

Internal Revenue bulletin

Bulletin No. 2015–2
January 12, 2015

7 HIGHLIGHTS OF THIS ISSUE

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–109187–11, page 277.

The proposed regulations provide the general rule that a transferor of an installment obligation does not recognize gain or loss under section 453B on certain dispositions of an installment obligation if gain or loss is not recognized on the disposition under another provision of the Code. The proposed regulations also provide that this general rule does not apply to the satisfaction of an installment obligation.

Notice 2015–1, page 249.

This notice provides the maximum vehicles values for use with the special valuation rules under regulation section 1.61–21 (d) and (e) for 2014. These values are adjusted for inflation and must be adjusted annually by reference to the Consumer Price Index.

Rev. Proc. 2015–12, page 265.

Rev. Proc. 2015–12 provides guidance that taxpayers may use to determine whether expenditures to maintain, replace, or improve cable system network assets may be deducted under § 162 or must be capitalized under § 263(a), as well as guidance on computing depreciation for certain cable system network assets under §§ 167 and 168.

T.D. 9707, page 247.

These regulations remove a provision on filing Form 5472, “Information Return of a 25% Foreign-Owned U.S. Corporation or a Foreign Corporation Engaged in a U.S. Trade or Business”, when the filer’s income tax return will be late. Form 5472 will always be required to be filed with the filer’s income tax return, by the due date (including extensions) of that return.

EMPLOYEE PLANS

REG–132751–14, page 279.

This document contains proposed rules that would amend the regulations regarding excepted benefits under the Employee Retirement Income Security Act of 1974, the Internal Revenue Code, and the Public Health Service Act related to limited wraparound coverage. Excepted benefits are generally exempt from the requirements that were added to those laws by the Health Insurance Portability and Accountability Act and the Patient Protection and Affordable Care Act.

REG–145878–14, page 290.

This document contains proposed rules that would amend the regulations regarding the summary of benefits and coverage (SBC) and the uniform glossary for group health plans and health insurance coverage in the group and individual markets under the Patient Protection and Affordable Care Act. It proposes changes concerning the disclosure requirements under section 2715 of the Public Health Service Act and to documents required for compliance with section 2715 of the Public Health Service Act, including to: a template for the SBC; instructions; sample language; a guide for coverage example calculations, and the uniform glossary.

(Continued on the next page)

Finding Lists begin on page ii.



EXEMPT ORGANIZATIONS

Rev. Proc. 2015–9, page 249.

This document sets forth procedures for issuing determination letters on the exempt status of organizations under sections 501 and 521 of the Code. The procedures also apply to the revocation and modification of determination letters, and provide guidance on the exhaustion of administrative remedies for purposes of declaratory judgment under section 7428 of the Code. Rev. Proc. 2014–9 is superseded.

Rev. Proc. 2015–10, page 262.

This document sets forth procedures for issuing determination letters and rulings on private foundation status under section 509(a) of the Code, operating foundation status under section 4942(j)(3), and exempt operating foundation status under section 4940(d)(2), of organizations exempt from Federal income tax under section 501(c)(3). This revenue procedure also applies to the issuance of determination letters on the foundation status under section 509(a)(3) of nonexempt charitable trusts described in section 4947(a)(1). Rev. Proc. 2014–10 is superseded.

EXCISE TAX

REG–132751–14, page 279.

This document contains proposed rules that would amend the regulations regarding excepted benefits under the Employee Retirement Income Security Act of 1974, the Internal Revenue Code, and the Public Health Service Act related to limited wraparound coverage. Excepted benefits are generally exempt from the requirements that were added to those laws by the Health Insurance Portability and Accountability Act and the Patient Protection and Affordable Care Act.

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ADMINISTRATIVE

Notice 2015–1, page 249.

This notice provides the maximum vehicles values for use with the special valuation rules under regulation section 1.61–21 (d) and (e) for 2014. These values are adjusted for inflation and must be adjusted annually by reference to the Consumer Price Index.

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 351.—Transfer to Corporation Controlled by Transferor

Proposed regulations will amend § 1.351-1(a)(1) to include a cross-reference to § 1.453B-1(c) for rules requiring a transferor to recognize gain or loss upon the satisfaction of an installment obligation of a corporation when the obligation is exchanged for stock in that corporation. See REG-109187-11, page 277.

Section 361.— Nonrecognition of Gain or Loss to Corporations; Treatment of Distributions

Proposed regulations will amend § 1.361-1 to include a cross-reference to § 1.453B-1(c) for rules requiring a corporation transferring an installment obligation to the acquiring corporation to recognize gain or loss upon receipt of stock of the acquiring corporation or another party to the reorganization in satisfaction of that installment obligation. See REG-109187-11, page 277.

Section 721.— Nonrecognition of Gain or Loss on Contribution

Proposed regulations will amend § 1.721-1(a) to include a cross-reference to § 1.453B-1(c) for rules in determining a partner's gain or loss when an installment obligation of a partnership is contributed to the partnership. See REG-109187-11, page 277.

Section 6038A.— Information with respect to certain foreign-owned corporations

26 CFR 1.6038A-2: Requirement of return.

TD 9707

DEPARTMENT OF THE TREASURY Internal Revenue Service 26 CFR Part 1

Filing of Form 5472

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations.

SUMMARY: This document contains final regulations concerning the manner of filing Form 5472, "Information Return of a 25% Foreign-Owned U.S. Corporation or a Foreign Corporation Engaged in a U.S. Trade or Business." The final regulations affect certain 25-percent foreign-owned domestic corporations and certain foreign corporations that are engaged in a trade or business in the United States that are required to file Form 5472.

DATES: *Effective date:* These regulations are effective on December 24, 2014.

Applicability date: For dates of applicability, see §§ 1.6038A-1(n)(2) and (n)(3) and 1.6038A-2(g).

FOR FURTHER INFORMATION

CONTACT: Anand Desai at (202) 317-6939 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

On June 6, 2014, the Department of the Treasury (Treasury Department) and the IRS published a notice of proposed rule-making (REG-114942-14) in the **Federal Register** (79 FR 32687, 2014-26 IRB 1117) under sections 6038A and 6038C of the Internal Revenue Code (Code) (proposed regulations). The proposed regulations proposed removing a provision for timely filing Form 5472 separately from an income tax return that is untimely filed ("untimely filed return provision"). As a result, Form 5472 would be required to be filed in all cases only with the filer's income tax return for the taxable year by the due

date (including extensions) of that return. No public hearing was requested or held. The Treasury Department and the IRS received two written comments on the proposed regulations, which are available at www.regulations.gov. After consideration of the comments, this Treasury decision adopts the proposed regulations, without substantive change, as final regulations.

Summary of Comments

One comment recommended that the "untimely filed return provision" be retained because the IRS may not timely receive the information required by Form 5472 if the untimely filed return provision is removed. The comment also recommended conforming changes to permit the filing of Form 5471, "Information Return of U.S. Persons With Respect to Certain Foreign Corporations," and Form 8865, "Return of U.S. Persons With Respect to Certain Foreign Partnerships," separately from an income tax return that is untimely filed.

The Treasury Department and the IRS decline to adopt this comment. The Treasury Department and the IRS have determined that tax administration generally is more efficient when forms (for example, Form 5471, Form 5472, and Form 8865) are filed with the filer's timely filed income tax return.

The second comment addressed issues unrelated to the proposed regulatory change. The final regulations do not incorporate the suggestions contained in this comment, which are outside the scope of the proposed regulations.

Special Analyses

It has been determined that these regulations are not a significant regulatory action as defined in Executive Order 12866, as supplemented 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 regulations, and because the regulations do not impose a collection of information, the Regulatory Flexibility Act (5 U.S.C.

chapter 6) does not apply. Pursuant to section 7805(f) of the Code, the notice of proposed rulemaking preceding this regulation was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Drafting information

The principal author of these regulations is Anand Desai, Office of Associate Chief Counsel (International). However, other personnel from the Treasury Department and the IRS participated in their development.

Adoption of Amendments to the Regulations

Accordingly, 26 CFR part 1 is amended as follows:

Part 1—INCOME TAXES

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

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

Par. 2. Section 1.6038A-1 is amended by revising the third sentence of, and adding a new fourth sentence to, paragraph (n)(2), and adding a third sentence to paragraph (n)(3), to read as follows:

§ 1.6038A-1 General requirements and definitions.

(n) * * *

(2) Section 1.6038A-2. * * * Section 1.6038A-2(d) applies for taxable years ending on or after June 10, 2011. For taxable years ending on or after June 10, 2011, but before December 24, 2014, see § 1.6038A-2(e) as contained in 26 CFR part 1 revised as of April 1, 2014. * * *

(3) Section 1.6038A-4. * * * For taxable years ending before December 24, 2014, see § 1.6038A-4(a)(1) as contained in 26 CFR part 1 revised as of April 1, 2014.

§ 1.6038A-2 [Amended]

Par. 3. Section 1.6038A-2 is amended by:

1. Removing paragraph (e).
2. Redesignating paragraphs (f), (g), and (h) as paragraphs (e), (f), and (g), respectively.

Par. 4. Section 1.6038A-4 is amended by revising paragraph (a)(1) to read as follows:

§ 1.6038A-4 Monetary penalty.

(a) * * *

(1) *In general.* If a reporting corporation fails to furnish the information de-

scribed in § 1.6038A-2 within the time and manner prescribed in § 1.6038A-2(d), fails to maintain or cause another to maintain records as required by § 1.6038A-3, or (in the case of records maintained outside the United States) fails to meet the non-U.S. record maintenance requirements within the applicable time prescribed in § 1.6038A-3(f), a penalty of \$10,000 shall be assessed for each taxable year with respect to which such failure occurs. The filing of a substantially incomplete Form 5472 constitutes a failure to file Form 5472. Where, however, the information described in § 1.6038A-2(b)(3) through (5) is not required to be reported, a Form 5472 filed without such information is not a substantially incomplete Form 5472.

John Dalrymple,
*Deputy Commissioner for
Services and Enforcement.*

Approved: December 8, 2014

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

(Filed by the Office of the Federal Register on December 23, 2014, 8:45 a.m., and published in the issue of the Federal Register for December 24, 2014, 79 F.R. 77388)

Part III. Administrative, Procedural, and Miscellaneous

Maximum Vehicle Values for 2015 for Use With Vehicle Cents-Per-Mile and Fleet-Average Valuation Rules

Notice 2015-1

PURPOSE

This notice provides the maximum vehicle values for 2015 that taxpayers need to determine the value of personal use of employer-provided vehicles under the special valuation rules provided under section 1.61-21 (d) and (e) of the Income Tax Regulations.

MAXIMUM VEHICLE VALUES

The maximum value of employer-provided vehicles first made available to employees for personal use in calendar year 2015 for which the vehicle cents-per-mile valuation rule provided under Regulation section 1.61-21(e) may be applicable is \$16,000 for a passenger automobile and \$17,500 for a truck or van.

The maximum value of employer-provided vehicles first made available to employees for personal use in calendar year 2015 for which the fleet-average valuation rule provided under Regulation section 1.61-21(d) may be applicable is \$21,300 for a passenger automobile and \$22,900 for a truck or van.

EFFECTIVE DATE

This notice applies to employer provided passenger automobiles first made available to employees for personal use in calendar year 2015.

DRAFTING INFORMATION

The principal author of this notice is Don M. Parkinson of the Office of the Division Counsel/Associate Chief Counsel (Tax Exempt & Government Entities). For further information on this notice contact Don Parkinson on (202) 317-4766 (not a toll-free number).

26 CFR 601.201: Rulings and determination letters.

Rev. Proc. 2015-9

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SECTION 1. WHAT IS THE PURPOSE OF THIS REVENUE PROCEDURE?

This revenue procedure sets forth procedures for issuing determination letters on the exempt status of organizations under § 501 and 521 of the Internal Revenue Code other than those subject to Rev. Proc. 2015–6, last bulletin (relating to pension, profit-sharing, stock bonus, annuity, and employee stock ownership plans) or Rev. Proc. 2015–5, last bulletin (relating to applications for recognition of exemption made on Form 1023–EZ, *Streamlined Application for Recognition of Exemption Under Section 501(c)(3) of the Internal Revenue Code*). Generally, the Service issues these determination letters in response to applications for recognition of exemption from Federal

income tax. These procedures also apply to revocation or modification of determination letters. This revenue procedure also provides guidance on the exhaustion of administrative remedies for purposes of declaratory judgment under § 7428.

Although the Service released separate procedures for issuing determination letters on exempt status for organizations applying on Form 1023-EZ with Rev. Proc. 2015-5, the Service is considering whether to merge these procedures into this revenue procedure in a future update.

**Description of terms used
in this revenue procedure**

.01 For purposes of this revenue procedure—

(1) The term “Service” means the Internal Revenue Service.

(2) The term “application” means the appropriate form or letter that an organization must file or submit to the Service for recognition of exemption from Federal income tax under the applicable section of the Internal Revenue Code. *See* section 3 for information on specific forms.

(3) The term “EO Determinations” means the office in EO Rulings and Agreements of the Service that is primarily responsible for processing initial applications for tax-exempt status. It includes the main EO Determinations office located in Cincinnati, Ohio, and other field offices. Applications are generally processed in the centralized EO Determinations office in Cincinnati, Ohio.

(4) The term “EO Rulings and Agreements” means the office in EO that is primarily responsible for up-front, customer-initiated activities such as determination applications, taxpayer assistance, and assistance to other EO offices. The EO Rulings and Agreements office includes EO Technical (or its successor office).

(5) The term “Appeals Office” means any office under the direction and control of the Chief, Appeals. The purpose of the Appeals Office is to resolve tax controversies, without litigation, on a fair and impartial basis. The Appeals Office is independent of EO Determinations and EO Rulings and Agreements.

(6) The term “determination letter” means a written statement issued by EO Rulings and Agreements or an Appeals Office in response to an application for recognition of exemption from Federal income tax under § 501 and 521. This includes a written statement issued by EO Determinations or an Appeals Office on the basis of advice secured from the Office of the Associate Chief Counsel (Tax Exempt and Government Entities) pursuant to the procedures prescribed in Rev. Proc. 2015-2, last bulletin.

(7) The term “Code” means the Internal Revenue Code.

Updated annually

.02 This revenue procedure is updated annually, but may be modified or amplified during the year.

**SECTION 2. NATURE OF
CHANGES AND
RELATED REVENUE
PROCEDURES**

**Rev. Proc. 2014-9 is
superseded**

.01 This revenue procedure is a general update of Rev. Proc. 2014-9, 2013-2 I.R.B. 255, which is hereby superseded.

**Related revenue
procedures**

.02 The following revenue procedures are related to Rev. Proc. 2015-9

(1) This revenue procedure supplements Rev. Proc. 2015-5, last bulletin, which provides alternative application and processing procedures for applications made on Form 1023-EZ, *Streamlined Application for Recognition of Exemption Under Section 501(c)(3) of the Internal*

Revenue Code. This revenue procedure does not apply to applications made and determination letters issued under Rev. Proc. 2015–5 except to the extent specifically noted therein.

(2) This revenue procedure supplements Rev. Proc. 2015–10, this bulletin, with respect to the effects of § 7428 on the classification of organizations under §§ 509(a) and 4942(j)(3). Rev. Proc. 80–27, 1980–1 C.B. 677, sets forth procedures under which exemption may be recognized on a group basis for subordinate organizations affiliated with and under the general supervision and control of a central organization. Rev. Proc. 72–5, 1972–1 C.B. 709, provides information for religious and apostolic organizations seeking recognition of exemption under § 501(d). General procedures for requests for a determination letter are provided in Rev. Proc. 2015–8, last bulletin. User fees for requests for determination letters are set forth in Rev. Proc. 2014–8, last bulletin. Information regarding procedures for organizations described in § 501(c)(29) can be found in Rev. Proc. 2012–11, 2012–7 I.R.B. 368.

What changes have been made to Rev. Proc. 2014–9?

.03 Notable changes to Rev. Proc. 2014–9 that appear in this year’s update include –

(1) Changes in the assignment of applications and provision of advice on the applications. EO Rulings and Agreements no longer issues letter rulings or technical advice memoranda. Rev. Proc. 2015–1, last bulletin, sets forth procedures for obtaining letter rulings. Rev. Proc. 2015–2, last bulletin, sets forth procedures for requesting technical advice.

(2) Provides a Transition Rule for applications processed in EO Technical (or its successor)

(3) Cross-references to Rev. Proc. 2015–5, last bulletin. As of July 1, 2014, eligible organizations may request recognition of exemption under § 501(c)(3) by filing Form 1023–EZ. The procedures for Form 1023–EZ are found in Rev. Proc. 2015–5. Cross-references to Rev. Proc. 2015–5 have been added to this revenue procedure where appropriate.

(4) Dates, cross references, and names have been changed to reflect the appropriate annual Revenue Procedures.

SECTION 3. WHAT ARE THE PROCEDURES FOR REQUESTING RECOGNITION OF EXEMPT STATUS?

In general

.01 An organization seeking recognition of exempt status under § 501 or § 521 is required to submit the appropriate application. In the case of a numbered application form, the current version of the form must be submitted. A central organization that has previously received recognition of its own exemption can request a group exemption letter by submitting a letter application along with Form 8718, *User Fee for Exempt Organization Determination Letter Request*. See Rev. Proc. 80–27. Form 8718 is not a determination letter application. Attach this form to the determination letter application.

User fee

.02 An application must be submitted with the correct user fee, as set forth in Rev. Proc. 2015–8, last bulletin.

Form 1023 application

.03 An organization seeking recognition of exemption under § 501(c)(3) and § 501(e), (f), (k), (n), (q), or (r) must submit a completed Form 1023, *Application for Recognition of Exemption Under Section 501(c)(3) of the Internal Revenue Code*. In the case of an organization that provides credit counseling services, see § 501(q). In the case of an organization that is a hospital and is seeking exemption under § 501(c)(3), see § 501(r). Notwithstanding the foregoing, eligible organizations may seek recognition of exemption under § 501(c)(3) by submitting a completed Form 1023–EZ, *Streamlined Application for Recognition of Exemption under Section 501(c)(3)*

of the Internal Revenue Code. See Rev. Proc. 2015–5, last bulletin, for the procedures that apply to the Form 1023–EZ application.

Form 1024 application

.04 An organization seeking recognition of exemption under § 501(c)(9), § 501(c)(17), or § 501(c)(20), must submit a completed Form 1024, *Application for Recognition of Exemption Under Section 501(a)*, along with Form 8718. An organization seeking a determination letter from the Service recognizing exemption under § 501(c)(2), (4), (5), (6), (7), (8), (10), (12), (13), (15), (19), or (25) must submit a completed Form 1024, *Application for Recognition of Exemption Under Section 501(a)*, along with Form 8718. In the case of an organization that provides credit counseling services and seeks recognition of exemption under § 501(c)(4), see § 501(q).

Letter application

.05 An organization seeking recognition of exemption under § 501(c)(11), (14), (16), (18), (21), (22), (23), (26), (27), (28), or (29), or under § 501(d), must submit a letter application along with Form 8718.

Form 1028 application

.06 An organization seeking recognition of exemption under § 521 must submit a completed Form 1028, *Application for Recognition of Exemption Under Section 521 of the Internal Revenue Code*, along with Form 8718.

Form 8871 notice for political organizations

.07 A political party, a campaign committee for a candidate for federal, state or local office, and a political action committee are all political organizations subject to tax under § 527. To be tax-exempt, a political organization may be required to notify the Service that it is to be treated as a § 527 organization by electronically filing Form 8871, *Political Organization Notice of Section 527 Status*. For details, go to the IRS website at www.irs.gov/polorgs.

Requirements for a substantially completed application

.08 A substantially completed application, including a letter application, is one that:

- (1) is signed by an authorized individual;
- (2) includes an Employer Identification Number (EIN);
- (3) for organizations other than those described in § 501(c)(3), includes a statement of receipts and expenditures and a balance sheet for the current year and the three preceding years (or the years the organization was in existence, if less than four years), and if the organization has not yet commenced operations or has not completed one accounting period, a proposed budget for two full accounting periods and a current statement of assets and liabilities; for organizations described in § 501(c)(3), see Form 1023 and Notice 1382;
- (4) includes a detailed narrative statement of proposed activities, including each of the fundraising activities of a § 501(c)(3) organization, and a narrative description of anticipated receipts and contemplated expenditures;
- (5) includes a copy of the organizing or enabling document that is signed by a principal officer or is accompanied by a written declaration signed by an authorized individual certifying that the document is a complete and accurate copy of the original or otherwise meets the requirements of a “conformed copy” as outlined in Rev. Proc. 68–14, 1968–1 C.B. 768;
- (6) if the organizing or enabling document is in the form of articles of incorporation, includes evidence that it was filed with and approved by an appropriate state official (*e.g.*, stamped “Filed” and dated by the Secretary of State); alternatively, a copy of the articles of incorporation may be submitted if accompanied by a written declaration signed by an authorized individual that the copy is a complete and accurate copy of the original copy that was filed with and approved by the state; if a copy is submitted, the written declaration must include the date the articles were filed with the state;
- (7) if the organization has adopted by-laws or similar governing rules, includes a current copy; the by-laws need not be signed if submitted as an attachment to the application for recognition of exemption; otherwise, the by-laws must be verified as current by an authorized individual; and
- (8) is accompanied by the correct user fee and Form 8718, when applicable.

Terrorist organizations not eligible to apply for recognition of exemption

.09 An organization that is identified or designated as a terrorist organization within the meaning of § 501(p)(2) is not eligible to apply for recognition of exemption.

SECTION 4. WHAT ARE THE STANDARDS FOR ISSUING A DETERMINATION LETTER ON EXEMPT STATUS?

Exempt status must be established in application and supporting documents

.01 A favorable determination letter will be issued to an organization only if its application and supporting documents establish that it meets the particular requirements of the section under which exemption from Federal income tax is claimed.

Determination letter based solely on administrative record

.02 A determination letter on exempt status is issued based solely upon the facts and representations contained in the administrative record.

(1) The applicant is responsible for the accuracy of any factual representations contained in the application.

(2) Any oral representation of additional facts or modification of facts as represented or alleged in the application must be reduced to writing over the signature of an officer or director of the taxpayer under a penalties of perjury statement.

(3) The failure to disclose a material fact or misrepresentation of a material fact on the application may adversely affect the reliance that would otherwise be obtained through issuance by the Service of a favorable determination letter.

Exempt status may be recognized in advance of actual operations

.03 Exempt status may be recognized in advance of the organization's operations if the proposed activities are described in sufficient detail to permit a conclusion that the organization will clearly meet the particular requirements for exemption pursuant to the section of the Code under which exemption is claimed.

(1) A mere restatement of exempt purposes or a statement that proposed activities will be in furtherance of such purposes will not satisfy this requirement.

(2) The organization must fully describe all of the activities in which it expects to engage, including the standards, criteria, procedures, or other means adopted or planned for carrying out the activities, the anticipated sources of receipts, and the nature of contemplated expenditures.

(3) Where the organization cannot demonstrate to the satisfaction of the Service that it qualifies for exemption pursuant to the section of the Code under which exemption is claimed, the Service will generally issue a proposed adverse determination letter. *See also* section 7 of this revenue procedure.

No letter if exempt status issue in litigation or under consideration within the Service

.04 A determination letter on exempt status ordinarily will not be issued if an issue involving the organization's exempt status under § 501 or § 521 is pending in litigation, is under consideration within the Service, or if issuance of a determination letter is not in the interest of sound tax administration. If the Service declines to issue a determination to an organization seeking exempt status under § 501(c)(3), the organization may be able to pursue a declaratory judgment under § 7428, provided that it has exhausted its administrative remedies.

Incomplete application

.05 If an application does not contain all of the items set out in section 3.08 of this revenue procedure, the Service may return it to the applicant for completion.

(1) In lieu of returning an incomplete application, the Service may retain the application and request additional information needed for a substantially completed application.

(2) In the case of an application under § 501(c)(3) that is returned incomplete, the 270-day period referred to in § 7428(b)(2) will not be considered as starting until the date a substantially completed Form 1023 is refiled with or remailed to the Service. If the application is mailed to the Service and a postmark is not evident, the 270-day period will start to run on the date the Service actually receives the substantially completed Form 1023. The same rules apply for purposes of the notice requirement of § 508.

(3) Generally, the user fee will not be refunded if an incomplete application is filed. *See* Rev. Proc. 2015–8, section 10, last bulletin.

Even if application is complete, additional information may be required

.06 Even though an application is substantially complete, the Service may request additional information before issuing a determination letter.

(1) If the application involves an issue where contrary authorities exist, an applicant’s failure to disclose and distinguish contrary authorities may result in requests for additional information, which could delay final action on the application.

(2) In the case of an application under § 501(c)(3), the period of time beginning on the date the Service requests additional information until the date the information is submitted to the Service will not be counted for purposes of the 270-day period referred to in § 7428(b)(2).

Expedited handling

.07 Applications are normally processed in the order of receipt by the Service. However, expedited handling of an application may be approved where a request is made in writing and contains a compelling reason for processing the application ahead of others. Upon approval of a request for expedited handling, an application will be considered out of its normal order. This does not mean the application will be immediately approved or denied. Circumstances generally warranting expedited processing include:

(1) a grant to the applicant is pending and the failure to secure the grant may have an adverse impact on the organization’s ability to continue to operate;

(2) the purpose of the newly created organization is to provide disaster relief to victims of emergencies such as flood and hurricane; and

(3) there have been undue delays in issuing a determination letter caused by a Service error.

May decline to issue group exemption

.08 The Service may decline to issue a group exemption letter when appropriate in the interest of sound tax administration.

SECTION 5. WHAT OFFICES ISSUE AN EXEMPT STATUS DETERMINATION LETTER?

EO Determinations issues a determination letter

.01 Under the general procedures outlined in Rev. Proc. 2015–4, last bulletin, EO Determinations is authorized to issue determination letters on applications for exempt status under § 501 and § 521.

Transition Rule for applications processed in EO Technical (or its successor)

.02 In limited circumstances, applications for exempt status are transferred to EO Technical (or its successor office) for processing.

(1) All the procedures herein apply to applications for exempt status transferred to EO Technical (or its successor), including the opportunity for the applicant to request consideration by Appeals of a proposed adverse determination as set forth in Section 7.

(2) An applicant receiving a proposed adverse determination with regard to an application that has been transferred to EO Technical (or its successor) may also request a conference with EO Technical (or its successor) in addition to requesting appeals office consideration as described in Section 7.

Technical advice may be requested in certain cases

.03 At any time during the course of consideration of an exemption application by EO Determinations, if either EO Determinations or the organization believes that its case involves an issue on which there is no published precedent, or there has been non-uniformity in the Service's handling of similar cases, EO Determinations may decide to, or the organization may request that EO Determinations seek technical advice from the Office of Associate Chief Counsel (Tax Exempt and Government Entities). *See* Rev. Proc. 2014-2, last bulletin.

Technical advice must be requested in certain cases

.04 If EO Determinations proposes to recognize the exemption of an organization to which a contrary ruling or technical advice was previously issued, EO Determinations must seek technical advice from the Office of Associate Chief Counsel (Tax Exempt and Government Entities) before issuing a determination letter. This does not apply where an adverse ruling was issued and the organization subsequently made changes to its purposes, activities, or operations to remove the basis for which exempt status was denied.

**SECTION 6.
WITHDRAWAL OF AN
APPLICATION**

Application may be withdrawn prior to issuance of a determination letter

.01 An application may only be withdrawn upon the written request of an authorized individual prior to the issuance of a determination letter. The issuance of a determination letter includes the issuance of a proposed adverse determination letter.

(1) When an application is withdrawn, the Service will retain the application and all supporting documents. The Service may consider the information submitted in connection with the withdrawn request in a subsequent examination of the organization.

(2) Generally, the user fee will not be refunded if an application is withdrawn. *See* Rev. Proc. 2015-8, section 10, last bulletin.

§ 7428 implications of withdrawal of application under § 501(c)(3)

.02 The withdrawal of an application under § 501(c)(3) is not a failure to make a determination within the meaning of § 7428(a)(2) or an exhaustion of administrative remedies within the meaning of § 7428(b)(2).

SECTION 7. WHAT ARE THE PROCEDURES WHEN EXEMPT STATUS IS DENIED?

Proposed adverse determination letter

.01 If EO Rulings and Agreements reaches the conclusion that the organization does not satisfy the requirements for exempt status pursuant to the section of the Code under which exemption is claimed, the Service generally will issue a proposed adverse determination letter, which will:

- (1) include a detailed discussion of the Service's rationale for the denial of tax-exempt status; and
- (2) advise the organization of its opportunity to appeal the decision and request a conference.

Appeal of a proposed adverse determination letter issued by EO Rulings and Agreements

.02 A proposed adverse determination letter issued by EO Rulings and Agreements will advise the organization of its opportunity to appeal the determination by requesting Appeals Office consideration. To do this, the organization must submit a statement of the facts, law and arguments in support of its position within 30 days from the date of the adverse determination letter. The organization must also state whether it wishes an Appeals Office conference.

Final adverse determination letter or ruling where no appeal or protest is submitted

.03 If an organization does not submit a timely appeal of a proposed adverse determination letter issued by EO Rulings and Agreements, a final adverse determination letter will be issued to the organization. The final adverse letter will provide information about the filing of tax returns and the disclosure of the proposed and final adverse letters.

How EO Rulings and Agreements handles an appeal of a proposed adverse determination letter

.04 If an organization submits a protest of the proposed adverse determination letter, EO Rulings and Agreements will first review the protest, and, if it determines that the organization qualifies for tax-exempt status, issue a favorable exempt status determination letter. If EO Rulings and Agreements maintains its adverse position after reviewing the protest, it will forward the protest and the exemption application case file to the Appeals Office. As described in Section 5, for protests of proposed adverse determinations issued by EO Technical (or its successor), organizations may request a conference with EO Technical (or its successor) in addition to having its protest and exemption application file forwarded to the Appeals Office.

Consideration by the Appeals Office

.05 The Appeals Office will consider the organization's appeal. If the Appeals Office agrees with the proposed adverse determination, it will either issue a final adverse determination or, if a conference was requested, contact the organization to schedule a conference. At the end of the conference process, which may involve the submission of additional information, the Appeals Office will either issue a final adverse determination letter or a favorable determination letter. If the Appeals Office believes that an exemption or private foundation status issue is not covered by published precedent or that there is non-uniformity, the Appeals Office must request technical advice from the Office of Associate Chief Counsel (Tax Exempt and Government Entities). *See Rev. Proc. 2015-2*, last bulletin.

An appeal may be withdrawn

.06 An organization may withdraw its appeal or protest before the Service issues a final adverse determination letter. Upon receipt of the withdrawal request, the Service will complete the processing of the case in the same manner as if no appeal or protest was received.

Appeal and conference rights not applicable in certain situations

.07 The opportunity to appeal a proposed adverse determination letter and the conference rights described above are not applicable to matters where delay would be prejudicial to the interests of the Service (such as in cases involving fraud, jeopardy, the imminence of the expiration of the statute of limitations, or where immediate action is necessary to protect the interests of the Government).

**SECTION 8.
DISCLOSURE OF
APPLICATIONS AND
DETERMINATION
LETTERS**

Sections 6104 and 6110 provide rules for the disclosure of applications, including supporting documents, and determination letters.

Disclosure of applications, supporting documents, and favorable determination letters or rulings

.01 The applications, any supporting documents, and the favorable determination letter issued, are available for public inspection under § 6104(a)(1). However, there are certain limited disclosure exceptions for a trade secret, patent, process, style of work, or apparatus, if the Service determines that the disclosure of the information would adversely affect the organization.

(1) The Service is required to make the applications, supporting documents, and favorable determination letters available upon request. The public can request this information by submitting Form 4506-A, *Request for Public Inspection or Copy of Exempt or Political Organization IRS Form*. Organizations should ensure that applications and supporting documents do not include unnecessary personal identifying information (such as bank account numbers or social security numbers) that could result in identity theft or other adverse consequences if publicly disclosed.

(2) The exempt organization is required to make its exemption application, supporting documents, and determination letter available for public inspection without charge. For more information about the exempt organization's disclosure obligations, see Publication 557, *Tax-Exempt Status for Your Organization*.

Disclosure of adverse determination letters

.02 The Service is required to make adverse determination letters available for public inspection under § 6110. Upon issuance of the final adverse determination letter to an organization, both the proposed adverse determination letter and the final adverse determination letter will be released pursuant to § 6110.

(1) These documents are made available to the public after the deletion of names, addresses, and any other information that might identify the taxpayer. *See* § 6110(c) for other specific disclosure exemptions.

(2) The final adverse determination letter will enclose Notice 437, *Notice of Intention to Disclose*, and redacted copies of the final and proposed adverse determination letters. Notice 437 provides instructions if the organization disagrees with the deletions proposed by the Service.

Disclosure to State officials when the Service refuses to recognize exemption under § 501(c)(3)

.03 The Service may notify the appropriate State officials of a refusal to recognize an organization as tax-exempt under § 501(c)(3). *See* § 6104(c). The notice to the State officials may include a copy of a proposed or final adverse determination letter the Service issued to the organization. In addition, upon request by the appropriate State official, the Service may make available for inspection and copying the exemption application and other information relating to the Service's determination on exempt status.

Disclosure to State officials of information about § 501(c)(3) applicants

.04 The Service may disclose to State officials the name, address, and identification number of any organization that has applied for recognition of exemption under § 501(c)(3).

SECTION 9. REVIEW OF DETERMINATION LETTERS

Determination letters may be reviewed by the Office of Associate Chief Counsel (Tax Exempt and Government Entities) or EO Rulings and Agreements to assure uniformity

.01 Determination letters issued by EO Determinations may be reviewed by EO Rulings and Agreements, the Office of Associate Chief Counsel (Tax Exempt and Government Entities), or the Office of the Associate Chief Counsel (Passthroughs and Special Industries) (for cases under § 521), to assure uniform application of the statutes or regulations, or rulings, court opinions, or decisions published in the Internal Revenue Bulletin.

SECTION 10. DECLARATORY JUDGMENT PROVISIONS OF § 7428

Actual controversy involving certain issues

.01 Generally, a declaratory judgment proceeding under § 7428 can be filed in the United States Tax Court, the United States Court of Federal Claims, or the district court of the United States for the District of Columbia with respect to an actual controversy involving a determination by the Service or a failure of the Service to make a determination with respect to the initial or continuing qualification or classification of an organization under § 501(c)(3) (charitable, educational, etc.); § 170(c)(2) (deductibility of contributions); § 509(a) (private foundation status); § 4942(j)(3) (operating foundation status); or § 521 (farmers cooperatives).

Exhaustion of administrative remedies

.02 Before filing a declaratory judgment action, an organization must exhaust its administrative remedies by taking, in a timely manner, all reasonable steps to secure a determination from the Service. These include:

(1) the filing of a substantially completed application Form 1023 under § 501(c)(3) pursuant to section 3.08 of this revenue procedure, or the request for a determination of foundation status pursuant to Rev. Proc. 2015-10, this bulletin, or its successor;

(2) in appropriate cases, requesting relief pursuant to Treas. Reg. § 301.9100-1 of the

Procedure and Administration Regulations regarding the extension of time for making an election or application for relief from tax;

(3) the timely submission of all additional information requested by the Service to perfect an exemption application or request for determination of private foundation status; and

(4) exhaustion of all administrative appeals available within the Service pursuant to section 7 of this revenue procedure.

Not earlier than 270 days after seeking determination

.03 An organization will in no event be deemed to have exhausted its administrative remedies prior to the earlier of:

(1) the completion of the steps in section 10.02, and the sending by the Service by certified or registered mail of a final determination letter; or

(2) the expiration of the 270-day period described in § 7428(b)(2) in a case where the Service has not issued a final determination letter, and the organization has taken, in a timely manner, all reasonable steps to secure a determination letter.

Service must have reasonable time to act on an appeal

.04 The steps described in section 10.02 will not be considered completed until the Service has had a reasonable time to act upon an appeal.

Final determination to which § 7428 applies

.05 A final determination to which § 7428 applies is a determination letter, sent by certified or registered mail, which holds that the organization is not described in § 501(c)(3) or § 170(c)(2), is a public charity described in a part of § 509 or § 170(b)(1)(A) other than the part under which the organization requested classification, is not a private foundation as defined in § 4942(j)(3), or is a private foundation and not a public charity described in a part of § 509 or § 170(b)(1)(A).

SECTION 11. EFFECT OF DETERMINATION LETTER RECOGNIZING EXEMPTION

Effective date of exemption

.01 A determination letter recognizing exemption of an organization described in § 501(c), other than § 501(c)(29), is usually effective as of the date of formation of an organization if: (1) its purposes and activities prior to the date of the determination letter have been consistent with the requirements for exemption; (2) it has not failed to file required Form 990 series returns or notices for three consecutive years; and (3) it has filed an application for recognition of exemption within 27 months from the end of the month in which it was organized. Special rules may apply to an organization applying for exemption under § 501(c)(3), (9), (17) or (20). See §§ 505 and 508, and Treas. Reg. §§ 1.508-1(a)(2), 1.508-1(b)(7) and 301.9100-2(a)(2)(iii) and (iv). In addition, special rules apply with respect to organizations described in § 501(c)(29). See Rev. Proc. 2012-11, 2012-7 IRB 368.

(1) If the Service requires the organization to alter its activities or make substantive amendments to its enabling instrument, the exemption will be effective as of the date specified in a determination letter.

(2) If the Service requires the organization to make a nonsubstantive amendment, exemption will ordinarily be recognized as of the date of formation. Examples of nonsubstantive amendments include correction of a clerical error in the enabling instrument or the addition of a dissolution clause where the activities of the organization prior to the determination letter are consistent with the requirements for exemption.

(3) An organization that otherwise meets the requirements for tax-exempt status and the issuance of a determination letter that does not meet the requirements for recognition from date of formation will generally be recognized from the postmark date of its application.

(4) Organizations that claim exempt status under § 501(c) generally must file annual Form 990 series returns or notices, even if they have not yet received their determination letter recognizing exemption. If an organization fails to file required Form 990 series returns or notices for three consecutive years, its exemption will be automatically revoked by operation of § 6033(j). Such an organization may apply for reinstatement of its exempt status, and such recognition may be granted retroactively, only in accordance with the procedure described in Rev. Proc. 2014–11, 2014–3 I.R.B. 411.

Reliance on determination letter

.02 A determination letter recognizing exemption may not be relied upon by the organization submitting the application if there is a material change, inconsistent with exemption, in the character, the purpose, or the method of operation of the organization, or a change in the applicable law. Also, a determination letter issued to an organization that submitted a Form 1023 in accordance with this revenue procedure may not be relied upon by the organization submitting the application if it was based on any inaccurate material information submitted by the organization *See* section 12.01.

While the procedures for obtaining a determination letter by submitting Form 1023 differ from those for obtaining a determination letter by submitting Form 1023–EZ, grantors and contributors may rely on a determination letter issued pursuant to Rev. Proc. 2015–5, last bulletin, to the same extent as a determination letter issued pursuant to this Revenue Procedure. *See*, Rev. Proc. 2011–33, 2011–25 I.R.B. 887.

**SECTION 12.
REVOCATION OR
MODIFICATION OF
DETERMINATION
LETTER RECOGNIZING
EXEMPTION**

A determination letter recognizing exemption may be revoked or modified: (1) by a notice to the taxpayer to whom the determination letter was issued; (2) by enactment of legislation or ratification of a tax treaty; (3) by a decision of the Supreme Court of the United States; (4) by the issuance of temporary or final regulations; (5) by the issuance of a revenue ruling, revenue procedure, or other statement published in the Internal Revenue Bulletin; or (6) automatically, pursuant to § 6033(j), for failure to file a required annual return or notice for three consecutive years.

Revocation or modification of a determination letter may be retroactive

.01 The revocation or modification of a determination letter recognizing exemption may be retroactive if there has been a change in the applicable law, the organization omitted or misstated a material fact, operated in a manner materially different from that originally represented, or, in the case of organizations to which § 503 applies, engaged in a prohibited transaction with the purpose of diverting corpus or income of the organization from its exempt purpose and such transaction involved a substantial part of the corpus or income of such organization. In certain cases an organization may seek relief from retroactive revocation or modification of a determination letter under § 7805(b). Requests for § 7805(b) relief are subject to the procedures set forth in Rev. Proc. 2015–1, last bulletin.

(1) Where there is a material change, inconsistent with exemption, in the character, the purpose, or the method of operation of an organization, revocation or modification will ordinarily take effect as of the date of such material change.

(2) In the case where a determination letter is issued in error or is no longer in accord with the Service’s position and § 7805(b) relief is granted (*see* sections 13 and 14 of Rev. Proc. 2015–4, last bulletin), ordinarily, the revocation or modification will be effective not earlier than the date when the Service modifies or revokes the original determination letter.

Appeal and conference procedures in the case of revocation or modification of exempt status letter

.02 In the case of a revocation or modification of a determination letter, the appeal and conference procedures are generally the same as set out in section 7 of this revenue procedure. However, appeal and conference rights are not applicable to matters where delay would be prejudicial to the interests of the Service (such as in cases involving fraud, jeopardy, the imminence of the expiration of the statute of limitations, or where immediate action is necessary to protect the interests of the Government). Organizations revoked under § 6033(j) will not have an opportunity for Appeal consideration.

(1) If the case involves an exempt status issue on which EO Rulings and Agreements or the Office of Chief Counsel had issued a previous contrary ruling or technical advice, EO Determi-

nations generally must seek technical advice from the Office of Associate Chief Counsel (Tax Exempt and Government Entities).

(2) EO Determinations does not have to seek technical advice if the prior ruling or technical advice has been revoked by subsequent contrary published precedent, if the proposed revocation involves a subordinate unit of an organization that holds a group exemption letter issued by EO Technical, or if the EO Technical ruling or technical advice was issued under the Internal Revenue Code of 1939 or prior revenue acts.

**SECTION 13. EFFECT
ON OTHER REVENUE
PROCEDURES**

Rev. Proc. 2014-9 is superseded.

**SECTION 14. EFFECTIVE
DATE**

This revenue procedure is effective January 2, 2015.

**SECTION 15.
PAPERWORK
REDUCTION ACT**

The collection of information for a letter application under section 3.05 of this revenue procedure has been reviewed and approved by the Office of Management and Budget (OMB) in accordance with the Paperwork Reduction Act (44 U.S.C. § 3507) under control number 1545-2080. All other collections of information under this revenue procedure have been approved under separate OMB control numbers.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number.

The collection of this information is required if an organization wants to be recognized as tax-exempt by the Service. We need the information to determine whether the organization meets the legal requirements for tax-exempt status. In addition, this information will be used to help the Service delete certain information from the text of an adverse determination letter before it is made available for public inspection, as required by § 6110.

The time needed to complete and file a letter application will vary depending on individual circumstances. The estimated average time is 10 hours.

Books and records relating to the collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. The rules governing the confidentiality of letter applications are covered in § 6104.

**DRAFTING
INFORMATION**

The principal author of this revenue procedure is Mr. Jonathan Carter of the Exempt Organizations, Tax Exempt and Government Entities Division. For further information regarding this revenue procedure, please contact the TE/GE Customer Service office at (877) 829-5500 (a toll-free call), or send an e-mail to Darla Trilli or Tracy Dornette at tege.eo@irs.gov and include "Question about Rev. Proc. 2015-9" in the subject line.

Rev. Proc. 2015-10

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SECTION 1. PURPOSE AND SCOPE

The purpose of this revenue procedure is to set forth updated procedures of the Internal Revenue Service (the “Service”) with respect to issuing determination letters on private foundation status under § 509(a) of the Internal Revenue Code, operating foundation status under § 4942(j)(3), and exempt operating foundation status under § 4940(d)(2) of organizations exempt from Federal income tax under § 501(c)(3). This revenue procedure also applies to the issuance of determination letters on the foundation status under § 509(a)(3) of nonexempt charitable trusts described in § 4947(a)(1).

SECTION 2. WHAT CHANGES HAVE BEEN MADE TO REV. PROC. 2015-10?

- .01 This revenue procedure is a general update of Rev. Proc. 2014-10, 2014-2 I.R.B. 293.
- .02 Changes in the assignment of applications and provision of advice on the applications. EO Rulings and Agreements no longer issues private letter rulings or technical advice memoranda. Rev. Proc. 2015-1, last bulletin, sets forth procedures for obtaining private letter rulings. Rev. Proc. 2015-2, last bulletin, sets forth procedures for requesting technical advice.
- .03 Dates and cross references have been changed to reflect the appropriate annual Revenue Procedures.

SECTION 3. BACKGROUND

.01 All § 501(c)(3) organizations are classified as private foundations under § 509(a) unless they qualify as a public charity under § 509(a)(1) (which cross-references § 170(b)(1)(A)(i)-(vi), (2), (3), or (4). *See* Treas. Reg. §§ 1.170A-9, 1.509(a)-1 through 1.509(a)-7. The Service determines an organization’s private foundation or public charity status when the organization files its Form 1023 or, when eligible, Form 1023-EZ. This status will be included in the organization’s determination letter.

.02 In its Form 990, *Return of Organization Exempt From Income Tax Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except black lung benefit trust or private foundation)*, a public charity indicates the paragraph of § 509(a), and subparagraph of § 170(b)(1)(A), if applicable, under which it qualifies as a public charity. Because of changes in its activities or operations, this may differ from the public charity status listed in its original determination letter. Although an organization is not required to obtain a determination letter to

qualify for the new public charity status, in order for Service records to recognize any change in public charity status, an organization must obtain a new determination of foundation status pursuant to this revenue procedure.

.03 If a public charity no longer qualifies as a public charity under § 509(a)(1)–(4), then it becomes a private foundation, and as such, it must file Form 990–PF, *Return of Private Foundation or Section 4947(a)(1) Nonexempt Charitable Trust Treated as a Private Foundation*. It is not necessary for the organization to obtain a determination letter on its new private foundation status (although it is permitted to do so pursuant to this revenue procedure). The organization indicates this change in foundation status by filing its Form 990–PF return and following any procedures specified in the form, instructions, or other published guidance. Thereafter, the organization may terminate its private foundation status, such as by giving notice and qualifying as a public charity again under § 509(a)(1)–(3) during a 60-month termination period in accordance with the procedures under § 507(b)(1)(B) and Treas. Reg. § 1.507–2(b).

.04 This revenue procedure applies to organizations that may have erroneously determined that the organization was a private foundation and wish to correct the error. For example, an organization may have erroneously classified an item or items in its calculation of public support, causing the organization to classify itself as a private foundation and to file Forms 990–PF. Pursuant to this revenue procedure, the organization can request to be classified as a public charity by showing that it continuously met the public support tests during the relevant periods. See section 7 below.

.05 A private foundation may qualify as an operating foundation under § 4942(j)(3) without a determination letter from the Service, but the Service will not recognize such status in its records without a determination letter from the Service. An organization claiming to be an exempt operating foundation under § 4940(d)(2) must obtain a determination letter from the Service recognizing such status to be exempt from the § 4940 tax on net investment income.

SECTION 4. DETERMINATIONS OF FOUNDATION STATUS

.01 EO Determinations will issue determination letters on foundation status, including whether an organization is:

- (1) a private foundation;
- (2) a public charity described in §§ 509(a)(1) and 170(b)(1)(A) (other than clauses (v), (vii), and (viii));
- (3) a public charity described in § 509(a)(2) or (4);
- (4) a public charity described in § 509(a)(3), whether such organization is described in § 509(a)(3)(B)(i), (ii), or (iii) (“supporting organization type”), and whether or not a Type III supporting organization is functionally integrated;
- (5) a private operating foundation described in § 4942(j)(3); or
- (6) an exempt operating foundation described in § 4940(d)(2).

.02 EO Determinations will also issue determination letters on whether a nonexempt charitable trust described in § 4947(a)(1) is described in § 509(a)(3).

.03 EO Determinations will issue such determinations in response to applications for recognition of exempt status under § 501(c)(3) (Form 1023 or, when eligible, Form 1023–EZ), submitted by organizations pursuant to § 508(b). EO Determinations will also issue such determinations in response to separate requests for determination of foundation status submitted on Form 8940, *Request for Miscellaneous Determination*, pursuant to this revenue procedure or its successor revenue procedures.

**SECTION 5.
APPLICABILITY OF
ANNUAL REVENUE
PROCEDURES**

.01 Rev. Proc. 2015-9 (updated annually), this bulletin provides procedures of the Service in processing applications for recognition of exemption from Federal income tax under § 501(c)(3), other than those made on Form 1023-EZ. Rev. Proc. 2015-5 (updated annually), last bulletin provides procedures of the Service in processing applications for recognition of exemption from Federal income tax under § 501(c)(3) made on Form 1023-EZ. Rev. Proc. 2015-1 (updated annually), last bulletin governs requests for ruling letters. Rev. Proc. 2015-4 (updated annually), last bulletin governs requests for rulings and determination letters. Rev. Proc. 2015-8 (updated annually), this bulletin prescribes user fees for applications, rulings, and other determinations. Except as specifically noted herein, those revenue procedures and their annual successors also apply to requests for determinations of foundation status.

.02 The provisions of Rev. Proc. 2015-9, this bulletin and any successor revenue procedure regarding § 7428, protest, conference, and appeal rights also apply to all determinations of foundation status described in section 4.01 (except section 4.01(6) relating to exempt operating foundation status) and section 4.02, whether or not the request for determination is made in connection with an application for recognition of tax-exempt status. Notwithstanding the foregoing, the § 7428, protest, and appeal rights provisions of Rev. Proc. 2015-5, last bulletin and any successor revenue procedure apply in the case of the determinations described in the preceding sentence if such a determination is made in connection with a Form 1023-EZ.

**SECTION 6.
GENERALLY NO NEW
DETERMINATION
LETTER IF SAME
STATUS IS SOUGHT**

The Service generally will not issue a new determination letter to a taxpayer that seeks a determination of private foundation status that is identical to its current foundation status as determined by the Service. For example, an organization that is already recognized as described in §§ 509(a)(1) and 170(b)(1)(A)(ii) as a school generally will not receive a new determination letter that it is still described in §§ 509(a)(1) and 170(b)(1)(A)(ii) under the currently extant facts. However, the organization in such case could request a letter ruling pursuant to Rev. Proc. 2015-1, last bulletin that a given change of facts and circumstances will not adversely affect its status under §§ 509(a)(1) and 170(b)(1)(A)(ii).

**SECTION 7. FORMAT
OF REQUEST**

.01 Organizations that are seeking to change their foundation status (including requests from public charities for private foundation status and requests from public charities to change from one public charity classification to another public charity classification) or seeking a determination or a change as to supporting organization type or functionally integrated status, or seeking operating foundation or exempt operating foundation status, or subordinate organizations included in a group exemption letter seeking a change in public charity status, must submit Form 8940, *Request Miscellaneous Determination Under Section 507, 509(a), 4940, 4942, 4945, and 6033 of the Internal Revenue Code*, along with all information, documentation, and other materials required by Form 8940 and the instructions thereto, as well as the appropriate user fee pursuant to Rev. Proc. 2015-8 or its successor revenue procedures.

.02 For complete information about filing requirements and the submission process, refer to Form 8940 and the Instructions for Form 8940.

**SECTION 8. REQUESTS
BY NONEXEMPT
CHARITABLE TRUSTS**

.01 A nonexempt charitable trust described in § 4947(a)(1) seeking a determination that it is described in § 509(a)(3) should submit a written request for a determination pursuant to Rev. Proc. 2015-4, last bulletin or its successor revenue procedure.

.02 The request for determination must include the following information items, from the date that the organization became described in § 4947(a)(1) (but not before October 9, 1969) to the present:

(1) A subject line or other indicator on the first page of the request in bold, underlined, or all capitals font indicating “NONEXEMPT CHARITABLE TRUST REQUEST FOR DETERMINATION THAT IT IS DESCRIBED IN § 509(a)(3)”;

(2) The name, address, and Employer Identification Number of the beneficiary organizations, together with a statement whether each such beneficiary organization is described in § 509(a)(1) or (2);

(3) A list of all of the trustees that have served, together with a statement stating whether such trustees were disqualified persons within the meaning of § 4946(a) (other than as foundation managers);

(4) A copy of the original trust instrument and all subsequently adopted amendments to that instrument;

(5) Sufficient information to otherwise establish that the trust has met the requirements of § 509(a)(3) as provided for in Treas. Reg. § 1.509(a)-4 (other than § 1.509(a)-4(i)(4)); If the trust did not qualify under § 509(a)(3) in one or more prior years (after October 9, 1969) in which it was described in § 4947(a)(1), then it cannot be issued a § 509(a)(3) determination letter except in accordance with the procedures for termination of private foundation status under § 507(b)(1)(B); and

(6) Such other information as is required for a determination under Rev. Proc. 2015-4, last bulletin or any successor revenue procedure.

**SECTION 9.
DETERMINATIONS
OPEN TO PUBLIC
INSPECTION**

Determinations as to foundation status are open to public inspection pursuant to § 6104(a).

**SECTION 10. NOT
APPLICABLE TO
PRIVATE FOUNDATION
TERMINATIONS UNDER
§ 507 OR CHANGES OF
STATUS PURSUANT TO
EXAMINATION**

These procedures do not apply to a private foundation seeking to terminate its status under § 507. These procedures also do not apply to the examination of an organization which results in changes to its foundation status.

**SECTION 11. EFFECT
ON OTHER REVENUE
PROCEDURES**

Rev. Proc. 2014-10 is superseded.

**SECTION 12.
EFFECTIVE DATE**

This revenue procedure is effective January 2, 2015.

**SECTION 13.
PAPERWORK
REDUCTION ACT**

The collections of information contained in this revenue procedure have been reviewed and approved by the Office of Management and Budget in accordance with the Paperwork Reduction Act (44 U.S.C. § 3507) under control number 1545-1520.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number.

The collections of information in this revenue procedure are in sections 7.02 and 8.02. This information is required to evaluate and process the request for a letter ruling or determination letter. The collections of information are required to obtain a letter ruling or determination letter. The likely respondents are tax-exempt organizations.

**DRAFTING
INFORMATION**

The principal author of this revenue procedure is Mr. Dave Rifkin of the Exempt Organizations, Tax Exempt and Government Entities Division. For further information regarding this revenue procedure, please contact the TE/GE Customer Service office at (877) 829-5500 (a toll-free call), or send an e-mail to Darla Trilli or Tracy Dornette at tege.eo@irs.gov. and include "Question about Rev. Proc. 2015-10" in the subject line.

Section 162.—Trade or business expenses.

For purposes of determining whether the cost of replacement property may be deducted under § 162 of the Internal Revenue Code, what safe harbor approaches may be used by a cable system operator that has a depreciable interest in cable network assets used in a cable system that provides video, high-speed internet, and voice-over-internet-protocol phone services. See Rev. Proc. 2015-12, page 266.

Section 167.—Depreciation.

Is there a safe harbor method that may be used to determine whether cable distribution network assets are primarily used for providing one-way or two-way communication services? May a fiber optic transfer node and trunk line consisting of fiber optic cable used in a cable distribution system be treated as a single asset for depreciation purposes? See Rev. Proc. 2015-12, page 266.

Section 168.—Accelerated cost recovery system.

Is there a safe harbor method that may be used to determine whether cable distribution network assets are primarily used for providing one-way or two-way communication services? May a fiber optic transfer node and trunk line consisting of fiber optic cable used in a cable distribution system be treated as a single asset for depreciation purposes? See Rev. Proc. 2015-12, page 266.

Section 446.—General rule for methods of accounting.

What are the procedural requirements for obtaining automatic consent to change to one or more of the safe-harbor methods of accounting provided in Rev. Proc. 2015-12, which applies to a cable system operator that has a depreciable interest in cable network assets used in a cable system that provides video, high-speed internet, and voice-over-internet-protocol phone services. See Rev. Proc. 2015-12, page 266.

26 CFR 1.263(a)-1: Capital expenditures; in general. (Also: Part I, §§ 162, 167, 168, 446, 481; 1.167(a)-11, 1.168(i)-4, 1.446-1)

Rev. Proc. 2015-12

SECTION 1. PURPOSE

This revenue procedure provides several safe harbor methods of accounting for certain property costs paid or incurred by cable system operators. Specifically, this revenue procedure provides two alternative safe harbor approaches for determining whether expenditures to maintain, replace, or improve cable network assets must be capitalized under § 263(a) of the Internal Revenue Code (Code): (1) a “network asset maintenance allowance” method; and (2) a “units of property” method. In addition, this revenue procedure provides two alternative methods for determining whether costs for installations and customer drops may be deducted as repairs under § 162 or must be capitalized as improvements under § 263(a): (1) a “specific identification” method; and (2) a safe harbor method. This revenue procedure also permits a taxpayer to treat a fiber optic transfer node and trunk line consisting of fiber optic cable used in a cable distribution system as the asset for depreciation purposes. This revenue procedure also provides a safe harbor method for determining whether all cable distribution network assets are primarily used for providing one-way or two-way communication services. Finally, this revenue procedure provides procedures for a qualifying taxpayer to obtain automatic consent from the Commissioner of Internal Revenue to change to the safe harbor methods of accounting provided in this revenue procedure.

SECTION 2. BACKGROUND

.01 Cable system operators and their affiliates that provide video, high-speed internet, and voice-over-internet-protocol (VOIP) phone services incur significant costs to maintain, replace, and improve the real and personal property used to provide these services. Whether these costs may be deducted as repairs under § 162 or must be capitalized as improvements under § 263(a) depends on whether the costs are for a betterment to the unit of property, restore the unit of property, or

adapt the unit of property to a new or different use. See §§ 1.162-4 and 1.263(a)-3(d). Applying capitalization principles to assets used in a cable system can be particularly difficult, largely because the property consists of a network of interconnected items. Taxpayers and the Internal Revenue Service (IRS) often have difficulty identifying the units of property that comprise these networks and therefore disagree over whether the cost to replace a particular item (or the cost of a customer drop) is an improvement that must be capitalized.

.02 To reduce disputes regarding the deductibility or capitalization of expenditures to maintain, replace, or improve cable network assets, this revenue procedure provides two alternative safe harbor approaches for determining the amount of expenditures that can be deducted as repairs under § 162 or must be capitalized as improvements under § 263(a). Section 5 of this revenue procedure provides a “network asset maintenance allowance” method for cable network assets, which provides a simplified method for a taxpayer to determine the portion of costs capitalized for financial statement purposes that, for Federal tax purposes, may be deducted as repairs under § 162 or must be capitalized as improvements under § 263(a). As an alternative, section 6 of this revenue procedure defines “units of property” that, if properly applied under the principles of § 263(a), will not be challenged by the IRS.

.03 To reduce disputes regarding the deductibility and capitalization of costs for installations and customer drops (as defined in section 4.13 of this revenue procedure), section 7 of this revenue procedure provides two alternative methods for determining whether these costs may be deducted as repairs under § 162 or must be capitalized as improvements under § 263(a): (1) a “specific identification” method; and (2) a safe harbor method. The specific identification method clarifies that the costs of internal drops, drop replacements, and installing customer premises equipment may be deducted, while the costs of installing initial external drops (as defined in section 4.14 of this revenue procedure) must be capitalized. The safe harbor method provides a simplified allocation methodology for determining

which customer drop costs are for external drops and which are for internal drops (as defined in section 4.15 of this revenue procedure) or drop replacements.

.04 Revenue Procedure 2003–63, 2003–2 C.B. 304, provides a safe harbor method under which the IRS will treat a fiber optic transfer node and trunk line consisting of fiber optic cable used in a cable distribution system providing one-way and two-way communication services as the asset for computing depreciation under §§ 167 and 168. Section 8 of this revenue procedure incorporates this safe harbor, clarifies that the definitions in section 8 of this revenue procedure apply only for purposes of §§ 167 and 168, and supersedes Rev. Proc. 2003–63.

.05 Revenue Procedure 2003–63 also provides guidance on acceptable ways for determining whether the asset described in section 2.04 of Rev. Proc. 2003–63 primarily is used, within the meaning of § 1.167(a)–11(b)(4)(iii)(b), for providing one-way or two-way communication services. In particular, Rev. Proc. 2003–63 provides that taxpayers may use any reasonable manner that is consistently applied to determine how the asset primarily is used. To reduce disputes regarding whether a taxpayer’s manner of determining primary use for cable distribution network assets is reasonable, taxpayers requested more specific guidance on acceptable manners for determining whether cable distribution network assets primarily are used for providing one-way or two-way communication services. Section 9 of this revenue procedure restates the guidance originally provided in Rev. Proc. 2003–63, extends application of the guidance to all cable distribution network assets described in asset class 48.42 (CATV–Subscriber Connection and Distribution Systems) of Rev. Proc. 87–56, 1987–2 C.B. 674, and provides a new safe harbor manner for determining primary use for cable distribution network assets. While the safe harbor for determining primary use provided in this revenue procedure only applies to cable system operators, disputes have also arisen regarding the primary use of similar assets held by wireline telecommunication service providers that are used to provide video, high-speed internet, and voice communication services. It is anticipated that future

guidance will provide a safe harbor manner similar to the manner provided in this revenue procedure for determining the primary use of assets held by a wireline telecommunications service provider used to provide video, high-speed internet, and voice communication services.

.06 A change to use any of the safe harbor methods provided in sections 5 through 7 of this revenue procedure for determining whether a cost of tangible property is deductible or is required to be capitalized is a change in method of accounting under § 446(e) and § 1.446–1(e)(2)(ii)(a). In addition, a change to the depreciation safe harbor method of accounting provided in section 8 of this revenue procedure is a change in method of accounting under § 446(e) and § 1.446–1(e)(2)(ii)(d). Except as otherwise expressly provided in the Code and the regulations thereunder, § 446(e) and § 1.446–1(e)(2) require a taxpayer to secure the consent of the Commissioner before changing a method of accounting for Federal 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 10 of this revenue procedure provides the procedures by which a taxpayer may obtain automatic consent for a change in method of accounting to use the methods of accounting provided by this revenue procedure.

SECTION 3. SCOPE

This revenue procedure applies to a cable system operator, including a subsidiary or other downstream affiliate, that has a depreciable interest in cable network assets used in a cable system, as defined in sections 4.01 and 4.02 of this revenue procedure, that provides video, high-speed internet, and VOIP phone services. This revenue procedure does not apply to a taxpayer that is primarily a wireline or wireless telecommunications service provider. See Rev. Proc. 2011–27, 2011–18 I.R.B. 740, and Rev. Proc. 2011–28, 2011–18 I.R.B. 743, for guidance applicable to wireline or wireless telecommunications service providers.

SECTION 4. DEFINITIONS

The following definitions apply solely for purposes of this revenue procedure:

.01 *Cable network assets.* (1) *Cable network assets* mean personal or real property used in a cable system that provides video, high-speed internet, and VOIP phone services (“cable services”) to customer premises in the United States. Cable network assets consist of operating plant and equipment that receive signals and transmit programming from the headend, as defined in section 4.05 of this revenue procedure, to the customer, including signal receiving equipment, encoding and decoding devices, cables, connectors, switches, amplifiers, and distribution equipment at or near customer locations. Cable network assets do not include intangible property, other than computer software used in operating plant and equipment that provides cable services.

(2) Cable network assets do not include personal or real property (whether owned or leased) not directly used to provide cable services to customers, such as the following:

(a) *Land.* Any land;

(b) *Land improvements.* Any land improvements not directly used to provide cable services, such as a road;

(c) *Non-cable network buildings and improvements.* Non-cable network buildings and improvements consisting of real property, such as a corporate office building, call center, or service center;

(d) *Furniture and fixtures.* Furniture and fixtures;

(e) *Equipment and machinery.* General purpose office equipment (for example, printers and copiers);

(f) *Vehicles.* Transport motor vehicles; and

(g) *Customer premises equipment.* Customer premises equipment (“CPE”), which includes set-top boxes, modems, routers, and remotes used by customers to receive and select programming services. CPE also includes a customer connection box treated by a taxpayer as CPE and not treated as part of a customer drop.

.02 *Cable system* means a facility consisting of a set of closed transmission paths and associated signal generation, reception, and control equipment that provides cable services to multiple subscribers within a community, as defined in section 4.03 of this revenue procedure. In general, a

cable system is the lowest reporting unit of a cable system operator and its affiliates at which they maintain their management reporting records. A single cable system can be owned by multiple taxpayers, who may each have different ownership interests in different individual assets that are part of the cable system.

.03 *Community* means one or more geographically contiguous or proximate customer populations receiving cable services under one or more nonexclusive franchises granted by one or more state or local franchising authorities.

.04 *Cable distribution network* means the network of property that conveys signals between the headend, as defined in section 4.05 of this revenue procedure, and customer premises, as defined in section 4.12 of this revenue procedure. The cable distribution network generally consists of optic transmission and receiver devices, fiber optic cable, hubs, fiber optic transfer nodes, coaxial cable, amplifiers, taps, and customer drops.

.05 *Headend* means the primary location in a cable system that receives television programming signals (through satellite antennae or fiber optic cables) for distribution to the customer premises through a cable distribution network. Headend equipment includes computer-based electronic equipment that receives programming signals and uses prescribed processes to combine, amplify, and convert the programming signals and transmit them through the cable distribution network. The headend may include a headend building that houses headend equipment. The headend processes and combines signals for distribution to hubs, as defined in section 4.06 of this revenue procedure, or directly to customer premises. In most cases, the headend also serves as a distribution hub for the fiber optic transfer nodes closest to the headend. Headend also includes a “super headend,” which processes all incoming programming signals and transmits them to regional headends or directly to hubs.

.06 *Hub* means the secondary location in a cable system that is connected to the headend by fiber optic cable. A hub may contain electronic equipment that processes, converts, and transmits signals through the cable distribution network. A hub can serve a large number of business and residential communities.

.07 *Fiber optic cable* means a cable with flexible, transparent fiber made of very pure glass (silica) that transmits light between the two ends of the cable.

.08 *Coaxial cable* means an electric cable with an inner conductor surrounded by a flexible, tubular insulating layer that is further surrounded by a tubular conducting shield (typically an inner conductor of copper, an insulating layer of nylon foam, and a conducting shield of an external aluminum wrap overlaid with copper or aluminum braid, all enclosed within a protective plastic cover).

.09 *Node* means any point within a cable distribution network where communication channels are interconnected. Generally, a fiber optic node contains a device that converts optical signals into radio frequency signals for distribution in coaxial cable portions of the cable distribution network.

.10 *Amplifier* means an electric component used to increase the strength of a transmitted signal within a cable distribution network.

.11 *Tap* means the equipment that is the final interconnection point within a cable distribution network and directs the signal to be delivered to a customer. A tap may be on a pole or in a pedestal on the ground. From the tap, the external drop runs to the customer premises.

.12 *Customer premises* means the final point of service and does not refer to any specific customer.

.13 *Customer drop* means the property that connects the tap with the customer premises. A customer drop may run aerially or underground. Multiple drops may connect to one tap. Customer drops include external drops and internal drops. A customer drop also includes a connection box or similar equipment that is not treated as CPE. A customer drop refers to the point of service, not to any specific customer.

.14 *External drop* means the cable and any associated connectors that run (aerial or underground) from the tap to the exterior of the customer premises.

.15 *Internal drop* means the cable and any associated connectors within the interior of the customer premises.

SECTION 5. NETWORK ASSET MAINTENANCE ALLOWANCE METHOD FOR CABLE NETWORK ASSETS

.01 *In general.* Taxpayers generally must determine the amount of their cable network asset expenditures that may be deducted under § 162 and the amount of cable network asset expenditures that are required to be capitalized under § 263(a). Section 5.02 of this revenue procedure provides a method for determining the “network asset maintenance allowance” that may be deducted under § 162. Section 5.03 of this revenue procedure provides a method for determining the basis of cable network assets that are required to be capitalized under § 263(a). A taxpayer that uses the network asset maintenance allowance method described in this section 5 must use that method for all of its cable network asset costs, including subsequent costs relating to cable network assets acquired in an applicable asset acquisition as defined in § 1060 or in a transaction subject to a § 338(g) or § 338(h)(10) election, even though the initial cost of such property is removed from the total cost of capital additions for the taxable year, as provided in paragraphs 5.02(2)(b)(iii) and (iv) of this section. If used by a taxpayer, the network asset maintenance allowance method described in this section 5 provides the exclusive means for determining for Federal tax purposes whether cable network asset costs that are capitalized for financial statement purposes are deductible or must be capitalized, except for costs for customer drops (section 7 of this revenue procedure provides methods for determining whether costs for customer drops are deductible or must be capitalized) and costs deductible under section 174. For instance, a taxpayer using the network asset maintenance allowance method described in this section 5 may not determine whether cable network asset costs that are capitalized for financial statement purposes are deductible by applying the safe harbor for routine maintenance on property provided in § 1.263(a)–3(i).

.02 *Network asset maintenance allowance.* (1) The amount of the network asset maintenance allowance for a taxable year is determined using the methodology provided in paragraph 5.02(2). The methodology is a reclassification of

cable network asset costs that are capitalized for a taxpayer's financial statements. Therefore, the network asset maintenance allowance is a deduction in addition to operation and maintenance costs that generally are deductible for both financial statement and Federal tax purposes. References in this revenue procedure to financial statements encompass financial information that supports the amount shown on a taxpayer's financial statement, including supporting schedules or statements.

(2) The amount of the network asset maintenance allowance for a taxable year is determined as follows:

(a) Start with the cost of cable network asset capital additions for financial statement purposes that are placed in service, within the meaning of § 1.46-3(d)(1)(ii), during the taxable year.

(b) Decrease the amount determined in paragraph 5.02(a) of this section by the following amounts:

(i) Customer drop costs capitalized for financial statement purposes;

(ii) Costs capitalized for financial statement purposes that are deducted or deferred for Federal tax purposes, other than under this network asset maintenance allowance safe harbor, such as research and experimental expenditures under § 174;

(iii) The cost of cable network assets acquired during the taxable year in an applicable asset acquisition as defined in § 1060; and

(iv) The cost of cable network assets acquired during the taxable year in a transaction subject to a § 338(g) or § 338(h)(10) election.

(c) To determine the adjusted basis of the cable network assets under § 1011, make the adjustments required under § 1016 to the amount determined under paragraphs 5.02(2)(a) and (b) of this section to applicable 5-year property, 7-year property, 15-year property, and nonresi-

dential real property, except do not make adjustments for the following:

(i) Basis adjustments attributable to changes in the taxpayer's definition of units of property made through a prior change in accounting method implemented before changing to the network asset maintenance allowance method provided in this revenue procedure;

(ii) Adjustments described in § 1016(a)(2) or § 1016(a)(3); or

(iii) Adjustments that require tax basis to be reduced before depreciation is computed (for example, §§ 179 and 179D; §§ 44 and 46).

(d) Multiply the adjusted basis of the cable network assets resulting from paragraph 5.02(2)(c) of this section by 12%. The result is the taxpayer's total network asset maintenance allowance amount for the taxable year, which may be deducted by the taxpayer under § 162.

.03 Allocation of basis to individual assets. The adjusted basis of the cable network assets determined by applying paragraphs 5.02(2)(a), (b), and (c) of this section must be allocated to each cable network asset placed in service during the taxable year as described in this section. The allocation methodology provided in this paragraph 5.03 includes a reduction in the adjusted basis of the cable network assets to account for the total network asset maintenance allowance determined by applying paragraph 5.02(2)(d) of this section

(1) Start with the adjusted basis of 5-year property, 7-year property, 15-year property, and nonresidential real property determined by applying paragraphs 5.02(2)(a), (b), and (c) of this section.

(2) For each class of property, multiply the adjusted basis attributable to that class by 88%. The result is the adjusted basis for each class of property for the taxable year, which takes into account

the network asset maintenance allowance amount determined by applying paragraph 5.02(2)(d) of this section.

(3) Next, based on the cost of the individual assets in each class of property, proportionally allocate the adjusted basis for each class of property determined by applying paragraph 5.03(2) of this section among each cable network asset in the class of property that is placed in service, within the meaning of § 1.46-3(d)(1)(ii), during the taxable year. Any cable network assets acquired during the taxable year in an applicable asset acquisition as defined in § 1060 or in a transaction subject to a § 338(g) or § 338(h)(10) election must be excluded from this calculation. *See* paragraph 5.03(5) of this section.

(4) The amount determined in paragraph 5.03(3) for each cable network asset is the basis of such asset to be used to determine the deductions allowable or income tax credits available that require tax basis to be reduced before any depreciation is computed (for example, §§ 179 and 179D; §§ 44 and 46). The net amount for each cable network asset after the reduction in basis for such deductions and credits is the unadjusted depreciable basis of each asset for purposes of § 1.168(b)-1(a)(3).

(5) Expenditures for cable network assets acquired during the taxable year in an applicable asset acquisition as defined in § 1060 or in a transaction subject to a § 338(g) or § 338(h)(10) election are capital expenditures under § 263(a) to which ordinary basis and holding period rules apply.

.04 Example. B is a cable system operator that owns cable network assets. B changes its method of accounting to use the cable network asset maintenance allowance method provided in this revenue procedure. To determine the cable network asset maintenance allowance for the taxable year, B makes the following calculation:

| | |
|---|-----------------|
| Total cost of cable network asset capital additions for financial statement purposes that are placed in service, within the meaning of § 1.46-3(d)(1)(ii), during the taxable year (<i>see</i> paragraph 5.02(2)(a)). | \$900,000,000 |
| <i>Less:</i> Customer drop costs capitalized for financial statement purposes (<i>see</i> paragraph 5.02(2)(b)(i)). | (\$100,000,000) |
| <i>Less:</i> Costs capitalized for financial statement purposes that are deducted or deferred for Federal tax purposes, other than under this network asset maintenance allowance safe harbor, such as research and experimental expenditures under § 174 (<i>see</i> paragraph 5.02(2)(b)(ii)). | (\$100,000,000) |

| | |
|--|----------------|
| <i>Less:</i> Cost of assets acquired during the taxable year in a § 1060 or a § 338(g) or § 338(h)(10) transaction (<i>see</i> paragraphs 5.02(2)(b)(iii) and (iv)). | (\$25,000,000) |
| <i>Less/Plus:</i> Other basis adjustments (excluding adjustments described in paragraphs 5.02(2)(c)(i), (ii), and (iii) of this section) (<i>see</i> paragraph 5.02(2)(c)). | (\$5,000,000) |
| Adjusted basis of the cable network assets (<i>see</i> paragraph 5.02(2)(c)). | \$670,000,000 |
| <i>Multiply by:</i> Network asset maintenance allowance percentage (12%) (<i>see</i> paragraph 5.02(2)(d)). | X 12% |
| Total network asset maintenance allowance amount (deductible under § 162) (<i>see</i> paragraph 5.02(2)(d)). | \$80,400,000 |

SECTION 6. UNITS OF PROPERTY FOR CABLE NETWORK ASSETS

.01 *In general.* For cable network assets, each of the following groupings constitutes a separate unit of property within an individual cable system for purposes of § 263(a):

(1) All programming reception equipment, including antenna and satellite dishes;

(2) All towers, antenna support structures, and satellite dish support structures affixed to foundations;

(3) All concrete foundations upon which a tower, antenna support structure, or satellite support structure is installed, including the bolts embedded therein and other depreciable assets associated with the platform or other forms of anchoring to affix a tower, an antenna support structure, or a satellite support structure to a foundation;

(4) Each headend building and each hub building (including its structural components);

(5) The headend equipment, including computer-based electronic equipment that receives programming signals and uses prescribed processes to combine, amplify, and convert the programming signals and transmit them through the cable distribution network;

(6) All depreciable land improvements, including (a) landscaping that is replaced when a related depreciable asset is replaced, (b) fences, and (c) sidewalks, but excluding (d) enclosures, (e) buildings, and (f) any improvements properly capitalized to land;

(7) All equipment at the nodes;

(8) The fiber optic distribution system, including fiber optic cable, related PVC conduit and protective sheathing, and associated devices (including taps and drops), whether overhead or underground, but excluding permanent conduits and ducts; and

(9) The coaxial distribution system, including coaxial cable, related PVC

conduit or protective sheathing, and associated devices (including taps and drops), whether overhead or underground, but excluding permanent conduits and ducts.

.02 *Universal adoption not required.* A taxpayer within the scope of this revenue procedure is not required to use all of the unit of property determinations provided in section 6.01 of this revenue procedure and, therefore, may use one or more of the unit of property determinations provided. Once used, however, a unit of property determination applies to all assets in that grouping, including assets subsequently acquired in an applicable asset acquisition as defined in § 1060 or in a transaction subject to a § 338(g) or § 338(h)(10) election.

.03 *Limitation.* The unit of property determinations provided in this revenue procedure shall not apply for any other purpose of the Code or regulations, including for determining the unit of property under other Code sections (for example, § 263A), or determining the asset for depreciation purposes (for example, placed-in-service date, dispositions, classification under § 168(e) or Rev. Proc. 87-56, 1987-2 C.B. 674, or for purposes of § 168(j)), for the same or similar-type assets.

SECTION 7. CUSTOMER DROP AND CPE INSTALLATION COSTS

.01 Taxpayers may use either the method described in paragraph (1) of this section or the method described in paragraph (2) of this section for determining whether customer drops costs (including installation costs) may be deducted under § 162 or must be capitalized under § 263(a).

(1) *Specific identification method.* Taxpayers may specifically identify their costs for customer drops and CPE installations and treat them as follows:

(a) *Initial external drops.* The direct and indirect costs associated with installing an initial external drop must

be capitalized, unless the costs are otherwise deductible under another provision of the Code or regulations.

(b) *Replacement external drops.* The direct and indirect costs associated with replacing an external drop that do not result in a betterment (§ 1.263(a)-3(j)) or an adaption to a new or different use (§ 1.263(a)-3(l)) may be deducted.

(c) *Improved external drops.* The direct and indirect costs associated with replacing an external drop that result in a betterment (§ 1.263(a)-3(j)) or an adaption to a new or different use (§ 1.263(a)-3(l)) must be capitalized, unless the costs are otherwise deductible under another provision of the Code or regulations.

(d) *Internal drops.* The direct and indirect costs associated with installing or replacing any internal drop may be deducted.

(2) *Safe-harbor allocation method.* As an alternative to the specific identification method described in paragraph 7.01(1) of this section, taxpayers may treat customer drop costs as follows:

(a) *Methodology.* Allocate an amount equal to 12% of total customer drop costs for the taxable year to initial external drops and treat those costs as expenditures to be capitalized under § 263(a). Allocate the remaining 88% of total customer drop costs for the taxable year to internal drop costs and drop replacement costs, and treat those costs as deductible expenditures, except for the expenditures described in paragraph 7.01(2)(b) of this section.

(b) *Cable system improvements.* Notwithstanding paragraph 7.01(2)(a) of this section, the direct and indirect costs associated with replacing an external drop that result in a betterment (§ 1.263(a)-3(j)) or an adaption to a new

or different use (§ 1.263(a)-3(l)) must be capitalized, unless the costs are otherwise deductible under another provision of the Code or regulations.

.02 *CPE costs.* In general, whether the costs of acquiring CPE must be capitalized is determined under the general rules of the Code and regulations, such as § 263(a) and the corresponding regulations. The labor costs associated with installing CPE may be treated as expenditures deductible under § 162.

SECTION 8. DEPRECIATION OF FIBER OPTIC NODE AND CABLE

.01 *In general.* This section 8 provides a safe harbor method of accounting under which the IRS will treat a fiber optic transfer node and trunk line consisting of fiber optic cable used in a cable distribution network providing both one-way and two-way communication services as the asset for computing depreciation under §§ 167 and 168.

.02 *Definitions.* The following definitions apply solely for purposes of section 8 of this revenue procedure:

(1) *Node* means a fiber optic transfer node of the cable distribution network.

(2) *Fiber optic cable* means fiber optic cable that is used as a trunk line.

.03 *Safe harbor method.* (1) *Asset.* The asset for calculating depreciation under §§ 167 and 168 and the regulations thereunder is a node and the fiber optic cable to that node, excluding any fiber optic cable previously considered placed in service under section 8.03(2) of this revenue procedure or under section 4.03 of Rev. Proc. 2003-63, 2003-2 C.B. 304, and any optic fibers sold by the taxpayer.

(2) *Placed in service.* The asset described in paragraph 8.03(1) of this section is considered placed in service for depreciation purposes when placed in a condition or state of readiness and availability for its specifically assigned function. The specifically assigned function of a cable operator's cable system is to provide services to subscribers. Thus, when a node is connected to the equipment necessary for providing one-way or two-way communication services to subscribers, or potential subscribers, the property is considered placed in service

for depreciation purposes. Although a fiber optic cable may contain more optic fibers than are necessary to serve a single node, all optic fibers in the asset are considered placed in service when the node is ready and available as described above and connected to at least one optic fiber in the fiber optic cable.

(3) *Consistent treatment.* A taxpayer using the asset described in paragraph 8.03(1) of this section must use it for all of the nodes and fiber optic cable connected to an individual headend. Taxpayers also are required to treat the asset consistently for all purposes under §§ 167 and 168 and the regulations thereunder.

(4) *Example.* Taxpayer has a fiber optic cable containing 20 bundles of 6 optic fibers each (120 total optic fibers) and initially connects 2 optic fibers to the node in taxable year X. Assume that the node is connected to the equipment necessary for providing one-way or two-way communication services to subscribers or potential subscribers. The fiber optic cable (including all 120 optic fibers) and the node are the asset for depreciation purposes. The fiber optic node and cable is considered placed in service in taxable year X, even though only 2 of the 120 optic fibers are connected.

SECTION 9. PRIMARY USE

.01 *In general.* This section 9 provides guidance for determining whether a cable network asset, other than a headend, used in a cable system and described in asset class 48.42 (CATV-Subscriber Connection and Distribution Systems) of Rev. Proc. 87-56, 1987-2 C.B. 674, ("tested asset") is primarily used, within the meaning of § 1.167(a)-11(b)(4)(iii)(b), for providing one-way or two-way communication services to subscribers, including a safe harbor manner for determining primary use.

.02 *Definitions.* The following definitions apply solely for purposes of section 9 of this revenue procedure:

(1) *Video service* means video service that is not provided via internet broadband service, including multi-channel, on-demand, and other video service.

(2) *Telephony service* means bi-directional voice communication.

(3) *Broadband service* means internet or high-speed data telecommunications provided via multiple channels of data over a single communications medium.

(4) *Signal traffic or internet delivery protocols* means internet or high-speed-data signal traffic that can be either one-way or two-way communication.

(5) *One-way signal traffic* means signal traffic associated with streaming protocols (video and audio) and file transfer protocols (bulk file downloads).

(6) *Two-way signal traffic* means signal traffic associated with protocols other than one-way signal traffic.

(7) *One-way communication services* means communication services that are primarily transmitted downstream, including the following internet or high-speed data-signal traffic:

- (a) Video streaming;
- (b) Cable television;
- (c) Video programming;
- (d) Web-video streaming;
- (e) Over-the-top video;
- (f) Real-time entertainment video;
- (g) Bulk entertainment;
- (h) Audio streaming; and
- (i) Other video signals sent only downstream regardless of delivery protocols.

(8) *Two-way communication services* means all communication services other than one-way communication services. Two way communication services transmit internet or high-speed data-signal traffic both upstream and downstream. Two-way communication services include the following internet or high-speed data-signal traffic:

- (a) File exchange protocol;
- (b) Email;
- (c) Voice-over-internet protocols;
- (d) Peer-to-peer communications, such as video conferencing;
- (e) Instant messaging;
- (f) Gaming; and
- (g) Other similar communication services equivalent to telephone communications.

.03 *Determining primary use.*

(1) *General rule.* In determining whether a tested asset is primarily used, within the meaning of § 1.167(a)-11(b)(4)(iii)(b), for providing one-way or two-way communication services to subscribers, a taxpayer

must determine primary use by using any reasonable manner that is consistently applied within a taxable year to the taxpayer's tested asset. If a tested asset is primarily used for providing one-way communication services, the asset is included in asset class 48.42 and classified as 7-year property under § 168(e)(1), with a recovery period of 7 years under § 168(c) and a recovery period of 10 years under § 168(g). If a tested asset is primarily used for providing two-way communication services, the asset is classified as 15-year property pursuant to § 168(e)(3)(E)(ii), with a recovery period of 15 years under § 168(c) and a recovery period of 24 years under § 168(g).

(2) *Reasonable manner.* A reasonable manner includes, but is not limited to, determining primary use by gross receipts or by subscriber count for each service within the applicable cable system, as well as the safe harbor manner provided by paragraph 9.03(3) of this section. Determining primary use solely by bandwidth is not reasonable. A taxpayer may use different reasonable manners to determine primary use from taxable year to taxable year.

(3) *Safe harbor manner for determining primary use.* The following safe harbor manner is reasonable for determining primary use under paragraph 9.03(1) of this section for a taxable year. This manner for making the factual primary use determination applies solely for depreciation purposes and is applied at the cable system level. Thus, for the taxable year for which the safe harbor is applied to one or more cable systems, the safe harbor must be used for all of the taxpayer's tested assets in each cable system to which the safe harbor is applied.

(a) *Identification of total revenue.* Total revenue of the cable system generated by the use of tested assets must be identified.

(i) Revenue generated by the use of tested assets includes the following:

- (A) Video service revenue;
- (B) Telephony service revenue;
- (C) Home monitoring revenue;

(D) Broadband service revenue;

(E) Revenue derived from leasing or otherwise providing the right to use optical fibers or one or more fiber optic cables in the cable system; and

(F) Any other revenue generated by the use of tested assets identified in guidance published in the Internal Revenue Bulletin.

(ii) The revenue identified in paragraphs 9.03(3)(a)(i) of this section includes all of the following sub-categories of revenue:

- (A) Service revenue;
- (B) Advertising revenue;
- (C) Equipment rental;
- (D) Installation fees; and
- (E) Early service termination fees.

(iii) Total revenue generated by the use of tested assets excludes franchise fee revenue.

(b) *Substantiation of total revenue.* For purposes of paragraph 9.03(3)(a) of this section, revenue generated by the use of a tested asset may be substantiated by either of the following:

(i) Revenue reported on a taxpayer's financial statements, including the financial statements themselves and information contained on schedules or statements supporting the financial statements; or

(ii) Company reports (and supporting data) used for regulatory reporting of revenue for the following services:

- (A) Video service;
- (B) Telephony service;
- (C) Broadband service; or
- (D) Other similar services provided by the taxpayer.

(c) *Determination of one-way or two-way communication services revenue.* The revenue identified in paragraph 9.03(3)(a) of this section must be treated as revenue from one-way communication services or two-way communication services, using the methodology described in paragraphs 9.03(3)(c)(i)–(iv) of this section.

(i) *One-way communication services revenue.* The following revenue must be treated as revenue from one-way communication services:

(A) Video service revenue; and

(B) Any additional revenue treated as revenue from one-way communication services in guidance published in the Internal Revenue Bulletin.

(ii) *Two-way communication services revenue.* The following revenue must be treated as revenue from two-way communication services:

(A) Telephony service revenue;

(B) Home monitoring revenue; and

(C) Any additional revenue treated as revenue from two-way communication services in guidance published in the Internal Revenue Bulletin.

(iii) *Presumptive two-way communication services revenue.* Revenue derived from leasing or otherwise providing the right to use optical fibers or one or more fiber optic cables in the cable system is presumptively treated as revenue from two-way communication services, unless the taxpayer can substantiate through reasonable means that the revenue is from one-way communication services.

(iv) *Allocated revenue.* (A) *Revenue to be allocated between one-way and two-way.* The following types of revenue must be allocated between revenue from one-way communication services and revenue from two-way communication services:

a. Broadband service revenue; and

b. Any additional revenue treated as revenue that must be allocated between revenue from one-way communication services and revenue from two-way communication services in guidance published in the Internal Revenue Bulletin.

(B) *Allocation between one-way and two-way communication services revenue.* The allocation between revenue from one-way communication services and revenue from two-way communication services required by this paragraph

9.03(c)(iv) is determined pro rata, based on the ratio of one-way signal traffic to two-way signal traffic, determined from either of the following data sources:

a. Average signal traffic data determined from the taxpayer's records for the taxable year; or

b. Industry average signal traffic data published by commercially available third-party sources (not including news media outlets) for the taxable year or the most recent period available.

(d) *Primary use determination.* Primary use is determined based on total revenue under paragraph 9.03(3)(a) of this section and the one-way and two-way communication services revenue determinations under paragraph 9.03(3)(c) of this section. If total cable system revenue from one-way communication services is greater than total cable system revenue from two-way communication services for a taxable year, then the primary use of the tested assets in the cable system is for providing one-way communication services for that taxable year. If total cable system revenue from two-way commu-

nication services is greater than total cable system revenue from one-way communication services for a taxable year, then the primary use of tested assets in the cable system is for providing two-way communication services for that taxable year.

.04 *Example.* Z is a cable system operator that owns cable network assets. Z uses the safe harbor manner provided by paragraph 9.03(3) of this section to determine whether the primary use of Z's tested assets used in cable system S is for one-way or two-way communications for the taxable year.

During the taxable year, Z has the following total revenue generated by the use of tested assets in cable system S:

| | | | |
|-----------------------|-------------------------|--------------|--------------|
| Video service | Service revenue | \$10,000,000 | |
| | Advertising revenue | \$4,000,000 | |
| | Equipment rental | \$650,000 | |
| | Video installation fees | \$250,000 | |
| | Early termination fees | \$100,000 | |
| | | | \$15,000,000 |
| Telephony service | Service revenue | \$2,500,000 | |
| | Advertising revenue | \$0 | |
| | Equipment rental | \$325,000 | |
| | Installation fees | \$125,000 | |
| | Early termination fees | \$50,000 | |
| | | | \$3,000,000 |
| Home monitoring | Service revenue | \$1,000,000 | |
| | Advertising Revenue | \$0 | |
| | Equipment rental | \$750,000 | |
| | Installation fees | \$150,000 | |
| | Early termination fees | \$100,000 | |
| | | | \$2,000,000 |
| Broadband service | Service revenue | \$8,000,000 | |
| | Advertising revenue | \$1,000,000 | |
| | Equipment rental | \$500,000 | |
| | Installation fees | \$400,000 | |
| | Early termination fees | \$100,000 | |
| | | | \$10,000,000 |
| Optical fiber leasing | | \$500,000 | \$500,000 |
| Total revenue | | | \$30,500,000 |

Under the safe harbor manner for determining primary use, the video service revenue (\$15,000,000) is treated as revenue from one-way communication services, and the telephony service revenue (\$3,000,000) and the home monitoring revenue (\$2,000,000) are treated as revenue from two-way communication services. The revenue derived from leasing certain optical fibers (\$500,000) is treated as revenue from two-way communication services unless Z can substantiate through reasonable means

that the revenue is from one-way communication services. In this instance, Z does not know how the lessor is using the leased optical fiber, so the \$500,000 is treated as revenue from two-way communication services.

Under the safe harbor manner for determining primary use, Z must allocate its broadband service revenue pro rata between revenue from one-way communication services and revenue from two-way communication services based on a comparison of

one-way signal traffic to two-way signal traffic. Published industry data establish that during the taxable year 58% of signal traffic is one-way signal traffic and 42% of signal traffic is two-way signal traffic. Therefore, \$5,800,000 (\$10,000,000 x 58%) of Z's broadband service revenue must be treated as revenue from one-way communication services, and \$4,200,000 (\$10,000,000 x 42%) of Z's broadband service revenue must be treated as revenue from two-way communication services.

To determine whether the primary use for the taxable year of all of Z's tested assets used in cable system S is for one-way or two-way communication services, Z compares total cable system S revenue from one-way communication services for the taxable year to total cable system revenue from two-way communication services for the taxable year. Cable system S revenue from one-way communication services totals \$20,800,000 (\$15,000,000 + \$5,800,000). Cable system S revenue from two-way communication services totals \$9,700,000 (\$3,000,000 + \$2,000,000 + \$500,000 + \$4,200,000), which is less than the total cable system revenue from one-way communication services. Therefore, under the safe harbor manner for primary use provided by section 9.03(3) of this revenue procedure, for the taxable year all of Z's tested assets used in cable system S are primarily used for one-way communication services.

.05 *Change in use.* Section 168(i)(5) and § 1.168(i)-4 apply for determining depreciation of an asset beginning in the year of the change (as defined in § 1.168(i)-4(a)) if the primary use (determined under section 9.03(1) or section 9.03(2)) of tested asset changes—

(1) From providing one-way communication services to providing two-way communication services; or

(2) From providing two-way communication services to providing one-way communication services.

SECTION 10. CHANGE IN METHOD OF ACCOUNTING

.01 *In general.* Each of the following is a change in method of accounting to which the provisions of §§ 446 and 481, and the regulations thereunder, apply:

(1) A change to use the network asset maintenance allowance method for cable network assets provided in section 5 of this revenue procedure;

(2) A change to use any of the unit of property definitions provided in section 6 of this revenue procedure;

(3) A change to use the specific identification method for customer drops provided in section 7.01(1) of this revenue procedure;

(4) A change to use the safe harbor allocation method for external drops provided in section 7.01(2) of this revenue procedure;

(5) A change to deduct the labor costs associated with installing CPE provided in section 7.02 of this revenue procedure; and

(6) A change to the safe harbor method provided in section 8.03 of this revenue procedure for determining the asset and placed-in-service date under §§ 167 and 168 for a fiber optic transfer node and trunk line that consists of fiber optic cable used in a cable distribution network providing one-way and two-way communication services and that is placed in service in taxable years ending on or after December 30, 2003. A taxpayer also may treat a change to the safe harbor method for determining the asset provided in section 8.03 of this revenue procedure for a fiber optic transfer node and trunk line that consists of fiber optic cable used in a cable distribution network providing one-way and two-way communication services and that is placed in service in taxable years ending before December 30, 2003, as a change in method of accounting to which the provisions of §§ 446 and 481, and the regulations thereunder, apply.

.02 *Automatic changes.*

(1) A taxpayer that wants to change to a method of accounting described in this revenue procedure must use the automatic change in method of accounting provisions in Rev. Proc. 2011-14, 2011-4 I.R.B. 330, as modified by this revenue procedure, or its successor.

(2) Rev. Proc. 2011-14 is modified to add new section 3.21 to the APPENDIX, to read as follows:

3.21 *Cable network asset capitalization methods of accounting under Rev. Proc. 2015-12.*

(1) *Description of change.* This change applies to a cable system operator that is within the scope of Rev. Proc. 2015-12, 2015-2 I.R.B. 265, and wants to make one or more of the following changes in method of accounting:

(a) Change its treatment of cable network asset expenditures to the cable network asset maintenance allowance method of accounting provided in section 5 of Rev. Proc. 2015-12;

(b) Change to use any of the unit of property definitions provided in section 6 of Rev. Proc. 2015-12;

(c) Change to use the specific identification method for installations and customer drop costs described in section 7.01(1) of Rev. Proc. 2015-12;

(d) Change to use the safe harbor allocation method for installations and customer drop costs described in section 7.01(2) of Rev. Proc. 2015-12; or

(e) Change to deduct the labor costs associated with installing customer premises equipment under section 7.02 of Rev. Proc. 2015-12.

(2) *Scope limitations inapplicable.* The scope limitations in section 4.02 of this revenue procedure do not apply to a cable system operator that changes to a method of accounting provided in section 5, section 6, or section 7 of Rev. Proc. 2015-12 for its first or second taxable year ending after December 31, 2013.

(3) *Audit protection limited.* A taxpayer does not receive audit protection under section 7 of this revenue procedure in connection with this change, or a concurrent automatic change permitted under section (4) of this change, if the method of accounting to be changed is (a) an issue pending for any taxable year under examination, (b) an issue under consideration by an appeals office, or (c) an issue under consideration by a federal court. See sections 6.03(6), 6.04, and 6.05 of this revenue procedure.

(4) *Concurrent automatic change.* A taxpayer that wants to make both one or more changes in method of accounting pursuant to this section 3.21 of the APPENDIX and a change to a UNICAP method pursuant to the APPENDIX for the same year of change should file a single Form 3115 that includes all of these changes and must enter the designated automatic accounting method change numbers for all of these changes on the appropriate line on the Form 3115. For guidance on filing a single application for two or more changes, see section 6.02(1)(b)(ii) of this revenue procedure.

(5) *Section 481(a) adjustment.*

(a) In general, a change to one or more of the changes in method of

accounting described in paragraph (1) of this section requires an adjustment under § 481(a). The § 481(a) adjustment shall not include any amount attributable to property for which the taxpayer elected to apply the repair allowance under § 1.167(a)–11(d)(2).

(b) *Itemized listing on Form 3115.* The taxpayer must include on Form 3115, Part IV, line 25, the total § 481(a) adjustment for all changes in methods of accounting being made. If the taxpayer is making more than one change in method of accounting under Rev. Proc. 2015–12, the taxpayer must include on an attachment to Form 3115 —

(i) the information required by Part IV, line 25 for each change in method of accounting (including the amount of the § 481(a) adjustment for each change in method of accounting, which includes the portion of the § 481(a) adjustment attributable to UNICAP);

(ii) the information required by Part II, line 12 of Form 3115 that is associated with each change; and

(iii) the citation to the paragraph of Rev. Proc. 2015–12 that provides for each proposed method of accounting.

(6) *Ogden copy of Form 3115 required in lieu of national office copy.* A taxpayer changing its method of accounting under this section 3.21 of the APPENDIX must file a signed copy of its completed Form 3115 with the IRS in Ogden, UT (Ogden copy) in lieu of filing the national office copy no earlier than the first day of the year of change and no later than the date the taxpayer files the original Form 3115 with its Federal income tax return for the year of change. See section 6.02(3)(a)(ii)(B) (providing the general rules) and section 6.02(7)(b) (providing the mailing address) of this revenue procedure.

(7) *Designated automatic accounting method change number.* The designated automatic accounting method change number for a change to a method of accounting provided in section 5 or 6 of Rev. Proc. 2015–12 is “208.” The designated automatic accounting method

change number for a change to a method of accounting provided in section 7 of Rev. Proc. 2015–12 is “209.”

(8) *Contact information.* For further information regarding a change under this section, contact Merrill Feldstein at (202) 317-5100 (not a toll-free number).

(3) Rev. Proc. 2011–14 is modified to add new section 6.41 to the APPENDIX to read as follows:

6.41 *Depreciation of fiber optic transfer node and fiber optic cable used by a cable system operator (§§ 167 and 168)*

(1) *Description of change.*

(a) *Applicability.* This change applies to a cable system operator that is within the scope of Rev. Proc. 2015–12, 2015–2 I.R.B. 265, and wants to change to the safe harbor method of accounting provided in section 8.03 of Rev. Proc. 2015–12 for determining depreciation under §§ 167 and 168 of a fiber optic transfer node and trunk line consisting of fiber optic cable used in a cable distribution network providing one-way and two-way communication services. The safe harbor method provided by section 8.03 of Rev. Proc. 2015–12 determines the asset for purposes of §§ 167 and 168.

(b) *Inapplicability.* This change does not apply to the following:

(i) any property that is not depreciated under § 168 under the taxpayer’s present and proposed methods of accounting; or

(ii) any property that is not owned by the taxpayer at the beginning of the year of change.

(2) *Scope limitations inapplicable.*

(a) The scope limitations in section 4.02(1), (2), (3), (4), (6), and (7) of this revenue procedure do not apply to a taxpayer that makes this change for its first or second taxable year ending after December 31, 2013.

(b) The scope limitation in section 4.02(5) of this revenue procedure does not apply to a taxpayer that makes this change.

(3) *Audit protection limited.* A taxpayer does not receive audit protection under section 7 of this revenue procedure in connection with this change, or a concurrent automatic change permitted under section (4)(b) of this change, if the method of accounting to be changed is (a) an issue pending for any taxable year under exam-

ination, (b) an issue under consideration by an appeals office, or (c) an issue under consideration by a federal court. See sections 6.03(6), 6.04, and 6.05 of this revenue procedure.

(4) *Concurrent automatic change.*

(a) A taxpayer that wants to make this change for more than one asset for the same year of change should file a single Form 3115 for all such assets and provide a single net § 481(a) adjustment for all the changes included in that Form 3115. If one or more of the changes in that single Form 3115 generate a negative § 481(a) adjustment and other changes in that same Form 3115 generate a positive § 481(a) adjustment, the taxpayer may provide a single negative § 481(a) adjustment for all the changes that are included in that Form 3115 generating such adjustment and a single positive § 481(a) adjustment for all the changes that are included in that Form 3115 generating such adjustment.

(b) A taxpayer that wants to make both this change and a change to a UNICAP method under section 11.01, 11.02, or 11.09 of this APPENDIX, as applicable, 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. For guidance on filing a single application for two or more changes, see section 6.02(1)(b)(ii) of this revenue procedure.

(5) *Ogden copy of Form 3115 required in lieu of national office copy.* A taxpayer changing its method of accounting under section 6.41 of the APPENDIX must file a signed copy of its completed Form 3115 with the IRS in Ogden, UT (Ogden copy) in lieu of filing the national office copy no earlier than the first day of the year of change and no later than the date the taxpayer files the original Form 3115 with its Federal income tax return for the year of change. If a taxpayer makes both this change and a change to a UNICAP method under section 11.01, 11.02, or 11.09 of this APPENDIX, as applicable, on a single Form 3115 for the same year of change in accordance with section 6.41(3)(b) of this APPENDIX, the taxpayer must file a signed copy of that completed Form 3115 with the IRS in Ogden,

UT (Ogden copy) in lieu of filing the national office copy no earlier than the first day of the year of change and no later than the date the taxpayer files the original Form 3115 with its Federal income tax return for the year of change. See section 6.02(3)(a)(ii)(B) (providing the general rules) and section 6.02(7)(b) (providing the mailing address) of this revenue procedure.

(6) *Designated automatic accounting method change number.* The designated automatic accounting method change number for a change to the method of accounting under section 6.41 of this APPENDIX is “210.” See section 6.02(4) of this revenue procedure.

(7) *Contact information.* For further information regarding a change under this section, contact Charles Magee at (202) 317-7005 (not a toll-free number).

(4) Section 6.08 of the APPENDIX of Rev. Proc. 2011–14 is modified by adding a new sentence at the end of section 6.08(1) of the APPENDIX, to read as

follows: This change applies only to taxable years ending on or before December 31, 2013. For taxable years ending after December 31, 2013, see section 6.41 of this APPENDIX for making a change to the safe harbor method of accounting provided in section 8.03 of Rev. Proc. 2015–12, 2015–2 I.R.B. 265, for depreciation of fiber optic transfer node and trunk line consisting of fiber optic cable used in a cable distribution network. The safe harbor method of accounting provided in section 8.03 of Rev. Proc. 2015–12 determines the asset for purposes of §§ 167 and 168. See section 9 of Rev. Proc. 2015–12 for the safe harbor manner of determining the primary use of that asset for taxable years ending after December 31, 2013.

SECTION 11. EFFECT ON OTHER DOCUMENTS

- .01 Rev. Proc. 2003–63 is superseded.
- .02 Rev. Proc. 2011–14 is modified.

SECTION 12. EFFECTIVE DATE

This revenue procedure is effective for taxable years ending after December 31, 2013.

SECTION 13. DRAFTING INFORMATION

The principal author of this revenue procedure is Alan S. Williams of the Office of Associate Chief Counsel (Income Tax & Accounting). For further information regarding sections 5, 6, 7, 10.01, or 10.02(2) of this revenue procedure contact Merrill Feldstein at 202-317-5100 (not a toll free number). For further information regarding sections 8, 9, 10.02(3), or 10.02(4) of this revenue procedure contact Charles Magee of the Office of Associate Chief Counsel (Income Tax & Accounting) at 202-317-7005 (not a toll free number).

Part IV. Items of General Interest

Notice of Proposed Rulemaking Nonrecognition of Gain or Loss on Certain Dispositions of Installment Obligations

REG-109187-11

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking.

SUMMARY: This document contains proposed regulations relating to the nonrecognition of gain or loss on certain dispositions of an installment obligation. In general, under the proposed regulations a transferor does not recognize gain or loss on certain dispositions of an installment obligation if gain or loss is not recognized on the disposition under another provision of the Internal Revenue Code. The proposed regulations also provide that this general rule does not apply to the satisfaction of an installment obligation. For example, an installment obligation of an issuer, such as a corporation or partnership, is satisfied when the holder transfers the obligation to the issuer for an equity interest in the issuer.

DATES: Comments or a request for a public hearing must be received by March 23, 2015.

ADDRESSES: Send submissions to CC:PA:LPD:PR (REG-109187-11), 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-109187-11), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, DC, or sent electronically via the Federal eRulemaking Portal at www.regulations.gov (IRS REG-109187-11).

FOR FURTHER INFORMATION

CONTACT: Concerning the proposed regulations, Arvind Ravichandran, (202) 317-4718; concerning the submission of

comments and/or requests for a public hearing, Olawafunmilayo (Funmi) Taylor at (202) 317-6901 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Background

This document contains proposed amendments to the regulations in 26 CFR part 1 under section 453B of the Internal Revenue Code (Code) relating to gain or loss on the disposition of installment obligations. Section 453B was added to the Code by the Installment Sales Revision Act of 1980, Public Law 96-471 (94 Stat. 2252 (1980)).

Section 453B replaces and provides generally the same rules as former section 453(d). In general, under section 453B(a) gain or loss is recognized upon the satisfaction of an installment obligation at other than its face value, or upon the distribution, transmission, sale, or other disposition of the installment obligation. Section 1.453-9(c)(2) of the Income Tax Regulations, issued under former section 453(d), provides an exception to the general rule. Under § 1.453-9(c)(2), if the Code provides an exception to the recognition of gain or loss for certain dispositions, then gain or loss is not recognized under former section 453(d) on the disposition of an installment obligation within that exception. The exceptions identified in § 1.453-9(c)(2) include certain transfers to corporations under sections 351 and 361, contributions to partnerships under section 721, and distributions by partnerships to partners under section 731 (except as provided by section 736 and section 751).

Under Rev. Rul. 73-423, 1973-2 CB 161, the exceptions in § 1.453-9(c)(2) to recognition of gain or loss under the installment sale rules do not apply to the transfer of an installment obligation that results in a satisfaction of the obligation. Thus, the revenue ruling holds that the transfer of a corporation's installment obligation to the issuing corporation in exchange for stock of the issuing corporation results in a satisfaction of the obligation. In that case, the transferor must recognize gain or loss on the satisfaction of the obligation to the extent of

the difference between the transferor's basis in the obligation and the fair market value of the stock received, even though gain or loss generally is not recognized on section 351 transfers.

Explanation of Provisions

These proposed regulations republish in § 1.453B-1(c) the general rule in § 1.453-9(c)(2) under which gain or loss is not recognized upon certain dispositions. In addition, the proposed regulations incorporate and expand the holding of Rev. Rul. 73-423 to provide that a transferor recognizes gain or loss under section 453B(a) when the transferor disposes of an installment obligation in a transaction that results in the satisfaction of the installment obligation, including, for example, when an installment obligation of a corporation or partnership is contributed to the corporation or partnership in exchange for an equity interest in the corporation or partnership. Finally, the proposed regulations amend the regulations under sections 351, 361, and 721 to include a cross-reference to the regulations under section 453B regarding recognition of any gain or loss upon the satisfaction of an installment obligation. The IRS and the Treasury Department anticipate publishing regulations addressing the general rule under section 453B(a) and the basis of an obligation under section 453B(b) in the future. Therefore, regulations under § 1.453B-1(a) and (b) are reserved.

Proposed Effective/Applicability Date

These regulations are proposed to apply to satisfactions, distributions, transmissions, sales, or other dispositions of installment obligations after the date these regulations are published as final regulations in the **Federal Register**.

Special Analyses

This notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. It also has been determined that

section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations, and because the regulation does not impose a collection of information on small entities, the Regulatory Flexibility Act (5 U.S.C. chapter 6) does not apply. 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 a Public Hearing

Before these proposed regulations are adopted as final regulations, consideration will be given to any written comments that are submitted timely to the IRS as prescribed in this preamble under the “Addresses” heading. The Treasury Department and the IRS invite comments on all aspects of the proposed rules. In particular, the Treasury Department and the IRS request comments on how a partnership’s distribution of a partner’s installment obligation to the obligor partner should be treated under section 453B, and whether there are circumstances in which such a distribution should not result in gain or loss recognition by the partnership. All comments will be available for public inspection and copying at www.regulations.gov or upon request. A public hearing will be scheduled if requested in writing by any person who timely submits written comments. If a public hearing is scheduled, notice of the date, time and place for the hearing will be published in the **Federal Register**.

Drafting Information

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

Proposed Amendments to the Regulations

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

PART 1—INCOME TAXES

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

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

Par. 2. Section 1.351-1(a)(1) is amended by adding a heading and new second and third sentences to read as follows:

§ 1.351-1 Transfer to corporation controlled by transferor.

(a)(1) *In general.* * * * See § 1.453B-1(c) for rules requiring a transferor to recognize gain or loss upon the satisfaction of an installment obligation of a corporation when the obligation is exchanged for stock in that corporation. The preceding sentence applies to satisfactions of installment obligations after the date these regulations are published as final regulations in the **Federal Register**. * * *

* * * * *

Par. 3. Section 1.361-1 is amended by adding new second and third sentences to read as follows:

§ 1.361-1 Nonrecognition of gain or loss to corporations.

* * * See § 1.453B-1(c) for rules requiring a corporation transferring an installment obligation to the acquiring corporation (as that term is used in § 1.368-1) to recognize gain or loss upon the receipt of stock of the acquiring corporation or another party to the reorganization (as defined in § 1.368-2(f)) in satisfaction of that installment obligation. The preceding sentence applies to satisfactions of installment obligations after the date these regulations are published as final regulations in the **Federal Register**. * * *

Par. 4. Section 1.453B-1 is added to read as follows:

§ 1.453B-1 Gain or loss on disposition of installment obligations.

(a) *General rule.* [Reserved].
(b) *Basis of obligation.* [Reserved].
(c) *Dispositions on which no gain or loss is recognized.*

(1) *Certain nonrecognition transactions*—(i) *In general.* If the Internal Revenue Code provides an exception to the

recognition of gain or loss for certain dispositions, no gain or loss shall be recognized under section 453B on the disposition of an installment obligation within that exception. These exceptions include—

(A) Certain transfers to corporations under sections 351 and 361;

(B) Contributions to a partnership under section 721; and

(C) Distributions by a partnership to a partner under section 731 (except as provided by sections 704(c)(1)(B), 736, 737, and 751(b)).

(ii) *Transactions resulting in a satisfaction of installment obligations.* Paragraph (c)(1)(i) of this section does not apply to a disposition that results in a satisfaction of an installment obligation, regardless of whether the disposition occurs as part of a transaction for which the Internal Revenue Code provides an exception to the recognition of gain or loss. These dispositions include, but are not limited to—

(A) The receipt of stock of a corporation from the corporation in satisfaction of an installment obligation of the corporation; and

(B) The receipt of an interest in a partnership from the partnership in satisfaction of an installment obligation of the partnership.

(2) *Effective/applicability date.* This paragraph (c) applies to satisfactions, distributions, transmissions, sales, or other dispositions of installment obligations after the date these regulations are published as final regulations in the **Federal Register**.

Par. 5. Section 1.721-1(a) is amended by adding new ninth and tenth sentences to read as follows:

§ 1.721-1 Nonrecognition of gain or loss on contribution.

(a) * * * For rules in determining a partner’s gain or loss when an installment obligation of a partnership is contributed to the partnership, see section 453B and § 1.453B-1(c). The preceding sentence applies to satisfactions of installment obligations after the date these regulations are published as final regulations in the **Federal Register**.

* * * * *

John Dalrymple,
Deputy Commissioner for
Services and Enforcement.

(Filed by the Office of the Federal Register on December 22, 2014, 8:45 a.m., and published in the issue of the Federal Register or December 23, 2014, 79 F.R. 76928)

Notice of Proposed Rulemaking Amendments to Excepted Benefits

REG-132751-14

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: Proposed rules.

SUMMARY:

This document contains proposed rules that would amend the regulations regarding excepted benefits under the Employee Retirement Income Security Act of 1974, the Internal Revenue Code (the Code), and the Public Health Service Act related to limited wraparound coverage. Excepted benefits are generally exempt from the requirements that were added to those laws by the Health Insurance Portability and Accountability Act and the Patient Protection and Affordable Care Act.

DATES:

Comments are due on or before January 22, 2015.

ADDRESSES:

Written comments may be submitted to the Department of Labor as specified below. Any comment that is submitted will be shared with the other Departments and will also be made available to the public. Warning: Do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed. All comments may be posted on the Internet and can be retrieved by most Internet search engines. No deletions, modifications, or redactions will be made to the comments received, as they are public records. Comments may be submitted anonymously.

Comments, identified by “Excepted Benefits,” may be submitted by one of the following methods:

Federal eRulemaking Portal: <http://www.regulations.gov>. Follow the instructions for submitting comments.

Mail or Hand Delivery: Office of Health Plan Standards and Compliance Assistance, Employee Benefits Security Administration, Room N-5653, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC 20210, Attention: Excepted Benefits.

Comments received will be posted without change to www.regulations.gov and available for public inspection at the Public Disclosure Room, N-1513, Employee Benefits Security Administration, 200 Constitution Avenue NW., Washington, DC 20210, including any personal information provided.

FOR FURTHER INFORMATION

CONTACT: Amy Turner or Beth Baum, Employee Benefits Security Administration, Department of Labor, at (202) 693-8335; Karen Levin, Internal Revenue Service, Department of the Treasury, at (202) 317-5500; Jacob Ackerman, 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 website (<http://www.dol.gov/ebsa>). In addition, information from HHS on private health insurance for consumers can be found on the Centers for Medicare & Medicaid Services (CMS) website (www.cms.gov/ccio) and information on health reform can be found at www.HealthCare.gov.

SUPPLEMENTARY INFORMATION:

I. Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, 110 Stat. 1936 added title XXVII of the Public Health Service Act (PHS Act), part 7 of the Employee Retirement Income Security Act of 1974 (ERISA), and chapter 100 of the Internal Revenue Code (the Code), providing portability and nondiscrimination provisions with respect to health coverage. These provisions of the PHS Act, ERISA, and the Code were later augmented by other consumer protection laws, including the Mental Health Parity Act of 1996,¹ the Mental Health Parity and Addiction Equity Act of 2008,² the Newborns’ and Mothers’ Health Protection Act,³ the Women’s Health and Cancer Rights Act,⁴ the Genetic Information Nondiscrimination Act of 2008,⁵ the Children’s Health Insurance Program Reauthorization Act of 2009,⁶ Michelle’s Law,⁷ and the Affordable Care Act.⁸

The Affordable Care Act reorganizes, amends, and adds to the provisions of part

¹Pub. L. 104-204, 110 Stat. 2944 (September 26, 1996).

²Pub. L. 110-343, 122 Stat. 3881 (October 3, 2008).

³Pub. L. 104-204, 110 Stat. 2935 (September 26, 1996).

⁴Pub. L. 105-277, 112 Stat. 2681-436 (October 21, 1998).

⁵Pub. L. 110-233, 122 Stat. 881 (May 21, 2008).

⁶Pub. L. 111-3, 123 Stat. 65 (February 4, 2009).

⁷Pub. L. 110-381, 122 Stat. 4081 (October 9, 2008).

⁸The Patient Protection and Affordable Care Act, Public Law 111-148, was enacted on March 23, 2010, and the Health Care and Education Reconciliation Act, Public Law 111-152, was enacted on March 30, 2010. (These statutes are collectively known as the “Affordable Care Act”).

A of title XXVII of the 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.⁹ Section 715(a)(1) of ERISA and section 9815(a)(1) of the Code, as added by the Affordable Care Act, incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code to 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 by these references are sections 2701 through 2728.

Sections 2722 and 2763 of the PHS Act, section 732 of ERISA, and section 9831 of the Code provide that the requirements of title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, respectively, generally do not apply to excepted benefits. Excepted benefits are described in section 2791 of the PHS Act, section 733 of ERISA, and section 9832 of the Code.

The parallel statutory provisions establish four categories of excepted benefits. The first category includes benefits that are generally not health coverage¹⁰ (such as automobile insurance, liability insurance, workers compensation, and accidental death and dismemberment coverage). The benefits in this category are excepted in all circumstances. In contrast, the benefits in the second, third, and fourth categories are types of health coverage but are excepted only if certain conditions are met.

The second category of excepted benefits is limited excepted benefits, which may include limited scope vision or dental benefits, and benefits for long-term care,

nursing home care, home health care, or community based care. Section 2791(c)(2)(C) of the PHS Act, section 733(c)(2)(C) of ERISA, and section 9832(c)(2)(C) of the Code authorize the Secretaries of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Secretaries) to issue regulations establishing other, similar limited benefits as excepted benefits. The Secretaries exercised this authority previously with respect to certain health flexible spending arrangements (health FSAs).¹¹ To be excepted under this second category, the statute (specifically, ERISA section 732(c)(1), PHS Act section 2722(c)(1), and section 9831(c)(1) of the Code) provides that limited benefits must either: (1) be provided under a separate policy, certificate, or contract of insurance; or (2) otherwise not be an integral part of a group health plan, whether insured or self-insured.¹²

The third category of excepted benefits, referred to as “noncoordinated excepted benefits,” includes both coverage for only a specified disease or illness (such as cancer-only policies), and hospital indemnity or other fixed indemnity insurance. In the group market, these benefits are excepted only if all of the following conditions are met: (1) the benefits are provided under a separate policy, certificate, or contract of insurance; (2) there is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and (3) the benefits are paid with respect to any event without regard to whether benefits are provided under any group health plan maintained by the same plan sponsor.¹³

The fourth category of excepted benefits is supplemental excepted benefits.

Such benefits must be: (1) coverage supplemental to Medicare, coverage supplemental to the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) or to Tricare, or similar coverage that is supplemental to coverage provided under a group health plan; and (2) provided under a separate policy, certificate, or contract of insurance.¹⁴

In 2004, the Departments of the Treasury, Labor, and HHS published final regulations with respect to excepted benefits (the HIPAA regulations).¹⁵ (Subsequent references to the “Departments” include all three Departments, unless the headings or context indicate otherwise.)

On December 24, 2013, the Departments issued additional proposed regulations with respect to the second category of excepted benefits, limited excepted benefits (2013 proposed regulations).¹⁶ These regulations proposed to: (1) eliminate the requirement that participants in self-insured plans pay an additional premium or contribution for limited-scope vision or dental benefits to qualify as benefits that are not an integral part of the plan; (2) set forth the criteria under which employee assistance programs (EAPs) that do not provide significant benefits in the nature of medical care constitute excepted benefits; and (3) allow plan sponsors in limited circumstances to offer, as excepted benefits, coverage that wraps around certain individual health insurance coverage in certain circumstances.

After consideration of comments received on the 2013 proposed regulations, the Departments published final regulations regarding dental and vision benefits and EAP benefits on October 1, 2014

⁹The 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.

¹⁰See 62 FR 16894, 16903 (Apr. 8, 1997), which states that these benefits are generally not health insurance coverage).

¹¹26 CFR 54.9831-1(c)(3)(v); 29 CFR 2590.732(c)(3)(v); 45 CFR 146.145(b)(3)(v).

¹²See the discussion in the 2014 final regulations concerning the application of these requirements to benefits such as limited-scope dental and vision benefits and employee assistance programs at 79 FR 59131 (Oct. 1, 2014).

¹³26 CFR 54.9831-1(c)(4); 29 CFR 2590.732(c)(4); 45 CFR 146.145(b)(4). See also Q7 in Affordable Care Act Implementation FAQs Part XI, available at <http://www.dol.gov/ebsa/faqs/faq-aca11.html>.

¹⁴26 CFR 54.9831-1(c)(5); 29 CFR 2590.732(c)(5); 45 CFR 146.145(b)(5). The Departments issued additional guidance regarding supplemental health insurance coverage as excepted benefits. See EBSA Field Assistance Bulletin No. 2007-04 (available at <http://www.dol.gov/ebsa/pdf/fab2007-4.pdf>); CMS Insurance Standards Bulletin 08-01 (available at http://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa_08_01_508.pdf); and IRS Notice 2008-23 (available at http://www.irs.gov/irb/2008-07_IRB/ar09.html).

¹⁵69 FR 78720 (Dec. 30, 2004).

¹⁶78 FR 77632.

(2014 final regulations).¹⁷ Consistent with the 2013 proposed regulations, the 2014 final regulations eliminated the requirement under the HIPAA regulations that participants pay an additional premium or contribution for limited-scope vision or dental benefits to qualify as excepted benefits. With respect to EAPs, the Departments finalized the proposal with one modification related to financing.¹⁸ In the 2014 final regulations, the Departments also stated their intent to publish regulations that addressed limited wraparound coverage in the future, taking into account the extensive comments received on this issue.¹⁹

As explained in the preamble to the 2013 proposed regulations, some group health plan sponsors have asked whether certain limited benefits that “wrap around” employer-sponsored group health plan coverage²⁰ could be considered an excepted benefit if such benefits are provided to employees for whom the employer’s group health plan coverage that is otherwise offered to them (“primary” coverage) is unaffordable, and who instead obtain major medical coverage through the individual market, including through the Affordable Insurance Exchange, or “Exchange” (also called a Health Insurance Marketplace, or Marketplace). Specifically, the preamble to the 2013 proposed regulations noted that experts suggest that most workers who are offered minimum value coverage under their employer’s primary group health plan will not meet the criteria for that coverage to be considered “unaffordable” within the meaning of the statute and thus will not qualify for the premium tax credit for enrolling in individual health coverage through an Exchange.²¹ However, the preamble went on to note that coverage under such a primary group health plan may be unaffordable for some employees, who might instead purchase individual health coverage through an Exchange with a premium tax credit. While such individuals

might pay lower premiums for such individual health coverage through an Exchange than they would pay for major medical coverage offered through their employer’s group health plan, the individual coverage in the Exchange might also provide less generous coverage in terms of benefits or a different provider network than the coverage provided under their employer’s group health plan. The 2013 proposed regulations intended to permit employers to provide such employees with overall coverage that is comparable to the employer’s group health plan by providing them with limited employer-sponsored coverage that would add to and wrap around the individual market coverage that the employee purchases through the Exchange. If the employer chose to provide such limited employer-sponsored wraparound coverage, that coverage would qualify as an excepted benefit and therefore would not preclude the employee from obtaining a premium tax credit to assist in purchasing the individual coverage through the Exchange if the employee was otherwise eligible for a premium tax credit.

The 2013 proposed regulations outlined requirements under which certain employer-sponsored wraparound coverage provided under a group health plan would be treated as excepted benefits when offered to individuals who could have received the benefits provided in the wraparound coverage through their employer’s primary group health plan, however the primary plan is unaffordable and they do not enroll in that primary plan. The 2013 proposed regulations were intended to allow a plan sponsor to pursue equity in coverage by maintaining a comparable level of benefits for all potential enrollees, including not only higher-income workers enrolled in the employer’s primary group health plan but also lower-income workers, enrolled in non-grandfathered individual market coverage. Under the 2013 proposed regulations, employer-provided wraparound coverage

would constitute excepted benefits (limited wraparound coverage) and therefore would not disqualify an employee from eligibility for the premium tax credit and cost-sharing reductions, if five conditions were met.

First, under the 2013 proposed regulations, the coverage could wrap around only certain coverage provided through the individual market. Specifically, the individual health insurance coverage would have to be non-grandfathered and could not consist solely of excepted benefits. In States that elect to establish a Basic Health Program (BHP), certain low-income individuals (for example, those with household income between 133% and 200% of the Federal poverty level) who would otherwise qualify for a tax credit to obtain a qualified health plan through an Exchange would instead be enrolled in coverage through the BHP. The Departments invited comments on how an employer might make wraparound coverage available to BHP enrollees.

Second, the 2013 proposed regulations would have required that limited wraparound coverage be specifically designed to provide benefits beyond those offered by the individual health insurance coverage. Specifically, the limited wraparound coverage would have been required to provide either benefits that are in addition to essential health benefits (EHBs), or reimburse the costs of items and services provided by health care providers considered out-of-network under the individual health insurance coverage, or both. Additionally, the 2013 proposed regulations stated that the limited wraparound coverage could, but would not be required to, provide benefits to reimburse for participants’ otherwise applicable cost sharing under the individual health insurance policy. Reimbursement for participants’ otherwise applicable cost sharing could not be its primary purpose since Affordable Care Act-compliant individual health insurance policies already offer lower cost sharing at

¹⁷79 FR 59131 (Oct. 1, 2014).

¹⁸The 2014 final regulations do not include the requirement set forth in the 2013 proposed regulations that EAP benefits cannot be financed by another group health plan in order to qualify as excepted benefits. See 79 FR 59134.

¹⁹79 FR 59131.

²⁰A group health plan may be sponsored by an employer, an employee organization, or both. For simplicity, this preamble generally refers to employer-sponsored coverage. However, these proposed regulations would be equally applicable to group health plans sponsored by employee organizations, or jointly by employers and employee organizations.

²¹See Congressional Budget Office, CBO and JCT Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employer-Based Insurance, March 2012, at Table 2, available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-15-ACA_and_Insurance_2.pdf. See also Carter C. Price & Evan Saltzman, *Delaying the Employer Mandate*, July 2013, available at http://www.rand.org/pubs/research_reports/RR411.html.

higher metal tiers (gold and platinum). For the benefits to be considered specifically designed to wrap around the individual health insurance coverage, they would have to provide additional benefits; the coverage could not, under the proposed regulations, provide benefits solely pursuant to a coordination-of-benefits provision that simply pays benefits whenever the individual health insurance policy does not cover all or part of a medical expense.

The third condition of the 2013 proposed regulations would have required the plan sponsor offering the limited wrap-around coverage to sponsor another group health plan providing minimum value (as defined under section 36B(c)(2)(C)(ii) of the Code) for the plan year, referred to as the “primary plan.” This primary plan would have to be affordable for a majority of the employees eligible for the primary plan, and only individuals eligible for this primary plan could be eligible for the limited wraparound coverage.

Under the fourth condition set forth in the 2013 proposed regulations, the total cost of the employer’s limited wraparound coverage would have to be limited, so as not to exceed 15 percent of the cost of coverage under the employer’s primary plan offered to employees eligible for the wraparound coverage.²² For this purpose, the cost of coverage would include both employer and employee contributions towards coverage and would be determined in the same manner as that in which the applicable premium is calculated under a Consolidated Omnibus Reconciliation Act of 1985 (COBRA) continuation provision.²³ This is similar to the standard in the 2007 enforcement safe harbor for

treating supplemental health insurance coverage as excepted benefits, under which the cost of coverage under the supplemental policy, certificate, or contract of insurance must not exceed 15 percent of the cost of primary coverage.²⁴

The fifth and final condition for the limited wraparound coverage to qualify as excepted benefits under the 2013 proposed regulations relates to nondiscrimination. The limited wraparound coverage could not discriminate against individuals in eligibility, benefits, or premiums based on any health factor of an individual (or any dependent of the individual), consistent with the requirements of section 2705 of the PHS Act (incorporated by reference into ERISA section 715 and Code section 9815) and its implementing regulations. As explained in the preamble to the 2013 proposed regulations, this condition is similar to the standard in the 2007 enforcement safe harbor treating supplemental health insurance coverage as excepted benefits and rules for Medicare supplemental coverage.²⁵

To satisfy the fifth condition under the 2013 proposed regulations, the limited wraparound coverage also could not impose any preexisting condition exclusion, consistent with the requirements of section 2704 of the PHS Act (as incorporated into ERISA section 715 and Code section 9815) and its implementing regulations. Finally, both the primary coverage and the limited wraparound coverage could not discriminate in favor of highly compensated individuals, consistent with the provisions of section 2716 of the PHS Act (also incorporated by reference into ERISA section 715 and Code section

9815) and section 105(h) of the Code, and its implementing regulations at 26 CFR 1.105–11, as applicable.²⁶ The preamble to the 2013 proposed regulations clarified that these limitations were intended to ensure the coverage is available regardless of health status and to prevent employers from shifting employees with high medical costs to an Exchange.²⁷ Conditioning excepted benefit status on meeting standards consistent with the compensation-based nondiscrimination rules, in combination with the requirement that the primary plan be affordable for a majority of the employees who are eligible for it, was intended to help ensure that employers would not be able to use wraparound coverage to send excessive numbers of low wage workers to the Exchanges.²⁸

After consideration of comments on the 2013 proposed regulations, the Departments are publishing these proposed regulations to address limited wraparound coverage and solicit comment before promulgation of final regulations on limited wraparound benefits.

II. Overview of these Proposed Regulations

The Departments received general comments on the 2013 proposed regulations, as well as on the five conditions for wraparound coverage to qualify as excepted benefits. Many commenters suggested that limited wraparound coverage should be considered supplemental excepted benefits instead of limited excepted benefits, which would eliminate the need for the wraparound coverage to not be an integral part of a group health plan.²⁹ Some commenters suggested a more sim-

²²If an employer provides more than one primary plan option (for example, a health maintenance organization option and a preferred provider organization option), and one primary plan does not satisfy the 15 percent standard but another plan does, the Departments stated in the preamble to the 2013 proposed regulations that they would consider the 15 percent standard to be met if the average value of the primary plan options meets the 15 percent standard.

²³Under the COBRA rules, plans are generally permitted to charge up to 102 percent of the applicable premium. See § 4980B(f)(2)(C)(i) of the Code. The cost of coverage for purposes of these proposed regulations is 100 percent of the applicable premium, not 102 percent of the applicable premium that the plan is generally permitted to charge under the COBRA rules. “Applicable premium” is defined at § 4980B(f)(4) of the Code.

²⁴The Departments issued parallel guidance regarding supplemental health insurance coverage as excepted benefits under HIPAA and related legislation. See EBSA Field Assistance Bulletin No. 2007-04 (available at <http://www.dol.gov/ebsa/pdf/fab2007-4.pdf>); CMS Insurance Standards Bulletin 08-01 (available at http://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa_08_01_508.pdf); and IRS Notice 2008-23 (available at http://www.irs.gov/irb/2008-07_IRB/ar09.html).

²⁵75 FR 77636.

²⁶Section 2716 of the PHS Act (as incorporated into ERISA and the Code) generally applies to insured coverage and section 105(h) of the Code and its implementing regulations generally apply to self-insured coverage.

²⁷78 FR at 77636.

²⁸*Id.*

²⁹The Departments note that the exception for supplemental excepted benefits is for coverage that is supplemental to coverage provided under Medicare or Tricare, or similar supplemental coverage provided to coverage under a group health plan. None of these circumstances apply here. That is, the limited wraparound coverage that is the subject of these proposed regulations is supplemental to individual insurance.

plified approach to wraparound coverage rather than the five conditions outlined in the proposed regulations, such as adopting a more subjective test so that reasonable efforts to comply with the conditions to be excepted benefits will not cause a plan to fail to qualify as such. Others requested that the standards for limited wraparound coverage to qualify as excepted benefits track the same standards and safe harbors for applicable large employers under section 4980H of the Code and its implementing regulations, for ease of administration and consistency.

Many commenters suggested modifications to the second condition of the 2013 proposed regulations, requiring that limited wraparound coverage be specifically designed to provide benefits beyond those offered by the individual health insurance coverage. Some suggested that the goal of limited wraparound coverage should be to fill gaps in cost sharing, as the individual health insurance policy would provide coverage of EHB. Others disagreed, requesting that this condition be changed so that cost sharing would not be the primary purpose of the wraparound coverage, because individuals who wish to reduce their cost sharing can do so by purchasing a higher “metal level” of coverage. Additionally, commenters questioned how to choose which benefits to offer in addition to what is covered under the individual health insurance policy without knowing what benefits each employee will receive under their individual health insurance coverage. Some commenters suggested that benefits provided under the wraparound coverage mirror the benefits offered under the employer’s primary plan.

Commenters also recommended changes to the third condition, that the plan sponsor offer another, primary group health plan that provides minimum value and is affordable for a majority of the employees eligible for the primary plan. Some asked that this requirement be deleted altogether. Others stated that the “majority” test conflicts with the 95% test under sec-

tion 4980H(a) of the Code, and that this difference would introduce complexity and confusion, and suggested that Form W-2 employee wages and other safe harbor rules under section 4980H of the Code and the accompanying regulations be used to compute affordability. Some commenters requested that the eligibility test exclude part-time employees, Medicaid-eligible employees, and retirees. Other commenters asked that wraparound coverage be considered to meet this standard if the primary plan is affordable to the majority of employees enrolled in the primary plan (as opposed to the majority eligible for the primary plan).

Additionally, commenters addressed the limit that the total cost of coverage under the wraparound coverage not exceed 15 percent of the cost of coverage under the primary plan. Some commenters suggested increasing this percentage, stating that the 15 percent benchmark was based on rough Medicare estimates for supplemental coverage and is too low to wrap around a bronze or silver plan. Others asked that the limit be a simple dollar amount, similar to limits on health savings accounts or health FSAs. Additional commenters pointed out that as minimum value increases, so does the total cost of the wraparound coverage (and vice versa), and that wrapping around individual coverage makes these calculations confusing and uncertain.

After consideration of comments on the 2013 proposed regulations, the Departments are publishing these new proposed regulations with respect to limited wraparound coverage. These proposed regulations seek comment on two options for limited wraparound coverage to be considered an excepted benefit. The Departments intend that, after notice and comment, one or both options could be finalized. (That is, they are not necessarily alternatives and, therefore, could be implemented side by side).

The regulations include a sunset date and, therefore, would operate as a pilot program. While some elements of this

proposal are the same as those in the previous proposal, this new proposal contains changes in response to suggestions and adds new elements for reporting and data collection to gather information to inform future rulemaking.

A. Requirements of these New Proposed Regulations

These proposed regulations set forth five requirements under which limited benefits provided through a group health plan that wrap around either eligible individual insurance or coverage under a Multi-State Plan (limited wraparound coverage) constitute excepted benefits. For this purpose, “eligible individual health insurance” is individual health insurance coverage that is not a grandfathered health plan,³⁰ not a transitional individual health insurance market plan,³¹ and does not consist solely of excepted benefits.

1. Covers additional benefits

The limited wraparound coverage would have to be specifically designed to wrap around eligible individual health insurance.³² That is, the limited wraparound coverage would have to provide meaningful benefits beyond coverage of cost sharing under the eligible individual health insurance. For example, the limited wraparound coverage could provide coverage for expanded in-network medical clinics or providers, or provide benefits that are not EHB and that are not covered under the eligible individual health insurance. The limited wraparound coverage would not be permitted to provide benefits solely under a coordination-of-benefits provision and could not be solely an account-based reimbursement arrangement. Limited wraparound coverage that covers solely cost sharing is not permissible because reduced cost sharing can be obtained by choosing an individual health insurance policy with a higher actuarial value (for example, a platinum plan with a 90 percent actuarial value). Because the proposed regulations would permit certain eligible individuals to select any eligible individual health insurance (that is, indi-

³⁰See section 1251 of the Affordable Care Act, 29 CFR 2590.715-1251, and 45 CFR 147.140.

³¹As described in CMS Insurance Standards Bulletin (March 5, 2014) available at: <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf>.

³²In States that elect to establish a Basic Health Program (BHP), certain low-income individuals (for example, those with household income between 133% and 200% of the Federal poverty level) who would otherwise qualify for a tax credit to obtain a qualified health plan through an Exchange will instead be enrolled in coverage through the BHP. Therefore, the Departments invite comments on how an employer might make wraparound coverage available to BHP enrollees.

vidual health insurance coverage that is not a grandfathered health plan, not a transitional individual health insurance market plan, and does not consist solely of excepted benefits), and recognizing the complications some plan sponsors might encounter in determining what benefits or providers are not covered under that individual policy, the Departments invite comment on safe harbors standardizing the benefits in the limited wraparound coverage that could be established under this second proposed requirement.

2. *Limited in amount*

The second requirement is that the limited wraparound coverage be limited in amount. For this purpose, the annual cost of coverage per employee (and any covered dependents) under the limited wraparound coverage could not exceed the maximum annual contribution for health FSAs which is \$2,500 in 2014, indexed in the manner prescribed under section 125(i)(2) of the Code, and the cost of coverage would include both employer and employee contributions towards coverage and be determined in the same manner as the applicable premium is calculated under a COBRA continuation provision. The bright-line \$2,500 limitation is intended to be simpler to administer than the 15 percent cap set forth in the 2013 proposed regulations.

3. *Nondiscrimination*

The limited wraparound coverage must meet three requirements relating to nondiscrimination in order to qualify as excepted benefits. First, the wraparound coverage could not impose any preexisting condition exclusion, consistent with the requirements of section 2704 of the PHS Act (as incorporated into section 715 of ERISA and section 9815 of the Code) and implementing regulations.³³ Second, the wraparound coverage could not discriminate against individuals in eligibility, benefits, or premiums based on any health factor of an individual (or any dependent of the individual), consistent with the requirements of section 702 of ERISA, section 9802 of the Code, and section 2705 of the PHS Act (as incorporated into section

715 of ERISA and section 9815 of the Code) and implementing regulations.³⁴ Finally, neither the primary group health plan coverage nor the limited wraparound coverage could fail to comply with section 2716 of the PHS Act (as incorporated into section 715 of ERISA and section 9815 of the Code) or fail to be excludible from income with respect to any individual due to the application of section 105(h) of the Code (as applicable).

4. *Plan eligibility requirements*

The fourth requirement to qualify as excepted benefits would be that individuals eligible for the limited wraparound coverage cannot be enrolled in excepted benefit coverage that is a health FSA. In addition, plans must comply with one of two alternative sets of standards relating to eligibility and benefits. One set of plan eligibility requirements applies to wraparound benefits offered in conjunction with eligible individual health insurance for persons who are not full-time employees. A separate set of standards applies to coverage that wraps around certain Multi-State Plan coverage.

a. Eligible individual health insurance for individuals who are not full-time employees

Limited coverage that wraps around eligible individual health insurance for an individual who is not a full-time employee must satisfy three standards relating to plan eligibility. First, for each year that wraparound coverage is offered, the employer that is the sponsor of the plan offering wraparound coverage, or the employer participating in a plan offering wraparound coverage, must offer to its full-time employees coverage that: (1) is substantially similar to coverage that the employer would need to offer to its full-time employees in order not to be subject to a potential assessable payment under the employer shared responsibility provisions of section 4980H(a) of the Code, if such provisions were applicable (that is, substantially similar to an offer of minimum essential coverage (as defined in section 5000A(f) to at least 95 percent of its full-time employees (or to all but five of its full-time employees, if five is greater

than five percent of its full-time employees)); (2) provides minimum value (as defined in section 36B(c)(2)(C)(ii) of the Code); and (3) is reasonably expected to be affordable (applying the safe harbor rules for determining affordability set forth in 26 CFR 54.4980H-5(e)(2)). If a plan or issuer providing limited wraparound coverage takes reasonable steps to ensure that employers disclose necessary information regarding their coverage offered and affordability information to the plan or issuer, the plan or issuer may rely on reasonable representations by employers regarding this information, unless the plan or issuer has specific knowledge to the contrary. Second, eligibility for the limited wraparound coverage must be limited to employees who are not full-time employees (and their dependents), or who are retirees (and their dependents). For this purpose, the Departments propose that “full-time employees” would be employees who are reasonably expected to work at least an average of 30 hours per week. The Departments proposal would not require plans and issuers to define “full-time employees” strictly in accordance with the rules of section 4980H of the Code. Because this proposal is for part-time employees, some employers who wish to take advantage of this excepted benefits option may be exempt from Code 4980H and may not already be operating under that detailed set of rules. The Departments intend that employers could rely on the 4980H definition, or any reasonable interpretation of who is reasonably expected to work an average of 30 hours a week, for purposes of this provision affecting part-time employees and invite comment on this approach.

Third, other group health plan coverage, not limited to excepted benefits, must be offered to the individuals eligible for the wraparound coverage. Only individuals eligible for other group health plan coverage may be eligible for the wraparound coverage. This third requirement is consistent with the requirement for a health FSA to qualify as excepted benefits

³³29 CFR 2590.715-2704 and 45 CFR 147.108. See also Q2 in Affordable Care Act Implementation FAQs Part XXII, available at <http://www.dol.gov/ebsa/faqs/faq-aca22.html> regarding the prohibition against offering employees with high claims risk a choice between enrollment in its standard group health plan or cash.

³⁴26 CFR 54.9802-1, 29 CFR 2590.702, and 45 CFR 146.121.

under the Departments' excepted benefits regulations.³⁵

b. Multi-State Plan coverage

For Multi-State Plan coverage limited wraparound coverage, four requirements must be satisfied. The first of the four standards requires that the limited wrap-around coverage be specifically designed and approved by the Office of Personnel Management (OPM) to provide benefits in conjunction with coverage under a Multi-State Plan authorized under section 1334 of the Affordable Care Act. The Departments anticipate that health insurance issuers with whom OPM contracts to offer Multi-State Plans will be in the best position to offer this type of limited wrap-around coverage. OPM may revoke approval if it determines that continued approval is inconsistent with the reporting and evaluation criteria in the proposed regulations. Second, the employer must have offered coverage in the plan year that begins in 2014 that is substantially similar to coverage that the employer would need to have offered to its full-time employees in order to not be subject to an assessable payment under the employer shared responsibility provisions of section 4980H(a) of the Code, if such provisions had been applicable (that is, substantially similar to an offer of minimum essential coverage (as defined in section 5000A(f) of the Code) to at least 95 percent of its full-time employees (or to all but five of its full-time employees, if five is greater than five percent of its full-time employees). Third, in the plan year that begins in 2014, the employer must have offered coverage to a substantial portion of full-time employees that provided minimum value (as defined in section 36B(c)(2)(C)(ii) of the Code) and was affordable (applying the safe harbor rules for determining affordability set forth in 26 CFR 54.4980H-5(e)(2)). Fourth, for the duration of the pilot program, the employer's annual aggregate contributions for both primary and limited wraparound coverage must be substantially the same as the employer's aggregate contributions for coverage offered to full-time employees in 2014. The Departments are considering interpreting this "substantially the same" condition as a percentage (e.g., 80 or 90 percent) and potentially applying it

on a per-worker basis to allow for fluctuations in an employer's workforce. The Departments seek comment on such an interpretation, as well as on all aspects of this maintenance of effort condition.

For purposes of administering this provision, with respect to limited wraparound coverage offered in conjunction with Multi-State Plan coverage, the Departments propose that the term "full-time employee" means a "full-time employee" as defined in 26 CFR 54.4980H-1(a)(21) who is not in a limited non-assessment period for certain employees (as defined in 26 CFR 54.4980H-1(a)(26)). Moreover, if a plan or issuer providing limited wraparound coverage takes reasonable steps to ensure that employers disclose necessary information regarding their coverage offered and contribution levels for 2014 to the plan or issuer, the plan or issuer may rely on reasonable representations by employers regarding this information, unless the plan or issuer has specific knowledge to the contrary. Consistent with the reporting and evaluation criteria described later in this preamble, OPM may verify that plans and issuers have reasonable mechanisms in place to ensure that contributing employers meet these standards.

5. Reporting

The fifth and final requirement for limited wraparound coverage to qualify as excepted benefits is a reporting requirement, for group health plans and group health insurance issuers, as well as group health plan sponsors.

A self-insured group health plan, or a health insurance issuer offering or proposing to offer Multi-State Plan wraparound coverage, reports to OPM, in a form and manner specified in OPM guidance, information OPM reasonably requires to determine whether the plan or issuer qualifies to offer such coverage or complies with the applicable requirements of this section.

In addition, the plan sponsor of any group health plan offering either limited wraparound coverage that wraps around eligible individual health insurance or Multi-State Plan coverage must report to HHS, in a form and manner specified in guidance, information HHS reasonably

requires to determine whether the exception for limited wraparound coverage under these proposed regulations is allowing plan sponsors to provide workers with comparable benefits whether enrolled in minimum essential coverage under a group health plan offered by the plan sponsor, or a qualified health plan with additional limited wraparound coverage offered by the plan sponsor, without causing an erosion of coverage.

B. Pilot program with sunset date

Under these proposed regulations, limited wraparound coverage would be permitted under a pilot program for a limited time. Specifically, this type of wraparound coverage could be offered as excepted benefits to coverage that is first offered no later than December 31, 2017 and that ends on the later of: (1) the date that is three years after the date wraparound coverage is first offered; or (2) the date on which the last collective bargaining agreement relating to the plan terminates after the date wraparound coverage is first offered (determined without regard to any extension agreed to after the date the wraparound coverage is first offered). The Departments invite comments on this time frame for applicability, including whether the Departments should have the option to provide for an earlier termination date.

C. Comment Solicitation

The Departments invite comments on these proposed regulations generally, and on the specific issues identified earlier in this preamble. The Departments also seek comments on the special circumstances of small businesses that are not subject to section 4980H of the Code. Small employers may qualify to purchase coverage through the Small-Business Health Options Program (SHOP) in their State, or they may elect to buy coverage in their state's small group market outside of the SHOP. Small businesses, like other employers, can also contribute towards a health savings account (HSA) under section 223 of the Code, which may be used in combination with a high deductible health plan (HDHP). In addition, the Departments invite comments on whether modifications to health FSAs or other existing policies tailored to the needs of

³⁵See 26 CFR 54.9831-1(c)(3)(v); 29 CFR 2590.732(c)(3)(v); 45 CFR 146.145(b)(3)(v).

small businesses may also be beneficial to employers and employees.

III. Economic Impact and Paperwork Burden

A. Summary

As discussed in detail above, these proposed regulations would amend the definition of “limited excepted benefits” to provide plan sponsors with two mutually exclusive options to offer limited wrap-around coverage to certain individuals. Under the first option, plan sponsors could offer limited benefits provided through a group health plan that wraps around eligible individual health insurance to employees who are not full-time employees (and their dependents), or who are retirees (and their dependents). For this purpose, full-time employees are employees who are reasonably expected to work at least an average of 30 hours per week. Under the second option, the limited wrap-around coverage that satisfies the requirements outlined in the regulations must be approved by OPM and be offered in conjunction with Multi-State Plan coverage authorized under section 1334 of the Affordable Care Act.

B. Executive Orders 12866 and 13563 — Departments of Labor and HHS

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

Section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a regulation: (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, produc-

tivity, 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. OMB has determined that the action is significant within the meaning of section 3(f)(4) of Executive Order 12866, and the Departments accordingly provide the following assessment of its potential benefits and costs.

The Departments recognize that many plan sponsors provide comprehensive health benefits to their workers. One objective of the Affordable Care Act is to allow individuals with comprehensive health insurance plans to maintain their current level of benefits. Some employers are interested in offering wrap-around coverage to employees who are enrolled in a Multi-State Plan authorized under section 1334 of the Affordable Care Act or to part-time, seasonal, or part-year employees. These proposed regulations provide two options to employers that clarify the circumstances under which plan sponsors can provide such limited wrap-around coverage to their employees.

The cost (and Federal budget impact³⁶) of this proposal is difficult to quantify, because it is unclear how many plan sponsors will be eligible to offer and how many employees will be covered by limited wrap-around benefits. It is important to note that the cost of the proposed limited wrap-around coverage is limited by the proposed conditions on its availability.

For example, in order to qualify as limited excepted benefits under the individual coverage option, limited wrap-around coverage can be offered only to

individuals who are not full-time employees (and their dependents) or who are retirees (and their dependents), and can only wrap around eligible individual health insurance.³⁷ The limited wrap-around coverage must provide meaningful benefits beyond coverage of cost sharing under the individual health insurance coverage.

Plan designs will be limited by nondiscrimination rules aimed at preventing plan sponsors from discriminating in favor of highly compensated employees or offering different benefits for workers along certain other dimensions such as health status. The total cost of the wrap-around coverage per employee (and any covered dependents) under both options is limited to \$2,500 indexed in the manner prescribed under section 125(i)(2) of the Code.

Under the Multi-State Plan wrap-around option, the limited wrap-around coverage that satisfies the requirements outlined in the regulations must be approved by OPM and be offered in conjunction with Multi-State Plan coverage authorized under section 1334 of the Affordable Care Act. As part of the approval process, OPM will require the wrap-around coverage to provide meaningful benefits other than coverage of cost sharing under the Multi-State Plan.³⁸

Coverage under both options applies to limited wrap-around coverage that is first offered no later than December 31, 2017, and that ends on the later of: (1) the date that is three years after the date wrap-around coverage is first offered, or (2) the date on which the last collective bargaining agreement relating to the plan terminates after the date the wrap-around coverage is first offered.

Both options are designed so that wrap-around coverage could not replace employer-sponsored primary group coverage. Under the individual coverage option, the employer also must offer other group health coverage that is not limited to excepted benefits and provides minimum value to the class of participants

³⁶As with other group health coverage, employer contributions to the limited wrap-around coverage would be excluded from employee income for tax purposes. Similar to the cost of the proposal, the budget implications of adding limited wrap-around coverage as a form of excepted benefits depends on the number of employers that elect either option and the number of employees that in turn receive it.

³⁷As described earlier in this preamble, “eligible individual health insurance” is individual health insurance coverage is not a grandfathered health plan, not a transitional individual health insurance market plan, and does not consist solely of excepted benefits.

³⁸For example, the wrap-around coverage may provide coverage for expanded in-network medical clinics or providers, or provide benefits that are not essential health benefits that are not covered under the Multi-State Plan.

offered the wraparound coverage by reason of their employment. Only individuals who are not full-time workers and who are eligible for other group health plan coverage may be eligible for the wraparound coverage. Also, the employer coverage must substantially satisfy the employer responsibility provisions of section 4980H(a) of the Code (whether applicable or not), and the coverage would have to be affordable for at least 95% of full-time employees.

Under the Multi-State Plan option, the employer would have to offer coverage in the plan year beginning in 2014 that would have substantially satisfied the employer responsibility provisions of section 4980H(a) of the Code if the provision had been applicable, provided minimum value, and been affordable for a substantial portion of its full-time employees.³⁹ The employer's annual contributions for both its primary and wraparound coverage must be substantial (e.g., at least 80% or 90% of the employer's total contributions for coverage offered to full-time employees in 2014).

Another factor in assessing the proposal's cost is that the decision to offer the limited wraparound coverage is optional. There is greater administrative complexity associated with the wraparound coverage than primary coverage alone or primary coverage plus a health FSA which offers similar benefits. Given a choice, some plan sponsors may choose to increase the affordability of their primary coverage rather than offer limited wraparound coverage. Some plan sponsors may not have that choice: the employers may not be in a financial position to make their primary health plans affordable to more workers, let alone contribute to wraparound coverage. Employers may also continue to simply not provide employees with affordable, minimum value coverage, allowing their workers to purchase coverage and potentially qualify for premium tax credits in the Marketplace with no additional wraparound benefit, and these employers would continue to pay any shared responsibility payments as applicable, resulting in no additional cost to the employer or the Federal government.

This proposed regulation would not encumber any currently existing means by which employers can provide comprehensive health insurance coverage to their employees in compliance with the Affordable Care Act. Rather, it would clarify two additional, alternative means of doing so. In light of this, the Departments invite comment on to what degree, if any, might this regulation increase employers' propensity to provide health insurance. Existing rules against discrimination in favor of highly compensated employees would limit employer's decisions. The Departments invite comment on to what extent, if any, this proposed regulation could affect plan sponsors' decision making. Employers' (and their employees') economic incentive, if any, to pursue a program of wrap coverage will depend importantly on the demographics of each employer's work force – that is, the distribution of their employees by part-time, seasonal, and temporary employment status, and by pay and income. In light of this, the Departments invite comment on whether there are particular sectors of the economy in which employers will be more or less inclined to pursue wraparound coverage programs.

The Departments seek comment on the other effects of the proposal. Specifically, the Departments request detailed data that would inform the following questions: What will be the impact of limiting the cost of the wraparound coverage to \$2,500 per employee (and any covered dependents)? How many employers offer coverage that provides minimum value and is affordable for a substantial portion (under the first option) or 95 percent (under the second option) of employees who are eligible for coverage? To what extent would premiums for comprehensive health coverage change in the presence and absence of this rule?

C. Paperwork Reduction Act – Department of Labor and Department of the Treasury

The proposed rule is not subject to the requirements of the Paperwork Reduction Act of 1995 (PRA 95) (44 U.S.C. section 3501 et seq.), because it does not contain

a collection of information as defined in 44 U.S.C. section 3502(3).

D. Paperwork Reduction Act – Department of HHS

The proposed rule is not subject to the requirements of the Paperwork Reduction Act of 1995 (PRA 95) (44 U.S.C. section 3501 et seq.), because it does not contain a collection of information as defined in 44 U.S.C. section 3502(3). An analysis under the PRA will be conducted for any guidance establishing a collection of information related to the rule.

E. Regulatory Flexibility Act – Departments of Labor and HHS

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 that are likely to have a significant economic impact on a substantial number of small entities. Unless an agency certifies that a proposed rule is not likely to have a significant economic impact on a substantial number of small entities, section 603 of RFA requires that the agency present an initial regulatory flexibility analysis at the time of the publication of the notice of proposed rulemaking describing the impact of the rule on small entities and seeking public comment on such impact. Small entities include small businesses, organizations and governmental jurisdictions.

For purposes of the RFA, the Departments continue to consider a "small entity" to be an employee benefit plan with fewer than 100 participants. The basis for this definition is found in section 104(a)(2) of the act, which permits the Secretary of Labor to prescribe simplified annual reports for pension plans that cover fewer than 100 participants. Pursuant to the authority of section 104(a)(3), the Department has previously issued at 29 CFR 2520.104–20, 2520.104–21, 2520.104–41, 2520.104–46 and 2520.104b–10 certain simplified reporting provisions and limited exemptions from reporting and disclosure requirements for small plans, including unfunded or insured welfare

³⁹The substantial level was proposed to help minimize the implications for the primary plan's risk pool by preventing a large number of low-wage workers from leaving the primary plan for Marketplace coverage.

plans covering fewer than 100 participants and satisfying certain other requirements.

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 proposed 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 (13 CFR 121.201) pursuant to the Small Business Act (15 U.S.C. 631 et seq.). The Departments therefore request comments on the appropriateness of the size standard used in evaluating the impact of this proposed rule on small entities.

Because the proposed rule would impose no additional costs on employers or plans, the Departments believe that it would not have a significant economic impact on a substantial number of small entities. Accordingly, pursuant to section 605(b) of the RFA, the Departments hereby certify that the proposed rule, if promulgated, would not have a significant economic impact on a substantial number of small entities.

F. *Special Analyses – Department of the Treasury*

For purposes of the Department of the Treasury it has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866, as supplemented 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 proposed regulations, and, because these proposed regulations do not impose a collection of information on small entities, an analysis under the RFA is not required. Pursuant to section 7805(f) of the Code, this notice of proposed rulemaking has been submitted to the Small Business Administration for comment on its impact on small business.

G. *Unfunded Mandates Reform Act*

For purposes of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1501 et seq.), as well as Executive Order 12875,

these proposed rules do not include any federal mandate that may result in expenditures by State, local, or tribal governments, or the private sector, which may impose an annual burden of \$100 million adjusted for inflation since 1995.

H. *Federalism*

Executive Order 13132 outlines fundamental principles of federalism. It requires adherence to specific criteria by federal agencies in formulating and implementing 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 these 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 final regulation.

In the Departments’ view, the proposed regulations, by clarifying policy regarding certain expected benefits options that can be designed by employers to support their employees, would provide more certainty to employers and others in the regulated community as well as states and political subdivisions regarding the treatment of such arrangements under ERISA. Accordingly, the Departments will affirmatively engage in outreach with officials of state and political subdivisions regarding the proposed rule and seek their input on the proposed rules and any federalism implications that they believe may be presented by it.

I. *Congressional Review Act*

This proposed rule is 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.

IV. *Statutory Authority*

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

The Department of Labor regulations are proposed to be adopted pursuant to the authority contained in 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Public Law 104–191, 110 Stat. 1936; sec. 401(b), Public Law 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Public Law 110–343, 122 Stat. 3765; Public Law 110–460, 122 Stat. 5123; Secretary of Labor’s Order 1–2011, 77 FR 1088 (January 9, 2012).

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

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

Signed this 17th day of December, 2014.

Signed this 18th day of December, 2014.

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

Dated: December 17, 2014

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

DEPARTMENT OF THE TREASURY

Internal Revenue Service
26 CFR Chapter I

Accordingly, 26 CFR part 54 is proposed to be amended as follows:

Paragraph 1. The authority citation for part 54 continues to read in part as follows:

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

Section 54.9831-1 also issued under 26 U.S.C. 9833.

Paragraph 2. Section 54.9831-1 is amended by adding paragraph (c)(3)(vii) to read as follows:

§ 54.9831-1 Special rules relating to group health plans.

* * * * *

(c) * * *

(3) * * *

(vii) *Limited wraparound coverage.* Limited benefits provided through a group health plan that wrap around either “eligible individual health insurance” or coverage under a Multi-State Plan (limited wraparound coverage) are excepted benefits if all of the following conditions are satisfied. For this purpose, “eligible individual health insurance” is individual health insurance coverage that is not a grandfathered health plan (as described in section 1251 of the Patient Protection and Affordable Care Act and § 54.9815-1251), not a transitional individual health insurance market plan (as described in the March 5, 2014 Insurance Standards Bulletin Series – Extension of Transitional Policy through October 1, 2016), and does not consist solely of excepted benefits (as defined in paragraph (c) of this section).

(A) *Covers additional benefits.* The limited wraparound coverage provides meaningful benefits beyond coverage of cost sharing under either the eligible individual health insurance or Multi-State Plan coverage. The wraparound coverage must not provide benefits only under a coordination-of-benefits provision and must not merely be an account-based reimbursement arrangement.

(B) *Limited in amount.* The annual cost of coverage per employee (and any covered dependents) under the limited wraparound coverage does not exceed the maximum annual salary reduction contributions toward health flexible spending arrangements, which is \$2,500 for 2014, indexed in the manner prescribed under section 125(i)(2). For this purpose, the cost of coverage includes both employer and employee contributions towards coverage

and is determined in the same manner as the applicable premium is calculated under a COBRA continuation provision.

(C) *Nondiscrimination.* All of the conditions of this paragraph (c)(3)(vii)(C) are satisfied.

(1) *No preexisting condition exclusion.* The limited wraparound coverage does not impose any preexisting condition exclusion, consistent with the requirements of section 2704 of the PHS Act (incorporated by reference into section 9815) and 29 CFR 2590.715-2704.

(2) *No discrimination based on health status.* The limited wraparound coverage does not discriminate against individuals in eligibility, benefits, or premiums based on any health factor of an individual (or any dependent of the individual), consistent with the requirements of section 9802 and § 54.9802-1, and section 2705 of the PHS Act (incorporated by reference into section 9815) and § 54.9815-2705.

(3) *No discrimination in favor of highly compensated individuals.* Neither the limited wraparound coverage, nor any other group health plan coverage offered by the plan sponsor, fails to comply with section 2716 of the PHS Act (incorporated by reference into section 9815) or fails to be excludible from income for any individual due to the application of section 105(h) (as applicable).

(D) *Plan eligibility requirements.* Individuals eligible for the wraparound coverage are not enrolled in excepted benefit coverage under paragraph (c)(3)(v) of this section (relating to health FSAs). In addition, the conditions set forth in either paragraph (c)(3)(vii)(D)(1) or (2) of this section are met.

(1) *Limited wraparound coverage offered in conjunction with individual insurance for persons who are not full-time employees.* Wraparound benefits offered in conjunction with eligible individual health insurance satisfies all of the following requirements—

(i) For each year for which wraparound coverage is offered, the employer that is the sponsor of the plan offering wraparound coverage, or the employer participating in a plan offering wraparound coverage, offers to its full-time employees coverage that is substantially similar to coverage that the employer would need to offer to its full-time employees in order

not to be subject to a potential assessable payment under the employer shared responsibility provisions of section 4980H(a), if such provisions were applicable; provides minimum value (as defined in section 36B(c)(2)(C)(ii)); and is reasonably expected to be affordable (applying the safe harbor rules for determining affordability set forth in 54.4980H-5(e)(2)). If a plan or issuer providing limited wraparound coverage takes reasonable steps to ensure that employers disclose to the plan or issuer necessary information regarding their coverage offered and affordability information, the plan or issuer is permitted to rely on reasonable representations by employers regarding this information, unless the plan or issuer has specific knowledge to the contrary.

(ii) Eligibility for the wraparound coverage is limited to employees who are not full-time employees (and their dependents), or who are retirees (and their dependents). For this purpose, full-time employees are employees who are reasonably expected to work at least an average of 30 hours per week.

(iii) Other group health plan coverage, not limited to excepted benefits, is offered to the individuals eligible for the wraparound coverage. Only individuals eligible for the other group health plan coverage are eligible for the wraparound coverage.

(2) *Limited wraparound coverage offered in conjunction with Multi-State Plan coverage.* Limited wraparound coverage offered in conjunction with Multi-State Plan coverage satisfies all of the conditions of this paragraph (c)(3)(vii)(D)(2). For this purpose, the term “full-time employee” means a “full-time employee” as defined in § 54.4980H-1(a)(21) who is not in a limited non-assessment period for certain employees (as defined in § 54.4980H-1(a)(26)). Moreover, if a plan or issuer providing limited wraparound coverage takes reasonable steps to ensure that employers disclose to the plan or issuer necessary information regarding their coverage offered and contribution levels for 2014 and for any year in which limited wraparound coverage is offered, the plan or issuer is permitted to rely on reasonable representations by employers regarding this information, unless the plan or issuer has specific knowledge to the

contrary. Consistent with the reporting and evaluation criteria of paragraph (c)(3)(vii)(E) of this section, the Office of Personnel Management may verify that plans and issuers have reasonable mechanisms in place to ensure that contributing employers meet these standards.

(i) The limited wraparound coverage is specifically designed, and approved by the Office of Personnel Management, consistent with the reporting and evaluation criteria of paragraph (c)(3)(vii)(E) of this section, to provide benefits in conjunction with coverage under a Multi-State Plan authorized under section 1334 of the Patient Protection and Affordable Care Act. The Office of Personnel Management may revoke approval if it determines that continued approval is inconsistent with the reporting and evaluation criteria of paragraph (c)(3)(vii)(E) of this section.

(ii) The employer has offered coverage in the plan year that begins in 2014 that is substantially similar to coverage that the employer would need to have offered to its full-time employees in order to not be subject to an assessable payment under the employer shared responsibility provisions of section 4980H(a), if such provisions had been applicable.

(iii) In the plan year that begins in 2014, the employer has offered coverage to a substantial portion of full-time employees that provided minimum value (as defined in section 36B(c)(2)(C)(ii)) and was affordable (applying the safe harbor rules for determining affordability set forth in § 54.4980H-5(e)(2)).

(iv) For the duration of the pilot program, as described in paragraph (c)(3)(vii)(F) of this section, the employer's annual aggregate contributions for both primary and wraparound coverage are substantially the same as the employer's total contributions for coverage offered to full-time employees in 2014.

(E) *Reporting – (1) Reporting by group health plans and group health insurance issuers.* A self-insured plan, or a health insurance issuer, offering or proposing to offer Multi-State Plan wraparound coverage pursuant to paragraph (c)(3)(vii)(D)(2) of this section reports to the Office of Personnel Management (OPM), in a form and manner specified in guidance, information OPM reasonably requires to determine whether the plan or issuer qualifies to offer

such coverage or complies with the applicable requirements of this section.

(2) *Reporting by group health plan sponsors.* The plan sponsor of a group health plan offering wraparound coverage under paragraph (c)(3)(vii) of this section, must report to the Department of Health and Human Services (HHS), in a form and manner specified in guidance, information HHS reasonably requires.

(F) *Pilot program with sunset*—The provisions of paragraph (c)(3)(vii) of this section apply to limited wraparound coverage that is first offered no later than December 31, 2017 and that ends on the later of:

(1) The date that is three years after the date wraparound coverage is first offered; or

(2) The date on which the last collective bargaining agreement relating to the plan terminates after the date wraparound coverage is first offered (determined without regard to any extension agreed to after the date wraparound coverage is first offered).

* * * * *

Dated: December 17, 2014

Marilyn Tavenner,
*Administrator, Centers for
Medicare & Medicaid Services.*

(Filed by the Office of the Federal Register on December 19, 2014, 11:15 a.m., and published in the issue of the Federal Register on December 23, 2014, 79 F.R. 76931)

Notice of Proposed Rulemaking Summary of Benefits and Coverage and Uniform Glossary

REG-145878-14

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: Notice of proposed rulemaking.

SUMMARY: This document contains proposed regulations regarding the summary of benefits and coverage (SBC) and the uniform glossary for group health plans and health insurance coverage in the group and individual markets under the Patient Protection and Affordable Care Act. It proposes changes to the regulations that implement the disclosure requirements under section 2715 of the Public Health Service Act to help plans and individuals better understand their health coverage, as well as to gain a better understanding of other coverage options for comparison. It proposes changes to documents required for compliance with section 2715 of the Public Health Service Act, including a template for the SBC, instructions, sample language, a guide for coverage example calculations, and the uniform glossary.

DATES:

Comment date. Comments are due on or before March 2, 2015.

ADDRESSES: Written comments on these proposed regulations and documents required for compliance (including the template, instructions, sample language, guide for coverage example calculations, and the uniform glossary) may be submitted to the Department of Labor as specified below. Any comment that is submitted will be shared with the Department of Health and Human Services and the Department of the Treasury, and will also be made available to the public. **WARNING:** Do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed. All comments are posted on the Internet exactly as received, and can be retrieved by most Internet search engines. No deletions, modifications, or redactions will be made to the comments received, as they are public records. Comments may be submitted anonymously.

Comments, identified by “Summary of Benefits and Coverage,” may be submitted by one of the following methods:

- *Federal eRulemaking Portal:* <http://www.regulations.gov>. Follow the instructions for submitting comments.

- *Mail or Hand Delivery:* Office of Health Plan Standards and Compliance Assistance, Employee Benefits Security Administration, Room N-5653, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210, *Attention:* Summary of Benefits and Coverage.

Comments received will be posted without change to <http://www.regulations.gov>, and available for public inspection at the Public Disclosure Room, N-1513, Employee Benefits Security Administration, 200 Constitution Avenue, NW, Washington, DC 20210, including any personal information provided.

FOR FURTHER INFORMATION

CONTACT: Amy Turner or Beth Baum, Employee Benefits Security Administration, Department of Labor, at (202) 693-8335; Karen Levin, Internal Revenue Service, Department of the Treasury, at (202) 622-6080; Heather Raeburn or Tricia Beckmann, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at (301) 492-4224 or (301) 492-4328.

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 website (<http://www.dol.gov/ebsa>). In addition, information from HHS on private health insurance for consumers can be found on CMS's website (www.cms.gov/ccio) and information on health reform can be found at <http://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, 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.⁴⁰ 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 by this reference are sections 2701 through 2728.

Section 2715 of the PHS Act, added by the Affordable Care Act, directs the Departments of Labor, Health and Human Services (HHS), and the Treasury (the Departments) to develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage in compiling and providing a summary of benefits and coverage (SBC) that "accurately describes the benefits and coverage under the applicable plan or coverage." PHS Act section 2715 also calls for the "development of standards for the definitions of terms used in health insurance coverage."

In accordance with the statute, the Departments, in developing such standards,

consulted with the National Association of Insurance Commissioners (referred to in this document as the "NAIC") through a "working group composed of representatives of health insurance-related consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals."⁴¹ On July 29, 2011, the NAIC provided its final recommendations to the Departments regarding the SBC. On August 22, 2011, the Departments published in the **Federal Register** proposed regulations (2011 proposed regulations) and an accompanying document with templates, instructions, and related materials for implementing the disclosure provisions under PHS Act section 2715.⁴² After consideration of all the comments received on the 2011 proposed regulations and accompanying documents, the Departments published joint final regulations to implement the disclosure requirements under PHS Act section 2715 on February 14, 2012 (2012 final regulations) and an accompanying document soliciting comments on templates, instructions, and related materials.⁴³ The 2012 final regulations implemented standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage in compiling and providing an SBC that "accurately describes the benefits and coverage under the applicable plan or coverage" pursuant to PHS Act section 2715.

After the 2012 final regulations were published, the Departments released Frequently Asked Question (FAQs) regarding implementation of the SBC provisions as part of six issuances. The Departments released Affordable Care Act Implementation FAQs Parts VII, VIII, IX, X, XIV, and XIX to answer outstanding questions,

⁴⁰The 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.

⁴¹The NAIC convened a working group (NAIC working group) comprised of a diverse group of stakeholders. This working group met frequently for over one year while developing its recommendations. In developing its recommendations, the NAIC considered the results of various consumer testing sponsored by both insurance industry and consumer associations. Throughout the process, NAIC working group draft documents and meeting notes were displayed on the NAIC's website for public review, and several interested parties filed formal comments. In addition to participation from the NAIC working group members, conference calls and in-person meetings were open to other interested parties and individuals and provided an opportunity for non-member feedback. See www.naic.org/committees_b_consumer_information.htm.

⁴²See proposed regulations, published at 76 FR 52442 (August 22, 2011) and guidance document published at 76 FR 52475 (August 22, 2011).

⁴³See final regulations, published at 77 FR 8668 (February 14, 2012) and guidance document published at 77 FR 8706 (February 14, 2012).

including questions related to the SBC.⁴⁴ These FAQs addressed questions related to compliance with the requirements of the 2012 final regulations, implemented additional safe harbors,⁴⁵ and released updated SBC materials.

The Departments are issuing these proposed regulations, as well as a new set of proposed SBC templates, instructions, an updated uniform glossary, and other materials to incorporate some of the feedback the Departments have received and to make some improvements to the template. This will provide guidance necessary to plans and issuers as they continue to issue SBCs, and will improve the SBC for employers, participants and beneficiaries, and individuals and dependents for use as a tool in making important decisions regarding their health coverage. These modifications clarify when and how a plan or issuer must provide an SBC, and streamline and shorten the SBC template while also adding certain additional elements that the Departments believe will be useful to consumers. The draft updated template, instructions, and supplementary materials are available at <http://cciio.cms.gov> and <http://www.dol.gov/ebsa/healthreform/regulations/summaryofbenefits.html>. The Departments invite comments on all of the documents. Comments should be submitted as described above.

II. Overview of the Proposed Regulations

A. Requirement to Provide a Summary of Benefits and Coverage

1. Providing the SBC

Paragraph (a) of the 2012 final regulations implements the general disclosure requirement and sets forth the standards for who is required to provide an SBC, to whom, and when. PHS Act section 2715

generally requires that an SBC be provided to applicants, enrollees, and policyholders or certificate holders, at specified times. PHS Act section 2715(d)(3) places the responsibility to provide an SBC on “(A) a health insurance issuer (including a group health plan that is not a self-insured plan) offering health insurance coverage within the United States; or (B) in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan (as such terms are defined in section 3(16) of ERISA).”⁴⁶ Accordingly, the 2012 final regulations interpret PHS Act section 2715 to apply to both group health plans and health insurance issuers offering group or individual health insurance coverage. In addition, consistent with the statute, the 2012 final regulations hold the plan administrator of a group health plan responsible for providing an SBC. Under the 2012 final regulations, the SBC must be provided in writing and free of charge.

There are three general scenarios under which an SBC will be provided. An SBC will be provided: (1) by a group health insurance issuer to a group health plan; (2) by a group health insurance issuer or a group health plan to participants and beneficiaries; and (3) by a health insurance issuer to individuals and dependents in the individual market.

The 2012 final regulations specify timeframes according to which the SBC must be provided. After the 2012 regulations were published, the Departments were asked to clarify the meaning of the term “provided.” As the Departments stated in Affordable Care Act Implementation FAQs Part VIII, question 7, for purposes of providing an SBC in the context of these regulations, the term “provided” means sent. Accordingly, the SBC is timely if it is sent within seven business

days, even if it is not received until after that period.⁴⁷

a. Provision of the SBC by an Issuer to a Plan

Paragraph (a)(1)(i) of the 2012 final regulations requires a health insurance issuer offering group health insurance coverage to provide an SBC to a group health plan (or its sponsor) upon an application by the plan for health coverage. The issuer must provide the SBC as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application. These proposed regulations would clarify when the health insurance issuer offering group health insurance coverage (or plan, if applicable, under paragraph (a)(1)(ii)) must provide the SBC again if the issuer already provided the SBC before application to any entity or individual. If the issuer provides the SBC before application for coverage pursuant to paragraph (a)(1)(i)(D) of the regulations (relating to SBCs upon request), the requirement to provide an SBC upon application is deemed satisfied and such issuer is not required to automatically provide another SBC upon application to the same entity or individual, provided there is no change to the information required to be in the SBC. However, if there has been a change in the information required, a new SBC that includes the correct information must be provided upon application (that is, as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application).

Under the 2012 final regulations and these proposed regulations, if there is any change in the information required to be in the SBC that was provided upon application and before the first day of coverage, the issuer must update and provide a cur-

⁴⁴See Affordable Care Act Implementation FAQs Part VII (available at www.dol.gov/ebsa/faqs/faq-aca7.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs7.html); Part VIII (available at www.dol.gov/ebsa/faqs/faq-aca8.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html); Part IX (available at www.dol.gov/ebsa/faqs/faq-aca9.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html); Part X (available at www.dol.gov/ebsa/faqs/faq-aca10.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs10.html); Part XIV (available at www.dol.gov/ebsa/faqs/faq-aca14.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs14.html); and Part XIX (available at www.dol.gov/ebsa/faqs/faq-aca19.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs19.html).

⁴⁵Some of the enforcement safe harbors and transitions are proposed to be made permanent (several with modifications) by these proposed regulations. The Departments intend to use this rulemaking to develop a permanent approach to those issues and, thereby, discontinue all temporary enforcement policies that were used as a bridge to a permanent rule.

⁴⁶ERISA section 3(16) defines an administrator as: (i) the person specifically designated by the terms of the instrument under which the plan is operated; (ii) if an administrator is not so designated, the plan sponsor; or (iii) in the case of a plan for which an administrator is not designated and plan sponsor cannot be identified, such other person as the Secretary of Labor may by regulation prescribe.

⁴⁷See Affordable Care Act Implementation FAQs Part VIII, question 7, available at www.dol.gov/ebsa/faqs/faq-aca8.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html.

rent SBC to the plan (or its sponsor) no later than the first day of coverage. If the information is unchanged, the issuer does not need to provide the SBC again in connection with coverage for that plan year, except upon request. These proposed rules would provide clarification with respect to how to satisfy the requirement to provide an SBC when the terms of coverage are not finalized. If the plan sponsor is negotiating coverage terms after an application has been filed and the information required to be in the SBC changes, an updated SBC is not required to be provided to the plan (or its sponsor) (unless an updated SBC is requested) until the first day of coverage. The updated SBC should reflect the final coverage terms under the contract, certificate, or policy of insurance that was purchased.

b. Provision of the SBC by a Plan or Issuer to Participants and Beneficiaries

Under paragraph (a)(1)(ii) of the 2012 final regulations, a group health plan (including the plan administrator), and a health insurance issuer offering group health insurance coverage, must provide an SBC to a participant or beneficiary⁴⁸ with respect to each benefit package offered by the plan or issuer for which the participant or beneficiary is eligible.⁴⁹ This includes individuals who are qualified beneficiaries under the Consolidated Omnibus Reconciliation Act of 1985 (COBRA).⁵⁰ In Affordable Care Act Implementation FAQs Part VIII, question 8, the Departments clarified that while a qualifying event does not, itself, trigger a requirement to provide an SBC, during an open enrollment period, any COBRA qualified beneficiary who is receiving COBRA coverage must be given the same rights to elect different coverage as are provided to similarly situated non-COBRA beneficiaries.⁵¹ In this situation,

a COBRA qualified beneficiary who has elected coverage must be provided an SBC just as a similarly situated non-COBRA beneficiary must be provided with one. There are also limited situations in which a COBRA qualified beneficiary may need to be offered different coverage at the time of the qualifying event than the coverage he or she was receiving before the qualifying event and this may trigger a requirement to provide an SBC.⁵²

If a plan or issuer distributes any written application materials for enrollment, including any forms or requests for information (in paper form or through a website or email) that must be completed for enrollment, the plan or issuer must provide the SBC as part of those materials. If the plan or issuer does not distribute written application materials for enrollment (in either paper or electronic form), the SBC must be provided no later than the first date on which the participant is eligible to enroll in coverage for the participant or any beneficiaries. If there is any change to the information required to be in the SBC that was provided upon application for coverage and before the first day of coverage, the plan or issuer must update and provide a current SBC to a participant or beneficiary no later than the first day of coverage.

These proposed rules would clarify when a plan or issuer must provide the SBC again if the plan or issuer already provided the SBC prior to application. If the plan or issuer provides the SBC prior to application for coverage, the plan or issuer is not required to automatically provide another SBC upon application, if there is no change to the information required to be in the SBC. If there is any change to the information required to be in the SBC by the time the application is filed, the plan or issuer must update and

provide a current SBC as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application.

These proposed rules also would provide clarification with respect to how to satisfy the requirement to provide an SBC when the terms of coverage are not finalized. If the plan sponsor is negotiating coverage terms after an application has been filed and the information required to be in the SBC changes, the plan or issuer is not required to provide an updated SBC (unless an updated SBC is requested) until the first day of coverage. The updated SBC should reflect the final coverage terms under the contract, certificate, or policy of insurance that was purchased.

Under the 2012 final regulations, the plan or issuer must also provide the SBC to individuals enrolling through a special enrollment period, also called special enrollees.⁵³ Special enrollees must be provided the SBC no later than when a summary plan description is required to be provided under the timeframe set forth in ERISA section 104(b)(1)(A) and its implementing regulations, which is 90 days from enrollment. To the extent individuals who are eligible for special enrollment and are contemplating their coverage options would like to receive SBCs earlier, they may always request an SBC with respect to any particular plan, policy, or benefit package and the SBC is required to be provided as soon as practicable, but in no event later than seven business days following receipt of the request (as discussed more fully below).

c. Provision of the SBC Upon Request in Group Health Coverage

A health insurance issuer offering group health insurance coverage must provide the SBC to a group health plan or its sponsor (and a plan or issuer must

⁴⁸ERISA section 3(7) defines a participant as: any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employers or members of such organization, or whose beneficiaries may be eligible to receive any such benefit. ERISA section 3(8) defines a beneficiary as: a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

⁴⁹With respect to insured group health plan coverage, PHS Act section 2715 generally places the obligation to provide an SBC on both a plan and issuer. As discussed below, under section III.A.1.d., "Special Rules to Prevent Unnecessary Duplication with Respect to Group Health Coverage", if either the issuer or the plan provides the SBC, both will have satisfied their obligations. As they do with other notices required of both plans and issuers under Part 7 of ERISA, Title XXVII of the PHS Act, and Chapter 100 of the Code, the Departments expect plans and issuers to make contractual arrangements for sending SBCs. Accordingly, the remainder of this preamble generally refers to requirements for plans or issuers.

⁵⁰See Affordable Care Act Implementation FAQs Part VIII, question 7, available at www.dol.gov/ebsa/faqs/faq-aca8.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html.

⁵¹See 26 CFR 54.4980B-5, Q&A-4(c) (requirement to provide election) and 54.4980B-3, Q&A-3 (definition of similarly situated non-COBRA beneficiary).

⁵²See 26 CFR 54.4980B-5, Q&A-4(b).

⁵³Regulations regarding special enrollment are available at 26 CFR 54.9801-6, 29 CFR 2590.701-6, and 45 CFR 146.117.

provide the SBC to a participant or beneficiary) upon request for an SBC or summary information about the health coverage, as soon as practicable, but in no event later than seven business days following receipt of the request. The SBC must be provided upon request to participants, beneficiaries, and plans (or plan sponsors), including prior to submitting an application for coverage, because the SBC provides information that not only helps consumers and employers understand their coverage, but also helps consumers and employers compare coverage options prior to selecting coverage. Health insurance issuers offering individual market coverage must also provide the SBC to individuals upon request, according to the same timeframe, to allow consumers the same ability to compare coverage options in the individual market as the group market.

Since the issuance of the 2012 final regulations, the Departments have continued to receive questions about providing SBCs upon request, including whether issuers are required to provide SBCs to plans or their sponsors who are “shopping” for coverage from different issuers but have not yet submitted an application for coverage. In Affordable Care Act Implementation FAQs Part IX, question 4, the Departments reiterated that an SBC must be provided upon request for an SBC or “summary information about a health insurance product.” The latter phrase is intended to ensure that persons who do not ask exactly for a “summary of benefits and coverage” still receive one when they explicitly ask for a summary document with respect to a specific health coverage product.⁵⁴ The FAQ also referred to other guidance outlining the circumstances in which an SBC may be provided electronically, to assist in reducing the burden of providing multiple SBCs in paper form when requested. Additional information on electronic disclosure of SBCs is discussed later in this preamble.

d. Special Rules to Prevent Unnecessary Duplication with Respect to Group Health Coverage

Paragraph (a)(1)(iii) of the 2012 final regulations includes three special rules to streamline provision of the SBC and avoid unnecessary duplication with respect to group health coverage. The first provides that the requirement to provide an SBC generally will be considered satisfied for all applicable entities if it is provided by any entity, so long as all timing and content requirements are satisfied. The second provides that a single SBC may be provided to a participant and any beneficiaries at the participant’s last known address. However, if a beneficiary’s last known address is different than the participant’s last known address, a separate SBC is required to be provided to the beneficiary at the beneficiary’s last known address. Third, the 2012 final regulations provide that SBCs are not required to be provided automatically upon renewal for each benefit package option in group health plans that offer multiple benefit packages. Rather, a plan or issuer is required to provide an SBC automatically upon renewal or reissuance only with respect to the benefit package in which a participant or beneficiary is enrolled. In cases in which an issuer will automatically re-enroll participants and beneficiaries, these proposed rules propose to add that a new SBC is required to be provided with respect to the plan or product in which a participant or beneficiary will be automatically enrolled in accordance with the same timing requirements that apply to a renewal or reissuance. Consistent with the 2012 final regulations, if a participant or beneficiary requests an SBC with respect to one or more other benefit packages for which he or she is eligible, that requested SBC or SBCs must be provided as soon as practicable, but in no event later than seven business days following the receipt of the request.

In addition to retaining these three existing special rules, these proposed regulations would add an additional provision

to ensure participants receive information while preventing unnecessary duplication. This would address circumstances where an entity required to provide an SBC with respect to an individual has entered into a binding contract with another party to provide the SBC to the individual. In such a case, the proposed regulations state that the entity would be considered to satisfy the requirement to provide the SBC with respect to the individual if specified conditions are met:

(1) The entity monitors performance under the contract;⁵⁵

(2) If the entity has knowledge that the SBC is not being provided in a manner that satisfies the requirements of this section and the entity has all information necessary to correct the noncompliance, the entity corrects the noncompliance as soon as practicable; and

(3) If the entity has knowledge the SBC is not being provided in a manner that satisfies the requirements of this section and the entity does not have all information necessary to correct the noncompliance, the entity communicates with participants and beneficiaries who are affected by the noncompliance regarding the noncompliance, and begins taking significant steps as soon as practicable to avoid future violations.

The proposed regulations would also add a provision to prevent unnecessary duplication with respect to a group health plan that uses two or more insurance products provided by separate issuers to insure benefits under the plan. The proposed regulations would place responsibility for providing complete SBCs with respect to the plan in such a case on the group health plan administrator. This provision of the proposed regulations states that the group health plan administrator may contract with one of its issuers (or other service providers) to provide the SBC; however, absent a contract to perform the function, an issuer has no obligation to provide an SBC containing information for benefits that it does not insure.

⁵⁴The FAQ stated that other general questions about coverage options or discussions about health products do not trigger the requirement to provide an SBC.

⁵⁵The selection and monitoring of service providers for a group health plan, including parties assuming responsibility to complete, provide information for, or deliver SBCs, is a fiduciary act subject to prudence and loyalty duties and prohibited transaction provisions of ERISA. No single fiduciary procedure will be appropriate in all cases; the procedure for selecting and monitoring service providers may vary in accordance with the nature of the plan and other facts and circumstances relevant to the choice of the service provider. More general information on hiring and monitoring service providers is contained in the Department of Labor publication “Understanding Your Fiduciary Responsibilities Under a Group Health Plan,” which is available on the Department’s website at: www.dol.gov/ebsa/publications/ghpfiduciaryresponsibilities.html.

The Departments recognize that a plan sponsor may purchase an insurance product for certain coverage from a particular issuer and purchase a separate insurance product or self-insure with respect to other coverage (such as outpatient prescription drug coverage). In these circumstances, the first issuer may or may not know of the existence of other coverage, or whether the plan sponsor has arranged the two benefit packages as a single plan or two separate plans. To address these arrangements, these proposed rules propose that, with respect to a group health plan that uses two or more insurance products provided by separate issuers, the group health plan administrator is responsible for providing complete SBCs with respect to the plan. The group health plan administrator may contract with one of its issuers (or other service providers) to perform that function. Absent a contract to perform the function, an issuer has no obligation to provide coverage information for benefits that it does not insure.

The Departments published an FAQ on May 11, 2012⁵⁶ regarding the responsibility to provide an SBC in situations where plans may have benefits provided by more than one issuer. This FAQ provides an enforcement safe harbor for a group health plan that uses two or more insurance products provided by separate issuers with respect to a single group health plan. Under this enforcement safe harbor, the group health plan administrator may synthesize the information into a single SBC or provide multiple partial SBCs that, together, provide all the relevant information to meet the SBC content requirements. In such circumstances, the plan administrator should take steps (such as a cover letter or a notation on the SBCs themselves) to indicate that the plan provides coverage using multiple insurance products and that individuals may contact the plan administrator for more information (and provide the contact information). The Departments extended this enforcement safe harbor for one year on April 23, 2013,⁵⁷ and indefinitely on May 2, 2014,⁵⁸

and reiterate that the safe harbor continues to apply. The Departments seek comment on whether to codify this policy in the regulation.

e. Provision of the SBC by an Issuer Offering Individual Market Coverage

Paragraph (a)(1)(iv) of the HHS 2012 final regulations sets forth standards applicable to individual health insurance coverage, under which the provision of the SBC by an issuer offering individual market coverage largely parallels the group market requirements described above, with only those changes necessary to reflect the differences between the two markets. The SBC must be provided upon application. That is, a health insurance issuer offering individual health insurance coverage must provide an SBC to an individual or dependent upon receiving an application for any health insurance policy, as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application. If there is any change in the information required to be in the SBC that was provided upon application and before the first day of coverage, the issuer must update and provide a current SBC to an individual or dependent no later than the first day of coverage. These proposed rules would clarify when the issuer must provide the SBC again if the issuer already provided the SBC prior to application. If the issuer provides the SBC prior to application for coverage, the issuer is not required to automatically provide another SBC upon application, if there is no change to the information required to be in the SBC. If there is any change to the information required to be in the SBC that was provided prior to application for coverage by the time the application is filed, the issuer must update and provide a current SBC to the same individual or dependent as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application. Under the 2012 final regulations, a health insurance issuer offering individual health

insurance coverage must provide the SBC to an individual or dependent upon request for the SBC or summary information about the health insurance product, as soon as practicable, but in no event later than seven business days following receipt of the request.

These proposed rules would also address situations where an issuer offering individual market insurance coverage, consistent with applicable Federal and State law, automatically re-enrolls an individual and any dependents into a different plan or product than the plan in which these individuals were previously enrolled. If the issuer automatically re-enrolls an individual covered under a policy, certificate, or contract of insurance (including every dependent) into a policy, certificate, or contract of insurance under a different plan or product, HHS proposes that the issuer would be required to provide an SBC with respect to the coverage in which the individual (including every dependent) will be enrolled, consistent with the timing requirements that apply when the policy is renewed or reissued.

f. Special Rules to Prevent Unnecessary Duplication With Respect to Individual Health Insurance Coverage

In paragraph (a)(1)(v) of the 2012 final regulations, the Secretary of HHS states that, if a single SBC is provided to an individual and any dependents at the individual's last known address, then the requirement to provide the SBC to the individual and any dependents is generally satisfied. However, if a dependent's last known address is different than the individual's last known address, a separate SBC is required to be provided to the dependent at the dependent's last known address.

Student health insurance coverage is a type of individual health insurance coverage provided pursuant to a written agreement between an institution of higher education and a health insurance issuer to students enrolled in that institution of higher education, and their dependents,

⁵⁶See Affordable Care Act Implementation FAQs Part IX, question 10, available at <http://www.dol.gov/ebsa/faqs/faq-aca9.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html.

⁵⁷Affordable Care Act Implementation FAQs Set XIV, question 5, available at www.dol.gov/ebsa/faqs/faq-aca14.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs14.html.

⁵⁸Affordable Care Act FAQ Set XIX, question 8, available at www.dol.gov/ebsa/faqs/faq-aca19.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs19.html.

that meet certain specified conditions.⁵⁹ These proposed rules propose to extend an anti-duplication rule similar to that provided with respect to group health coverage to student health insurance coverage, as defined in 45 CFR 147.145(a). Specifically, HHS proposes that the requirement to provide an SBC with respect to an individual will be considered satisfied for an entity (such as an institution of higher education) if another party (such as a health insurance issuer) provides a timely and complete SBC to the individual. The Departments are also soliciting comments on whether or not a requirement to monitor the provisioning of the SBC in this circumstance should be added.

2. Content

PHS Act section 2715(b)(3) generally provides that the SBC must include:

- a. Uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage;
- b. A description of the coverage, including cost sharing, for each category of essential health benefits, and other benefits as identified by the Departments;
- c. The exceptions, reductions, and limitations on coverage;
- d. The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations;
- e. The renewability and continuation of coverage provisions;
- f. A coverage facts label that includes examples to illustrate common benefits scenarios (including pregnancy and serious or chronic medical conditions) and related cost sharing based on recognized clinical practice guidelines;
- g. A statement of whether the plan or coverage provides minimum essen-

tial coverage (MEC) as defined under section 5000A(f) of the Code, and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage is not less than 60% of such costs;

- h. A statement that the SBC is only a summary and that the plan document, policy, or certificate of insurance should be consulted to determine the governing contractual provisions of the coverage; and
- i. A contact number to call with questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.

Consistent with the Departments' authority to develop standards with respect to the SBC and with the statutory requirement to consult with the NAIC and other stakeholders, after considering recommendations by the NAIC and comments received on the 2011 proposed regulations, the 2012 final regulations added three content elements: (1) for plans and issuers that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of the network providers; (2) for plans and issuers that use a formulary in providing prescription drug coverage, an Internet address (or similar contact information) for obtaining information on prescription drug coverage under the plan or coverage; and (3) an Internet address for obtaining the uniform glossary, as well as a contact phone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies of the uniform glossary are available.

The Departments have received several questions related to content requirements under the 2012 final regulations. One such question relates to the statements about whether a plan or coverage provides

MEC, as defined under section 5000A(f) of the Code, and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable minimum value (MV) requirements. The preamble to the 2012 final regulations stated that future guidance would address these statements. In April 2013, the Departments issued an updated SBC template (and sample completed SBC) with the addition of statements of whether the plan or coverage provides MEC (as defined under section 5000A(f) of the Code) and whether the plan or coverage meets the MV requirements.⁶⁰ In Affordable Care Act Implementation FAQs Part XIV, issued contemporaneously with the updated SBC template, the Departments stated this language is required to be included in SBCs provided with respect to coverage beginning on or after January 1, 2014.⁶¹

An FAQ issued at that time stated that if a plan or issuer was unable to modify the SBC template for these disclosures, the Departments will not take any enforcement action against a plan or issuer for using the original template authorized at the time the 2012 final regulations were issued, provided that the SBC was furnished with a cover letter or similar disclosure stating whether the plan or coverage does or does not provide MEC and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage does or does not meet the MV standard under the Affordable Care Act.⁶² The Departments decline to extend this temporary enforcement safe harbor. Accordingly, effective for SBCs provided in accordance with the applicability date described below for these proposed rules, the statements regarding MEC and MV are required to be included in the SBC. These statements have been modified for added clarity and relevance for consumers, including consumers in the individual market. As of the

⁵⁹See 45 CFR 147.145, published at 77 FR 16453 (March 21, 2012).

⁶⁰See Affordable Care Act Implementation FAQs Part XIV, question 1, available at www.dol.gov/ebsa/faqs/faq-aca14.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs14.html.

⁶¹The guidance with respect to statements regarding MEC and MV was originally issued for SBCs provided with respect to coverage beginning on or after January 1, 2014, and before January 1, 2015 (referred to as the "second year of applicability"). See Affordable Care Act Implementation FAQs Part XIV, question 1, available at www.dol.gov/ebsa/faqs/faq-aca14.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs14.html. This guidance was extended to be applicable until further guidance was issued. See Affordable Care Act Implementation FAQs Part XIX, question 7, available at www.dol.gov/ebsa/faqs/faq-aca19.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs19.html.

⁶²See Affordable Care Act Implementation FAQs Part XIV, question 2, available at www.dol.gov/ebsa/faqs/faq-aca14.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs14.html.

applicability date described below, the option previously available to include this information in a cover letter or similar disclosure furnished with the SBC is no longer available.

Under section 1303(b)(3)(A) of the Affordable Care Act and implementing regulations at 45 CFR 156.280(f), a QHP issuer that elects to offer a QHP that provides coverage of abortion services for which public funding is prohibited (non-excepted abortion services) must provide a notice to enrollees, as part of the SBC provided at the time of enrollment, of coverage of such services.

In the interest of increasing transparency for consumers shopping for coverage, and to assist issuers with meeting applicable disclosure requirements under section 1303(b)(3)(A) of the Affordable Care Act and its implementing regulations, we are updating the SBC template published contemporaneously with these proposed rules. These proposed rules would require a QHP issuer to disclose on the SBC whether abortion services are covered or excluded and whether coverage is limited to services for which federal funding is allowed (excepted abortion services). The draft instruction guide for individual health insurance, released concurrently with these proposed rules, indicates that coverage of abortion services must be described in the “services your plan does not cover” or “other covered services” section. We seek comments on this guidance, including whether coverage of abortion services should be included in another section of the template, such as the table occurring immediately prior.

Neither the 2012 final regulations nor these proposed regulations require the SBC to include premium information. The Departments previously stated their understanding that it is administratively and logistically complex to convey premium information in an SBC due to a number of

variables, including, for example, when premiums differ based on family size; when, in the group market, employer contributions impact cost of coverage paid by participants and beneficiaries; and when, for coverage sold through an individual market Exchange, advance payments of the premium tax credit impact the cost of coverage paid by individuals and dependents. In Affordable Care Act Implementation FAQs Part VIII, question 16, the Departments clarified that a plan or issuer may choose to add premium information to the SBC.⁶³ If a plan or issuer wishes to include this information, it should be added at the end of the SBC template.⁶⁴

As mentioned above, the statute provides that the SBC must include “a contact number for the consumer to call with additional questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.” The 2012 final regulations state the SBC must include “contact information for questions and obtaining a copy of the plan document or the insurance policy, certificate, or contract of insurance (such as a telephone number for customer service and an Internet address for obtaining a copy of the plan document or the insurance policy, certificate, or contract of insurance).” Questions have arisen as to whether this provision of the statute and regulations requires that all plans and issuers must post underlying plan documents automatically on an Internet website.

These proposed rules would clarify that all plans and issuers must include on the SBC contact information for questions. However, because the statutory language regarding Internet posting uses the terms “individual coverage policy” and “group certificate of coverage,” which we interpret to refer only to insurance, these proposed regulations propose that only issuers must also include an Internet web

address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained. The Departments note that this proposal would require these documents to be easily available to individuals, plan sponsors, and participants and beneficiaries shopping for coverage prior to submitting an application for coverage. For the group market only, because the actual “certificate of coverage” is not available until after the plan sponsor has negotiated the terms of coverage with the issuer, an issuer is permitted to satisfy this requirement with respect to plan sponsors that are shopping for coverage by posting a sample group certificate of coverage for each applicable product. After the actual certificate of coverage is executed, it must be easily available to plan sponsors and participants and beneficiaries via an Internet web address. The Departments invite comments on this approach, including the costs and benefits of also requiring self-insured plans to post underlying plan documents on the Internet.

The Departments also note that, separate from the SBC requirement, provisions of other applicable law require disclosure of plan documents and other instruments governing the plan. For example, ERISA section 104 and the Department of Labor’s implementing regulations⁶⁵ provide that, for plans subject to ERISA, the plan documents and other instruments under which the plan is established or operated must generally be furnished by the plan administrator to plan participants⁶⁶ upon request. In addition, the Department of Labor’s claims procedure regulations (applicable to ERISA plans), as well as the Departments’ claims and appeals regulations under the Affordable Care Act (applicable to all non-grandfathered group health plans and health insurance issuers in the group and individual markets),⁶⁷ set forth rules regarding claims and appeals,

⁶³See Affordable Care Act Implementation FAQs Part VIII, question 16, available at www.dol.gov/ebsa/faqs/faq-aca8.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html.

⁶⁴In accordance with section 1303 (b)(3)(B) of the Affordable Care Act and 45 CFR 156.280(f)(2), if the SBC provided at the time of enrollment notice includes the QHP premium amount, it must display only the total premium for the plan, inclusive of all covered benefits and services.

⁶⁵29 CFR 2520.104b-1.

⁶⁶ERISA section 3(7) defines a “participant” to include any employee or former employee who is or may become eligible to receive a benefit of any type from an employee benefit plan or whose beneficiaries may be eligible to receive any such benefit. Accordingly, employees who are not enrolled but are, for example, in a waiting period for coverage, or who are otherwise shopping amongst benefit package options at open season, generally are considered plan participants for this purpose.

⁶⁷29 CFR 2560.503-1. See also 29 CFR 2590.715-2719(b)(2)(i) and 45 CFR 147.136(b)(2)(i), requiring nongrandfathered plans and issuers to incorporate the internal claims and appeals processes set forth in 29 CFR 2560.503-1.

including the right of claimants (or their authorized representatives) upon appeal of an adverse benefit determination (or a final internal adverse benefit determination) to be provided by the plan or issuer, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits. Plans and issuers must continue to comply with these provisions and any other applicable laws.

Section 2715(b)(3)(F) of the PHS Act also requires that an SBC contain a "coverage facts label." For ease of reference, the 2012 final regulations used the term "coverage examples" in place of the statutory term. Consumer testing performed on behalf of the NAIC⁶⁸ demonstrated that the coverage examples facilitated individuals' understanding of the benefits and limitations of a plan or policy and helped them make more informed choices about their options. That testing also showed that individuals were able to comprehend that the examples were only illustrative. Additionally, while some plans provide useful coverage calculators to their enrollees to help them make health coverage decisions, they are not uniform across all plans and most are not available to individuals prior to enrollment, making it difficult for individuals and employers to make coverage comparisons.

The Departments have taken a phased approach to implementing the coverage examples. The 2012 final regulations require the SBC to include two coverage examples: having a baby (normal delivery) and routine maintenance of well-controlled type 2 diabetes. Each benefit scenario represents a hypothetical situation consisting of a sample treatment plan and medical costs, based on national average allowed charges, for each of the conditions stated above. Each example de-

scribes the sample care costs and how much the hypothetical patient will be responsible for paying, including deductibles, copayments and coinsurance.

In addition to the two existing coverage examples, these proposed regulations would require a third coverage example – a simple foot fracture (with emergency room visit). This example is proposed as a health problem that most individuals could experience (whereas having a baby and type 2 diabetes affect a subset of the population). Comments are welcome on the choice of this coverage example.

In documents published contemporaneously with these proposed rules, the Departments are publishing draft updated claims and pricing data underlying the two existing coverage examples as well as a narrative description and claims and pricing data associated with the third proposed coverage example.⁶⁹ These materials would provide plans and issuers with the specific information necessary to simulate benefits covered under the plan or policy for the coverage example portion of the SBC (including relevant medical items and services, dates of service, billing codes, and allowed charges). The Departments invite comment on all aspects of the benefits scenario proposed as a third coverage example and on all aspects of the coverage example materials made available on the HHS website contemporaneously with the publication of these proposed regulations.

In May 2012, the Departments announced the development of a calculator that plans and issuers could use as a safe harbor for the first year of applicability to complete the coverage examples in a streamlined fashion.⁷⁰ The calculator allows plans and issuers to input a discrete number of informational elements about the benefit package, taken from data fields used to populate the "Important Ques-

tions" and "Common Medical Events" chart sections of the SBC template." The output of the calculator is a coverage example that can be added to the SBC. On its website, HHS provided the coverage examples calculator, instructions for using the calculator, the algorithm that was used to create the calculator, and a checklist providing information on the inputs needed to use the coverage calculator.

The original FAQ regarding the coverage example calculator stated that because using a limited number of inputs in the calculator will be less accurate than the results that a plan or issuer could obtain by processing the full list of claims associated with each coverage example through the plan's or issuer's system, the calculator would be allowed as a transitional tool for the first year of applicability of the SBC requirements. Use of the coverage example calculator was subsequently extended for the second year of applicability, and later extended until superseded by further guidance.⁷¹ Given the complexity of the existing coverage examples, the addition of a proposed new, third coverage example to the SBC requirements, and the fact that all coverage examples are merely illustrative and will not be an accurate predictor of a specific individual's actual costs, the Departments are proposing that the coverage example calculator be authorized for continued use. The Departments invite comments on this proposal.

3. Appearance

PHS Act section 2715 sets forth standards related to the appearance and language of the SBC. Specifically, the statute provides that the SBC is to be presented in a uniform format, in a culturally and linguistically appropriate manner utilizing terminology understandable by the average plan enrollee, that does not exceed four double-sided pages in length, and

⁶⁸A summary of the focus group testing done by America's Health Insurance Plans is available at: http://www.naic.org/documents/committees_b_consumer_information_101012_ahip_focus_group_summary.pdf, a summary of the focus group testing done by Consumers Union on the coverage examples is available at: http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/08/A_New_Way_of_Comparing_Health_Insurance.pdf.

⁶⁹For further discussion of changes to the claims and pricing data underlying the two existing coverage examples, as well as the claims and pricing data with respect to the new coverage example, see section III later in this preamble.

⁷⁰See ACA Implementation FAQ Set IX, question 9, available at www.dol.gov/ebsa/faqs/faq-aca9.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html.

⁷¹The FAQ with respect to the coverage example calculator was originally issued for SBCs provided for coverage beginning before January 1, 2014 (referred to as the "first year of applicability"). See Affordable Care Act Implementation FAQs Part IX, question 9, available at www.dol.gov/ebsa/faqs/faq-aca9.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html. It was extended for SBCs provided for coverage beginning on or after January 1, 2014, and before January 1, 2015 (referred to as the "second year of applicability"), in Affordable Care Act Implementation FAQs Part XIV, question 5 (available at www.dol.gov/ebsa/faqs/faq-aca14.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs14.html) and later extended until superseded by further guidance issued in Affordable Care Act Implementation FAQs Part XIX, question 7 (available at www.dol.gov/ebsa/faqs/faq-aca19.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs19.html).

does not include print smaller than 12-point font. Since the issuance of the 2011 proposed regulations, plans and issuers have informed the Departments that they are concerned about including all of the required information in the SBC while also satisfying the limitation on the length of the document of four double-sided pages.

The instruction guides for completing the SBC template (issued contemporaneously with the 2012 final regulations) included a special rule stating that, to the extent a plan's terms that are required to be in the SBC template cannot reasonably be described in a manner consistent with the template format and instructions, the plan or issuer must accurately describe the relevant plan terms while using its best efforts to do so in a manner that is still as consistent with the instructions and template format as reasonably possible. Such situations may occur, for example, if a plan provides a different structure for provider network tiers or drug tiers than is contemplated by the template and associated instructions, if a plan provides different benefits based on facility type (such as hospital inpatient versus non-hospital inpatient), in a case where the effects of a health flexible spending arrangement (health FSA) or a health reimbursement arrangement (HRA) are being described, or if a plan provides different cost sharing based on participation in a wellness program. The new SBC template that is being published contemporaneously with these proposed regulations eliminates some information from the SBC that is not required by statute based on comments from stakeholders, which is intended to make it easier for plans to include all of the required information in the SBC while also satisfying the statutory page limit. These reductions are significant; the sample completed template has been reduced from four double-sided pages to two and a half double-sided pages. The Departments invite comments on whether the modifications maintain critical information

while shortening it enough to ensure that SBCs do not extend beyond the statutory page limit and, if not, what other changes should be made to ensure the minimum content, appearance, and language requirements are met while also providing consistency in formatting to allow comparisons for individuals. Comments are invited on potential ways to reconcile the statutory page limit with the statutory contents, appearance, and format requirements, particularly the need for the summary to present information in an understandable, accurate, and meaningful way that facilitates comparisons of health options, including those that have disparate and comparatively complex features. Specifically, comments are invited on the sorts of plans that have difficulty meeting the statutory limit, and what other sorts of accommodations may be appropriate for those plans.

Paragraph (a)(3) of the 2012 final regulations requires plans and issuers to provide the SBC in the form, and in accordance with the instructions for completing the SBC, that are specified by the Secretaries in guidance. A guidance document published contemporaneously with the 2012 final regulations served as such guidance specified by the Secretaries, and stated that SBCs provided in connection with group health plan coverage may be provided either as a stand-alone document or in combination with other summary materials (for example, a summary plan description (SPD)), if the SBC information is intact and prominently displayed at the beginning of the materials (such as immediately after the Table of Contents in an SPD) and in accordance with the timing requirements for providing an SBC.⁷² For health insurance coverage offered in the individual market, the SBC must be provided as a stand-alone document, but HHS notes that it can be included in the same mailing as other plan materials. These proposed rules do not make any changes to these requirements.

In Affordable Care Act Implementation FAQs Part VIII, question 8, the Departments stated that an SBC provided in connection with a group health plan may include a reference to the SPD (although not as a substitute for any required content element of the SBC).⁷³ Another FAQ provided that for SBCs provided in connection with coverage in the individual market, while it is not permitted to substitute a reference to any other document for any content element of the SBC, an SBC may include a reference to another document in the SBC footer.⁷⁴ In addition, wherever an SBC provides information that fully satisfies a particular content element of the SBC, it may add to that information a reference to specified pages or portions of other documents in order to supplement or elaborate on that information. As stated in the previous FAQs, SBCs provided in connection with a group health plan may include a reference to the SPD or other documents and SBCs provided in connection with individual market coverage may reference other documents to supplement or elaborate on information in the SBC.

Affordable Care Act Implementation FAQs Part IX, question 7, addressed combining SBCs or SBC elements to provide a side-by-side comparison.⁷⁵ Some plans or issuers provide web-based or print materials to illustrate the differences between benefit package options (including comparison charts and broker comparison websites). Issuers and plans (and agents and brokers working with such plans) may display SBCs, or parts of SBCs, in a way that facilitates comparisons of different benefit package options by individuals and employers shopping for coverage. For example, on a website, viewers could be allowed to select a comparison of only the deductibles, out-of-pocket limits, or other cost sharing information relating to several benefit package options. This could be achieved by providing the information from the Answers column in the "What is the overall deductible?" row of the SBC for several benefit packages, but without

⁷²Summary of Benefits and Coverage and Uniform Glossary – Templates, Instructions, and Related Materials; and Guidance for Compliance, 77 FR 8706, 8707 (February 14, 2012).

⁷³See Affordable Care Act Implementation FAQs Part VIII, question 8, available at www.dol.gov/ebsa/faqs/faq-aca8.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html.

⁷⁴See Affordable Care Act Implementation FAQs Part IX, question 5, available at <http://www.dol.gov/ebsa/faqs/faq-aca9.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html.

⁷⁵See Affordable Care Act Implementation FAQs Part IX, question 7, available at <http://www.dol.gov/ebsa/faqs/faq-aca9.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html.

having to repeat the first “Important Questions” and “Why this Matters” columns, or the other content rows, of the SBC for each of the benefit packages. However, such a chart, website, or other comparison would not, itself, satisfy the requirements under PHS Act section 2715 and the 2012 final regulations to provide the SBC. The full SBC for each of the benefit packages included in the comparison view or tool must be made available in accordance with the statute and regulations.

4. Form

a. Group health plan coverage

To facilitate faster and less burdensome disclosure of the SBC, and to be consistent with PHS Act section 2715(d)(2), which permits disclosure in either paper or electronic form, the 2012 final regulations set forth rules to permit greater use of electronic transmittal of the SBC. For SBCs provided electronically by a plan or issuer to participants and beneficiaries, the 2012 final regulations make a distinction between a participant or beneficiary who is already covered under the group health plan, and a participant or beneficiary who is eligible for coverage but not enrolled in a group health plan. This distinction should provide new flexibility in some circumstances, while also ensuring adequate consumer protections. For participants and beneficiaries who are already covered under the group health plan, the 2012 final regulations permit provision of the SBC electronically if the requirements of the Department of Labor’s regulations at 29 CFR 2520.104b–1 are met. (Paragraph (c) of those regulations includes an electronic disclosure safe harbor.⁷⁶) For participants and beneficiaries who are eligible for but not enrolled in coverage, the 2012 final regulations permit the SBC to be provided electronically if the format is readily accessible and a paper copy is provided free of charge upon request. Additionally, to reduce paper copies that may be unnecessary, if the electronic form is an Internet posting, the plan or issuer must timely

advise the individual in paper form (such as a postcard) or email that the documents are available on the Internet, provide the Internet address, and notify the individual that the documents are available in paper form upon request. The Departments note that the rules for participants and beneficiaries who are eligible for but not enrolled in coverage are substantially similar to the requirements for an issuer providing an electronic SBC to a group health plan (or its sponsor) under paragraph (a)(4)(i) of the regulations. Finally, plans, and participants and beneficiaries (both those covered and those eligible but not enrolled) have the right to receive an SBC in paper format, free of charge, upon request.

In Affordable Care Act Implementation FAQs Part IX, question 1, the Departments adopted an additional safe harbor related to electronic delivery of SBCs.⁷⁷ That FAQ stated that SBCs may be provided electronically to participants and beneficiaries in connection with their online enrollment or online renewal of coverage under the plan. The FAQ also stated SBCs also may be provided electronically to participants and beneficiaries who request an SBC online. In either case, the individual must have the option to receive a paper copy upon request. These proposed regulations would include this additional safe harbor into the applicable regulations.

After the publication of the 2012 final regulations, the Departments were asked to provide model language to meet the requirement to advise participants and beneficiaries that the SBC is available on the Internet. In Affordable Care Act FAQs Part VIII, question 12, the Departments provided the following model language:⁷⁸

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC is available on the web at: www.website.com/SBC. A paper copy is also available, free of charge, by calling 1-XXX-XXX-XXXX (a toll-free number).

The FAQ also stated that plans and issuers have flexibility with respect to the postcard and may choose to tailor it in many ways.

b. Individual health insurance coverage and self-insured non-Federal governmental plans

The HHS 2012 final regulations established a provision under paragraph (a)(4)(iii)(C) that deems health insurance issuers in the individual market to be in compliance with the requirement to provide the SBC to an individual requesting summary information about a health insurance product prior to submitting an application for coverage if the issuer provides the content required under paragraph (a)(2) of the regulations to the federal health reform Web portal described in 45 CFR 159.120. Issuers must submit all of the content required under paragraph (a)(2), as specified in guidance by the Secretary, to be deemed compliant with the requirement to provide an SBC to an individual requesting summary information prior to submitting an application for coverage. HHS intends to continue to facilitate the operation of this deemed compliance option for individual market issuers. An issuer must provide all SBCs other than the “shopper” SBC contemplated in the deemed compliance provision as required under the 2012 final regulations (and any future final regulations), including providing the SBC at the time of application and renewal.

⁷⁶On April 7, 2011, the Department of Labor published a Request for Information regarding electronic disclosure at 76 FR 19285. In it, the Department of Labor stated that it is reviewing the use of electronic media by employee benefit plans to furnish information to participants and beneficiaries covered by employee benefit plans subject to ERISA. Because these proposed regulations propose to adopt the ERISA electronic disclosure rules by cross-reference, any changes that may be made to 29 CFR 2520.104b-1 in the future would also apply to the SBC.

⁷⁷See Affordable Care Act Implementation FAQs Part IX, question 4, available at <http://www.dol.gov/ebsa/faqs/faq-aca9.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html.

⁷⁸See Affordable Care Act Implementation FAQs Part VIII, question 12, available at <http://www.dol.gov/ebsa/faqs/faq-aca8.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html.

The Departments note that consistent with the 2012 final regulations, an issuer in the individual market must provide the SBC in a manner that can reasonably be expected to provide actual notice regardless of the format. An issuer in the individual market satisfies the form requirements set forth in the 2012 final regulations if it does at least one of the following: (1) hand-delivers a printed copy of the SBC to the individual or dependent; (2) mails a printed copy of the SBC to the mailing address provided to the issuer by the individual or dependent; (3) provides the SBC by email after obtaining the individual's or dependent's agreement to receive the SBC or other electronic disclosures by email; (4) posts the SBC on the Internet and advises the individual or dependent in paper or electronic form, in a manner compliant with 45 CFR 147.200(a)(4)(iii)(A)(1) through (3), that the SBC is available on the Internet and includes the applicable Internet address; or (5) provides the SBC by any other method that can reasonably be expected to provide actual notice.

The 2012 final regulations also provide that the obligation to provide an SBC cannot be satisfied electronically in the individual market unless: the format is readily accessible; the SBC is displayed in a location that is prominent and readily accessible; the SBC is provided in an electronic form that can be electronically retained and printed; the SBC is consistent with the appearance, content and language requirements; and the issuer notifies the individual that a paper SBC is available upon request without charge.

These proposed rules would clarify the form and manner for SBCs provided by a self-insured non-Federal governmental plan. Such SBCs may be provided in paper form. Alternatively, such SBCs may be provided electronically if the plan conforms to either the substance of the provisions applicable to ERISA plans (in paragraph (a)(4)(ii) of the regulations) or to individual health insurance coverage

(in paragraph (a)(4)(iii) of the regulations).

5. Language

PHS Act section 2715(b)(2) provides that standards shall ensure that the SBC "is presented in a culturally and linguistically appropriate manner." The 2012 final regulations provide that a plan or issuer for this purpose is considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards of 45 CFR 147.136(e), implementing standards for the form and manner of notices related to internal claims appeals and external review, are met as applied to the SBC.⁷⁹ At the time of publication of these proposed regulations, 268 U.S. counties (78 of which are in Puerto Rico) meet this threshold. The overwhelming majority of these are Spanish; however, Chinese, Navajo, and Tagalog are present in a few counties, affecting five states (specifically, Alaska, Arizona, California, New Mexico, and Utah).⁸⁰

To help plans and issuers meet the language requirements of paragraph (a)(5) of the 2012 final regulations, as requested by commenters, HHS has provided written translations of the SBC template, sample language, and the uniform glossary in Chinese, Navajo, Spanish, and Tagalog.⁸¹ HHS may also make these materials available in other languages to facilitate voluntary distribution of SBCs to other individuals with limited English proficiency. We seek comment on this standard, and on other potential standards that could facilitate consistency across the Departments' programs. The Departments anticipate that translations of the updated SBC template, sample language, and uniform glossary will be available when these proposed regulations are finalized.

Nothing in these proposed regulations should be construed as limiting an individual's rights under Federal or State civil rights statutes, such as Title VI of the Civil Rights Act of 1964 (Title VI) which prohibits recipients of Federal financial assistance, including issuers participating in Medicare Advantage, from discriminat-

ing on the basis of race, color, or national origin. To ensure non-discrimination on the basis of national origin, 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/specialtopics/lep/policyguidancedocument.html>.

B. Notice of Modification

PHS Act section 2715(d)(4) directs that a group health plan or health insurance issuer offering group or individual health insurance coverage must provide notice of any material modification (as defined under ERISA section 102) in any of the terms of the plan or coverage involved that is not reflected in the most recently provided SBC. For purposes of PHS Act section 2715, the 2012 final regulations interpret the statutory reference to the SBC to mean that only a material modification in the terms of the plan or coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage would trigger the notice. In these circumstances, the notice would be required to be provided to enrollees (or, in the individual market, covered individuals) no later than 60 days prior to the date on which such change will become effective. A material modification, within the meaning of section 102 of ERISA, includes any modification to the coverage offered under a plan or policy that, independently, or in conjunction with other contemporaneous modifications or changes, would be considered by an average plan participant (or in the case of individual market coverage, an average individual covered under a policy) to be an important change in covered benefits or other terms of coverage under the plan or

⁷⁹See 75 FR 43330 (July 23, 2010), as amended by 76 FR 37208 (June 24, 2011).

⁸⁰Guidance on the HHS website contains a list of the counties that meet this threshold. This information is available at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/2009-13-CLAS-County-Data_12-05-14_clean_508.pdf.

⁸¹Translations are available at <http://ccio.cms.gov/programs/consumer/summaryandglossary/index.html>.

policy.⁸² A material modification could be an enhancement of covered benefits or services or other more generous plan or policy terms. It includes, for example, coverage of previously excluded benefits or reduced cost-sharing. A material modification could also be a material reduction in covered services or benefits, as defined in 29 CFR 2520.104b-3(d)(3) of the Department of Labor's regulations, or more stringent requirements for receipt of benefits. As a result, it also includes changes or modifications that reduce or eliminate benefits, increase cost-sharing, or impose a new referral requirement.⁸³ (However, changes to the information in the SBC resulting from changes in the regulatory requirements for an SBC are not changes to the plan or policy requiring the mid-year provision of a notice of modification, unless specified in such new requirements.)

The 2012 final regulations require that this notice be provided only for changes other than in connection with a renewal or reissuance of coverage. At renewal, plans and issuers must provide an updated SBC in accordance with the requirements otherwise applicable to SBCs. PHS Act section 2715 and paragraph (b) of the 2012 final regulations specify the timing for providing a notice of modification in situations other than in connection with a renewal or reissuance of coverage. To the extent a plan or policy implements a mid-year change that is a material modification that affects the content of the SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the 2012 final regulations require a notice of modification to be provided 60 days in advance of the effective date of the change.⁸⁴ Plans and issuers are permitted to either provide an updated SBC reflect-

ing the modifications or provide a separate notice describing the material modifications. These proposed regulations do not make any changes to these requirements.

For ERISA-covered group health plans subject to PHS Act section 2715, this notice is required in advance of the timing requirements under the Department of Labor's regulations at 29 CFR 2520.104b-3 for providing a summary of material modification (SMM) (generally not later than 210 days after the close of the plan year in which the modification or change was adopted, or, in the case of a material reduction in covered services or benefits, not later than 60 days after the date of adoption of the modification or change). In situations where a complete notice is provided in a timely manner under PHS Act section 2715(d)(4), an ERISA-covered plan will also satisfy the requirement to provide an SMM under Part 1 of ERISA.

C. Requirement to Provide the Uniform Glossary

Sections 2715(g)(2) and (g)(3) of the PHS Act direct the Departments to develop standards for definitions, at a minimum, for certain insurance-related and medical terms (and also directs the Departments to develop standards for such other insurance-related and medical terms as will help consumers compare the terms of their coverage and the extent of medical benefits (or exceptions to those benefits)).⁸⁵ The 2012 final regulations included several additional terms in the uniform glossary.⁸⁶ As discussed later in this preamble, the Departments propose to revise definitions for several of these terms and also add several new terms to the Glossary.⁸⁷

A plan or issuer must make the uniform glossary available upon request within seven business days. To satisfy this re-

quirement, a plan or issuer must provide the content described in paragraph (a)(2)(i)(L) of the 2012 final regulations, discussed earlier in this preamble, which requires that the SBC include an Internet address for obtaining the uniform glossary, a contact phone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available upon request. The Internet address may be a place where the document can be found on the plan's or issuer's website, or the website of either the Department of Labor or HHS. However, a plan or issuer must make the glossary available upon request, in either paper or electronic form (as requested), within seven business days after receipt of the request. Group health plans and health insurance issuers must provide the uniform glossary in the appearance specified by the Departments and without modification, so that the glossary is presented in a uniform format and uses terminology understandable by the average plan enrollee or individual covered under an individual policy.

D. Preemption

Section 2715 of the PHS Act is incorporated into ERISA section 715, and Code section 9815, and is subject to the preemption provisions of ERISA section 731 and PHS Act section 2724 (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)). Under these provisions, the requirements of part 7 of ERISA and part A of title XXVII of the PHS Act, as amended 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 group or individual health insurance coverage except to the extent that such standard or

⁸²See DOL Information Letter, Washington Star/Washington-Baltimore Newspaper Guild to Munford Page Hall, II, Baker & McKenzie (February 8, 1985).

⁸³See, e.g., Ward v. Maloney, 386 F.Supp.2d 607, 612 (M.D.N.C. 2005), which discusses judicial interpretations of when an amendment is and is not a material modification.

⁸⁴In Affordable Care Act Implementation FAQs Part XX, the Departments addressed notice requirements triggered by a closely-held for-profit corporation's health plan ceasing to provide coverage for some or all contraceptive services mid-plan year. The FAQ clarified that, for plans subject to ERISA that reduce or eliminate coverage of contraceptive services after having provided such coverage, expedited disclosure requirements for material reductions in covered services or benefits apply. See <http://www.dol.gov/ebsa/pdf/faq-aca20.pdf> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs20.html.

⁸⁵The insurance-related terms identified in the statute are: co-insurance, co-payment, deductible, excluded services, grievance and appeals, non-preferred provider, out-of-network co-payments, out-of-pocket limit, preferred provider, premium, and UCR (usual, customary and reasonable) fees. The medical terms identified in the statute are: durable medical equipment, emergency medical transportation, emergency room care, home health care, hospice services, hospital outpatient care, hospitalization, physician services, prescription drug coverage, rehabilitation services, and skilled nursing care.

⁸⁶The additional terms in the uniform glossary issued with the 2012 final regulations are: allowed amount, balance billing, complications of pregnancy, emergency medical condition, emergency services, habilitation services, health insurance, in-network co-insurance, in-network co-payment, medically necessary, network, out-of-network co-insurance, plan, preauthorization, prescription drugs, primary care physician, primary care provider, provider, reconstructive surgery, specialist, and urgent care.

⁸⁷For further discussion of proposed changes to the Uniform Glossary, see section III later in this preamble.

requirement prevents the application of a requirement” of part A of title XXVII of the PHS Act. Accordingly, State laws that impose requirements on health insurance issuers that are stricter than those imposed by the Affordable Care Act will not be superseded by the Affordable Care Act. In addition, PHS Act section 2715(e) provides that the standards developed under PHS Act section 2715(a), “shall preempt any related State standards that require [an SBC] that provides less information to consumers than that required to be provided under this section, as determined by the [Departments].” Reading these two preemption provisions together, the 2012 final regulations do not, and these proposed regulations would not, prevent States from imposing separate, additional disclosure requirements on health insurance issuers.

E. Failure to Provide

PHS Act section 2715(f), incorporated into ERISA section 715 and Code section 9815, provides that a group health plan (including its administrator), and a health insurance issuer offering group or individual health insurance coverage, that “willfully fails to provide the information required under this section shall be subject to a fine of not more than \$1,000 for each such failure.” In addition, under PHS Act section 2715(f), a separate fine may be imposed for each individual or entity for whom there is a failure to provide an SBC. The 2012 final regulations addressed the different underlying enforcement structures and penalty mechanisms for the Departments.

HHS clarified in the 2012 final regulations that HHS will enforce these provisions in a manner consistent with 45 CFR 150.101 through 150.465. In these proposed regulations, the Department of Labor proposes to clarify that it will use the same process and procedures for assessment of the civil fine as used for failure to file an annual report under 29 CFR 2560.502c-2 and 29 CFR Part 2570, Subpart C. In accordance with ERISA section 502(b)(3), 29 U.S.C. 1132(b)(3), the Secretary of Labor is not authorized to assess this fine against a health insurance issuer. Moreover, in these proposed regulations, the IRS proposes to clarify that the IRS

will enforce this section using a process and procedure consistent with section 4980D of the Code.

III. Proposed Documents authorized for plan years beginning on or after September 23, 2015

Contemporaneously with the issuance of these proposed regulations, the Departments are making available on their websites a proposed revised SBC template and attendant materials (including a proposed revised uniform glossary) to comply with the disclosure requirements of PHS Act section 2715. These materials are proposed to be authorized by the Departments for disclosure provided in accordance with the applicability date proposed later in this preamble.⁸⁸ This section of the preamble describes the changes proposed to each document.

The following documents, available at <http://cciio.cms.gov> and www.dol.gov/ebsa/healthreform, are available for review and the Departments solicit comment on them:

1. *SBC template.* The document is available in accessible format (PDF) and modifiable format (MS Word).

2. *Sample completed SBC.* This document was completed using information for sample health coverage and provides a general illustration of a completed SBC for coverage under a group health plan.

3. *Instructions.* For assistance in completing the SBC template, separate instructions are available for group health coverage and for individual health insurance coverage. Additionally, with respect to the individual market instructions, the Office of Personnel Management (OPM) may provide additional instructions for Multi-State Plan issuers.

4. *Why This Matters language.* The SBC instructions include language that must be used when completing the “Why This Matters” column on the first page of the SBC template. Two language options are provided depending on whether the answer in the applicable row is “yes” or “no”, according to the terms of the plan or coverage.

5. *Coverage examples.* Information provided by HHS at <http://cciio.cms.gov>

(and accessible via hyperlink from www.dol.gov/ebsa/healthreform) the information necessary to perform the coverage example calculations.

6. *Uniform glossary.* The uniform glossary of health coverage and medical terms may not be modified by plans or issuers.

Many of the changes proposed in the updated versions of these documents streamline the SBC. As discussed earlier in this preamble, these changes were made after feedback the Departments received from stakeholders, and the revised proposed template and other documents are intended to make it easier for plans to satisfy the statutory page limit. The revised documents also incorporate information from several sets of FAQs that addressed implementation of the SBC provisions.

Additionally, the revised documents include changes made to conform with new requirements that have become applicable since the issuance of the 2012 final regulations. These changes include the addition of information regarding minimum value and minimum essential coverage and changes to be consistent with the Affordable Care Act’s requirement to eliminate all annual limits on essential health benefits.

Finally, the revised documents reflect changes to the coverage examples. The coding and pricing data for the existing coverage examples (having a baby through normal delivery and managing well controlled type 2 diabetes) have been updated to account for changes in the data since the issuance of the final regulations in 2012. Additionally the Departments proposed to change the data source for the claims and pricing information from a data source that used multiple commercial payor databases, to one based on a single database, the Truven Health Analytics MarketScan® Commercial Claims and Encounters database, adjusted to estimate 2014 pricing to account for health care inflation since 2010. The Departments seek comment on whether to update this data using more recent 2013 MarketScan® database claims data that will be available for the final rule, and on appropriate ways to inform consumers of the resulting increases in sample care costs when the

⁸⁸See section IV of this preamble for a full discussion of the proposed applicability date.

pricing data is updated, for example, through a cover letter or other disclosure provided along with the SBC. The Departments also seek specific comment on two diagnosis codes in the having a baby (normal delivery) scenario. The pricing data associated with these two codes, DRG 775 and DRG 795 (inpatient hospital charges for the mother, and inpatient hospital charges for the baby, respectively), appears higher than expected. These diagnosis codes represent bundled services and may include charges that are duplicated by other codes currently included in the scenario. The Departments seek comment on the accuracy of this pricing data.

Additionally, the SBC template, sample completed template, and coverage example documents have been updated to reflect that these proposed regulations would require a third coverage example – a simple foot fracture (with emergency room visit), as described earlier in this preamble. The same Marketscan® database has been used to produce the claim and pricing data for this scenario.

The Departments invite comment on all aspects of the proposed changes to the SBC template and other materials, and the uniform glossary. The Departments also request specific comments regarding the Instruction Guides about whether plans and issuers should be permitted to add additional benefits that are either covered or excluded in the “other covered services” and “excluded services” section that are not already required to be disclosed by the instructions.

IV. Applicability

After publication of the 2012 final regulations, the Departments received questions about the applicability of the SBC requirements to certain types of group health plans, including expatriate health plans, Medicare Advantage plans, and insurance products that are no longer being offered for

purchase (closed blocks of business). The Departments addressed the applicability of the SBC requirements to each of these types of coverage in FAQs issued after publication of the 2012 final regulations. The Departments also received questions regarding the applicability of the SBC requirements to benefits provided under certain account-type arrangements such as health flexible spending arrangements (health FSAs),⁸⁹ health reimbursement arrangements (HRAs),⁹⁰ and health savings accounts (HSAs),⁹¹ as well as benefits provided through an employee assistance program (EAP) and other excepted benefits.

In May 2012, the Departments issued FAQs that discussed the special circumstances and considerations faced by expatriate plans in complying with the SBC requirements.⁹² The FAQs provided temporary relief from enforcement. Under recently enacted legislation,⁹³ expatriate health plans are not subject to the requirement to provide an SBC. The Departments intend to issue guidance implementing this legislation. The temporary relief from enforcement for expatriate plans will remain in place until such guidance is issued.

Moreover, in August 2012, the Departments issued FAQs that discussed group health plans providing Medicare Advantage benefits, which are Medicare benefits financed by the Medicare Trust Funds, for which the benefits are set by Congress and regulated by the Centers for Medicare & Medicaid Services. Again, the FAQs provided a temporary nonenforcement policy, because Medicare Advantage benefits are not health insurance coverage and Medicare Advantage organizations are not required to provide an SBC with respect to such benefits. Additionally, there are separately required disclosures required to be provided by Medicare Advantage organizations, to ensure that enrollees in these plans receive the necessary informa-

tion about their coverage and benefits. These rules propose to exempt from the SBC requirements a group health plan benefit package that provides Medicare Advantage benefits.

The Departments also issued FAQs in May 2012 addressing insurance products that are no longer being offered for purchase (“closed blocks of business”). Some interested stakeholders had requested enforcement relief with respect to such products because the products are no longer offered for purchase and the SBC is intended to be a tool to help group health plans and individuals as they shop for coverage. The Departments had provided temporary relief through an FAQ provided that certain conditions were met: (1) the insurance product is no longer being actively marketed; (2) the health insurance issuer stopped actively marketing the product prior to September 23, 2012, when the requirement to provide an SBC was first applicable to health insurance issuers; and (3) the health insurance issuer has never provided an SBC with respect to such product.⁹⁴ The Departments reiterate that relief here, but note that if an insurance product was actively marketed for business on or after September 23, 2012, and is no longer being actively marketed for business, or if the plan or issuer ever provided an SBC in connection with the product, the plan and issuer must provide the SBC with respect to such coverage, as required by PHS Act section 2715 and the regulations.

As under the 2012 final regulations, an SBC need not be provided for plans, policies, or benefit packages that constitute excepted benefits. Thus, for example, an SBC need not be provided for stand-alone dental or vision plans or health FSAs if they constitute excepted benefits under the Departments’ regulations.⁹⁵ If benefits under a health FSA do not constitute excepted benefits, the health FSA is a group

⁸⁹See Code section 106(c)(2).

⁹⁰See IRS Notice 2002-45, 2002-2 C.B. 93.

⁹¹See Code section 223.

⁹²See Affordable Care Act Implementation FAQs Part IX, question 13, available at <http://www.dol.gov/ebsa/faqs/faq-aca9.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html.

⁹³See Consolidated and Further Continuing Appropriations Act, 2015, Division M, Expatriate Health Coverage Clarification Act of 2014, Section 3(d).

⁹⁴See Affordable Care Act Implementation FAQs Part IX, question 12, available at <http://www.dol.gov/ebsa/faqs/faq-aca9.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html.

⁹⁵See 26 CFR 54.9831-1(c), 29 CFR 2590.732(c), 45 CFR 146.145(c).

health plan generally subject to the SBC requirements. For a health FSA that does not meet the criteria for excepted benefits and that is integrated with other major medical coverage, the SBC is prepared for the other major medical coverage, and the effects of the health FSA can be denoted in the appropriate spaces on the SBC, including those for deductibles, copayments, coinsurance, and benefits otherwise not covered by the major medical coverage. A stand-alone health FSA, which does not meet the criteria for excepted benefits, must satisfy the SBC requirements independently.

On October 1, 2014, the Departments published final rules on excepted benefits.⁹⁶ These regulations stated that an EAP constitutes excepted benefits if it satisfies certain requirements.⁹⁷ If an EAP qualifies as excepted benefits, the EAP need not separately satisfy the SBC requirements.

The Departments have issued guidance regarding HRAs since the publication of the 2012 final regulations.⁹⁸ An HRA is a group health plan. The Departments' guidance on HRAs clarifies that such arrangements are subject to the group market reform provisions of the Affordable Care Act, including the prohibition on annual limits under PHS Act section 2711 and the requirement to provide certain preventive services without cost sharing under PHS Act section 2713. The Departments' guidance further clarifies that such arrangements will not violate the market reform provisions when integrated with a group health plan that complies with those provisions (and that such arrangements cannot be integrated with individual market policies to satisfy the market reforms).

Benefits under an HRA generally do not constitute excepted benefits, and thus HRAs are generally subject to the SBC

requirements. An HRA integrated with other major medical coverage under a group health plan need not separately satisfy the SBC requirements; the SBC is prepared for the other major medical coverage, and the effects of employer allocations to an account under the HRA can be denoted in the appropriate spaces on the SBC, including those for deductibles, copayments, coinsurance, and benefits otherwise not covered by the other major medical coverage.

HSAs generally are not group health plans and thus generally are not subject to the SBC requirements. Nevertheless, an SBC prepared for a high deductible health plan associated with an HSA can (but is not required to) mention the effects of employer contributions to HSAs in the appropriate spaces on the SBC, including those for deductibles, copayments, coinsurance, and benefits otherwise not covered by the high deductible health plan.

IV. Applicability Date

Changes to the current requirements to provide an SBC, notice of modification, and uniform glossary under PHS Act section 2715 and the 2012 final regulations are proposed to apply for disclosures with respect to participants and beneficiaries who enroll or re-enroll in group health coverage through an open enrollment period (including re-enrollees and late enrollees) beginning on the first day of the first open enrollment period that begins on or after September 1, 2015. With respect to disclosures to participants and beneficiaries who enroll in group health coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), the requirements of these proposed regulations are proposed to apply

beginning on the first day of the first plan year that begins on or after September 1, 2015. For disclosures to plans, and to individuals and dependents in the individual market, these requirements are proposed to apply to health insurance issuers beginning on September 1, 2015. We solicit comments on these proposed applicability dates.

V. Economic Impact and Paperwork Burden

A. Executive Orders 12866 and 13563—Departments of Labor and HHS

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. This rule has been designated a “significant regulatory action” under section 3(f) of Executive Order 12866. Accordingly, the rule has been reviewed by the Office of Management and Budget.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any one year). As discussed below, the Departments have concluded that these proposed regulations would not have economic impacts of \$100 million or more in any one year or otherwise meet the definition of an “economically significant rule” under Executive Order 12866. Nonetheless, consistent with Executive Orders 12866 and 13563, the Departments have provided an assessment

⁹⁶79 FR 59130 (October 1, 2014).

⁹⁷The first requirement is that the EAP does not provide significant benefits in the nature of medical care. For this purpose, the amount, scope, and duration of covered services are taken into account. (See preamble discussion at 79 FR 59133 for examples). The second requirement is that the EAP's benefits cannot be coordinated with the benefits under another group health plan. For this purpose, participants in the group health plan must not be required to use and exhaust benefits under the EAP (making the EAP a “gatekeeper”) before an individual is eligible for benefits under the other group health plan; and participant eligibility for benefits under the EAP must not be dependent on participation in another group health plan. The third requirement is that no employee premiums or contributions may be required as a condition of participation in the EAP. The fourth requirement is that an EAP that constitutes excepted benefits may not impose any cost-sharing requirements.

⁹⁸On September 13, 2013, DOL and the Treasury published guidance on the application of the market reforms and other provisions of the Affordable Care Act to health reimbursement arrangements (HRAs), certain health flexible spending arrangements (health FSAs) and certain other employer health care arrangements. See DOL Technical Release 2013-03, available at <http://www.dol.gov/ebsa/newsroom/tr13-03.html>, and IRS Notice 2013-54, available at <http://www.irs.gov/pub/irs-drop/n-13-54.pdf>. HHS also issued guidance to reflect that HHS concurs in the application of the laws under its jurisdiction as set forth in the DOL and Treasury Department guidance. See Insurance Standards Bulletin, Application of Affordable Care Act Provisions to Certain Healthcare Arrangements, September 16, 2013, available at <https://www.cms.gov/CCHIO/Resources/Regulations-and-Guidance/Downloads/cms-hra-notice-9-16-2013.pdf>. On May 13, 2013, two FAQs were made available on the IRS website addressing employer healthcare arrangements, available at: www.irs.gov/uac/Newsroom/Employer-Health-Care-Arrangements. On November 6, 2014, the Departments issued three FAQs on the compliance of premium reimbursement arrangements. See ACA Implementation FAQs Part XXII, available at <http://www.dol.gov/ebsa/pdf/faq-aca22.pdf> and http://www.cms.gov/CCHIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs22.html.

of the potential benefits and the costs associated with this proposed regulation.

The primary benefits of these proposed regulations come from improved information, which will enable consumers, both individuals and employers, to better understand the health insurance coverage they have and provide, and make better coverage decisions based on their preferences with respect to benefit design, level of financial protection, and cost. The Departments believe that such improvements will result in a more efficient, competitive market. These proposed regulations will also benefit consumers by reducing the time they spend searching for and compiling health plan and coverage information.

The Departments have continued using the cost methodology that was used to estimate the costs presented in the 2012 final regulations. Since publication of the 2012 final regulations, the Departments have refined assumptions and estimates to incorporate better data. The estimates presented in these proposed regulations are a result of those efforts and represent the Departments' best estimates.

The primary cost of the proposed regulations is requiring issuers and plans to create a third coverage example, a simple foot fracture (with emergency room visit). This third coverage example will fit on the

same page as the two existing coverage examples in the SBC template, so no new material costs are required by these proposed regulations. The quantified costs of these proposed regulations are for the actual production of the new coverage example.

These proposed regulations allow issuers and plans to continue to use the "Coverage Example Calculator."⁹⁹ This calculator benefits issuers and plan sponsors by reducing the required time to produce the coverage examples. The calculator allows plans to either manually populate less than 20 data points on the plan's design for one plan at a time, or to enter the data points for multiple plans at once. Most of the data fields needed for the new, proposed coverage example are already required to create the other two, already required coverage examples. While plan sponsors and issuers are not required to use the Coverage Example Calculator, the Departments expect that many will. Those choosing to perform the calculations without the calculator will make their own determination that it is more efficient and economically advantageous, or otherwise more appropriate for them to do so.

Using assumptions similar to those used in the regulatory impact analysis of the 2012 final regulations, with respect to

plans and issuers that do not use the Coverage Example Calculator, the Departments estimate that large issuers and third-party administrators (TPAs), for all their plans and products, would spend a total of approximately 40 additional hours creating the new coverage example (30 hours for medium firms, and 20 hours for small firms). Once the new coverage example is completed, the Departments estimate that large firms would spend an estimated 25 hours in later years updating, while medium firms would spend 19 hours and small firms would spend 13 hours.

This leads to an estimated cost in the first year of \$3.4 million and for each subsequent year of \$2.1 million to produce the coverage example. Actual cost could be lower as firms organize their data in a manner that will allow them to use the automated functions of the Coverage Example Calculator. Table 1 details the calculations used to obtain the cost estimate for creating the new, proposed coverage example. The Paperwork Reduction Act section below contains a discussion of additional assumptions and data used to develop this estimate.

TABLE 1.— Year 1, Creating New Coverage Example

| | Type of Labor | Number of Firms | Hours Per Firm | Cost per Hour | Total Hour Burden | Equivalent Costs of Hours |
|----------------|---------------|-----------------|----------------|---------------|-------------------|---------------------------|
| Issuers | | | | | | |
| Large | IT | 75 | 22.0 | \$84 | 1,650 | \$138,584 |
| | Benefits | 75 | 16.0 | \$62 | 1,200 | \$74,796 |
| | Legal | 75 | 2.0 | \$130 | 150 | \$19,491 |
| | Sub-Total | | | | 3,000 | \$232,871 |
| Medium | IT | 250 | 16.5 | \$84 | 4,125 | \$346,459 |
| | Benefits | 250 | 12.0 | \$62 | 3,000 | \$186,990 |
| | Legal | 250 | 1.5 | \$130 | 375 | \$48,728 |
| | Sub-Total | | | | 7,500 | \$582,176 |
| Small | IT | 175 | 11.0 | \$84 | 1,925 | \$161,681 |
| | Benefits | 175 | 8.0 | \$62 | 1,400 | \$87,262 |
| | Legal | 175 | 1.0 | \$130 | 175 | \$22,740 |
| | Sub-Total | | | | 3,500 | \$271,682 |
| TPAs | | | | | | |
| Large | IT | 158 | 22.0 | \$84 | 3,476 | \$291,949 |
| | Benefits | 158 | 16.0 | \$62 | 2,528 | \$157,570 |

⁹⁹<http://www.cms.gov/ccio/Resources/forms-reports-and-other-resources/index.html#sbcug>. For more information on the calculator, see section II.A.3 earlier in this preamble.

TABLE 1.— Year 1, Creating New Coverage Example

| | Type of Labor | Number of Firms | Hours Per Firm | Cost per Hour | Total Hour Burden | Equivalent Costs of Hours |
|--------|---------------|-----------------|----------------|---------------|-------------------|---------------------------|
| Medium | Legal | 158 | 2.0 | \$130 | 316 | \$41,061 |
| | Sub-Total | | | | 6,320 | \$490,581 |
| | IT | 526 | 16.5 | \$84 | 8,679 | \$728,949 |
| | Benefits | 526 | 12.0 | \$62 | 6,312 | \$393,427 |
| Small | Legal | 526 | 1.5 | \$130 | 789 | \$102,523 |
| | Sub-Total | | | | 15,780 | \$1,224,899 |
| | IT | 368 | 11.0 | \$84 | 4,048 | \$339,992 |
| | Benefits | 368 | 8.0 | \$62 | 2,944 | \$183,500 |
| Total | Legal | 368 | 1.0 | \$130 | 368 | \$47,818 |
| | Sub-Total | | | | 7,360 | \$571,309 |
| | | | | | 43,460 | \$3,373,517 |

TABLE 2.— Year 2, Creating New Coverage Example

| | Type of Labor | Number of Firms | Hours Per Firm | Cost per Hour | Total Hour Burden | Equivalent Costs of Hours |
|------------------|---------------|-----------------|----------------|---------------|-------------------|---------------------------|
| Issuers Large | IT | 75 | 13.8 | \$84 | 1,031 | \$86,615 |
| | Benefits | 75 | 10.0 | \$62 | 750 | \$46,748 |
| | Legal | 75 | 1.3 | \$130 | 94 | \$12,182 |
| | Sub-Total | | | | 1,875 | \$145,544 |
| Medium | IT | 250 | 10.3 | \$84 | 2,578 | \$216,537 |
| | Benefits | 250 | 7.5 | \$62 | 1,875 | \$116,869 |
| | Legal | 250 | 0.9 | \$130 | 234 | \$30,455 |
| | Sub-Total | | | | 4,688 | \$363,860 |
| Small | IT | 175 | 6.9 | \$84 | 1,203 | \$101,050 |
| | Benefits | 175 | 5.0 | \$62 | 875 | \$54,539 |
| | Legal | 175 | 0.6 | \$130 | 109 | \$14,212 |
| | Sub-Total | | | | 2,188 | \$169,801 |
| TPAs Large | IT | 158 | 13.8 | \$84 | 2,173 | \$182,468 |
| | Benefits | 158 | 10.0 | \$62 | 1,580 | \$98,481 |
| | Legal | 158 | 1.3 | \$130 | 198 | \$25,663 |
| | Sub-Total | | | | 3,950 | \$306,613 |
| Medium | IT | 526 | 10.3 | \$84 | 5,424 | \$455,593 |
| | Benefits | 526 | 7.5 | \$62 | 3,945 | \$245,892 |
| | Legal | 526 | 0.9 | \$130 | 493 | \$64,077 |
| | Sub-Total | | | | 9,863 | \$765,562 |
| Small | IT | 368 | 6.9 | \$84 | 2,530 | \$212,495 |
| | Benefits | 368 | 5.0 | \$62 | 1,840 | \$114,687 |
| | Legal | 368 | 0.6 | \$130 | 230 | \$29,886 |
| | Sub-Total | | | | 4,600 | \$357,068 |
| Total | | | | | 27,163 | \$2,108,448 |

B. Paperwork Reduction Act

1. Department of Labor and Department of the Treasury

To implement PHS Act section 2715 and these proposed regulations, collection

of information requirements relate to the provision of the following:

- Summary of benefits and coverage.
- Coverage examples (as components of each SBC).
- A uniform glossary of health coverage and medical terms (uniform glossary).
- Notice of modifications.

A copy of the information collection request (ICR) may be obtained by contacting the PRA addressee: G. Christopher Cosby, Office of Policy and Research, U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, NW, Room N-5718, Washington, DC 20210. Telephone: (202) 693-8410; Fax: (202) 219-4745. These are not toll-free numbers. E-mail: ebesa.opr@dol.gov. ICRs submitted to OMB also are available at [reginfo.gov](http://www.reginfo.gov) (<http://www.reginfo.gov/public/do/PRAMain>).

This analysis includes the coverage examples that are part of the SBC disclosure, therefore, the Departments calculate a single burden estimate for purposes of this section, assuming the information collection request for the SBC (including coverage examples) totals eight (8) sides of a page in length.

The Departments assume fully-insured ERISA plans will rely on health insurance issuers and self-insured plans will rely on TPAs to perform these functions. While self-insured plans may prepare SBCs internally, the Departments make this simplifying assumption because most plans appear to rely on issuers and TPAs for the purpose of administrative duties, such as enrollment and claims processing. Thus, the Departments use health insurance issuers and TPAs as the unit of analysis for the

purposes of estimating administrative costs.

The Departments estimate there are a total of 500 issuers and 1,050 TPAs affected by this information collection.¹⁰⁰ Because HHS shares the hour and cost burden for fully-insured plans with the Departments of Labor and the Treasury, HHS assumes 50 percent of the hour and cost burden estimates to account for burden for issuers in the individual market and 15 percent of the burden for TPAs to account for those TPAs serving self-insured non-Federal governmental plans. The Departments of Labor and the Treasury assume the other 50 percent of the burden related to issuers to account for burden servicing fully insured ERISA plans, and 85 percent of the burden related to TPAs to account for the burden related to ERISA self-insured plans.

To account for variation in costs due to firm size and the number of plans and individuals they service, the Departments divide issuers into small, medium, and large categories.¹⁰¹ Accordingly, the Departments estimate that there are approximately 175 small, 250 medium, and 75 large issuers. The Departments lack information to create a similar split for TPAs, so they assume a similar distribution resulting in an estimate of approximately 368 small, 526 medium, and 158 large TPAs.

The estimated hour burden and equivalent cost for the collections of information are as follows: The Departments estimate an administrative burden on issuers and TPAs to make appropriate changes to IT systems and processes

and make updates to the SBCs and coverage examples. The Departments estimate that large firms would spend 190 hours (40 hours of which would be new due to the proposed regulation) in the first year, medium firms would spend 75 percent of large firm hour burden, and small firms would spend 50 percent of the large firm hour burden to perform these tasks. The total burden would be split among IT professionals (55 percent), benefits professionals (40 percent), and legal professionals (5 percent), with hourly labor rates of \$83.99, \$62.33, and \$129.94 respectively.¹⁰² Clerical labor rates are \$30.42 per hour.

Tables 3 (first year) and 4 (subsequent years) show the calculations used to obtain the hours burden of 153,600 hours (first year) and 141,600 hours (subsequent years) and the equivalent cost burden of \$11.9 million (first year) and \$11.0 million (subsequent years) for issuers and TPAs to prepare the SBCs and coverage examples. In addition, clerical employees would spend 653,000 hours with an equivalent cost of \$19.8 million in each year preparing and distributing the SBCs.

Based on the foregoing, the total hours burden for this information collection would be 806,000 hours for the first year (794,000 hours for subsequent years) with an equivalent cost of \$31.7 million for the first year (\$30.8 million for subsequent years). This burden is split evenly between the Departments of Labor and the Treasury.

¹⁰⁰The estimate for the number of issuers is based on the number of issuers for the group and individual market filing with HHS for the Medical Loss Ratio regulations. See 45 CFR Part 158. The number of TPAs is based on the U.S. Census's 2011 Statistics of U.S. Businesses that reports there are 3,157 TPA's. Previous discussions with industry experts led to assuming about one-third of the TPA's (1,052) could be providing services to self-insured plans.

¹⁰¹The Departments define small issuers as those with total earned premiums less than \$50 million; medium issuers as those with total earned premiums between \$50 million and \$99 million; and large issuers as those with total earned premiums of \$1 billion or more. The premium revenue data come from the 2009 NAIC financial statements, also known as "Blanks," where insurers report information about their various lines of business.

¹⁰²The Departments' 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/ecec.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>). Computer Systems Analysts (15-1121): \$41.02(2013 BLS Wage rate) /0.69(ECEC ratio) *1.35(Overhead Load Factor) *1.023(Inflation rate) ²(Inflated 2 years from base year) = \$83.99; Compensation, benefits, and job analysis specialists (13-1141): \$30.44(2013 BLS Wage rate) /0.69(ECEC ratio) *1.35(Overhead Load Factor) *1.023(Inflation rate) ²(Inflated 2 years from base year) = \$62.33; Legal 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; Secretaries, 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.

TABLE 1.—Update SBC including Coverage Examples, Year 1

| | Type of Labor | Number of Firms | Hours Per Firm | Cost per Hour | Total Hour Burden | Total Cost Burden |
|---------|---------------|-----------------|----------------|---------------|-------------------|-------------------|
| Issuers | | | | | | |
| Large | IT | 75 | 52.3 | \$84 | 3,919 | \$329,136 |
| | Benefits | 75 | 38.0 | \$62 | 2,850 | \$177,641 |
| | Legal | 75 | 4.8 | \$130 | 356 | \$46,291 |
| | Sub-Total | | | | 7,125 | \$553,067 |
| Medium | IT | 250 | 39.9 | \$84 | 9,969 | \$837,275 |
| | Benefits | 250 | 29.0 | \$62 | 7,250 | \$451,893 |
| | Legal | 250 | 3.6 | \$130 | 906 | \$117,758 |
| | Sub-Total | | | | 18,125 | \$1,406,926 |
| Small | IT | 175 | 26.1 | \$84 | 4,572 | \$383,992 |
| | Benefits | 175 | 19.0 | \$62 | 3,325 | \$207,247 |
| | Legal | 175 | 2.4 | \$130 | 416 | \$54,006 |
| | Sub-Total | | | | 8,313 | \$645,245 |
| TPAs | | | | | | |
| Large | IT | 158 | 88.8 | \$84 | 14,034 | \$1,178,745 |
| | Benefits | 158 | 64.6 | \$62 | 10,207 | \$636,190 |
| | Legal | 158 | 8.1 | \$130 | 1,276 | \$165,784 |
| | Sub-Total | | | | 25,517 | \$1,980,719 |
| Medium | IT | 526 | 67.8 | \$84 | 35,656 | \$2,994,766 |
| | Benefits | 526 | 49.3 | \$62 | 25,932 | \$1,616,329 |
| | Legal | 526 | 6.2 | \$130 | 3,241 | \$421,197 |
| | Sub-Total | | | | 64,830 | \$5,032,293 |
| Small | IT | 368 | 44.4 | \$84 | 16,344 | \$1,372,716 |
| | Benefits | 368 | 32.3 | \$62 | 11,886 | \$740,879 |
| | Legal | 368 | 4.0 | \$130 | 1,486 | \$193,065 |
| | Sub-Total | | | | 29,716 | \$2,306,660 |
| Total | | | | | 153,625 | \$11,924,910 |

TABLE 1.— Update SBC including Coverage Examples, Subsequent Years

| | Type of Labor | Number of Firms | Hours Per Firm | Cost per Hour | Total Hour Burden | Total Cost Burden |
|---------|---------------|-----------------|----------------|---------------|-------------------|-------------------|
| Issuers | | | | | | |
| Large | IT | 75 | 48.1 | \$84 | 3,609 | \$303,151 |
| | Benefits | 75 | 35.0 | \$62 | 2,625 | \$163,616 |
| | Legal | 75 | 4.4 | \$130 | 328 | \$42,637 |
| | Sub-Total | | | | 6,563 | \$509,404 |
| Medium | IT | 250 | 36.8 | \$84 | 9,195 | \$772,314 |
| | Benefits | 250 | 26.8 | \$62 | 6,688 | \$416,832 |
| | Legal | 250 | 3.3 | \$130 | 836 | \$108,622 |
| | Sub-Total | | | | 16,719 | \$1,297,768 |
| Small | IT | 175 | 24.1 | \$84 | 4,211 | \$353,677 |
| | Benefits | 175 | 17.5 | \$62 | 3,063 | \$190,886 |
| | Legal | 175 | 2.2 | \$130 | 383 | \$49,743 |
| | Sub-Total | | | | 7,656 | \$594,305 |
| TPAs | | | | | | |

TABLE 1.— Update SBC including Coverage Examples, Subsequent Years

| | Type of Labor | Number of Firms | Hours Per Firm | Cost per Hour | Total Hour Burden | Total Cost Burden |
|--------|---------------|-----------------|----------------|---------------|-------------------|-------------------|
| Large | IT | 158 | 81.8 | \$84 | 12,926 | \$1,085,686 |
| | Benefits | 158 | 59.5 | \$62 | 9,401 | \$585,964 |
| | Legal | 158 | 7.4 | \$130 | 1,175 | \$152,696 |
| | Sub-Total | | | | 23,503 | \$1,824,346 |
| Medium | IT | 526 | 62.5 | \$84 | 32,890 | \$2,762,414 |
| | Benefits | 526 | 45.5 | \$62 | 23,920 | \$1,490,924 |
| | Legal | 526 | 5.7 | \$130 | 2,990 | \$388,518 |
| | Sub-Total | | | | 59,800 | \$4,641,856 |
| Small | IT | 368 | 40.9 | \$84 | 15,054 | \$1,264,343 |
| | Benefits | 368 | 29.8 | \$62 | 10,948 | \$682,389 |
| | Legal | 368 | 3.7 | \$130 | 1,369 | \$177,823 |
| | Sub-Total | | | | 27,370 | \$2,124,555 |
| Total | | | | 141,610 | \$10,992,235 | |

The Departments also estimate the cost burden associated with the SBC, Uniform Glossary and Notice of Modification. These costs are discussed below.

- **SBC**—The Departments estimate that approximately 60.6 million SBCs will be delivered with 527,000 going to ERISA plans and 60.1 million going to participants and beneficiaries annually.¹⁰³ The Departments assume 50 percent of the SBCs going to plans would be sent electronically while 38 percent of SBCs would be sent electronically to plan participants. Accordingly, the Departments estimate that about 23.4 million SBCs would be distributed electronically and about 37.2 million SBCs would be distributed on paper. The Departments assume there are costs only for paper disclosures, with de minimis costs for electronic disclosures. The SBC, with coverage

examples, is assumed to be four double-sided pages (eight page sides) in length. Paper SBCs sent to participants would have no postage costs as they could be included in mailings with other plan materials, however all notices sent to beneficiaries living apart from the participant would be mailed and have a 49 cent postage costs. Printing costs would be five cents per page. Each document sent by mail would have a one minute preparation burden, with the task performed by a clerical worker. Based on the foregoing, the total cost burden to prepare and distribute the SBC would be \$16.4 million.

- **Uniform Glossary** – The Departments assume that 2.5 percent of those who receive paper SBCs will request glossaries in paper form (that is, about 1.1 million glossary requests). The total cost burden to prepare and distrib-

ute paper copies of the Uniform Glossaries would be \$760,000.

- **Notice of Modifications** – The Departments assume that issuers and plans will send notices of modification to covered participants and beneficiaries, and that 2 percent of covered participants and beneficiaries will receive such notices (1.2 million notices). As with the SBC, 50 percent of plans and 38 percent of policy holders will receive electronic notices. Paper notices are assumed to be of the same length as an SBC, and will incur a postage cost of 49 cents. The total cost burden to prepare and distribute the notices of modification would be \$640,000.

Based on the foregoing, the total annual cost burden is estimated to be \$16.4 million. This burden is split evenly between the Departments of Labor and the Treasury.

TABLE.—Preparation and Distribution Costs: Cost Burden

| | Number of Disclosures | Number of Disclosures Sent on Paper | Material and Printing Costs | Postage Costs | Total Cost Burden |
|---|-----------------------|-------------------------------------|-----------------------------|---------------|-------------------|
| <i>SBC with Coverage Examples to Group Health Plan</i> | | | | | |
| Renewal or Application | 527,328 | 263,664 | \$105,466 | \$0 | \$105,466 |
| Sub-Total | 527,328 | 263,664 | \$105,466 | \$0 | \$105,466 |
| <i>SBC with Coverage Examples To Participants and Beneficiaries</i> | | | | | |

¹⁰³Based on the 2012 Current Population Survey the Department estimates there are 58.0 million policy holders in ERISA plans <http://www.dol.gov/ebsa/pdf/coveragebulletin2013.pdf> table 2.

TABLE.—Preparation and Distribution Costs: Cost Burden

| | Number of Disclosures | Number of Disclosures Sent on Paper | Material and Printing Costs | Postage Costs | Total Cost Burden |
|---------------------------------|-----------------------|-------------------------------------|-----------------------------|---------------|-------------------|
| Upon Application or Eligibility | 2,030,000 | 1,015,000 | \$406,000 | \$0 | \$406,000 |
| Upon Renewal | 58,000,000 | 35,960,000 | \$14,384,000 | \$0 | \$14,384,000 |
| Beneficiaries Living Apart | 90,000 | 90,000 | \$36,000 | \$44,100 | \$80,100 |
| Sub-Total | 60,120,000 | 36,975,000 | \$14,826,000 | \$44,100 | \$14,870,100 |
| <i>Uniform Glossary</i> | 1,102,000 | 1,102,000 | \$220,400 | \$539,980 | \$760,380 |
| <i>Notice of Modification</i> | 1,160,000 | 719,200 | \$287,680 | \$352,408 | \$640,088 |
| Total | 62,909,328 | 39,059,864 | \$15,439,546 | \$936,488 | \$16,376,034 |

TABLE.—Preparation and Distribution Costs: Hour Burden

| | Number of Disclosures | Number of Disclosures Sent on Paper | Clerical Hours | Clerical Costs | Total Hour Burden | Total Equivalent Cost |
|---|-----------------------|-------------------------------------|----------------|----------------|-------------------|-----------------------|
| <i>SBC with Coverage Examples to Group Health Plan</i> | | | | | | |
| Renewal or Application | 527,328 | 263,664 | 4,394 | \$130,074 | 4,394 | \$130,074 |
| Sub-Total | 527,328 | 263,664 | 4,394 | \$130,074 | 4,394 | \$130,074 |
| <i>SBC with Coverage Examples To Participants and Beneficiaries</i> | | | | | | |
| Upon Application or Eligibility | 2,030,000 | 1,015,000 | 16,917 | \$500,733 | 16,917 | \$500,733 |
| Upon Renewal | 58,000,000 | 35,960,000 | 599,333 | \$17,740,267 | 599,333 | \$17,740,267 |
| Beneficiaries Living Apart | 90,000 | 90,000 | 1,500 | \$44,400 | 1,500 | \$44,400 |
| Sub-Total | 60,120,000 | 36,975,000 | 617,750 | \$18,285,400 | 617,750 | \$18,285,400 |
| <i>Uniform Glossary</i> | 1,102,000 | 1,102,000 | 18,367 | \$543,653 | 18,367 | \$543,653 |
| <i>Notice of Modification</i> | 1,160,000 | 719,200 | 11,987 | \$354,805 | 11,987 | \$354,805 |
| Total | 62,909,328 | 39,059,864 | 652,498 | \$19,313,933 | 652,498 | \$19,313,933 |

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 2015–2017 paperwork burden estimates are summarized as follows:

Type of Review:

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

Title: Affordable Care Act Uniform Explanation of Coverage Documents

OMB Number: 1210–0147; 1545–2229.

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

Total Respondents: 2,389,000

Total Responses: 62,909,000

Frequency of Response: On-going.

Estimated Total Annual Burden Hours (three year average): 399,000 hours (Employee Benefits Security Administration); 399,000 hours (Internal Revenue Service).

Estimated Total Annual Cost Burden (three year average): \$8,188,000 (Em-

ployee Benefits Security Administration); \$8,188,000 (Internal Revenue Service).

2. Department of Health and Human Services

The Paperwork Reduction Act (PRA) section for the Departments of Labor and the Treasury above contain the assumptions, data sources, and explanations of the Departments’ methodology for estimating the PRA burden. The following tables summarize the Department of Health and Human Services’ burden estimates.

TABLE 1.— Update SBC including Coverage Examples; Year 1

| | Type of Labor | Number of Firms | Hours Per Firm | Cost per Hour | Total Hour Burden | Equivalent Costs |
|----------------|---------------|-----------------|----------------|---------------|-------------------|------------------|
| <i>Issuers</i> | | | | | | |
| Large | IT | 75 | 52.3 | \$84 | 3,919 | \$329,136 |
| | Benefits | 75 | 38.0 | \$62 | 2,850 | \$177,641 |
| | Legal | 75 | 4.8 | \$130 | 356 | \$46,291 |
| | Sub-Total | | | | 7,125 | \$553,067 |
| Medium | IT | 250 | 39.9 | \$84 | 9,969 | \$837,275 |
| | Benefits | 250 | 29.0 | \$62 | 7,250 | \$451,893 |
| | Legal | 250 | 3.6 | \$130 | 906 | \$117,758 |
| | Sub-Total | | | | 18,125 | \$1,406,926 |
| Small | IT | 175 | 26.1 | \$84 | 4,572 | \$383,992 |
| | Benefits | 175 | 19.0 | \$62 | 3,325 | \$207,247 |
| | Legal | 175 | 2.4 | \$130 | 416 | \$54,006 |
| | Sub-Total | | | | 8,313 | \$645,245 |
| <i>TPAs</i> | | | | | | |
| Large | IT | 158 | 15.7 | \$84 | 2,477 | \$208,014 |
| | Benefits | 158 | 11.4 | \$62 | 1,801 | \$112,269 |
| | Legal | 158 | 1.4 | \$130 | 225 | \$29,256 |
| | Sub-Total | | | | 4,503 | \$349,539 |
| Medium | IT | 526 | 12.0 | \$84 | 6,292 | \$528,488 |
| | Benefits | 526 | 8.7 | \$62 | 4,576 | \$285,235 |
| | Legal | 526 | 1.1 | \$130 | 572 | \$74,329 |
| | Sub-Total | | | | 11,441 | \$888,052 |
| Small | IT | 368 | 7.8 | \$84 | 2,884 | \$242,244 |
| | Benefits | 368 | 5.7 | \$62 | 2,098 | \$130,743 |
| | Legal | 368 | 0.7 | \$130 | 262 | \$34,070 |
| | Sub-Total | | | | 5,244 | \$407,058 |
| Total | | | | | 54,750 | \$4,249,887 |

TABLE 1.— Update SBC including Coverage Examples, Subsequent Years

| | Type of Labor | Number of Firms | Hours Per Firm | Cost per Hour | Total Hour Burden | Equivalent Costs |
|----------------|---------------|-----------------|----------------|---------------|-------------------|------------------|
| <i>Issuers</i> | | | | | | |
| Large | IT | 75 | 48.1 | \$84 | 3,609 | \$303,151 |
| | Benefits | 75 | 35.0 | \$62 | 2,625 | \$163,616 |
| | Legal | 75 | 4.4 | \$130 | 328 | \$42,637 |
| | Sub-Total | | | | 6,563 | \$509,404 |
| Medium | IT | 250 | 36.8 | \$84 | 9,195 | \$772,314 |
| | Benefits | 250 | 26.8 | \$62 | 6,688 | \$416,832 |
| | Legal | 250 | 3.3 | \$130 | 836 | \$108,622 |
| | Sub-Total | | | | 16,719 | \$1,297,768 |
| Small | IT | 175 | 24.1 | \$84 | 4,211 | \$353,677 |
| | Benefits | 175 | 17.5 | \$62 | 3,063 | \$190,886 |
| | Legal | 175 | 2.2 | \$130 | 383 | \$49,743 |
| | Sub-Total | | | | 7,656 | \$594,305 |
| <i>TPAs</i> | | | | | | |
| Large | IT | 158 | 14.4 | \$84 | 2,281 | \$191,592 |

TABLE 1.— Update SBC including Coverage Examples, Subsequent Years

| Type of Labor | Number of Firms | Hours Per Firm | Cost per Hour | Total Hour Burden | Equivalent Costs |
|---------------|-----------------|----------------|---------------|-------------------|------------------|
| Benefits | 158 | 10.5 | \$62 | 1,659 | \$103,405 |
| Legal | 158 | 1.3 | \$130 | 207 | \$26,946 |
| Sub-Total | | | | 4,148 | \$321,943 |
| Medium IT | 526 | 11.0 | \$84 | 5,804 | \$487,485 |
| Benefits | 526 | 8.0 | \$62 | 4,221 | \$263,104 |
| Legal | 526 | 1.0 | \$130 | 528 | \$68,562 |
| Sub-Total | | | | 10,553 | \$819,151 |
| Small IT | 368 | 7.2 | \$84 | 2,657 | \$223,119 |
| Benefits | 368 | 5.3 | \$62 | 1,932 | \$120,422 |
| Legal | 368 | 0.7 | \$130 | 242 | \$31,381 |
| Sub-Total | | | | 4,830 | \$374,922 |
| Total | | | | 50,468 | \$3,917,493 |

TABLE 2.— Preparation and Distribution Costs

| | Number of Disclosures | Number of Disclosures Sent on Paper | Clerical Hour Burden | Total Equivalent Cost |
|--|-----------------------|-------------------------------------|----------------------|-----------------------|
| <i>Group Health Plan</i> | | | | |
| SBC with Coverage Examples | 15,750 | 7,875 | 131.25 | \$3,885 |
| <i>SBC with Coverage Examples—Participants and Beneficiaries</i> | | | | |
| Upon Application or Eligibility | 222,680 | 111,340 | 1,855.67 | \$54,928 |
| Upon Renewal | 17,129,262 | 8,564,631 | 142,743.85 | \$4,225,218 |
| Beneficiaries Living Apart | 33,000 | 33,000 | 550.00 | \$16,280 |
| Sub-Total | 17,384,942 | 8,708,971 | 145,150 | \$4,296,426 |
| Uniform Glossary | 428,232 | 428,232 | 7,137 | \$211,261 |
| Notice of Modification | 342,585 | 171,293 | 2,855 | \$84,504 |
| <i>Individual Market</i> | | | | |
| SBC with Coverage Examples | 21,784,217 | 6,535,265 | 108,921 | \$3,224,064 |
| Uniform Glossary | 762,448 | 762,448 | 12,707 | \$376,141 |
| Notice of Modification | 435,684.34 | 130,705 | 2,178 | \$64,481 |
| Total | 41,153,858 | 16,744,788 | 279,080 | \$8,260,762 |

TABLE 3.— Preparation and Distribution Costs

| | Number of Disclosures | Number of Disclosures Sent on Paper | Material and Printing Costs | Postage Costs | Total Cost Burden |
|--|-----------------------|-------------------------------------|-----------------------------|---------------|-------------------|
| <i>Group Health Plan</i> | | | | | |
| SBC with Coverage Examples | 15,750 | 7,875 | \$3,150 | | \$3,150 |
| <i>SBC with Coverage Examples—Participants and Beneficiaries</i> | | | | | |
| Upon Application or Eligibility | 222,680 | 111,340 | \$44,536 | | \$44,536 |
| Upon Renewal | 17,129,262 | 8,564,631 | \$3,425,852 | | \$3,425,852 |
| Beneficiaries Living Apart | 33,000 | 33,000 | \$13,200 | \$16,170 | \$29,370 |
| Sub-Total | 17,384,942 | 8,708,971 | \$3,483,588 | \$16,170 | \$3,499,758 |
| Uniform Glossary | 428,232 | 428,232 | \$85,646 | \$209,833 | \$295,480 |
| Notice of Modification | 342,585 | 171,293 | \$68,517 | \$83,933 | \$152,450 |

TABLE 3.— Preparation and Distribution Costs

| | Number of Disclosures | Number of Disclosures Sent on Paper | Material and Printing Costs | Postage Costs | Total Cost Burden |
|-----------------------------------|-----------------------|-------------------------------------|-----------------------------|------------------|--------------------|
| <i>Individual Market</i> | | | | | |
| <i>SBC with Coverage Examples</i> | 21,784,217 | 6,535,265 | \$2,614,106 | | \$2,614,106 |
| <i>Uniform Glossary</i> | 762,448 | 762,448 | \$152,490 | \$373,599 | \$526,089 |
| <i>Notice of Modification</i> | 435,684.34 | 130,705 | \$52,282 | \$64,046 | \$116,328 |
| Total | 41,153,858 | 16,744,788 | \$6,459,780 | \$747,582 | \$7,207,361 |

HHS is proposing that issuers be required to make available on an Internet web address a copy of the actual individual coverage policy or group certificate of coverage.¹⁰⁴ HHS estimates that the burden of this request will be de minimis because the documents will have already been created and issuers already have web addresses on which the materials can be made available.

The Department notes 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 2015–2017 paperwork burden estimates are summarized as follows:

Type of Review: Revision.

Agency: Department of Health and Human Services.

Title: Summary of benefits and Coverage Uniform Glossary

CMS Identifier (OMB Control Number): CMS-10407 (0938-1146).

Affected Public: State, Local, or Tribal Governments.

Total Respondents: 126,500.

Total Responses: 41,154,000.

Frequency of Response: On-going.

Estimated Total Annual Burden Hours (three year average): 331,000 hours.

Estimated Total Annual Cost Burden (three year average): \$7,207,000 ICRs Related to Deemed Compliance Reporting (45 CFR 147.200(a)(4)(iii)(C))

Under 45 CFR 147.200(a)(4)(iii)(C), if individual health insurance issuers provide the content required for the SBC to the federal health reform Web portal described in 45 CFR 159.120 (HealthCare.gov), then they will be deemed to have satisfied the requirement to provide an SBC to individuals who request informa-

tion about coverage prior to submitting an application for coverage. Individual health insurance issuers already provide most SBC content elements to HealthCare.gov, except for five data elements related to patient responsibility for each coverage example: deductibles, co-payments, co-insurance, coverage limits or exclusions, and the total out-of-pocket cost to the enrollee in view of these cost-sharing amounts and coverage limits or exclusions.

Accordingly, the additional burden associated with the requirements under § 147.200(a)(4)(iii)(C) is the time and effort it would take each of the 320 issuers submitting this data in the individual market to enter the five additional data elements into an Excel spreadsheet. We estimate that it will take these issuers about 160 hours, at a total estimated cost of about \$4,800, for each coverage example. For three coverage examples, the burden and cost would be about 480 hours at a cost of about \$14,400.

In deriving these figures, we used the following hourly labor rates and estimated the time to complete each task: \$ 30.78/hr. and 0.5 hr./issuer for clerical staff to enter data into an Excel spreadsheet, or about \$15 per respondent per coverage example.

This information collection requirement reflects the requirement that issuers must provide all content required in the SBC, including the information necessary for coverage examples, to HealthCare.gov to be deemed compliant. The aforementioned burden estimates will be submitted for OMB review and approval as a revision to the information collection request currently approved under OMB control number 0938-1086.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web site at <http://www.cms.gov/PaperworkReductionActof1995/PRAL/list.asp#TopOfPage> or email your request, including your address, phone number, OMB control number, and CMS document identifier, to Paperwork@cms.hhs.gov, or call the Reports Clearance Office at 410-786-1326.

C. 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. Unless the head of an agency certifies that a proposed rule is not likely to have a significant economic impact on a substantial number of small entities, section 603 of the RFA requires that the agency present an initial regulatory flexibility analysis (IRFA) describing the rule's impact on small entities and explaining how the agency made its decisions with respect to the application of the rule to 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.")

¹⁰⁴See proposed 45 CFR 147.200(a)(2)(i)(J).

There are several different types of small entities affected by these proposed regulations. For issuers and TPAs, 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. For plans, the Departments continue to consider a small plan to be an employee benefit plan with fewer than 100 participants.¹⁰⁵ 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 proposed 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.). The Departments therefore request comments on the appropriateness of the size standard used in evaluating the impact of these proposed regulations on small entities.

The Departments carefully considered the likely impact of the rule on small entities in connection with their assessment under Executive Order 12866. The Departments believe that the proposed regulations include flexibility like allowing use of the Coverage Example Calculator that would minimize the burden on small entities. Also, the Departments believe that the burden imposed by the proposed regulation on small insurers and small TPAs will be 20 hours or less annually.

The Departments hereby certify that these proposed regulations will not have a significant economic impact on a substantial number of small entities, as described above. Consistent with the policy of the RFA, the Departments encourage the public to submit comments that would allow the Departments to assess the impacts specifically on small entities or suggest alternative rules that accomplish the stated purpose of PHS Act section 2715 and minimize the impact on small entities.

D. 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 proposed 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 2014, that threshold level is approximately \$141 million. These proposed regulations include no mandates on State, local, or Tribal governments. These proposed regulations propose requirements regarding standardized consumer disclosures that would affect private sector firms (for example, health insurance issuers offering coverage in the individual and group markets, and third-party administrators providing administrative services to group health plans), but we conclude that these costs would not exceed the \$141 million threshold. Thus, the Departments of Labor and HHS conclude that these proposed regulations would not impose an unfunded mandate on State, local or Tribal governments or the private sector. Regardless, consistent with policy embodied in UMRA, the proposed requirements described in this notice of proposed rule-making 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.

E. 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 proposed rules have federalism implications because they would have direct effects on the States, the relationship between national governments and States, or on the distribution of power and responsibilities among various levels of government relating to the disclosure of health insurance coverage information to consumers. Under these proposed rules, all group health plans and health insurance issuers offering group or individual health insurance coverage, including self-funded non-federal governmental plans as defined in section 2791 of the PHS Act, would be required to follow uniform standards for compiling and providing a summary of benefits and coverage to consumers. Such Federal standards developed under PHS Act section 2715(a) would preempt any related State standards that require a summary of benefits and coverage that provides less information to consumers than that required to be provided under PHS Act section 2715(a).

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 2724 of the PHS Act (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the HIPAA requirements (including those of 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 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

¹⁰⁵The 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.

“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. However, under these proposed rules, a State would not be allowed to impose a requirement that modifies the summary of benefits and coverage required to be provided under PHS Act section 2715(a), because it would prevent the application of this proposed rule’s uniform disclosure requirement.

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, including the provisions of section 2715 of the PHS Act. Throughout the process of developing these proposed regulations, to the extent feasible within the specific preemption provisions of HIPAA as it applies to the Affordable Care Act, 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 proposed 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 proposed rule in a meaningful and timely manner.

F. Special Analyses – Department of the Treasury

For purposes of the Department of the Treasury it has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866, as supplemented 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 proposed regulations. For a discussion of the impact of this proposed rule on small entities, please see section V.C. of this preamble. Pursuant to section 7805(f) of the Code, this notice of proposed rulemaking has been submitted to the Small Business Administration for comment on its impact on small business.

G. Congressional Review Act

This proposed rule is 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.

VI. Statutory Authority

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

The Department of Labor regulations are proposed to be adopted pursuant to the authority contained in 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1185d, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Pub. L. 104–191, 110 Stat. 1936; sec. 401(b), Pub. L. 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Pub. L. 110–343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Pub. L. 111–148, 124 Stat. 119, as amended by Pub. L. 111–152, 124 Stat. 1029; Secre-

tary of Labor’s Order 1–2011, 77 FR 1088 (January 9, 2012).

The Department of Health and Human Services regulations are proposed to be 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.

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John Dalrymple,
*Deputy Commissioner for
Services and Enforcement,*

Internal Revenue Service.
Signed this 18th day of December,
2014.

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

CMS–9938–P

Dated: December 18, 2014

Marilyn Tavenner,
*Administrator,
Centers for Medicare
& Medicaid Services.*

Dated: December 19, 2014

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

**DEPARTMENT OF THE
TREASURY**

Internal Revenue Service
26 CFR Chapter 1

Accordingly, 26 CFR Part 54 is proposed to be amended as follows:

**PART 54 —PENSION EXCISE
TAXES**

Paragraph 1. The authority citation for Part 54 continues to read as follows:

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

* * *

Section 54.9815–2715 also issued under 26 U.S.C. 9833.

Paragraph 2. Section 54.9815–2715 is revised to read as follows:

§ 54.9815–2715 Summary of benefits and coverage and uniform glossary.

(a) *Summary of benefits and coverage—*

(1) *In general.* A group health plan (and its administrator as defined in section 3(16)(A) of the Employee Retirement Income Security Act of 1974 (ERISA)), and a health insurance issuer offering group health insurance coverage, is required to provide a written summary of benefits and coverage (SBC) for each benefit package without charge to entities and individuals described in this paragraph (a)(1) in accordance with the rules of this section.

(i) *SBC provided by a group health insurance issuer to a group health plan – (A) Upon application.* A health insurance issuer offering group health insurance coverage must provide the SBC to a group health plan (or its sponsor) upon application for health coverage, as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application. If an SBC was provided before application pursuant to paragraph (a)(1)(i)(D) of this section (relating to SBCs upon request), this paragraph (a)(1)(i)(A) is deemed satisfied, provided there is no change to the information required to be in the SBC. However, if there has been a change in the information required, a new SBC that includes the correct information must be provided upon application pursuant to this paragraph (a)(1)(i)(A).

(B) *By first day of coverage (if there are changes).* If there is any change in the information required to be in the SBC that was provided upon application and before the first day of coverage, the issuer must update and provide a current SBC to the plan (or its sponsor) no later than the first day of coverage.

(C) *Upon renewal, reissuance, or re-enrollment.* If the issuer renews or reissues a policy, certificate, or contract of insurance for a succeeding policy year, or automatically re-enrolls the policyholder or its participants and beneficiaries in cov-

erage, the issuer must provide a new SBC as follows:

(1) If written application is required (in either paper or electronic form) for renewal or reissuance, the SBC must be provided no later than the date the written application materials are distributed.

(2) If renewal, reissuance, or re-enrollment is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year; however, with respect to an insured plan, if the policy, certificate, or contract of insurance has not been issued or renewed before such 30-day period, the SBC must be provided as soon as practicable but in no event later than seven business days after issuance of the new policy, certificate, or contract of insurance, or the receipt of written confirmation of intent to renew, whichever is earlier.

(D) *Upon request.* If a group health plan (or its sponsor) requests an SBC or summary information about a health insurance product from a health insurance issuer offering group health insurance coverage, an SBC must be provided as soon as practicable, but in no event later than seven business days following receipt of the request.

(ii) *SBC provided by a group health insurance issuer and a group health plan to participants and beneficiaries – (A) In general.* A group health plan (including its administrator, as defined under section 3(16) of ERISA), and a health insurance issuer offering group health insurance coverage, must provide an SBC to a participant or beneficiary (as defined under sections 3(7) and 3(8) of ERISA), and consistent with the rules of paragraph (a)(1)(iii) of this section, with respect to each benefit package offered by the plan or issuer for which the participant or beneficiary is eligible.

(B) *Upon application.* The SBC must be provided as part of any written application materials that are distributed by the plan or issuer for enrollment. If the plan or issuer does not distribute written application materials for enrollment, the SBC must be provided no later than the first date on which the participant is eligible to enroll in coverage for the participant or any beneficiaries. If an SBC was provided before application pursuant to paragraph (a)(1)(ii)(F) of this section (relating to

SBCs upon request), this paragraph (a)(1)(ii)(B) is deemed satisfied, provided there is no change to the information required to be in the SBC. However, if there has been a change in the information content, a new SBC that includes the correct information must be provided upon application pursuant to this paragraph (a)(1)(ii)(B).

(C) *By first day of coverage (if there are changes).* If there is any change to the information required to be in the SBC that was provided upon application and before the first day of coverage, the plan or issuer must update and provide a current SBC to a participant or beneficiary no later than the first day of coverage.

(D) *Special enrollees.* The plan or issuer must provide the SBC to special enrollees (as described in § 54.9801–6) no later than the date by which a summary plan description is required to be provided under the timeframe set forth in ERISA section 104(b)(1)(A) and its implementing regulations, which is 90 days from enrollment.

(E) *Upon renewal, reissuance, or re-enrollment.* If the plan or issuer requires participants or beneficiaries to renew in order to maintain coverage (for example, for a succeeding plan year), or automatically re-enrolls participants and beneficiaries in coverage, the plan or issuer must provide a new SBC, as follows:

(1) If written application is required for renewal, reissuance, or re-enrollment (in either paper or electronic form), the SBC must be provided no later than the date on which the written application materials are distributed.

(2) If renewal, reissuance, or re-enrollment is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year; however, with respect to an insured plan, if the policy, certificate, or contract of insurance has not been issued or renewed before such 30-day period, the SBC must be provided as soon as practicable but in no event later than seven business days after issuance of the new policy, certificate, or contract of insurance, or the receipt of written confirmation of intent to renew, whichever is earlier.

(F) *Upon request.* A plan or issuer must provide the SBC to participants or beneficiaries upon request for an SBC or

summary information about the health coverage, as soon as practicable, but in no event later than seven business days following receipt of the request.

(iii) *Special rules to prevent unnecessary duplication with respect to group health coverage* – (A) An entity required to provide an SBC under this paragraph (a)(1) with respect to an individual satisfies that requirement if another party provides the SBC, but only to the extent that the SBC is timely and complete in accordance with the other rules of this section. Therefore, for example, in the case of a group health plan funded through an insurance policy, the plan satisfies the requirement to provide an SBC with respect to an individual if the issuer provides a timely and complete SBC to the individual. An entity required to provide an SBC under this paragraph (a)(1) with respect to an individual that contracts with another party to provide such SBC is considered to satisfy the requirement to provide such SBC if:

(1) The entity monitors performance under the contract;

(2) If the entity has knowledge that the SBC is not being provided in a manner that satisfies the requirements of this section and the entity has all information necessary to correct the noncompliance, the entity corrects the noncompliance as soon as practicable; and

(3) If the entity has knowledge the SBC is not being provided in a manner that satisfies the requirements of this section and the entity does not have all information necessary to correct the noncompliance, the entity communicates with participants and beneficiaries who are affected by the noncompliance regarding the noncompliance, and begins taking significant steps as soon as practicable to avoid future violations.

(B) If a single SBC is provided to a participant and any beneficiaries at the participant's last known address, then the requirement to provide the SBC to the participant and any beneficiaries is generally satisfied. However, if a beneficiary's last known address is different than the participant's last known address, a separate SBC is required to be provided to the beneficiary at the beneficiary's last known address.

(C) With respect to a group health plan that offers multiple benefit packages, the plan or issuer is required to provide a new SBC automatically to participants and beneficiaries upon renewal or re-enrollment only with respect to the benefit package in which a participant or beneficiary is enrolled (or will be automatically re-enrolled under the plan); SBCs are not required to be provided automatically upon renewal or re-enrollment with respect to benefit packages in which the participant or beneficiary is not enrolled (or will not automatically be enrolled). However, if a participant or beneficiary requests an SBC with respect to another benefit package (or more than one other benefit package) for which the participant or beneficiary is eligible, the SBC (or SBCs, in the case of a request for SBCs relating to more than one benefit package) must be provided upon request as soon as practicable, but in no event later than seven business days following receipt of the request.

(2) *Content* – (i) *In general*. Subject to paragraph (a)(2)(iii) of this section, the SBC must include the following:

(A) Uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage, in accordance with guidance as specified by the Secretary;

(B) A description of the coverage, including cost sharing, for each category of benefits identified by the Secretary in guidance;

(C) The exceptions, reductions, and limitations of the coverage;

(D) The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations;

(E) The renewability and continuation of coverage provisions;

(F) Coverage examples, in accordance with the rules of paragraph (a)(2)(ii) of this section;

(G) With respect to coverage beginning on or after January 1, 2014, a statement about whether the plan or coverage provides minimum essential coverage as defined under section 5000A(f) and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable requirements;

(H) A statement that the SBC is only a summary and that the plan document, policy, certificate, or contract of insurance should be consulted to determine the governing contractual provisions of the coverage;

(I) Contact information for questions;

(J) For issuers, an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained;

(K) For plans and issuers that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of network providers;

(L) For plans and issuers that use a formulary in providing prescription drug coverage, an Internet address (or similar contact information) for obtaining information on prescription drug coverage; and

(M) An Internet address for obtaining the uniform glossary, as described in paragraph (c) of this section, as well as a contact phone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available.

(ii) *Coverage examples*. The SBC must include coverage examples specified by the Secretary in guidance that illustrate benefits provided under the plan or coverage for common benefits scenarios (including pregnancy and serious or chronic medical conditions) in accordance with this paragraph (a)(2)(ii).

(A) *Number of examples*. The Secretary may identify up to six coverage examples that may be required in an SBC.

(B) *Benefits scenarios*. For purposes of this paragraph (a)(2)(ii), a benefits scenario is a hypothetical situation, consisting of a sample treatment plan for a specified medical condition during a specific period of time, based on recognized clinical practice guidelines as defined by the National Guideline Clearinghouse, Agency for Healthcare Research and Quality. The Secretary will specify, in guidance, the assumptions, including the relevant items and services and reimbursement information, for each claim in the benefits scenario.

(C) *Illustration of benefit provided*. For purposes of this paragraph (a)(2)(ii), to illustrate benefits provided under the plan or coverage for a particular benefits scenario, a plan or issuer simulates claims

processing in accordance with guidance issued by the Secretary to generate an estimate of what an individual might expect to pay under the plan, policy, or benefit package. The illustration of benefits provided will take into account any cost sharing, excluded benefits, and other limitations on coverage, as specified by the Secretary in guidance.

(iii) *Coverage provided outside the United States.* In lieu of summarizing coverage for items and services provided outside the United States, a plan or issuer may provide an Internet address (or similar contact information) for obtaining information about benefits and coverage provided outside the United States. In any case, the plan or issuer must provide an SBC in accordance with this section that accurately summarizes benefits and coverage available under the plan or coverage within the United States.

(3) *Appearance.* (i) A group health plan and a health insurance issuer must provide an SBC in the form, and in accordance with the instructions for completing the SBC, that are specified by the Secretary in guidance. The SBC must be presented in a uniform format, use terminology understandable by the average plan enrollee, not exceed four double-sided pages in length, and not include print smaller than 12-point font.

(ii) A group health plan that utilizes two or more benefit packages (such as major medical coverage and a health flexible spending arrangement) may synthesize the information into a single SBC, or provide multiple SBCs.

(4) *Form* – (i) An SBC provided by an issuer offering group health insurance coverage to a plan (or its sponsor), may be provided in paper form. Alternatively, the SBC may be provided electronically (such as by email or an Internet posting) if the following three conditions are satisfied –

(A) The format is readily accessible by the plan (or its sponsor);

(B) The SBC is provided in paper form free of charge upon request; and

(C) If the electronic form is an Internet posting, the issuer timely advises the plan (or its sponsor) in paper form or email that the documents are available on the Internet and provides the Internet address.

(ii) An SBC provided by a group health plan or health insurance issuer to a partic-

ipant or beneficiary may be provided in paper form. Alternatively, the SBC may be provided electronically (such as by email or an Internet posting) if the requirements of this paragraph (a)(4)(ii) are met.

(A) With respect to participants and beneficiaries covered under the plan, the SBC may be provided electronically as described in this paragraph (a)(4)(ii)(A). However, in all cases, the plan must provide the SBC in paper form if paper form is requested.

(1) In accordance with the Department of Labor's disclosure regulations at 29 CFR 2520.104b-1;

(2) In connection with online enrollment or online renewal of coverage under the plan; or

(3) In response to an online request made by a participant or beneficiary for the SBC.

(B) With respect to participants and beneficiaries who are eligible but not enrolled for coverage, the SBC may be provided electronically if:

(1) The format is readily accessible;

(2) The SBC is provided in paper form free of charge upon request; and

(3) In a case in which the electronic form is an Internet posting, the plan or issuer timely notifies the individual in paper form (such as a postcard) or email that the documents are available on the Internet, provides the Internet address, and notifies the individual that the documents are available in paper form upon request.

(5) *Language.* A group health plan or health insurance issuer must provide the SBC in a culturally and linguistically appropriate manner. For purposes of this paragraph (a)(5), a plan or issuer is considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards of 29 CFR 2590.715-2719(e) are met as applied to the SBC.

(b) *Notice of modification.* If a group health plan, or health insurance issuer offering group health insurance coverage, makes any material modification (as defined under section 102 of ERISA) in any of the terms of the plan or coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance

of coverage, the plan or issuer must provide notice of the modification to enrollees not later than 60 days prior to the date on which the modification will become effective. The notice of modification must be provided in a form that is consistent with the rules of paragraph (a)(4) of this section.

(c) *Uniform glossary* – (1) *In general.* A group health plan, and a health insurance issuer offering group health insurance coverage, must make available to participants and beneficiaries the uniform glossary described in paragraph (c)(2) of this section in accordance with the appearance and form and manner requirements of paragraphs (c)(3) and (c)(4) of this section.

(2) *Health-coverage-related terms and medical terms.* The uniform glossary must provide uniform definitions, specified by the Secretary in guidance, of the following health-coverage-related terms and medical terms:

(i) Allowed amount, appeal, balance billing, co-insurance, complications of pregnancy, co-payment, deductible, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, in-network co-insurance, in-network co-payment, medically necessary, network, non-preferred provider, out-of-network co-insurance, out-of-network co-payment, out-of-pocket limit, physician services, plan, preauthorization, preferred provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, reconstructive surgery, rehabilitation services, skilled nursing care, specialist, usual customary and reasonable (UCR), and urgent care; and

(ii) Such other terms as the Secretary determines are important to define so that individuals and employers may compare and understand the terms of coverage and medical benefits (including any exceptions to those benefits), as specified in guidance.

(3) *Appearance.* A group health plan, and a health insurance issuer, must provide the uniform glossary with the appear-

ance specified by the Secretary in guidance to ensure the uniform glossary is presented in a uniform format and uses terminology understandable by the average plan enrollee.

(4) *Form and manner.* A plan or issuer must make the uniform glossary described in this paragraph (c) available upon request, in either paper or electronic form (as requested), within seven business days after receipt of the request.

(d) *Preemption.* State laws that require a health insurance issuer to provide an

SBC that supplies less information than required under paragraph (a) of this section are preempted.

(e) *Failure to provide.* A group health plan that willfully fails to provide information required under this section to a participant or beneficiary is subject to a fine of not more than \$1,000 for each such failure. A failure with respect to each participant or beneficiary constitutes a separate offense for purposes of this paragraph (e). The IRS will enforce this section us-

ing a process and procedure consistent with section 4980D of the Code.

(f) *Applicability.* The requirements of this section do not apply to a group health plan benefit package that provides Medicare Advantage benefits pursuant to or 42 USC Chapter 7, Subchapter XVIII, Part C.

(Filed by the Office of the Federal Register on December 22, 2014, 4:15 p.m., and published in the issue of the Federal Register on December 30, 2014, 79 F.R. 78578)

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.

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