior to their original use. You do not need approval for a substitute form if its only change is the preprinted year and you had received a prior year approval letter.

Exception. If the approval letter specifies a one-time exception for your form, the next year's form must be approved.

5.1.2 Prohibited Forms

The following are prohibited.

Computer-generated tax forms (for example, Form 1040, etc.) on lined or color barred paper.

Tax forms that differ from the official IRS forms in a manner that makes them non-standard or unable to process.

5.1.3 Changes Permitted to Forms 1040 and 1040A

Certain changes (listed in *Sections 5.2 through 5.4*) are permitted to the graphics of the form without prior approval, but these changes apply to only acceptable preprinted forms. Changes not requiring prior approval are good only for the annual filing period, which is the current tax year. Such changes are valid in subsequent years only if the official form does not change.

5.1.4 Other Changes Not Listed

All changes not listed in *Sections 5.2 through 5.4* require approval from the IRS before the form can be filed.

Section 5.2 – Changes Permitted to Graphics (Forms 1040A and 1040)

5.2.1 Adjustments

You may make minor vertical and horizontal spacing adjustments to allow for computer or word processing printing. This includes widening the amount columns or tax entry areas if the adjustments comply with other provisions stated in revenue procedures. No prior approval is needed for these changes.

5.2.2 Name and Address Area

The horizontal rules and instructions within the name and address area may be removed and the entire area left blank. No line or instruction can remain in the area. The heavy ruled border (when present) that outlines the name, address area, and social security number must not be removed, relocated, expanded, or contracted.

5.2.3 Required Format

When the name and address area is left blank, the following format must be used when printing the taxpayer's name and address.

- 1st name line (35 characters maximum).
- 2nd name line (35 characters maximum).
- In-care-of name line (35 characters maximum).
- City, state (25 characters maximum), one blank character, and ZIP code.

5.2.4 Conventional Name and Address Data

When there is no in-care-of name line, the name and address will consist of only three lines (single filer) or four lines (joint filer). Name and address (joint filer) with no in-care-of name line:

JOHN Q. DOE
MARY Q. DOE
000 ANYWHERE ST., APT. 000
ANYTOWN, STATE 00000

5.2.5 Example of In- Care-Of Name Line

Name and address (single filer) with in-care-of name line:

JOHN Q. DOE
C/O JOHN R. DOE
0000 SOMEWHERE AVE.
SAMETOWN, STATE 00000

5.2.6 SSN and Employer Identification Number (EIN) Area

The broken vertical lines separating the format arrangement of the SSN/EIN may be removed. When the vertical lines are removed, the SSN and EIN formats must be 000-00-0000 or 00-0000000, respectively.

5.2.7 Cents Column

- You may remove the vertical rule that separates the dollars from the cents.
- All entries in the amount column should have a decimal point following the whole dollar amounts whether or not the vertical line that separates the dollars from the cents is present.
- You may omit printing the cents, but all amounts entered on the form must follow a consistent format. You are strongly urged to round off the figures to whole dollar amounts, following the official form instructions.
- When several amounts are summed together, the total should be rounded off after addition (that is, individual amounts should not be rounded off for computation purposes).
- When printing money amounts, you must use one of the following formats: (a) 0,000,000.; (b) 0,000,000.00.
- When there is no entry for a line, leave the line blank.

5.2.8 “Paid Preparer’s Use Only” Area

On all forms, the paid preparer’s information area may not be rearranged or relocated. You may add three lines and remove the horizontal rules in the preparer’s address area.

Section 5.3 – Changes Permitted to Form 1040A Graphics

**5.3.1
General** No prior approval is needed for the following changes (for use with computer-prepared forms only).

**5.3.2
Line 4 of Form 1040A** This line may be compressed horizontally (to allow for same line entry for the name of the qualifying child) by using the following caption: “Head of household; child’s name” (name field).

**5.3.3
Other Lines** Any line with text that takes up two or more vertical lines may be compressed to one line by using contractions, etc., and by removing instructional references.

**5.3.4
Page 2 of Form 1040A** All lines must be present and numbered in the order shown on the official form. These lines may also be compressed.

**5.3.5
Color Screening** It is not necessary to duplicate the color screening used on the official form. A substitute Form 1040A may be printed in black and white only with no color screening.

**5.3.6
Other Changes Prohibited** No other changes to the Form 1040A graphics are allowed without prior approval except for the removal of instructions and references to instructions.

Section 5.4 – Changes Permitted to Form 1040 Graphics

**5.4.1
General** No prior approval is needed for the following changes (for use with computer-prepared forms only). Specific line numbers in the following headings may have changed due to tax law changes.

**5.4.2
Line 4 of Form 1040** This line may be compressed horizontally (to allow for a larger entry area for the name of the qualifying child) by using the following caption: “Head of household; child’s name” (name field).

**5.4.3
Line 6c of Form 1040** The vertical lines separating columns (1) through (4) may be removed. The captions may be shortened to allow a one-line caption for each column.

**5.4.4
Other Lines** Any other line with text that takes up two or more vertical lines may be compressed to one line by using contractions, etc., and by removing instructional references.

**5.4.5
Line 21 – Other Income** The fill-in portion of this line may be expanded vertically to three lines. The amount entry box must remain a single entry.

5.4.6
Line 44 of Form
1040 – Tax

You may change the line caption to read “Tax” and computer print the words “Total includes tax from” and either “Form(s) 8814” or “Form 4972” or “962 election.” If both forms are used, print both form numbers. This specific line number may have changed.

5.4.7
Line 54 of Form
1040 – Other Credits

You may change the caption to read: “Other credits from Form” and computer print only the form(s) that apply.

5.4.8
Color Screening

It is not necessary to duplicate the color screening used on the official form. A substitute Form 1040 may be printed in black and white only with no color screening.

5.4.9
Other Changes Prohibited

No other changes to the Form 1040 graphics are permitted without prior approval except for the removal of instructions and references to instructions.

Part 6
Format and Content of Substitute Returns

Section 6.1 – Acceptable Formats for Substitute Forms and Schedules

6.1.1
Exhibits and Use of
Acceptable Formats

Exhibits of acceptable formats for Schedule A, usually attached to the Form 1040, and Form 2106–EZ are shown in the exhibits section of this revenue procedure.

- If your computer-generated forms appear exactly like the exhibits, no prior authorization is needed.
 - You may computer-generate forms not shown here, but you must design them by following the manner and style of those in the exhibits section.
 - Take care to observe other requirements and conditions in this revenue procedure. The IRS encourages the submission of all proposed forms covered by this revenue procedure.
-

6.1.2
Instructions

The format of each substitute form or schedule must follow the format of the official form or schedule as to item captions, line references, line numbers, sequence, form arrangement and format, etc. Basically, try to make the form look like the official one, with readability and consistency being primary factors. You may use periods and/or other similar special characters to separate the various parts and sections of the form. Do not use alpha or numeric characters for these purposes. All line numbers and items must be printed even though an amount is not entered on the line.

6.1.3
Line Numbers

When a line on an official form is designated by a number or a letter, that designation (reference code) must be used on a substitute form. The reference code must be printed to the left of the text of each line and immediately preceding the data entry field, even if no reference code precedes the data entry field on the official form. If an entry field contains multiple lines and shows the line references once on the left and right side of the form, use the same number of line references on the substitute form.

In addition, the reference code that is immediately before the data field must either be followed by a period or enclosed in parentheses. There also must be at least two blank spaces between the period or the right parenthesis and the first digit of the data field. (See *Section 6.1.4.*)

6.1.4 Decimal Points

A decimal point (that is, a period) should be used for each money amount regardless of whether the amount is reported in dollars and cents or in whole dollars, or whether or not the vertical line that separates the dollars from the cents is present. The decimal points must be vertically aligned when possible.

Example:

5	STATE & LOCAL INC. TAXES.....	5.	000.00
6	REAL ESTATE TAXES.....	6.	
7	PERSONAL PROPERTY TAXES.....	7.	000.00
	or		
5	STATE & LOCAL INC. TAXES.....	(5)	000.00
6	REAL ESTATE TAXES.....	(6)	
7	PERSONAL PROPERTY TAXES.....	(7)	000.00

6.1.5 Multi-Page Forms

When submitting a multi-page form, send all its pages in the same package.

Exception. If you will not be producing certain pages, please note that in your cover letter.

Section 6.2 – Additional Instructions for All Forms

6.2.1 Use of Your Own Internal Control Numbers and Identifying Symbols

You may show the computer-prepared internal control numbers and identifying symbols on the substitute if using such numbers or symbols is acceptable to the taxpayer and the taxpayer's representative. Such information must not be printed in the top ½-inch clear area of any form or schedule requiring a signature. Except for the actual tax return form (Forms 1040, 111D Number on 20, 940, 941, etc.), you may print in the left vertical and bottom left margins. The bottom left margin you may use extends 3½ inches from the left edge of the form. You may print internal control numbers in place of the removed IRS catalog number.

6.2.2 Required Software ID Number (Source Code) on Computer- Prepared Substitutes

In the February 2009 Government Accountability Office (GAO) report, "Many Taxpayers Rely on Tax Software and IRS Needs to Assess Associated Risks" (GAO-09-297), GAO recommended that IRS require a software identification number on all individual returns to specifically identify the software package used to prepare each tax return. IRS already has this capability for all e-filed returns. In addition, many tax preparation software firms already print an IRS-issued 3-letter Source Code on paper returns that are generated by their individual tax software. This Source Code was assigned when the firms were seeking substitute forms approval under this current publication.

In order to respond properly to this GAO recommendation, the IRS will require all tax preparation software firms to include the 3-letter Source Code on all paper tax returns created by their individual tax preparation software. The many firms that currently have and display their Source Code on paper returns generated from their software should continue to do so, and no change is necessary.

We have reviewed all software companies that passed PATS testing last filing season and have determined that some firms do not currently have a Source Code. To save you the burden of contacting us and for your convenience, we have assigned Source Codes to those firms.

You should program your Source Code to be placed in the bottom left-hand corner of page one of each paper form that will be generated by your individual tax return package. You do not need to apply for a new Source Code annually.

If you already use a 3-letter Source Code and we have issued you one in error, you are unsure if you were ever issued one, or have other questions or concerns, you may contact Tax Forms and Publications Special Services Section at substituteforms@irs.gov.

6.2.3
**Descriptions for Captions,
Lines, etc.**

Descriptions for captions, lines, etc., appearing on the substitute forms may be limited to one print line by using abbreviations and contractions, and by omitting articles, prepositions, etc. However, sufficient key words must be retained to permit ready identification of the caption, line, or item.

6.2.4
Determining Final Totals

Explanatory detail and/or intermediate calculations for determining final line totals may be included on the substitute. We prefer that such calculations be submitted in the form of a supporting statement. If intermediate calculations are included on the substitute, the line on which they appear may not be numbered or lettered. Intermediate calculations may not be printed in the right column. This column is reserved only for official numbered and lettered lines that correspond to the ones on the official form. Generally, you may choose the format for intermediate calculations or subtotals on supporting statements to be submitted.

6.2.5
**Instructional Text on the
Official Form**

Text on the official form, which is solely instructional (for example, “See instructions.” etc.), may generally be omitted from the substitute form.

6.2.6
**Mixing Forms on the Same
Page Prohibited**

You may not show more than one form or schedule on the same printout page. Both sides of the paper may be printed for multi-page official forms, but it is unacceptable to intermix single page schedules of forms.

For instance, Schedule E can be printed on both sides of the paper because the official form is multi-page, with page 2 continued on the back. However, do not print Schedule E on the front page and Schedule SE on the back, or Schedule A on the front and Form 8615 on the back, etc. Both pages of a substitute form must match the official form. The back page may be left blank if the back page of the official form contains only the instructions.

6.2.7
Identifying Substitutes

Identify all computer-prepared substitutes clearly. Print the form designation ½ inch from the top margin and 1½ inches from the left margin. Print the title centered on the first line of print. Print the taxable year and, where applicable, the sequence number on the same line ½ inch to 1 inch from the right margin. Include the taxpayer’s name and SSN on all forms and attachments. Also, print the OMB number as reflected on the official form.

6.2.8
Negative Amounts

Negative (or loss) amount entries should be enclosed in brackets or parentheses or include a minus sign. This assists in accurate computation and input of form data. The IRS pre-prints parentheses in negative data fields on many official forms. These parentheses should be retained or inserted on printouts of affected substitute forms.

Part 7
Miscellaneous Forms and Programs

Section 7.1 – Specifications for Substitute Schedules K-1

7.1.1
Requirements for
Schedules K-1 That
Accompany Forms 1041,
1065, 1065–B, and 1120S

Because of significant changes to improve processing, prior approval is now required for substitute Schedules K-1 that accompany Form 1041 (for estates and trusts), Form 1065 (for partnerships), Form 1065–B (for electing large partnerships), or Form 1120S (for S corporations). Substitute Schedules K-1 should be as close as possible to exact replicas of copies of the official IRS schedules and follow the same process for submitting other substitute forms and schedules. Before releasing their substitute forms, software vendors are responsible for making any subsequent changes that have been made to the final official IRS forms after the draft forms have been posted.

You must include all information on the form. Submit Schedules K-1 to the IRS at *substituteforms@irs.gov* with “Attn: PDF Submissions” on the subject line or at:

Internal Revenue Service
Attn: Substitute Forms Program
SE:W:CAR:MP P TP
5000 Ellin Road, C6–440
Lanham, MD 20706

Submit Schedule K-1 forms, in PDF format, to *scrips@irs.gov* for scannability acceptance. IRS will review and provide feedback of any changes needed so that your forms can be recognized correctly.

Include the 6-digit form ID code in the upper right of Schedules K-1 of Forms 1041, 1065, and 1120S. Please allow white space around the 6-digit code.

- 661113 for Form 1041,
- 651113 for Form 1065, and
- 671113 for Form 1120S.

Schedules K-1 that accompany Forms 1041, 1065, 1065–B, or 1120S must meet all specifications. The specifications include, but are not limited to, the following requirements.

- You will no longer be able to produce Schedules K-1 that contain only those lines or boxes that taxpayers are required to use. All lines must be included.
- The words “*See attached statement for additional information.” must be preprinted in the lower right-hand side on Schedules K-1 of Forms 1041, 1065, and 1120S.
- All K-1s that are filed with the IRS should be printed on standard 8.5” x 11” paper (the international standard (A4) of 8.27” x 11.69” may be substituted).
- Each recipient’s information must be on a separate sheet of paper. Therefore, you must separate all continuously printed substitutes, by recipient, before filing with the IRS.
- No carbon copies or pressure-sensitive copies will be accepted.
- The Schedule K-1 must contain the name, address, and SSN or EIN of both the entity (estate, trust, partnership, or S corporation) and the recipient (beneficiary, partner, or shareholder).
- The Schedule K-1 must contain the tax year, the OMB number, the schedule number (K-1), the related form number (1041, 1065, 1065–B, or 1120S), and the official schedule name in substantially the same position and format as shown on the official IRS schedule.
- The Schedule K-1 must contain all the line items as shown on the official form, except for the instructions, if any are printed on the back of the official Schedule K-1.
- The line items or boxes must be in the same order and arrangement as those on the official form.
- The amount of each recipient’s share of each item must be shown. A partial percent should be reflected as a decimal (example: 50½% should be 50.5%). Furnishing a total amount of each item and a percentage (or decimal equivalent) to be applied to such total amount by the recipient does not satisfy the law and the specifications of this revenue procedure.

- State or local tax-related information may not be included on the Schedules K-1 filed with the IRS.
- The entity may have to pay a penalty if substitute Schedules K-1 are filed that do not conform to specifications.
- Additionally, the IRS may consider the Schedules K-1 that do not conform to specifications as not being able to be processed and may return Forms 1041, 1065, 1065-B, or 1120S to the filer to be filed correctly.

Schedules K-1 that are 2-D bar-coded will continue to require prior approval from the IRS (see *Sections 7.1.3 through 7.1.5*).

7.1.2 Special Requirements for Recipient Copies of Schedules K-1

Standardization for reporting information is required for recipient copies of substitute Schedules K-1 of Forms 1041, 1065, 1065-B, and 1120S. Uniform visual standards are provided to increase compliance by allowing recipients and practitioners to more easily recognize a substitute Schedule K-1. The entity must furnish to each recipient a copy of Schedule K-1 that meets the following requirements.

- Include the 6-digit form ID code in the upper right of Schedules K-1 of Forms 1041, 1065, and 1120S. Please allow white space around the 6-digit code.
 - 661113 for Form 1041,
 - 651113 for Form 1065, and
 - 671113 for Form 1120S.
- You will no longer be able to produce Schedules K-1 that contain only those lines or boxes that taxpayers are required to use. All lines must be included.
- The words “*See attached statement for additional information.” must be preprinted in the lower right-hand side on Schedules K-1 of Forms 1041, 1065, and 1120S.
- The Schedule K-1 must contain the name, address, and SSN or EIN of both the entity and recipient.
- The Schedule K-1 must contain the tax year, the OMB number, the schedule number (K-1), the related form number (1041, 1065, 1065-B, or 1120S), and the official schedule name in substantially the same position and format as shown on the official IRS schedule.
- All applicable amounts and information required to be reported must be titled and numbered in the same manner as shown on the official IRS schedule. The line items or boxes must be in the same order and arrangement and must be numbered like those on the official IRS schedule.
- The Schedule K-1 must contain all items required for use by the recipient. The instructions to the schedule must identify the line or box number and code, if any, for each item as shown in the official IRS schedule.
- The amount of each recipient’s share of each item must be shown. A partial percent should be reflected as a decimal (example 50½% should be 50.5%). Furnishing a total amount of each line item and a percentage (or decimal equivalent) to be applied to such total amount by the recipient does not satisfy the law and the specifications of this revenue procedure.
- Instructions to the recipient that are substantially similar to those on or accompanying the official IRS schedule must be provided to aid in the proper reporting of the items on the recipient’s income tax return. Where items are not reported to a recipient because they do not apply, the related instructions may be omitted.
- The quality of the ink or other material used to generate recipients’ schedules must produce clearly legible documents. In general, black chemical transfer inks are preferred.

- In order to assure uniformity of substitute Schedules K-1, the paper size should be standard 8.5" x 11" (the international standard (A4) of 8.27" x 11.69" may be substituted.)
- The paper weight, paper color, font type, font size, font color, and page layout must be such that the average recipient can easily decipher the information on each page. The preferred font is "Helvetica" and a minimal of 10pt. font.
- State or local tax-related information may be included on recipient copies of substitute Schedules K-1. All non-tax-related information should be separated from the tax information on the substitute schedule to avoid confusion for the recipient.
- The legend "Important Tax Return Document Enclosed" must appear in a bold and conspicuous manner on the outside of the envelope that contains the substitute recipient copy of Schedule K-1.
- The entity may have to pay a penalty if a substitute Schedule K-1 furnished to any recipient does not conform to the specifications of this revenue procedure and results in impeding processing.

7.1.3 Requirements for Schedules K-1 with Two- Dimensional (2-D) Bar Codes

Electronic filing is now and will continue to be the preferred method of filing; however, 2-D bar code is the best alternative method for paper processing.

In an effort to improve efficiency and at the same time increase data accuracy, the IRS partnered with the tax software development community on a two-dimensional bar code project in 2003. Certain tax software packages have been modified to generate 2-D bar codes on Schedules K-1. As a result, when K-1s are printed using these programs, a bar code will print on the page.

Rather than manually transcribe information from the Schedule K-1, the IRS will scan the bar code and electronically upload the information from the K-1. The results will be more efficient operation within the IRS and fewer transcription errors for your clients.

Note. If software vendors do not want to produce bar-coded Schedules K-1, they may produce the official IRS Schedules K-1 but cannot use the expedited process for approving bar-coded K-1s and their parent returns as outlined in *Section 7.1.6*.

In addition to the requirements in *Sections 7.1.1 and 7.1.2*, the bar-coded Schedules K-1 must meet the following specifications.

- The bar code should print in the space labeled "For IRS Use Only" on each Schedule K-1. The entire bar code must print within the "For IRS Use Only" box surrounded by a white space of at least 1/4 inch.
- Bar codes must print in PDF 417 format.
- The bar codes must always be in the specified format with every field represented by at least a field delimiter (carriage return). Leaving out a field in a bar code will cause every subsequent field to be misread.
- Be sure to include the 6-digit form ID code in the upper right of Schedules K-1 of Forms 1041, 1065, and 1120S. Please allow white space around the 6-digit code.
 - 661113 for Form 1041,
 - 651113 for Form 1065, and
 - 671113 for Form 1120S.

**7.1.4
2-D Bar Code
Specifications for Schedules
K-1**

Follow these general specifications for preparing all 2-D bar-coded Schedules K-1:

- Numeric fields –
 - Do not include leading zeros (except Taxpayer Identification Numbers, Zip Codes, and percentages).
 - If negative value, the minus sign “-” must be present immediately to the left of the number and part of the 12 position field.
 - Do not use non-numeric characters except that the literal “STMT” can be put in money fields.
 - All money fields should be rounded to the nearest whole dollar amount – if a money amount ends in 00 to 49 cents, drop the cents; if it ends in 50 to 99 cents, truncate the cents and increment the dollar amount by one. Use the same rounding technique for the bar-coded and the printed K-1s.
 - All numeric-only fields are right justified (except Taxpayer Identification Numbers and Zip Codes).
- All field lengths are expressed as maximum lengths. If the value in the field has fewer positions or the software program does not support that many positions, put in the bar code only those positions actually used.
- Alpha fields –
 - Do not include leading blanks (left justified).
 - Do not include trailing blanks.
 - Use uppercase alpha characters only.
- Variable fields –
 - Do not include leading blanks (left justified).
 - Do not include trailing blanks.
 - Use uppercase alpha characters, numerics, and special characters as defined in each field.
- Delimit each field with a carriage return.
- Express percentages as 6-digit numbers without the percent sign. Left justify with leading zero(s) (for percentages less than 100%) and no decimal point (decimal point is assumed between 3rd and 4th positions). Examples: 25.32% expressed as “025320”; 105% expressed as “105000”; 8.275% expressed as “008275”; 10.24674% expressed as “010247”.
- It is vital that the print routine reinitialize the bar code prior to printing each succeeding K-1. Failure to do this will result in each K-1 for a parent return having the same bar code as the document before it.

**7.1.5
Approval Process for
Bar-Coded Schedules K-1**

Prior to releasing commercially available tax software that creates bar-coded Schedules K-1, the printed schedule and the bar code must both be tested. If your company is creating bar-coded Schedules K-1, you must receive certification for both the printed K-1, as well as the bar code before offering your product for sale. Bar-code testing must be done using the final official IRS Schedule K-1. Bar-code approval requests must be resubmitted for any subsequent changes to the official IRS form that would affect the bar code. Below are instructions and a sequence of events that will comprise the testing process.

- The IRS has released the final Schedule K-1 bar-code specifications by publishing them on the IRS.gov website (see www.irs.gov/uac/Schedule-K-1,-Two-Dimensional-Bar-Code-Specifications-and-Certification-Process).
- The IRS will publish a set of test documents that will be used to test the ability of tax preparation software to create bar codes in the correct format.
- Software developers will submit two identical copies of the test documents – one to the IRS and one to a contracted testing vendor. The IRS will use one set to ensure the printed schedules comply with standard substitute forms specifications.

- If the printed forms fail to meet the substitute form criteria, the IRS will inform the software developer of the reason for noncompliance.
- The software developer must resubmit the Schedule(s) K-1 until they pass the substitute forms criteria.
- The testing vendor will review the bar codes to ensure they meet the published bar-code specifications.
- If the bar code(s) does not meet published specifications, the testing vendor will contact the software developer directly informing them of the reason for noncompliance.
- Software developers must submit new bar-coded schedules until they pass the bar-code test.
- When the bar code passes, the testing vendor will inform the IRS that the developer has passed the bar-code test and the IRS will issue an overall approval for both the substitute form and the bar code.
- After receiving this consolidated response, the software vendor is free to release software for tax preparation as long as any subsequent revisions to the schedules do not change the fields.
- Find the mailing address for the testing vendor below. Separate and simultaneous mailings to the IRS and the vendor will reduce testing time.

7.1.6 Procedures for Reducing Testing Time

In order to help provide incentives to the software development community to participate in the Schedule K-1 2-D project, the IRS has committed to expediting the testing of bar-coded Schedules K-1 and their associated parent returns. To receive this expedited service, follow the instructions below.

- Mail the parent returns (Forms 1065, 1120S, 1041) and associated bar-coded Schedule(s) K-1 to the appropriate address below in a separate package from all other approval requests.
Internal Revenue Service
Attn: Bar-Coded K-1
SE:W:CAR:MP:T:M:S, IR 6526
1111 Constitution Avenue, NW
Washington, DC 20224
- Mail one copy of the parent form(s) and Schedule(s) K-1 to the IRS and another copy to the testing vendor at the address below.
Northrop Grumman Information Systems
Attn: Twanna Wiley
7555 Colshire Drive
McLean, VA 22102
Phone: 703-483-5678
- Include multiple email and phone contact points in the packages.
- While the IRS can expedite bar-coded Schedules K-1 and their associated parent returns, it cannot expedite the approval of non-associated tax returns.
- Vendors should comply with all NACTP guidelines especially in regards to mil size and error-correction level.
- Submissions should include vendor ID code printed and in the bar code.
- If a change is made to the bar code after approval, be sure to increment the version number.

Section 7.2 – Guidelines for Substitute Forms 8655

7.2.1 Increased Standardization for Forms 8655

Increased standardization for reporting information on substitute Forms 8655 is now required to aid in processing and for compliance purposes. Please follow the guidelines in *Section 7.2.2*.

7.2.2 Requirements for Substitute Forms 8655

Please follow these specific requirements when producing substitute Forms 8655.

- The first line of the title must be “Reporting Agent Authorization.”
 - If you want to include a reference to “State Limited Power of Attorney,” it can be in parentheses under the title. “State” must be the first word within the parentheses.
 - You must include “Form 8655” on the form.
 - While the line numbers do not have to match the official form, the sequence of the information must be in the same order.
 - The size of any variable data must be printed in a font no smaller than 10-point.
 - For adequate disclosure checks, the following must be included for each taxpayer:
 - Name,
 - EIN, and
 - Address.
 - At this time, Form 944 will not be required if Form 941 is checked. Only those forms that the reporting agent company supports need to be listed.
 - The jurat (perjury statement) must be identical with the exception of references to line numbers.
 - A contact name and number for the reporting agent is not required.
 - You must include line 17, or the equivalent line, and it must include two checkboxes.
 - Any state information included should be contained in a separate section of the substitute form. Preferably this information will be in the same area as line 19 of the official form.
 - All substitute Forms 8655 must be approved by the Substitute Forms Unit as outlined in the Form 8655 specifications in this current publication.
 - If you have not already been assigned a 3-letter Source Code, you will be given one when your substitute form is submitted for approval. This Source Code should be included in the lower left corner of the form.
 - The 20-day assumed approval policy does not apply to Form 8655 approvals.
-

Part 8 Additional Information

Section 8.1 – Forms for Electronically Filed Returns

8.1.1 Electronic Filing Program

Electronic filing is a method by which authorized providers transmit tax return information to an IRS Service Center in the format of the official IRS forms. The IRS accepts both refund and balance due forms that are filed electronically.

8.1.2 Applying to Participate in IRS e-file

Anyone wishing to participate in IRS *e-file* of tax returns must submit an *e-file* application. The application can be completed and submitted electronically on the IRS website at IRS.gov after first registering for e-services on the website.

**8.1.3
Obtaining the Taxpayer
Signature/ Submission of
Required Paper Documents**

Taxpayers choosing to electronically prepare and file their return will be required to use the Self-Select PIN method as their signature.

Electronic Return Originators (EROs) can e-file individual income tax returns only if the returns are signed electronically using either the Self-Select or Practitioner PIN method.

Taxpayers must use Form 8453, U.S. Individual Income Tax Transmittal for an IRS *e-file* Return, to send supporting documents that are required to be submitted to the IRS.

For specific information about electronic filing, refer to Pub. 1345, Handbook for Authorized IRS *e-file* Providers of Individual Income Tax Returns.

**8.1.4
Guidelines for Preparing
Substitute Forms in the
Electronic Filing Program**

A participant in the electronic filing program who wants to develop a substitute form should follow the guidelines throughout this publication and send a sample form for approval to the Substitute Forms Unit at the address in *Part 1*. If you do not prepare Substitute Form 8453 using a font in which all IRS wording fits on a single page, the form will not be accepted.

Note. Use of unapproved forms could result in suspension of the participant from the electronic filing program.

Section 8.2 – Effect on Other Documents

**8.2.1
Effect on Other
Documents**

This revenue procedure supersedes Revenue Procedure 2015–18, 2015–8, I.R.B. 620.

Schedule A (Preferred Format)

Exhibit A-1

SCHEDULE A (Form 1040)

Department of the Treasury
Internal Revenue Service (99)

Itemized Deductions

► Information about Schedule A and its separate instructions is at www.irs.gov/schedulea.
► Attach to Form 1040.

OMB No. 1545-0074

2014

Attachment
Sequence No. **07**

Name(s) shown on Form 1040

Your social security number

Medical and Dental Expenses		Caution. Do not include expenses reimbursed or paid by others.			
1	Medical and dental expenses (see instructions)		1		
2	Enter amount from Form 1040, line 38	2			
3	Multiply line 2 by 10% (.10). But if either you or your spouse was born before January 2, 1950, multiply line 2 by 7.5% (.075) instead		3		
4	Subtract line 3 from line 1. If line 3 is more than line 1, enter -0-			4	
Taxes You Paid		5 State and local (check only one box):			
	a <input type="checkbox"/> Income taxes, or		5		
	b <input type="checkbox"/> General sales taxes				
6	Real estate taxes (see instructions)		6		
7	Personal property taxes		7		
8	Other taxes. List type and amount ►		8		
9	Add lines 5 through 8			9	
Interest You Paid		10 Home mortgage interest and points reported to you on Form 1098	10		
Note. Your mortgage interest deduction may be limited (see instructions).	11 Home mortgage interest not reported to you on Form 1098. If paid to the person from whom you bought the home, see instructions and show that person's name, identifying no., and address ►		11		
	12 Points not reported to you on Form 1098. See instructions for special rules		12		
	13 Mortgage insurance premiums (see instructions)		13		
	14 Investment interest. Attach Form 4952 if required. (See instructions.)		14		
	15 Add lines 10 through 14			15	
Gifts to Charity		16 Gifts by cash or check. If you made any gift of \$250 or more, see instructions	16		
If you made a gift and got a benefit for it, see instructions.	17 Other than by cash or check. If any gift of \$250 or more, see instructions. You must attach Form 8283 if over \$500		17		
	18 Carryover from prior year		18		
	19 Add lines 16 through 18			19	
Casualty and Theft Losses		20 Casualty or theft loss(es). Attach Form 4684. (See instructions.)		20	
Job Expenses and Certain Miscellaneous Deductions		21 Unreimbursed employee expenses—job travel, union dues, job education, etc. Attach Form 2106 or 2106-EZ if required. (See instructions.) ►	21		
	22 Tax preparation fees		22		
	23 Other expenses—investment, safe deposit box, etc. List type and amount ►		23		
	24 Add lines 21 through 23		24		
	25 Enter amount from Form 1040, line 38	25			
	26 Multiply line 25 by 2% (.02)		26		
	27 Subtract line 26 from line 24. If line 26 is more than line 24, enter -0-			27	
Other Miscellaneous Deductions		28 Other—from list in instructions. List type and amount ►		28	
Total Itemized Deductions		29 Is Form 1040, line 38, over \$152,525?		29	
	<input type="checkbox"/> No. Your deduction is not limited. Add the amounts in the far right column for lines 4 through 28. Also, enter this amount on Form 1040, line 40.				
	<input type="checkbox"/> Yes. Your deduction may be limited. See the Itemized Deductions Worksheet in the instructions to figure the amount to enter.				
	30 If you elect to itemize deductions even though they are less than your standard deduction, check here <input type="checkbox"/>				

For Paperwork Reduction Act Notice, see Form 1040 instructions.

Cat. No. 17145C

Schedule A (Form 1040) 2014

Schedule A (Acceptable Format)

Exhibit A-2 SCHEDULE A (Form 1040)

Department of the Treasury
Internal Revenue Service (99)

Itemized Deductions

► Information about Schedule A and its separate instructions is at www.irs.gov/schedulea.
► Attach to Form 1040.

OMB No. 1545-0074

2014
Attachment
Sequence No. **07**

Name(s) shown on Form 1040

Your social security number

Medical and Dental Expenses		Caution. Do not include expenses reimbursed or paid by others.		
1	Medical and dental expenses (see instructions)	1		
2	Enter amount from Form 1040, line 38	2		
3	Multiply line 2 by 10% (.10). But if either you or your spouse was born before January 2, 1950, multiply line 2 by 7.5% (.075) instead	3		
4	Subtract line 3 from line 1. If line 3 is more than line 1, enter -0-	4		
Taxes You Paid		5 State and local (check only one box):		
a	<input type="checkbox"/> Income taxes, or	5		
b	<input type="checkbox"/> General sales taxes	6		
6	Real estate taxes (see instructions)	7		
7	Personal property taxes	8		
8	Other taxes. List type and amount ►	9		
9	Add lines 5 through 8	9		
Interest You Paid		10 Home mortgage interest and points reported to you on Form 1098		
11	Home mortgage interest not reported to you on Form 1098. If paid to the person from whom you bought the home, see instructions and show that person's name, identifying no., and address ►	11		
Note. Your mortgage interest deduction may be limited (see instructions).		12		
12	Points not reported to you on Form 1098. See instructions for special rules	13		
13	Mortgage insurance premiums (see instructions)	14		
14	Investment interest. Attach Form 4952 if required. (See instructions.)	15		
15	Add lines 10 through 14	15		
Gifts to Charity		16 Gifts by cash or check. If you made any gift of \$250 or more, see instructions		
17	Other than by cash or check. If any gift of \$250 or more, see instructions. You must attach Form 8283 if over \$500	17		
18	Carryover from prior year	18		
19	Add lines 16 through 18	19		
Casualty and Theft Losses		20 Casualty or theft loss(es). Attach Form 4684. (See instructions.)		
Job Expenses and Certain Miscellaneous Deductions		21 Unreimbursed employee expenses—job travel, union dues, job education, etc. Attach Form 2106 or 2106-EZ if required. (See instructions.) ►		
22	Tax preparation fees	22		
23	Other expenses—investment, safe deposit box, etc. List type and amount ►	23		
24	Add lines 21 through 23	24		
25	Enter amount from Form 1040, line 38	25		
26	Multiply line 25 by 2% (.02)	26		
27	Subtract line 26 from line 24. If line 26 is more than line 24, enter -0-	27		
Other Miscellaneous Deductions		28 Other—from list in instructions. List type and amount ►		
Total Itemized Deductions		29 Is Form 1040, line 38, over \$152,525?		
		<input type="checkbox"/> No. Your deduction is not limited. Add the amounts in the far right column for lines 4 through 28. Also, enter this amount on Form 1040, line 40.		29
		<input type="checkbox"/> Yes. Your deduction may be limited. See the Itemized Deductions Worksheet in the instructions to figure the amount to enter.		
30 If you elect to itemize deductions even though they are less than your standard deduction, check here				

For Paperwork Reduction Act Notice, see Form 1040 instructions.

Cat. No. 17145C

Schedule A (Form 1040) 2014

Form 2106-EZ (Preferred Format)

Exhibit B-1

Form **2106-EZ**

Department of the Treasury
Internal Revenue Service (99)

Unreimbursed Employee Business Expenses

▶ Attach to Form 1040 or Form 1040NR.

▶ Information about Form 2106 and its separate instructions is available at www.irs.gov/form2106.

OMB No. 1545-0074

2014

Attachment
Sequence No. **129A**

Your name

Occupation in which you incurred expenses

Social security number

You Can Use This Form Only if All of the Following Apply.

- You are an employee deducting ordinary and necessary expenses attributable to your job. An ordinary expense is one that is common and accepted in your field of trade, business, or profession. A necessary expense is one that is helpful and appropriate for your business. An expense does not have to be required to be considered necessary.
- You **do not** get reimbursed by your employer for any expenses (amounts your employer included in box 1 of your Form W-2 are not considered reimbursements for this purpose).
- If you are claiming vehicle expense, you are using the standard mileage rate for 2014.

Caution: You can use the standard mileage rate for 2014 **only if:** (a) you owned the vehicle and used the standard mileage rate for the first year you placed the vehicle in service, **or** (b) you leased the vehicle and used the standard mileage rate for the portion of the lease period after 1997.

Part I Figure Your Expenses

- | | | | | |
|---|---|---|--|--|
| 1 | Complete Part II. Multiply line 8a by 56¢ (.56). Enter the result here | 1 | | |
| 2 | Parking fees, tolls, and transportation, including train, bus, etc., that did not involve overnight travel or commuting to and from work | 2 | | |
| 3 | Travel expense while away from home overnight, including lodging, airplane, car rental, etc. Do not include meals and entertainment | 3 | | |
| 4 | Business expenses not included on lines 1 through 3. Do not include meals and entertainment | 4 | | |
| 5 | Meals and entertainment expenses: \$ _____ × 50% (.50). (Employees subject to Department of Transportation (DOT) hours of service limits: Multiply meal expenses incurred while away from home on business by 80% (.80) instead of 50%. For details, see instructions.) | 5 | | |
| 6 | Total expenses. Add lines 1 through 5. Enter here and on Schedule A (Form 1040), line 21 (or on Schedule A (Form 1040NR), line 7). (Armed Forces reservists, fee-basis state or local government officials, qualified performing artists, and individuals with disabilities: See the instructions for special rules on where to enter this amount.) | 6 | | |

Part II Information on Your Vehicle. Complete this part **only** if you are claiming vehicle expense on line 1.

- 7 When did you place your vehicle in service for business use? (month, day, year) ▶ _____ / _____ / _____
- 8 Of the total number of miles you drove your vehicle during 2014, enter the number of miles you used your vehicle for:
- a Business _____ b Commuting (see instructions) _____ c Other _____
- 9 Was your vehicle available for personal use during off-duty hours? ☐ Yes ☐ No
- 10 Do you (or your spouse) have another vehicle available for personal use? ☐ Yes ☐ No
- 11a Do you have evidence to support your deduction? ☐ Yes ☐ No
- b If "Yes," is the evidence written? ☐ Yes ☐ No

For Paperwork Reduction Act Notice, see your tax return instructions.

Cat. No. 20604Q

Form **2106-EZ** (2014)

Form 2106-EZ (Acceptable Format)

Exhibit B-2

Form **2106-EZ**

Department of the Treasury
Internal Revenue Service (99)

Unreimbursed Employee Business Expenses

▶ Attach to Form 1040 or Form 1040NR.

▶ Information about Form 2106 and its separate instructions is available at www.irs.gov/form2106.

OMB No. 1545-0074

2015

Attachment
Sequence No. **129A**

Your name

Occupation in which you incurred expenses

Social security number

You Can Use This Form Only if All of the Following Apply.

- You are an employee deducting ordinary and necessary expenses attributable to your job. An ordinary expense is one that is common and accepted in your field of trade, business, or profession. A necessary expense is one that is helpful and appropriate for your business. An expense does not have to be required to be considered necessary.
- You **do not** get reimbursed by your employer for any expenses (amounts your employer included in box 1 of your Form W-2 are not considered reimbursements for this purpose).
- If you are claiming vehicle expense, you are using the standard mileage rate for 2015.

Caution: You can use the standard mileage rate for 2015 **only if:** (a) you owned the vehicle and used the standard mileage rate for the first year you placed the vehicle in service, or (b) you leased the vehicle and used the standard mileage rate for the portion of the lease period after 1997.

Part I Figure Your Expenses

1	Complete Part II. Multiply line 8a by 57.5¢ (.575). Enter the result here	1
2	Parking fees, tolls, and transportation, including train, bus, etc., that did not involve overnight travel or commuting to and from work	2
3	Travel expense while away from home overnight, including lodging, airplane, car rental, etc. Do not include meals and entertainment	3
4	Business expenses not included on lines 1 through 3. Do not include meals and entertainment	4
5	Meals and entertainment expenses: \$ _____ × 50% (.50). (Employees subject to Department of Transportation (DOT) hours of service limits: Multiply meal expenses incurred while away from home on business by 80% (.80) instead of 50%. For details, see instructions.)	5
6	Total expenses. Add lines 1 through 5. Enter here and on Schedule A (Form 1040), line 21 (or on Schedule A (Form 1040NR), line 7). (Armed Forces reservists, fee-basis state or local government officials, qualified performing artists, and individuals with disabilities: See the instructions for special rules on where to enter this amount.)	6

Part II Information on Your Vehicle. Complete this part **only** if you are claiming vehicle expense on line 1.

7 When did you place your vehicle in service for business use? (month, day, year) ▶ _____ / _____ / _____

8 Of the total number of miles you drove your vehicle during 2015, enter the number of miles you used your vehicle for:

a Business _____ **b** Commuting (see instructions) _____ **c** Other _____

9 Was your vehicle available for personal use during off-duty hours? ☐ **Yes** ☐ **No**

10 Do you (or your spouse) have another vehicle available for personal use? ☐ **Yes** ☐ **No**

11a Do you have evidence to support your deduction? ☐ **Yes** ☐ **No**

b If "Yes," is the evidence written? ☐ **Yes** ☐ **No**

For Paperwork Reduction Act Notice, see your tax return instructions.

Cat. No. 20604Q

Form **2106-EZ** (2015)

Software Developers Voucher
Exhibit C
Software Developers Voucher

Tear off here

Form 1040-ES Department of the Treasury Internal Revenue Service	2015 Estimated Tax	Payment Voucher 1	OMB No. 1545-0074				
		Calendar year—Due April 15, 2015					
File only if you are making a payment of estimated tax by check or money order. Mail this voucher with your check or money order payable to "United States Treasury." Write your social security number and "2015 Form 1040-ES" on your check or money order. Do not send cash. Enclose, but do not staple or attach, your payment with this voucher.		Amount of estimated tax you are paying by check or money order.	<table border="1"><tr><td>Dollars</td><td>Cents</td></tr><tr><td>0,000</td><td></td></tr></table>	Dollars	Cents	0,000	
		Dollars	Cents				
0,000							
		XXXX					

John Q Doe
000 Someplace Somewhere Blvd.
City, ST 00000

PO BOX 000000
City, ST 00000 - 0000

0000000000 XX DOE 00 0 201512 000

IRS Check Sheet

Exhibit D

Check Sheet of IRS Substitute Forms 20 :

Submitted on

Company:

Contact:

Phone:

Fax:

Source Code:

[illegible]

Authorized Name: _____

Title: _____

Reviewer's Name: _____

Telephone: _____

Date: _____

Rev. Proc. 2015-56

SECTION 1. PURPOSE

This revenue procedure provides certain taxpayers engaged in the trade or business of operating a retail establishment or a restaurant with a safe harbor method of accounting for determining whether expenditures paid or incurred to remodel or refresh a qualified building (as defined in section 4.02) are deductible under § 162(a) of the Internal Revenue Code (Code), must be capitalized as improvements under § 263(a), or must be capitalized as the costs of property produced by the taxpayer for use in its trade or business under § 263A. This revenue procedure also provides procedures for obtaining automatic consent to change to the safe harbor method of accounting permitted by this revenue procedure.

SECTION 2. BACKGROUND

.01 Taxpayers operating in the retail and restaurant industries regularly incur expenditures to remodel or refresh buildings used in the trade or business of selling tangible personal property or services to the general public. A project to remodel or refresh a retail establishment or a restaurant is generally referred to as a “remodel” or a “refresh,” depending on the extent of work performed (collectively referred to as a “remodel-refresh project” as defined in section 4.03). Generally, a retail or restaurant taxpayer undertakes a remodel-refresh project to remain competitive and to improve the customer experience. These projects typically involve a planned undertaking to alter the physical appearance and layout of the building to maintain a contemporary and attractive environment, to more efficiently locate different functions and products, to conform to current industry standards and practices, to standardize the customer experience, to offer the most relevant goods, food, or beverages, and to address changes in demographics by changing offerings and their presentation. Typically, taxpayers also perform routine repairs and

maintenance during a remodel-refresh project.

.02 Section 162 generally allows a deduction for all the ordinary and necessary expenses paid or incurred during the taxable year in carrying on any trade or business, including the costs of repairs and maintenance. Section 263(a) generally requires the capitalization of amounts paid to acquire, produce, or improve tangible property.

.03 Section 1.162-4 allows taxpayers to deduct amounts paid for repairs and maintenance of tangible property if the amounts are not otherwise required to be capitalized. Section 1.263(a)-3 generally requires taxpayers to capitalize amounts paid to improve a unit of property. Section 1.263(a)-3(d) defines improvements as amounts paid that are for a betterment to a unit of property, that restore a unit of property, or that adapt a unit of property to a new or different use. Sections 1.263(a)-3(j), (k), and (l) provide detailed criteria for determining whether amounts fall into any of these categories. Section 1.263(a)-3(e)(2) provides for the application of these criteria to the building unit of property by applying the criteria separately to the building structure and specifically designated building systems.

.04 Although § 1.263(a)-3 provides several examples that apply the improvement criteria and the unit of property rules to remodel or refresh costs, many remodel-refresh projects are more complicated and diverse than the scenarios included in the examples. Because remodel-refresh projects frequently involve work performed on building structures and a variety of building systems, the final tangible property regulations generally require taxpayers performing remodel-refresh projects to apply separate legal analyses to many different components of the building. These analyses become especially difficult in situations where, as part of their remodel-refresh projects, taxpayers adapt portions of space to a new and different use. Moreover, the application of the improvement rules to particular buildings can be complex because remodel-refresh projects vary so much in frequency, quality, and degree. Consequently, taxpayers and the IRS frequently encounter questions regarding whether the costs for a particular remodel-refresh proj-

ect should be characterized as repairs, maintenance, or an improvement of the taxpayers' property, causing taxpayers and the IRS to expend significant resources on this factually intensive issue.

.05 In addition, § 263A requires the capitalization of the direct and allocable indirect costs of real or tangible property produced by a taxpayer for use in its trade or business or acquired for resale. *See also* § 1.263A-1(a)(3)(ii). Section 263A and its regulations apply to a retail or restaurant taxpayer's self-constructed property and, therefore, require the capitalization of the direct and allocable indirect costs of property constructed, built, installed, or improved during a remodel-refresh project. *See* § 1.263A-2(a)(1). Thus, the rules under § 263A require taxpayers to apply an additional analysis to their remodel-refresh projects to determine which costs must be capitalized as the direct or allocable indirect costs of producing property used in their trade or business.

.06 To reduce disputes regarding the deductibility or capitalization of remodel-refresh costs (as defined in section 4.04), this revenue procedure provides a safe harbor approach under which qualified taxpayers (as defined in section 4.01(1)-(3)) may determine the portions of their remodel-refresh costs that may be deducted or must be capitalized for purposes of §§ 162(a), 263(a), and 263A(b)(1). This safe harbor method minimizes the need to perform a detailed factual analysis to determine whether each remodel-refresh cost incurred during a remodel-refresh project is for repair and maintenance under § 1.162-4 or for an improvement under § 1.263(a)-3. In addition, because this safe harbor method is applied to the entire building unit of property, the safe harbor method also eliminates the need to apply these rules separately to each building structure and each building system designated under § 1.263(a)-3(e). Moreover, the safe harbor eases the factual inquiry into whether costs incurred during a remodel-refresh project adapt property to a new or different use, requiring qualified taxpayers to exclude from the safe harbor only amounts that adapt more than 20 percent of the total square footage of the building to a new or different use. Finally, the safe harbor removes the qualified taxpayer's requirement to complete a sepa-

rate analysis under § 263A and the corresponding regulations to determine whether any remodel-refresh costs, including interest, must be capitalized as direct and allocable indirect costs of producing property used in its trade or business.

.07 Section 4 provides definitions for purposes of applying the remodel-refresh safe harbor. This section defines qualified taxpayers, qualified projects, and remodel or refresh costs that are eligible for treatment under the safe harbor. Section 4 also defines excluded remodel-refresh costs for purposes of determining which costs incurred during a qualified project must be excluded in determining the total qualified costs (as defined in section 4.07) subject to the safe harbor. Excluded remodel-refresh costs generally consist of amounts that are clearly characterized as capital expenditures, amounts that are paid for properties that are not part of a qualified building, and amounts that are properly analyzed under Code and regulation provisions outside the context of this revenue procedure. To summarize, the remodel-refresh costs eligible for the safe harbor are the costs incurred in a typical remodel-refresh project for § 1250 property that are often subject to controversy regarding the proper treatment for federal income tax purposes.

.08 Section 5 provides a remodel-refresh safe harbor method. Section 5.02(1) provides the allocation ratio for determining the portion of qualified costs that may be deducted under § 162(a) and the portion that must be capitalized as improvements under § 263(a) or as property produced by the qualified taxpayer for use in its trade or business under § 263A(b)(1). The allocation ratio takes into account non-inventory § 263A costs, amounts that adapt a portion of a qualified building to a new or different use, and losses on the dispositions of relevant building assets (or portions thereof). The allocation ratio is based on an analysis of data compiled from taxpayers, IRS Examination, and IRS Appeals.

.09 Section 5.02(3) provides rules under the remodel-refresh safe harbor for the capitalization, depreciation, and disposition of a qualified building (or a portion thereof) to which the qualified taxpayer

has applied the remodel-refresh safe harbor.

.10 Sections 5.02(4), 5.02(5), and 5.02(6) provide limitations on how the disposition rules may be applied by a qualified taxpayer using the remodel-refresh safe harbor. Because the allocation ratio takes into account losses on the dispositions of relevant building assets (or portions thereof), these limitations exist to ensure that a taxpayer using the remodel-refresh safe harbor does not use the allocation ratio to determine its deductible costs for a remodel-refresh project while also claiming a disposition loss on the related assets disposed of.

.11 Section 1.168(i)-1 provides rules for general asset accounts. Section 1.168(i)-8 provides rules for dispositions of property depreciated under § 168. Sections 1.168(i)-1(e)(2)(viii)(B)(I) and 1.168(i)-8(c)(4)(ii)(A) provide that each building, including its structural components, is the asset for tax disposition purposes, except as otherwise provided in the final disposition regulations. Where a taxpayer places in service an improvement or addition to the building after the original building is placed in service, the improvement or addition is the asset for depreciation and disposition purposes in accordance with §§ 168(i)(6), 1.168(i)-1(e)(2)(viii)(B)(I), and 1.168(i)-8(c)(4)(ii)(D).

.12 Section 1.168(i)-8(d)(2) permits a taxpayer to elect in most cases to treat the disposed portion of an asset as a disposition (for example, the disposition of a roof (or a portion of the roof)) in the taxable year in which the portion is disposed of. If an asset is not included in a general asset account, a taxpayer generally must recognize gain or loss and cease depreciation on the disposition of (1) the asset (for example, the original building, including its structural components, or the building addition or improvement) or (2) a portion thereof for which the taxpayer makes the partial disposition election. *See* § 1.168(i)-8(e). If an asset is included in a general asset account, a taxpayer generally does not realize a loss upon disposition of the asset or a portion thereof, and continues to depreciate the disposed asset or disposed portion of an asset. *See* § 1.168(i)-1(e)(2)(i).

.13 Because the safe harbor allocation ratio takes into account losses on the dispositions of relevant building assets (or portions thereof), section 5.02(4) provides that a qualified taxpayer using the remodel-refresh safe harbor method provided in this revenue procedure may not make the partial disposition election under § 1.168(i)-8(d)(2), Prop. Reg. § 1.168(i)-8(d)(2), section 6.33 of the Appendix of Rev. Proc. 2011-14, 2011-4 I.R.B. 330, as modified by section 3.03(1) of Rev. Proc. 2014-17, 2014-12 I.R.B. 661, 677, and section 3.02(4) of Rev. Proc. 2014-54, 2014-41 I.R.B. 675, 679, or section 6.33 of Rev. Proc. 2015-14, 2015-5 I.R.B. 450, 483, to dispose of a portion of a qualified building, including an asset placed in service and disposed of in a taxable year prior to the year that the safe harbor was utilized by the taxpayer. Section 5.02(4)(b) provides the time and manner of revoking a partial disposition election that is related to a qualified building and made in a prior taxable year. If the taxpayer does not make this revocation, section 5.02(4)(c) provides that the change in method of accounting to utilize the safe harbor is made on a cut-off basis for the qualified building to which the unrevoked partial disposition election pertains.

.14 In addition, if a qualified taxpayer recognized a gain or loss on the disposition of a component of a qualified building under § 1.168(i)-1T or § 1.168(i)-8T, as applicable, or in a taxable year beginning before January 1, 2012, section 5.02(5) provides that the taxpayer must change its method of accounting to be in accord with § 1.168(i)-1(e)(2)(viii) or § 1.168(i)-8(c)(4) (determination of asset disposed of), as applicable, and must take into account the entire amount of the § 481(a) adjustment in computing taxable income for the year of change. If the taxpayer does not make this change in method of accounting, the remodel-refresh safe harbor provided in this revenue procedure does not apply to any qualified building for which the taxpayer recognized a gain or loss on the disposition of a component under § 1.168(i)-1T or § 1.168(i)-8T, or in a taxable year beginning before January 1, 2012.

.15 Section 5.02(6) provides that a qualified taxpayer using the remodel-

refresh safe harbor method must include in general asset accounts the assets comprised of the capitalized portion of the qualified costs and assets previously placed in service and subject to the remodel-refresh safe harbor method. Section 5.02(6)(d) permits qualified taxpayers utilizing the remodel-refresh safe harbor to make a late general asset account election under § 168(i)(4) and § 1.168(i)-1 for assets previously placed in service and subject to the safe harbor method.

.16 A taxpayer's method for determining whether an amount is deducted or is capitalized is a method of accounting under § 446. Except as otherwise expressly provided in the Code or in Treasury regulations, § 446(e) and § 1.446-1(e)(2) require a taxpayer to secure the consent of the Commissioner of Internal Revenue (Commissioner) before changing a method of accounting for federal income tax purposes. Section 1.446-1(e)(3)(ii) authorizes the Commissioner to prescribe administrative procedures setting forth the limitations, terms, and conditions necessary to permit a taxpayer to obtain consent to change a method of accounting. Section 7 provides the procedures for a qualified taxpayer to obtain automatic consent for a change in method of accounting to use the safe harbor method provided by this revenue procedure.

SECTION 3. SCOPE

.01 *In general.* This revenue procedure applies to a qualified taxpayer as defined in section 4.01 that pays qualified costs defined under section 4.07 in the course of performing a remodel-refresh project defined under section 4.03 on a qualified building defined under section 4.02.

.02 *Exclusions.* This revenue procedure does not apply:

- (1) To excluded remodel-refresh costs defined under section 4.06;
- (2) To de minimis costs defined under section 5.05(1);
- (3) To remodel-refresh costs that, if capitalized, are not depreciated by the qualified taxpayer under § 168;
- (4) To expenditures treated as qualified lessee construction allowances under § 110 and the accompanying regulations;
- (5) If the qualified taxpayer made a partial disposition election under § 1.168(i)-8(d)(2), Prop. Reg. § 1.168(i)-

8(d)(2), section 6.33 of the Appendix of Rev. Proc. 2011-14, or section 6.33 of Rev. Proc. 2015-14 for any portion of a qualified building and the qualified taxpayer has not revoked the partial disposition election within the time and in the manner provided in section 5.02(4)(b)(ii), to qualified costs paid for that qualified building prior to the year of change (as defined in section 3.19 of Rev. Proc. 2015-13, 2015-5 I.R.B. 419, 429 (or its predecessor)) for the change in method of accounting to utilize the remodel-refresh safe harbor. *See* section 5.02(4)(c);

(6) If the qualified taxpayer recognized a gain or loss upon the disposition of a component of a qualified building under § 1.168(i)-1T or § 1.168(i)-8T, or in a taxable year beginning before January 1, 2012, and the qualified taxpayer (i) has not changed its method of accounting (including changes initiated by the IRS) under section 6.38(3)(a) or 6.40(3)(a) of Rev. Proc. 2015-14, 2015-5 I.R.B. 450 (or its predecessor), as applicable, for that qualified building (change in method of accounting to be in accord with § 1.168(i)-1(e)(2)(viii) or § 1.168(i)-8(c)(4) (determination of asset disposed of)) on or before the first taxable year that the qualified taxpayer uses the remodel-refresh safe harbor, and (ii) has not taken the entire amount of the § 481(a) adjustment into account in computing the qualified taxpayer's income for the year of change, to any qualified costs paid for that qualified building prior to the year of change (as defined in section 3.19 of Rev. Proc. 2015-13) for a change made by the qualified taxpayer or the IRS under section 6.38(3)(a) or 6.40(3)(a) of Rev. Proc. 2015-14, as applicable, for that qualified building. *See* section 5.02(5)(b) of this revenue procedure; or

(7) To any direct or allocable indirect costs of acquiring property described in § 1221(a) for resale, and therefore, subject to capitalization under §§ 263A(a)(1)(A) and (b)(2). *See* § 1.263A-3.

.03 *Scope determined at entity level for consolidated groups and pass-through entities.* The determination of whether a qualified taxpayer is within the scope of this revenue procedure is made separately with respect to each member of a consolidated group and with respect to each partnership, S corporation, or trust.

SECTION 4. DEFINITIONS

The following definitions apply solely for the purposes of this revenue procedure:

.01 *Qualified taxpayer* means a taxpayer that has an Applicable Financial Statement, as defined in section 4.08, and that—

(1) Is in the trade or business of selling merchandise to customers at retail, for which the taxpayer reports or conducts activities within NAICS codes 44 or 45, except those taxpayers that primarily report or conduct activities within the following codes:

- (a) Code 4411 (automotive dealers);
- (b) Code 4412 (other motor vehicle dealers);
- (c) Code 447 (gas stations);
- (d) Code 45393 (manufactured home dealers); and
- (e) Code 454 (nonstore retailers); or

(2) Is in the trade or business of preparing and selling meals, snacks, or beverages to customer order for immediate on-premises and/or off-premises consumption, for which the taxpayer reports or conducts activities within NAICS code 722 except:

(a) Those taxpayers that are primarily in the trade or business of operating hotels and motels; civic or social organizations; or amusement parks, theaters, casinos, country clubs, or similar recreation facilities; and

(b) Those taxpayers that primarily report or conduct activities within code 7223 (special food services, *i.e.*, food service contractors, caterers, and mobile food services); or

(3) Owns, or leases, a qualified building as defined under section 4.02 that is leased, or sublet, to a taxpayer that meets the requirements of section 4.01(1) or (2) and incurs remodel-refresh costs as defined under section 4.04 .

.02 *Qualified building* means each building unit of property used by a qualified taxpayer primarily for selling merchandise to customers at retail or primarily for preparing and selling food or beverages to customer order for immediate on-premises and/or off-premises consumption. For these purposes, selling merchandise to customers at retail includes the sale of identical goods to resellers if

the sales to resellers are conducted in the same building and in the same manner as retail sales to non-reseller customers (for example, warehouse clubs, home improvement stores). For purposes of this revenue procedure, a building unit of property is comprised of each building, as defined in § 1.48-1(e)(1), and its structural components, as defined in § 1.48-1(e)(2), modified by the following, as applicable:

(1) *Condominium*. In the case of an individual unit in a building with multiple units (such as a condominium), the building unit of property is each individual unit owned by the qualified taxpayer and the structural components that are part of the unit.

(2) *Cooperative*. In the case of an interest in a cooperative housing corporation, the building unit of property is the portion of the building in which the qualified taxpayer has possessory rights and the structural components that are part of the portion of the building subject to the qualified taxpayer's possessory rights.

(3) *Leased building*. In the case of a lease of an entire building to a qualified taxpayer, the building unit of property is the building and its structural components subject to the lease. In the case of a lease of a portion of a building (such as a store, a floor, or certain square footage) to a qualified taxpayer, the building unit of property is the portion of the building and the associated structural components subject to the lease.

.03 *Remodel-refresh project*.

(1) *In general*. A *remodel-refresh project* means a planned undertaking by a qualified taxpayer on a qualified building to alter its physical appearance and/or layout for one or more of the following purposes:

- (a) To maintain a contemporary and attractive appearance;
- (b) To more efficiently locate retail or restaurant functions and products;
- (c) To conform to current retail or restaurant building standards and practices;
- (d) To standardize the consumer experience if a qualified taxpayer operates more than one qualified building;
- (e) To offer the most relevant and popular goods within the industry; or

(f) To address changes in demographics by changing product or service offerings and their presentations.

(2) *Exception*. A remodel-refresh project does not include a planned undertaking solely to repaint or to clean the interior or exterior of an existing qualified building.

.04 *Remodel-refresh costs* mean amounts paid by a qualified taxpayer for remodel, refresh, repair, maintenance, or similar activities performed on a qualified building as part of a remodel-refresh project. See section 4.06 for excluded amounts. For purposes of the remodel-refresh safe harbor method of accounting provided in section 5, remodel-refresh costs are not treated as paid or incurred ("paid"), and therefore are not taken into account, until the taxable year when the capital expenditure portion under the safe harbor, as determined under section 5.02(1), is placed in service within the meaning of § 1.46-3(d)(1)(ii). However, if the qualified building is sold or otherwise disposed of before the capital expenditure portion is placed in service, then the remodel-refresh costs are treated as paid in the taxable year such building is sold or otherwise disposed of. For purposes of this revenue procedure, an amount paid does not include an amount reimbursed to the qualified taxpayer, such as a lessee construction allowance.

.05 *Remodel, refresh, repair, maintenance, or similar activities* include, but are not limited to, the following activities:

- (1) Painting, polishing, or finishing interior walls;
- (2) Adding, replacing, repairing, maintaining, or relocating permanent floor, ceiling, or wall coverings, including millwork;
- (3) Adding, replacing, repairing, maintaining, or relocating kitchen fixtures;
- (4) Adding, replacing, or modifying signage or fixtures;
- (5) Relocating departments, eating areas, check-out areas, kitchen areas, beverage areas, management space, storage space, or similar areas, within the existing footprint of the qualified building;
- (6) Increasing or decreasing the square footage of departments, eating areas, check-out areas, kitchen areas, beverage areas, management space, storage space,

or similar areas within the existing footprint of the qualified building;

(7) Adding, relocating, or removing a room or rooms (for example, dressing rooms, "private" dining space, front office space, or break rooms) within the existing footprint of the qualified building;

(8) Moving, constructing, or altering walls within the existing footprint of the qualified building;

(9) Adding, relocating, removing, replacing, or re-lamping lighting fixtures, or adding reflectors, mirrors, or other similar devices to existing lighting fixtures;

(10) Repairing, maintaining, retrofitting, relocating, adding, or replacing building systems defined in § 1.263(a)-3(e)(2)(ii)(B) within the existing footprint of the qualified building;

(11) Making non-structural changes to exterior facades;

(12) Relocating, replacing, or adding windows or doors (including replacing a manual door with an automatic door) within the existing footprint of the qualified building;

(13) Repairing, maintaining, or replacing the roof or portion of the roof within the existing footprint of the qualified building;

(14) Replacing façade materials around windows and entrances;

(15) Repair and maintenance to the qualified building that directly benefits or is incurred by reason of a remodel-refresh project;

(16) Removal and demolition, other than demolition subject to § 280B, of structural components of a qualified building (for example, insulation, windows, drywall, and similar property) that directly benefit or are incurred by reason of a remodel-refresh project;

(17) Obtaining permits or other similar authorizations that directly benefit or are incurred by reason of a remodel-refresh project; and

(18) Architectural, engineering, and similar services that directly benefit or are incurred by reason of a remodel-refresh project.

.06 *Excluded remodel-refresh costs* mean amounts paid during a remodel-refresh project for—

- (1) Section 1245 property (as defined in § 1245(a)(3));

(2) An intangible under § 1.263(a)-4(b), including the creation or maintenance of computer software;

(3) Land, including nondepreciable land improvements, or depreciable land improvements described in Asset Class 00.3 of Rev. Proc. 87-56, 1987-2 C.B. 674 (for example, sidewalks, parking lots, depreciable landscaping);

(4) The initial acquisition, production, or lease of a qualified building, including purchase price, construction costs, transaction costs, and the costs of work performed prior to the date that the qualified building is initially placed in service by the qualified taxpayer;

(5) The initial build-out of a leased qualified building, or a portion thereof, for a new lessee;

(6) Activities to rebrand a qualified building performed within two taxable years following the closing date of (1) an acquisition or initial lease of the qualified building by the qualified taxpayer or a person related, within the meaning of § 267(b) or § 707(b), to the qualified taxpayer or (2) the acquisition by the qualified taxpayer or a person related, within the meaning of § 267(b) or § 707(b), to the qualified taxpayer of a controlling interest in the qualified building or in a lease of the qualified building;

(7) Activities performed to ameliorate a material condition or defect that existed prior to the qualified taxpayer's acquisition or lease of the qualified building or that arose during the production of the qualified building (generally, an unusual event in the retail or restaurant business), regardless of whether the qualified taxpayer was aware of the condition or defect at the time of acquisition or production;

(8) Material additions to a qualified building, including the building systems defined in § 1.263(a)-3(e)(2)(ii)(B). Solely for purposes of this revenue procedure, *additions* mean enlarging, expanding, or extending the square footage of the qualified building, or enlarging, expanding, or extending the building systems in conjunction with enlarging, expanding, or extending the square footage of the qualified building.

(9) Restoration caused by damage to the qualified building for which the qualified taxpayer is required to take a basis adjustment as a result of a casualty loss

under § 165, or relating to a casualty event described in § 165, subject to the limitation in § 1.263(a)-3(k)(4);

(10) Adapting more than twenty percent (20%) of the total square footage of a qualified building to new or different use or uses, as described in § 1.263(a)-3(l), as part of a remodel-refresh project. For this purpose, square footage is measured based on the total square footage of the qualified building prior to the remodel-refresh project at issue.

(11) Remodel-refresh costs incurred during a temporary closing. A temporary closing is closing the qualified building during normal business hours for more than 21 consecutive calendar days.

(12) The cost of any property for which the qualified taxpayer has claimed a deduction under § 179, § 179D, or § 190.

.07 Qualified costs are the qualified taxpayer's remodel-refresh costs less the qualified taxpayer's excluded remodel-refresh costs. For documentation requirements for the qualified costs, see section 5.02(2).

.08 Applicable Financial Statement means an applicable financial statement defined under § 1.263(a)-1(f)(4). If the qualified taxpayer's financial results are reported on an applicable financial statement defined under § 1.263(a)-1(f)(4) for a group of entities, then for purposes of this revenue procedure and the application of the remodel-refresh safe harbor provided in section 5, the group's applicable financial statement is the applicable financial statement of the qualified taxpayer.

SECTION 5. REMODEL-REFRESH SAFE HARBOR METHOD OF ACCOUNTING

.01 In general. This section 5 provides the remodel-refresh safe harbor method of accounting for a qualified taxpayer within the scope of this revenue procedure. This safe harbor determines the amount of the qualified costs that are deducted under § 162 and the amount of such costs that are required to be capitalized under §§ 263(a) and 263A. The safe harbor also provides for the treatment of the capitalized amount for depreciation and disposition purposes. Except as provided in section 5.02(4)(c) or 5.02(5)(b), the remodel-refresh safe harbor applies to all of the qualified taxpayer's qualified costs paid

(within the meaning of section 4.04) during the taxable year. Except as provided in section 5.02(4)(c) or 5.02(5)(b), a qualified taxpayer within the scope of this revenue procedure who uses the remodel-refresh safe harbor is required to use the method for all of its qualified costs (defined in section 4.07) until the qualified taxpayer secures permission from the IRS to use another method of accounting.

.02 Remodel-refresh safe harbor. To use the remodel-refresh safe harbor, the qualified taxpayer is required to comply with sections 5.02(1), 5.02(2), 5.02(3), 5.02(4), 5.02(5), and 5.02(6).

(1) *Allocation of qualified costs.* The qualified taxpayer must treat 75% of its qualified costs paid during the taxable year as amounts deductible under § 162(a) ("the deduction portion") and must treat the remaining 25% of its qualified costs paid during the taxable year as costs for improvements to a qualified building under § 263(a) and as costs for the production of property for use in the qualified taxpayer's trade or business under § 263A ("the capital expenditure portion").

(2) *Documentation requirements.* A qualified taxpayer utilizing the remodel-refresh safe harbor provided in this section 5 must document its qualified costs in a manner substantially similar to the standard set forth in Appendix A to this revenue procedure.

(3) *Treatment of the capital expenditure portion.*

(a) *Capitalized amounts.* The capital expenditure portion must be charged to capital account.

(b) *Depreciation of capitalized amounts.*

(i) *General rule.* The capital expenditure portion for each qualified building is a separate asset (or separate assets if the remodel-refresh project produces property qualifying under §§ 168(e)(2)(B) and 168(e)(6), (e)(7), or (e)(8)) for depreciation purposes and is depreciated under §§ 167 and 168 beginning when the capital expenditure portion is placed in service by the qualified taxpayer, taking into account the applicable convention under § 168(d). The qualified taxpayer must make an election to include the capital expenditure portion in a general asset account under § 168(i)(4) and § 1.168(i)-1.

See section 5.02(6) for the general asset account election.

(ii) *Classification under § 168(e)*. For purposes of determining the appropriate classification under § 168(e), the capital expenditure portion is treated as qualified leasehold improvement property (as defined in § 168(e)(6)) under § 168(e)(3)(E)(iv), as qualified restaurant property (as defined in § 168(e)(7)) under § 168(e)(3)(E)(v), or as qualified retail improvement property (as defined in § 168(e)(8)) under § 168(e)(3)(E)(ix), as applicable, only to the extent that the qualified taxpayer can substantiate that the capital expenditure portion is qualified leasehold improvement property, qualified restaurant property, or qualified retail improvement property, as applicable. The remaining capital expenditure portion is classified as nonresidential real property under § 168(e)(2)(B). Also, if § 168(e)(3)(E)(iv), (v), or (ix), as applicable, is not in effect when the qualified taxpayer places in service the capital expenditure portion, the capital expenditure portion is classified as nonresidential real property under § 168(e)(2)(B).

(c) *Disposition of capitalized amounts*. The capital expenditure portion for each qualified building is a separate asset (or separate assets if the remodel-refresh project produces property qualifying under §§ 168(e)(2)(B) and 168(e)(6), (e)(7), or (e)(8)) for disposition purposes. See § 1.168(i)-1(e)(2)(viii)(B)(4).

(4) *Limitation on partial disposition elections*.

(a) *General rule*. A qualified taxpayer must not make the partial disposition election under § 1.168(i)-8(d)(2), Prop. Reg. § 1.168(i)-8(d)(2), section 6.33 of the Appendix of Rev. Proc. 2011-14, or section 6.33 of Rev. Proc. 2015-14 for any portion of an original qualified building or any portion of any improvement or addition to an original qualified building.

(b) *Revocation of partial disposition election made in a prior year*.

(i) *General rule*. If a qualified taxpayer made the partial disposition election under § 1.168(i)-8(d)(2), Prop. Reg. § 1.168(i)-8(d)(2), section 6.33 of the Appendix of Rev. Proc. 2011-14, or section 6.33 of Rev. Proc. 2015-14 for any portion of an original qualified building, or any portion of an improvement or addition to an orig-

inal qualified building, prior to the first taxable year that the qualified taxpayer uses the remodel-refresh safe harbor, the qualified taxpayer must revoke that partial disposition election.

(ii) *Time and manner of revoking prior year's partial disposition election*. If, under section 5.02(4)(b)(i), a qualified taxpayer must revoke a partial disposition election, the Commissioner grants the qualified taxpayer consent to revoke that election provided the qualified taxpayer makes this revocation within the time and in the manner described in this section 5.02(4)(b)(ii). The qualified taxpayer may revoke the partial disposition election by filing either:

(A) An amended federal tax return for the taxable year for which the partial disposition election was made if the period of limitations on assessment under § 6501(a) for that taxable year has not expired before the date stated in the next sentence. This amended return must be filed no later than the due date, including extensions, of the qualified taxpayer's federal tax return for the first taxable year that the qualified taxpayer uses the remodel-refresh safe harbor. This amended return must include the adjustment to taxable income for the revocation of the partial disposition election and any collateral adjustments to taxable income or to tax liability (for example, allowable depreciation in that taxable year for the portion of the asset to which the revocation pertains). Such collateral adjustments must also be made on amended federal tax returns for any affected succeeding taxable year; or

(B) A Form 3115, *Application for Change in Accounting Method*, with the qualified taxpayer's timely filed original federal tax return for the qualified taxpayer's first or second taxable year beginning after December 31, 2013. The revocation of the partial disposition election under this section 5.02(4)(b)(ii)(B) will be treated as a change in method of accounting only during this limited period of time. The manner of making this revocation is described in section 7.02(1). This Form 3115 must include under § 481(a) the adjustment to taxable income for the revocation of the partial disposition election and any collateral adjustments to taxable income (for example, allowable depreciation in that taxable year for the portion of

the asset to which the revocation pertains). The qualified taxpayer must take the entire amount of the § 481(a) adjustment into account in computing its taxable income for the year of change.

(c) *Qualified taxpayer does not revoke the partial disposition election*. If, under section 5.02(4)(b)(i), a qualified taxpayer must revoke a partial disposition election but the qualified taxpayer does not make this revocation within the time and in the manner provided in section 5.02(4)(b)(ii), then the change in method of accounting to utilize the remodel-refresh safe harbor is made on a cut-off basis for the qualified building to which the unrevoked partial disposition election pertains.

(5) *Disposition of a component of a qualified building*.

(a) *General rule*. This section 5.02(5) applies to a qualified taxpayer that recognized a gain or loss upon the disposition of a component of a qualified building, a structural component of a qualified building, or a component of such structural component (i) under § 1.168(i)-1T or § 1.168(i)-8T, as applicable, and that component or structural component is not an improvement or addition as described in § 1.168(i)-1T(e)(2)(viii)(B)(5) or § 1.168(i)-8T(c)(4)(ii)(E), as applicable, or (ii) in a taxable year beginning before January 1, 2012, and that component or structural component is MACRS property (as defined in § 1.168(b)-1(a)(2)). If the qualified taxpayer or the IRS changed the qualified taxpayer's method of accounting to be in accord with § 1.168(i)-1(e)(2)(viii) or § 1.168(i)-8(c)(4) (determination of asset disposed of), as applicable, and to make a partial disposition election for such disposition under § 1.168(i)-1, § 1.168(i)-8, Prop. Reg. § 1.168(i)-1, Prop. Reg. § 1.168(i)-8, section 6.33 of the Appendix of Rev. Proc. 2011-14, or section 6.33 of Rev. Proc. 2015-14, as applicable (thereby, for example, changing from recognizing gain or loss under § 1.168(i)-1T or § 1.168(i)-8T, as applicable, to recognizing the gain or loss under § 1.168(i)-1 or § 1.168(i)-8, as applicable, for the partial disposition), section 5.02(4) applies instead of this section 5.02(5).

(b) *Change in method of accounting*. If this section 5.02(5) applies, the qualified taxpayer must (i) change its present

method of accounting to be in accord with § 1.168(i)–1(e)(2)(viii) or § 1.168(i)–8(c)(4) (determination of asset disposed of), as applicable, on or before the first taxable year that the qualified taxpayer uses the remodel-refresh safe harbor, and (ii) take the entire amount of the § 481(a) adjustment into account in computing the qualified taxpayer's taxable income for that year of change. *See* sections 6.38(3)(a) and 6.38(8)(a) of Rev. Proc. 2015–14, 2015–5 I.R.B. 450 (or its successor) (building or structural component), and sections 6.40(3)(a) and 6.40(6)(a) of Rev. Proc. 2015–14 (general asset account). A qualified taxpayer that does not comply with these conditions is not eligible to use the remodel-refresh safe harbor for any qualified costs paid prior to the year of change (for a change made by the qualified taxpayer or the IRS under section 6.38(3)(a) or 6.40(3)(a) of Rev. Proc. 2015–14, as applicable) for the qualified building to which the gain or loss pertains.

(6) *Requirement to use general asset accounts.*

(a) *General rule.* A qualified taxpayer must make a general asset account election under § 168(i)(4) and § 1.168(i)–1(l) to include in a general asset account any asset that is MACRS property and that comprises a qualified building. Thus, a qualified taxpayer must include in general asset accounts:

- (i) The capital expenditure portion;
- (ii) Existing qualified buildings (including their structural components) that are MACRS property (see section 5.02(6)(d) for making a late general asset account election); and
- (iii) Prior years' improvements that are MACRS property and made to a qualified building (even if the qualified building is not MACRS property) (see section 5.02(6)(d) for making a late general asset account election).

(b) *Exception.* If a qualified taxpayer is not eligible to use the remodel-refresh safe harbor for certain qualified costs pursuant to section 5.02(4)(c) or section 5.02(5)(b), the qualified taxpayer is not required to include in general asset accounts:

- (i) The existing qualified building (including its structural components) to which those qualified costs pertain; and

- (ii) Improvements made to that qualified building and placed in service prior to the first taxable year that the qualified taxpayer uses the remodel-refresh safe harbor.

(c) *Establishing general asset accounts.*

(i) *General rule.* In establishing a general asset account, all assets that are MACRS property, that comprise qualified buildings, that are placed in service in the same taxable year, and that meet the requirements in § 1.168(i)–1(c)(2), must be grouped in the same general asset account. However, see section 5.02(6)(c)(ii) for an exception to this general rule.

(ii) *Original qualified buildings (including their structural components).* A qualified taxpayer may include in one general asset account the original cost of an original qualified building, including its original structural components, if such building and structural components are MACRS property and meet the requirements in § 1.168(i)–1(c)(2). If a qualified taxpayer has multiple qualified buildings, the qualified taxpayer may have separate general asset accounts for the original cost of each original qualified building, including the original structural components of that building. Any improvement made to a qualified building cannot be included in the general asset account or accounts permitted under this section 5.02(6)(c)(ii).

(d) *Late general asset account election.* A qualified taxpayer must make a late general asset account election under § 168(i)(4) and § 1.168(i)–1 to include in a general asset account any asset that is MACRS property, that comprises a qualified building, that was placed in service in a taxable year prior to the first taxable year that the qualified taxpayer uses the remodel-refresh safe harbor, and that is owned by the qualified taxpayer at the beginning of the first taxable year that the qualified taxpayer uses the remodel-refresh safe harbor. The qualified taxpayer must make this late election on its original federal tax return for the first taxable year that the qualified taxpayer uses the remodel-refresh safe harbor. The IRS will treat the making of the late general asset account election under this section 5.02(6)(d) as a change in method of accounting under § 446(e). The manner of

making this change in method of accounting is described in section 7.02(2).

(e) *Effect of late election.* By making the general asset account election under section 5.02(6)(d), the qualified taxpayer consents to, and agrees to apply, all of the provisions of § 1.168(i)–1 to the assets included in a general asset account. *See* § 1.168(i)–1(l)(1). Accordingly, if the qualified taxpayer's present methods of accounting are not in accord with § 1.168(i)–1, the qualified taxpayer must change to the methods of accounting permitted under § 1.168(i)–1 no later than the first taxable year that the qualified taxpayer uses the remodel-refresh safe harbor. For example, if the qualified taxpayer's present method of accounting is not in accord with § 1.168(i)–1(e)(2)(viii) (determination of asset disposed of), the qualified taxpayer must change to the appropriate asset as determined under § 1.168(i)–1(e)(2)(viii) by making the change specified in section 6.40(3)(a) of Rev. Proc. 2015–14 no later than the first taxable year that the qualified taxpayer uses the remodel-refresh safe harbor. But if the qualified taxpayer recognized a gain or loss under § 1.168(i)–1T, § 1.168(i)–8T, or in a taxable year beginning before January 1, 2012, as applicable, on the disposition of a portion of the asset (as determined under § 1.168(i)–1(e)(2)(viii)) in a taxable year prior to the year of change, see section 5.02(5)(b).

(f) *Qualifying dispositions.* The cessation, termination, or disposition of an entire qualified building, other than by transfer to a supplies, scrap, or similar account, is a qualifying disposition under § 1.168(i)–1(e)(3)(iii)(B)(3), provided that all other requirements in § 1.168(i)–1(e)(3)(iii)(B) are met. If a lessee terminates the lease for an entire qualified building and irrevocably disposes of or abandons the leasehold improvements associated with that qualified building other than by transfer to a supplies, scrap, or similar account, such disposition is a qualifying disposition under § 1.168(i)–1(e)(3)(iii)(B)(3), provided that all other requirements in § 1.168(i)–1(e)(3)(iii)(B) are met. However, the disposition of an improvement as a result of a remodel-refresh project does not constitute a qualifying disposition under § 1.168(i)–1(e)(3)(iii)(B)(3).

.03 *Applicability of § 263A.* Amounts paid to which the qualified taxpayer applies the remodel-refresh safe harbor are not capitalized separately under § 263A(a)(1)(B) and (b)(1) as a direct or indirect cost of producing property used in the qualified taxpayer's trade or business. However, a qualified taxpayer that produces for sale or acquires for resale property described in § 1221(a) must capitalize separately under § 263A the direct costs of producing or acquiring such property and the property's properly allocable share of indirect costs. See §§ 1.263A-2 and 1.263A-3.

.04 *Treatment of excluded remodel-refresh costs.* Excluded remodel-refresh costs under section 4.06 are not eligible for the remodel-refresh safe harbor. Accordingly, excluded remodel-refresh costs must be deducted or capitalized in accordance with the provisions of the Code and regulations that are otherwise applicable. See, for example, § 1.162-4 (repairs); § 1.263(a)-2 (amounts paid to acquire and produce tangible property); § 1.263(a)-3 (costs to improve units of property); and § 263A (capitalization and inclusion in inventory costs of certain costs). For depreciation and dispositions of excluded remodel-refresh costs that are capital expenditures, see § 168 and §§ 1.168(i)-1 and 1.168(i)-8, as applicable.

.05 *Coordination with other safe harbor methods and elections.*

(1) *Treatment of amounts eligible for safe harbor for small taxpayers under § 1.263(a)-3(h).* A qualified taxpayer that uses the remodel-refresh safe harbor may not elect to apply the safe harbor for small taxpayers under § 1.263(a)-3(h) to amounts paid for repair, maintenance, improvement, or similar activities related to a remodel-refresh project during the taxable year.

(2) *Treatment of amounts eligible for the safe harbor for routine maintenance.* A qualified taxpayer that uses the remodel-refresh safe harbor may not utilize the safe harbor for routine maintenance under § 1.263(a)-3(i) for amounts paid for qualified costs that are subject to the remodel-refresh safe harbor method. This rule does not apply to amounts paid for excluded remodel-refresh costs or amounts not incurred in a remodel-refresh project.

SECTION 6. EXAMPLES

The following examples illustrate the application of this revenue procedure. In each example, it is assumed that V, W, X, and Y are qualified taxpayers within the scope of this revenue procedure, that V, W, X, and Y file their federal income tax returns on a calendar year basis, that they have not elected to apply the de minimis safe harbor under § 1.263(a)-1(f) during such taxable year, and that, unless otherwise stated, they use the remodel-refresh safe harbor method of accounting. It is also assumed that § 110 does not apply to the amounts paid by V, W, X, and Y, that any amounts paid by V, W, X, and Y that qualify as capital expenditures are depreciated under §§ 167 and 168, and that section 5.02(4) and section 5.02(5) do not apply to any of V's, W's, and Y's qualified buildings. The following examples do not address the requirement or computation of the § 481(a) adjustment, if applicable, for purposes of changing the qualified taxpayers' methods of accounting under section 7 of this revenue procedure.

Example 1. (i) V is in the trade or business of operating a nationwide chain of retail stores that sell a variety of retail goods to customers. To maintain a contemporary and attractive environment, to continue to offer the most relevant and popular products, and to reflect the changing demographics of its customers, V periodically undertakes planned projects whereby it incurs amounts to alter the physical appearance and layout of the buildings it uses for its retail sales. These projects often include the remodel, refresh, repair, and maintenance of § 1250 property that is comprised of V's qualified buildings and § 1245 property that is located within these qualified buildings. Each project includes activities such as relocating or changing the square footage of certain departments, check-out areas, storage spaces, and dressing rooms within the footprint of the existing buildings; removing, constructing, and altering walls within the footprint of the existing buildings; moving lighting and replacing lighting fixtures with more efficient lighting; replacing bathroom fixtures with more updated and efficient fixtures; replacing or reconfiguring display tables and racks; patching and repainting interior walls and exterior structures; and replacing floor tiles, ceiling tiles, and signage. These projects also include changes to the electrical systems, HVAC systems, and plumbing systems within the buildings' existing footprints to accommodate the structural changes, new product offerings, and bathroom upgrades. V's retail stores remain open to customers during the project, although parts of the store buildings are closed at different times during the process. In Year 1, V pays \$3 million for these activities to be performed on one of its qualified buildings and places the related property into service. Of the \$3 million, V pays \$1 million for § 1245

property, including new display tables and racks, information kiosks, check-out counters, and other equipment. For Year 1, V files a change in method of accounting to use the remodel-refresh safe harbor method of accounting.

(ii) V's \$3 million project on its building is a remodel-refresh project as described in section 4.03 because V pays amounts to alter the physical appearance and layout of its retail sales building to maintain a contemporary and attractive environment, to continue to offer the most relevant and popular products, and to reflect the changing demographics of its customers. Of the \$3 million remodel-refresh costs paid for the project, \$1 million was paid for § 1245 property, which is treated as excluded remodel-refresh costs under section 4.06(1). Accordingly, under section 4.07 V incurs \$2 million of qualified costs (\$3 million remodel-refresh costs less \$1 million excluded remodel-refresh costs). Under the remodel-refresh safe harbor method of accounting: (A) V treats 75% of the \$2 million qualified costs (\$1,500,000) as amounts deductible under § 162 in Year 1, the taxable year the improvements to the qualified building are placed in service, and V treats the remaining 25% of the \$2 million qualified costs (\$500,000) as improvements to the qualified building that must be capitalized in Year 1 under §§ 263(a) and 263A; (B) V depreciates the \$500,000 of improvements under §§ 167 and 168, and classifies the \$500,000 of improvements under § 168(e) in accordance with section 5.02(3)(b)(ii); and (C) V makes a general asset account election to include the \$500,000 of improvements in a general asset account (or multiple general asset accounts if the costs are for improvements with different recovery periods). Because Year 1 is the first taxable year that V uses the remodel-refresh safe harbor method of accounting, V also must make a late general asset account election to include in general asset accounts all assets that are MACRS property that comprise the qualified building, that are placed in service by V before Year 1, and that are owned by V at the beginning of Year 1. Because the qualified building (including the structural components) is in a general asset account, V would not recognize a loss for, and would continue to depreciate, the amounts allocable to the portions of the building and building systems re-

moved as part of the remodel-refresh project. Finally, to determine the tax treatment of the \$1 million it paid for excluded remodel-refresh costs (costs for § 1245 property), *V* must analyze these costs under §§ 162, 263, and 263A, and the corresponding regulations.

Example 2. Assume the same facts as *Example 1*, except during *V*'s remodel-refresh project, a portion of the \$2 million paid for the project is for constructing an addition to the back of the qualified building to increase its storage and unloading space. This addition materially increases the square footage of the qualified building. The work also involves adding extensions to the electrical system and the HVAC system of the building to provide lighting, power, and ventilation throughout the new space. As part of the material addition to the qualified building, the extensions of the electrical system and HVAC system also constitute material additions. Thus, the amounts paid for these additions, including related removals costs for the previously existing wall and any removed HVAC and electrical system components, are excluded remodel-refresh costs under section 4.06(8) and, as such, are excluded from the qualified costs for purposes of applying the remodel-refresh safe harbor.

For purposes of applying the remodel-refresh safe harbor, *V* must exclude from qualified costs the amount paid for constructing the addition to the back of the qualified building and extending the electrical and HVAC systems through this addition, and these excluded costs must be analyzed separately under §§ 162, 263, and 263A, and the corresponding regulations, and be treated in accordance with those provisions (or any other applicable provisions). However, *V* may apply the remodel-refresh safe harbor method to the amounts in *Example 1* that are qualified costs (\$2 million less the amount paid for constructing the addition to the back of the qualified building and extending the electrical and HVAC systems through this addition). In addition, because the qualified building (including its structural components) is in a general asset account, *V* would not recognize a loss for, and would continue to depreciate, the amounts allocable to the portions of the building, electrical system, and HVAC system removed as part of the remodel-refresh project.

Example 3. Assume the same facts as *Example 1*, except during *V*'s remodel-refresh project, *V* pays \$100,000 (of the \$3 million total) to reinforce the foundation of the qualified building by sealing cracks and adding additional structural support to the building's basement. Beginning prior to the date *V* acquired the qualified building, the building began shifting and sinking as a result of inadequate foundation support. The sealing and addition of structural support in the building's basement consist of activities that ameliorate the inadequate foundation support, a material condition

or defect that existed prior to *V*'s acquisition of the building. Accordingly, the amounts paid by *V* for this work constitute excluded remodel-refresh costs under section 4.06(7) of this revenue procedure and are not included in determining qualified costs for purposes of applying the remodel-refresh safe harbor.

Thus, *V* must exclude the \$100,000 paid to reinforce the foundation of the qualified building from qualified costs, and these excluded costs must be analyzed under §§ 162, 263, and 263A, and corresponding regulations, and treated in accordance with those provisions (or any other applicable provisions). However, *V* may still apply the remodel-refresh safe harbor method to the \$1,900,000 of qualified costs (\$3,000,000 less \$1,100,000). In addition, because the qualified building (including its structural components) is in a general asset account, *V* would not recognize a loss for, and would continue to depreciate, the amounts allocable to the portions of the qualified building removed by reason of this work.

Example 4. Assume the same facts as *Example 1*, except *V* is in the trade or business of operating a nationwide chain of hardware stores that sell a variety of home maintenance and home improvement goods to customers. As a part of *V*'s remodel-refresh project on its qualified building, *V* pays \$80,000 (of the \$3 million total) in Year 1 to add an office suite that uses 20% of the square footage of the qualified building's existing footprint, measured prior to beginning the remodel-refresh project. *V* intends to use this suite to offer home design and architectural services that will be provided in addition to *V*'s primary business of selling retail hardware goods.

Because the addition of the new office suite is part of *V*'s remodel-refresh project and consists of adding rooms within the existing footprint of the building, the amounts paid to construct the office suite constitute remodel-refresh costs under sections 4.04 and 4.05. Moreover, because the addition of the new suite does not expand or extend the square footage of the qualified building and does not adapt more than 20% of the floor space of the qualified building to a new or different use under § 1.263(a)–3(l), the amounts paid to construct the office suite do not constitute excluded remodel-refresh costs under section 4.06(10). Therefore, provided that no other exclusion under section 4.06 applies, the amounts paid to construct the office suite are part of the \$2 million of qualified costs under the remodel-refresh safe harbor method. In addition, because the qualified building (including its structural components) must be placed in a general asset account, *V* would not recognize a loss for, and would continue to de-

preciate, the amounts allocable to the portions of the building and building systems removed as part of the remodel-refresh project.

Example 5. *W* is in the trade or business of operating several restaurants that prepare and sell meals, snacks, and beverages to customer order for immediate on-premises and/or off-premises consumption. *W* periodically undertakes remodel-refresh projects of the buildings it uses for its restaurants. For these projects, which *W* performs every 5 years, *W* qualified for and adopted the remodel-refresh safe harbor method in Year 1. *W* completed the last remodel-refresh project on qualified building *A* in Year 1 and applied the remodel-refresh safe harbor to that remodel-refresh project's qualified costs. In Year 3, *W* experiences climate control problems in the dining area of its qualified building *A* and consults with a contractor to determine the cause. The contractor recommends that *W* replace one of the two roof mounted HVAC units that provide heating and cooling to qualified building *A*. In Year 3, *W* pays amounts to replace one of the HVAC units as recommended by the contractor. Because the replacement of components of the HVAC system in qualified building *A* is not undertaken by *W* to alter the physical appearance or layout of qualified building *A*, the amounts paid for the HVAC component replacement are not remodel-refresh costs as defined under section 4.04. Accordingly, the remodel-refresh safe harbor method does not apply to the amounts paid by *W* to replace the HVAC unit. Rather, *W*'s costs must be analyzed separately under §§ 162, 263, and 263A, and the corresponding regulations, and treated in accordance with those provisions (or any other applicable provisions). In addition, because qualified building *A* and its structural components are in general asset accounts, *W* would not recognize a loss for, and would continue to depreciate, the remaining adjusted basis of the HVAC unit replaced.

Example 6. *X* is in the trade or business of operating a nationwide chain of retail stores that sell a variety of retail goods to customers. *X* periodically undertakes remodel-refresh projects for the buildings it uses for its retail sales. With its federal tax return for the taxable year ended December 31, 2012, *X* filed a Form 3115 to change its method of accounting for dispositions to be in accord with § 1.168(i)–8T(c)(4) and to recognize a loss upon the disposition of the roof of qualified building *B*. In 2015, *X* pays for a remodel-refresh project on qualified building *B*. For the 2013 through 2015 taxable years, *X* did not file a Form 3115 to change its method of accounting to be in accord with § 1.168(i)–8. With its federal tax return for the taxable year ending December 31, 2015, *X* files a Form 3115 to begin using the remodel-refresh safe harbor. Pursuant to section 5.02(5)(b), *X* cannot apply the remodel-refresh safe harbor to the amounts paid for any remodel-refresh project on qualified building *B* before the year of change applicable to a Form 3115 filed by *X* to change its method of accounting to be in accord with § 1.168(i)–8. Therefore, the remodel-refresh safe harbor does not apply to the costs paid in 2015 for the 2015 remodel-refresh project on qualified building *B*.

Example 7. The facts are the same as in *Example 6*, except that *X* files a Form 3115 with its federal tax return for the taxable year ending December 31, 2016, to change its method of accounting to be in accord with § 1.168(i)–8 and takes the entire amount

of the net positive § 481(a) adjustment into account in computing its taxable income for that taxable year. Also, in 2019, X pays for a new remodel-refresh project on qualified building B. Pursuant to section 5.02(5)(b), X cannot apply the remodel-refresh safe harbor to the amounts paid for any remodel-refresh project on qualified building B before the year of change applicable to a Form 3115 filed by X to change its method of accounting to be in accord with § 1.168(i)–8. Therefore, the remodel-refresh safe harbor does not apply to any costs paid before 2016 for any remodel-refresh project on qualified building B. However, X filed the applicable Form 3115 in 2016 and took the entire amount of the net positive § 481(a) adjustment into account in computing its taxable income for that taxable year. Therefore, the remodel-refresh safe harbor applies to the costs paid in 2019 for the 2019 remodel-refresh project on qualified building B.

Example 8. The facts are the same as in *Example 6*, except X filed a Form 3115 with its federal tax return for the taxable year ended December 31, 2014, to change its method of accounting to be in accord with § 1.168(i)–8 and to make a late partial disposition election for the roof of qualified building B. For the 2015 taxable year, X has not revoked such partial disposition election. Pursuant to section 5.02(4)(c), X cannot apply the remodel-refresh safe harbor to the amounts paid for any remodel-refresh project for qualified building B that are paid before the taxable year in which X changes its method of accounting to utilize the remodel-refresh safe harbor. Therefore, the remodel-refresh safe harbor does not apply to the costs paid before 2015 for any remodel-refresh project on qualified building B but does apply to the costs paid in 2015 and subsequent taxable years for any remodel-refresh project on qualified building B.

Example 9. The facts are the same as in *Example 8*, except X files a Form 3115 to begin using the remodel-refresh safe harbor with its federal tax return for the taxable year ending December 31, 2016. Pursuant to section 5.02(4)(c), X cannot apply the remodel-refresh safe harbor to the amounts paid for any remodel-refresh project for qualified building B that are paid before the taxable year in which X changes its method of accounting to utilize the remodel-refresh safe harbor. Therefore, the remodel-refresh safe harbor does not apply to the costs paid before 2016 for any remodel-refresh project on qualified building B but does apply to the costs paid in 2016 and subsequent taxable years for any remodel-refresh project on qualified building B.

Example 10. Y is in the trade or business of operating two restaurants that prepare and sell meals, snacks, and beverages to customer order for immediate on-premises and/or off-premises consumption. The two restaurant buildings that Y uses for preparing and selling food are qualified building E and qualified building F. Y acquired both buildings and placed them in service in March 2007. In February 2010, Y completed a remodel-refresh project on qualified building E and paid \$8 million in qualified costs for that project. At the same time, Y also completed a remodel-refresh project on qualified building F and paid \$4 million in qualified costs for that project. With its federal tax return for the taxable year ended December 31, 2015, Y filed a Form 3115 to begin using the remodel-refresh safe harbor. As a result, for the February 2010 project for qualified building E, Y treats 75% of the \$8 million qualified

costs (\$6 million) as amounts deductible under § 162 and treats the remaining 25% of the \$8 million qualified costs (\$2 million) as improvements to qualified building E that must be capitalized under §§ 263(a) and 263A. In addition, for the February 2010 project for qualified building F, Y treats 75% of the \$4 million qualified costs (\$3 million) as amounts deductible under § 162 and treats the remaining 25% of the \$4 million qualified costs (\$1 million) as improvements to qualified building F that must be capitalized under §§ 263(a) and 263A. On the same Form 3115, Y made a late general asset account (GAA) election to include in general asset accounts the original cost of qualified building E and its \$2 million of improvements and the original cost of qualified building F and its \$1 million of improvements. Qualified buildings E and F and their improvements are nonresidential real property for purposes of § 168. In accordance with section 5.02(6)(c) and § 1.168(i)–1(c)(2), Y establishes three general asset accounts: one for the original cost of qualified building E (GAA #1), one for the original cost of qualified building F (GAA #2), and one for the improvements in the total amount of \$3 million to qualified buildings E and F (GAA #3).

Example 11. The facts are the same as in *Example 10*, except Y sells qualified building F to an unrelated party in 2016. This transaction is a qualifying disposition under § 1.168(i)–1(e)(3)(iii)(B)(3) and section 5.02(6)(f). Also, because GAA #2 includes only one asset, the original qualified building F, Y has disposed of all of the assets in GAA #2. As a result, Y may do the following: (A) elect to apply § 1.168(i)–1(e)(3)(ii) to terminate GAA #2 and recognize gain or loss for GAA #2; and (B) elect to apply § 1.168(i)–1(e)(3)(iii) to remove the improvements for qualified building F (original cost of \$1 million) from GAA #3 and to put such improvements into a single asset account under § 1.168(i)–7, as of January 1, 2016. If Y makes the election under § 1.168(i)–1(e)(3)(iii), Y will recognize gain or loss for the improvements for qualified building F under § 1.168(i)–8.

SECTION 7. CHANGE IN METHOD OF ACCOUNTING

.01 In general. Except as provided in section 7.02(1), a change to the remodel-refresh safe harbor method of accounting provided in section 5.02 for remodel-refresh costs is a change in method of accounting to which the provisions of §§ 446 and 481, and the corresponding regulations, apply. A qualified taxpayer that wants to change to the method of accounting described in this revenue procedure must use the automatic change procedures in Rev. Proc. 2015–13, 2015–5 I.R.B. 419, or its successor, except as otherwise provided in section 7.02.

.02 Automatic change.

(1) Rev. Proc. 2015–14 is modified to add new section 6.43 to read as follows:

6.43 Revocation of partial disposition election under the remodel-refresh safe harbor described in Rev. Proc. 2015–56

(1) *Description of change.*

(a) *Applicability.* This change applies to a qualified taxpayer as defined in section 4.01 of Rev. Proc. 2015–56 and that is within the scope of Rev. Proc. 2015–56 and wants to revoke a partial disposition election, as provided in section 5.02(4)(b)(ii)(B) of Rev. Proc. 2015–56, related to a qualified building, as defined in section 4.02 of Rev. Proc. 2015–56, for which the qualified taxpayer uses the remodel-refresh safe harbor method of accounting provided in section 5.02 of Rev. Proc. 2015–56. See section 10.13 for making a change to this safe harbor method of accounting.

(b) *Inapplicability.* The IRS will treat the revocation of the partial disposition election specified in section 6.43(1)(a) as a change in method of accounting only for the taxable years specified in section 6.43(2). This treatment does not apply to a qualified taxpayer, as described in section 6.43(1)(a), that makes this revocation before or after the time specified in section 6.43(2), and any such revocation is not a change in method of accounting pursuant to § 1.446–1(e)(2)(ii)(d)(3)(iii).

(2) *Time for making the change.* The change under this section 6.43 must be made for the qualified taxpayer's first or second taxable year beginning after December 31, 2013.

(3) *Certain eligibility rules temporarily inapplicable.*

(a) *In general.* The eligibility rules in sections 5.01(1)(d) and (f) of Rev. Proc. 2015–13, 2015–5 I.R.B. 419, do not apply to this change for the qualified taxpayer's first or second taxable year beginning after December 31, 2013.

(b) *Concurrent automatic change.* If a qualified taxpayer makes both a change under this section 6.43 and a change under section 10.13 for its first or second taxable year beginning after December 31, 2013, on a single Form 3115 for the same asset for the same year of change in accordance with section 6.43(6)(b), the eligibility rules in sections 5.01(1)(d) and (f) of Rev. Proc. 2015–13 do not apply to the qualified taxpayer for either change.

(4) *Section 481(a) adjustment period.* A qualified taxpayer making this change must take the entire § 481(a) adjustment into account in computing taxable income for the year of change.

(5) *Reduced filing requirement for qualified small taxpayers.* A qualified small taxpayer, as defined in section 6.01(4)(b), may complete only the following information on Form 3115 (Rev. December 2009):

(a) The identification section of page 1 (above Part I);

(b) The signature section at the bottom of page 1;

(c) Part I, line 1(a);

(d) Part II, all lines except lines 11, 13, 14, 15, and 17;

(e) Part IV, lines 24, 25, and 26; and

(f) Schedule E.

(6) *Concurrent automatic change.*

(a) A qualified taxpayer making this change for more than one asset for the same year of change should file a single Form 3115 for all such assets. The single Form 3115 must provide a single net § 481(a) adjustment for all such changes.

(b) A qualified taxpayer making this change and a change under section 10.13 for the same year of change should file a single Form 3115 for both changes and must enter the designated automatic accounting method change numbers for the changes on the appropriate line on the Form 3115. See section 6.03(1)(b) of Rev. Proc. 2015-13 for information on making concurrent changes.

(7) *Designated automatic accounting method change number.* The designated automatic accounting method change number for a change to the method of accounting under this section 6.43 is “221.”

(8) *Contact information.* For further information regarding a change under this section, contact Elizabeth R. Binder at (202) 317-7003 (not a toll-free number).

(2) Rev. Proc. 2015-14 is modified to add new section 10.13 to read as follows:

10.13 Remodel-refresh safe harbor method.

(1) *Description of change.*

(a) *Applicability.* This change applies to a qualified taxpayer as defined in section 4.01 of Rev. Proc. 2015-56 and within the scope of Rev. Proc. 2015-56 that wants to change to the remodel-refresh safe harbor method of accounting provided in section 5.02 of Rev. Proc. 2015-56 for its qualified costs, including the making of a late general asset account

election as provided under section 5.02(6)(d) of Rev. Proc. 2015-56.

(b) *Inapplicability.* This change does not apply to the following:

(i) The revocation of a partial disposition election that is made pursuant to section 5.02(4)(b)(ii)(B) of Rev. Proc. 2015-56. See section 6.43 for making this revocation;

(ii) A change in determination of the asset disposed of described in section 5.02(5) of Rev. Proc. 2015-56 (which is made under section 6.38(3)(a) or 6.40(3)(a)). See section 10.13(6)(b) for making the change under section 6.38(3)(a) or 6.40(3)(a) as a concurrent change;

(iii) The making of a late general asset account election not provided under section 5.02(6)(d) of Rev. Proc. 2015-56;

(iv) If section 5.02(4)(c) of Rev. Proc. 2015-56 applies to a qualified building (partial disposition election made in a prior year and the qualified taxpayer did not revoke such election within the time and in the manner provided in section 5.02(4)(b)(ii) of Rev. Proc. 2015-56), any qualified costs paid for that qualified building prior to the year of change for a Form 3115 filed to make the change to the remodel-refresh safe harbor method of accounting under this section 10.13; or

(v) If section 5.02(5)(b) of Rev. Proc. 2015-56 applies to a qualified building (recognized gain or loss under § 1.168(i)-1T or § 1.168(i)-8T, or in a taxable year beginning before January 1, 2012, for disposition of a component of a qualified building) and the qualified taxpayer did not make the required change in method of accounting to be in accord with § 1.168(i)-1(e)(2)(viii) or § 1.168-8(c)(4) on or before the first taxable year that the qualified taxpayer uses the remodel-refresh safe harbor and take the entire amount of the § 481(a) adjustment into account in computing the qualified taxpayer's taxable income for that year of change, any qualified costs paid for that qualified building prior to the first taxable year that the qualified taxpayer or the IRS makes the change specified in section 6.38(3)(a) or 6.40(3)(a), as applicable, for that qualified building and takes into account the entire amount of the § 481(a) adjustment in computing taxable income for the year of change.

(2) *Certain eligibility rules inapplicable.*

(a) *In general.* The eligibility rules in sections 5.01(1) (d) and (f) of Rev. Proc. 2015-13, 2015-5 I.R.B. 419, do not apply to a qualified taxpayer that changes to a method of accounting provided under this section 10.13 for its first or second taxable year beginning after December 31, 2013.

(b) *Concurrent automatic change.* If a qualified taxpayer makes both a change under this section 10.13 and a change under section 6.37(3)(b), 6.38(3)(a), and/or 6.40 for its first or second taxable year beginning after December 31, 2013, on a single Form 3115 for the same asset for the same year of change in accordance with section 10.13(7)(b), the eligibility rules in sections 5.01(1) (d) and (f) of Rev. Proc. 2015-13 do not apply to the qualified taxpayer for either change.

(3) *No audit protection.* If section 5.02(4)(c) or 5.02(5)(b) of Rev. Proc. 2015-56 applies to a qualified building (and, in the case of section 5.02(5)(b), the qualified taxpayer does not make the required change on or before the first taxable year that the qualified taxpayer uses the remodel-refresh safe harbor), the qualified taxpayer does not receive audit protection under section 8.01 of Rev. Proc. 2015-13 in connection with this change for that qualified building. See section 8.02(2) of Rev. Proc. 2015-13.

(4) *Manner of making change.*

(a) *Reduced filing requirement for qualified small taxpayers.* A qualified small taxpayer, as defined in section 6.01(4)(b), may complete only the following information on Form 3115 (Rev. December 2009):

(i) The identification section of page 1 (above Part I);

(ii) The signature section at the bottom of page 1;

(iii) Part I, line 1(a);

(iv) Part II, all lines except lines 11, 13, 14, 15, and 17;

(v) Part IV, lines 24, 25, and 26;

(vi) Schedule E; and

(vii) if applicable, the election statement described in section 10.13(4)(b)(ii).

(b) *Late general asset account election.*

(i) *In general.* If under section 5.02(6)(d) of Rev. Proc. 2015-56 the qualified taxpayer is required to make a late general asset account election, the late

general asset account election change is made using a modified cut-off method under which the unadjusted depreciable basis and the depreciation reserve of the asset as of the beginning of the year of change are accounted for using the new method of accounting. The late general asset account election change requires the general asset account to include a beginning balance for both the unadjusted depreciable basis and the depreciation reserve. The beginning balance for the unadjusted depreciable basis of each general asset account is equal to the sum of the unadjusted depreciable bases as of the beginning of the year of change for all assets included in that general asset account. The beginning balance of the depreciation reserve of each general asset account is equal to the sum of the greater of the depreciation allowed or allowable as of the beginning of the year of change for all assets included in that general asset account.

(ii) *Election statement.* The qualified taxpayer (including a qualified small taxpayer) must attach to its Form 3115 a statement providing that the qualified taxpayer agrees to the following additional terms and conditions:

(A) The qualified taxpayer consents to, and agrees to apply, all of the provisions of § 1.168(i)-1 to the assets that are subject to the election specified in section 5.02(6)(d) of Rev. Proc. 2015-56; and

(B) Except as provided in § 1.168(i)-1(c)(1)(iii)(A), (e)(3), (g), or (h), the election made by the qualified taxpayer under section 5.02(6)(d) of Rev. Proc. 2015-56 is irrevocable and will be binding on the qualified taxpayer for computing taxable income for the year of change and for all subsequent taxable years with respect to the assets that are subject to this election.

(c) *Cut-off method required for certain changes.*

(i) If section 5.02(4)(c) of Rev. Proc. 2015-56 applies to a qualified building, the change to the remodel-refresh safe harbor method of accounting for that qualified building, and any improvements to that qualified building, is made using a cut-off method and applies only to qualified costs paid or incurred for that qualified building, and any improvements to that qualified building, beginning in the year of change for the change made to the remodel-refresh safe harbor method of accounting.

(ii) If section 5.02(5)(b) of Rev. Proc. 2015-56 applies to a qualified building and the qualified taxpayer does not change its present method of accounting to be in accord with § 1.168(i)-1(e)(2)(viii) or § 1.168(i)-8(c)(4), as applicable, on or before the first taxable year that the qualified taxpayer used the remodel-refresh safe harbor and take the entire amount of the § 481(a) adjustment into account in computing the qualified taxpayer's taxable income for that year of change, the change to the remodel-refresh safe harbor method of accounting for that qualified building, and any improvements to that qualified building, is made using a cut-off method and applies only to qualified costs paid or incurred for that qualified building, and any improvements to that qualified building, beginning in the year of change for the change made to comply with § 1.168(i)-1(e)(2)(viii) or § 1.168(i)-8(c)(4). See section 6.38(3)(a) and section 6.40(3)(a).

(5) *Section 481(a) adjustment.*

(a) *In general.* A qualified taxpayer changing its method of accounting under this section 10.13 must apply § 481(a) and take into account any applicable § 481(a) adjustment in the manner provided in section 7.03 of Rev. Proc. 2015-13. However, a § 481(a) adjustment is neither required nor permitted for the late general asset account election under section 5.02(6)(d) of Rev. Proc. 2015-56 or, if section 5.02(4)(c) or 5.02(5)(b) of Rev. Proc. 2015-56 applies to a qualified building, and an improvement to a qualified building (and, in the case of section 5.02(5)(b), the qualified taxpayer did not make the required change on or before the first taxable year that the qualified taxpayer uses the remodel-refresh safe harbor), for the change to the remodel-refresh safe harbor method of accounting for that qualified building and an improvement to that qualified building.

(b) *Repair allowance property.* A qualified taxpayer changing to the method of accounting provided under this section 10.13 must not include in the § 481(a) adjustment any amount attributable to property for which the qualified taxpayer elected to apply the repair allowance under § 1.167(a)-11(d)(2) for any taxable year in which the repair allowance election was made.

(c) *Statistical sampling.* A qualified taxpayer changing its method of account-

ing under this section 10.13 may use statistical sampling in determining the § 481(a) adjustment only by following the sampling procedures provided in Rev. Proc. 2011-42, 2011-37 I.R.B. 318.

(6) *Concurrent automatic change.*

(a) A qualified taxpayer making this change for more than one asset for the same year of change should file a single Form 3115 for all such assets. The single Form 3115 must provide a single net § 481(a) adjustment for all such changes.

(b) A qualified taxpayer making this change, a change under section 6.38(3)(a) or 6.43, and any change listed in section 6.37(4)(b) or section 6.40 for the same year of change should file a single Form 3115 for all such changes and must enter the designated automatic accounting method change numbers for the changes on the appropriate line on the Form 3115. See section 6.03(1)(b) of Rev. Proc. 2015-13 for information on making concurrent changes.

(7) *Designated automatic accounting method change number.* The designated automatic accounting method change number for a change to the method of accounting under this section 10.13 is "222."

(8) *Contact information.* For further information regarding a change under this section, contact Elizabeth R. Binder at (202) 317-7003 (not a toll-free number).

SECTION 8. EFFECT ON OTHER DOCUMENTS

Rev. Proc. 2015-14 is modified to include the accounting method changes provided in section 7.02 in sections 6 and 10 of Rev. Proc. 2015-14, as applicable.

SECTION 9. EFFECTIVE DATE

This revenue procedure is effective for taxable years beginning on or after January 1, 2014.

SECTION 10. DRAFTING INFORMATION

The principal author of this revenue procedure is Elizabeth R. Binder of the Office of Associate Chief Counsel (Income Tax & Accounting). For further information regarding this revenue procedure, contact Ms. Binder at (202) 317-7003 (not a toll-free number).

Appendix A

Documentation Standards

In addition to the information required to be included in the Form 3115, qualified taxpayers using the remodel-refresh safe harbor provided by this revenue procedure must document this accounting method with the appropriate books and records, including work papers that identify:

- 1) The total cost of book fixed asset additions placed in service, within the meaning of § 1.46–3(d)(1)(ii), for the taxable year, reconciled to total capital expenditures reported in the qualified taxpayer's Applicable Financial Statement (as defined in § 4.08).
- 2) The total cost of tax fixed asset additions placed in service, within the meaning of § 1.46–3(d)(1)(ii), for the taxable year, after all tax reclassifications for tax depreciation attributes and before application of this revenue procedure to remodel-refresh costs, reconciled to the total cost of book fixed asset additions.
 - The tax depreciation attribute identification should show the adjustments made to determine the adjusted basis of the tax fixed assets under § 1011. In other words, any adjustments required under § 1016 to remodel-refresh costs or excluded remodel-refresh costs for all qualified buildings prior to the following exclusions:
 - (1) Basis adjustments attributable to changes in the qualified taxpayer's definition of units of property made through a prior change in accounting implemented before changing to the method provided in this revenue procedure;
 - (2) Adjustments made as described in § 1016(a)(2) or § 1016(a)(3); and
 - (3) Adjustments made that require tax basis to be reduced before depreciation is computed (for example §§ 179 and 179D; §§ 44 and 50(c)).

The summary work papers should identify the tax fixed asset additions subtotaled for each excluded remodel-refresh cost described in section 4.06. For these purposes, the timing rules provided in section 4.04 apply to determine when the fixed asset additions, including excluded remodel-refresh costs, are taken into account.

The summary work papers should describe the methods and procedures used by the qualified taxpayer to identify the tax fixed assets for the excluded remodel-refresh costs. If excluded remodel-refresh costs are identified by fields within the fixed asset system, the description should list the applicable fixed asset system fields, including, for example, the following:

- Book classification/life;
- Tax classification/life;
- Project identifier;
- Store or restaurant unit identifier;
- Date the store or restaurant is initially placed in service (i.e., new versus existing);
- Date the remodel-refresh project assets are placed in service;
- Capital expenditure request identifier; and,
- Building-type identifier (e.g., retail versus non-retail building; restaurant versus non-restaurant building).

The summary work papers should identify source document references for any applicable documentation outside the fixed asset system needed to account for excluded remodel-refresh costs when the fixed asset system does not include pertinent identifiers. For example, reference to source documentation outside the fixed asset system is necessary if the fixed asset system does not identify whether an asset is related to a restoration caused by damage to a qualified building for which the qualified taxpayer is required to take a basis adjustment as a result of a casualty loss under § 165.

Appendix B

Example Schedule of Qualified Costs Subject to Remodel-Refresh Safe Harbor

Change Between Beginning of Year and End of Year Applicable Financial Statement (“AFS”) Fixed Assets

Beginning of year balance of consolidated U.S. fixed assets*	\$ XXXXXX	
Additions during year:	XXXXX	(1)
Less sales/disposals:	(XXX)	
Other transfers to/from account:	(X)	
End of year balance of consolidated U.S. fixed assets:*	<u>\$ XXXXXX</u>	

AFS Additions Converted to Capitalized Cost Additions for Tax:

(1) Additions during year per AFS:	\$ XXXXX	
Less reductions for all tax reclassifications for tax depreciation attributes:	(XX)	
Capitalized cost additions for tax:	<u>\$ XXXX</u>	(2)

Qualified Costs Subject to Safe Harbor:

(2) Capitalized cost additions for tax:	\$ XXXX
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Less the following excluded remodel-refresh costs for:

Section 1245 property (section 4.06(1))	\$ XX
Intangibles per Reg. § 1.263(a)–4(b) (section 4.06(2))	XX
Land or depreciable land improvements (section 4.06(3))	XX
Initial acquisition, production, or lease of qualified building (section 4.06(4))	XX
The initial build-out of a leased qualified building, or a portion thereof, for a new lessee (section 4.06(5))	XX
Activities performed to rebrand, refresh, remodel, repair, or maintain a qualified building (section 4.06(6))	XX
Activities performed to ameliorate an existing material condition or defect (section 4.06(7))	XX
Material additions to a qualified building (section 4.06(8))	XX
Restoration costs to a damaged qualified building subject to § 165 (section 4.06(9))	XX
Costs to adapt more than 20% of a qualified building to a new or different use (section 4.06(10))	XX
Costs incurred during temporary store or restaurant closings of more than 21 days (section 4.06(11))	XX
Cost of any property for which the qualified taxpayer has claimed a deduction under § 179, § 179D, or § 190 (section 4.06(12))	<u>XX</u>
Total excluded remodel-refresh costs included in AFS additions:	<u>\$ (XX)</u>

Qualified Costs Subject to Safe Harbor:	<u>\$ XXX</u>
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*Amount should reconcile to applicable BOY or EOY AFS balance sheet fixed assets account.

Part IV. Items of General Interest

Correction to Revenue Procedure 2015-51, I.R.B. 2015-42

Announcement 2015-31

This document contains corrections to Revenue Procedure 2015-51, as published on Monday, October 19, 2015 (I.R.B. 2015-42, 583). In particular, this announcement corrects certain specifications for checkboxes on Form W-2 and the address to send sample substitute forms to receive approval from the SSA.

Correction 1:

In **Section 2.1 Specifications for Red-Ink Substitute Form W-2 (Copy AP and Form W-3 Filed with the SSA)**, the measurements under 2.1(11) for the placement of the checkboxes are incorrect.

Section 2.1(11) should read as follows:

11. The checkboxes in box 13 of Form W-2 (Copy A) must be .14 inches each; the space before the first checkbox is .24 inches; the spacing between the three checkboxes is .36 inches; the space after the last checkbox is .32 inches (see Exhibit A). The checkboxes in box b of Form W-3 must also be .14 inches.

Correction 2:

The Room number in the address in **Section 2.2(04)** for sending sample substitute black-and-white Copy A and W-3 forms to the SSA has changed. The address is:

Social Security Administration
Data Operations Center
Attn: Substitute Black-and-White Copy A Forms, Room 341
1150 E. Mountain Drive
Wilkes-Barre, PA 18702-7997

Section 7428(c) Validation of Certain Contributions Made During Pendency of Declaratory Judgment Proceedings

Announcement 2015-32

This announcement serves notice to potential donors that the organization listed below has recently filed a timely declaratory judgment suit under section 7428 of the Code, challenging revocation

of its status as an eligible donee under section 170(c)(2).

Protection under section 7428(c) of the Code begins on the date that the notice of revocation is published in the Internal Revenue Bulletin and ends on the date on which a court first determines that an organization is not described in section 170(c)(2), as more particularly set forth in section 7428(c)(1).

In the case of individual contributors, the maximum amount of contributions protected during this period is limited to \$1,000.00, with a husband and wife being treated as one contributor. This protection is not extended to any individual who was responsible, in whole or in part, for the acts or omissions of the organization that were the basis for the revocation. This protection also applies (but without limitation as to amount) to organizations described in section 170(c)(2) which are exempt from tax under section 501(a). If the organization ultimately prevails in its declaratory judgment suit, deductibility of contributions would be subject to the normal limitations set forth under section 170.

Name of Organization	Date Suit Filed	Effective Date of Revocation	Location
American Housing Foundation	11/19/2014	1/1/2006	Amarillo, TX
Academy of America, a Michigan Non-Profit Corporation	03/25/2015	07/01/2001	Oak Park, MI
International Center For Earth Concerns	12/19/2014	1/1/2008	Ojai, CA
Conservation Endowment Fund	12/19/2014	1/1/2008	Ojai, CA
Taft Foundation	12/19/2014	1/1/2008	Ojai, CA
Educational Assistance Foundation For The Descendants of Hungarian Immigrants in The Performing Arts, Inc.	8/30/2011	12/24/2003	Aventura, FL
The United Fund For The Education Of Russian Immigrant Children In Israel, Inc.	3/10/2014	1/1/2000	Brooklyn, NY

Deletions From Cumulative List of Organizations, Contributions to Which are Deductible Under Section 170 of the Code

Announcement 2015–33

The Internal Revenue Service has revoked its determination that the organizations listed below qualify as organizations described in sections 501(c)(3) and 170(c)(2) of the Internal Revenue Code of 1986.

Generally, the IRS will not disallow deductions for contributions made to a listed organization on or before the date of

announcement in the Internal Revenue Bulletin that an organization no longer qualifies. However, the IRS is not precluded from disallowing a deduction for any contributions made after an organization ceases to qualify under section 170(c)(2) if the organization has not timely filed a suit for declaratory judgment under section 7428 and if the contributor (1) had knowledge of the revocation of the ruling or determination letter, (2) was aware that such revocation was imminent, or (3) was in part responsible for or was aware of the activities or omissions of the organization that brought about this revocation.

If on the other hand a suit for declaratory judgment has been timely filed, con-

tributions from individuals and organizations described in section 170(c)(2) that are otherwise allowable will continue to be deductible. Protection under section 7428(c) would begin on December 07, 2015 and would end on the date the court first determines the organization is not described in section 170(c)(2) as more particularly set for in section 7428(c)(1). For individual contributors, the maximum deduction protected is \$1,000, with a husband and wife treated as one contributor. This benefit is not extended to any individual, in whole or in part, for the acts or omissions of the organization that were the basis for revocation.

NAME OF ORGANIZATION	Effective Date of Revocation	LOCATION
Community Education Foundation	1/1/2008	Baltimore, MD

Relief from Joint and Several Liability

REG–134219–08

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking.

SUMMARY: This document contains proposed regulations relating to relief from joint and several liability under section 6015 of the Internal Revenue Code (Code). The regulations reflect changes in the law made by the Tax Relief and Health Care Act of 2006 as well as changes in the law arising from litigation. The regulations provide guidance to married individuals who filed joint returns and later seek relief from joint and several liability.

DATES: Written or electronic comments and requests for a public hearing must be received by February 18, 2016.

ADDRESSES: Send submissions to: CC:PA:LPD:PR (REG–134219–08), room 5203, Internal Revenue Service, PO Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand-

delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (REG–134219–08), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, N.W., Washington, DC; or sent electronically via the Federal eRulemaking Portal at www.regulations.gov (IRS REG–134219–08).

FOR FURTHER INFORMATION

CONTACT: Concerning the proposed regulations, Nancy Rose at (202) 317-6844; concerning submissions of comments contact Oluwafunmilayo Taylor, (202) 317-6901 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Background

This document contains proposed amendments to the Income Tax Regulations (26 CFR part 1) for relief from joint and several liability under section 6015 of the Code and relief from the operation of state community property law under section 66.

Section 6013(a) permits a husband and wife to file a joint income tax return. Section 6013(d)(3) provides that spouses filing a joint income tax return are jointly and severally liable for liabilities for tax arising from that return. The term “tax”

includes additions to tax, additional amounts, penalties, and interest. See sections 6665(a)(2) and 6601(e)(1). Joint and several liability allows the IRS to collect the entire liability from either spouse who signed the joint return, without regard to whom the items of income, deduction, credit, or basis that gave rise to the liability are attributable. Prior to 1998, section 6013(e) provided limited relief from joint and several liability. In 1998, Congress enacted the Internal Revenue Service Restructuring and Reform Act of 1998, Public Law No. 105–206, 112 Stat. 685 (1998), which repealed section 6013(e) and replaced it with section 6015. Section 6015 applies to liabilities arising after July 22, 1998, and liabilities that arose on or before July 22, 1998, but remained unpaid as of that date.

Section 6015 provides three avenues for relief from joint and several liability — sections 6015(b), (c) and (f). To be eligible for relief from joint and several liability, a spouse must request relief. Under section 6015(b), a requesting spouse may be entitled to relief from joint and several liability for an understatement of tax attributable to erroneous items of the nonrequesting spouse. Section 6015(c) permits a taxpayer who is divorced, sep-

arated, widowed, or who had been living apart from the other spouse for 12 months to allocate his or her tax deficiency between the spouses as if separate returns had been filed. Claims for relief under section 6015(b) and (c) must be made within two years of the IRS's first collection activity against the requesting spouse. Finally, section 6015(f) confers discretion upon the Commissioner to grant equitable relief from joint and several liability for understatements and underpayments, based on all the facts and circumstances. Regulations under section 6015 were first prescribed in TD 9003, **Federal Register** (67 FR 47278) on July 18, 2002.

These proposed amendments are necessary to carry out the provisions of section 6015 and to reflect changes in the law since the publication of TD 9003. On December 20, 2006, Congress enacted the Tax Relief and Health Care Act of 2006, Public Law No. 109-432, div. C, title IV, section 408, 120 Stat. 2922, 3061-62 (2006) (the 2006 Act). The 2006 Act amended section 6015 to provide the United States Tax Court with jurisdiction to review the Commissioner's determination to deny equitable relief under section 6015(f) when the Commissioner has not determined a deficiency and to suspend the period of limitation for collection under section 6502 when relief is requested only under section 6015(f). The proposed regulations also provide clarification and additional guidance on procedural and substantive issues related to the three types of relief from joint and several liability under section 6015.

Section 66 provides relief for a spouse who did not file a joint return in a community property state and did not include in gross income an item of community income that would be attributable solely to the nonrequesting spouse but for the operation of state community property law. Regulations under section 66 were first prescribed in TD 9074, **Federal Register** (68 FR 41067) on July 10, 2003. The proposed regulations under section 66 contain only non-substantive changes.

Recently, other amendments to the regulations under section 6015 were proposed in a notice of proposed rulemaking (REG-132251-11) published in the **Federal Register** (78 FR 49242) on August 13, 2013. Those regulations proposed

changes to § 1.6015-5 to remove the two-year deadline for taxpayers to file requests for equitable relief under section 6015(f), and other changes related to the time and manner for requesting relief. Additionally, on September 16, 2013, the IRS issued Rev. Proc. 2013-34 (2013-2 CB 397). Rev. Proc. 2013-34 revised the factors used in determining if a requesting spouse is eligible for equitable relief under sections 66(c) and 6015(f).

Explanation of Provisions

These regulations propose to make a number of significant changes to the existing regulations. These changes include providing additional guidance on the judicial doctrine of res judicata and the section 6015(g)(2) exception to res judicata when a requesting spouse did not meaningfully participate in a prior court proceeding. The regulations propose to add a list of acts to be considered in making the determination as to whether the requesting spouse meaningfully participated in a prior proceeding and provide examples of the operation of these rules. The regulations also (1) propose a definition of underpayment or unpaid tax for purposes of section 6015(f); (2) provide detailed rules regarding credits and refunds in innocent spouse cases; (3) expand the rule that penalties and interest are not separate items from which relief can be obtained to cases involving underpayments; (4) incorporate an administratively developed rule that attribution of an erroneous item follows the attribution of the underlying item that caused the increase to adjusted gross income (AGI); (5) update the discussion of the allocation rules under section 6015(c) and (d); and (6) revise the rules regarding prohibition on collection and suspension of the collection statute.

1. Section 1.6015-1

The procedures for requesting relief on Form 8857, "Request for Innocent Spouse Relief," under section 6015 have changed since 2006 because of the amendments to section 6015(e) made by Section 408 of Title IV of Division C of the 2006 Act. The amendments to section 6015(e) conferred jurisdiction on the Tax Court to review the Commissioner's denial of relief under section 6015(f) in cases in

which a deficiency had not been asserted. The amendments also provided for a prohibition on collection and a corresponding tolling of the collection statute under section 6502 upon the filing of a request for relief under section 6015(f). The amendments apply to any liability for taxes arising on or after December 20, 2006, and to any liability for taxes arising before December 20, 2006, and remaining unpaid as of that date. As a result of the amendments, any request for relief under section 6015 will toll the collection statute, making it unnecessary for a spouse to elect or request a particular type of relief as required under § 1.6015-1(a)(2) of the current regulations. Accordingly, § 1.6015-1 and all sections referencing an election under §§ 1.6015-2 and 1.6015-3 or a request for relief under § 1.6015-4 are proposed to be revised to reflect that a requesting spouse is no longer required to elect or request relief under a specific provision of section 6015. Thus, beginning with the June 2007 revision to the Form 8857, a requesting spouse makes a single request for relief on Form 8857. Section 1.6015-1 is also being revised to provide that the IRS will consider in all cases whether the requesting spouse is eligible for relief under § 1.6015-2 or § 1.6015-3, and if relief is not available under either of those sections, under § 1.6015-4.

Section 6015(g)(2) provides an exception to the common law doctrine of res judicata except in a case in which relief under section 6015 was at issue in a prior court proceeding or if a requesting spouse meaningfully participated in a prior proceeding in which relief under section 6015 could have been raised. Current § 1.6015-1(e) is being revised in these proposed regulations to provide more detailed guidance on how the exception to res judicata and the meaningful participation rule work, and to reflect developments in the case law since 2002 (described below). Proposed § 1.6015-1(e)(1) restates the general rule from the current regulations.

Proposed § 1.6015-1(e)(2) incorporates the holding in *Deihl v. Commissioner*, 134 T.C. 156 (2010) (When a requesting spouse generally raises relief under section 6015 in a proceeding but does not specifically plead relief under any subsection of section 6015, relief under section 6015(c) will not be treated as

being at issue in that proceeding if the requesting spouse was not eligible to elect relief under section 6015(c) because the requesting spouse was not divorced, widowed, legally separated, or living apart for 12 months at any time during the prior proceeding).

Proposed § 1.6015-1(e)(3) provides guidance on the meaningful participation exception to res judicata provided by section 6015(g)(2). A requesting spouse meaningfully participated in the prior proceeding if the requesting spouse was involved in the proceeding so that the requesting spouse could have raised the issue of relief under section 6015 in that proceeding. Meaningful participation is a facts and circumstances determination. A nonexclusive list of acts was added in proposed § 1.6015-1(e)(3) to provide indicators of “meaningful participation” within the context of a bar against relief based on the judicial doctrine of res judicata. Whether a requesting spouse meaningfully participated in a prior proceeding is based on all the facts and circumstances. No one act necessarily determines the outcome. The degree of importance of each act varies depending on the requesting spouse’s facts and circumstances. The following acts, derived from case law and experience since 2002, are among the acts the IRS and courts consider in making the determination regarding meaningful participation: whether the requesting spouse participated in the IRS Appeals process while the prior case was docketed; whether the requesting spouse participated in discovery; whether the requesting spouse participated in pretrial meetings, settlement negotiations, or trial; whether the requesting spouse signed court documents; and whether the requesting spouse was represented by counsel in the prior proceedings.

Proposed § 1.6015-1(e)(3)(i) provides a new rule under which the requesting spouse will not be considered to have meaningfully participated in the prior proceeding if the requesting spouse establishes that the requesting spouse performed any of the acts listed in proposed § 1.6015-1(e)(3) because the nonrequesting spouse abused or maintained control over the requesting spouse, and the requesting spouse did not challenge the nonrequesting spouse for fear of the nonre-

questing spouse’s retaliation. Proposed § 1.6015-1(e)(3)(ii) restates the rule from the current regulations that a requesting spouse did not meaningfully participate in a prior proceeding if, due to the effective date of section 6015, relief under section 6015 was not available in that proceeding.

Proposed § 1.6015-1(e)(3)(iii) provides that in a case petitioned from a statutory notice of deficiency under section 6213, the fact that the requesting spouse did not have the ability to effectively contest the underlying deficiency is irrelevant for purposes of determining whether the requesting spouse meaningfully participated in the prior proceeding. Treasury and the IRS disagree with the holding in *Harbin v. Commissioner*, 137 T.C. 93 (2011), in which the Tax Court concluded that Mr. Harbin did not meaningfully participate in the deficiency case in part because he could not effectively contest the part of the deficiency related to his ex-wife’s gambling losses without her. The Tax Court found that Mr. Harbin could not effectively contest this part of the deficiency without his ex-wife because she “was the one with personal knowledge of the winnings and losses from the gambling activities” and was the one “who maintained and provided all of the documentation relating to the gambling activities.” The Tax Court concluded that this knowledge and control of the documentation resulted in Mr. Harbin’s ex-wife effectively exercising “exclusive control” of the case. *Harbin v. Commissioner*, 137 T.C. at 98.

Treasury and the IRS believe that the Tax Court applied the incorrect standard to determine whether a taxpayer meaningfully participated in a proceeding for purposes of section 6015(g)(2). The purpose of the meaningful participation exception to res judicata is not to ensure that a taxpayer had the opportunity to contest the deficiency but rather to ensure that the taxpayer could have raised relief under section 6015. *Moore v. Commissioner*, T.C. Memo. 2007-156. This is evident because, if section 6015 relief was at issue in the prior case, the taxpayer is not permitted to raise section 6015 relief in a subsequent proceeding regardless of the degree to which the taxpayer participated or whether the taxpayer’s ability to contest

the deficiency was impaired. See *Deihl v. Commissioner*, 134 T.C. 156, 161 (2010).

Proposed § 1.6015-1(e)(4) provides examples of how the rules in paragraphs (e)(1), (e)(2), and (e)(3) work. Proposed § 1.6015-1(e)(5) restates the collateral estoppel rule from current § 1.6015-1(e) without change.

Proposed § 1.6015-1(h)(1) and (h)(5) are being revised to remove the distinction between electing and requesting relief as discussed earlier in this preamble.

Proposed § 1.6015-1(h)(6) defines “unpaid tax” for purposes of § 1.6015-4. For purposes of § 1.6015-4, the regulations propose that the terms “unpaid tax” and “underpayment” have the same meaning. The unpaid tax or underpayment on a joint return is the balance shown as due on the return reduced by the tax paid with the return or paid on or before the due date for payment (without considering any extension of time to pay). The balance due is determined after applying withholding credits, estimated tax payments, payments with an extension, and other credits applied against the total tax reported on the return. Payments made with the return include payments made by check in the same envelope with the return or remitted at a later date (but before the due date for payment) with Form 1040-V, “Payment Voucher.” Payments made with the return also include remittances made by direct debit, credit card, or other commercially acceptable means under section 6311 on or before the due date for payment. The determination of the existence and amount of unpaid tax is made as of the date the joint return is filed, or as of the due date for payment if payments are made after the return is filed but on or before the due date.

If the payments made with the joint return, including any payments made on or before the due date for payment (without considering any extension of time for payment), completely satisfy the balance due shown on the return, then there is no unpaid tax for purposes of § 1.6015-4. A requesting spouse is not entitled to be considered for relief (credit or refund) under § 1.6015-4 for any tax paid with the joint return (including a joint amended return). Payments made after the later of the date the joint return is filed or the due date for payment (without considering any

extension of time for payment), including offsets of overpayments from other tax years, do not change the amount of unpaid tax reported on the joint return. Under § 1.6015-4, a requesting spouse can only get relief from the unpaid tax on the return, and if refunds are available, from any payments made on the liability after the later of the date the joint return was filed or the due date for payment (without considering any extension of time for payment).

Proposed § 1.6015-1(h)(7) and (h)(8) define understatement and deficiency, respectively. Section 6015(b)(3) provides that an “understatement” for purposes of section 6015 has the same meaning given to that term by section 6662(d)(2)(A). The definition of understatement is in current § 1.6015-2(b) and therefore only applies to requests under that section. The term “understatement,” however, is a term that is relevant to relief under sections 6015(b), (c), and (f). These regulations propose to move the definition of “understatement” to proposed § 1.6015-1(h)(7) to allow a consistent definition to apply throughout the regulations. Likewise, proposed § 1.6015-1(h)(8) adds a definition of deficiency, by reference to section 6211 and the regulations under section 6211, to clarify that the term deficiency has the same meaning throughout the regulations.

Section 6015(g)(1) provides that requesting spouses generally can receive a credit or refund of payments made on the joint liability if the requesting spouse is entitled to relief under section 6015. This general rule is set forth in proposed § 1.6015-1(k)(1). Section 6015(g) also provides some limitations on the availability of credit or refund. New § 1.6015-1(k)(2) through (5) discuss these and other limitations on credit or refund when a requesting spouse is eligible for relief.

Proposed § 1.6015-1(k)(2) sets forth the limitation on refunds from section 6015(g)(3) when a requesting spouse is entitled to relief under § 1.6015-3. Proposed § 1.6015-1(k)(3) sets forth the rule from current § 1.6015-4(b) that relief under § 1.6015-4 is not available when the requesting spouse is entitled to full relief under § 1.6015-3 but is not entitled to a refund because of the limitation in section 6015(g)(3) and proposed § 1.6015-1(k)(2). Proposed § 1.6015-1(k)(4) incor-

porates, consistent with section 6015(g)(1), the limitations on credit or refund provided by sections 6511 (general limitations on credits or refunds) and 6512(b) (limitations on credits or refunds where the Tax Court determines that a taxpayer made an overpayment). This section also clarifies that, in general, Form 8857 will be treated as the requesting spouse’s claim for credit or refund.

Proposed § 1.6015-1(k)(5) sets forth the general rule that a requesting spouse who is entitled to relief is generally not eligible for a credit or refund of joint payments made with the nonrequesting spouse. Under the proposed rule, a requesting spouse, however, may be eligible for a credit or refund of the requesting spouse’s portion of the requesting and nonrequesting spouse’s joint overpayment from another tax year that was applied to the joint income tax liability to the extent that the requesting spouse can establish his or her contribution to the overpayment. Both spouses have an interest in a joint overpayment relative to each spouse’s contribution to the overpayment. See, for example, *Gordon v. United States*, 757 F.2d 1157, 1160 (11th Cir. 1985) (“Where spouses claim a refund under a joint return, the refund is divided between the spouses, with each receiving a percentage of the refund equivalent to his or her proportion of the withheld tax payments.”). If the requesting spouse contributed to the joint overpayment through withholding, estimated tax, or other payments, then the requesting spouse may be entitled to a refund of that portion of the overpayment that was applied to the joint liability. Under the proposed rule, a requesting spouse in a state that is not a community property state may establish his or her portion of a joint overpayment using the allocation rules of Rev. Rul. 80-7 (1980-1 CB 296), or successor guidance. A requesting spouse in a community property state may establish his or her portion of a joint overpayment using the allocation rules of Rev. Rul. 2004-71 (2004-2 CB 74), Rev. Rul. 2004-72 (2004-2 CB 77), Rev. Rul. 2004-73 (2004-2 CB 80), or Rev. Rul. 2004-74 (2004-2 CB 84), or successor guidance, whichever is applicable to the state in which the requesting spouse is domiciled. For copies of Revenue Procedures, Reve-

nue Rulings, notices, and other guidance published in the Internal Revenue Bulletin, please visit the IRS website at <http://www.irs.gov>.

These proposed regulations reflect the elimination of the more restrictive rule regarding credit or refund when relief is granted under § 1.6015-4 in cases involving a deficiency, as provided by Rev. Proc. 2013-34. A credit or refund, subject to the limitations in § 1.6015-1(k), is available to a requesting spouse who is entitled to relief under § 1.6015-4 in both underpayment and deficiency cases.

Current § 1.6015-1(h)(4) provides, in part, that penalties and interest are not separate erroneous items from which a requesting spouse can be relieved separate from the tax. Rather, relief from penalties and interest related to an understatement or deficiency will generally be determined based on the proportion of the total erroneous items from which the requesting spouse is relieved.

Thus, under the existing regulations, a requesting spouse who is determined not to be eligible for relief from the understatement or deficiency stemming from an erroneous item cannot be separately relieved from a penalty, such as the accuracy-related penalty, related to the item under section 6015. If a requesting spouse is entitled to partial relief (such as relief from two of three erroneous items giving rise to the understatement or deficiency), then the requesting spouse will be entitled to relief from the accuracy-related penalty applicable to those two items.

These regulations propose to move the discussion in current § 1.6015-1(h)(4) to proposed § 1.6015-1(m). Proposed § 1.6015-1(m) additionally clarifies, consistent with the statutory interpretation in current § 1.6015-1(h)(4), that penalties and interest on an underpayment also are not separate items from which a requesting spouse may obtain relief under § 1.6015-4. Rather, relief from penalties and interest on the underpayment will be determined based on the amount of relief from the underpayment to which the requesting spouse is entitled. If a requesting spouse remains liable for a portion of the underpayment after application of § 1.6015-4, the requesting spouse is not eligible for relief under section 6015 for the penalties and interest related to that

portion of the underpayment. *Cf. Weiler v. Commissioner*, T.C. Memo. 2003-255 (a requesting spouse is not relieved from liabilities for penalties and interest resulting from items attributable to the requesting spouse). This position is consistent with how the IRS currently treats relief from penalties and interest after determining the relief from the underlying tax. See IRM 25.15.3.4.1.1(2) (Revised 03/08/2013).

If an assessed deficiency is paid in full, or the unpaid tax reported on the joint return is later paid in full, but penalties and interest remain unpaid, under the proposed rule, a requesting spouse may be considered for relief from the penalties and interest under section 6015. The determination of relief from the penalties and interest is made by considering whether the requesting spouse would be entitled to relief from the underlying tax and not considering the penalties and interest as if they were separate items. A requesting spouse may be relieved from the penalties and interest even if relief in the form of a refund of the payments made on the underlying tax is barred (for example, § 1.6015-1(k)(2) (no refunds allowed under § 1.6015-3) or § 1.6015-1(k)(4) (refund barred by the limitations of sections 6511 or 6512(b))).

Proposed § 1.6015-1(n) provides attribution rules for a portion of an understatement or deficiency relating to the disallowance of certain items. Specifically, § 1.6015-1(n) addresses items that are otherwise not erroneous items, but are disallowed solely due to the increase of adjusted gross income (or modified adjusted gross income) over a phase-out threshold as a result of an erroneous item attributable to the nonrequesting spouse. One common example of this is when the nonrequesting spouse's omitted income increases adjusted gross income so that the Earned Income Tax Credit (EITC) is phased out and the understatement or deficiency partially represents the recapture of the refunded EITC.

Under proposed § 1.6015-1(n), the understatement or deficiency related to the item disallowed due to the increase to adjusted gross income will be attributable to the spouse whose erroneous item caused the increase to adjusted gross income, unless the evidence shows that a

different result is appropriate. If the increase to adjusted gross income is the result of erroneous items of both spouses, the item disallowed due to the increase to adjusted gross income will be attributable to the requesting spouse in the same ratio as the amount of the item or items attributable to the requesting spouse over the total amount of the items that resulted in the increase to adjusted gross income. Corresponding rules are proposed to be added to §§ 1.6015-2(b) and 1.6015-3(c)(2)(i) to provide that a requesting spouse knows or has reason to know of the item disallowed due to the increase in adjusted gross income if the requesting spouse knows or has reason to know of the erroneous item or items that resulted in the increase to adjusted gross income. Likewise, for purposes of proposed § 1.6015-4 and Rev. Proc. 2013-34, a requesting spouse knows or has reason to know of the portion of an understatement or deficiency related to an item attributable to the nonrequesting spouse under § 1.6015-1(n) if the requesting spouse knows or has reason to know of the nonrequesting spouse's erroneous item or items that resulted in the increase to adjusted gross income.

Examples are provided to illustrate how this rule applies in situations involving the EITC, the phase-out of itemized deductions, and the application of the alternative minimum tax. This rule, however, can be implicated in other situations. It should be noted that this proposed rule would not apply if there is another reason for disallowing the item, such as no qualifying child for the EITC, no substantiation for a claimed deduction, or the lack of any basis in law or fact for the deduction. In this situation, the normal attribution rules applicable to §§ 1.6015-2, 1.6015-3, and 1.6015-4 apply.

Proposed § 1.6015-1(o) provides a definition of abuse for purposes of proposed §§ 1.6015-2(b) and 1.6015-3(c)(vi). The definition of abuse is taken directly from Rev. Proc. 2013-34, section 4.03(2)(c)(iv).

2. Section 1.6015-2

Only minor substantive changes are proposed to current § 1.6015-2. The proposed amendments reorganize the section,

update references, and provide clarification where needed. Proposed § 1.6015-2(a) changes the language in the existing regulations, "the requesting spouse elects the application of this section," to "the requesting spouse requests relief" consistent with the discussion earlier in this preamble. The definition of "understatement" in current § 1.6015-2(b) is removed as the definition will now be located in proposed § 1.6015-1(h)(7). Current § 1.6015-2(c) is redesignated as proposed § 1.6015-2(b), adds additional facts and circumstances from Rev. Proc. 2013-34 to consider in determining whether a requesting spouse had reason to know, adds a knowledge rule to correspond to proposed § 1.6015-1(n) as discussed earlier in this preamble, and clarifies, consistent with the changes made in Rev. Proc. 2013-34, that abuse or financial control by the nonrequesting spouse will result in the requesting spouse being treated as not having knowledge or reason to know of the items giving rise to the understatement. Current § 1.6015-2(d) is redesignated as proposed § 1.6015-2(c) and provides an updated cross-reference to the most recent revenue procedure providing the criteria to be used in determining equitable relief, Rev. Proc. 2013-34. Current § 1.6015-2(e)(1) is redesignated as proposed § 1.6015-2(d)(1) and the word "only" is removed to clarify the rule. Current § 1.6015-2(e)(2) is redesignated as proposed § 1.6015-2(d)(2) and the example is updated to use more current years and dates, but otherwise no substantive changes were made.

3. Section 1.6015-3

Among other clarifying changes, these regulations propose to clarify the difference between full and partial relief under section 6015(c) and to reflect case law regarding the tax benefit rule of section 6015(d)(3)(B), including new examples.

Proposed § 1.6015-3(a) provides a revised heading and a cross-reference to the definition of deficiency in proposed § 1.6015-1(h)(8).

Section 6015(g)(3) provides that no credit or refund is allowed as a result of an allocation of a deficiency under section 6015(c). Proposed § 1.6015-3(c)(1) clarifies the existing regulations and provides

that whether relief is available to a requesting spouse under section 6015(c) is not dependent on the availability of credit or refund. Thus, if a requesting spouse is eligible to allocate the entire deficiency to the nonrequesting spouse, the requesting spouse has received full relief even if the requesting spouse made payments on the deficiency and is not entitled to a refund of those payments because of section 6015(g)(3). Further, the requesting spouse is not eligible to be considered for relief (and a refund) under section 6015(f) for the amount of any paid liability because a prerequisite to relief under section 6015(f) is the unavailability of relief under section 6015(b) or (c) and the spouse received full relief under section 6015(c). A requesting spouse may still be considered for relief (and a refund) under section 6015(b) for the amount of any paid liability. If a requesting spouse only receives partial relief (for example, some part of the deficiency is still allocated to the requesting spouse), then the requesting spouse may be considered for relief under section 6015(f) for the portion of the deficiency allocable to the requesting spouse. A new sentence is added to § 1.6015-3(c)(2)(i) to add a knowledge rule to correspond to proposed § 1.6015-1(n), which, as discussed earlier in this preamble, provides an attribution rule for the portion of a deficiency relating to the disallowance or reduction of an otherwise valid item solely due to the increase in AGI as a result of the disallowance of an erroneous item.

Proposed § 1.6015-3(d)(2)(i) illustrates that, under the tax benefit rule of section 6015(d)(3)(B), the amount of an erroneous item allocated to a requesting spouse may increase or decrease depending upon the tax benefit to the requesting and nonrequesting spouses. Thus, these proposed regulations adopt the holding of *Hopkins v. Commissioner*, 121 T.C. 73 (2003) (a requesting spouse was entitled to relief from her own item under the tax benefit rule of section 6015(d)(3)(B) because the nonrequesting spouse was the only person who reported income on the returns, and therefore, the only one who received any tax benefit from the item). In addition, five new examples have been added to § 1.6015-3(d)(5) to provide additional guidance on the application of the

tax benefit rule of § 1.6015-3(d)(2)(i). *Example 7* demonstrates the application of § 1.6015-3(d)(2)(i)(B), which provides that each spouse's hypothetical separate taxable income may need to be determined to properly apply the tax benefit rule. *Example 8* demonstrates the holding in *Hopkins* by showing that a requesting spouse's allocated portion of a deficiency will be decreased when the nonrequesting spouse receives a tax benefit from the item. *Example 9* demonstrates the allocation of a liability when the erroneous item is a loss from a jointly-owned investment. *Example 10* demonstrates how the tax benefit rule works when the erroneous item is a loss from a jointly-owned investment. In addition, *Example 11* is added to demonstrate how the rule in § 1.6015-3(d)(2)(ii) regarding fraud works.

Section 1.6015-3(c)(2)(iv) currently provides that the requesting spouse's joint ownership (with the nonrequesting spouse) of the property that resulted in the erroneous item is a factor that may be relied upon in demonstrating that the requesting spouse had actual knowledge of the item. Under the tax benefit rule of § 1.6015-3(d)(2)(i), as stated earlier in this preamble, a requesting spouse can be relieved of liability for the requesting spouse's own erroneous item if the item is otherwise allocable in full or in part to the nonrequesting spouse under section 6015(d). Therefore, proposed § 1.6015-3(c)(2)(iv) revises the current regulations to clarify that the requesting spouse's separate ownership of the erroneous item is also a factor that may be relied upon in demonstrating that the requesting spouse had actual knowledge of the item. Current § 1.6015-3(c)(2)(v) is redesignated as proposed § 1.6015-3(c)(2)(vi) and the discussion of community property in current § 1.6015-3(c)(iv) is removed and is now located in proposed § 1.6015-3(c)(2)(v). Proposed § 1.6015-3(c)(vi) is revised to clarify, consistent with the changes made in Rev. Proc. 2013-34, that abuse or financial control by the nonrequesting spouse will result in the requesting spouse being treated as not having actual knowledge of the items giving rise to the understatement.

4. Section 1.6015-4

No substantive changes are proposed to current § 1.6015-4. The proposed amendments update references and provide a clarifying change consistent with proposed § 1.6015-3(c)(1), which provides the rule that refunds are not allowed under section 6015(c).

Proposed § 1.6015-4(a) was revised to provide a cross-reference to the definitions of unpaid tax, understatement, and deficiency in proposed §§ 1.6015-1(h)(6), (h)(7), and (h)(8).

Proposed § 1.6015-4(b) was revised to provide a cross-reference to proposed § 1.6015-1(k)(3). The paragraph also clarifies that if only partial relief is available under § 1.6015-3, then relief may be considered under § 1.6015-4 for the portion of the deficiency for which the requesting spouse remains liable.

Proposed § 1.6015-4(c) replaces the citation to Rev. Proc. 2000-15 (2000-1 CB 447) with Rev. Proc. 2013-34, which revised the factors used in determining if the requesting spouse is eligible for equitable relief under section 6015(f).

5. Section 1.6015-5

A notice of proposed rulemaking (REG-132251-11) was published in the **Federal Register** (78 FR 49242) on August 13, 2013. Those regulations proposed changes to § 1.6015-5 to remove the two-year deadline for taxpayers to file requests for equitable relief under section 6015(f), and other changes related to the time and manner for requesting relief. These proposed regulations revise the notice of proposed rulemaking published on August 13, 2013 to add an effective date provision.

6. Section 1.6015-6

The changes in proposed § 1.6015-6 are intended to update the current regulations to reflect existing practice and guidance. Proposed § 1.6015-6(a)(1) replaces the term "election" under § 1.6015-2 or § 1.6015-3 with "request for relief." Proposed § 1.6015-6(a)(2) includes a reference to Rev. Proc. 2003-19 (2003-1 CB 371), which provides guidance on a non-

requesting spouse's right to appeal a preliminary determination to IRS Appeals.

7. Section 1.6015-7

Section 1.6015-7 was revised to reflect the amendments to section 6015(e) in the 2006 Act that, as noted earlier in this preamble, conferred jurisdiction on the United States Tax Court to review the IRS's denial of relief in cases in which taxpayers requested equitable relief under section 6015(f), without regard to whether the IRS has determined a deficiency. Prior to these amendments, the United States Tax Court lacked jurisdiction to review section 6015(f) determinations if no deficiency had been determined. The amendments apply to any liability for tax that arose on or after December 20, 2006, and any liability for tax that arose before December 20, 2006, but remained unpaid as of that date. Proposed § 1.6015-7(c) revises the current regulations to reflect the changes to the restrictions on collection and corresponding tolling of the collection statute under section 6502. On versions of the Form 8857 dated before June 2007 a requesting spouse could request relief under just one subsection of section 6015. For claims for relief that were made under sections 6015(b) and (c) (and the corresponding §§ 1.6015-2 and 1.6015-3), the IRS is prohibited from collecting against the requesting spouse (and the collection statute is tolled) beginning on the date the claim is filed. For requests for relief made solely under section 6015(f) (and the corresponding § 1.6015-4), the IRS is prohibited from collecting against the requesting spouse (and the collection statute is tolled) only for liabilities arising on or after December 20, 2006, or liabilities arising before December 20, 2006, but remaining unpaid as of that date. For requests for relief made solely under § 1.6015-4, the restrictions on collection and tolling of the collection statute do not start until December 20, 2006, for any requests filed before that date, assuming the tax remained unpaid as of that date. The restrictions on collection and tolling of the collection statute start as of the date the request is filed for requests filed on or after December 20, 2006.

8. Section 1.66-4

The only changes to the existing regulations under section 66 are non-substantive changes. Proposed § 1.66-4(a)(3) and (b) replace the citation to Rev. Proc. 2000-15 with Rev. Proc. 2013-34, which revised the factors used in determining whether a requesting spouse is eligible for equitable relief under section 66(c).

9. Effective and Applicability Dates

Additionally, the effective and applicability date sections in the regulations under section 66 and section 6015 are reorganized to move the effective and applicability date sections within the specific regulation to which the dates apply. The separate effective date sections under §§ 1.66-5 and 1.6015-9 are removed.

Special Analyses

Certain IRS regulations, including this one, are exempt from the requirements of Executive Order 12866, as supplemented and reaffirmed by Executive Order 13563. Therefore, a regulatory impact assessment is not required. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations. In addition, because the regulations do not impose a collection of information on small entities, the Regulatory Flexibility Act (5 U.S.C. chapter 6) does not apply. Accordingly, a regulatory flexibility analysis is not required under the Regulatory Flexibility Act (5 U.S.C. chapter 6). Pursuant to section 7805(f) of the Code, this notice of proposed rulemaking has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Comments and Requests for Public Hearing

Before these proposed regulations are adopted as final regulations, consideration will be given to any comments that are submitted timely to the IRS as prescribed in the preamble under the "Addresses" heading. Treasury and the IRS request comments on all aspects of the proposed

regulations. All comments will be available at www.regulations.gov or upon request. A public hearing will be scheduled if requested in writing by any person that timely submits written comments. If a public hearing is scheduled, notice of the date, time, and place for the public hearing will be published in the **Federal Register**.

Drafting Information

The principal author of these regulations is Nancy Rose of the Office of the Associate Chief Counsel (Procedure and Administration).

* * * * *

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 is amended by adding the following entries in numerical order as follows:

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

Section 1.66-1 also issued under 26 U.S.C. 66(c).

Section 1.66-2 also issued under 26 U.S.C. 66(c).

Section 1.66-3 also issued under 26 U.S.C. 66(c).

Par. 2. Section 1.66-1 is amended by adding paragraph (d) to read as follows:

§ 1.66-1 Treatment of community income.

* * * * *

(d) *Effective/applicability date.* This section is applicable beginning July 10, 2003.

Par. 3. Section 1.66-2 is amended by adding paragraph (e) to read as follows:

§ 1.66-2 Treatment of community income where spouses live apart.

* * * * *

(e) *Effective/applicability date.* This section is applicable beginning July 10, 2003.

Par. 4. Section 1.66-3 is amended by adding paragraph (d) to read as follows:

§ 1.66–3 Denial of the Federal income tax benefits resulting from the operation of community property law where spouses not notified.

* * * * *

(d) *Effective/applicability date.* This section is applicable beginning July 10, 2003.

Par. 5. Section 1.66–4 is amended by:

1. The last sentences of paragraphs (a)(3) and (b) are revised.
2. Paragraph (l) is added and reserved.
3. Paragraph (m) is added.

The revisions and additions read as follows:

§ 1.66–4 Request for relief from the Federal income tax liability resulting from the operation of community property law.

(a) * * *

(3) * * * Factors relevant to whether it would be inequitable to hold a requesting spouse liable, more specifically described under the applicable administrative procedure issued under section 66(c) (Rev. Proc. 2013–34 (2013–2 CB 397) (See § 601.601(d)(2) of this chapter), or other applicable guidance published by the Secretary), are to be considered in making a determination under this paragraph (a).

(b) * * * Factors relevant to whether it would be inequitable to hold a requesting spouse liable, more specifically described under the applicable administrative procedure issues under section 66(c) (Rev. Proc. 2013–34 (2013–2 CB 397) (See § 601.601(d)(2) of this chapter), or other applicable guidance published by the Secretary), are to be considered in making a determination under this paragraph (b).

* * * * *

(l) [Reserved]

(m) *Effective/applicability date.* This section is applicable beginning July 10, 2003, except that paragraphs (a)(3) and (b) of this section will be applicable on the date of publication of a Treasury Decision adopting these rules as final regulations in the **Federal Register**.

§ 1.66–5 [Removed]

Par. 6. Section 1.66–5 is removed.

Par. 7. Section 1.6015–0 is amended by:

1. In § 1.6015–1, entries for paragraphs (e)(1), (e)(2), (e)(3), (e)(4), (e)(5), (h)(6),

(h)(7), (h)(8), (k), (l), (m), (n), (o), and (p) are added and the entry for paragraph (h)(5) is revised.

2. In § 1.6015–2, entries for paragraphs (b), (c), (d), and (e) are revised and the entries for paragraphs (e)(1) and (e)(2) are removed.

3. In § 1.6015–3, entries for paragraphs (a) and (c)(2)(v) are revised and entries for paragraphs (c)(2)(vi), (d)(2)(i)(A), (d)(2)(i)(B), and (e) are added.

4. In § 1.6015–4, an entry for paragraph (d) is added.

5. In § 1.6015–5, an entry for paragraph (d) is added.

6. In § 1.6015–6, an entry for paragraph (d) is added.

7. In § 1.6015–7, entries for paragraphs (c)(1) and (c)(4)(iii) are revised and entries for paragraphs (c)(1)(i), (c)(1)(ii), (c)(1)(iii), and (d) are added.

8. In § 1.6015–8, an entry for paragraph (d) is added.

9. Section 1.6015–9 entry is removed.
The revisions and additions read as follows:

§ 1.6015–0 Table of contents.

* * * * *

§ 1.6015–1 Relief from joint and several liability on a joint return.

* * * * *

(e) * * *

(1) In general.
(2) Situations in which relief under § 1.6015–3 will not be considered to have been at issue in the prior proceeding.

(3) Meaningful participation.

(4) Examples.

(5) Collateral estoppel.

* * * * *

(h) * * *

(5) Request for relief.

(6) Unpaid tax and underpayment.

(7) Understatement.

(8) Deficiency.

* * * * *

(k) Credit or refund.

(1) In general.

(2) No credit or refund allowed under § 1.6015–3.

(3) No circumvention of §§ 1.6015–1(k)(2) and 1.6015–3(c)(1).

(4) Limitations on credit or refund.

(5) Requesting spouse limited to credit or refund of payments made by the requesting spouse.

(l) [Reserved]

(m) Penalties and interest.

(n) Attribution of understatement or deficiency resulting from an increase to adjusted gross income.

(1) In general.

(2) Examples.

(o) Abuse by nonrequesting spouse.

(p) Effective/applicability date.

§ 1.6015–2 Relief from liability applicable to all qualifying joint filers.

* * * * *

(b) Know or reason to know.

(c) Inequity.

(d) Partial relief.

(1) In general.

(2) Example.

(e) Effective/applicability date.

§ 1.6015–3 Allocation of deficiency for individuals who are no longer married, are legally separated, or are not members of the same household.

(a) Allocation of deficiency.

* * * * *

(c) * * *

(2) * * *

(v) Actual knowledge and community property.

(vi) Abuse exception.

* * * * *

(d) * * *

(2) * * *

(i) * * *

(A) In general.

(B) Calculating separate taxable income and tax due.

(e) Effective/applicability date.

§ 1.6015–4 Equitable relief.

(d) Effective/applicability date.

§ 1.6015–5 Time and manner for requesting relief.

* * * * *

(d) Effective/applicability date.

§ 1.6015-6 *Nonrequesting spouse's notice and opportunity to participate in administrative proceedings.*

* * * * *

(d) Effective/applicability date.

§ 1.6015-7 *Tax Court review.*

* * * * *

(c) * * *

(1) Restrictions on collection.

(i) Restrictions on collection for requests for relief made on or after December 20, 2006.

(ii) Restrictions on collection for requests for relief made before December 20, 2006.

(iii) Rules for determining the period of the restrictions on collection.

* * * * *

(4) * * *

(iii) Assessment to which the request relates.

(d) Effective/applicability date.

§ 1.6015-8 *Applicable liabilities.*

* * * * *

(d) Effective/applicability date.

Par. 8. Section 1.6015-1 is amended by:

1. Paragraphs (a)(2), (e), (h)(1), and (h)(5) are revised.

2. The last three sentences of paragraph (h)(4) are removed.

3. Paragraphs (h)(6), (7), and (8) and (k) are added.

4. Paragraph (l) is added and reserved.

5. Paragraphs (m), (n), (o), and (p) are added.

The revisions and additions read as follows:

§ 1.6015-1 *Relief from joint and several liability on a joint return.*

(a) * * *

(2) A requesting spouse may submit a single request for relief under §§ 1.6015-2, 1.6015-3, and 1.6015-4. Upon submitting a request for relief, the IRS will consider whether relief is appropriate under §§ 1.6015-2 and 1.6015-3 and, to the extent relief is unavailable under both of those provisions, under § 1.6015-4. Equitable relief under § 1.6015-4 is available only to a request-

ing spouse who fails to qualify for relief under §§ 1.6015-2 and 1.6015-3.

* * * * *

(e) *Res judicata and collateral estoppel*—(1) *In general.* A requesting spouse is barred from relief from joint and several liability under section 6015 by res judicata for any tax year for which a court of competent jurisdiction has rendered a final decision on the requesting spouse's tax liability if relief under section 6015 was at issue in the prior proceeding, or if the requesting spouse meaningfully participated in that proceeding and could have raised the issue of relief under section 6015.

(2) *Situations in which relief under § 1.6015-3 will not be considered to have been at issue in the prior proceeding.* Relief under § 1.6015-3 will not be considered to have been at issue in a prior proceeding if the requesting spouse only raised the issue of relief under section 6015 in general and did not specify under which subsection relief was being requested, and the requesting spouse was not eligible for relief under § 1.6015-3 during the prior proceeding because the requesting spouse was not divorced, widowed, or legally separated, or had been a member of the same household as the nonrequesting spouse during the prior 12 months.

(3) *Meaningful participation.* A requesting spouse meaningfully participated in the prior proceeding if the requesting spouse was involved in the proceeding so that the requesting spouse could have raised the issue of relief under section 6015 in that proceeding. Meaningful participation is a facts and circumstances determination. Absent abuse as set forth in paragraph (i) of this section, the following is a nonexclusive list of acts to be considered in making the facts and circumstances determination: whether the requesting spouse participated in the IRS Appeals process while the prior proceeding was docketed; whether the requesting spouse participated in pretrial meetings; whether the requesting spouse participated in discovery; whether the requesting spouse participated in settlement negotiations; whether the requesting spouse signed court documents, such as a petition, a stipulation of facts, motions, briefs, or any other documents; whether the re-

questing spouse participated at trial (for example, the requesting spouse was present or testified at the prior proceeding); and whether the requesting spouse was represented by counsel in the prior proceeding. No one act necessarily determines the outcome. The degree of importance of each act varies depending on the requesting spouse's facts and circumstances.

(i) Notwithstanding the fact that a requesting spouse performed any of the acts listed in paragraph (e)(3) of this section in the prior proceeding, the requesting spouse will not be considered to have meaningfully participated in the prior proceeding if the requesting spouse establishes that the requesting spouse performed the acts because the nonrequesting spouse abused (as described in paragraph (o) of this section) or maintained control over the requesting spouse, and the requesting spouse did not challenge the nonrequesting spouse for fear of the nonrequesting spouse's retaliation.

(ii) A requesting spouse did not meaningfully participate in a prior proceeding if, due to the effective date of section 6015, relief under section 6015 was not available in that proceeding.

(iii) In a case petitioned from a statutory notice of deficiency under section 6213, the fact that the requesting spouse did not have the ability to effectively contest the underlying deficiency is irrelevant for purposes of determining whether the requesting spouse meaningfully participated in the court proceeding for purposes of paragraph (e)(1) of this section.

(4) *Examples.* The following examples illustrate the rules of this paragraph (e):

Example 1. In a prior court proceeding involving a petition from a notice of deficiency related to a joint income tax return, H and W were still married and filed a timely joint petition to the United States Tax Court. The petition stated that W was entitled to relief under section 6015 without specifying under which subsection she was requesting relief. Before trial, H negotiates with the IRS Chief Counsel attorney and settles the case. W did not meaningfully participate. A stipulated decision was entered that did not mention relief under section 6015. One year later W files a request for relief under section 6015. While W did not meaningfully participate in the prior court proceeding, because relief under section 6015 was at issue in that case, res judicata applies except with respect to relief under § 1.6015-3. Because W did not specify that she was requesting relief under § 1.6015-3, and W was not eligible to request relief under that section because she was still

married to the nonrequesting spouse throughout the court proceeding, relief under § 1.6015-3 is not considered to have been at issue in that case. Thus, W is not barred by res judicata from raising relief under § 1.6015-3 in a later case. However, any later claim from W requesting relief under § 1.6015-2 or § 1.6015-4 would be barred by res judicata.

Example 2. Same facts as in *Example 1* of this paragraph (e)(4) except that H and W are divorced at the time the petition was filed. Because W was eligible to request relief under § 1.6015-3 as she was divorced from H, relief under § 1.6015-3 is considered to be at issue in the prior court proceeding and W is barred by res judicata from raising relief under § 1.6015-3 in a later case. Thus, any later claim from W requesting relief under any subsection of section 6015 would be barred by res judicata.

Example 3. The IRS issued a notice of deficiency to H and W determining a deficiency on H and W's joint income tax return based on H's Schedule C business. H and W timely filed a petition in the United States Tax Court. W signed the petition and numerous other documents, participated in discussions regarding the case with the IRS Chief Counsel attorney, and ultimately agreed to a settlement of the case. W could have raised any issue, but W did not have any access to H's records regarding his Schedule C business, over which H maintained exclusive control. Relief under section 6015 was never raised in the court proceeding. If W were to later file a request for relief under section 6015, W's claim would be barred by res judicata. Considering these facts and circumstances, W meaningfully participated in the prior court proceeding regarding the deficiency. The fact that W could not have effectively contested the underlying deficiency because she had no access to H's Schedule C records is not relevant to the determination of whether W meaningfully participated. Instead the meaningful participation exception looks to W's involvement in the prior court proceeding and her ability to raise relief under section 6015 as a defense.

Example 4. Same facts as *Example 3* of this paragraph (e)(4), except that W's participation in discussions with the IRS Chief Counsel attorney were clearly controlled by H, and W was fearful of H when she agreed to settle the case. In this situation, her involvement in the prior proceeding would not be considered meaningful participation because W was able to establish that H maintained control over her and that she did not challenge H for fear of the H's retaliation. If W were to later file a request for relief under section 6015, her claim would not be barred by res judicata.

Example 5. In March 2014, the IRS issued a notice of deficiency to H and W determining a deficiency on H and W's joint income tax return for tax year 2011. H and W timely filed a pro se petition in the United States Tax Court for redetermination of the deficiency. W signed the petition, but otherwise, H handled the entire litigation, from discussing the case with the IRS Chief Counsel attorney to agreeing to a settlement of the case. Relief under section 6015 was never raised. W signed the decision document that H had agreed to with the IRS Chief Counsel attorney. If W were to later file a claim requesting relief under section 6015, W's claim would not be barred by res judicata. Considering these facts and

circumstances, W's involvement in the prior court proceeding regarding the deficiency did not rise to the level of meaningful participation.

Example 6. Same facts as in *Example 5* of this paragraph (e)(4) except that W also participated in settlement negotiations with the IRS Chief Counsel attorney that resulted in the decision document entered in the case. Considering these facts and circumstances—signing the petition and the decision document, along with participating in the negotiations that led to the settlement reflected in the decision document—W meaningfully participated in the prior court proceeding regarding the deficiency because W could have raised relief under section 6015. Any later claim from W requesting relief under section 6015 would be barred by res judicata.

Example 7. In a prior court proceeding involving a petition from a notice of deficiency, H and W hired counsel, C, to represent them in the United States Tax Court. W agreed to C's representation, but otherwise, only H met and communicated with C about the case. C signed and filed the petition, discussed the case with the IRS Chief Counsel attorney, and agreed to a settlement of the case after discussing it with H. Relief under section 6015 was never raised. C signed the decision document on behalf of H and W. If W were to later file a claim requesting relief under section 6015, W's claim would not be barred by res judicata. Even though W was represented by counsel in the prior court proceeding regarding the deficiency, considering all the facts and circumstances, W's involvement in the prior court proceeding did not rise to the level of meaningful participation.

Example 8. In a prior court proceeding involving a petition from a notice of deficiency, H did not sign the petition or other court documents, participate in the Appeals or Counsel settlement negotiations, attend pretrial meetings, or hire separate counsel. H did, however, attend the trial and testify. Considering these facts and circumstances, H's participation in the trial is sufficient to establish that H meaningfully participated in the prior court proceeding regarding the deficiency because H's participation provided H with a definite opportunity to raise relief under section 6015 in that proceeding. Any later claim from H requesting relief under section 6015 would be barred by res judicata.

Example 9. The IRS issued a joint notice of deficiency to H and W determining a deficiency on H and W's joint income tax return based on H's Schedule C business. Only W timely filed a petition in the United States Tax Court. W conceded the deficiency shortly before trial and signed a decision document. W did not raise relief under section 6015. If W were to later file a claim requesting relief under section 6015, W's claim would be barred by res judicata. Because W was the only petitioner in the prior court proceeding, W's participation in that proceeding was meaningful participation.

(5) *Collateral estoppel.* Any final decisions rendered by a court of competent jurisdiction regarding issues relevant to section 6015 are conclusive, and the requesting spouse may be collaterally estopped from relitigating those issues.

* * * * *

(h) *Definitions—(1) Requesting spouse.* A requesting spouse is an individual who filed a joint income tax return and requests relief from Federal income tax liability arising from that return under § 1.6015-2, § 1.6015-3, or § 1.6015-4.

* * * * *

(5) *Request for relief.* A qualifying request under § 1.6015-2, § 1.6015-3, or § 1.6015-4 is the first timely request for relief from joint and several liability for the tax year for which relief is sought. A qualifying request also includes a requesting spouse's second request for relief from joint and several liability for the same tax year under § 1.6015-3 when the additional qualifications of paragraphs (h)(5)(i) and (ii) of this section are met—

(i) The requesting spouse did not qualify for relief under § 1.6015-3 at the time of the first request solely because the qualifications of § 1.6015-3(a) were not satisfied; and

(ii) At the time of the second request, the qualifications for relief under § 1.6015-3(a) were satisfied.

(6) *Unpaid tax and underpayment.* Unpaid tax and underpayment for purposes of § 1.6015-4 means the balance due shown on the joint return, reduced by the tax paid with the joint return. The balance due shown on the joint return is determined after application of the credits for tax withheld under section 31, any amounts paid as estimated income tax, any amounts paid with an extension of time to file, or any other credits applied against the total tax reported on the return. Tax paid with the joint return includes a check or money order remitted with the return or Form 1040-V, "Payment Voucher," or payment by direct debit, credit card, or other commercially acceptable means under section 6311. If the joint return is filed on or before the last day prescribed for filing under section 6072 (determined without regard to any extension of time to file under section 6081), the tax paid with the joint return includes any tax paid on or before the last day prescribed for payment under section 6151. If the joint return is filed after the last day prescribed for filing, the tax paid with the joint return includes any tax paid on or before the date the joint return is filed. A requesting spouse is not entitled to be considered for relief under § 1.6015-4

for any tax paid with the joint return. If the tax paid with the joint return completely satisfies the balance due shown on the return, then there is no unpaid tax for purposes of § 1.6015-4.

(7) *Understatement*. The term understatement means the excess of the amount of tax required to be shown on the return for the taxable year over the amount of the tax imposed which is shown on the return, reduced by any rebate (within the meaning of section 6211(b)(2)).

(8) *Deficiency*. The term deficiency has the same meaning given to that term in section 6211 and § 301.6211-1 of this chapter.

* * * * *

(k) *Credit or refund*—(1) *In general*. Except as provided in paragraphs (k)(2) through (5) of this section, a requesting spouse who is eligible for relief can receive a credit or refund of payments made to satisfy the joint income tax liability, whether the liability resulted from an understatement or an underpayment.

(2) *No credit or refund allowed under § 1.6015-3*. A requesting spouse is not entitled to a credit or refund of any payments made on the joint income tax liability as a result of allocating the deficiency under § 1.6015-3. See section 6015(g)(3) and § 1.6015-3(c)(1).

(3) *No circumvention of §§ 1.6015-1(k)(2) and 1.6015-3(c)(1)*. Section 1.6015-4 may not be used to circumvent the limitation of § 1.6015-3(c)(1) (such as, no refunds under § 1.6015-3). Therefore, relief is not available under this section to obtain a credit or refund of liabilities already paid, for which the requesting spouse would otherwise qualify for relief under § 1.6015-3. For purposes of determining whether the requesting spouse qualifies for relief under § 1.6015-3, the fact that a refund was barred by section 6015(g)(2) and paragraph (k)(2) of this section does not mean that the requesting spouse did not receive full relief. A requesting spouse is entitled to full relief under § 1.6015-3 if the requesting spouse was eligible to allocate the deficiency in full to the nonrequesting spouse.

(4) *Limitations on credit or refund*. The availability of credit or refund is subject to the limitations provided by sections 6511 and 6512(b). Generally the filing of Form 8857, “Request for Innocent Spouse Re-

lief,” will be treated as the filing of a claim for credit or refund even if the requesting spouse does not specifically request a credit or refund. The amount allowable as a credit or refund, assuming the requesting spouse is eligible for relief, includes payments made after the filing of the Form 8857, as well as payments made within the applicable look-back period provided by section 6511(b).

(5) *Requesting spouse limited to credit or refund of payments made by the requesting spouse*. A requesting spouse is only eligible for a credit or refund of payments to the extent the requesting spouse establishes that he or she provided the funds used to make the payment for which he or she seeks a credit or refund. Thus, a requesting spouse is not eligible for a credit or refund of payments made by the nonrequesting spouse. A requesting spouse is also generally not eligible for a credit or refund of joint payments made with the nonrequesting spouse. A requesting spouse, however, may be eligible for a credit or refund of the requesting spouse’s portion of an overpayment from a joint return filed with the nonrequesting spouse that was offset under section 6402 to the spouses’ joint income tax liability, to the extent that the requesting spouse can establish his or her contribution to the overpayment.

(l) [Reserved]

(m) *Penalties and interest*. Generally, a spouse who is entitled to relief under § 1.6015-2, § 1.6015-3, or § 1.6015-4 is also entitled to relief from related penalties, additions to tax, additional amounts, and interest (collectively, penalties and interest). Penalties and interest, however, are not separate erroneous items (as defined in paragraph (h)(4) of this section) from which a requesting spouse can be relieved separate from the tax. Rather relief from penalties and interest related to an understatement or deficiency will generally be determined based on the proportion of the total erroneous items from which the requesting spouse is relieved. For penalties that relate to a particular erroneous item, see § 1.6015-3(d)(4)(iv)(B). Penalties and interest on an underpayment are also not separate items from which a requesting spouse may obtain relief under § 1.6015-4. Relief from penalties and interest on the un-

derpayment will be determined based on the amount of relief from the underpayment to which the requesting spouse is entitled. If the underlying tax liability (whether an assessed deficiency or an underpayment) was paid in full after the joint return was filed but penalties and interest remain unpaid, the requesting spouse may be relieved from the penalties and interest if the requesting spouse is entitled to relief from the underlying tax. The fact that the requesting spouse is entitled to relief from the underlying tax but is not entitled to a refund because of § 1.6015-1(k) does not prevent the requesting spouse from being relieved from liability for the penalties and interest.

(n) *Attribution of understatement or deficiency resulting from an increase to adjusted gross income*—(1) *In general*. Any portion of an understatement or deficiency relating to the disallowance of an item (or increase to an amount of tax) separately listed on an individual income tax return solely due to the increase of adjusted gross income (or modified adjusted gross income or other similar phase-out thresholds) as a result of an erroneous item solely attributable to the nonrequesting spouse will also be attributable to the nonrequesting spouse unless the evidence shows that a different result is appropriate. If the increase to adjusted gross income is the result of an erroneous item(s) of both the requesting and nonrequesting spouses, the item disallowed (or increased tax) due to the increase to adjusted gross income will be attributable to the requesting spouse in the same ratio as the amount of the item or items attributable to the requesting spouse over the total amount of the items that resulted in the increase to adjusted gross income.

(2) *Examples*. The following examples illustrate the rules of this paragraph (n):

Example 1. H and W file a joint Federal income tax return. After applying withholding credits there is a tax liability of \$500. Based on the earned income reported on the return and the number of qualifying children, H and W are entitled to an Earned Income Tax Credit (EITC) in the amount of \$1,500. The EITC satisfies the \$500 in tax due and H and W receive a refund in the amount of \$1,000. Later the IRS concludes that H had additional unreported income, which increased the tax liability on the return to \$1,000 and resulted in H and W’s EITC being reduced to zero due to their adjusted gross income exceeding the maximum amount. The IRS determines a deficiency in the amount of \$2,000 – \$1,500

of which relates to the EITC and \$500 of which relates to H's erroneous item – the omitted income. If W requests relief under section 6015, the entire \$2,000 deficiency is attributable to H because the EITC was disallowed solely due to the increase of adjusted gross income as a result of H's omitted income. W satisfies the attribution factor of § 1.6015–2(a)(2) and the threshold condition in section 4.01(7) of Rev. Proc. 2013–34 with respect to the entire deficiency. Under § 1.6015–3(d)(4)(ii), the portion of the deficiency related to the disallowance of the EITC is initially allocated to H.

Example 2. H and W file a joint Federal income tax return reporting a total tax liability of \$22,000. Later the IRS concludes that H had additional unreported income in the amount of \$20,000, which increased H and W's adjusted gross income and their alternative minimum taxable income. As a result, H and W now owe the Alternative Minimum Tax (AMT). The IRS determines a deficiency in the amount of \$5,250 – \$250 of which relates to H and W's AMT liability as determined under section 55 and \$5,000 of which relates to the increase in H and W's section 1 income tax liability. If W requests relief under section 6015, the entire \$5,250 deficiency is attributable to H because H and W owe the AMT solely due to H's erroneous item – the omitted income. W satisfies the attribution factor of § 1.6015–2(a)(2) and the threshold condition in section 4.01(7) of Rev. Proc. 2013–34 with respect to the entire deficiency. Under § 1.6015–3(d)(4)(ii), the portion of the deficiency related to the AMT is initially allocated to H.

Example 3. H and W file a joint Federal income tax return reporting itemized deductions on Schedule A, "Itemized Deductions," in the amount of \$50,000. Later the IRS concludes that \$10,000 of W's expenses reported on her Schedule C, "Profit or Loss From Business," were not allowable, which increased H and W's adjusted gross income. As a result, H and W's itemized expenses are reduced to \$45,000 as their adjusted gross income exceeded the phase-out amount. The IRS determines a deficiency in the amount of \$5,000. If H requests relief under section 6015, the entire \$5,000 deficiency is attributable to W because the itemized deductions were reduced solely due to the increase of adjusted gross income as a result of W's erroneous item – the Schedule C expenses. H satisfies the attribution factor of § 1.6015–2(a)(2) and the threshold condition in section 4.01(7) of Rev. Proc. 2013–34 with respect to the entire deficiency. Under § 1.6015–3(d)(2)(iv), the portion of the deficiency related to the disallowance of the Schedule A deductions is initially allocated to W.

Example 4. H and W file a joint Federal income tax return reporting itemized deductions on Schedule A in the amount of \$50,000. Later the IRS concludes that H had additional unreported income in the amount of \$4,000 and W had additional unreported income in the amount of \$6,000, which increased H and W's adjusted gross income. As a result, H and W's itemized expenses are reduced to \$45,000 as their adjusted gross income exceeded the phase-out amount. The IRS determines a deficiency in the amount of \$6,000 – \$1,500 of which relates to H's erroneous item, \$2,500 of which relates to W's erroneous item, and \$2,000 of which relates to the

reduced itemized deductions. Assuming the conditions for relief under section 6015 are otherwise satisfied, the \$2,500 deficiency from W's omitted income is attributable to W and the \$1,500 deficiency from H's omitted income is attributable to H. Because the increase to adjusted gross income as a result of both H and W's erroneous items reduced the itemized deductions, the portion of the deficiency related to the disallowed itemized deductions is partially attributable to both H and W. Of the \$2,000 deficiency from the disallowed itemized deductions, \$800 is attributable to H because 40 percent (\$4,000/\$10,000) of the items that resulted in the increase to adjusted gross income are attributable to H, and \$1,200 is attributable to W because 60 percent (\$6,000/\$10,000) of the items that resulted in the increase to adjusted gross income are attributable to W. If both H and W requested relief the most H could be relieved from is \$3700, the amount attributable to W (\$2500 + \$1200), and the most W could be relieved from is \$2300, the amount attributable to H (\$1500 + \$800).

(o) *Abuse by the nonrequesting spouse.* Abuse comes in many forms and can include physical, psychological, sexual, or emotional abuse, including efforts to control, isolate, humiliate, and intimidate the requesting spouse, or to undermine the requesting spouse's ability to reason independently and be able to do what is required under the tax laws. All the facts and circumstances are considered in determining whether a requesting spouse was abused. The impact of a nonrequesting spouse's alcohol or drug abuse is also considered in determining whether a requesting spouse was abused. Depending on the facts and circumstances, abuse of the requesting spouse's child or other family member living in the household may constitute abuse of the requesting spouse.

(p) *Effective/applicability date.* This section will be applicable on the date of publication of a Treasury decision adopting these rules as final regulations in the **Federal Register**.

Par. 9. Section 1.6015–2 is amended by:

1. Paragraph (a) introductory text is revised.
2. Paragraph (b) is removed.
3. Paragraphs (c), (d), and (e) are redesignated as paragraphs (b), (c), and (d).
4. Newly designated paragraph (b) is revised.
5. The last sentence of newly designated paragraph (c) is revised.
6. Newly designated paragraph (d) is revised.
7. Paragraph (e) is added.

The revisions and addition read as follows:

§ 1.6015–2 Relief from liability applicable to all qualifying joint filers.

(a) *In general.* A requesting spouse may be relieved from joint and several liability for tax (including related additions to tax, additional amounts, penalties, and interest) from an understatement for a taxable year under this section if the requesting spouse requests relief in accordance with §§ 1.6015–1(h)(5) and 1.6015–5, and—

* * * * *

(b) *Knowledge or reason to know.* A requesting spouse has knowledge or reason to know of an understatement if he or she actually knew of the understatement, or if a reasonable person in similar circumstances would have known of the understatement. For rules relating to a requesting spouse's actual knowledge, see § 1.6015–3(c)(2). All of the facts and circumstances are considered in determining whether a requesting spouse had reason to know of an understatement. The facts and circumstances that are considered include, but are not limited to, the nature of the erroneous item and the amount of the erroneous item relative to other items; any deceit or evasiveness of the nonrequesting spouse; the couple's financial situation; the requesting spouse's educational background and business experience; the extent of the requesting spouse's participation in the activity that resulted in the erroneous item; the requesting spouse's involvement in business or household financial matters; whether the requesting spouse failed to inquire, at or before the time the return was signed, about items on the return or omitted from the return that a reasonable person would question; any lavish or unusual expenditures compared with past spending levels; and whether the erroneous item represented a departure from a recurring pattern reflected in prior years' returns (for example, omitted income from an investment regularly reported on prior years' returns). A requesting spouse has knowledge or reason to know of the portion of an understatement related to an item attributable to the nonrequesting spouse under § 1.6015–1(n) if the requesting spouse knows or has reason

to know of the nonrequesting spouse's erroneous item or items that resulted in the increase to adjusted gross income. Depending on the facts and circumstances, if the requesting spouse was abused by the nonrequesting spouse (as described in § 1.6015-1(o)), or the nonrequesting spouse maintained control of the household finances by restricting the requesting spouse's access to financial information, and because of the abuse or financial control, the requesting spouse was not able to challenge the treatment of any items on the joint return for fear of the nonrequesting spouse's retaliation, the requesting spouse will be treated as not having knowledge or reason to know of the items giving rise to the understatement. If, however, the requesting spouse involuntarily executed the return, the requesting spouse may choose to establish that the return was signed under duress. In such a case, § 1.6013-4(d) applies.

(c) * * * For guidance concerning the criteria to be used in determining whether it is inequitable to hold a requesting spouse jointly and severally liable under this section, see Rev. Proc. 2013-34 (2013-2 CB 397), or other guidance published by the Treasury and IRS (see § 601.601(d)(2) of this chapter).

(d) *Partial relief*—(1) *In general*. If a requesting spouse had no knowledge or reason to know of a portion of an erroneous item, the requesting spouse may be relieved of the liability attributable to that portion of that item, if all other requirements are met with respect to that portion.

(2) *Example*. The following example illustrates the rules of this paragraph (d):

Example. H and W are married and file their 2014 joint income tax return in March 2015. In April 2016, H is convicted of embezzling \$2 million from his employer during 2014. H kept all of his embezzlement income in an individual bank account, and he used most of the funds to support his gambling habit. H and W had a joint bank account into which H and W deposited all of their reported income. Each month during 2014, H transferred an additional \$10,000 from the individual account to H and W's joint bank account. Although H paid the household expenses using this joint account, W regularly received the bank statements relating to the account. W did not know or have reason to know of H's embezzling activities. W did, however, know or have reason to know of \$120,000 of the \$2 million of H's embezzlement income at the time she signed the joint return because that amount passed through the couple's joint bank account and she regularly received bank statements showing the monthly depos-

its from H's individual account. Therefore, W may be relieved of the liability arising from \$1,880,000 of the unreported embezzlement income, but she may not be relieved of the liability for the deficiency arising from \$120,000 of the unreported embezzlement income of which she knew and had reason to know.

(e) *Effective/applicability date*. This section will be applicable on the date of publication of a Treasury decision adopting these rules as final regulations in the **Federal Register**.

Par. 10. Section 1.6015-3 is amended by:

1. The paragraph heading and first sentence of paragraph (a) are revised.
2. Paragraphs (c)(1) and (c)(2)(iv) are revised.
3. A sentence is added at the end of paragraph (c)(2)(i).
4. Paragraph (c)(2)(v) is redesignated as paragraph (c)(2)(vi) and paragraph (c)(2)(v) is added.
5. Newly redesignated paragraph (c)(2)(vi) is revised.
6. Paragraphs (d)(2)(i) and (d)(5) introductory text are revised.
7. In paragraph (d)(5), *Examples 7, 8, 9, 10, and 11* are added.
8. Paragraph (e) is added.

The revisions and additions read as follows:

§ 1.6015-3 Allocation of deficiency for individuals who are no longer married, are legally separated, or are not members of the same household.

(a) *Allocation of deficiency*. A requesting spouse may allocate a deficiency (as defined in § 1.6015-1(h)(8)) if, as defined in paragraph (b) of this section, the requesting spouse is divorced, widowed, or legally separated, or has not been a member of the same household as the nonrequesting spouse at any time during the 12-month period ending on the date the request for relief is filed. * * *

(c) * * * (1) *No refunds*. Although a requesting spouse may be eligible to allocate the deficiency to the nonrequesting spouse, refunds are not authorized under this section. Refunds of paid liabilities for which a requesting spouse was entitled to allocate the deficiency under this section may be considered under § 1.6015-2 but not under § 1.6015-4. See § 1.6015-1(k)(3).

(2) * * * (i) * * * A requesting spouse has actual knowledge of the portion of an

understatement related to an item attributable to the nonrequesting spouse under § 1.6015-1(n) and allocable to the nonrequesting spouse under paragraph (d) of this section if the requesting spouse has actual knowledge of the nonrequesting spouse's erroneous item or items that resulted in the increase to adjusted gross income.

* * * * *

(iv) *Factors supporting actual knowledge*. To demonstrate that a requesting spouse had actual knowledge of an erroneous item at the time the return was signed, the Internal Revenue Service (IRS) will consider all the facts and circumstances, including but not limited to, whether the requesting spouse made a deliberate effort to avoid learning about the item to be shielded from liability; whether the erroneous item would have been allocable to the requesting spouse but for the tax benefit rule in paragraph (d)(2)(i) of this section; and whether the requesting spouse and the nonrequesting spouse jointly owned the property that resulted in the erroneous item. These factors, together with all other facts and circumstances, may demonstrate that the requesting spouse had actual knowledge of the item. If the requesting spouse had actual knowledge of an erroneous item, the portion of the deficiency with respect to that item will not be allocated to the nonrequesting spouse.

(v) *Actual knowledge and community property*. A requesting spouse will not be considered to have had an ownership interest in an item based solely on the operation of community property law. Rather, a requesting spouse who resided in a community property state at the time the return was signed will be considered to have had an ownership interest in an item only if the requesting spouse's name appeared on the ownership documents, or there otherwise is an indication that the requesting spouse asserted dominion and control over the item. For example, assume H and W live in State A, a community property state. After their marriage, H opens a bank account in his name. Under the operation of the community property laws of State A, W owns one-half of the bank account. Assuming there is no other indication that she asserted dominion and control over the item, W does not have an ownership interest in the account for purposes of this paragraph (c)(2)(v) because she does not hold the account in her name.

(vi) *Abuse exception.* Depending on the facts and circumstances, if the requesting spouse was abused by the nonrequesting spouse (as described in § 1.6015-1(o)), or the nonrequesting spouse maintained control of the household finances by restricting the requesting spouse's access to financial information, and because of the abuse or financial control, the requesting spouse was not able to challenge the treatment of any items on the joint return for fear of the nonrequesting spouse's retaliation, the limitation on the requesting spouse's ability to allocate the deficiency because of actual knowledge will not apply. The requesting spouse will be treated as not having knowledge of the items giving rise to the deficiency. If, however, the requesting spouse involuntarily executed the return, the requesting spouse may choose to establish that the return was signed under duress. In such a case, § 1.6013-4(d) applies.

* * * * *

(d) * * *

(2) * * *

(i) *Benefit on the return—(A) In general.* An erroneous item that would otherwise be allocated to one spouse is allocated to the second spouse to the extent that the second spouse received a tax benefit on the joint

return and the first spouse did not receive a tax benefit. An erroneous item under this paragraph can be allocated to a requesting spouse or a nonrequesting spouse, but only a spouse who requests relief under this section may allocate the deficiency. A spouse who does not request relief under section 6015 remains fully liable for the deficiency. An allocation from a requesting spouse to a nonrequesting spouse reduces the amount for which a requesting spouse remains liable while an allocation from a nonrequesting spouse to a requesting spouse increases the amount for which a requesting spouse remains liable.

(B) *Calculating separate taxable income and tax due.* Under section 6015(d)(3)(A), the items giving rise to the deficiency must be allocated to each spouse in the same manner as the items would have been allocated if the spouses had filed separate returns. In determining whether a spouse received a tax benefit from the item, it may be necessary to calculate each spouse's hypothetical separate return taxable income, determined without regard to the erroneous items, and taking into consideration adjusted gross income, allowable deductions and losses, and allowable credits against tax.

* * * * *

(5) *Examples.* The following examples illustrate the rules of this paragraph (d). In each example, assume that the requesting spouse or spouses qualify to allocate the deficiency, that a request under section 6015 was timely made, and that the deficiency remains unpaid. In addition, unless otherwise stated, assume that neither spouse actually knew of the erroneous items allocable to the other spouse. The examples are as follows:

* * * * *

Example 7. Calculation of tax benefit based on taxable income. (i) On their joint Federal income tax return for tax year 2009, H reports \$60,000 of wage income; W reports \$25,000 of wage income; and H and W report joint interest income of \$2,000 and joint ordinary income from investments in the amount of \$6,000. In addition, H and W properly deduct \$30,000 for their two personal exemptions and itemized deductions, and W erroneously reports a loss from her separate investment in a partnership in the amount of \$20,000. On May 3, 2012, a \$5,000 deficiency is assessed with respect to their 2009 joint return. W dies in November 2012. H requests innocent spouse relief. The deficiency on the joint return results from a disallowance of all of W's \$20,000 loss (which is initially allocable to W).

(ii) After taking all sources of income and all allowable deductions into consideration, H's separate taxable income is \$49,000 and W's separate taxable income is \$14,000, calculated as follows:

	H	W
Wages	\$60,000	\$25,000
Interest Income	\$1,000	\$1,000
Investment Income	\$3,000	\$3,000
	<hr/>	<hr/>
Adj. Gross Income	\$64,000	\$29,000
Exemptions and Deductions	(\$15,000)	(\$15,000)
	<hr/>	<hr/>
Taxable Income	\$49,000	\$14,000
W's Disallowed Loss		(\$20,000)
		<hr/>
Tax Benefit Not Used by W		(\$6,000)
Tax Benefit to W		(\$14,000)
Tax Benefit to H	(\$6,000)	

(iii) As W only used \$14,000 of her \$20,000 loss from her separate investment in a partnership to offset her separate taxable income, H benefited from the other \$6,000 of the disallowed loss used to offset his separate taxable income. Therefore, \$14,000 of the disallowed \$20,000 loss is allocable to W (7/10) and \$6,000 of the disallowed loss is allocable to H (3/10). H's liability

is limited to \$1,500 (3/10 of the \$5,000 deficiency).

Example 8. Nonrequesting spouse receives a benefit on the joint return from the requesting spouse's erroneous item. (i) On their joint Federal income tax return for tax year 2008, W reports \$40,000 of wage income and H reports \$12,000 of wage income. In addition, H and W properly deduct

\$20,000 for their two personal exemptions and itemized deductions, H erroneously deducts a casualty loss in the amount of \$5,000 related to a loss on his separately held property, and W erroneously takes a loss in the amount of \$7,000 from an investment in a tax shelter. H and W legally separate in 2010, and on October 21, 2011, a \$2,400 deficiency is assessed with respect to their 2008 joint return. H requests

innocent spouse relief. The deficiency on the joint return results from a disallowance of all of H's \$5,000 loss and all of W's \$7,000 loss (which is allocable to W and for which H did not have actual knowledge).

(ii) The \$5,000 casualty loss is initially allocated to H. As H's separate taxable income is only \$2,000 (\$12,000 wage income less \$10,000 – 50 percent of the exemptions and itemized deductions), H only used \$2,000 of his \$5,000 casualty loss to offset his separate taxable income, and W benefited from the other \$3,000 of the disallowed loss, which offset a portion of her separate taxable income. Therefore, \$3,000 of the disallowed loss is allocable to W even though the loss is H's item, and \$2,000 of the loss is allocable to H. The \$7,000 tax shelter loss is also allocable to W as H did not have knowledge of the facts that made the tax shelter item unallowable as a loss. H's allocation percentage is 1/6 (\$2,000/\$12,000) and H's liability is limited to \$400 (1/6 of \$2,400 deficiency). The IRS may collect up to \$400 from H and up to \$2,400 from W (although the total amount collected may not exceed \$2,400).

(iii) If the IRS could establish that H had knowledge of the facts that made the deduction for his casualty loss unallowable, the entire \$5,000 casualty loss would be allocable to H. H's allocation percentage would be 5/12 (\$5,000/\$12,000) and H's liability would be limited to \$1,000 (5/12 of \$2,400 deficiency).

(iv) If W also requested innocent spouse relief (and H did not have knowledge of the facts that made his loss unallowable), there would be no remaining joint and several liability, and the IRS would be permitted to collect \$400 from H (1/6 (\$2,000/\$12,000) of the \$2,400 deficiency) and \$2,000 (5/6 (\$10,000/\$12,000) of \$2,400 deficiency) from W. If the IRS could establish that W had knowledge of the facts that made the deduction for the casualty loss unallowable, W would then be liable for the entire \$2,400 deficiency, while H would remain liable for up to \$400.

Example 9. Allocation of liability based on joint erroneous loss item. (i) On their joint Federal income tax return for tax year 2009, H reports \$100,000 of wage income and W reports \$50,000 of wage income. In addition, H and W properly deduct \$40,000 for their two personal exemptions and itemized deductions, and erroneously report a loss in the amount of \$50,000 from a jointly-held investment in a tax shelter. H and W divorce in 2011, and on August 14, 2012, a \$12,000 deficiency is assessed with respect to their 2009 joint return. W requests innocent spouse relief. The deficiency on the joint return results from a disallowance of all of the \$50,000 loss.

(ii) Under paragraph (d)(2)(iv) of this section, in the absence of clear and convincing evidence supporting a different allocation, an erroneous deduction item related to a jointly-owned investment is generally allocated 50 percent to each spouse. Thus, \$25,000 of the loss is allocated to each spouse. In determining the effect, if any, of the tax benefit rule of § 1.6015-1(d)(2)(i), H's separate taxable income is \$80,000: \$100,000 wage income minus \$20,000, or 50 percent of the exemptions and itemized deductions; and W's separate taxable income is \$30,000:

\$50,000 minus \$20,000. As both H's and W's separate taxable income exceeds their allocated share of the disallowed loss, no additional amount is allocated between the spouses. W's allocation percentage is 1/2 (\$25,000/\$50,000) and W's liability is limited to \$6,000 (1/2 of \$12,000 deficiency). The IRS may collect up to \$6,000 from W and up to \$12,000 from H (although the total amount collected may not exceed \$12,000).

(iii) If the IRS could establish that W had knowledge of the facts that made the loss unallowable, both H and W would then remain jointly and severally liable for the \$12,000 deficiency.

Example 10. Calculation of tax benefit based on joint erroneous item. Assume the same facts as in Example 9 of this paragraph (d)(5), except that W's wage income is only \$40,000. W's separate taxable income would then be only \$20,000 (\$40,000 wage income minus \$20,000 – 50 percent of the exemptions and itemized deductions). W would only be able to use \$20,000 of the \$25,000 loss from the tax shelter to offset her separate taxable income. Accordingly, H benefited from the other \$5,000 of the disallowed loss, which was used to offset a portion of his separate taxable income. Therefore, \$20,000 of the disallowed loss is allocable to W, and \$30,000 is allocable to H: \$25,000 (H's 50 percent of the disallowed loss) plus \$5,000 (the portion of W's 50 percent that is allocable to H because H received a tax benefit). W's allocation percentage is 2/5 (\$20,000/\$50,000) and W's liability is limited to \$4,800 (2/5 of \$12,000 deficiency). The IRS may collect up to \$4,800 from W and up to \$12,000 from H (although the total amount collected may not exceed \$12,000).

Example 11. Allocation of erroneous item based on fraud of the nonrequesting spouse. During 2009, W fraudulently accesses H's brokerage account to sell stock that H had separately received from an inheritance. W deposits the funds from the sale in a separate bank account to which H did not have access. H and W file a joint Federal income tax return for tax year 2009. The return did not include the income from the sale of the stock. H and W divorce in November 2010. The divorce decree states that W committed forgery and defrauded H with respect to his brokerage account. The IRS commences an audit in March 2011 and determines a deficiency based on the omission of the income from the sale of the stock. H requests innocent spouse relief. Under paragraph (d)(2)(iii) of this section, items of investment income are generally allocated to the spouse who owned the investment, which in this case would be H. Under paragraph (d)(2)(ii) of this section, however, the IRS may allocate any item between the spouses if the IRS determines that the allocation is appropriate due to fraud by one or both spouses. The IRS determines that W committed fraud with respect to H and as a result it is appropriate to allocate the deficiency to W under paragraph (d)(2)(ii).

(e) **Effective/applicability date.** This section will be applicable on the date of publication of a Treasury decision adopting these rules as final regulations in the **Federal Register**.

Par. 11. Section 1.6015-4 is revised to read as follows:

§ 1.6015-4 Equitable relief.

(a) A requesting spouse who files a joint return for which an understatement or deficiency (as defined by § 1.6015-1(h)(7) and (8)) was determined or for which there was unpaid tax (as defined by § 1.6015-1(h)(6)), and who does not qualify for full relief under § 1.6015-2 or § 1.6015-3, may be entitled to equitable relief under this section. The Internal Revenue Service (IRS) has the discretion to grant equitable relief from joint and several liability to a requesting spouse when, considering all of the facts and circumstances, it would be inequitable to hold the requesting spouse jointly and severally liable.

(b) This section may not be used to circumvent the limitation of § 1.6015-3(c)(1). Therefore, relief is not available under this section to obtain a refund of liabilities already paid, for which the requesting spouse would otherwise qualify for relief under § 1.6015-3. See § 1.6015-1(k)(3). If the requesting spouse is only eligible for partial relief under § 1.6015-3 (i.e., some portion of the deficiency is allocable to the requesting spouse), then the requesting spouse may be considered for relief under this section with respect to the portion of the deficiency for which the requesting spouse was not entitled to relief.

(c) For guidance concerning the criteria to be used in determining whether it is inequitable to hold a requesting spouse jointly and severally liable under this section, see Rev. Proc. 2013-34 (2013-1 IRB 397), or other guidance published by the Treasury and IRS (see § 601.601(d)(2) of this chapter).

(d) **Effective/applicability date.** This section will be applicable on the date of publication of a Treasury decision adopting these rules as final regulations in the **Federal Register**.

Par. 12. Section 1.6015-5 is amended by adding paragraph (d) to read as follows:

§ 1.6015-5. Time and manner for requesting relief.

* * * * *

(d) *Effective/applicability date.* This section will be applicable on the date of publication of a Treasury decision adopting these rules as final regulations in the **Federal Register**.

Par. 13. Section 1.6015-6 is amended by revising the first sentence of paragraph (a)(1), adding a sentence at the end of paragraph (a)(2), and adding paragraph (d) to read as follows:

§ 1.6015-6 Nonrequesting spouse's notice and opportunity to participate in administrative proceedings.

(a) * * * (1) When the Internal Revenue Service (IRS) receives a request for relief under § 1.6015-2, § 1.6015-3, or § 1.6015-4, the IRS must send a notice to the nonrequesting spouse's last known address that informs the nonrequesting spouse of the requesting spouse's request for relief. * * *

(2) * * * For guidance concerning the nonrequesting spouse's right to appeal the preliminary determination to IRS Appeals, see Rev. Proc. 2003-19 (2003-1 CB 371), or other guidance published by the Treasury Department and the IRS (see § 601.601(d)(2) of this chapter).

* * * * *

(d) *Effective/applicability date.* This section will be applicable on the date of publication of a Treasury decision adopting these rules as final regulations in the **Federal Register**.

Par. 14. In § 1.6015-7, paragraphs (b), (c)(1), (c)(3), and (c)(4)(iii) are revised and paragraph (d) is added to read as follows:

§ 1.6015-7 Tax Court review.

* * * * *

(b) *Time period for petitioning the Tax Court.* Pursuant to section 6015(e), the requesting spouse may petition the Tax Court to review the denial of relief under § 1.6015-1 within 90 days after the date the Internal Revenue Service's (IRS) final determination is mailed by certified or registered mail (the 90-day period). If the IRS does not mail the requesting spouse a final determination letter within 6 months

of the date the requesting spouse files a request for relief under section 6015, the requesting spouse may petition the Tax Court to review the request at any time after the expiration of the 6-month period and before the expiration of the 90-day period. The Tax Court also may review a request for relief if the Tax Court has jurisdiction under another section of the Internal Revenue Code, such as section 6213(a) or section 6330(d). This paragraph (b) applies to liabilities arising on or after December 20, 2006, or arising prior to December 20, 2006, and remaining unpaid as of that date. For liabilities arising prior to December 20, 2006, which were fully paid prior to that date, the requesting spouse may petition the Tax Court to review the denial of relief as discussed above, but only with respect to denials of relief involving understatements under § 1.6015-2, § 1.6015-3, or § 1.6015-4.

(c) *Restrictions on collection and suspension of the running of the period of limitations—*(1) *Restrictions on collection—*(i) *Restrictions on collection for requests for relief made on or after December 20, 2006.* Unless the IRS determines that collection will be jeopardized by delay, no levy or proceeding in court shall be made, begun, or prosecuted against a spouse requesting relief under § 1.6015-2, § 1.6015-3, or § 1.6015-4 (except for certain requests for relief made solely under § 1.6015-4) for the collection of any assessment to which the request relates until the expiration of the 90-day period described in paragraph (b) of this section, or, if a petition is filed with the Tax Court, until the decision of the Tax Court becomes final under section 7481. For requests for relief made solely under § 1.6015-4, the restrictions on collection only apply if the liability arose on or after December 20, 2006, or arose prior to December 20, 2006, and remained unpaid as of that date. The restrictions on collection begin on the date the request is filed.

(ii) *Restriction on collection for requests for relief made before December 20, 2006.* Unless the IRS determines that collection will be jeopardized by delay, no levy or proceeding in court shall be made, begun, or prosecuted against a requesting spouse requesting relief under § 1.6015-2 or § 1.6015-3 for the collection of any assessment to which the request relates

until the expiration of the 90-day period described in paragraph (b) of this section, or if a petition is filed with the Tax Court, until the decision of the Tax Court becomes final under section 7481. The restrictions on collection begin on the date the request is filed with the IRS. For requests for relief made solely under § 1.6015-4, the restrictions on collection do not begin until December 20, 2006, and only apply with respect to liabilities remaining unpaid on or after that date.

(iii) *Rules for determining the period of the restrictions on collection.* For more information regarding the date on which a decision of the Tax Court becomes final, see section 7481 and the regulations thereunder. Notwithstanding paragraphs (c)(1)(i) and (ii) of this section, if the requesting spouse appeals the Tax Court's decision, the IRS may resume collection of the liability from the requesting spouse on the date the requesting spouse files the notice of appeal, unless the requesting spouse files an appeal bond pursuant to the rules of section 7485. Jeopardy under paragraphs (c)(1)(i) and (ii) of this section means conditions exist that would require an assessment under section 6851 or 6861 and the regulations thereunder.

* * * * *

(3) *Suspension of the running of the period of limitations.* The running of the period of limitations in section 6502 on collection against the requesting spouse of the assessment to which the request under § 1.6015-2, § 1.6015-3, or § 1.6015-4 relates is suspended for the period during which the IRS is prohibited by paragraph (c)(1) of this section from collecting by levy or a proceeding in court and for 60 days thereafter. If the requesting spouse, however, signs a waiver of the restrictions on collection in accordance with paragraph (c)(2) of this section, the suspension of the period of limitations in section 6502 on collection against the requesting spouse will terminate on the date that is 60 days after the date the waiver is filed with the IRS.

(4) * * *

(iii) *Assessment to which the request relates.* For purposes of this paragraph (c), the assessment to which the request relates is the entire assessment of the understatement or the balance due shown on the return to which the request relates, even if

the request for relief is made with respect to only part of that understatement or balance due.

(d) *Effective/applicability date.* This section will be applicable on the date of publication of a Treasury decision adopting these rules as final regulations in the **Federal Register**.

Par. 15. Section 1.6015–8 is amended by adding paragraph (d) to read as follows:

§ 1.6015–8 *Applicable liabilities.*

* * * * *

(d) *Effective/applicability date.* This section will be applicable on the date of publication of a Treasury decision adopting these rules as final regulations in the **Federal Register**.

§ 1.6015–9 [Removed]

Par. 16. Section 1.6015–9 is removed.

§§ 1.6015–3 and 1.6015–8 [Amended]

Par. 17. For each entry in the “Section” column remove the language in the “Remove” column and add the language in the “Add” column in its place.

Section	Remove	Add
1.6015–3(c)(4) <i>Example 4</i> (ii), (iii), (iv), and (v), first sentence	<i>Example 5</i>	<i>Example 4</i>
1.6015–3(c)(4) <i>Example 5</i> (ii), (iii), and (iv), first sentence	<i>Example 6</i>	<i>Example 5</i>
1.6015–8(c) <i>Example 1</i> , fifth sentence	6015(b)	6015

John Dalrymple,
Deputy Commissioner for
Services and Enforcement.

(Filed by the Office of the federal Register on November 19, 2015, 8:45 a.m., and published in the issue of the Federal Register for November 20, 2015, 80 F.R. 72649)

Definition of Terms

Revenue rulings and revenue procedures (hereinafter referred to as "rulings") that have an effect on previous rulings use the following defined terms to describe the effect:

Amplified describes a situation where no change is being made in a prior published position, but the prior position is being extended to apply to a variation of the fact situation set forth therein. Thus, if an earlier ruling held that a principle applied to A, and the new ruling holds that the same principle also applies to B, the earlier ruling is amplified. (Compare with modified, below).

Clarified is used in those instances where the language in a prior ruling is being made clear because the language has caused, or may cause, some confusion. It is not used where a position in a prior ruling is being changed.

Distinguished describes a situation where a ruling mentions a previously published ruling and points out an essential difference between them.

Modified is used where the substance of a previously published position is being changed. Thus, if a prior ruling held that a principle applied to A but not to B, and the new ruling holds that it applies to both A

and B, the prior ruling is modified because it corrects a published position. (Compare with amplified and *clarified*, above).

Obsoleted describes a previously published ruling that is not considered determinative with respect to future transactions. This term is most commonly used in a ruling that lists previously published rulings that are obsoleted because of changes in laws or regulations. A ruling may also be obsoleted because the substance has been included in regulations subsequently adopted.

Revoked describes situations where the position in the previously published ruling is not correct and the correct position is being stated in a new ruling.

Superseded describes a situation where the new ruling does nothing more than restate the substance and situation of a previously published ruling (or rulings). Thus, the term is used to republish under the 1986 Code and regulations the same position published under the 1939 Code and regulations. The term is also used when it is desired to republish in a single ruling a series of situations, names, etc., that were previously published over a period of time in separate rulings. If the new ruling does more than restate the sub-

stance of a prior ruling, a combination of terms is used. For example, modified and *superseded* describes a situation where the substance of a previously published ruling is being changed in part and is continued without change in part and it is desired to restate the valid portion of the previously published ruling in a new ruling that is self contained. In this case, the previously published ruling is first modified and then, as modified, is superseded.

Supplemented is used in situations in which a list, such as a list of the names of countries, is published in a ruling and that list is expanded by adding further names in subsequent rulings. After the original ruling has been supplemented several times, a new ruling may be published that includes the list in the original ruling and the additions, and supersedes all prior rulings in the series.

Suspended is used in rare situations to show that the previous published rulings will not be applied pending some future action such as the issuance of new or amended regulations, the outcome of cases in litigation, or the outcome of a Service study.

Abbreviations

The following abbreviations in current use and formerly used will appear in material published in the Bulletin.

A—Individual.
Acq.—Acquiescence.
B—Individual.
BE—Beneficiary.
BK—Bank.
B.T.A.—Board of Tax Appeals.
C—Individual.
C.B.—Cumulative Bulletin.
CFR—Code of Federal Regulations.
CI—City.
COOP—Cooperative.
Ct.D.—Court Decision.
CY—County.
D—Decedent.
DC—Dummy Corporation.
DE—Donee.
Del. Order—Delegation Order.
DISC—Domestic International Sales Corporation.
DR—Donor.
E—Estate.
EE—Employee.
E.O.—Executive Order.
ER—Employer.

ERISA—Employee Retirement Income Security Act.
EX—Executor.
F—Fiduciary.
FC—Foreign Country.
FICA—Federal Insurance Contributions Act.
FISC—Foreign International Sales Company.
FPH—Foreign Personal Holding Company.
F.R.—Federal Register.
FUTA—Federal Unemployment Tax Act.
FX—Foreign corporation.
G.C.M.—Chief Counsel's Memorandum.
GE—Grantee.
GP—General Partner.
GR—Grantor.
IC—Insurance Company.
I.R.B.—Internal Revenue Bulletin.
LE—Lessee.
LP—Limited Partner.
LR—Lessor.
M—Minor.
Nonacq.—Nonacquiescence.
O—Organization.
P—Parent Corporation.
PHC—Personal Holding Company.
PO—Possession of the U.S.
PR—Partner.
PRS—Partnership.

PTE—Prohibited Transaction Exemption.
Pub. L.—Public Law.
REIT—Real Estate Investment Trust.
Rev. Proc.—Revenue Procedure.
Rev. Rul.—Revenue Ruling.
S—Subsidiary.
S.P.R.—Statement of Procedural Rules.
Stat.—Statutes at Large.
T—Target Corporation.
T.C.—Tax Court.
T.D.—Treasury Decision.
TFE—Transferee.
TFR—Transferor.
T.I.R.—Technical Information Release.
TP—Taxpayer.
TR—Trust.
TT—Trustee.
U.S.C.—United States Code.
X—Corporation.
Y—Corporation.
Z—Corporation.

Numerical Finding List¹

Bulletins 2015–27 through 2015–49

Announcements:

2015-17, 2015-28 I.R.B. 67
2015-18, 2015-33 I.R.B. 198
2015-19, 2015-32 I.R.B. 157
2015-20, 2015-38 I.R.B. 355
2015-21, 2015-34 I.R.B. 220
2015-22, 2015-35 I.R.B. 288
2015-23, 2015-36 I.R.B. 311
2015-24, 2015-36 I.R.B. 313
2015-25, 2015-39 I.R.B. 422
2015-26, 2015-47 I.R.B. 677
2015-27, 2015-48 I.R.B. 694
2015-28, 2015-46 I.R.B. 673
2015-29, 2015-46 I.R.B. 673
2015-30, 2015-46 I.R.B. 673
2015-31, 2015-49 I.R.B. 841
2015-32, 2015-49 I.R.B. 841
2015-33, 2015-49 I.R.B. 842

Notices:

2015-43, 2015-29 I.R.B. 73
2015-46, 2015-28 I.R.B. 64
2015-47, 2015-30 I.R.B. 76
2015-48, 2015-30 I.R.B. 77
2015-49, 2015-30 I.R.B. 79
2015-50, 2015-30 I.R.B. 81
2015-51, 2015-31 I.R.B. 133
2015-52, 2015-35 I.R.B. 227
2015-53, 2015-33 I.R.B. 190
2015-54, 2015-34 I.R.B. 210
2015-55, 2015-34 I.R.B. 217
2015-56, 2015-35 I.R.B. 235
2015-57, 2015-36 I.R.B. 294
2015-58, 2015-37 I.R.B. 322
2015-59, 2015-40 I.R.B. 459
2015-60, 2015-43 I.R.B. 604
2015-61, 2015-39 I.R.B. 408
2015-62, 2015-39 I.R.B. 411
2015-63, 2015-40 I.R.B. 461
2015-64, 2015-40 I.R.B. 464
2015-65, 2015-40 I.R.B. 466
2015-66, 2015-41 I.R.B. 541
2015-67, 2015-41 I.R.B. 546
2015-68, 2015-41 I.R.B. 547
2015-69, 2015-41 I.R.B. 550
2015-70, 2015-43 I.R.B. 604
2015-71, 2015-43 I.R.B. 606
2015-72, 2015-44 I.R.B. 613
2015-73, 2015-46 I.R.B. 660
2015-74, 2015-46 I.R.B. 663
2015-75, 2015-46 I.R.B. 668
2015-76, 2015-46 I.R.B. 669
2015-77, 2015-47 I.R.B. 676
2015-78, 2015-48 I.R.B. 690

Notices:—Continued

2015-79, 2015-49 I.R.B. 775
2015-80, 2015-48 I.R.B. 691
2015-81, 2015-49 I.R.B. 784

Proposed Regulations:

REG-140379-02, 2015-45 I.R.B. 653
REG-134219-08, 2015-49 I.R.B. 842
REG-136459-09, 2015-37 I.R.B. 332
REG-155164-09, 2015-41 I.R.B. 560
REG-109370-10, 2015-33 I.R.B. 198
REG-112997-10, 2015-39 I.R.B. 422
REG-103033-11, 2015-37 I.R.B. 325
REG-109813-11, 2015-37 I.R.B. 330
REG-138344-13, 2015-41 I.R.B. 557
REG-139483-13, 2015-40 I.R.B. 475
REG-148998-13, 2015-45 I.R.B. 653
REG-115452-14, 2015-32 I.R.B. 158
REG-127895-14, 2015-41 I.R.B. 556
REG-132075-14, 2015-35 I.R.B. 288
REG-138526-14, 2015-28 I.R.B. 67
REG-143800-14, 2015-37 I.R.B. 347
REG-102648-15, 2015-31 I.R.B. 134
REG-102837-15, 2015-27 I.R.B. 43
REG-121496-15, 2015-46 I.R.B. 674
REG-123640-15, 2015-37 I.R.B. 350

Revenue Procedures:

2015-34, 2015-27 I.R.B. 4
2015-36, 2015-27 I.R.B. 20
2015-38, 2015-36 I.R.B. 295
2015-39, 2015-33 I.R.B. 195
2015-40, 2015-35 I.R.B. 236
2015-41, 2015-35 I.R.B. 263
2015-42, 2015-36 I.R.B. 310
2015-43, 2015-40 I.R.B. 467
2015-44, 2015-38 I.R.B. 354
2015-45, 2015-39 I.R.B. 412
2015-46, 2015-39 I.R.B. 414
2015-47, 2015-39 I.R.B. 419
2015-48, 2015-40 I.R.B. 469
2015-49, 2015-41 I.R.B. 555
2015-50, 2015-42 I.R.B. 583
2015-51, 2015-42 I.R.B. 583
2015-52, 2015-45 I.R.B. 638
2015-53, 2015-44 I.R.B. 615
2015-54, 2015-45 I.R.B. 648
2015-55, 2015-49 I.R.B. 788
2015-56, 2015-49 I.R.B. 827

Revenue Rulings:

2015-15, 2015-27 I.R.B. 1
2015-16, 2015-31 I.R.B. 130
2015-17, 2015-39 I.R.B. 358
2015-18, 2015-34 I.R.B. 209
2015-19, 2015-36 I.R.B. 291
2015-20, 2015-38 I.R.B. 353

Revenue Rulings:—Continued

2015-21, 2015-40 I.R.B. 447
2015-22, 2015-44 I.R.B. 610
2015-24, 2015-48 I.R.B. 687
2015-25, 2015-49 I.R.B. 695
2015-26, 2015-49 I.R.B. 696

Treasury Decisions:

9723, 2015-31 I.R.B. 84
9726, 2015-31 I.R.B. 98
9727, 2015-32 I.R.B. 154
9728, 2015-33 I.R.B. 169
9729, 2015-35 I.R.B. 221
9730, 2015-35 I.R.B. 223
9731, 2015-37 I.R.B. 314
9732, 2015-39 I.R.B. 371
9733, 2015-41 I.R.B. 494
9734, 2015-41 I.R.B. 500
9735, 2015-37 I.R.B. 316
9736, 2015-39 I.R.B. 402
9737, 2015-40 I.R.B. 449
9738, 2015-40 I.R.B. 453
9739, 2015-41 I.R.B. 528
9740, 2015-42 I.R.B. 573
9741, 2015-45 I.R.B. 628
9742, 2015-46 I.R.B. 657
9743, 2015-48 I.R.B. 679
9744, 2015-49 I.R.B. 700

¹A cumulative list of all revenue rulings, revenue procedures, Treasury decisions, etc., published in Internal Revenue Bulletins 2015–01 through 2015–26 is in Internal Revenue Bulletin 2015–26, dated June 29, 2015.

Finding List of Current Actions on Previously Published Items¹

Bulletins 2015–27 through 2015–49

Notices:

2011-55

Amplified by
Notice 2015-77, 2015-47 I.R.B. 676

2013-7

Amplified by
Notice 2015-77, 2015-47 I.R.B. 676

2014-4

Modified by
Notice 2015-51, 2015-31 I.R.B. 133

2014-17

Superseded by
Notice 2015-67, 2015-41 I.R.B. 546

Proposed Regulations:

2009-57

Obsoleted by
REG-112997-10 2015-39 I.R.B. 422

2013-17

Obsoleted by
REG-148998-13 2015-45 I.R.B. 653

Revenue Procedures:

1992-75

Clarified by
Rev. Proc. 2015-40, 2015-35 I.R.B. 236

2003-40

Modified by
Rev. Proc. 2015-40, 2015-35 I.R.B. 236

2003-78

Modified by
Rev. Proc. 2015-46, 2015-39 I.R.B. 414

2006-9

Modified by
Rev. Proc. 2015-41, 2015-35 I.R.B. 263

2006-9

Superseded by
Rev. Proc. 2015-41, 2015-35 I.R.B. 263

2006-54

Modified by
Rev. Proc. 2015-40, 2015-35 I.R.B. 236

2006-54

Superseded by
Rev. Proc. 2015-40, 2015-35 I.R.B. 236

Revenue Procedures:—Continued

2008-31

Modified by
Rev. Proc. 2015-41, 2015-35 I.R.B. 263

2008-31

Superseded by
Rev. Proc. 2015-41, 2015-35 I.R.B. 263

2011-49

Modified by
Rev. Proc. 2015-36, 2015-27 I.R.B. 20

2011-49

Superseded by
Rev. Proc. 2015-36, 2015-27 I.R.B. 20

2015-8

Superseded by
Rev. Proc. 2015-55, 2015-49 I.R.B. 788

2015-14

Modified by
Rev. Proc. 2015-39, 2015-33 I.R.B. 195

2015-14

Modified by
Rev. Proc. 2015-56, 2015-49 I.R.B. 827

2015-18

Superseded by
Rev. Proc. 2015-55, 2015-49 I.R.B. 788

2015-40

Amplified by
Rev. Proc. 2015-41, 2015-35 I.R.B. 263

2015-41

Amplified by
Rev. Proc. 2015-40, 2015-35 I.R.B. 236

Revenue Rulings:

2014-30

Supplemented by
Rev. Rul. 2015-24, 2015-48 I.R.B. 687

2014-30

Superseded by
Rev. Rul. 2015-24, 2015-48 I.R.B. 687

Treasury Decisions:

58-422

Obsoleted by
T.D. 9739 2015-41 I.R.B. 528

66-284

Obsoleted by
T.D. 9739 2015-41 I.R.B. 528

Treasury Decisions:—Continued

79-250

Obsoleted by
T.D. 9739 2015-41 I.R.B. 528

79-289

Obsoleted by
T.D. 9739 2015-41 I.R.B. 528

96-29

Obsoleted by
T.D. 9739 2015-41 I.R.B. 528

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