

INTERNAL REVENUE BULLETIN



HIGHLIGHTS OF THIS ISSUE

Bulletin No. 2015-31
August 3, 2015

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

INCOME TAX

Rev. Rul. 2015-16, page 130.

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

Notice 2015-51, page 133.

This notice modifies Notice 2015-4 by providing a revised effective date of the performance and quality standards that certain small wind energy property must meet to qualify for the energy credit under section 48 of the Internal Revenue Code.

EMPLOYEE PLANS

REG-102648-15, page 134.

These proposed regulations relate to multiemployer pension plans that are projected to have insufficient funds, at some point in the future, to pay the full benefits to which individuals will be entitled under the plans (referred to as plans in "critical and declining status"). The Multiemployer Pension Reform Act of 2014 ("MPRA") amended the Internal Revenue Code to incorporate suspension of benefits provisions that permit these multiemployer plans to reduce pension benefits payable to participants and beneficiaries if certain conditions are satisfied. MPRA requires the Secretary of the Treasury, in consultation with the Pension Benefit Guaranty Corporation and the Secretary of Labor, to approve or deny applications by these plans to reduce benefits. As required by MPRA, these proposed regulations, together with temporary regulations being published at the same time, provide guidance implementing these

statutory provisions. These proposed regulations would affect active, retired, and deferred vested participants and beneficiaries of multiemployer plans that are in critical and declining status as well as employers contributing to, and sponsors and administrators of, those plans.

T.D. 9723, page 84.

These temporary regulations relate to multiemployer pension plans that are projected to have insufficient funds, at some point in the future, to pay the full benefits to which individuals will be entitled under the plans (referred to as plans in "critical and declining status"). The Multiemployer Pension Reform Act of 2014 ("MPRA") amended the Internal Revenue Code to incorporate suspension of benefits provisions that permit these multiemployer plans to reduce pension benefits payable to participants and beneficiaries if certain conditions are satisfied. MPRA requires the Secretary of the Treasury, in consultation with the Pension Benefit Guaranty Corporation and the Secretary of Labor, to approve or deny applications by these plans to reduce benefits. As required by MPRA, these temporary regulations, together with proposed regulations being published at the same time, provide guidance implementing these statutory provisions. These temporary regulations affect active, retired, and deferred vested participants and beneficiaries of multiemployer plans that are in critical and declining status as well as employers contributing to, and sponsors and administrators of, those plans.

(Continued on the next page)

T.D. 9726, page 98.

This rulemaking finalizes three separate proposed regulations issued under section 2713 of the Public Health Service Act (PHS Act), incorporated into section 9815 of the Internal Revenue Code. They finalize rules proposed in: July 2010 related to the coverage of preventive services (also published as a temporary rule as part of an interim final regulation), August 2014 related to the alternative process that an eligible organization may use to provide notice of a religious objection to the coverage of contraceptive services (also published as a temporary rule as part of an interim final regulation), and August 2014 that proposed changes to the definition of eligible organization. These final rules concern the coverage of recommended preventive services that were not previously finalized. They define who qualifies as an eligible organization and explain how an eligible organization can provide notice of a religious objection to providing coverage and include details concerning the self-certification process. The final rules also define what is a closely held for-profit entity for purposes of the accommodation in connection with the coverage of contraceptive services.

EXCISE TAX**T.D. 9726, page 98.**

This rulemaking finalizes three separate proposed regulations issued under section 2713 of the Public Health Service Act (PHS Act), incorporated into section 9815 of the Internal Revenue Code. They finalize rules proposed in: July 2010 related to the coverage of preventive services (also published as a temporary rule as part of an interim final regulation), August 2014 related to the alternative process that an eligible organization may use to provide notice of a religious objection to the coverage of contraceptive services (also published as a temporary rule as part of an interim final regulation), and August 2014 that proposed changes to the definition of eligible organization. These final rules concern the coverage of recommended preventive services that were not previously finalized. They define who qualifies as an eligible organization and explain how an eligible organization can provide notice of a religious objection to providing coverage and include details concerning the self-certification process. The final rules also define what is a closely held for-profit entity for purposes of the accommodation in connection with the coverage of contraceptive services.

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

§ 1.432(e)(9)-1T: Benefit suspensions for multiemployer plans in critical and declining status (temporary).

T.D. 9723

DEPARTMENT OF THE TREASURY Internal Revenue Service 26 CFR Parts 1 and 602

Suspension of Benefits under the Multiemployer Pension Reform Act of 2014

AGENCY: Internal Revenue Service (IRS),
Treasury.

ACTION: Temporary regulations.

SUMMARY: This document contains temporary regulations relating to multiemployer pension plans that are projected to have insufficient funds, at some point in the future, to pay the full benefits to which individuals will be entitled under the plans (referred to as plans in “critical and declining status”). The Multiemployer Pension Reform Act of 2014 (“MPRA”) amended the Internal Revenue Code to incorporate suspension of benefits provisions that permit these multiemployer plans to reduce pension benefits payable to participants and beneficiaries if certain conditions are satisfied. MPRA requires the Secretary of the Treasury, in consultation with the Pension Benefit Guaranty Corporation and the Secretary of Labor, to approve or deny applications by these plans to reduce benefits. As required by MPRA, these temporary regulations, together with proposed regulations being published at the same time, provide guidance implementing these statutory provisions. These temporary regulations affect active, retired, and deferred vested participants and beneficiaries of multiemployer plans that are in critical and declining status as well as employers contributing to, and sponsors and administrators of, those plans. The text of these temporary regulations also serves, in part,

as the text of the proposed regulations (REG-102648-15) set forth in the notice of proposed rulemaking on this subject in the Proposed Rules section of this issue of the **Federal Register**.

DATES: Effective Date: These regulations are effective on June 19, 2015.

Applicability Date: For date of applicability, see § 1.432(e)(9)-1T(j).

FOR FURTHER INFORMATION CONTACT: The Department of the Treasury MPRA guidance information line at (202) 622-1559 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

These temporary regulations are being issued without prior notice and public procedure pursuant to the Administrative Procedure Act (5 U.S.C. 553). For this reason, the collection of information contained in these regulations has been reviewed and, pending receipt and evaluation of public comments, approved by the Office of Management and Budget under control number 1545-2260.

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 control number.

For further information concerning this collection of information, and where to submit comments on the collection of information and the accuracy of the estimated burden, and suggestions for reducing this burden, please refer to the preamble to the cross-referenced notice of proposed rulemaking on this subject in the Proposed Rules section in this issue of the **Federal Register**.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Background

Overview

Section 432(e)(9)¹ of the Internal Revenue Code (Code) permits the plan sponsor of a multiemployer plan that is projected to have insufficient funds, at some point in the future, to pay the full benefits to which individuals will be entitled under the plan (referred to as a plan in “critical and declining status”) to reduce the pension benefits payable to participants and beneficiaries under the plan if certain conditions are satisfied (referred to as a “suspension of benefits”). MPRA requires the Secretary of the Treasury, in consultation with the Pension Benefit Guaranty Corporation and the Secretary of Labor (generally referred to in this preamble as the Treasury Department, PBGC, and Labor Department, respectively), to issue appropriate guidance to implement the provisions of section 432(e)(9). This document contains temporary regulations under section 432(e)(9) that, together with proposed regulations that are being published elsewhere in this issue of the **Federal Register** and a revenue procedure being published in the Internal Revenue Bulletin, Rev. Proc. 2015-34, implement section 432(e)(9) as required by the statute. The Treasury Department consulted with the PBGC and the Labor Department on these temporary regulations.

The temporary regulations in this document, which are applicable immediately, provide sufficient guidance to enable a plan sponsor that wishes to apply for approval of a suspension of benefits to prepare and submit such an application, and to enable the Department of the Treasury to begin the processing of such an application. The temporary regulations provide general guidance regarding section 432(e)(9), including guidance regarding the meaning of the term “suspension of benefits,” the general conditions for a suspension of benefits, and the implementation of a suspension after a participant

¹Section 432(e)(9) was added to the Internal Revenue Code by the Pension Protection Act of 2006, Public Law 109-280 (120 Stat. 780 (2006)) (PPA '06) and amended by the Multiemployer Pension Reform Act of 2014, Division O of the Consolidated and Further Continuing Appropriations Act, 2015, Public Law No. 113-235 (128 Stat. 2130 (2014)) (MPRA).

vote. The notice of proposed rulemaking, published elsewhere in this issue of the **Federal Register**, includes the proposed regulations and requests comments on the provisions of the proposed regulations as well as these temporary regulations. The provisions of the temporary regulations and proposed regulations are expected to be integrated and issued as a single set of final regulations with any changes that are made following consideration of the comments.

The proposed regulations, which are not applicable immediately, contain additional provisions with respect to which the Department of the Treasury intends to consider public comments before finalizing a decision to approve an application for suspension of benefits. The proposed regulations also provide additional guidance regarding section 432(e)(9), including guidance relating to the standards that will be applied in reviewing an application for suspension of benefits and the statutory limitations on a suspension of benefits.

The regulations implementing the statutory suspension of benefits provisions have been divided, as described, into temporary regulations and proposed regulations in order to balance the interest in considering public comments on rules before they apply with the evident statutory intent, reflected in MPRA, to implement the statutory provisions without undue delay. Although the Department of the Treasury is issuing proposed and temporary regulations under section 432(e)(9), it is expected that no application proposing a benefit suspension will be approved prior to the issuance of final regulations. If a plan sponsor chooses to submit an application for approval of a proposed benefit suspension in accordance with the proposed and temporary regulations before the issuance of final regulations, then the plan sponsor may need to revise the proposed suspension (and potentially the related notices to plan participants) or supplement the application to take into account any differences in the requirements relating to suspensions of benefits that might be included in the final regulations.

Rev. Proc. 2015–34 prescribes the specifics of the application process for approval of a proposed benefit suspension. The revenue procedure also provides a model notice that a plan sponsor proposing a benefit suspension may use to satisfy the statutory notice requirement.

Statutory Background

Code section 412 contains minimum funding rules that generally apply to pension plans. Code section 431, added by section 211 of PPA '06, sets forth the funding rules that apply specifically to multiemployer defined benefit plans. Code section 432, added by section 212 of PPA '06, sets forth additional rules that apply to certain multiemployer plans in endangered or critical status, and permits plans in critical status to be amended to reduce certain otherwise protected benefits (referred to as adjustable benefits). Section 202 of PPA '06 amended section 305 of the Employee Retirement Income Security Act of 1974, Public Law 93–406 (88 Stat. 829 (1974)), as amended (ERISA), to prescribe parallel rules. PPA '06 provided that Code section 432 and ERISA section 305 would sunset for plan years beginning after December 31, 2014. However, section 101 of MPRA made them permanent, with certain modifications.

Section 201 of MPRA amended Code section 432 to add a new status, called critical and declining status, for multiemployer defined benefit plans. Section 432(b)(6) provides that a plan in critical status is treated as being in critical and declining status if the plan satisfies the criteria for critical status and in addition is projected to become insolvent within the meaning of section 418E during the current plan year or any of the 14 succeeding plan years (or 19 succeeding plan years if the plan has a ratio of inactive participants to active participants that exceeds two to one or if the funded percentage of the plan is less than 80 percent). Section 201 of MPRA also amended Code section 432(e)(9) to prescribe benefit suspension rules for plans in critical and declining status.²

MPRA was enacted on December 16, 2014. Section 201(b)(7) of MPRA provides that, not later than 180 days after the date of enactment, the Treasury Department, in consultation with the PBGC and the Labor Department, is required to publish appropriate guidance to implement section 432(e)(9). Section 201(c) of MPRA provides that the amendments made by section 201 will take effect on the date of enactment.

On February 18, 2015, the Department of the Treasury issued a Request for Information on Suspensions of Benefits under the Multiemployer Pension Reform Act of 2014 in the **Federal Register** (80 FR 8578). The Request for Information included questions focusing on certain matters to be addressed in guidance implementing section 432(e)(9) and indicated that multiemployer plans should not submit applications for suspensions of benefits prior to a date specified in such future guidance. These temporary regulations, and the proposed regulations published elsewhere in this issue of the **Federal Register**, reflect consideration of comments received in response to the Request for Information.

Definition of suspension of benefits and general rules under section 432(e)(9)(A) and 432(e)(9)(B)(i) through (iv)

Section 201 of MPRA prescribes benefit suspension rules for multiemployer defined benefit plans in critical and declining status. Section 432(e)(9)(A) provides that notwithstanding section 411(d)(6) and subject to section 432(e)(9)(B) through (I), the plan sponsor of a plan in critical and declining status may, by plan amendment, suspend benefits that the sponsor deems appropriate.

The statute defines suspension of benefits as the temporary or permanent reduction of any current or future payment obligation of the plan to any participant or beneficiary under the plan, whether or not in pay status at the time of the suspension of benefits. Any suspension will remain in effect until the earlier of when the plan sponsor provides benefit improvements in accordance with section 432(e)(9)(E) or

²Section 201 of MPRA makes parallel amendments to section 305 of ERISA and the Department of the Treasury has interpretive jurisdiction over the subject matter of these provisions under ERISA as well as the Code. See also section 101 of Reorganization Plan No. 4 of 1978 (43 FR 47713).

when the suspension expires by its own terms. Thus, if a suspension does not expire by its own terms, it continues indefinitely.

Under the statute, a plan will not be liable for any benefit payments not made as a result of a suspension of benefits. All references to suspensions of benefits, increases in benefits, or resumptions of suspended benefits with respect to participants will also apply with respect to benefits of beneficiaries or alternative payees³ of participants. See section 432(e)(9)(B)(iv).

Retiree representative

In the case of a plan with 10,000 or more participants, section 432(e)(9)(B)(v) requires the plan sponsor to select a plan participant in pay status to act as a retiree representative. The retiree representative is required to advocate for the interests of the retired and deferred vested participants and beneficiaries of the plan throughout the suspension approval process. The plan must provide for the retiree representative's reasonable expenses, including reasonable legal and actuarial support, commensurate with the plan's size and funded status.

Conditions for suspensions

Section 432(e)(9)(C) sets forth conditions that must be satisfied before a plan sponsor of a plan in critical and declining status for a plan year may suspend benefits. Under one of the conditions, the plan actuary must certify, taking into account the proposed suspension of benefits (and, if applicable, a proposed partition of the plan under section 4233 of ERISA (partition)), that the plan is projected to avoid insolvency within the meaning of section 418E, assuming the suspension of benefits continues until it expires by its own terms

or if no such expiration date is set, indefinitely.

Another condition requires a plan sponsor to determine, in a written record to be maintained throughout the period of the benefit suspension, that although all reasonable measures to avoid insolvency have been taken (and continue to be taken during the period of the benefit suspension), the plan is still projected to become insolvent unless benefits are suspended. In making this determination, the plan sponsor may take into account factors including a specified list of 10 statutory factors.⁴ See section 432(e)(9)(C)(ii).

Limitations on suspensions

Section 432(e)(9)(D) contains limitations on the benefits that may be suspended, some of which apply to plan participants and beneficiaries on an individual basis and some of which apply on an aggregate basis. Under the statute, an individual's monthly benefit may not be reduced below 110 percent of the monthly benefit that is guaranteed by the PBGC under section 4022A of ERISA on the date of the suspension. In addition, no benefits based on disability (as defined under the plan) may be suspended.

In the case of a participant or beneficiary who has attained age 75 as of the effective date of a suspension, section 432(e)(9)(D)(ii) provides that the suspension may not exceed the applicable percentage of the individual's maximum suspendable benefit (the age-based limitation). The maximum suspendable benefit is the maximum amount of an individual's benefit that would be suspended without regard to the age-based limitation. The applicable percentage is a percentage that is calculated by dividing (i) the number of months during the period that begins with the month after the month in which the suspension is effective and ends with the month in which that

participant or beneficiary attains the age of 80 by (ii) 60 months.

Section 432(e)(9)(D) also requires the aggregate benefit suspensions (considered, if applicable, in connection with a partition) to be reasonably estimated to achieve, but not materially exceed, the level that is needed to avoid insolvency.

Under the statute, any suspension of benefits must be equitably distributed across the participant and beneficiary population, taking into account factors that may include one or more of a list of 11 statutory factors.⁵ Finally, with regard to a suspension of benefits that is made in combination with a partition, section 432(e)(9)(D)(v) provides that the suspension may not occur before the effective date of the partition.

Benefit improvements

Section 432(e)(9)(E) sets forth rules relating to benefit improvements made while a suspension of benefits is in effect. Under this provision, a benefit improvement is defined as a resumption of suspended benefits, an increase in benefits, an increase in the rate at which benefits accrue, or an increase in the rate at which benefits become nonforfeitable under the plan.

The statute also provides that, while a suspension of benefits is in effect, a plan sponsor generally has discretion to provide benefit improvements. However, a sponsor may not increase plan liabilities by reason of any benefit improvement for any participant or beneficiary who is not in pay status (in other words, those who are not yet receiving benefits, such as active employees or deferred vested employees) unless (1) this benefit improvement is accompanied by an equitable distribution of benefit improvements for those who have begun to receive benefits (typically, retirees), and (2) the plan actuary certifies that, after taking those benefit

³The Department of the Treasury and the IRS understand this provision to refer to alternate payees.

⁴These 10 factors are current and past contribution levels; levels of benefit accruals (including prior reductions in the rate of benefit accruals); prior adjustable benefit reductions and suspensions of benefits; the impact on plan solvency of the subsidies and ancillary benefits available to active participants; compensation levels of active participants relative to employees in the participants' industry generally; competitive and other economic factors facing contributing employers; the impact of benefit and contribution levels on retaining active participants and bargaining groups under the plan; the impact of past and anticipated contribution increases under the plan on employer attrition and retention levels; and measures undertaken by the plan sponsor to retain or attract contributing employers.

⁵These 11 factors are age and life expectancy; length of time in pay status; amount of benefit; type of benefit; extent of a subsidized benefit; extent of post-retirement benefit increases; history of benefit increases and reductions; years to retirement for active employees; any discrepancies between active and retiree benefits; extent to which participants are reasonably likely to withdraw support for the plan, resulting in accelerated employer withdrawal; and the extent to which the benefits are attributed to service with an employer that failed to pay its withdrawal liability.

improvements into account, the plan is projected to avoid insolvency indefinitely.⁶ Whether an individual is in pay status for this purpose is generally based on whether the individual's benefits began before the first day of the plan year for which the benefit improvement took effect.

Notice of proposed suspension

A plan sponsor may not suspend benefits unless notice is provided in accordance with section 432(e)(9)(F). Under this section, concurrently with an application to suspend benefits under section 432(e)(9)(G), the plan sponsor must give notice to plan participants and beneficiaries who may be contacted by reasonable efforts, each employer that has an obligation to contribute (within the meaning of section 4212(a) of ERISA) under the plan, and each employee organization that represents plan participants employed by those employers for purposes of collective bargaining. The notice must contain sufficient information to enable individuals to understand the effect of any suspension of benefits, including an individualized estimate, on an annual or monthly basis, of the effect on each participant or beneficiary. The notice must also contain certain other specified information.⁷ Notice must be provided in a form and manner prescribed in agency guidance, written in a manner so as to be understood by the average plan participant, and provided in written, electronic, or other appropriate form to the extent it is reasonably accessible to those to whom notice must be furnished.

Any notice provided under section 432(e)(9)(F)(i) will satisfy the requirement for notice of a significant reduction in benefits described in section 4980F. See section 432(e)(9)(F)(iv).

Suspension applications

Section 432(e)(9)(G) describes the process for approval or rejection of a plan sponsor's application for a suspension of benefits. Under the statute, the Treasury Department, in consultation with the PBGC and the Labor Department, must approve an application upon finding that the plan is eligible for the suspensions and has satisfied the criteria of sections 432(e)(9)(C), (D), (E), and (F) (each described earlier). In evaluating whether a plan sponsor has met the criteria in section 432(e)(9)(C)(ii) (a plan sponsor's determination that, although all reasonable measures have been taken, the plan will become insolvent if benefits are not suspended), the plan sponsor's consideration of factors under that clause must be reviewed. The statute also requires that the plan sponsor's determinations in an application for a suspension of benefits be accepted unless they are clearly erroneous.

Section 432(e)(9)(G) also requires an application for a suspension of benefits to be published on the web site of the Department of the Treasury and requires the Treasury Department to publish a **Federal Register** notice within 30 days of receiving a suspension application, soliciting comments from contributing employers, employee organizations, and participants and beneficiaries of the plan for which a suspension application was made, as well as other interested parties.

Within 225 days after an application for a suspension of benefits is submitted, the statute requires the Treasury Department, in consultation with the PBGC and the Labor Department, to approve or deny the application. If the plan sponsor is not notified that it has failed to satisfy one or more applicable criteria within that 225-day period, the application is deemed approved. If the application is denied, a no-

tice to the plan sponsor must detail the specific reasons for the rejection, including reference to the specific requirement not satisfied. Approval or denial of an application is treated as final agency action for purposes of 5 U.S.C. 704 (that is, the approval or denial is treated as final agency action for purposes of the Administrative Procedure Act, Public Law 79-404, 60 Stat. 237, as amended (APA)).

Participant vote on proposed benefit reduction

If a suspension application is approved, it then goes to a vote of plan participants and beneficiaries. See section 432(e)(9)(H). The vote will be administered by the Treasury Department, in consultation with the PBGC and the Labor Department, within 30 days after approval of the suspension application. The plan sponsor is required to provide a ballot for a vote (subject to approval by the Treasury Department, in consultation with the PBGC and the Labor Department). The statute specifies information that the ballot must include.⁸ If a majority of plan participants and beneficiaries do not vote to reject the suspension, the statute requires the Treasury Department to issue a final authorization to suspend benefits within seven days after the vote.

If a majority of plan participants and beneficiaries vote to reject the suspension, the statute requires the Treasury Department, in consultation with the PBGC and the Labor Department, to determine whether the plan is a systemically important plan. A systemically important plan is a plan for which the PBGC projects the present value of projected financial assistance payments to exceed \$1.0 billion, as indexed, if suspensions are not implemented.

⁶Avoidance of insolvency is determined by reference to section 418E under which a plan is insolvent if it is unable to pay scheduled benefits for a year. Pursuant to section 432(e)(9)(E)(iv), this restriction does not apply to certain benefit improvements if the Treasury Department determines either that the benefit improvements are reasonable and provide for only de minimis increases in plan liabilities or that the benefit improvements are required as a condition of qualification or to comply with other applicable law.

⁷The specified information includes a description of the factors considered by the plan sponsor in designing the benefit suspension; a statement that the application for suspension of benefits will be available on the web site of the Department of the Treasury and that comments on the application will be accepted; information on the rights and remedies of plan participants and beneficiaries; if applicable, a statement about the appointment of a retiree representative, the date of appointment of the retiree representative, identifying information about the retiree representative (including whether the representative is a plan trustee) and how to contact the representative; and information on how to contact the Department of the Treasury for more information and assistance where appropriate.

⁸This information includes a statement from the plan sponsor in support of the suspension; a statement in opposition to the suspension compiled from comments received in response to the **Federal Register** notice issued by Treasury within 30 days of receiving the suspension application; a statement that the suspension has been approved by the Secretary of the Treasury, in consultation with the PBGC and the Secretary of Labor; a statement that the plan sponsor has determined that the plan will become insolvent unless the suspension takes effect; a statement that insolvency of the plan could result in benefits lower than benefits paid under the suspension; and a statement that insolvency of the PBGC would result in benefits lower than benefits otherwise paid in the case of plan insolvency.

If a majority of plan participants and beneficiaries vote to reject the suspension and the plan is not a systemically important plan, a final authorization to suspend benefits will not be issued. In such a case, the statute provides that the plan sponsor may submit a new application for approval of a suspension of benefits to the Treasury Department.

Within 30 days after a plan is determined to be a systemically important plan, the Participant and Plan Sponsor Advocate selected under ERISA may submit recommendations to the Treasury Department with respect to the suspension that was rejected by the vote or recommendations for any revisions to that suspension. Notwithstanding the vote rejecting the suspension, the statute requires the Treasury Department, in consultation with the PBGC and the Labor Department, to permit the plan sponsor to implement either the proposed benefit suspension or a modification by the Treasury Department, in consultation with the PBGC and the Labor Department, of that suspension. The Treasury Department must complete this requirement within 90 days after the results of a vote rejecting a suspension for a systemically important plan are certified, and a modification of the suspension by the Treasury Department is only permitted if the plan is still projected to avoid insolvency under the modification.

If the Treasury Department is required to permit the suspension or a modified suspension to go into effect in the case of a systemically important plan with respect to which there has been a vote rejecting the suspension, the statute requires the Treasury Department to issue the final authorization to suspend at a time sufficient to allow the suspension to be implemented by the end of the 90-day period following certification of the results of that vote.

Judicial Review

Section 432(e)(9)(I)(i) allows a plan sponsor to challenge a denial of an application for suspension only after the application is denied. Under the statute, an action challenging the approval of a suspension may be brought only following the issuance of a final authorization to suspend. The statute also provides that a court will review an action challenging

approval of a suspension of benefits in accordance with 5 U.S.C. 706 (that is, the standard of review applicable for purposes of the APA) and will not grant a temporary injunction with respect to a suspension unless it finds a clear and convincing likelihood that the plaintiff will prevail on the merits. Under section 432(e)(9)(I)(iii), participants and beneficiaries affected by a suspension “shall not have a cause of action under this title.” An action challenging either the approval of a suspension of benefits or the denial of an application for a suspension of benefits may not be brought more than one year after the earliest date on which the plaintiff acquired or should have acquired actual knowledge of the existence of the cause of action. See section 432(e)(9)(I)(iv).

Explanation of Provisions

I. Overview

These temporary regulations provide guidance on certain requirements under section 432(e)(9) regarding suspension of benefits for multiemployer defined benefit plans in critical and declining status. The temporary regulations do not address certain other requirements that are addressed in the text of the proposed regulations (REG-102648-15) set forth in the notice of proposed rulemaking on this subject in the Proposed Rules section of this issue of the **Federal Register**. The provisions of these temporary regulations are cross referenced in the proposed regulations so that comments on these provisions may be included with comments on the proposed regulations. In addition to the proposed and temporary regulations, the procedural requirements for submitting an application to suspend benefits, as well as a model notice, are set forth in Rev. Proc. 2015-34.

II. General rules on suspension of benefits

These temporary regulations provide that, subject to section 432(e)(9)(B) through (I), the plan sponsor of a multiemployer plan that is in critical and declining status within the meaning of section 432(b)(6) for a plan year may, by plan amendment, implement a suspension of benefits that the plan sponsor deems ap-

propriate. Such a suspension is permitted notwithstanding the generally applicable anti-cutback provisions of section 411(d)(6). The plan amendment implementing a suspension of benefits must be adopted in a plan year in which the plan is in critical and declining status.

Under the regulations, once a plan is amended to suspend benefits, a plan may pay or continue to pay a reduced level of benefits pursuant to a suspension only if the terms of the plan are consistent with the requirements of section 432(e)(9) and the regulations.

III. Definitions

The temporary regulations include definitions for the terms pay status and plan sponsor. A person is in pay status under a multiemployer plan if, as described in section 432(j)(6), at any time during the current plan year, the person is a participant, beneficiary, or alternate payee under the plan and is paid an early, late, normal, or disability retirement benefit under the plan (or a death benefit under the plan related to a retirement benefit).

The term plan sponsor means the association, committee, joint board of trustees, or other similar group of representatives of the parties that establishes or maintains the multiemployer plan. However, in the case of a plan described in section 404(c), or a continuation of such a plan, the term plan sponsor means the association of employers that is the employer settlor of the plan.

IV. Definition of suspension of benefits and related rules

The temporary regulations provide that the term suspension of benefits means the temporary or permanent reduction, pursuant to the terms of the plan, of any current or future payment obligation of the plan with respect to any participant under the plan. A suspension of benefits can apply with respect to a participant of the plan regardless of whether the participant, beneficiary, or alternate payee has commenced receiving benefits before the effective date of the suspension of benefits. If a plan pays a reduced level of benefits pursuant to a suspension of benefits that complies with the requirements of section

432(e)(9), then the plan is not liable for any benefits not paid as a result of the suspension.

A suspension of benefits may be of indefinite duration or may expire as of a certain date. Under the regulations, if the suspension of benefits has an expiration date, that date must be specified in the plan amendment implementing the suspension.

The temporary regulations provide that a plan sponsor may amend the plan to eliminate some or all of a suspension of benefits, provided that the amendment satisfies the requirements that apply to benefit improvements in the proposed rules under section 432(e)(9)(E).

The temporary regulations clarify that, except as otherwise specified, all references to suspensions of benefits, increases in benefits, or resumptions of suspended benefits with respect to participants also apply with respect to benefits of beneficiaries or alternate payees (as defined in section 414(p)(8)) of participants.

V. *Retiree representative*

A retiree representative must be selected for a plan with 10,000 or more participants. The temporary regulations implement this condition by requiring that a retiree representative be selected if 10,000 or more participants were reported on the most recently filed Form 5500, "Annual Return/Report of Employee Benefit Plan."⁹ The plan sponsor must select the retiree representative at least 60 days before the plan sponsor submits an application to suspend benefits. The retiree representative must be a plan participant who is in pay status and may or may not be a plan trustee.

The role of the retiree representative is to advocate for the interests of the retired and deferred vested participants and beneficiaries of the plan throughout the suspension approval process. However, in the discretion of the plan sponsor, the retiree representative may continue in this role throughout the period of the benefit suspension. This would enable the retiree representative to monitor compliance with

the ongoing requirements during the period of the suspension, such as the requirement that the plan sponsor make annual determinations that all reasonable measures to avoid insolvency have been taken and that a suspension is necessary to avoid insolvency as well as to monitor compliance with the rules relating to benefit improvements. The regulations refer to section 432(e)(9)(B)(v)(III) for rules relating to the fiduciary status of a retiree representative, but do not provide additional guidance with respect to this provision.

The plan must pay reasonable expenses incurred by the retiree representative, including reasonable legal and actuarial support, commensurate with the plan's size and funded status. Upon request, the plan sponsor must promptly provide the retiree representative with relevant information, such as plan documents and data, that is reasonably necessary to enable the retiree representative to perform the representative's role, described earlier under this paragraph V.

The temporary regulations permit a plan sponsor of a plan that has reported fewer than 10,000 participants to select a retiree representative in connection with an application for approval of a suspension of benefits in order to encourage such a plan sponsor to do so. If a retiree representative is selected for such a plan, the rules that apply to retiree representatives for plans with 10,000 or more participants (other than the rule concerning the size of the plan and the timing of the appointment) will apply.

VI. *Conditions for suspensions*

A plan sponsor of a plan in critical and declining status¹⁰ may suspend benefits only if the actuarial certification requirement in section 432(e)(9)(C)(i) and the plan-sponsor determinations requirements in section 432(e)(9)(C)(ii) are satisfied.

A. *Actuarial certification*

Under the temporary regulations, the actuarial certification requirement in section 432(e)(9)(C)(i) is satisfied if, taking

into account the proposed suspension of benefits (and, if applicable, a proposed partition of the plan), the plan's actuary certifies that the plan is projected to avoid insolvency within the meaning of section 418E, assuming the suspension of benefits continues until it expires by its own terms or if no such expiration date is set, indefinitely. The temporary regulations do not provide guidance on this topic. However, the proposed regulations provide rules for the comparable requirement that the suspension (in combination with a partition, if applicable) be reasonably estimated to avoid insolvency under section 432(e)(9)(D)(iv).

B. *Plan-sponsor determinations*

A plan may not suspend benefits unless the plan sponsor makes initial and annual determinations that the plan is projected to become insolvent unless benefits are suspended, although all reasonable measures to avoid insolvency have been taken and continue to be taken.

Under the temporary regulations, a plan satisfies the initial-plan-sponsor determinations requirement only if the plan sponsor determines that (1) all reasonable measures to avoid insolvency, within the meaning of section 418E, have been taken, and (2) the plan is projected to become insolvent within the meaning of section 418E unless the proposed suspension of benefits (or another suspension of benefits under section 432(e)(9)) is implemented for the plan.

In making its determination that all reasonable measures to avoid insolvency have been taken, the plan sponsor may take into account the non-exclusive list of factors set forth in section 432(e)(9)(C)(ii). In making the initial determination that the plan is projected to become insolvent without the proposed suspension of benefits (or another suspension under section 432(e)(9)), a plan sponsor may rely on the actuarial certification made pursuant to section 432(b)(3)(A)(i) that the plan is in critical and declining status for the plan year.

⁹On the Form 5500 for the 2014 plan year, this is the total number of participants as of the end of the plan year that is reported on Part II, Line 6f.

¹⁰In making the projections related to whether a plan is in critical and declining status, the plan actuary's projections are required to be based on reasonable actuarial assumptions. Rev. Proc. 2015-34 requires disclosure of a 10-year history of certain critical assumptions for this purpose as well as for purposes of the conditions for suspensions required by section 432(e)(9)(C).

The rules relating to the annual-plan-sponsor determinations are included in the proposed regulations.

VII. *Limitations on suspensions*

The proposed and temporary regulations reflect the individual and aggregate limitations on a suspension of benefits under section 432(e)(9)(D).¹¹ The temporary regulations provide that after applying the individual limitations, the overall size and distribution of the suspension is subject to the aggregate limitations.

The temporary regulations provide that the monthly benefit payable to a participant, beneficiary, or alternate payee may not be reduced below 110 percent of the monthly benefit that would be guaranteed by the PBGC under section 4022A of ERISA if the plan were to become insolvent as of the effective date of the suspension. The proposed regulations provide more detailed rules for applying this limitation.

The temporary regulations reflect the statutory prohibition in section 432(e)(9)(D)(iii) on applying a suspension of benefits to benefits based on disability (as defined under the plan). The proposed regulations include more detailed rules for applying this limitation.

The rules regarding the age-based limitation of section 432(e)(9)(D)(ii) and the aggregate limitations of section 432(e)(9)(D)(iv) and (vi) are set forth in the proposed regulations.

In any case in which a suspension of benefits with respect to a plan is made in combination with a partition of the plan, the suspension of benefits may not take effect prior to the effective date of the partition. This requirement will not be satisfied if the partition order under section 4233 of ERISA has not been provided to the Treasury Department by the last day of the 225-day review period described in section 432(e)(9)(G)(iii), after which deemed approval of the suspension would occur.

VIII. *Benefit improvements*

The rules regarding restrictions on benefit improvements are set forth in the proposed regulations.

IX. *Notice of proposed suspension*

The temporary regulations prescribe rules implementing the statutory notice requirements in section 432(e)(9)(F).

Specifically, the temporary regulations require the plan sponsor to provide notice of a proposed suspension to all plan participants, beneficiaries of deceased participants, and alternate payees (regardless of whether their benefits are proposed to be suspended) except those who cannot be contacted by reasonable efforts; each employer that has an obligation to contribute (within the meaning of section 4212(a) of ERISA) under the plan; and each employee organization which, for purposes of collective bargaining, represents plan participants employed by such an employer. The temporary regulations provide two examples illustrating what efforts constitute reasonable efforts to contact individuals for purposes of this notice requirement. These examples indicate that it is not sufficient to merely send notices to the individuals' last known mailing addresses and illustrate additional steps that may be used to satisfy these requirements if the plan sponsor becomes aware that some individuals did not receive notice.

The temporary regulations require the notice to contain the following in order to satisfy the requirement that the notice contain sufficient information to enable plan participants and beneficiaries to understand the effect of the suspension of benefits:

- An individualized estimate, on an annual or monthly basis, of the effect of the suspension on the participant or beneficiary. However, if it is not possible to provide an individualized estimate on an annual or monthly basis of the quantitative effect of the suspension on the participant or beneficiary, such as in the case of a suspension that affects the payment of any future cost-of-living adjustment, a narrative description of the effect of the suspension;
- A statement that the plan sponsor has determined that the plan will become insolvent unless the proposed suspension (and, if applicable, the proposed

partition) takes effect, and the year in which insolvency is projected to occur without a suspension of benefits (and, if applicable, a proposed partition);

- A statement that insolvency of the plan could result in benefits lower than benefits paid under the proposed suspension and a description of the projected benefit payments upon insolvency;
- A description of the proposed suspension and its effect, including a description of the different categories or groups affected by the suspension, how those categories or groups are defined, and the formula that is used to calculate the amount of the proposed suspension for individuals in each category or group;
- A description of the effect of the proposed suspension on the plan's projected insolvency;
- A description of whether the suspension will remain in effect indefinitely or will expire by its own terms; and
- A statement describing the right to vote on the suspension application.

The notice of proposed suspension may not include false or misleading information (or omit information so as to cause the information provided to be misleading). The notice is permitted to include information in addition to the required information that is listed under this paragraph IX., including information relating to an application for partition under section 4233 of ERISA, provided that it satisfies these requirements.

The notice of proposed suspension must be written in a manner that can be readily understood by the average plan participant. The temporary regulations provide that the Treasury Department will provide a model notice. The use of the model notice will satisfy the content requirement and the readability requirement with respect to the language provided in the model.

The temporary regulations provide that notice may be provided in writing or in electronic form to the extent that the electronic form is reasonably accessible to persons to whom the notice is required to be provided. Permissible electronic methods include those permitted under regulations of the Department of Labor at 29

¹¹The temporary regulations refer to section 432(e)(9)(D)(vii) for additional rules applicable to certain plans, but do not provide additional guidance with respect to this provision.

CFR 2520.104b-1(c) and those described at § 54.4980F-1, Q&A-13(c) of the Excise Tax Regulations.

Section 432(e)(9)(F) provides that the notice of proposed suspension must be given “concurrently” with the submission of an application to the Treasury Department, but does not specify a precise time-frame for satisfying this requirement. Interpreting “concurrently” as meaning either simultaneously or on the same day was rejected because it would require the difficult synchronization of the plan sponsor’s electronic submission of its application and its giving of notice in written and/or in electronic form. Because the temporary regulations require a plan sponsor to submit its application electronically but authorize it to give notice in writing, interpreting the term “concurrently” to allow a plan sponsor to give written notice a few days earlier than the electronic submission of the application will allow for the receipt of such written notices on or about the time that a plan sponsor submits its application. The temporary regulations thus permit a plan sponsor to give notice no earlier than four business days before the submission of its application.

The temporary regulations also anticipate that a plan sponsor is permitted to give written notice no later than four business days after the submission of its application. This period of time will enable the Department of the Treasury to make a preliminary “completeness check” of the application during the first two business days, and the plan sponsor two business days thereafter to give the required notices.¹² This approach will help participants by minimizing the risk of confusion and plan expense. For example, if a plan sponsor submits an incomplete application, compiles the additional information, and then finds the individualized estimates that the plan sponsor already gave to be inaccurate (or simply takes too long to compile the additional information), the plan sponsor would have to re-send the notices, increasing the likelihood that the notice would not be understood by the average plan participant as a result of receiving two different notices, each with a different individualized estimate. Although the temporary regulations allow

plan sponsors to give participants notice when or before the application is submitted, sponsors are encouraged to delay giving notice until after the Department of the Treasury provides notification that the application is complete. If additional individuals who are entitled to notice are located after the time notice is required to be delivered, the plan sponsor must give those newly located individuals notice as soon as practicable after they are located.

The temporary regulations further provide that a notice of proposed suspension satisfies the requirement for notice of a significant reduction in benefits described in section 4980F that would otherwise be required as a result of that suspension of benefits. To the extent that other reductions accompany a suspension of benefits, such as a reduction in the future accrual rate described in section 4980F for active participants or a reduction in adjustable benefits under section 432(e)(8), notice that satisfies the requirements (including the applicable timing requirements) of section 4980F or section 432(e)(8), as applicable, must be provided.

X. Approval or denial of an application for suspension of benefits

The temporary regulations provide that the plan sponsor of a plan in critical and declining status for a plan year that seeks to suspend benefits must submit an application for approval of the proposed suspension of benefits to the Treasury Department. The Treasury Department will approve, in consultation with the PBGC and the Labor Department, a complete application upon finding that the plan is eligible for the suspension and has satisfied the criteria of section 432(e)(9)(C), (D), (E), and (F). An application must be submitted electronically.

After receiving a submission, the plan sponsor will be notified within two business days whether the submission constitutes a complete application. If the submission is a complete application, the application will be treated as submitted on the date on which it was originally submitted to the Treasury Department. If a submission is incomplete, the notification will inform the plan sponsor of the infor-

mation that is needed to complete the submission and give the plan sponsor a reasonable opportunity to submit a complete application. In such a case, the complete application will be treated as submitted on the date on which the additional information needed to complete the application is submitted to the Treasury Department.

Additional guidance that may be necessary or appropriate with respect to applications, including procedures for submitting applications and the information required to be included in a complete application, may be published in the form of revenue procedures, notices, or other guidance published in the Internal Revenue Bulletin.

In the case of a plan sponsor that is not submitting an application for suspension in combination with an application to PBGC for a plan partition, the temporary regulations provide that the application for suspension generally will not be accepted unless the proposed effective date of the suspension is at least nine months after the date on which the application is submitted. This is to ensure adequate time to review the proposed suspension without a need to delay the effective date of the proposed suspension. A delayed effective date could require other changes to the design of the suspension. For example, if, as a result of a delayed effective date, the age-based limitation under section 432(e)(9)(D)(ii) applies to more participants than under the terms of the proposed suspension, then benefits of other participants may be subject to greater reductions in order to satisfy the limitation in section 432(e)(9)(D)(iv) that the suspension, in the aggregate, must be reasonably estimated to achieve, but not materially exceed, the level necessary to avoid insolvency. However, in appropriate circumstances, an earlier effective date may be permitted. Appropriate circumstances could include an application for a proposed suspension that is a modification of a previous submission that was withdrawn or denied.

In the case of an application for suspension in combination with an application for partition, the impact of a delayed effective date for the suspension would be larger benefits for retirees rather than a redesign of the suspension. Accordingly,

¹²The completeness check is described under paragraph X. in this preamble (“Approval or denial of an application for suspension of benefits”).

these temporary regulations do not apply the rule described in the preceding paragraph to such an application. See Part 4233 of the PBGC regulations for a coordinated application process that applies in the case of a plan sponsor that is submitting an application for suspension in combination with an application to PBGC for a plan partition under section 4233 of ERISA.

The temporary regulations provide that, no later than 30 days after receiving a complete application, the application will be published on the web site of the Department of the Treasury, and the Treasury Department will publish a notice in the **Federal Register** soliciting comments from contributing employers, employee organizations, and participants and beneficiaries of the plan for which an application was made, and other interested parties. The notice soliciting comments will generally request that comments be submitted no later than 45 days after publication of that notice in the **Federal Register**, but the comment period may be shorter in appropriate circumstances. Appropriate circumstances could include an application for a proposed suspension that is a modification of a previous submission that was withdrawn or denied. Comments received in response to this notice will be made publicly available.

Under the temporary regulations, a complete application will be deemed approved unless, within 225 days after the complete application is submitted, the Treasury Department notifies the plan sponsor that its application does not satisfy one or more of the requirements for approval. If the Treasury Department denies a plan sponsor's application, the notification of the denial will detail the specific reasons for the denial, including reference to the specific requirement or requirements not satisfied. If the Treasury Department approves a plan sponsor's application and believes that the plan is a systemically important plan, then the Treasury Department will notify the plan sponsor of that belief and that it will be required to provide individual participant data upon request. This data may be used in the event of a vote to reject the suspension in order to assist the Treasury Department in determining whether to permit a modification of the rejected suspension.

The temporary regulations provide that the Secretary of the Treasury may appoint a Special Master for purposes of section 432(e)(9). If a Special Master is appointed, the Special Master will be an employee of the Department of the Treasury, will coordinate the implementation of the regulations and the review of applications for the suspension of benefits and other appropriate documents, and will provide recommendations to the Secretary of the Treasury with respect to decisions required under these regulations.

Certain rules relating to the Treasury Department's review of an application under section 432(e)(9)(G) are included in the proposed regulations.

XI. Participant vote on proposed benefit reduction

The temporary regulations provide that if an application for suspension is approved by the Treasury Department, then the Treasury Department, in consultation with the PBGC and the Labor Department, will administer a vote of all plan participants and all beneficiaries of deceased participants (eligible voters). Any suspension of benefits will take effect only after the vote and after a final authorization to suspend benefits.

Under the temporary regulations, any ballot provided by the plan sponsor in connection with a vote on the suspension must be approved by the Treasury Department, in consultation with the PBGC and the Labor Department. The ballot must be written in a manner that can be readily understood by the average plan participant and may not include any false or misleading information. The information that is required to be included in the ballot is described in the proposed regulations.

The temporary regulations provide that unless a majority of all eligible voters vote to reject the suspension, it is permitted to go into effect. If a majority of all eligible voters vote to reject the suspension, the suspension is not permitted to go into effect, except that the suspension or a modified suspension will be permitted to go into effect if the plan is a systemically important plan as described later under this paragraph XI. A plan sponsor is permitted to submit a new suspension application to the Treasury Department for ap-

proval in any case in which a suspension is prohibited from taking effect as a result of a vote.

The temporary regulations set forth rules for systemically important plans. If a majority of all eligible voters vote to reject the suspension, the Treasury Department will consult with the PBGC and the Labor Department to determine if the plan is a systemically important plan. The Treasury Department is required to make this determination no later than 14 days after the results of the vote are certified. No later than 30 days after a determination that the plan is a systemically important plan, the Participant and Plan Sponsor Advocate selected under section 4004 of ERISA may submit recommendations to the Treasury Department with respect to the suspension or any revisions to the suspension.

If a plan is a systemically important plan for which a majority of all eligible voters vote to reject the suspension, then the Treasury Department is required to either permit the implementation of the suspension that was rejected by the vote or permit the implementation of a modification of that suspension. Under any such modification, the plan must be projected to avoid insolvency in accordance with section 432(e)(9)(D)(iv). No later than 60 days after the results of a vote to reject a suspension are certified, the Treasury Department will notify the plan sponsor that the suspension or modified suspension is permitted to be implemented.

The temporary regulations define a systemically important plan as a plan with respect to which the PBGC projects that the present value of financial assistance payments will exceed \$1.0 billion if the suspension is not implemented. For calendar years beginning after 2015, this dollar amount will be replaced by an amount equal to the product of the dollar amount and a fraction, the numerator of which is the contribution and benefit base (determined under section 230 of the Social Security Act) for the preceding calendar year and the denominator of which is the contribution and benefit base for calendar year 2014. If that amount is not a multiple of \$1.0 million, it will be rounded to the next lowest multiple of \$1.0 million.

The temporary regulations provide that, in any case in which a proposed

suspension (or a modification of a proposed suspension) is permitted to go into effect, the Treasury Department, in consultation with the PBGC and the Labor Department, will issue a final authorization to suspend with respect to the suspension. If a suspension is permitted to go into effect following a vote, the final authorization will be issued no later than seven days after the vote. If a suspension is permitted to go into effect following a determination that the plan is a systemically important plan, the final authorization will be issued at a time sufficient to allow the implementation of the suspension prior to the end of the 90-day period beginning on the date the results of the vote rejecting the suspension are certified. Under the temporary regulations, no later than 60 days after the certification, the Treasury Department will notify the plan sponsor that the suspension that was rejected by the vote or a modified suspension is permitted to be implemented.

The temporary regulations provide that, in any case in which a suspension of benefits with respect to a plan is made in combination with a partition of the plan under section 4233 of ERISA, the suspension of benefits is not permitted to take effect prior to the effective date of the partition.

Effective/Applicability Date

These regulations apply on and after June 17, 2015 and expire on June 15, 2018.

Availability of IRS Documents

For copies of recently issued revenue procedures, revenue rulings, notices and other guidance published in the Internal Revenue Bulletin, please visit the IRS Web site at <http://www.irs.gov> or contact the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

Special Analyses

Certain IRS regulations, including this one, are exempt from the requirements of Executive Order 12866, as supplemented and reaffirmed by Executive Order 13563. Therefore, a regulatory impact assessment is not required. It also has been determined that section 553(b) of the Admin-

istrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations. For the applicability of the Regulatory Flexibility Act (5 U.S.C. chapter 6) please refer to the Special Analyses section of the preamble to the cross-referenced notice of proposed rulemaking published in the Proposed Rules section in this issue of the Federal Register. Pursuant to section 7805(f) of the Code, these regulations have been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on their impact on small business.

Contact Information

For general questions regarding these regulations, please contact the Department of the Treasury at (202) 622-1559 (not a toll-free number). For information regarding a specific application for a suspension of benefits, please contact the Department of the Treasury at (202) 622-1534 (not a toll-free number).

* * * * *

Amendments to the Regulations

Accordingly, 26 CFR parts 1 and 602 are 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 1.432(e)(9)–1T is added to read as follows:

§ 1.432(e)(9)–1T Benefit suspensions for multiemployer plans in critical and declining status (temporary).

(a) *General rules on suspension of benefits*—(1) *General rule.* Subject to section 432(e)(9)(B) through (I) and paragraphs (b) through (h) of this section, the plan sponsor of a multiemployer plan that is in critical and declining status (within the meaning of section 432(b)(6)) for a plan year may, by plan amendment adopted in the plan year, implement a suspension of benefits that the plan sponsor deems appropriate. Such a suspension is permitted notwithstanding the anti-cutback provisions of section 411(d)(6).

(2) *Adoption of plan terms inconsistent with suspension requirements*—(i) *Gen-*

eral rule. A plan may implement (or continue to implement) a reduction of benefits pursuant to a suspension of benefits only if the terms of the plan are consistent with the requirements of section 432(e)(9) and this section.

(ii) *Changes in level of suspension.* [Reserved]

(3) *Organization of the regulation.* This paragraph (a) contains definitions and general rules relating to a suspension of benefits by a multiemployer plan under section 432(e)(9). Paragraph (b) of this section defines a suspension of benefits and describes the length of a suspension, the treatment of beneficiaries and alternate payees under this section, and the requirement to select a retiree representative. Paragraph (c) of this section prescribes certain rules for the actuarial certification and plan-sponsor determinations that must be made in order for a plan to suspend benefits. Paragraph (d) of this section describes certain limitations on suspensions of benefits. Paragraph (e) of this section is reserved for rules on benefit improvements under section 432(e)(9)(E). Paragraph (f) of this section describes the requirement to provide notice in connection with an application to suspend benefits. Paragraph (g) of this section describes certain requirements with respect to the approval or denial of an application for a suspension of benefits. Paragraph (h) of this section contains certain rules relating to the vote on an approved suspension, systemically important plans, and the issuance of a final authorization to suspend benefits. Paragraph (j) of this section provides the effective/applicability date of this section. Paragraph (k) provides the expiration date.

(4) *Definitions.* The following definitions apply for purposes of this section—

(i) *Pay status.* A person is in pay status under a multiemployer plan if, as described in section 432(j)(6), at any time during the current plan year, the person is a participant, beneficiary, or alternate payee under the plan and is paid an early, late, normal, or disability retirement benefit under the plan (or a death benefit under the plan related to a retirement benefit).

(ii) *Plan sponsor.* The term plan sponsor means the association, committee, joint board of trustees, or other similar

group of representatives of the parties that establishes or maintains the multiemployer plan. However, in the case of a plan described in section 404(c), or a continuation of such a plan, the term plan sponsor means the association of employers that is the employer settlor of the plan.

(iii) *Effective date of suspension of benefits.* [Reserved]

(b) *Definition of suspension of benefits and related rules—(1) In general—(i) Definition.* For purposes of this section, the term suspension of benefits means the temporary or permanent reduction, pursuant to the terms of the plan, of any current or future payment obligation of the plan with respect to any participant under the plan. A suspension of benefits may apply with respect to a participant of the plan regardless of whether the participant, beneficiary, or alternate payee commenced receiving benefits before the effective date of the suspension of benefits.

(ii) *Plan not liable for suspended benefits.* If a plan pays a reduced level of benefits pursuant to a suspension of benefits that complies with the requirements of section 432(e)(9) and this section, then the plan is not liable for any benefits not paid as a result of the suspension.

(2) *Length of suspension—(i) In general.* A suspension of benefits may be of indefinite duration or may expire as of a date that is specified in the plan amendment implementing the suspension.

(ii) *Effect of a benefit improvement.* A plan sponsor may amend the plan to eliminate some or all of a suspension of benefits, provided that the amendment satisfies the requirements that apply to a benefit improvement under section 432(e)(9)(E), in accordance with the rules of paragraph (e) of this section.

(3) *Treatment of beneficiaries and alternate payees.* Except as otherwise specified in this section, all references to suspensions of benefits, increases in benefits, or resumptions of suspended benefits with respect to participants also apply with respect to benefits of beneficiaries or alternate payees (as defined in section 414(p)(8)) of participants.

(4) *Retiree representative—(i) In general—(A) Requirement to select retiree representative.* The plan sponsor of a plan that intends to submit an application for a suspension of benefits and that has re-

ported a total of 10,000 or more participants as of the end of the plan year for the most recently filed Form 5500, “Annual Return/Report of Employee Benefit Plan,” must select a retiree representative. The plan sponsor must select the retiree representative at least 60 days before the date the plan sponsor submits an application to suspend benefits. The retiree representative must be a plan participant who is in pay status. The retiree representative may or may not be a plan trustee.

(B) *Role of retiree representative.* The role of the retiree representative is to advocate for the interests of the retired and deferred vested participants and beneficiaries of the plan throughout the suspension approval process. In the discretion of the plan sponsor, the retiree representative may continue in this role throughout the period of the benefit suspension.

(ii) *Reasonable expenses from plan.* The plan must pay reasonable expenses incurred by the retiree representative, including reasonable expenses for legal and actuarial support, commensurate with the plan’s size and funded status.

(iii) *Disclosure of information.* Upon request, the plan sponsor must promptly provide the retiree representative with relevant information, such as plan documents and data, that is reasonably necessary to enable the retiree representative to perform the role described in paragraph (b)(4)(i)(B) of this section.

(iv) *Special rules relating to fiduciary status.* See section 432(e)(9)(B)(v)(III) for rules relating to the fiduciary status of a retiree representative.

(v) *Retiree representative for other plans.* The plan sponsor of a plan that has reported fewer than 10,000 participants as of the end of the plan year for the most recently filed Form 5500, “Annual Return/Report of Employee Benefit Plan” is permitted to select a retiree representative. The rules in this paragraph (b)(4) (other than the rules in the first two sentences of paragraph (b)(4)(i)(A) of this section concerning the size of the plan and the timing of the appointment of the retiree representative) apply to such a representative.

(c) *Conditions for suspension—(1) In general—(i) Actuarial certification and initial-plan-sponsor determinations.* The plan sponsor of a plan in critical and declining status for a plan year may suspend

benefits only if the actuarial certification requirement in paragraph (c)(2) of this section and the initial-plan-sponsor determinations requirement in paragraph (c)(3) of this section are met.

(ii) *Annual requirement to make plan-sponsor determinations.* [Reserved]

(2) *Actuarial certification.* A plan satisfies the actuarial certification requirement of this paragraph (c)(2) if, taking into account the proposed suspension of benefits (and, if applicable, a proposed partition of the plan under section 4233 of the Employee Retirement Income Security Act of 1974, Public Law 93–406 (88 Stat. 829 (1974)), as amended (ERISA)), the plan’s actuary certifies that the plan is projected to avoid insolvency within the meaning of section 418E, assuming the suspension of benefits continues until it expires by its own terms or if no such expiration date is set, indefinitely.

(3) *Initial-plan-sponsor determinations—(i) General rule.* A plan satisfies the initial-plan-sponsor determinations requirement of this paragraph (c)(3) only if the plan sponsor determines that—

(A) All reasonable measures to avoid insolvency, within the meaning of section 418E, have been taken; and

(B) The plan is projected to become insolvent within the meaning of section 418E unless the proposed suspension of benefits (or another suspension of benefits under section 432(e)(9)) is implemented for the plan.

(ii) *Factors.* In making its determination that all reasonable measures to avoid insolvency, within the meaning of section 418E, have been taken, the plan sponsor may take into account the following non-exclusive list of factors—

(A) Current and past contribution levels;

(B) Levels of benefit accruals (including any prior reductions in the rate of benefit accruals);

(C) Prior reductions (if any) of adjustable benefits;

(D) Prior suspensions (if any) of benefits under this section;

(E) The impact on plan solvency of the subsidies and ancillary benefits available to active participants;

(F) Compensation levels of active participants relative to employees in the participants’ industry generally;

(G) Competitive and other economic factors facing contributing employers;

(H) The impact of benefit and contribution levels on retaining active participants and bargaining groups under the plan;

(I) The impact of past and anticipated contribution increases under the plan on employer attrition and retention levels; and

(J) Measures undertaken by the plan sponsor to retain or attract contributing employers.

(iii) *Reliance on certification of critical and declining status.* For purposes of the insolvency projection under paragraph (c)(3)(i)(B) of this section, a plan sponsor may rely on the actuarial certification made pursuant to section 432(b)(3)(A)(i) that the plan is in critical and declining status for the plan year in making the determination that the plan is projected to become insolvent unless benefits are suspended.

(4) *Annual-plan-sponsor determinations.* [Reserved]

(5) *Failure to make annual-plan-sponsor determinations.* [Reserved]

(d) *Limitations on suspension—(1) In general.* Any suspension of benefits with respect to a participant made by a plan sponsor pursuant to this section is subject to the individual limitations of sections 432(e)(9)(D)(i) through (iii), in accordance with the rules of paragraphs (d)(2) through (d)(4) of this section. After applying the individual limitations in sections 432(e)(9)(D)(i) through (iii), in accordance with the rules of paragraphs (d)(2) through (d)(4) of this section, the overall size and distribution of the suspension is subject to the aggregate limitations of sections 432(e)(9)(D)(iv) and (vi) in accordance with the rules of paragraphs (d)(5) and (d)(6) of this section. See section 432(e)(9)(D)(vii) for additional rules applicable to certain plans.

(2) *Guarantee-based limitation—(i) General rule.* The monthly benefit with respect to any participant may not be reduced below 110 percent of the monthly benefit payable to a participant, beneficiary, or alternate payee that would be guaranteed by the Pension Benefit Guaranty Corporation (PBGC) under section 4022A of ERISA if the plan were to be-

come insolvent as of the effective date of the suspension.

(ii) *PBGC guarantee.* [Reserved]

(iii) *Calculation of accrual rate.* [Reserved]

(iv) *Special rules for non-vested participants.* [Reserved]

(v) *Examples.* [Reserved]

(3) *Age-based limitation.* [Reserved]

(4) *Disability-based limitation—(i) General rule.* Benefits based on disability (as defined under the plan) may not be suspended.

(ii) *Benefits based on disability.* [Reserved]

(5) *Limitation on aggregate size of suspension.* [Reserved]

(6) *Equitable distribution.* [Reserved]

(7) *Effective date of suspension made in combination with partition.* In any case in which a suspension of benefits with respect to a plan is made in combination with a partition of the plan, the suspension of benefits may not take effect prior to the effective date of the partition. This requirement will not be satisfied if the partition order under section 4233 of ERISA has not been provided to the Secretary of the Treasury by the last day of the 225-day period described in paragraph (g)(3)(i) of this section.

(e) *Benefit improvements.* [Reserved]

(f) *Notice requirements—(1) In general.* No suspension of benefits may be made pursuant to this section unless notice of the proposed suspension has been given by the plan sponsor to—

(i) All participants, beneficiaries of deceased participants, and alternate payees under the plan (regardless of whether their benefits are proposed to be suspended), except those who cannot be contacted by reasonable efforts;

(ii) Each employer who has an obligation to contribute (within the meaning of section 4212(a) of ERISA) under the plan; and

(iii) Each employee organization which, for purposes of collective bargaining, represents plan participants employed by an employer described in paragraph (f)(1)(ii) of this section.

(2) *Content of notice—(i) In general.* The notice described under paragraph (f)(1) of this section must contain—

(A) Sufficient information to enable a participant or beneficiary to understand

the effect of any suspension of benefits, including an individualized estimate (on an annual or monthly basis) of the effect on that participant or beneficiary;

(B) A description of the factors considered by the plan sponsor in designing the benefit suspension;

(C) A statement that the application for approval of any suspension of benefits will be available on the web site of the Department of the Treasury and that comments on the application will be accepted;

(D) Information as to the rights and remedies of plan participants and beneficiaries;

(E) If applicable, a statement describing the appointment of a retiree representative, the date of appointment of the representative, the role and responsibilities of the retiree representative, identifying information about the retiree representative (including whether the representative is a plan trustee), and how to contact the retiree representative; and

(F) Information on how to contact the Department of the Treasury for further information and assistance where appropriate.

(ii) *Description of suspension of benefits.* The notice described under paragraph (f)(1) of this section will not satisfy the requirements of paragraph (f)(2)(i) of this section unless it includes the following—

(A) If it is not possible to provide an individualized estimate on an annual or monthly basis of the quantitative effect of the suspension on a participant or beneficiary, such as in the case of a suspension that affects the payment of any future cost-of-living adjustment, a narrative description of the effect of the suspension;

(B) A statement that the plan sponsor has determined that the plan will become insolvent unless the proposed suspension takes effect, and the year in which insolvency is projected to occur without a suspension of benefits;

(C) A statement that insolvency of the plan could result in benefits lower than benefits paid under the proposed suspension and a description of the projected benefit payments upon insolvency;

(D) A description of the proposed suspension and its effect, including a description of the different categories or groups affected by the suspension, how those cat-

egories or groups are defined, and the formula that is used to calculate the amount of the proposed suspension for individuals in each category or group;

(E) A description of the effect of the proposed suspension on the plan's projected insolvency;

(F) A description of whether the suspension will remain in effect indefinitely or will expire by its own terms; and

(G) A statement describing the right to vote on the suspension application.

(iii) *Readability requirement.* A notice given under paragraph (f)(1) of this section must be written in a manner that is readily understandable by the average plan participant.

(iv) *Model notice.* The Secretary of the Treasury will provide a model notice. The use of the model notice will satisfy the content and readability requirements of this paragraph (f)(2) with respect to the language provided in the model.

(3) *Form and manner—(i) Timing—(A) In general.* A notice under paragraph (f)(1) of this section must be given no earlier than four business days before the date on which an application is submitted and no later than two business days after the Secretary of the Treasury notifies the plan sponsor that it has submitted a complete application, as described in paragraph (g)(1)(ii) of this section.

(B) *Timing for lost participants.* If additional individuals who are entitled to notice are located after the time period in paragraph (f)(3)(i)(A) of this section has elapsed, then the plan sponsor must give notice to these individuals as soon as practicable thereafter.

(ii) *Method of delivery of notice—(A) Written or electronic delivery.* A notice given under paragraph (f)(1) of this section may be provided in writing. It may also be provided in electronic form to the extent that the form is reasonably accessible to persons to whom the notice is required to be provided. Permissible electronic methods include those permitted under regulations of the Department of Labor at 29 CFR § 2520.104b-1(c) and those described at § 54.4980F-1, Q&A-13(c) of the Excise Tax Regulations.

(B) *No alternative method of delivery.* [Reserved]

(iii) *Additional information in notice.* A notice given under paragraph (f)(1) of this section is permitted to include information in addition to the information that is required under paragraph (f)(2) of this section, including, if applicable, information relating to an application for partition under section 4233 of ERISA (such as the model notice at Appendix A of 29 CFR Part 4233), provided that the requirements of paragraph (f)(3)(iv) of this section are satisfied.

(iv) *No false or misleading information.* A notice given under paragraph (f)(1) of this section may not include false or misleading information (or omit information in a manner that causes the information provided to be misleading).

(4) *Other notice requirement.* Any notice given under paragraph (f)(1) of this section satisfies the requirement for notice of a significant reduction in benefits described in section 4980F that would otherwise be required as a result of that suspension of benefits. To the extent that there are other reductions that accompany a suspension of benefits, such as a reduction in the future accrual rate described in section 4980F for active participants or a reduction in adjustable benefits under section 432(e)(8), notice that satisfies the requirements (including the applicable timing requirements) of section 4980F or section 432(e)(8), as applicable, must be provided.

(5) *Examples.* The following examples illustrate the requirement in paragraph (f)(1)(i) of this section to give notice to all participants, beneficiaries of deceased participants, and alternate payees, except those who cannot be contacted by reasonable efforts.

Example 1. (i) Facts. A plan sponsor distributes notice of a proposed suspension of benefits to plan participants, beneficiaries of deceased participants, and alternate payees by mailing the notice to their last known mailing addresses, using the same information that it used to send the most recent annual funding notice. Of 5,000 such notices, 300 were returned as undeliverable. The plan sponsor takes no additional steps to contact the individuals for whom the notice was returned as undeliverable.

(ii) *Conclusion.* The plan sponsor did not make any effort beyond the initial mailing to locate the 300 individuals for whom the notice was returned as undeliverable. Therefore, the plan sponsor did not satisfy the requirement to provide notice to all participants, beneficiaries of deceased participants, and alternate payees under the plan (regardless of whether their benefits are proposed to be suspended),

except those who cannot be contacted by reasonable efforts.

Example 2. (i) Facts. The facts are the same as *Example 1*, but the plan sponsor contacts the bargaining parties to locate the missing individuals for whom the notice was returned as undeliverable. The plan sponsor then uses an Internet search tool, a credit reporting agency, and a commercial locator service to search for individuals for whom it was not able to obtain updated information from bargaining parties. Through these efforts, the plan sponsor locates the updated addresses of 250 of the 300 individuals whom it previously failed to contact. The plan sponsor mails notices to those individuals within one week of locating them.

(ii) *Conclusion.* By using effective search methods to find the previously missing individuals and promptly mailing the notice of suspension to them, the plan sponsor has satisfied the requirement to provide notice to all participants, beneficiaries of deceased participants, and alternate payees under the plan (regardless of whether their benefits are proposed to be suspended), except those who cannot be contacted by reasonable efforts.

(g) *Approval or denial of an application for suspension of benefits—(1) Application—(i) In general.* The plan sponsor of a plan in critical and declining status for a plan year that seeks to suspend benefits must submit an application for approval of the proposed suspension of benefits to the Secretary of the Treasury. The Secretary of the Treasury will approve, in consultation with the PBGC and the Secretary of Labor, a complete application described in paragraph (g)(1)(ii) of this section upon finding that the plan is eligible for the suspension and has satisfied the criteria of section 432(e)(9)(C), (D), (E), and (F), in accordance with the rules of paragraphs (c), (d), (e), and (f) of this section.

(ii) *Complete application.* After receiving a submission, the plan sponsor will be notified within two business days whether the submission constitutes a complete application. A complete application will be treated as submitted on the date that it was originally submitted to the Secretary of the Treasury. If a submission is incomplete, the notification will inform the plan sponsor of the information that is needed to complete the submission and give the plan sponsor a reasonable opportunity to submit a complete application. In such a case, the complete application will be treated as submitted on the date on which the additional information needed to complete the application is submitted to the Secretary of the Treasury.

(iii) *Submission of application.* An application described in this paragraph (g)(1) must be submitted electronically.

(iv) *Requirements for application.* Additional guidance that may be necessary or appropriate with respect to applications described in this paragraph (g)(1), including procedures for submitting applications and the information required to be included in a complete application, may be published in the form of revenue procedures, notices, or other guidance in the Internal Revenue Bulletin.

(v) *Requirement to provide adequate time to process application.* An application for suspension that is not submitted in combination with an application to PBGC for a plan partition under section 4223 of ERISA generally will not be accepted unless the proposed effective date of the suspension is at least nine months from the date on which the application is submitted. However, in appropriate circumstances, an earlier effective date may be permitted.

(vi) *Plan sponsors that also apply for partition.* See Part 4233 of the PBGC regulations for a coordinated application process that applies in the case of a plan sponsor that is submitting an application for suspension in combination with an application to PBGC for a plan partition under section 4233 of ERISA.

(2) *Solicitation of comments—(i) In general.* Not later than 30 days after receipt of a complete application described in paragraph (g)(1) of this section—

(A) The application for approval of the suspension of benefits will be published on the web site of the Department of the Treasury; and

(B) The Secretary of the Treasury will publish a notice in the **Federal Register** soliciting comments from contributing employers, employee organizations, and participants and beneficiaries of the plan for which an application was made, and other interested parties.

(ii) *Public comments.* The notice described in paragraph (g)(2)(i)(B) of this section will generally request that comments be submitted no later than 45 days after publication of that notice in the **Federal Register**, but the comment period may be shorter in appropriate circumstances. Comments received in response

to this notice will be made publicly available.

(3) *Approval or denial—(i) Deemed approval.* A complete application described in paragraph (g)(1)(ii) of this section will be deemed approved unless, within 225 days following the date that the complete application is submitted, the Secretary of the Treasury notifies the plan sponsor that its application does not satisfy one or more of the requirements described in this paragraph (g).

(ii) *Notice of denial.* If the Secretary of the Treasury denies a plan sponsor's application, the notification of the denial will detail the specific reasons for the denial, including reference to the specific requirement not satisfied.

(iii) *Special rules for systemically important plans.* If the Secretary of the Treasury approves a plan sponsor's application and the Secretary believes that the plan is or may be a systemically important plan (as defined in paragraph (h)(5)(iv) of this section), the Secretary will notify the plan sponsor of that belief and that it will be required to provide individual participant data upon request. In such a case, this data would be used in the event of a vote to reject the suspension (as described in paragraph (h)(4) of this section) in order to assist the Secretary in determining whether to permit a modification of the rejected suspension.

(iv) *Agreement to stay 225-day period.* [Reserved]

(4) *Consideration of certain factors.* [Reserved]

(5) *Standard for accepting plan sponsor determinations.* [Reserved]

(6) *Plan-sponsor certifications with respect to plan amendments.* [Reserved]

(7) *Special Master.* The Secretary of the Treasury may appoint a Special Master for purposes of this section. If a Special Master is appointed, the Special Master will coordinate the implementation of this section and the review of applications for the suspension of benefits and other appropriate documents, and will provide recommendations to the Secretary of the Treasury with respect to decisions required under this section.

(h) *Participant vote on proposed benefit reduction—(1) Requirement for vote—(i) In general.* If an application for suspension is approved under paragraph

(g) of this section, then the Secretary of the Treasury, in consultation with the PBGC and the Secretary of Labor, will administer a vote of all plan participants and beneficiaries of deceased participants (eligible voters), as described in section 432(e)(9)(H) and this paragraph (h). Any suspension of benefits will take effect only after the vote and after a final authorization to suspend benefits under paragraph (h)(6) of this section.

(ii) *Communication by plan sponsor.* [Reserved]

(2) *Administration of vote.* [Reserved]

(3) *Ballots—(i) In general.* [Reserved]

(ii) *Additional rules—(A) Readability requirement.* A ballot provided under section 432(e)(9)(H)(iii), in accordance with the rules of paragraph (h)(3)(i) of this section, must be written in a manner that is readily understandable by the average plan participant.

(B) *No false or misleading information.* A ballot provided under section 432(e)(9)(H)(iii), in accordance with the rules of paragraph (h)(3)(i) of this section, may not include false or misleading information (or omit information in a manner that causes the information provided to be misleading).

(iii) *Ballot must be approved.* Any ballot provided under section 432(e)(9)(H)(iii), in accordance with the rules of paragraph (h)(3)(i) of this section, must be approved by the Secretary of the Treasury, in consultation with the PBGC and the Secretary of Labor, before it is provided.

(4) *Implementing suspension following vote—(i) In general.* Unless a majority of all eligible voters vote to reject the suspension that was approved under paragraph (g) of this section, the suspension will be permitted to go into effect. If a majority of all eligible voters vote to reject the suspension that was approved under paragraph (g) of this section, a suspension of benefits will not be permitted to go into effect except as provided under paragraph (h)(5)(iii) of this section relating to the implementation of a suspension for a systemically important plan (as defined in paragraph (h)(5)(iv) of this section).

(ii) *Effect of not sending ballot.* [Reserved]

(5) *Systemically important plans*—(i) *In general.* If a majority of all eligible voters vote to reject the suspension that was approved under paragraph (g) of this section, the Secretary of the Treasury will consult with the PBGC and the Secretary of Labor to determine if the plan is a systemically important plan. This determination will be made no later than 14 days after the results of the vote are certified.

(ii) *Recommendations from Participant and Plan Sponsor Advocate.* Not later than 30 days after a determination that the plan is a systemically important plan, the Participant and Plan Sponsor Advocate selected under section 4004 of ERISA may submit recommendations to the Secretary of the Treasury with respect to the suspension that was approved under paragraph (g) of this section or any revisions to the suspension.

(iii) *Implementation of original or modified suspension by systemically important plans.* If a plan is a systemically important plan for which a majority of all eligible voters vote to reject the suspension that was approved under paragraph (g) of this section, then the Secretary of the Treasury must determine whether to permit the implementation of the suspension that was approved under paragraph (g) of this section or whether to permit the implementation of a modification of that suspension. Under any such modification, the plan must be projected to avoid insolvency in accordance with section 432(e)(9)(D)(iv). No later than 60 days after the results of a vote to reject a suspension are certified, the Secretary of the Treasury will notify the plan sponsor that the suspension or modified suspension is permitted to be implemented.

(iv) *Systemically important plan defined*—(A) *In general.* For purposes of this paragraph (h)(5), a systemically important plan is a plan with respect to which the PBGC projects that the present value of financial assistance payments will exceed \$1.0 billion if the suspension is not implemented.

(B) *Indexing.* For calendar years beginning after 2015, the dollar amount specified in paragraph (h)(5)(iv)(A) of this section will be replaced with an amount equal to the product of the dollar

amount and a fraction, the numerator of which is the contribution and benefit base (determined under section 230 of the Social Security Act) for the preceding calendar year and the denominator of which is the contribution and benefit base for calendar year 2014. If the amount otherwise determined under this paragraph (h)(5)(iv)(B) is not a multiple of \$1.0 million, the amount will be rounded to the next lowest multiple of \$1.0 million.

(6) *Final authorization to suspend*—(i) *In general.* In any case in which a suspension is permitted to go into effect following a vote pursuant to section 432(e)(9)(H)(ii) and paragraph (h)(4) of this section, the Secretary of the Treasury, in consultation with the PBGC and the Secretary of Labor, will issue a final authorization to suspend with respect to the suspension not later than seven days after the vote.

(ii) *Systemically important plans.* In any case in which a suspension is permitted to go into effect following a determination under paragraph (h)(5) of this section that the plan is a systemically important plan, the Secretary of the Treasury, in consultation with the PBGC and the Secretary of Labor, will issue a final authorization to suspend, at a time sufficient to allow the implementation of the suspension prior to the end of the 90-day period beginning on the date the results of the vote are certified.

(iii) *Plan partitions.* Notwithstanding any other provision of this section, in any case in which a suspension of benefits with respect to a plan is made in combination with a partition of the plan, the suspension of benefits is not permitted to take effect prior to the effective date of the partition.

(i) [Reserved].

(j) *Effective/applicability date.* This section applies on and after June 17, 2015.

(k) *Expiration date.* The applicability of this section expires on June 15, 2018.

PART 602—OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

Par. 3. The authority citation for part 602 continues to read as follows:

Authority: 26 U.S.C. 7805

Par. 4. In § 602.101, paragraph (b) is amended by adding the following entry in numerical order to the table to read as follows:

§ 602.101 OMB Control numbers.

* * * * *

(b) * * * *

CFR part or section where identified and described	Current OMB control no.
* * * * *	
1.432(e)(9)–1T. . . .	1545-2260
* * * * *	

John Dalrymple
Deputy Commissioner for Services and Enforcement.

Approved: June 9, 2015

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

(Filed by the Office of the Federal Register on June 17, 2015, 11:15 a.m., and published in the issue of the Federal Register for June 19, 2015, 80 F.R. 35207)

T.D. 9726

**DEPARTMENT OF THE TREASURY
Internal Revenue Service
26 CFR Part 54**

**DEPARTMENT OF LABOR
Employee Benefits Security Administration
29 CFR Parts 2510 and 2590**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
45 CFR Part 147**

Coverage of Certain Preventive Services Under the Affordable Care Act

AGENCIES: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare &

Medicaid Services, Department of Health and Human Services.

ACTION: Final rules.

SUMMARY: This document contains final regulations regarding coverage of certain preventive services under section 2713 of the Public Health Service Act (PHS Act), added by the Patient Protection and Affordable Care Act, as amended, and incorporated into the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code. Section 2713 of the PHS Act requires coverage without cost sharing of certain preventive health services by non-grandfathered group health plans and health insurance coverage. These regulations finalize provisions from three rulemaking actions: interim final regulations issued in July 2010 related to coverage of preventive services, interim final regulations issued in August 2014 related to the process an eligible organization uses to provide notice of its religious objection to the coverage of contraceptive services, and proposed regulations issued in August 2014 related to the definition of “eligible organization,” which would expand the set of entities that may avail themselves of an accommodation with respect to the coverage of contraceptive services.

DATES: *Effective Date:* These final regulations are effective on September 14, 2015.

Applicability Date: These final regulations are applicable beginning on the first day of the first plan year (or, for individual health insurance coverage, the first day of the first policy year) that begins on or after September 14, 2015.

FOR FURTHER INFORMATION

CONTACT: David Mlawsky, Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS), at (410) 786-1565; Amy Turner or Elizabeth Schumacher, Employee Benefits Security Administration (EBSA), Department of Labor, at (202) 693-8335; or Karen Levin, Internal Revenue Service (IRS), Department of the Treasury, at (202) 927-9639.

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

SUPPLEMENTARY INFORMATION:

I. Background

The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) was enacted on March 30, 2010. These statutes 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 Affordable Care Act adds section 715(a)(1) to the Employee Retirement Income Security Act of 1974 (ERISA) and section 9815(a)(1) to the Internal Revenue Code (Code) to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. The sections of the PHS Act incorporated into ERISA and the Code are sections 2701 through 2728.

Section 2713 of the PHS Act, as added by the Affordable Care Act and incorporated into ERISA and the Code, requires that non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage provide coverage of certain specified preventive services without cost sharing. These preventive services include:

- Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (Task Force) with respect to the individual involved.
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual involved. A recommendation of the Advisory Committee is considered to be “in effect” after it has been adopted by the Director of the Centers for Disease Control and Prevention (CDC). A recommendation is considered to be for “routine use” if it appears on the Immunization Schedules of the CDC.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- With respect to women, preventive care and screenings provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force), including all Food and Drug Administration (FDA)-approved contraceptives, sterilization procedures, and patient education and counseling for women with reproductive capacity, as prescribed by a health care provider (collectively, contraceptive services).¹

The complete list of recommendations and guidelines that are required to be covered under these final regulations can be found at: <https://www.healthcare.gov/preventive-care-benefits>. Together, the items and services described in these recommendations and guidelines are referred to in this preamble as “recommended preventive services.”

The Departments of Labor, Health and Human Services, and the Treasury (the

¹ The HRSA Guidelines exclude services relating to a man’s reproductive capacity, such as vasectomies and condoms.

Departments)² have issued rulemaking to implement these requirements:

- Interim final regulations on July 19, 2010, at 75 FR 41726 (July 2010 interim final regulations), implemented the preventive services requirements of PHS Act section 2713;
- Interim final regulations amending the July 2010 interim final regulations on August 3, 2011, at 76 FR 46621, provided HRSA with the authority to exempt group health plans established or maintained by certain religious employers (and group health insurance coverage provided in connection with those plans) from the requirement to cover contraceptive services consistent with the HRSA Guidelines;³
- Final regulations on February 15, 2012, at 77 FR 8725 (2012 final regulations), finalized the definition of religious employer in the 2011 amended interim final regulations without modification;⁴
- An advance notice of proposed rulemaking (ANPRM) on March 21, 2012, at 77 FR 16501, solicited comments on how to provide for coverage of recommended preventive services, including contraceptive services, without cost sharing, while simultaneously ensuring that certain nonprofit organizations with religious objections to contraceptive coverage would not be required to contract, arrange, pay, or refer for that coverage;
- Proposed regulations on February 6, 2013, at 78 FR 8456, proposed to sim-

- plify and clarify the definition of “religious employer” for purposes of the religious employer exemption, and proposed accommodations for group health plans established or maintained by certain nonprofit religious organizations with religious objections to contraceptive coverage (and group health insurance coverage provided in connection with those plans) and for insured student plans arranged by certain nonprofit religious organizations that are institutions of higher education with religious objections to contraceptive coverage;
- Final regulations on July 2, 2013, at 78 FR 39870 (July 2013 final regulations), simplified and clarified the definition of religious employer for purposes of the religious employer exemption and established accommodations for health coverage established or maintained or arranged by eligible organizations;⁵
 - Interim final regulations on August 27, 2014, at 79 FR 51092 (August 2014 interim final regulations), amended the July 2013 final regulations in light of the United States Supreme Court’s interim order in connection with an application for an injunction in *Wheaton College v. Burwell* (Wheaton interim order),⁶ and provided an alternative process that an eligible organization may use to provide notice of its religious objection to the coverage of contraceptive services; and
 - Proposed regulations on August 27, 2014, at 79 FR 51118 (August 2014

proposed regulations), proposed potential changes to the definition of “eligible organization” in light of the United States Supreme Court’s decision in *Burwell v. Hobby Lobby Stores, Inc.*⁷

In addition to these regulations, the Departments released six sets of Frequently Asked Questions (FAQs) regarding the preventive services coverage requirements. The Departments released FAQs about Affordable Care Act Implementation Parts II, V, XII, XIX, XX, and XXVI to answer outstanding questions, including questions related to the coverage of preventive services. These FAQs provided guidance related to compliance with the 2010 and 2014 interim final regulations, and addressed issues related to specific services required to be covered without cost sharing, subject to reasonable medical management, under recommendations and guidelines specified in section 2713 of the PHS Act. Information on related safe harbors, forms, and model notices is available at <http://www.dol.gov/ebsa/healthreform> and <http://www.cms.gov/ccio/resources/regulations-and-guidance/index.html>.

After consideration of the comments and feedback received from stakeholders, the Departments are publishing these final regulations⁸, which finalize the July 2010 interim final regulations related to coverage of recommended preventive services, the August 2014 interim final regulations related to the process an eligible organization uses to provide notice of its religious objection to the coverage of contraceptive services, and the August 2014

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

³ On the same date, HRSA exercised this authority in the HRSA Guidelines to exempt group health plans established or maintained by these religious employers (and group health insurance coverage provided in connection with such plans) from the HRSA Guidelines with respect to contraceptive services.

⁴ Contemporaneous with the issuance of the 2012 final regulations, HHS, with the agreement of the Departments of Labor and the Treasury, issued guidance establishing a temporary safe harbor from enforcement of the contraceptive coverage requirement by the Departments for group health plans established or maintained by certain nonprofit organizations with religious objections to contraceptive coverage (and group health insurance coverage provided in connection with such plans) originally issued on February 10, 2012, and reissued on August 15, 2012, and June 28, 2013; available at: <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/preventive-services-guidance-6-28-2013.pdf>. The guidance clarified, among other things, that plans that took some action before February 10, 2012, to try, without success, to exclude or limit contraceptive coverage were not precluded from eligibility for the safe harbor. The temporary enforcement safe harbor was also available to student health insurance coverage arranged by nonprofit institutions of higher education with religious objections to contraceptive coverage that met the conditions set forth in the guidance. See Student Health Insurance Coverage, 77 FR 16457 (Mar. 21, 2012).

⁵ A contemporaneously re-issued HHS guidance document extended the temporary safe harbor from enforcement of the contraceptive coverage requirement by the Departments to encompass plan years beginning on or after August 1, 2013, and before January 1, 2014. This guidance included a form to be used by an organization during this temporary period to self-certify that its plan qualified for the temporary enforcement safe harbor. In addition, HHS and the Department of Labor (DOL) issued a self-certification form, EBSA Form 700, to be executed by an organization seeking to be treated as an eligible organization for purposes of an accommodation under the July 2013 final regulations. This self-certification form was provided for use with the accommodation under the July 2013 final regulations, after the expiration of the temporary enforcement safe harbor (that is, for plan years beginning on or after January 1, 2014). See <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/preventive-services-guidance-6-28-2013.pdf>

⁶134 S. Ct. 2806 (2014).

⁷134 S. Ct. 2751 (2014).

⁸The Department of the Treasury/Internal Revenue Service published temporary regulations and proposed regulations with the text of the temporary regulations serving as the text of the proposed regulations as part of each of the joint rulemaking interim final rules listed above. The Departments of Labor and HHS published their rules as interim final rules and are finalizing their interim final rules. The Department of the Treasury/Internal Revenue Service is finalizing its proposed rules.

proposed regulations related to the definition of eligible organization.

II. Overview of the Final Regulations

A. Coverage of Recommended Preventive Services under 26 CFR 54.9815–2713, 29 CFR 2590.715–2713, and 45 CFR 147.130.

(i) *Scope of recommended preventive services*

Section 2713 of the PHS Act, as added by the Affordable Care Act, requires that a non-grandfathered group health plan or a health insurance issuer offering non-grandfathered group or individual health insurance coverage provide, without cost sharing, coverage for recommended preventive services, as outlined above. The July 2013 final regulations finalized the requirement to provide coverage without cost sharing with respect to those preventive services provided for in the HRSA Guidelines for women. These regulations finalize the requirement to provide coverage without cost sharing with respect to the other three categories of recommendations and guidelines specified in section 2713 of the PHS Act: evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the Task Force, immunizations for routine use that have in effect a recommendation from the Advisory Committee, and evidence-informed preventive care and screenings for infants, children, and adolescents, provided for in guidelines supported by HRSA. The complete list of recommendations and guidelines can be found at: <https://www.healthcare.gov/preventive-care-benefits>.

Commenters requested additional clarity on the specific items and services required to be covered without cost sharing. The Departments previously released FAQs about Affordable Care Act Implementation Parts XII⁹ and XIX¹⁰ to provide guidance related to the scope of coverage required under the recommendations and guidelines, including coverage of spi-

rin and other over-the-counter medication, colonoscopies, BRCA testing, well-woman visits, screening and counseling for interpersonal and domestic violence, HIV and HPV testing, contraception, breastfeeding and lactation counseling, and tobacco cessation interventions. Moreover, on May 11, 2015, the Departments issued FAQs about Affordable Care Act Implementation¹¹ to address specific coverage questions related to BRCA testing, contraception, sex-specific recommended preventive services, services for dependents covered under the plan or policy, and colonoscopies. If additional questions arise regarding the application of the preventive services coverage requirements, the Departments may issue additional subregulatory guidance.

(ii) *Office visits*

The July 2010 interim final regulations clarified the cost-sharing requirements applicable when a recommended preventive service is provided during an office visit through the use of the “primary purpose” test: First, if a recommended preventive service is billed separately (or is tracked as individual encounter data separately) from an office visit, a plan or issuer may impose cost sharing with respect to the office visit. Second, if a recommended preventive service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of the recommended preventive service, a plan or issuer may not impose cost sharing with respect to the office visit. Finally, if a recommended preventive service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of the recommended preventive service, a plan or issuer may impose cost sharing with respect to the office visit. The reference to tracking individual encounter data was included to provide guidance with respect to plans and issuers that use capitation or similar payment ar-

rangements that do not bill individually for items and services.

Several commenters supported the primary purpose test, while other commenters were concerned that the test provides too much discretion to providers or issuers to determine the primary purpose of the visit. Some commenters stated that many individuals only seek medical care from their physician when they are sick, and physicians must be able to provide preventive services, along with other treatment, in a single office visit. Other commenters recommended that the Departments eliminate the primary purpose test. Some of these commenters recommended that cost sharing be prohibited if any recommended preventive service is provided during the visit.

These final regulations continue to provide that when a recommended preventive service is not billed separately (or is not tracked as individual encounter data separately) from an office visit, plans and issuers must look to the primary purpose of the office visit when determining whether they may impose cost sharing with respect to the office visit. Nothing in these requirements precludes a health care provider from providing preventive services, along with other treatment, in a single office visit. These rules only establish the circumstances under which an office visit that includes a recommended preventive service may be subject to cost sharing. The Departments anticipate that the determination of the primary purpose of the visit will be resolved through normal billing and coding activities, as they are for other services. If questions arise regarding the application of this rule to common medical scenarios, the Departments may issue additional subregulatory guidance.

(iii) *Out-of-network providers.*

With respect to a plan or health insurance coverage that maintains a network of providers, the July 2010 interim final regulations provided that the plan or issuer is not required to provide coverage for

⁹See FAQs about Affordable Care Act Implementation Part XII, available at <http://www.dol.gov/ebsa/faqs/faq-aca12.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html

¹⁰See FAQs about Affordable Care Act Implementation Part XIX, available at <http://www.dol.gov/ebsa/faqs/faq-aca19.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs19.html

¹¹See FAQs about Affordable Care Act Implementation Part XXVI, available at www.dol.gov/ebsa/faqs/faq-FAQs/Downloads/aca_implementation_faqs26.pdf and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf

recommended preventive services delivered by an out-of-network provider. The plan or issuer may also impose cost sharing for recommended preventive services delivered by an out-of-network provider.

Several commenters requested the rule be amended to require that preventive services be provided without cost sharing when services are provided out-of-network in all instances. Other commenters suggested that the rule be amended to require out-of-network coverage if an in-network provider is not available to the individual, or if the services are not available to a material segment of the plan's population. One commenter asked that, in a situation where preventive services are obtained from a network provider with the assistance of medical professionals who are out-of-network, all of the services be treated as in-network services, and thus not subject to cost sharing. Several commenters stated that cost sharing for recommended preventive services received from out-of-network providers should not be higher than cost sharing for other ambulatory health services provided on an out-of-network basis.

In response to comments, the Departments issued an FAQ clarifying that, if a plan or issuer does not have in its network a provider who can provide a particular recommended preventive service, then, consistent with the statute and July 2010 interim final regulations, the plan or issuer must cover, without cost sharing, the item or service when performed by an out-of-network provider.¹² These final regulations adopt the rule of the July 2010 interim final regulations with respect to out-of-network providers, with one clarification. These final regulations incorporate the clarification that a plan or issuer that does not have in its network a provider who can provide a particular recommended preventive service is required to

cover the preventive service when performed by an out-of-network provider, and may not impose cost sharing with respect to the preventive service.

(iv) *Reasonable medical management.*

The July 2010 interim final regulations included a provision on reasonable medical management. Specifically, if a recommendation or guideline for a recommended preventive service does not specify the frequency, method, treatment, or setting for the provision of that service, the plan or issuer may use reasonable medical management techniques to determine any coverage limitations.

The Departments received a number of comments related to the use of reasonable medical management techniques. Some commenters were concerned that the July 2010 interim final regulations did not clearly outline what constitutes reasonable medical management techniques, and requested that the Departments provide greater clarity, particularly with respect to a situation where a patient's attending provider determines that the frequency, method, treatment, or setting of a particular item or service is medically appropriate for a particular patient. The Departments issued an FAQ clarifying that, under the July 2010 interim final regulations, to the extent not specified in a recommendation or guideline, a plan or issuer may rely on the relevant evidence base and established reasonable medical management techniques to determine the frequency, method, treatment, or setting for the provision of a recommended preventive service.¹³ These final regulations incorporate the clarification of the July 2010 interim final regulations set forth in the FAQ.

On May 11, 2015, the Departments issued FAQs to provide further guidance on the extent to which plans and issuers

may utilize reasonable medical management when providing coverage for recommended women's contraception services in the HRSA guidelines.¹⁴ If further questions arise regarding the permissible application of reasonable medical management techniques, the Departments may issue additional sub-regulatory guidance.

Other commenters cited the importance of flexibility to permit plans and issuers to maintain programs that are cost-effective, negotiate treatments with high-quality providers at reduced costs, and reduce fraud and abuse. Commenters requested guidance on how plans and issuers may employ value-based insurance designs (VBID) in a manner that complies with the preventive services coverage requirements.¹⁵ Some commenters requested that the final regulations permit plans and issuers to impose cost sharing on non-preferred network tiers for VBIDs. Another commenter requested the Departments permit cost sharing for preventive care delivered at centers of excellence. On December 22, 2010, the Departments issued an FAQ to provide guidance regarding VBID related to the coverage of preventive services.¹⁶ If questions arise regarding VBID and the preventive services coverage requirements, the Departments may issue additional sub-regulatory guidance. Several commenters stated that plans and issuers should be required to use and identify credible references or sources supporting their medical management techniques. The Departments recognize the importance of having access to information relating to medical management techniques that a plan or issuer may apply. Several provisions applicable to plans and issuers address these concerns. ERISA section 104 and the Department of Labor's im-

¹²See FAQ about Affordable Care Act Implementation Part XII, Q3 at <http://www.dol.gov/ebsa/faqs/faq-aca12.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html.

¹³See FAQs about Affordable Care Act Implementation Part II, Q8 available at <http://www.dol.gov/ebsa/faqs/faq-aca2.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs2.html

¹⁴See FAQs about Affordable Care Act Implementation Part XXVI, available at <http://www.dol.gov/ebsa/faqs/faq-aca26.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf.

¹⁵The Departments first solicited comments on value-based insurance designs in the July 2010 interim final regulations. 75 FR 41726, 41729. Subsequently, the Departments published a request for information (RFI) related to value-based insurance design on December 28, 2010. 75 FR 81544.

¹⁶See FAQs about Affordable Care Act Implementation Part V, Q1, available at <http://www.dol.gov/ebsa/faqs/faq-aca5.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html.

plementing regulations¹⁷ 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 participants¹⁸ upon request. In addition, the Department of Labor's claims procedure regulations¹⁹ (applicable to ERISA plans), as well as the Departments' internal claims and appeals and external review regulations under the Affordable Care Act (applicable to all non-grandfathered group health plans and health insurance issuers in the group and individual markets),²⁰ set forth rules regarding claims and appeals, 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. Other Federal and State law requirements may also apply, as applicable.

(v) *Services not described.*

The July 2010 interim final regulations clarified that a plan or issuer may cover preventive services in addition to those required to be covered by PHS Act section 2713. These final regulations continue to provide that for the additional preventive services, a plan or issuer may impose cost sharing at its discretion, consistent with applicable law. Moreover, a plan or issuer may impose cost sharing for a treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service.

(vi) *Timing.*

The July 2010 interim final regulations provided that plans and issuers must provide coverage for new recommended preventive services for plan years (in the individual market, policy years) beginning on or after the date that is one year after the date the relevant recommendation or guideline under PHS Act section 2713 is issued. Some commenters encouraged the Departments to adopt a shorter implementation timeframe. With respect to the Advisory Committee recommendations, one commenter requested that the effective date for any new recommendation be either the publication of the committee's provisional recommendations or the publication of the official CDC immunization schedules, whichever occurs first. Other commenters expressed support for the implementation timeframe set forth in the July 2010 interim final regulations. The statute requires the Departments to establish an interval of not less than one year between when recommendations or guidelines under PHS Act section 2713(a)²¹ are issued, and the plan year (in the individual market, policy year) for which coverage of the services addressed in the recommendations or guidelines must be in effect.

To provide plans and issuers adequate time to incorporate changes or updates to recommendations and guidelines, as provided in the July 2010 interim final regulations, these final regulations continue to provide that a recommendation or guideline of the Task Force is considered to be issued on the last day of the month on which the Task Force publishes or otherwise releases the recommendation; a recommendation or guideline of the Advisory Committee is considered to be issued on the date on which it is adopted by the

Director of the CDC; and a recommendation or guideline in the comprehensive guidelines supported by HRSA is considered to be issued on the date on which it is accepted by the Administrator of HRSA or, if applicable, adopted by the Secretary of HHS.

Several commenters supported the policy that plans and issuers should not need to check the recommendations or guidelines for changes during the plan or policy year in order to determine coverage requirements and should not be required to implement changes during the plan or policy year. The Departments adopted this approach in the July 2010 interim final regulations with respect to new recommendations or guidelines that impose additional preventive services coverage requirements, but adopted a different standard for changes in recommendations or guidelines, allowing plans and issuers to eliminate coverage for preventive services that are no longer recommended during the plan or policy year, consistent with other applicable federal and state law. We agree with those commenters who stated that changes in coverage should not occur during the plan or policy year, and are implementing an approach with respect to changes in recommendations or guidelines that narrow or eliminate coverage requirements for previously recommended services that is similar to the one adopted in the July 2010 interim final regulations for new recommendations or guidelines. Furthermore, participants and beneficiaries of group health plans (and enrollees and dependents in individual market coverage) may make coverage choices based on the benefits offered at the beginning of the plan or policy year. Plan years (and individual market policy years) vary and recommen-

¹⁷29 CFR 2520.104b-1.

¹⁸ERISA 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 among benefit package options during open season, generally are considered plan participants for this purpose.

¹⁹29 CFR 2560.503-1(h)(2)(iii).

²⁰29 CFR 2590.715-2719(b)(2)(i) and 45 CFR 147.136(b)(2)(i).

²¹Section 2713(b)(1) refers to an interval between "the date on which a recommendation described in subsection (a)(1) or (a)(2) or a guideline under subsection (a)(3) is issued and the plan year with respect to which the requirement described in subsection (a) is effective with respect to the service described in such recommendation or guideline." While the first part of this statement does not mention guidelines under subsection (a)(4), it is the Departments' view that it would not be reasonable to treat the services covered under subsection (a)(4) any differently than those in subsections (a)(1), (a)(2), and (a)(3). First, the statement refers to "the requirement described in subsection (a)," which would include a requirement under subsection (a)(4). Secondly, the guidelines under (a)(4) are from the same source as those under (a)(3), except with respect to women, rather than infants, children and adolescents; and other preventive services involving women are addressed in subsection (a)(1), so it is reasonable to treat the guidelines under subsection (a)(4) similarly. Third, without this clarification, it would be unclear when such services would have to be covered. The July 2010 interim final regulations and these final regulations accordingly apply the intervals established therein to services under section 2713(a)(4).

dations and guidelines may be issued at any time during a plan or policy year. These final regulations protect against disruption and provide certainty in coverage (including cost-sharing requirements) for the duration of the plan or policy year. Accordingly, these final regulations state that a plan or issuer that is required to provide coverage for any recommended preventive service on the first day of a plan or policy year under a particular recommendation or guideline must generally provide that coverage through the last day of the plan or policy year, even if the recommendation or guideline changes or is eliminated during the plan or policy year.

However, there are limited circumstances under which it may be inadvisable for a plan or issuer to continue to cover preventive items or services associated with a recommendation or guideline that was in effect on the first day of a plan year or policy year (for example, due to safety concerns). Therefore, these final regulations establish that if, during a plan or policy year, (1) an “A” or “B” recommendation or guideline of the Task Force that was in effect on the first day of a plan or policy year is downgraded to a “D” rating (meaning that the Task Force has determined that there is strong evidence that there is no net benefit, or that the harms outweigh the benefits, and therefore discourages the use of this service), or (2) any item or service associated with any preventive service recommendation or guideline specified in 26 CFR 54.9815–2713(a)(1) or 29 CFR 2590.715–2713(a)(1) or 45 CFR 147.130(a)(1) that was in effect on the first day of a plan or policy year is the subject of a safety recall or is otherwise determined to pose a significant safety concern by a federal agency authorized to regulate that item or service, there is no requirement under this section to cover these items and services through the last day of the plan or policy year. Should such circumstances arise, the Departments expect to issue subregulatory guidance to this effect with respect to such preventive item or service.

Other requirements of federal or state law may apply in connection with ceasing

to provide coverage or changing cost-sharing requirements for any item or service. For example, PHS Act section 2715(d)(4) and its implementing regulations state that if a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved that would affect the content of the Summary of Benefits and Coverage (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 notification will become effective.

A list of the recommended preventive services is available at <https://www.healthcare.gov/preventive-care-benefits>. We intend to update this list to include the date on which the recommendation or guideline was accepted or adopted. New recommendations and guidelines will also be reflected on this site. Plans and issuers need not make changes to coverage and cost-sharing requirements based on a new recommendation or guideline until the first plan year (in the individual market, policy year) beginning on or after the date that is one year after the new recommendation or guideline goes into effect. Therefore, by visiting this site once per year, plans or issuers should have access to all the information necessary to identify any additional items or services that must be covered without cost sharing, or to identify any items or services that are no longer required to be covered.

B. Accommodations in Connection with Coverage of Preventive Health Services – 26 CFR 54.9815–2713A, 29 CFR 2510.3–16 and 2590.715–2713A, and 45 CFR 147.131.

(i) The process an eligible organization uses to provide notice of its religious objection to the coverage of contraceptive services.

After issuing the July 2013 final regulations, the Departments issued August

2014 interim final regulations in light of the Supreme Court’s *Wheaton* interim order concerning notice to the federal government that an eligible organization has a religious objection to providing contraceptive coverage, as an alternative to the EBSA Form 700 method of self-certification, and to preserve participants’ and beneficiaries’ (and, in the case of student health insurance coverage, enrollees’ and dependents’) access to coverage for the full range of FDA-approved contraceptives, as prescribed by a health care provider, without cost sharing.

These final regulations continue to allow eligible organizations to choose between using EBSA Form 700 or the alternative process consistent with the *Wheaton* interim order. The alternative process provides that an eligible organization may notify HHS in writing of its religious objection to covering all or a subset of contraceptive services. The notice must include the name of the eligible organization and the basis on which it qualifies for an accommodation; its objection based on sincerely held religious beliefs to covering some or all contraceptive services, as applicable (including an identification of the subset of contraceptive services to which coverage the eligible organization objects, if applicable); the plan name and type (that is, whether it is a student health insurance plan within the meaning of 45 CFR 147.145(a) or a church plan within the meaning of ERISA section 3(33)); and the name and contact information for any of the plan’s third party administrators and health insurance issuers.²² A model notice to HHS that eligible organizations may, but are not required to, use is available at: <http://www.cms.gov/ccio/resources/Regulations-and-Guidance/index.html#Prevention>. If there is a change in any of the information required to be included, the organization must provide updated information to HHS.

The content required for the notice represents the minimum information necessary for the Departments to determine which entities are covered by the accommodation, to administer the accommoda-

²²Church plans are exempt from ERISA pursuant to ERISA section 4(b)(2). As such, a third party administrator of a self-insured church plan established or maintained by an eligible organization does not become the plan administrator by operation of 29 CFR 2510.3–16, although such third party administrators may voluntarily provide or arrange separate payments for contraceptive services and seek reimbursement for associated expenses under the process set forth in 45 CFR 156.50.

tion, and to implement the policies in the July 2013 final regulations.²³ Comments on the August 2014 interim final regulations did not identify any way to administer the accommodation without this information, or any alternative means the Departments can use to obtain the required information. Nothing in this alternative notice process (or in the EBSA Form 700 notice process) provides for a government assessment of the sincerity of the religious belief underlying the eligible organization's objection. The notice to HHS, and any subsequent updates, should be sent electronically to: marketreform@cms.hhs.gov, or by regular mail to: Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, 200 Independence Avenue SW, Washington, D.C. 20201, Room 739H.

When an eligible organization that establishes or maintains a self-insured plan subject to ERISA provides a notice to HHS, the Department of Labor (DOL) (working with HHS) will send a separate notification to each third party administrator of the ERISA plan. The DOL notification will inform each third party administrator of the eligible organization's religious objection to funding or administering some or all contraceptive coverage, will list the contraceptive services to which the employer objects, will describe the obligations of the third party administrator(s) under 29 CFR 2590.715–2713A and 26 CFR 54.9815–2713A, and will designate the relevant third party administrator(s) as plan administrator under section 3(16) of ERISA for those contraceptive benefits that the third party administrator would otherwise manage on behalf of the eligible organization. The DOL notification will be an instrument under which the plan is operated, and will supersede any earlier designation. In establishing and implementing this alternative process, DOL is exercising its broad rule-making authority under title I of ERISA, which includes the ability to interpret and apply the definition of a plan administrator under ERISA section 3(16)(A).

If an eligible organization that establishes or maintains an insured group health plan or insured student health plan provides a notice to HHS under this alternative process, HHS will send a separate notification to each health insurance issuer of the plan. HHS's notification will inform each health insurance issuer of the eligible organization's religious objection to funding or administering some or all contraceptive coverage, will list the contraceptive services to which the organization objects, and will describe the obligations of the issuer(s) under 26 CFR 54.9815–2713A, 29 CFR 2590.715–2713A, and 45 CFR 147.131. Issuers remain responsible for compliance with the statutory and regulatory requirement to provide coverage for contraceptive services without cost sharing to participants and beneficiaries of insured group health plans, and to enrollees and dependents of insured student health plans, notwithstanding that the policyholder is an eligible organization with a religious objection to contraceptive coverage that will not have to contract, arrange, pay, or refer for the coverage.

Several comments addressed oversight and enforcement to monitor the accommodation. The Departments will use their established oversight processes, applicable to all the Affordable Care Act market reforms of PHS Act title XXVII, part A to monitor compliance with the requirement to arrange for or provide separate payments for contraceptive services without cost sharing.²⁴

(ii) *Definition of a closely held for-profit entity.*

(a) *General structure of a closely held for-profit entity.*

After issuing the July 2013 final regulations, the Departments issued August 2014 proposed regulations in light of the Supreme Court's ruling in *Hobby Lobby*, that, under the Religious Freedom Restoration Act of 1993 (RFRA),²⁵ the requirement to provide contraceptive coverage

could not be applied to certain closely held for-profit entities that had a religious objection to providing coverage for some or all the FDA-approved contraceptive methods. The proposed regulations solicited comments on a number of different approaches for defining a closely held for-profit entity for purposes of qualifying as an eligible organization that can avail itself of an accommodation, and solicited comments on a number of other related issues.

The Departments received more than 75,000 comments in response to the August 2014 proposed regulations. Numerous comments addressed matters outside the scope of the proposed regulations (for example, many comments expressed support for or disagreement with the Supreme Court's *Hobby Lobby* decision, contraception in general, or different methods of contraception), and are not addressed in this preamble. To the extent comments addressed matters that were within the scope of the proposed regulations, those portions of the comments were considered, and all significant comments related to matters within the scope of the proposed regulations are discussed in this preamble. Many commenters expressed support for or disagreement with the general requirement to provide coverage for contraceptive services without cost sharing. Some commenters expressed support for the notion that any employer that has religious objections to covering contraceptive services should either be exempt from doing so, or should be able to avail itself of the accommodation. Other commenters stated that women should have access to contraceptive services without cost sharing, regardless of where they work, and that employers should not be permitted to deny them coverage, whether the employer's decision is for religious or other reasons. Many commenters suggested that the set of closely held for-profit entities eligible for the accommodation be defined as narrowly as possible.

The August 2014 proposed regulations would extend the availability of the ac-

²³An accommodation cannot be effectuated until all of the necessary information is submitted. If HHS receives a notice that does not include all of the required information, HHS will attempt to notify the organization of the incompleteness, so the organization can submit additional information to make its notice complete.

²⁴The Departments' oversight and enforcement role with respect to the market reforms under the Affordable Care Act builds upon their respective roles with respect to the market reforms under title I of HIPAA. For a description of the latter, see Notice of Signing of a Memorandum of Understanding among the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services at 64 FR 70165 (Dec. 15, 1999).

²⁵42 U.S.C. 2000bb *et. seq.*

commodation to closely held for-profit entities. The preamble proposed two possible approaches to defining a closely held for-profit entity. Under the first proposed approach, a qualifying closely held for-profit entity would be a for-profit entity where none of the ownership interests in the entity are publicly traded, and where the entity has fewer than a specified number of shareholders or owners (the Departments did not propose a specific number, but solicited comment on what the number should be). As explained in the preamble to the August 2014 proposed regulations, there is precedent in other areas of federal law for limiting the definition of closely held entities to those with a relatively small number of owners.²⁶ Under the second proposed approach, a qualifying closely held entity would be a for-profit entity in which the ownership interests are not publicly traded, and in which a specified fraction of the ownership interest is concentrated in a limited and specified number of owners (the Departments did not propose a specific level of ownership concentration but solicited comment on what that level should be). As explained in the preamble to the August 2014 proposed regulations, this approach also has precedent in federal law, which limits certain tax treatment to entities that are more than 50 percent owned by or for not more than five individuals.²⁷ The Departments invited comments on the appropriate scope of the definition of a qualifying closely held for-profit entity.

As explained in more detail below, these final regulations extend the accommodation to a for-profit entity that is not publicly traded, is majority-owned by a relatively small number of individuals, and objects to providing contraceptive coverage based on its owners' religious beliefs. This definition includes for-profit entities that are controlled and operated by individual owners who are likely to have associational ties, are personally identified with the entity, and can be regarded as conducting personal business affairs through the entity. Those entities appear to be the types of closely held for-profit

entities contemplated by *Hobby Lobby*, which involved two family-owned corporations that were operated in accordance with their owners' shared religious beliefs.²⁸ The Departments also believe that the definition adopted in these regulations includes the for-profit entities that are likely to have religious objections to providing contraceptive coverage. That assessment is supported by the comments received on the proposed regulation. As explained below, the Departments sought comment on a definition similar to the one adopted here, and we believe that no commenter identified an entity that would want to avail itself of the accommodation but that would be excluded by the definition. In addition, based on the available information, it appears that the definition adopted in these final regulations includes all of the for-profit entities that have as of the date of issuance of these regulations challenged the contraceptive coverage requirement in court.

The Departments believe that the definition adopted in these regulations complies with and goes beyond what is required by RFRA and *Hobby Lobby*. The Departments have extended the accommodations to the specified class of for-profit entities in order to provide additional protection to entities that may have religious objections to providing contraceptive coverage, and because the Departments believe that eligibility for the accommodations should be based on a rule that has origins in existing law.

Under the August 2014 proposed regulations and these final regulations, the first prong that an eligible organization (whether it be a nonprofit entity or a closely held for-profit entity) must meet in order to avail itself of the accommodation is that the entity must oppose providing coverage for some or all of any contraceptive item or service required to be covered, on account of religious objections. This requirement remains unchanged in these final regulations. (In the case of a for-profit entity, the entity must be opposed to providing these services on account of its owners' religious objections).

Many commenters supported excluding publicly traded entities from the definition of a closely held for-profit entity. However, a few commenters stated that a publicly traded entity should not be disqualified from the accommodation. Although the entities in *Hobby Lobby* were not publicly traded, one commenter noted that the Court did not expressly preclude publicly traded corporations from the protections of RFRA. Another commenter stated that if a publicly traded corporation could provide evidence of a sincere religious objection to providing contraceptive coverage, it should not be precluded from the accommodation.

These final regulations exclude publicly traded entities from the definition of an eligible organization. *Hobby Lobby* did not involve RFRA's application to publicly traded companies, and the Supreme Court emphasized that "the idea that unrelated shareholders – including institutional investors with their own sets of stakeholders – would agree to run a corporation under the same religious beliefs seems improbable."²⁹

Many commenters favored limiting the number of owners to "a handful," without specifying a maximum number. One commenter urged the Departments to establish a limit on the maximum number of shareholders for closely held entities of 999.

One commenter favored limiting the number of owners, but stated that any particular limit could lead to anomalous results for entities with more than the permitted number of owners that seek the accommodation. The commenter noted, for example, that if the maximum number of shareholders or owners is ten, nonpublicly traded companies with eleven shareholders would have to provide contraceptive coverage, no matter how sincerely held the religious objections of the owners. Another commenter who favored the approach stated that the definition should be limited to entities that have ten or fewer shareholders, and that shareholders should be counted based upon the definitions under subchapter S – that is, individuals should be counted along with

²⁶See discussion of definition of S corporations under section 1361 of the Tax Code, at 79 FR 51122.

²⁷See discussion of several Tax code provisions, including 26 U.S.C. 856(h), 542(a)(2), and 469(j)(1), at 79 FR 51122.

²⁸See 134 S. Ct. at 2764–2768.

²⁹134 S. Ct. at 2744.

certain trusts and estates. This would account for Qualified Subchapter S Trusts, but would not allow for other partnerships or corporations to be shareholders. This commenter also urged that members of the same family be counted as separate shareholders. Another commenter explained that a closely held company is commonly understood to be one that chooses S-corporation status or has fewer than 100 shareholders, and that many are privately held and owned by family members. Beyond these characteristics, the commenter urged, the size of the company should not matter. One commenter suggested following the close corporation definition from the applicable state or, in the absence of a corporate form, following the definition of a close corporation under Delaware law.

A few commenters supported a test that would be aligned with one of the federal tax law's definitions of a "closely held corporation." For example, commenters supported a definition that provides that the corporation may not have ownership interests that are publicly traded, that more than 50 percent of the outstanding ownership interests in the corporation must be owned (directly or indirectly) by five or fewer individuals at any time during the last half of the tax year, and that the corporation may not be a personal service corporation. The commenters favored identifying closely held entities through an approach based on this definition because such an approach would be easy to apply and already familiar to corporations that apply similar concepts under the Code.

Other commenters were generally opposed to a limited ownership-concentration test. One commenter observed that under this approach, a corporation would be able to concentrate a fraction of ownership, for example 50 percent, in a specified number of owners, such as ten people. The commenter observed that those ten individuals, who might comprise fewer than half of the total number of owners, would be able to direct the corporation to seek the accommo-

modation, potentially against the wishes of the minority shareholders.

Several commenters suggested that basing the definition either on the number of owners, or upon a concentration of ownership, would be inappropriate. One commenter stated that there is no basis in the *Hobby Lobby* decision to restrict the definition based on measures such as shareholder numbers, fractions of ownership, or tax rules. Another commenter stated that each of the proposed definitions of a "closely held corporation" is based on an arbitrary metric unrelated to the religious beliefs of the owners of the corporation. Another commenter stated that any rule that defines "closely held" in a narrow manner, such as by limiting the number, kind, or percentage control of a share of its owners, or by adopting definitions used in the Code, will violate RFRA and the *Hobby Lobby* decision. One commenter stated that a numerical test of shareholders will be both under- and over-inclusive, capturing corporations that meet the numerical test but whose shareholders are not expressing a religious belief through the corporation, and failing to capture corporations with a relatively large number of shareholders united in their religious interests. Another commenter believed that basing the definition of "closely held entity" solely on the number of owners would not limit eligibility to those types of entities addressed in the *Hobby Lobby* case.

One commenter believed that, for purposes of qualifying for the accommodation, an entity should only employ individuals who adhere to the owners' religious beliefs. The Departments do not believe this is a necessary characteristic for an entity to qualify as an eligible organization that can avail itself of the accommodation, and in *Hobby Lobby* the court granted relief to companies that did not possess this feature. Additionally, while the Departments have noted that exempting churches and their integrated auxiliaries (which the regulations refer to as "religious employers") from the requirement to provide contraceptive coverage does not impermissibly undermine the

government's compelling interests in promoting public health and ensuring that women have equal access to health care because churches are more likely to hire co-religionists,³⁰ the exemption to the contraceptive coverage requirement was provided against the backdrop of the longstanding governmental recognition of a particular sphere of autonomy for houses of worship, such as the special treatment given to those organizations in the Code.³¹ This exemption for churches and houses of worship is consistent with their special status under longstanding tradition in our society and under federal law, and is not a mere product of the likelihood that these institutions hire coreligionists. Hiring coreligionists is not itself a determinative factor as to whether an organization should be accommodated or exempted from the contraceptive requirements.

Another commenter stated that ownership of the entity should be limited to family members. The Departments do not believe that ownership of a closely held for-profit entity eligible for the accommodation should be limited to members of one family. Although many closely held corporations are family-owned, existing state and federal definitions of closely held or close corporations do not typically include this requirement. As stated below, however, for purposes of these final regulations, an individual is considered to own the ownership interests owned, directly or indirectly, by or for his or her family, meaning brothers and sisters (including half-brothers and half-sisters), spouses, ancestors, and lineal descendants. The Departments agree with the commenters who urged us to define a closely held entity, for purposes of these regulations, based on an existing federal definition. The Departments believe that this approach will minimize confusion for entities seeking the accommodation.

At the same time, the Departments also recognize the need for flexibility in the definition for purposes of the accommodation. Therefore, the Departments are adopting in these regulations a definition that is generally based on – but is more flexible than – the definition of a closely

³⁰78 FR 39887.

³¹26 U.S.C. 6033(a)(3)(A).

held corporation found in the Code³² (which we refer to as the tax-law definition). Under the tax-law definition, a closely held corporation is a corporation that has more than 50 percent of the value of its outstanding stock owned (directly or indirectly) by five or fewer individuals at any time during the last half of the tax year, and is not a personal service corporation.³³ The definitions for closely held corporation in various Code provisions reference the ownership test for personal holding companies contained in Code section 542(a)(2), which generally has the effect of identifying those corporations that are controlled by a small group of individuals and closely affiliated with their owners.

Drawing on the tax-law definition, with appropriate modifications to reflect the context here, these regulations establish that to be eligible for the accommodation, a closely held, for-profit entity must, among other criteria, be an entity that is not a non-profit entity, and have more than 50 percent of the value of its ownership interests owned directly or indirectly by five or fewer individuals, or must have an ownership structure that is substantially similar.

As previously stated, for purposes of defining a closely held for-profit entity in these regulations, the Departments are using a definition that is more flexible than the tax-law definition of closely held corporation. Because the Departments believe that the tax-law definition might exclude some entities that should be considered to be closely held for purposes of the accommodation, and because some for-profit entities may have unusual or non-traditional ownership structures not readily analyzed under the 5/50 test, the definition under these final regulations also includes, as stated above, entities with ownership structures that are “substantially similar” to structures that satisfy the 5-owner/50-percent requirement.

For example, an entity where 49 percent of the value of the outstanding ownership interests are owned directly by six individuals could also qualify as a closely held for-profit entity because it has an ownership structure that is substantially similar

to one in which five or fewer individuals hold at least 50 percent of the value of the outstanding ownership interests.

As another example, an entity owned by a series of corporate parents, where among the ultimate stockholders are a nonprofit entity and a for-profit corporation with three individual owners, who collectively own 45 percent of the outstanding ownership interests, also has a substantially similar ownership structure.

We note, however, that a publicly traded entity would not qualify as having a substantially similar ownership structure.

For purposes of the accommodation, the value of the ownership interests in the entity, whether the total ownership interests or those owned by five or fewer individuals, should be calculated based on all ownership interests, regardless of whether they have associated voting rights or any other privileges. This is consistent with how the tax-law definition of a closely held corporation is applied.

Because the accommodation will be sought on a prospective basis, the Departments do not believe it appropriate to incorporate, from the tax-law definition, the time interval over which the test is measured – that the given ownership structure be in place during the last half of the tax year – and instead adopt a test that is measured as of the date of the entity’s self-certification or notice of its objection to provide contraceptive services on account of religious objections.

The tax-law definition of “closely held corporation” excludes certain “personal services corporations,” such as accounting firms, actuarial science firms, architecture firms, and law firms. Although there are legitimate reasons for excluding personal service firms from the definition of “closely held corporation” for purposes of taxation, the Departments do not believe the distinction is necessary in this context. Therefore, a personal services corporation may qualify as a closely held for-profit entity under these final regulations, provided it satisfies the other criteria.

Following the tax-law definition, to determine if more than 50 percent of the value

of the ownership interests is owned by five or fewer individuals, the following rules apply:

- Ownership interests owned by or for a corporation, partnership, estate, or trust are considered owned proportionately by the entity’s shareholders, partners, or beneficiaries. For example, if a for-profit entity is 100 percent owned by a partnership, and the partnership is owned 100 percent by four individuals, the for-profit entity, for purposes of these regulations, is considered to be owned 100 percent by those four individuals.
- An individual is considered to own the ownership interests owned, directly or indirectly, by or for his or her family. The “family” includes only brothers and sisters (including half-brothers and half-sisters), a spouse, ancestors, and lineal descendants. Accordingly, the family members count as a single owner for purposes of these final regulations.
- If a person holds an option to purchase ownership interests, he or she is considered to be the owner of those ownership interests.

To assist potentially eligible for-profit entities seeking further information regarding whether they qualify for the accommodation, an entity may send a letter describing its ownership structure to HHS at accommodation@cms.hhs.gov. If the entity does not receive a response from HHS to a properly submitted letter describing the entity’s current ownership structure within 60 calendar days, as long as the entity maintains that structure, it will be considered to meet the requirement set forth in 26 CFR 54.9815–2713A(a)(4)(iii), 29 USC 2590.715–2713A(a)(4)(iii), and 45 CFR 147.131(b)(4)(iii). However, an entity is not required to avail itself of this process in order to qualify as a closely held for-profit entity.

Based on the information available, it appears that the definition of closely held for-profit entity set forth in these final regulations includes all the for-profit corporations that have filed lawsuits alleging that the contraceptive coverage require-

³²Code section 469(j)(1) states the “term ‘closely held C corporation’ means any C corporation described in section 465(a)(1)(B).” Section 465(a)(1)(B) provides “a C corporation with respect to which the stock ownership requirement of paragraph (2) of section 542(a) is met.” Section 542(a)(2) provides that the applicable stock ownership requirement is met if “[a]t any time during the last half of the taxable year more than 50 percent in value of its outstanding stock is owned, directly or indirectly, by or for not more than 5 individuals.” Similarly, section 856(h)(1)(A) provides “a corporation, trust, or association is closely held if the stock ownership requirement of section 542(a)(2) is met.”

³³See <http://www.irs.gov/Help-&-Resources/Tools-&-FAQs/FAQs-for-Individuals/Frequently-Asked-Tax-Questions-&-Answers/Small-Business,-Self-Employed,-Other-Business/Entities/Entities-5>.

ment, absent an accommodation, violates RFRA.

One commenter stated that the definition should include any for-profit entity that is controlled directly or indirectly by a nonprofit eligible organization. The Departments agree, because in this case the nonprofit entity will represent one shareholder that owns more than 50 percent of the ownership interests in the for-profit entity.³⁴ The same facts and circumstances that are considered in determining whether a given for-profit entity qualifies as an eligible for-profit organization under these final regulations will also apply when one or more of its owners is a nonprofit organization. For purposes of the ownership concentration test set forth in these final regulations that applies to for-profit entities, a nonprofit organization that has an ownership interest in a for-profit entity will be considered one individual owner of the for-profit entity, and the non-profit organization's percentage ownership in the for-profit entity will be attributed to that nonprofit organization.

(b) The process for making the decision to object to covering contraceptive services.

The August 2014 proposed regulations proposed that a closely held for-profit entity's objection to covering some or all of the contraceptive services otherwise required to be covered on account of its owners' sincerely held religious beliefs must be made in accordance with the organization's applicable rules of governance, consistent with state law. Some comments proposed alternative or additional criteria for how the decision must be made. One criterion suggested by many commenters was unanimity among all owners regarding opposition to contraception. However, one commenter objected to this requirement, stating that the regulations should not require unanimous shareholder consent because neither the *Hobby Lobby* decision nor state corporate law imposes such a requirement.

Some commenters favored requiring each equity holder to certify, under penalty of perjury, that he or she has a reli-

gious objection to the entity providing contraceptive coverage.

These final regulations do not adopt a requirement that the owners unanimously decide that the entity will not offer contraceptive coverage based on a religious objection, or that any equity holder certify under penalty of perjury that he or she has a religious objection to the entity providing the coverage. The Departments believe that either requirement would be unduly restrictive, and would unnecessarily interfere with for-profit entities' decision-making processes. Instead, these final regulations provide that the organization's highest governing body (such as its board of directors, board of trustees, or owners, if managed directly by the owners) must adopt a resolution (or take other similar action consistent with the organization's applicable rules of governance and with state law) establishing that the organization objects to covering some or all of the contraceptive services on account of its owners' sincerely held religious beliefs.

(c) Documentation of the decision to assert a religious objection to contraceptive coverage.

In the August 2014 proposed regulations, the Departments sought comments on whether a for-profit entity seeking the accommodation should be required to document its decision-making process for objecting to coverage for some or all contraceptive services on account of religious objections (as opposed to merely disclosing the fact that it made such a decision). Many comments supported a requirement that the decision-making process be documented, and that the entity submit, to its third party administrator or health insurance issuer, as applicable, and to the federal government, documentation of the entity's decision. These final regulations require that a for-profit entity seeking the accommodation must make the decision pursuant to a resolution (or other similar action), as described above. However, the Departments are not requiring that this resolution be provided as a matter of course to the federal government or any other party. Generally, the Departments believe it is sufficient that the fact of the

decision itself, as opposed to documentation of the decision, be communicated as set forth in August 2014 interim final regulations and these final regulations. However, with respect to documentation of the decision, record retention requirements under section 107 of ERISA apply directly to ERISA-covered plans and, with respect to other plans or coverage subject to these final regulations, by operation of these final regulations, which incorporate the record retention requirements under ERISA section 107 by reference. This approach is consistent with document standards for nonprofit entities seeking the accommodation.

(d) Disclosure of the decision to assert a religious objection to contraceptive services.

In the August 2014 proposed regulations, the Departments sought comments on whether a for-profit entity seeking the accommodation should be required to disclose publicly or to its employees its decision not to cover some or all contraceptive services on account of religious objections. This requirement would be in addition to the requirement that an eligible organization that is a for-profit entity that seeks the accommodation make its self-certification or notice of objection to providing contraceptive coverage on account of religious objections available for examination upon request by the first day of the plan year to which the accommodation applies, and be maintained in a manner consistent with the record retention requirements under section 107 of ERISA.

Many commenters suggested that the entity should be required to notify HHS of its decision to object (even if it chooses to self-certify and send the self-certification to its issuer or third party administrator). A few commenters stated that all employees and prospective employees (or student enrollees and their covered dependents) must be made aware of their employer's (or educational institution's) refusal to offer contraceptive coverage. One commenter stated that a closely held for-profit entity should disclose the following to its shareholders and employees: (A) the rea-

³⁴See EBSA Form 700.

sons the decision was made, (B) the changes that will take place as a result of the decision, and (C) the number of people that will be affected by the decision. Another commenter stated that entities availing themselves of the accommodation should be required to publicize their justifications for denying women access to coverage of medications that serve purposes other than contraception. One commenter noted the need of employees to know by the employer's annual open enrollment period whether the employer is availing itself of the accommodation.

These final regulations do not establish any additional requirements to disclose the decision. The Departments believe that the current notice and disclosure standards afford individuals eligible for or enrolled in group health plans (and students eligible for or enrolled in student health insurance) with an accommodation adequate opportunity to know that the employer (or educational institution) has elected the accommodation for its group health plan (or insurance coverage), and that they are entitled to separate payment for contraceptive services from another source without cost sharing. Those standards require that, for each plan year to which the accommodation applies, a third party administrator that is required to provide or arrange payments for contraceptive services, and a health insurance issuer required to provide payment for these services, provide to plan participants and beneficiaries (or student enrollees and their covered dependents) written notice of the availability of separate payments for these services contemporaneous with (to the extent possible), but separate from, any application materials distributed in connection with enrollment or re-enrollment in health coverage. Model language for this notice is provided in the regulations.

(e) Sincerity of the owners' religious beliefs.

Many commenters suggested that, for a closely held for-profit entity to be eligible for an accommodation, it should not be sufficient that the entity's owners object to providing contraceptive coverage. Rather,

the commenters proposed that owners should also be required to agree to operate the entity in a manner consistent with religious principles, and in fact to so operate the entity. Some commenters pointed out that the July 2013 final regulations require non-profit religious organizations that avail themselves of the accommodation to "hold themselves out" as religious organizations.

The Departments have not adopted such a criterion for for-profit entities. The Supreme Court's decision in *Hobby Lobby* discussed the application of RFRA in connection with the religious beliefs of the owners of a closely held corporation.³⁵ These final regulations similarly focus on the religious exercise of the owners of the closely held entity and provide that the entity, in advancing the religious objection, represent that it does so on the basis of the religious beliefs of the owners. The Departments do not believe it is also necessary that the entity itself demonstrate by its bylaws, mission statement, or other documents or practices that it has a religious character. Non-profit entities ordinarily do not have owners in the same way as do for-profit entities, and thus the religious character of a non-profit entity would be reflected in how it holds itself out.

(f) Other steps the Departments should take to ensure contraceptive coverage with no cost sharing.

The August 2014 proposed regulations solicited comments on other steps the Departments should take to help ensure that participants and beneficiaries (in the case of student health insurance coverage, enrollees and dependents) in plans subject to an accommodation are able to obtain, without cost, the full range of FDA-approved contraceptives without cost sharing. Many commenters stated that a government enforcement body should be established to monitor compliance by plan sponsors, third party administrators, and health insurance issuers, of their respective obligations associated with the accommodation. At this time, the Departments do not believe that an independent body need be established, although as

stated above, the Departments will use their established oversight processes, applicable to all the Affordable Care Act market reforms of title XXVII of the PHS Act to monitor compliance with the requirement to provide contraceptive services without cost sharing. As part of those processes, the Departments will work with non-compliant parties to bring them into compliance, and will take enforcement action as appropriate.

Other commenters stated that the federal government should ensure that no barriers to contraceptive coverage exist due to an enrollee's cultural background, English proficiency, disability, or sexual orientation. The Departments agree that no barriers should exist. The same federal and applicable state laws that would prohibit discrimination by employers, group health plans, third party administrators, and health insurance issuers generally would also apply with respect to the entities arranging for or providing separate payments for contraceptive services for women in group health plans and student health insurance subject to an accommodation.

Other commenters urged that the separate payments for contraceptive services be provided in the same manner in which the group health plan or student health insurance would have otherwise covered these services had they not had an accommodation, or in the same manner in which the plan or coverage subject to an accommodation covers other, non-contraceptive benefits. The Departments, however, maintain the view that reasonable differences in the way services are paid for or provided would not necessarily be inappropriate, provided those differences do not create barriers to accessing payments for contraceptive services. Another commenter stated that health insurance issuers of plans subject to an accommodation should not be permitted to require enrollees to have two insurance cards, one for contraceptive benefits, and one for other benefits. The Departments do not believe that this practice, in of itself, would constitute a barrier to accessing separate payments for contraceptive services.

³⁵See 134 S. Ct. at 2768.

(g) Other comments that relate to the July 2013 final regulations.

In the August 2014 proposed regulations and interim final regulations, the Departments sought comment on other potential changes to the July 2013 final regulations in light of the proposed change to the definition of eligible organization. In particular, the Departments sought comment on applying the approach set forth in the July 2013 final regulations in the context of the expanded definition of eligible organization. The July 2013 final regulations provide for separate payments for contraceptive services for participants and beneficiaries in self-insured group health plans of eligible organizations in a manner that enables these organizations to completely separate themselves from administration and payment for contraceptive coverage. Specifically, the third party administrator must provide or arrange the payments, and the third party administrator can seek reimbursement for the costs (including an allowance for administrative costs and margin) by making an arrangement with a participating issuer – that is, an issuer offering coverage through a Federally-facilitated Exchange (FFE). The participating issuer can receive an adjustment to its FFE user fees to finance these costs.

One commenter suggested that the federal government set up a program to dispense these services using contractors. Another commenter suggested that pharmaceutical companies could provide certain contraceptives directly by mail to persons who are told at a dispensing pharmacy that their plan has denied coverage. Additionally, the pharmaceutical companies could directly supply doctors who prescribe birth control, who in turn could dispense directly to patients who are not covered under their employer-sponsored group health plan or student health insurance coverage. One commenter suggested making contraception available for any woman free of charge through a doctor. One commenter suggested providing contraceptive care through Medicaid.

The Departments have not adopted the proposals advanced by these comments for two reasons. First, the Departments do not have the legal authority to require

pharmaceutical companies or doctors to provide contraceptives directly, nor do they have the authority to implement the other alternative arrangements proposed by these commenters. Second, these alternatives raise obstacles to access to seamless coverage. Consistent with the statutory objective of promoting access to contraceptive coverage and other preventive services without cost sharing, plan beneficiaries and enrollees should not be required to incur additional costs – financial or otherwise – to receive access and thus should not be required to enroll in new programs or to surmount other hurdles to receive access to coverage. The Departments believe that the third party administrators and health insurance issuers already paying for other medical and pharmacy services on behalf of the women seeking the contraceptive services are better placed to provide seamless coverage of the contraceptive services, than are other providers that may not be in the insurance coverage network, and that lack the coverage administration infrastructure to verify the identity of women in accommodated health plans and provide formatted claims data for government reimbursement.

Some commenters suggested other changes to the July 2013 regulations, with respect to how separate payments for contraceptive services provided under the accommodation are funded. One commenter expressed concern that the August 2014 proposed regulations are silent as to possible funds for reimbursement of costs incurred for contraception services where there is no FFE operating in the state. This commenter also noted that the regulations do not consider the possibility that the cost for contraceptive services may exceed the issuer's FFE user fee, nor do they address how a third party administrator would be reimbursed if the issuer is no longer a participating issuer in the FFE. The commenter suggested the Departments consider several different financing options: the user fee for the risk adjustment program; the CMS program management fund; the user fee for the Medicare Part D program; the Prevention and Public Health Fund; medical loss ratio rebates; CMS innovation funding; and the health insurance provider fee.

Another commenter recommended that HHS provide for an expedited process of adjusting FFE user fees in case the volume of contraceptive claims is greater than expected. This commenter also suggested that the Departments also consider alternative means of generating funding for this purpose, such as allowing an issuer to charge a premium of at least an amount equal to the pro rata share of the rate the eligible organization would have paid had it not elected the accommodation, or directly subsidize the cost of contraception using funding provided by the Prevention and Public Health Fund.

One commenter stated that the Departments should evaluate the limitations of current funding arrangements with respect to the current accommodation for eligible non-profit entities, given the additional demands of the proposal to expand the accommodation to certain for-profit entities. The commenter suggested allowing a separate government funded reimbursement mechanism for enrollees in both insured and self-funded plans as an alternative approach to funding the program. If the current funding approach is continued, the commenter recommended a reassessment of the limitations of the approach for third party administrators. If third party administrators remain responsible for providing or arranging separate payments for contraceptive services, the commenter recommended a broadening of the pool available for reimbursement beyond individually negotiated arrangements with issuers participating in the FFE, including potentially establishing a single pool for reimbursement or finding an alternative, simpler financing mechanism for third party administrators, including offsets from federal income taxes, and offsets to amounts due from other lines of business operated by the third party administrator.

At this time, the Departments are not adopting an alternative approach to funding separate payments for contraceptive services with respect to costs incurred for women in plans subject to an accommodation, although the Departments will continue to explore the feasibility of different ideas, including those proposed in the comments.

One commenter suggested that issuers should be permitted to treat the cost of providing separate payments for contra-

ceptive services for women in plans subject to an accommodation as an adjustment to claims costs for purposes of calculating their medical loss ratios, while still being allowed to treat such payments as an administrative cost spread across the issuer's entire risk pool.³⁶ With respect to calculating medical loss ratios, HHS has previously stated in rulemaking that an insurer of an accommodated insured group health or student plan may include the cost of the actual payments it makes for contraceptive services in the numerator of its medical loss ratio.³⁷

Several commenters asked whether, in light of the fact that the accommodation was proposed to be expanded to a new set of entities, if the Department's discussion in the preamble to the July 2013 final regulations about the extent to which the accommodation has an effect on other laws, continues to apply.³⁸ The Departments explained in that discussion that state insurance laws that provide greater access to contraceptive coverage than federal standards are unlikely to be preempted, and that, in states with broader religious exemptions and accommodations with respect to health insurance issuers than those in the regulations, plans are still required to comply with the federal standard. These principles continue to apply.

One commenter stated that the *Hobby Lobby* decision applies to every form of medical care, not just contraception, and that the regulations should reflect that. However, in *Hobby Lobby*, the Court stated:

In any event, our decision in these cases is concerned solely with the contraceptive mandate. Our decision should not be understood to hold that an insurance-coverage mandate must necessarily fail if it conflicts with an employer's religious beliefs. Other coverage requirements, such as immunizations, may be supported by different interests (for example, the need to combat the spread of infectious diseases) and may involve different

arguments about the least restrictive means of providing them.³⁹

Regarding fully insured plans, one commenter noted that the July 2013 final regulations permit issuers that are providing separate payments for contraceptive services under the accommodation, to pay for all FDA-approved contraceptive services, or only for those services to which the eligible organization objects to covering on religious grounds. The commenter noted that this approach simplifies the operational issues associated with implementing the accommodation across multiple employers, and sought clarification that this approach is available to third party administrators as well. The Departments clarify that this option is available to third party administrators with respect to self-insured plans.

One commenter requested that notices of objection to covering contraceptive services on religious grounds be provided with at least 60 days' advance notice, and that any change in objection status based on change of ownership of the employer not be implemented until the next plan year or policy year. The Departments do not adopt this suggestion. Instead, the Departments are extending, to closely held for-profit entities, the same timeframes that have been in effect for non-profit eligible organizations, that is, a plan sponsor can provide such notice, and implement plan benefit changes associated with the accommodation, at any time. For group health plans subject to ERISA, existing notice and timeframe requirements under ERISA apply.

Another commenter stated that health insurance issuers and third party administrators should only be required to provide or arrange for separate payments for contraceptive services for eligible organizations that have invoked an accommodation no earlier than the first day of the first plan year that follows publication of these final regulations. To provide employers, institutions of higher education, third party administrators, and health insurance issuers adequate time to comply, these

final regulations apply beginning on the first day of the first plan year (or, in the individual market, the first policy year) after these regulations are effective. Accordingly these final regulations are effective beginning on the first day of the first plan year (or, in the individual market, the first policy year) that begins on or after September 14, 2015.

Several commenters stated that the decision to not cover some or all contraceptives on religious grounds should be made annually. The Departments do not believe such a requirement is appropriate or necessary.

One commenter asked for clarification as to how a notice of objection would be provided by employers purchasing coverage through the Small Business Health Options Program (SHOP) and whether there will be a mechanism in place that permits an eligible organization to select a small group plan and provide a notice of objection. With respect to employers purchasing coverage through the SHOP, health insurance issuers selling policies through it, and participants and beneficiaries in such plans, all of the rights and obligations that are associated with these regulations apply no differently than if the employer were to purchase coverage outside of the SHOP.

One commenter stated that providing separate payments for contraceptive services is not cost-neutral for an issuer, and that it is not appropriate for an issuer of a student health insurance plan to be required to make separate payments for contraceptive services for enrollees in student health plans subject to an accommodation, and suggested that the Marketplaces should instead offer free individual market policies covering contraception to those who desire such coverage, or that such individuals get such services through existing clinics. In the alternative, the commenter proposed an "above the line" deduction on their federal income taxes for all costs incurred for separate payments made for contraceptive services for enrollees in a student health plan subject to an accommodation. The Departments do not adopt the comment. For the

³⁶See Discussion of how an issuer may achieve cost neutrality in the preamble to the July 2013 final regulations, at 78 FR 39878.

³⁷See Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015 (Mar. 11, 2014), at 79 FR 13809.

³⁸78 FR 39888.

³⁹134 S. Ct. at 2783.

reasons stated in the July 2013 final regulations, the Departments believe that covering contraceptive services is cost-neutral for an issuer at risk for the enrollees in a plan subject to an accommodation. With respect to student health insurance plans, these regulations finalize a clarification proposed in the August 2014 proposed regulations under which a reference to the definition of “institution of higher education” found in 20 U.S.C. 1002 is added to 45 CFR 147.131(f), to clarify that both nonprofit and closely held for-profit institutions of higher education, with respect to their insured student health plans, may qualify as eligible organizations.

III. Economic Impact and Paperwork Burden

A. Executive Orders 12866 and 13563 – Department of Health and Human Services and Department of Labor.

Executive Order 12866 (58 FR 51735) directs 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 (76 FR 3821, January 21, 2011) is supplemental to and reaffirms the principles, structures, and definitions governing regulatory review as established in Executive Order 12866.

Section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a proposed rule—(1) having an annual effect on the economy of \$100 million or more in any one year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as “economically significant”); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or

the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year), and a “significant” regulatory action is subject to review by the Office of Management and Budget (OMB). As discussed below, the Departments anticipate that these regulations – most notably the policies first established in the 2010 interim final rule – are likely to have economic impacts of \$100 million or more in any one year, and therefore meet the definition of “significant rule” under Executive Order 12866. Therefore, the Departments have provided an assessment of the potential costs, benefits, and transfers associated with these final regulations. In accordance with the provisions of Executive Order 12866, these final regulations were reviewed by the OMB.

1. Need for Regulatory Action

These final regulations finalize the July 2010 interim final regulations related to coverage of recommended preventive services, the August 2014 interim final regulations related to the process an eligible organization uses to provide notice of its religious objections to the coverage of contraceptive services, and the August 2014 proposed regulations related to the definition of eligible organization.

As discussed later in the RIA, historically there has been an underutilization of preventive services, as health insurance issuers have had little incentive to cover these services. Currently, there is still an underutilization of some preventive services due to a number of barriers, including costs, ethnic/gender disparities⁴⁰, and a general lack of knowledge by those with medical coverage.⁴¹ While many of these factors are being addressed through the Affordable Care Act and these final regulations, the current underutilization of preventive services stems from three main

factors. First, due to turnover in the health insurance market, health insurance issuers have historically lacked incentives to cover preventive services, whose benefits may only be realized in the future when an individual may no longer be enrolled with that issuer. Second, many preventive services generate benefits that do not accrue immediately to the individual that receives the services, making the individual less likely to avail themselves of the services, especially in the face of direct, immediate costs. Third, some of the benefits of preventive services accrue to society as a whole, and thus do not get factored into an individual’s decision making over whether to obtain such services.

The July 2010 interim final regulations and these final regulations address these market failures through two avenues. First, the regulations require coverage of recommended preventive services by non-grandfathered group health plans and health insurance issuers in the group and individual markets, thereby overcoming plans’ lack of incentive to invest in these services. Second, the regulations eliminate cost-sharing requirements, thereby removing a barrier that could otherwise lead an individual to not obtain such services, given the long-term and partially external nature of these benefits.

The August 2014 interim final regulations provided an alternate process that eligible organizations can use to provide notice of their religious objections to providing coverage for some or all of the contraceptive services to HHS, instead of providing the EBSA Form 700 to the issuers or third party administrators of their group health plan. The provisions of those interim final regulations are being finalized without any changes.

These final regulations also amend the definition of an eligible organization to include a closely held for-profit entity that has a religious objection to providing coverage for some or all of the contraceptive services otherwise required to be covered by the group health plan or student health insurance plan established, maintained, or arranged by the organization.

⁴⁰Call, K. T., McAlpine, D. D., Garcia, C. M., Shippee, N., Beebe, T., Adeniyi, T. C., & Shippee, T. (2014). Barriers to Care in an Ethnically Diverse Publicly Insured Population. *Medical Care*.

⁴¹Reed, M. E., Graetz, I., Fung, V., Newhouse, J. P., & Hsu, J. (2012). In consumer-driven health plans, a majority of patients were unaware of free or low-cost preventive care. *Health Affairs*, 31(12), 2641–2648.

These final regulations are necessary in order to provide rules that plan sponsors and issuers can continue to use to determine how to provide coverage for certain recommended preventive services without the imposition of cost sharing, to ensure women's ability to receive those services, and to respect the religious beliefs of qualifying eligible organizations with respect to their objection to covering contraceptive services.

2. Summary of Impacts

In accordance with OMB Circular A-4, Table III.1 below depicts an accounting statement summarizing the Departments' assessment of the benefits, costs, and transfers associated with this regulatory action. It is expected that all non-grandfathered plans are already complying with the provisions of the July 2010 and August 2014 interim final regu-

lations. Therefore, benefits related to those regulations have been experienced and costs have already been incurred. The Departments are providing an assessment of the impacts of existing provisions already experienced and expected in the future, in addition to the anticipated impacts of new provisions in these final regulations.

Table III.1: Accounting Table

Benefits:
<p>Qualitative:</p> <ul style="list-style-type: none"> * Increased access to and utilization of recommended preventive services, leading to the following benefits: <ol style="list-style-type: none"> (1) prevention and reduction in transmission of illnesses as a result of immunization and screening of transmissible diseases; (2) delayed onset, earlier treatment, and reduction in morbidity and mortality as a result of early detection, screening, and counseling; (3) increased productivity and reduced absenteeism; and (4) savings from lower health care costs. * Benefits to eligible for-profit entities from not being required to facilitate access to or pay for services that contradict their owners' religious beliefs.
Costs:
<p>Qualitative:</p> <ul style="list-style-type: none"> * New costs to the health care system when individuals increase their use of preventive services in response to the changes in coverage and cost-sharing requirements of preventive services. The magnitude of this effect on utilization depends on the price elasticity of demand and the percentage change in prices facing those with reduced cost sharing or newly gaining coverage. * Administrative cost to eligible for-profit entities to provide self-certification to issuers or third party administrators or notice to HHS. * Administrative cost to issuers and third party administrators for plans sponsored by eligible closely held for-profit entities to provide notice to enrollees.
Transfers:
<ul style="list-style-type: none"> * Costs previously paid out-of-pocket for certain preventive services are now covered by group health plans and issuers. * Risk pooling in the group market will result in sharing expected cost increases across an entire plan or employee group as higher average premiums for all enrollee. However, not all of those covered will utilize preventive services to an equivalent extent. As a result, these final regulations create a small transfer from those paying premiums in the group market utilizing less than the average volume of preventive services in their risk pool to those whose utilization is greater than average. To the extent there is risk pooling in the individual market, a similar transfer will occur. * Transfer of costs related to certain preventive services from eligible self-funded closely held for-profit entities to third party administrators and issuers that provide (or arrange) separate payments for contraceptive services. Third party administrators can make arrangements with an issuer offering coverage through an FFE to obtain reimbursement for its costs, and the issuer offering coverage through the FFE can receive an adjustment to the FFE user fee.

3. Estimated number of Affected Entities

For purposes of this analysis, the Departments have defined a large group health plan as an employer plan with 100

or more workers and a small group plan as an employer plan with less than 100 workers. The Departments estimate that there are approximately 140,000 large and 2.2 million small ERISA-covered group

health plans with an estimated 93.2 million participants in large group plans and 36 million participants in small group plans. The Departments estimate that there are approximately 128,000 govern-

mental plans with 39 million participants in large plans and 2.8 million participants in small plans.⁴² In 2013, approximately 12.26 million participants were covered by individual health insurance policies.⁴³

Group health plans and health insurance issuers offering group and individual health insurance coverage that are not grandfathered health plans will be affected by these regulations. There are an estimated 500 issuers offering group and individual health insurance coverage.⁴⁴ The number of employer-sponsored grandfathered plans has been decreasing steadily since 2010. Thirty-seven percent of employers offering health benefits offered at least one grandfathered health plan in 2014, compared to 54 percent in 2013 and 72 percent in 2011. Therefore, more and more enrollees in employer-sponsored plans have gained access to preventive services without cost sharing. Twenty-six percent of covered workers were enrolled in a grandfathered health plan in 2014, as compared to 36 percent in 2013 and 56 percent in 2011.⁴⁵ In the individual market, it is expected that a large proportion of individual policies are not grandfathered. In addition, enrollees in qualified health plans purchased through the Marketplaces have non-grandfathered policies. At the end of the second enrollment period, nearly 11.7 million individuals selected or were automatically reenrolled into a 2015 health insurance plan through the Marketplaces.⁴⁶

It is uncertain how many closely held for-profit entities have religious objections to providing coverage for some or all

of the contraceptive services otherwise required to be covered. Based on litigation and communication received by HHS, the Departments estimate that at least 87 closely held for-profit eligible organizations will seek the religious accommodation provided in these final regulations. Health insurance issuers (or third party administrators for self-insured plans) for the group health plans established or maintained by these eligible organizations (and health insurance issuers of closely held for-profit institutions of higher education) will assume sole responsibility for providing (or arranging) separate payments for contraceptive services directly for plan participants and beneficiaries (and for student enrollees and dependents), without cost sharing, premium, fee, or other charge to plan participants or beneficiaries (or student enrollees and dependents) or to the eligible organization or its plan. In addition, based on litigation, the Departments estimate that at least 122 non-profit eligible organizations will have the option to provide notice of their religious objections to HHS, instead of providing the EBSA Form 700 to the issuer or third party administrator of their group health plan. These numbers are likely to underestimate the number of eligible organizations that will seek the accommodation. However, these are the best estimates available to the Departments at this time.

4. Benefits

In the July 2010 interim final regulations, the Departments anticipated several

types of benefits that will result from expanding coverage and eliminating cost sharing for recommended preventive services. First, individuals will experience improved health as a result of reduced transmission, prevention or delayed onset, and earlier treatment of disease. Second, healthier workers and children will be more productive with fewer missed days of work or school. Third, some of the recommended preventive services will result in savings due to lower health care costs.

As stated in the July 2010 interim final regulations, preventive service coverage is limited to those recommended by the Task Force (grade of A or B), an applicable Advisory Committee, and HRSA.⁴⁷ These final regulations can be expected to continue to increase access to and utilization of these services, which have been historically underutilized. For example, 27.7 percent of adults aged 50 to 75 have never been screened for colorectal cancer (such as sigmoidoscopy and/or colonoscopy).⁴⁸ In 2012, the median percentage of women over the age of 18 that have not had a pap test in the past 3 years was 22 percent.⁴⁹ The CDC recently found that in adults over 50, fewer than 30 percent are up-to-date with core preventive services.⁵⁰

As explained in the July 2010 interim final regulations, numerous studies have shown that improved coverage, or reduced costs, of preventive services results in higher utilization of these services⁵¹ leading to potentially substantial benefits. Research suggests there are significant health benefits associated with a number of newly covered preventive services re-

⁴²All participant counts and the estimates of individual policies are from the U.S. Department of Labor, EBSA calculations using the March 2013 Current Population Survey Annual Social and Economic Supplement and the 2012 Medical Expenditure Panel Survey and the 2012 Census of Government.

⁴³This estimate includes enrollment in student health insurance plans. Source: Data from Medical Loss Ratio submissions for 2013 reporting year, available at <http://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html>.

⁴⁴Source: Data from Medical Loss Ratio submissions for 2013 reporting year.

⁴⁵See Kaiser Family Foundation and Health Research and Education Trust, Employer Health Benefits 2014 Annual Survey (2014), available at <http://kff.org/private-insurance/report/2014-employer-health-benefits-survey/>; and Employer Health Benefits 2011 Annual Survey (2011) available at <http://kff.org/health-costs/report/employer-health-benefits-annual-survey-archives/>.

⁴⁶This estimate represents the number of individuals who have selected, or been automatically reenrolled into a 2015 plan through the Marketplaces, with or without payment of premium. See ASPE, Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report, available at http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf.

⁴⁷See <http://www.ahrq.gov/research/findings/final-reports/uspstf/uspstfval.pdf> for details of the Task Force grading and <http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/> for current recommendations.

⁴⁸CDC. Vital Signs: colorectal cancer screening test use – United States, 2012. *MMWR* 2013;62:881–888.

⁴⁹Behavioral Risk Factor Surveillance System Numbers (2012), <http://apps.nccd.cdc.gov/BRFSS/page.asp?cat=CC&yr=2012&state=All#CC>.

⁵⁰CDC Focuses on Need for Older Adults To Receive Clinical Preventive Services, brief released by CDC (2012), <http://www.cdc.gov/aging/pdf/cps-clinical-preventive-services.pdf>.

⁵¹See e.g., Meeker D, Joyce GF, Malkin J, et al. Coverage and preventive screening. *Health Serv Res.* 2011; 46:173–184. Study found that patients responded to the exclusion of preventive services from deductibles and reducing cost sharing resulted in increased utilization of lipid screening, pap smears, and other services. See e.g., Jill Bernstein, Deborah Chollet, and G. Gregory Peterson, Encouraging Appropriate Use of Preventive Health Services, Issue Brief *Mathematica Policy Research Inc.*, Princeton, NJ (May 2010) Number 2.

quired under the statute and these final regulations. The National Council on Preventive Priorities (NCP) has estimated that achieving a utilization rate of 90 percent for eight clinical preventive services would save more than 150,000 lives each year in the U.S., including 42,000 if smokers were offered medication or other cessation assistance (Table III.2).⁵² From

an economic viewpoint, many preventive services offer high economic value⁵³ resulting in an estimated savings of \$3.7 billion.⁵⁴ Even if a rate of 90 percent utilization is not achieved due to a variety of barriers, including financial, service accessibility, and socioeconomic disparities, the Departments expect that utilization will increase among those individuals in

plans subject to the regulations because the provisions eliminate cost sharing and require coverage for these services. It is expected that the increased utilization of these services will lead providers to increase their use of these services knowing that they will be covered without cost sharing.

Table III.2 – Lives Saved From Increasing Utilization of Selected Preventive Services

Preventive Service	Population Group	Percent utilization (2005)	Lives saved annually if 90 percent utilization
Regular aspirin use	Men 40+ / Women 50+	40	45,000
Smoking cessation (medication and advice)	All adult smokers	28	42,000
Colorectal cancer screening	Adults 50+	48	14,000
Influenza vaccination	Adults 50+	37	12,000
Cervical cancer screening (in past 3 years)	Women 18–64	83	620
Cholesterol screening	Men 35+ / Women 45+	79	2,450
Breast cancer screening (in past 2 years)	Women 40+	67	3,700
Chlamydia screening	Women 16–25	40	30,000

Source: National Commission on Prevention Priorities, 2007

Studies comparing the utilization of preventive services among adults show utilization rates range from as high as 89 percent for blood pressure checks to only 40 percent for annual flu vaccinations.⁵⁵ Under the Affordable Care Act, there have been significantly higher usage rates of several preventive services in young adults and women, including blood pressure tests, cholesterol screening, and contraceptive services.⁵⁶ Numerous studies have shown that improved coverage, or reduced costs, of preventive services results in higher utilization of these ser-

vices⁵⁷ leading to potentially substantial benefits. The Departments expect that utilization of preventive services will continue to increase over time among those individuals in plans affected by these regulations because the provisions eliminate cost sharing and require coverage for these services.

Some recommended preventive services have both individual and public health value. Vaccines have reduced or eliminated serious diseases that, prior to vaccination, routinely caused serious illnesses or deaths. Maintaining high levels

of immunization in the general population protects the un-immunized from exposure so that individuals who cannot receive, or who do not have a sufficient immune response to the vaccine, are indirectly protected.⁵⁸

A second type of benefit of these final regulations is improved workplace productivity and decreased absenteeism for school children. A study by *Gallup* has found that among workers working at least 30 hours a week, those considered overweight or obese with one or more chronic condition will miss one to 3.5

⁵²National Commission on Prevention Priorities. *Preventive Care: A National Profile on Use, Disparities, and Health Benefits*. Partnership for Prevention, August 2007. <http://www.prevent.org/data/files/initiatives/ncpppreventivecarereport.pdf>.

⁵³Wolf, Steven. A Closer Look at the Economic Argument for Disease Prevention. *JAMA* 2009; 301(5):536–538.

⁵⁴Maciosek, Michael V., Coffield, Ashley B., Flottemesch, et al., Use of Preventive Services In U.S. Health Care Could Save Lives At Little Or No Cost. *Health Affairs* 2010, 29(9) 1656–1660.

⁵⁵The Commonwealth Fund. “Current Trends in Health Coverage and the Effects of Implementing the Affordable Care Act” (2013). http://www.commonwealthfund.org/~media/files/publications/fund-report/2013/apr/1681_collins_insuring_future_biennial_survey_2012_final.pdf.

⁵⁶See, e.g., Lau JS, Adams SH, Park MJ, Boscardin WJ, Irwin CE. Improvement in preventive care of young adults after the affordable care act: the affordable care act is helping. *JAMA Pediatr.* 2014; 168(12):1101-1106. See e.g., Sonfield, A., Tapales, A., Jones RK., Finer, LB. Impact of the federal contraceptive coverage guarantee on out-of-pocket payments for contraceptives: 2014 update. *Contraception*, 2015: 91(1): 44–48.

⁵⁷See e.g., Meeker D, Joyce GF, Malkin J, et al. Coverage and preventive screening. *Health Serv Res.* 2011; 46:173–184. Study found exclusion of deductibles from, and reduced cost sharing of preventive services resulted in increased utilization of lipid screening, pap smears, and other services. See e.g., Jill Bernstein, Deborah Chollet, and G. Gregory Peterson, Issue Brief Mathematica Research Policy Inc., Princeton, NJ (May 2010) Number 2.

⁵⁸See *Modern Infectious Disease Epidemiology* by Johan Giesecke 1994, Chapter 18, The Epidemiology of Vaccination.

days of work a month.⁵⁹ With an estimated 450 million days lost to absenteeism, the cost of lost productivity due to personal health or the inability to concentrate due to their own or a family member's illness is estimated to be between \$153 and \$260 billion annually.⁶⁰

Illness and poorly controlled chronic disease also contribute to increased absenteeism among school children. Recent data indicates that in the 2011–2012 academic year, 6.2 percent of children aged 6 through 17 missed 11 or more days of school.⁶¹ Studies have shown that student health and well-being have been positively linked to students' academic outcomes, including attendance, grades, test scores, and high school graduation.⁶² As discussed in the July 2010 interim final rules, studies show that reduced cost sharing and increased access to care can improve productivity in both schools and the labor market. Thus, it is expected that these final regulations can have a substantial benefit to the children in the nation's education system and the labor market, both current and future.

A third type of benefit from some preventive services is cost savings. Increasing the provision of preventive services is expected to reduce the incidence or severity of illness, and, as a result, reduce expenditures on treatment of illness. As discussed in the July 2010 interim final regulations and elsewhere,⁶³ childhood vaccinations have been found to generate considerable benefit and savings to both individuals and society. Employing a decision analysis cohort model of U.S. children born during 1994–2013, researchers

at CDC analyzed the economic impact of DTaP (diphtheria and tetanus toxoids and acellular Pertussis), Hib (*Haemophilus influenzae* type b), Polio (OPV then IPV), MMR (measles, mumps and rubella), Hepatitis B, varicella, pneumococcal disease (PCV, 7-valent and 13-valent), and rotavirus vaccines in children aged ≤ 6 years. The study estimates that among the 78.6 million children born during this period, these routine immunizations will prevent 322 million illnesses and 21 million hospitalizations, averting 732,000 premature deaths over their lifetime. Furthermore, it was estimated that these routine vaccinations will potentially avert \$402 billion in direct costs and \$1.5 trillion in societal costs and a net savings of \$295 billion and \$1.38 trillion for payers and society, respectively (in 2013 dollars).⁶⁴

As with immunizations, other preventive services have been estimated to have cost-savings benefits. As discussed in the July 2010 interim final regulations, aspirin use with high risk adults and tobacco cessation and screening can both yield net savings. For example, in Massachusetts, the availability of tobacco cessation treatments combined with promotional campaigns resulted in a ten percent decline in Medicaid enrolled smokers, a \$3.12 savings for every dollar spent on the benefit.⁶⁵ As discussed in more detail in the July 2010 interim final regulations, another area where prevention can achieve savings is obesity prevention and reduction. Based on recent guidelines, up to 116.1 million American adults are candidates for both pharmaceutical and behav-

ioral treatments for weight loss, and up to 32 million are eligible for bariatric surgery.⁶⁶ According to the CDC, from 2011–2012, 16.9 percent of children 2 through 19 years of age and 34.9 percent of adults aged 20 and over were obese (defined as having a body mass index (BMI) greater than or equal to the age and sex-specific 95th percentiles of the 200 CDC growth charts).⁶⁷ One study used the number of obese and overweight twelve-year olds in 2005 to simulate a cohort over their lifetimes, indicating that a sustained one-percentage-point decrease in the prevalence of obesity over the lifetime of this cohort would result in an estimated savings of \$260.4 million in total medical expenditures.⁶⁸ These final regulations are expected to increase the take-up rate of preventative services counseling for obesity and other conditions among patients, and lead physicians to increase appropriate referrals for such services. The effect of these final regulations is expected to be magnified due to the numerous public and private sector initiatives dedicated to combating the obesity epidemic and smoking cessation.

Eligible closely held for-profit entities that seek the accommodation to exclude coverage for contraceptive services from health coverage offered to their employees and students, and eligible organizations that opt to provide notice to HHS, will benefit from not being required to facilitate access to or pay for coverage that are contrary to their owners' religious beliefs. Women enrolled in plans under this accommodation will have continued

⁵⁹Unhealthy U.S. Workers' Absenteeism Costs \$153 Billion. Well-Being, Gallop October 17, 2011 at <http://www.gallup.com/poll/150026/Unhealthy-Workers-Absenteeism-Costs-153-Billion.aspx>.

⁶⁰Ibid, see e.g., Health and Productivity Among U.S. Workers, Karen Davis, Ph.D., Sara R. Collins, Ph.D., Michelle M. Doty, Ph.D., Alice Ho, and Alyssa L. Holmgren, The Commonwealth Fund, August 2005. <http://www.commonwealthfund.org/publications/issue-briefs/2005/aug/health-and-productivity-among-u-s-workers>

⁶¹Children Who Missed 11 or More Days of School per Year Due to Illness or Injury, Kids Count Data Center at <http://datacenter.kidscount.org/data/tables/5202-children-who-missed-11-or-more-days-of-school-per-year-due-to-illness-or-injury?loc=1&loct=2#detailed/1/any/false/1021,18,14/691,30,18/11683>

⁶²Vaughn, B., Princiotta, D., Barry, M., Fish, H., & Schmitz, H. (2013). Safe Supportive Living Brief: Schools and The Affordable Care Act. https://safesupportivelearning.ed.gov/sites/default/files/1953_Schools%20Affordable%20Care%20Brief_d3%20lvr.pdf

⁶³See e.g. Maciosek, Michael V., Coffield, Ashley B., Flottemesch, et al., Use of Preventive Services In U.S. Health Care Could Save Lives At Little Or No Cost. *Health Affairs* 2010 29(9) 1656-1660. See e.g. Zhou F, Santoli J, Messonnier ML, et al. Economic Evaluation of the 7-Vaccine Routine Childhood Immunization Schedule in the United States, 2001. *Arch Pediatr Adolesc Med.* 2005; 159(12):1136–1144.

⁶⁴Whitney, CG., Zhou, F., Singleton, J., Schuchat, A.. Benefits from Immunization During the Vaccines of Children Program Era – United States, 1994–2013. *MMWR* 2014;63(16):352–355.

⁶⁵McAfee, T., Babb, S., McNabb, S., Fiore, MC. *N Engl J Med* 2015; 372:5–7.

⁶⁶Stevens, J., Oakkar, EE., Cui, Z., Cai, J., Truesdale, KP. US adults recommended for weight reduction by 1998 and 2013 obesity guidelines, NHANES 2007–2012, 2015 *Obesity* 23(3) 527–531.

⁶⁷Ogden CL, Carroll MD, Kit BK, Flegal KM. Prevalence of Childhood and Adult Obesity in the United States, 2011–2012. *JAMA.* 2014; 311(8):806–814.

⁶⁸Trasande, L., 2010, How Much Should We Invest in Preventing Childhood Obesity? *Health Affairs*, 29, no. 3 :372–378

access to contraceptive services without cost sharing.

5. Costs and Transfers

The changes in how plans and issuers continue to cover the recommended preventive services resulting from these final regulations will result in changes in covered benefits and premiums for individuals in plans and health insurance coverage subject to these final regulations. New costs to the health system result when individuals increase their use of preventive services in response to the changes in coverage of those services. Cost sharing, including coinsurance, deductibles, and copayments, divides the costs of health services between the plan or issuer and the enrollees. The removal of cost sharing increases the quantity of services demanded by lowering the direct cost of the service to consumers. Therefore, the Departments expect that the statute and these final regulations will continue to increase utilization of the covered preventive services. The magnitude of this effect on utilization depends on the price elasticity of demand.

Several studies have found that individuals are sensitive to prices for health services.⁶⁹ CDC researchers who studied out-of-pocket costs of immunizations for privately insured children up to age 5 (in families in Georgia in 2003) found that a one percent increase in out-of-pocket costs for routine immunizations (DTaP, IPV, MMR, Hib, and Hep B) was associated with a 0.07 percent decrease in utilization.⁷⁰

Eligible closely held for-profit entities that seek the accommodation for contraceptive services will incur administrative costs to provide self-certifications to issuers or third party administrators or notices to HHS. Issuers and third party administrators for health plans sponsored by these eligible organizations will also incur ad-

ministrative costs to provide notifications to enrollees. The costs related to these information collection requirements are estimated in section D below.

Along with new costs of induced utilization, there are transfers associated with these final regulations. A transfer is a change in who pays for the services, where there is not an actual change in the level of resources used. For example, costs that were previously paid out-of-pocket for certain preventive services will now be covered by plans and issuers under these final regulations. Such a transfer of costs could be expected to lead to an increase in premiums.

In the July 2010 interim final regulations, the Departments analyzed the impact of eliminating cost sharing, increases in services covered, and induced utilization on the average insurance premium using a model to evaluate private health insurance plans against a nationally representative population. In the July 2010 interim final regulations, the Departments analyzed Medical Expenditure Panel Survey (MEPS) data and determined the average person with employer-sponsored insurance (ESI) would have \$264 in covered preventive service expenses, of which \$240 would be paid by insurance and \$24 paid out-of-pocket.⁷¹ When preventive services are covered with zero copayment, the Departments estimated the average preventive benefit (holding utilization constant) would increase by \$24, or a 0.6 percent increase in insurance benefits and premiums for plans that have relinquished their grandfather status. Furthermore, in the July 2010 interim final regulations, the Departments estimated that additional coverage for genetic screening, depression screening, lead testing, autism testing, and oral health screening would result in a total average increase in insurance benefits on these services to be 0.12 percent, or just over \$4 per insured person. This increase represented a mixture of new costs

and transfers, dependent on whether beneficiaries previously purchased these services on their own. Impacts were expected to vary depending on baseline benefit levels, and grandfathered health plans were not expected to experience any impact from those interim final regulations.

As discussed in the July 2010 interim final regulations, the Departments used the standard actuarial “induction formula” $1/(1 + \alpha * P)$, where alpha is the “induction parameter” and P is the average fraction of the cost of services paid by consumers to estimate behavioral changes to estimate the induced demand for preventive services.⁷² Removing cost sharing for preventive services lowers the direct cost to consumers of using preventive services, which induces additional utilization, estimated with the model above to increase covered expenses and benefits by approximately \$17, or 0.44 percent in insurance benefits in group health plans. A similar, but larger, effect was anticipated in the individual market because individual health insurance policies generally had less generous benefits for preventive services than group health plans.

When eligible closely held for-profit entities seek the accommodation, health insurance issuers (or third party administrators for self-insured plans) for the group health plans established or maintained by the eligible organizations (and health insurance issuers of student health plans arranged by eligible organizations that are institutions of higher education) will assume sole responsibility for providing (or arranging) separate payments for contraceptive services directly for plan participants and beneficiaries (or student enrollees and dependents), without cost sharing, premium, fee, or other charge to plan participants or beneficiaries (or student enrollees and dependents) or to the eligible organization or its plan. The Departments continue to believe that issuers will find that providing contraceptive cov-

⁶⁹Liu, S., and Chollet, D., Price and Income Elasticity of the Demand for Health Insurance and Health Care Services: A Critical Review of the Literature, *Mathematica Policy Research Inc.*, (March 2006) <http://www.mathematica-mpr.com/~media/publications/PDFs/priceincome.pdf>. See e.g., Ringel, JS., Hosek, SD., Vollaard, BA., and S. Mahnovski (2002), The elasticity of demand for health care: A review of the literature and its application to the military health system, National Defense Research Institute, RAND Health. http://www.rand.org/content/dam/rand/pubs/monograph_reports/2005/MR1355.pdf.

⁷⁰See e.g., Noelle-Angelique Molinari et al., “Out-of-Pocket Costs of Childhood Immunizations: A Comparison by Type of Insurance Plan,” *Pediatrics*, 120(5) pp. e1148–e1156 (2007).

⁷¹The model does not distinguish between recommended and non-recommended preventive services, and so this likely represents an overestimate of the insurance benefits for preventive services.

⁷²Standard formula best described in “Quantity- Price Relationships in Health Insurance”, Charles L Trowbridge, Chief Actuary, Social Security Administration (DHEW Publication No. (SSA) 73– 11507, November 1972).

erage is at least cost neutral because they will be insuring the same set of individuals under both the group or student health insurance policies for whom they will also be making the separate payments for contraceptive services and, as a result, will experience lower costs from improvements in women's health, healthier timing and spacing of pregnancies, and fewer unplanned pregnancies. Several studies have estimated that the costs of providing contraceptive coverage are balanced by cost savings from lower pregnancy-related costs and from improvements in women's health.⁷³ A third party administrator can make arrangements with an issuer offering coverage through an FFE to obtain reimbursement for its costs (including an allowance for administrative costs and margin). The issuer offering coverage through the FFE can receive an adjustment to the FFE user fee, and the issuer is expected to pass on a portion of that adjustment to the third party administrator to account for the costs of providing or arranging payments for contraceptive services.

B. Regulatory Alternatives

Several provisions in these final regulations involved policy choices. One was whether to allow a plan or issuer to impose cost sharing for an office visit when a recommended preventive service is provided in that visit. Sometimes a recommended preventive service is billed separately from the office visit; sometimes it is not. The Departments decided that the cost-sharing prohibition of these final regulations applies to the specific preventive service as recommended by the guidelines. Therefore, if the preventive service is billed separately (or is tracked as individual encounter data separately) from the office visit, it is the preventive service that has cost sharing waived, not the entire office visit.

A second policy choice was, if the preventive service is not billed separately (or is not tracked as individual encounter data separately) from the office visit, whether

these final regulations should prohibit cost sharing for any office visit in which any recommended preventive service was administered, or whether cost sharing should be prohibited only when the preventive service is the primary purpose of the office visit. Prohibiting cost sharing for office visits when any recommended preventive service is provided, regardless of the primary purpose of the visit, could lead to an overly broad application of these final regulations; for example, a person who sees a specialist for a particular condition could end up with a zero copayment simply because his or her blood pressure was taken as part of the office visit. This could create financial incentives for consumers to request preventive services at office visits that are intended for other purposes in order to avoid copayments and deductibles. The increased prevalence of the application of zero cost sharing would lead to increased premiums compared with the chosen option, without a meaningful additional gain in access to preventive services.

A third issue involves health plans that have differential cost sharing for services provided by in-network vs. out-of-network providers. These final regulations provide that a plan or issuer generally is not required to provide coverage for recommended preventive services delivered by an out-of-network provider. The plan or issuer generally may also impose cost sharing for recommended preventive services delivered by an out-of-network provider. However, if the plan or issuer does not have in its network a provider who can provide the recommended preventive service, the plan or issuer must cover the item or service when performed by an out-of-network provider, and may not impose cost sharing with respect to the item or service. The Departments considered that requiring coverage by out-of-network providers with no cost sharing would result in higher premiums. Plans and issuers negotiate allowed charges with in-network providers as a way to promote effective, efficient health care, and allowing differences in cost sharing in- and

out-of-network enables plans to encourage use of in-network providers. Allowing zero cost sharing for out-of-network providers could reduce providers' incentives to participate in insurer networks. The Departments decided that permitting cost sharing for recommended preventive services provided by out-of-network providers (except in cases where the recommended service is only available from an out-of-network provider) is the appropriate option to preserve a choice of providers for individuals, while avoiding potentially larger increases in costs and transfers as well as potentially lower quality care.

As discussed previously in the preamble, the Departments also considered different ways to define a closely held for-profit entity. Under one approach, a qualifying closely held for-profit entity would have been defined as a for-profit entity where none of the ownership interests in the entity is publicly traded and where the entity has fewer than a specified number of shareholders or owners.

Under the second approach, a qualifying closely held for-profit entity would have been defined as a for-profit entity in which the ownership interests are not publicly traded, and in which a specified fraction of the ownership interest is concentrated in a limited and specified number of owners. Within the second approach, the Departments considered adopting the IRS test to define a closely held corporation. The definition adopted in these final rules, although based on the IRS test, is more flexible and ensures that it does not exclude some entities that should be considered to be closely held for the purposes of these final regulations.

Under a third approach, the Departments considered a test under which none of the ownership interests in the entity is publicly traded, without any other restrictions on the number of owners or on ownership concentration. The Departments believe, however, that such a test would be excessively broad.

⁷³Bertko, J., Glied, S., et al. The Cost of Covering Contraceptives Through Health Insurance (February 9, 2012), <http://aspe.hhs.gov/health/reports/2012/contraceptives/ib.shtml>; Washington Business Group on Health, Promoting Healthy Pregnancies: Counseling and Contraception as the First Step, Report of a Consultation with Business and Health Leader (September 20, 2000), Campbell, K.P., Investing in Maternal and Child Health: An Employer's Toolkit, National Business Group on Health (2007) http://www.businessgrouphealth.org/healthtopics/maternalchild/investing/docs/mch_toolkit.pdf; Trussell, J., et al. The Economic Value of Contraception: A Comparison of 15 Methods, American Journal Public Health, 1995; 85(4):494-503, Revenues of H.R. 3162, the Children's Health and Medicare Protection Act, for the Rules Committee (August 1, 2007)

C. Special Analyses – Department of Treasury

For purposes of the Department of the Treasury, it has been determined that this rule 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 this rule. Pursuant to the Regulatory Flexibility Act (5 U.S.C. chapter 6), it is hereby certified that this rule will not have a significant economic impact on a substantial number of small entities. This certification is based on the fact that the regulations merely modify the definition of eligible organization to include certain closely held for-profit entities. This modification, as adopted, will not increase costs to or burdens on the affected organizations. Pursuant to section 7805(f) of the Code, the proposed rule preceding these regulations was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on their impact on small business and no comments were received.

D. Paperwork Reduction Act - Department of Health and Human Services

These final regulations contain information collection requirements that are subject to review by OMB. A description of these provisions is given in the following paragraphs with an estimate of the annual burden. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

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

1. Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2014 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm).

2. Information Collection Requirements (ICRs)

a. ICRs Regarding Self-Certification (§ 147.131(b)(3))

All eligible organizations will have the option of either providing a self-certification (EBSA Form 700) to the issuers or third party administrators of the plans that would otherwise arrange for or provide coverage for the contraceptive services, or providing a notice to HHS. For the purpose of estimating burdens, HHS is assigning the burden of the self-certification to eligible for-profit entities and the burden of notice to HHS to eligible non-profit organizations.

The July 2013 final regulations require an eligible organization that seeks an accommodation to self-certify that it meets the definition of an eligible organization using the EBSA Form 700 and provide it directly to each third party administrator or issuer of the plan that would otherwise arrange for or provide coverage for the contraceptive services. These final regulations continue to allow eligible organizations to use EBSA Form 700 to notify their third party administrators and issuers, as set forth in the July 2013 final regulations and guidance.

The Departments received comments that HHS underestimated the number of closely held for-profit eligible organizations that may seek the accommodation. Some commenters noted that it would be difficult to estimate this number. One commenter estimated that about 1.3 million S-corporations offer health insurance to their employees and, based on this data, objection rates of 1 percent of S-corporations would result in 13,000 objecting firms, an objection rate of 2 percent would result in 26,000 objecting firms and an objection rate of 5 percent would result in 65,000 objecting firms. However, the Departments have no indi-

cation that such large numbers of closely held for-profit entities would seek the accommodation. The Departments also note that the definition of a qualifying closely held for-profit entity adopted in these final regulations differs from the definition of an S-corporation. In the proposed rules, based on the number of plaintiffs that are for-profit employers in recent litigation objecting on religious grounds to the provision of contraceptive services, HHS estimated that 71 closely held for-profit entities would seek the accommodation. In the final regulations, based on updated information, HHS is revising the estimate to 87. Even though this may underestimate the number of eligible closely held for-profit entities that will seek the accommodation, this is the best estimate available to the Departments at this time.

For each eligible organization, it is assumed that clerical staff will gather and enter the necessary information, send the self-certification to its issuer(s) or third party administrator(s) or the notice to HHS, and retain a copy for recordkeeping. A manager and legal counsel will subsequently review the information, and a senior executive will execute it. It is estimated that an organization will need approximately 50 minutes (30 minutes of clerical labor at a cost of \$30 per hour, 10 minutes for a manager at a cost of \$102 per hour, 5 minutes for legal counsel at a cost of \$127 per hour, and 5 minutes for a senior executive at a cost of \$121 per hour) to execute the self-certification. Therefore, the total one-time burden for preparing and providing the information in the self-certification is estimated to be approximately \$53 for each eligible organization. The certification may be electronically transmitted to the issuer or third party administrator at minimal cost or mailed. For purposes of this analysis, HHS assumes that all notices will be mailed. It is estimated that mailing each notice will require \$0.49 in postage and \$0.05 in materials cost (paper and ink) and the total postage and materials cost for each notice sent via mail will be \$0.54.

Based on this estimate of 87 affected entities and the individual burden estimates of 50 minutes and a cost of \$53, we estimate the total hour burden to be 72.5 hours with an equivalent cost of \$4,611. The total paper filing cost burden for the

notices is approximately \$47. As DOL and HHS share jurisdiction, they are splitting the hour burden so each will account for 36.25 burden hours at an equivalent cost of approximately \$2,306 and a paper filing cost burden of approximately \$23, with approximately 44 respondents.

b. ICRs Regarding Notice to HHS
(§ 147.131(b)(3))

These final regulations provide an organization seeking to be treated as an eligible organization under the August 2014 interim final regulations an alternative process, consistent with the Supreme Court's interim order in *Wheaton College*, under which an eligible organization may notify HHS of its religious objection to coverage of all or a subset of contraceptive services. The eligible organization must maintain the notice to HHS in its records. The burden related to this alternate notice is currently approved under OMB Control Number 0938-1248.

Based on litigation, HHS believes that at least 122 eligible non-profit organizations will have the option to provide the alternative notice to HHS rather than their third party administrators or issuers. Even though this likely underestimates the number of eligible non-profit organizations that will seek the accommodation, this is the best estimate available to the Departments at this time. In order to complete this task, HHS assumes that clerical staff for each eligible organization will gather and enter the necessary information and send the notice. HHS assumes that a compensation and benefits manager and inside legal counsel will review the notice and a senior executive will execute it. HHS estimates that an eligible organization will spend approximately 50 minutes (30 minutes of clerical labor at a cost of \$30 per hour, 10 minutes for a compensation and benefits manager at a cost of \$102 per hour, 5 minutes for legal counsel at a cost of \$127 per hour, and 5 minutes by a senior executive at a cost of \$121 per hour) preparing and sending the notice and filing it to meet the recordkeeping requirement. Therefore, the total annual burden for preparing and providing the notice to HHS will require approximately 50 minutes for each eligible organization

with an equivalent cost burden of approximately \$53 for a total hour burden of 102 hours with an equivalent cost of \$6,425. As HHS and DOL share jurisdiction, they are splitting the hour burden so each will account for 51 burden hours with an equivalent cost of \$3,213, with a total of 61 respondents.

Notices to HHS may be sent electronically at minimal cost or by mail. For purposes of this analysis, HHS assumes that all notices will be mailed. It is estimated that mailing each notice will require \$0.49 in postage and \$0.05 in materials cost (paper and ink) with a total postage and materials cost for each notice sent via mail of \$0.54. The total cost burden for the notices is approximately \$66. As DOL and HHS share jurisdiction, they are splitting the cost burden so each will account for \$33 of the cost burden.

c. Notice of Availability of Separate Payments for Contraceptive Services
(§ 147.131(d))

As required by the July 2013 final regulations, a health insurance issuer or third party administrator providing or arranging separate payments for contraceptive services for participants and beneficiaries in insured plans (or student enrollees and covered dependents in student health insurance coverage) of eligible organizations is required to provide a written notice to plan participants and beneficiaries (or student enrollees and covered dependents) informing them of the availability of such payments. The notice must be separate from but contemporaneous with (to the extent possible) any application materials distributed in connection with enrollment (or re-enrollment) in group or student coverage of the eligible organization in any plan year to which the accommodation is to apply and will be provided annually. To satisfy the notice requirement, issuers may, but are not required to, use the model language set forth in the July 2013 final regulations or substantially similar language.

As mentioned, HHS is anticipating that at least 122 non-profit and 87 closely held for-profit entities will seek an accommodation. It is unknown how many issuers or third party administrators provide health

insurance coverage or services in connection with health plans of eligible organizations, but HHS will assume at least 209. It is estimated that each issuer or third party administrator will need approximately 1 hour of clerical labor (at \$30 per hour) and 15 minutes of management review (at \$102 per hour) to prepare the notices. The total burden for each issuer or third party administrator to prepare notices will be 1.25 hours with an equivalent cost of approximately \$56. The total burden for all issuers or third party administrators will be 261.25 hours, with an equivalent cost of \$11,600. As DOL and HHS share jurisdiction, they are splitting the hour burden so each will account for 130.63 burden hours with an equivalent cost of \$5,800, with approximately 105 respondents.

d. Letter to HHS Regarding Ownership Structure
(§ 147.131(b)(4)(v))

To assist potentially eligible for-profit entities seeking further information regarding whether they qualify for the accommodation, an entity may send a letter describing its ownership structure to HHS at accommodation@cms.hhs.gov. However, an entity is not required to avail itself of this process in order to qualify as a closely held for-profit entity.

As stated earlier in the preamble, the Departments believe that the definition adopted in these regulations includes the for-profit entities that are likely to have religious objections to providing contraceptive coverage. In addition, it appears based on available information that the definition adopted in these final regulations includes all of the for-profit entities that have, as of the date of issuance of these regulations, challenged the contraceptive coverage requirement in court. Therefore, the Departments anticipate that fewer than 10 entities will submit a letter to HHS. Under 5 CFR 1320.3(c)(4), this provision is not subject to the PRA as it will affect fewer than 10 entities in a 12-month period.

3. Summary of Proposed Annual Burden Estimates

Table III.3 Annual Recordkeeping and Reporting Requirements

Regulation Section(s)	OMB Control No.	Respondents	Total Responses	Burden per Response (hours)	Total Annual Burden (hours)	Burden Cost per respondent (\$)	Total Labor Cost of Reporting (\$)	Total Capital/Maintenance Costs (\$)	Total Cost (\$)
Self-Certification (§ 147.131(b)(3))	New	44	44	0.83	36.25	\$53	\$2,306	\$23	\$2,329
Notice to HHS (§ 147.131(b)(3))	0938-1248	61	61	0.83	51	\$53	\$3,213	\$33	\$3,246
Notice of Availability of Separate Payments for Contraceptive Services (§ 147.131(d))	New	105	105	1.25	130.63	\$56	\$5,800	\$0	\$5,800
Total		210	210		217.88		\$11,319	\$56	\$11,375

4. Submission of PRA-Related Comments

We have submitted a copy of this rule to OMB for its review of the rule's information collection and recordkeeping requirements. These requirements are not effective until they have been approved by OMB.

E. Paperwork Reduction Act – Department of Labor

In accordance with the requirements of the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3506(c)(2)), the Department submitted an information collection request (ICR) to OMB in accordance with 44 U.S.C. 3507(d), contemporaneously with the publication of the interim final regulation, for OMB's review under the emergency PRA procedures.⁷⁴ OMB approved the ICR on August 27, 2014 under OMB Control Number 1210-0150 through February 28, 2015. Contemporaneously with the publication of the emergency ICR, the Department published a separate **Federal Register** notice informing the public that it intends to request OMB to extend the approval for 3 years and soliciting comments on the ICR.⁷⁵ The Department submitted the extension request to OMB on February 27, 2015. OMB approved the ICR extension on

April 14, 2015, which currently is scheduled to expire on April 30, 2018.

The Department also submitted an ICR to OMB in accordance with 44 U.S.C. 3507(d), for the ICR contained in the August 2014 proposed regulations contemporaneously with the publication of the proposal that solicited public comments on the ICR. OMB filed a comment regarding the proposed ICR on October 16, 2014, stating that it was not approving the ICR associated with the proposed rule at the proposed rule stage and requesting the Department to resubmit the ICR at the final rule stage after taking into account public comments. OMB assigned OMB Control Number 1210-0152 to the proposed ICR.

Although no public comments were received in response to the ICRs contained in the August 2014 interim final and proposed regulations that specifically addressed the paperwork burden analysis of the information collections, the comments that were submitted, and which are described earlier in this preamble, contained information relevant to the costs and administrative burdens attendant to the proposals. The Department took into account the public comments in connection with making changes to the proposal, analyzing the economic impact of the proposals, and

developing the revised paperwork burden analysis summarized below.

In connection with publication of this final rule, the Department submitted ICRs to OMB as a revision to OMB Control Number 1210-0150 for eligible non-profit organizations and under new OMB Control Number 1210-0152 for eligible for-profit organizations and received OMB approval for both ICRs.

A copy of the ICRs may be obtained by contacting the PRA addressee shown below or at <http://www.RegInfo.gov>. PRA ADDRESSEE: G. Christopher Cosby, Office of Policy and Research, U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, NW., Room N-5718, Washington, DC 20210. Telephone: 202-693-8410; Fax: 202-219-4745. These are not toll-free numbers.

1. ICRs Regarding Self-Certification (29 CFR 2590.2713A(b) or (c))

Under these final regulations, all eligible organizations will have the option of either providing (1) a self-certification (EBSA Form 700) to the issuers or third party administrators of the plans that would otherwise arrange for or provide coverage for the contraceptive services or (2) a notice to HHS. For the purpose of estimating burdens, the Department is as-

⁷⁴5 CFR 1320.13.

⁷⁵79 FR 51197 (Aug. 27, 2014).

signing the burden of the self-certification to eligible for-profit entities and the burden of notice to HHS to eligible non-profit organizations.

The July 2013 final regulations require an eligible organization that seeks an accommodation to self-certify that it meets the definition of an eligible organization using the EBSA Form 700 and provide it directly to each third party administrator or issuer of the plan that would otherwise arrange for or provide coverage for the contraceptive services. These final regulations continue to allow eligible organizations to use EBSA Form 700 to notify their third party administrators and issuers, as set forth in the July 2013 final regulations and guidance.

In response to the public comment solicitation for the ICRs in the August 2014 proposed regulations, the Departments received comments that they underestimated the number of closely held for-profit eligible organizations that may seek the accommodation. Some commenters noted that it would be difficult to estimate this number. One commenter estimated that about 1.3 million S-corporations offer health insurance to their employees and, based on this data, objection rates of 1 percent of S-corporations would result in 13,000 objecting firms, an objection rate of 2 percent would result in 26,000 objecting firms and an objection rate of 5 percent would result in 65,000 objecting firms. However, the Departments have no indication that such large numbers of closely held for-profit entities would seek the accommodation. The Departments also note that the definition of a qualifying closely held for-profit entity adopted in these final regulations differs from the definition of an S-corporation. In the proposed rules, based on the number of plaintiffs that are for-profit employers in recent litigation objecting on religious grounds to the provision of contraceptive services, the Departments estimated that 71 closely held for-profit entities would seek the accommodation. In these final regulations,

based on updated information, the Departments are revising the estimate to 87. Even though this may underestimate of the number of eligible closely held for-profit entities that will seek the accommodation, this is the best estimate available to the Departments at this time.

For each eligible organization, the Departments assume that clerical staff will gather and enter the necessary information, send the self-certification to its issuer(s) or third party administrator(s) or the notice to HHS, and retain a copy for recordkeeping. A manager and legal counsel will subsequently review the information, and a senior executive will execute it. It is estimated that an organization will need approximately 50 minutes (30 minutes of clerical labor at a cost of \$30 per hour,⁷⁶ 10 minutes for a manager at a cost of \$102 per hour,⁷⁷ 5 minutes for legal counsel at a cost of \$127 per hour,⁷⁸ and 5 minutes for a senior executive at a cost of \$121 per hour⁷⁹) to execute the self-certification. Therefore, the Departments estimate that the total one-time burden for preparing and providing the information in the self-certification is estimated to be approximately \$53 for each eligible organization. The certification may be electronically transmitted to the issuer or third party administrator at minimal cost or mailed. For purposes of this analysis, the Departments assume that all notices will be mailed. The Departments estimate that mailing each notice will require \$0.49 in postage and \$0.05 in materials cost (paper and ink) and the total postage and materials cost for each notice sent via mail will be \$0.54.

Based on this estimate of 87 affected entities and the individual burden estimates of 50 minutes and a cost of \$53, the Departments estimate the total hour burden associated with the ICR to be 72.5 hours with an equivalent cost of \$4,611. The total paper filing cost burden for the notices is approximately \$47. The hour burden associated with the ICR is allocated equally between DOL and HHS,

because the agencies share jurisdiction of preventive health services resulting in an hour burden for each agency of 36.25 burden hours at an equivalent cost of approximately \$2,306 and a paper filing cost burden of approximately \$23, with approximately 44 respondents.

2. ICRs Regarding Notice to HHS (29 CFR 2590.2713A (b) or (c))

These final regulations provide an organization seeking to be treated as an eligible organization under the August 2014 interim final regulations with an alternative process, consistent with the Supreme Court's interim order in *Wheaton College*, under which an eligible organization may notify HHS of its religious objection to coverage of all or a subset of contraceptive services. The eligible organization must maintain the notice to HHS in its records. The burden related to this alternate notice is currently approved under OMB Control Number 1210-0150.

Based on litigation, the Departments estimate that at least 122 eligible non-profit organizations will have the option to provide the alternative notice to HHS rather than their third party administrators or issuers. Even though this may underestimate the number of eligible non-profit organizations that will seek the accommodation, it is the best estimate available to the Departments at this time. In order to complete this task, the Departments assume that clerical staff for each eligible organization will gather and enter the necessary information and send the notice. The Departments assume that a compensation and benefits manager and inside legal counsel will review the notice and a senior executive will execute it. The Departments estimate that an eligible organization will spend approximately 50 minutes (30 minutes of clerical labor at a cost of \$30 per hour, 10 minutes for a compensation and benefits manager at a cost of \$102 per hour, 5 minutes for legal counsel at a cost of \$127 per hour, and 5

⁷⁶Secretaries, Except Legal, Medical, and Executive (43-6014): \$16.13(2012 BLS Wage rate)/0.679(ECEC ratio) *1.2(Overhead Load Factor) *1.019(Inflation rate) ²(Inflated 2 years from base year) = \$29.60

⁷⁷Compensation and Benefits Manager (11-3041): \$50.92(2012 BLS Wage rate) /0.697(ECEC ratio) *1.35(Overhead Load Factor) *1.019(Inflation rate) ²(Inflated 2 years from base year) = \$102.41

⁷⁸Legal Professional (23-1011): \$62.93(2012 BLS Wage rate) /0.697(ECEC ratio) *1.35(Overhead Load Factor) *1.019(Inflation rate) ²(Inflated 2 years from base year) = \$126.56

⁷⁹Financial Managers (11-3031): \$59.26(2012 BLS Wage rate) /0.689(ECEC ratio) *1.35(Overhead Load Factor) *1.019(Inflation rate) ²(Inflated 2 years from base year) = \$120.57

minutes by a senior executive at a cost of \$121 per hour) preparing and sending the notice and filing it to meet the recordkeeping requirement. Therefore, the total annual burden for preparing and providing the notice to HHS will require approximately 50 minutes for each eligible organization with an equivalent cost burden of approximately \$53 for a total hour burden of 102 hours with an equivalent cost of \$6,425. As HHS and DOL share jurisdiction, they are splitting the hour burden so each will account for 51 burden hours with an equivalent cost of \$3,213, with a total of 61 respondents.

Notices to HHS may be sent electronically at minimal cost or by mail. For purposes of this analysis, the Departments assume that all notices will be mailed. It is estimated that mailing each notice will require \$0.49 in postage and \$0.05 in materials cost (paper and ink) with a total postage and materials cost for each notice sent via mail of \$0.54. The total cost burden for the notices is approximately \$66. As DOL and HHS share jurisdiction, they are sharing the cost burden equally and each is attributed \$33 of the cost burden.

3. *Notice of Availability of Separate Payments for Contraceptive Services (29 CFR 2590.2713A(d))*

As required by the July 2013 final regulations, a health insurance issuer or third party administrator providing or arranging separate payments for contraceptive services for participants and beneficiaries (or student enrollees and covered dependents) in insured plans of eligible organizations is required to provide a written notice to plan participants and beneficiaries (or student enrollees and covered dependents) informing them of the availability of such payments. The notice must be separate from but contemporaneous with (to the extent possible) any application materials distributed in connection with enrollment (or re-enrollment) in group or student coverage of the eligible organization in any plan year to which the accommodation is to apply and will be provided annually. To satisfy the notice requirement, issuers may, but are not required to, use the

model language set forth in the July 2013 final regulations or substantially similar language.

As mentioned, the Departments anticipate that at least 122 non-profit and 87 closely held for-profit entities will seek an accommodation. It is unknown how many issuers or third party administrators provide health insurance coverage or services in connection with health plans of eligible organizations, but that for the purposes of the analysis, the Departments assume at least 209 do. The Departments assume that each issuer or third party administrator will need approximately one hour of clerical labor (at \$30 per hour) and 15 minutes of management review (at \$102 per hour) to prepare the notices. Therefore, the Departments estimate that the total burden for each issuer or third party administrator to prepare notices will be 1.25 hours with an equivalent cost of approximately \$56. The total burden for all issuers or third party administrators will be 261.25 hours, with an equivalent cost of \$11,600. The cost burden associated with this ICR is allocated equally between DOL and HHS, because the agencies share jurisdiction under the provision. Therefore, the hour burden for each is 130.63 burden hours with an equivalent cost of \$5,800 for approximately 105 respondents.

4. *Letter to HHS Regarding Ownership Structure (29 CFR 2590.2713A(a)(4)(v))*

To assist potentially eligible for-profit entities seeking further information regarding whether they qualify for the accommodation, an entity may send a letter describing its ownership structure to HHS at accommodation@cms.hhs.gov. However, an entity is not required to avail itself of this process in order to qualify as a closely held for-profit entity.

As stated earlier in the preamble, the Departments believe that the definition adopted in these regulations includes the for-profit entities that are likely to have religious objections to providing contraceptive coverage. In addition, it appears based on available information that the definition adopted in these final regula-

tions includes all of the for-profit entities that have, as of the date of issuance of these regulations, challenged the contraceptive coverage requirement in court. Therefore, the Departments anticipate that fewer than 10 entities will submit a letter to HHS. Under 5 CFR 1320.3(c)(4), this provision is not subject to the PRA as it will affect fewer than 10 entities in a 12-month period.

F. *Regulatory Flexibility Act – Department of Labor and Department of Health and Human Services*

The Regulatory Flexibility Act (RFA) requires agencies that issue a rule to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. The RFA generally defines a “small entity” as—(1) a proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a non-profit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000 (states and individuals are not included in the definition of “small entity”). The Departments use as their measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 percent to 5 percent.

As discussed in the Web Portal interim final rule with comment period published on May 5, 2010 (75 FR 24481), HHS examined the health insurance industry in depth in the Regulatory Impact Analysis we prepared for the proposed rule on establishment of the Medicare Advantage program (69 FR 46866, August 3, 2004). In that analysis it was determined that there were few, if any, insurance firms underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) that fell below the size thresholds for “small” business established by the SBA (currently \$38.5 million in annual receipts for health insurance issuers).⁸⁰ In addition, analysis of data from Medical Loss Ratio annual report submissions for the 2013 reporting year was used to develop an estimate of the

⁸⁰“Table of Small Business Size Standards Matched To North American Industry Classification System Codes,” effective July 14, 2014, U.S. Small Business Administration, available at <http://www.sba.gov>.

number of small entities that offer comprehensive major medical coverage. It is estimated that 141 out of 500 issuers of health insurance coverage nationwide had total premium revenue of \$38.5 million or less. This estimate may overstate the actual number of small health insurance companies that would be affected, since 77 percent of these small companies belong to larger holding groups, and many if not all of these small companies are likely to have non-health lines of business that would result in their revenues exceeding \$38.5 million. For these reasons, the Departments expect that these final regulations will not affect a significant number of small issuers.

The provisions of these final regulations affect small employers with self-insured group health plans by requiring them to include coverage under their group health plans for recommended preventive services without cost sharing. However, small employers also benefit from having healthier employees and reduced absenteeism. Small employers are less likely to be self-insured compared to large employers; only about 13.3 percent of employers with less than 100 employees that offer a group health plan have a self-funded plan.⁸¹

With respect to contraceptive coverage, some eligible organizations that seek the accommodation may be small entities and will incur costs to provide the self-certification to issuers or third party administrators or notice to HHS. However, the related administrative costs are expected to be minimal.

Third party administrators for self-insured group health plans established or maintained by eligible organizations will incur administrative costs to send notices to enrollees and arrange for separate payments for contraceptive services. It is unknown how many third party administrators impacted by this requirement have revenues below the size thresholds for “small” business established by the SBA (currently \$32.5 million for third party administrators). However, a third party administrator can make arrangements with an issuer offering coverage through an FFE to obtain reimbursement for the third party administrator’s costs.

G. 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. In the Departments’ view, these final regulations have federalism implications, but the federalism implications are substantially mitigated because, with respect to health insurance issuers, 45 states are either enforcing the requirements related to coverage of specified preventive services (including contraception) without cost sharing pursuant to state law or otherwise are working collaboratively with HHS to ensure that issuers meet these standards. In five states, HHS ensures that issuers comply with these requirements. Therefore, the final regulations are not likely to require substantial additional oversight of states by HHS.

In general, section 514 of ERISA provides that state laws are superseded to the extent that they relate to any covered employee benefit plan, and preserves state laws that regulate insurance, banking, or securities. ERISA also prohibits states from regulating a covered plan as an insurance or investment company or bank. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) added a new preemption provision to ERISA (as well as to the PHS Act) narrowly preempting state requirements on group health insurance coverage. States may continue to apply state law requirements but not to the extent that such requirements prevent the application of the federal requirement that group health insurance coverage provided in connection with certain group health plans (or student health insurance issuers) provide coverage for specified preventive services without cost sharing. HIPAA’s Conference Report states that the conferees intended the narrowest preemption of state laws with re-

gard to health insurance issuers (H.R. Conf. Rep. No. 104–736, 104th Cong. 2d Session 205, 1996). State insurance laws that are more stringent than the federal requirement are unlikely to “prevent the application of” the preventive services coverage provision, and therefore are unlikely to be preempted. Accordingly, states have significant latitude to impose requirements on health insurance issuers that are more restrictive than those in federal law.

Guidance conveying this interpretation was published in the **Federal Register** on April 8, 1997 (62 FR 16904) and December 30, 2004 (69 FR 78720), and these final regulations implement the preventive services coverage provision’s minimum standards and do not significantly reduce the discretion given to states under the statutory scheme.

The PHS Act provides that states may enforce the provisions of title XXVII of the PHS Act as they pertain to issuers, but that the Secretary of HHS will enforce any provisions that a state does not have authority to enforce or that a state has failed to substantially enforce. When exercising its responsibility to enforce provisions of the PHS Act, HHS works cooperatively with the state to address the state’s concerns and avoid conflicts with the state’s exercise of its authority. HHS has developed procedures to implement its enforcement responsibilities, and to afford states the maximum opportunity to enforce the PHS Act’s requirements in the first instance. In compliance with Executive Order 13132’s requirement that agencies examine closely any policies that may have federalism implications or limit the policymaking discretion of states, the Departments have engaged in numerous efforts to consult and work cooperatively with affected state and local officials.

In conclusion, throughout the process of developing these final regulations, to the extent feasible within the specific preemption provisions of ERISA and the PHS Act, the Departments have attempted to balance states’ interests in regulating health insurance coverage and health insurance issuers, and the rights of individuals intended to be protected in the PHS Act, ERISA, and the Code.

⁸¹Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2013 Medical Expenditure Panel Survey-Insurance Component.

H. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act (UMRA) of 1995 requires that agencies assess anticipated costs and benefits before issuing any final rule that includes a Federal mandate that could result in expenditure in any one year by state, local or tribal governments, in the aggregate, or by the private sector, of \$100 million in 1995 dollars, updated annually for inflation. In 2015, that threshold level is approximately \$144 million.

UMRA does not address the total cost of a regulatory action. Rather, it focuses on certain categories of cost, mainly those “Federal mandate” costs resulting from— (1) imposing enforceable duties on state, local, or tribal governments, or on the private sector; or (2) increasing the stringency of conditions in, or decreasing the funding of, state, local, or tribal governments under entitlement programs. These final regulations include no mandates on state, local, or tribal governments. Health insurance issuers, third party administrators and eligible organizations would incur costs to comply with the provisions of these final regulations. However, consistent with policy embodied in UMRA, these final regulations have been designed to be the least burdensome alternative while achieving the objectives of the Affordable Care Act.

I. Congressional Review Act

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

IV. Statutory Authority

The Department of the Treasury regulations are adopted pursuant to the author-

ity contained in sections 7805 and 9833 of the Code.

The Department of Labor regulations are adopted pursuant to the authority contained in 29 U.S.C. 1002(16), 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; Secretary of Labor’s Order 1–2011, 77 FR 1088 (Jan. 9, 2012).

The Department of Health and Human Services regulations are 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; and Title I of the Affordable Care Act, sections 1301–1304, 1311–1312, 1321–1322, 1324, 1334, 1342–1343, 1401–1402, and 1412, Pub. L. 111–148, 124 Stat. 119 (42 U.S.C. 18021–18024, 18031–18032, 18041–18042, 18044, 18054, 18061, 18063, 18071, 18082, 26 U.S.C. 36B, and 31 U.S.C. 9701).

* * * * *

Approved: July 8, 2015.

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

Approved: July 8, 2015.

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

Signed this 7th day of May 2015.

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

Dated: May 7, 2015.

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

Approved: May 20, 2015.

Sylvia M. 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 amended as follows:

PART 54—PENSION EXCISE TAXES

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

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

Section 54.9815–2713 also issued under 26 U.S.C. 9833;

* * * * *

Par.2. Section 54.9815–2713 is amended by adding paragraphs (a)(1)(i), (ii), and (iii), and revising paragraphs (a)(2), (3), (4), and (5), (b), and (c) to read as follows:

§ 54.9815–2713 Coverage of preventive health services.

(a) * * *

(1) * * *

(i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved (except as otherwise provided in paragraph (c) of this section);

(ii) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Cen-

ters for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

(iii) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

* * * * *

(2) *Office visits* – (i) If an item or service described in paragraph (a)(1) of this section is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(ii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit.

(iii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(iv) The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) Facts. An individual covered by a group health plan visits an in-network health care provider. While visiting the provider, the individual is screened for cholesterol abnormalities, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit and for the laboratory work of the cholesterol screening test.

(ii) *Conclusion.* In this *Example 1*, the plan may not impose any cost-sharing requirements with respect to the separately-billed laboratory work of the cholesterol screening test. Because the office visit is billed separately from the cholesterol screening test, the plan may impose cost-sharing requirements for the office visit.

Example 2. (i) Facts. Same facts as *Example 1* of this section. As the result of the screening, the individual is diagnosed with hyperlipidemia and is prescribed a course of treatment that is not included in

the recommendations under paragraph (a)(1) of this section.

(ii) *Conclusion.* In this *Example 2*, because the treatment is not included in the recommendations under paragraph (a)(1) of this section, the plan is not prohibited from imposing cost-sharing requirements with respect to the treatment.

Example 3. (i) Facts. An individual covered by a group health plan visits an in-network health care provider to discuss recurring abdominal pain. During the visit, the individual has a blood pressure screening, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit.

(ii) *Conclusion.* In this *Example 3*, the blood pressure screening is provided as part of an office visit for which the primary purpose was not to deliver items or services described in paragraph (a)(1) of this section. Therefore, the plan may impose a cost-sharing requirement for the office visit charge.

Example 4. (i) Facts. A child covered by a group health plan visits an in-network pediatrician to receive an annual physical exam described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. During the office visit, the child receives additional items and services that are not described in the comprehensive guidelines supported by the Health Resources and Services Administration, nor otherwise described in paragraph (a)(1) of this section. The provider bills the plan for an office visit.

(ii) *Conclusion.* In this *Example 4*, the service was not billed as a separate charge and was billed as part of an office visit. Moreover, the primary purpose for the visit was to deliver items and services described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. Therefore, the plan may not impose a cost-sharing requirement with respect to the office visit.

(3) *Out-of-network providers.* (i) Subject to paragraph (a)(3)(ii) of this section, nothing in this section requires a plan or issuer that has a network of providers to provide benefits for items or services described in paragraph (a)(1) of this section that are delivered by an out-of-network provider. Moreover, nothing in this section precludes a plan or issuer that has a network of providers from imposing cost-sharing requirements for items or services described in paragraph (a)(1) of this section that are delivered by an out-of-network provider.

(ii) If a plan or issuer does not have in its network a provider who can provide an item or service described in paragraph (a)(1) of this section, the plan or issuer must cover the item or service when performed by an out-of-network provider, and may not impose cost-sharing with respect to the item or service.

(4) *Reasonable medical management.* Nothing prevents a plan or issuer from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service described in paragraph (a)(1) of this section to the extent not specified in the relevant recommendation or guideline. To the extent not specified in a recommendation or guideline, a plan or issuer may rely on the relevant clinical evidence base and established reasonable medical management techniques to determine the frequency, method, treatment, or setting for coverage of a recommended preventive health service.

(5) *Services not described.* Nothing in this section prohibits a plan or issuer from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided for by guidelines supported by the Health Resources and Services Administration, or from denying coverage for items and services that are not recommended by that task force or that advisory committee, or under those guidelines. A plan or issuer may impose cost-sharing requirements for a treatment not described in paragraph (a)(1) of this section, even if the treatment results from an item or service described in paragraph (a)(1) of this section.

(b) *Timing*—(1) *In general.* A plan or issuer must provide coverage pursuant to paragraph (a)(1) of this section for plan years that begin on or after September 23, 2010, or, if later, for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(2) *Changes in recommendations or guidelines.* (i) A plan or issuer that is required to provide coverage for any items and services specified in any recommendation or guideline described in paragraph (a)(1) of this section on the first day of a plan year must provide coverage through the last day of the plan year, even if the recommendation or guideline changes is or is no longer described in paragraph (a)(1) of this section, during the plan year.

(ii) Notwithstanding paragraph (b)(2)(i) of this section, to the extent a

recommendation or guideline described in paragraph (a)(1)(i) of this section that was in effect on the first day of a plan year is downgraded to a “D” rating, or any item or service associated with any recommendation or guideline specified in paragraph (a)(1) of this section is subject to a safety recall or is otherwise determined to pose a significant safety concern by a federal agency authorized to regulate the item or service during a plan year, there is no requirement under this section to cover these items and services through the last day of the plan year.

(c) *Recommendations not current.* For purposes of paragraph (a)(1)(i) of this section, and for purposes of any other provision of law, recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current.

Par.3 Section 54.9815–2713A is amended by revising paragraphs (a), (b), (c)(1), and (c)(2)(i) introductory text to read as follows:

§ 54.9815–2713A Accommodations in connection with coverage of preventive health services.

(a) *Eligible organizations.* An eligible organization is an organization that meets the criteria of paragraphs (a)(1) through (3) of this section.

(1) The organization opposes providing coverage for some or all of any contraceptive items or services required to be covered under § 54.9815–2713(a)(1)(iv) on account of religious objections.

(2)(i) The organization is organized and operates as a nonprofit entity and holds itself out as a religious organization; or

(ii) The organization is organized and operates as a closely held for-profit entity, as defined in paragraph (a)(4) of this section, and the organization’s highest governing body (such as its board of directors, board of trustees, or owners, if managed directly by its owners) has adopted a resolution or similar action, under the organization’s applicable rules of governance and consistent with state law, establishing that it objects to covering some or all of the contraceptive services on account of the owner’s sincerely held religious beliefs.

(3) The organization must self-certify in the form and manner specified by the Secretary of Labor or provide notice to the Secretary of Health and Human Services as described in paragraph (b) or (c) of this section. The organization must make such self-certification or notice available for examination upon request by the first day of the first plan year to which the accommodation in paragraph (b) or (c) of this section applies. The self-certification or notice must be executed by a person authorized to make the certification or notice on behalf of the organization, and must be maintained in a manner consistent with the record retention requirements under section 107 of ERISA.

(4) A closely held for-profit entity is an entity that —

(i) Is not a nonprofit entity;

(ii) Has no publicly traded ownership interests, (for this purpose, a publicly traded ownership interest is any class of common equity securities required to be registered under section 12 of the Securities Exchange Act of 1934); and

(iii) Has more than 50 percent of the value of its ownership interest owned directly or indirectly by five or fewer individuals, or has an ownership structure that is substantially similar thereto, as of the date of the entity’s self-certification or notice described in paragraph (b) or (c) of this section.

(iv) For the purpose of the calculation in paragraph (a)(4)(iii) of this section, the following rules apply:

(A) Ownership interests owned by a corporation, partnership, estate, or trust are considered owned proportionately by such entity’s shareholders, partners, or beneficiaries. Ownership interests owned by a nonprofit entity are considered owned by a single owner.

(B) An individual is considered to own the ownership interests owned, directly or indirectly, by or for his or her family. Family includes only brothers and sisters (including half-brothers and half-sisters), a spouse, ancestors, and lineal descendants.

(C) If a person holds an option to purchase ownership interests, he or she is considered to be the owner of those ownership interests.

(v) A for profit entity that seeks further information regarding whether it qualifies

for the accommodation described in this section may send a letter describing its ownership structure to the Department of Health and Human Services. An entity must submit the letter in the manner described by the Department of Health and Human Services. If the entity does not receive a response from the Department of Health and Human Services to a properly submitted letter describing the entity’s current ownership structure within 60 calendar days, as long as the entity maintains that structure it will be considered to meet the requirement set forth in paragraph (a)(4)(iii) of this section.

(b) *Contraceptive coverage—self-insured group health plans.* (1) A group health plan established or maintained by an eligible organization that provides benefits on a self-insured basis complies for one or more plan years with any requirement under § 54.9815–2713(a)(1)(iv) to provide contraceptive coverage if all of the requirements of this paragraph (b)(1) are satisfied:

(i) The eligible organization or its plan contracts with one or more third party administrators.

(ii) The eligible organization provides either a copy of the self-certification to each third party administrator or a notice to the Secretary of Health and Human Services that it is an eligible organization and of its religious objection to coverage of all or a subset of contraceptive services.

(A) When a copy of the self-certification is provided directly to a third party administrator, such self-certification must include notice that obligations of the third party administrator are set forth in 29 CFR 2510.3–16 and this section.

(B) When a notice is provided to the Secretary of Health and Human Services, the notice must include the name of the eligible organization and the basis on which it qualifies for an accommodation; its objection based on sincerely held religious beliefs to coverage of some or all contraceptive services (including an identification of the subset of contraceptive services to which coverage the eligible organization objects, if applicable); the plan name and type (that is, whether it is a student health insurance plan within the meaning of 45 CFR 147.145(a) or a church plan within the meaning of ERISA section 3(33)); and the name and contact

information for any of the plan's third party administrators and health insurance issuers. If there is a change in any of the information required to be included in the notice, the organization must provide updated information to the Secretary of Health and Human Services. The Department of Labor (working with the Department of Health and Human Services), will send a separate notification to each of the plan's third party administrators informing the third party administrator that the Secretary of Health and Human Services has received a notice under paragraph (b)(1)(ii) of this section and describing the obligations of the third party administrator under 29 CFR 2510.3-16 and this section.

(2) If a third party administrator receives a copy of the self-certification from an eligible organization or a notification from the Department of Labor, as described in paragraph (b)(1)(ii) of this section, and agrees to enter into or remain in a contractual relationship with the eligible organization or its plan to provide administrative services for the plan, the third party administrator shall provide or arrange payments for contraceptive services using one of the following methods—

(i) Provide payments for contraceptive services for plan participants and beneficiaries without imposing any cost-sharing requirements (such as a copayment, coinsurance, or a deductible), or imposing a premium, fee, or other charge, or any portion thereof, directly or indirectly, on the eligible organization, the group health plan, or plan participants or beneficiaries; or

(ii) Arrange for an issuer or other entity to provide payments for contraceptive services for plan participants and beneficiaries without imposing any cost-sharing requirements (such as a copayment, coinsurance, or a deductible), or imposing a premium, fee, or other charge, or any portion thereof, directly or indirectly, on the eligible organization, the group health plan, or plan participants or beneficiaries.

(3) If a third party administrator provides or arranges payments for contraceptive services in accordance with either paragraph (b)(2)(i) or (ii) of this section, the costs of providing or arranging such payments may be reimbursed through an adjustment to the Federally-facilitated Exchange user fee for a participating issuer pursuant to 45 CFR 156.50(d).

(4) A third party administrator may not require any documentation other than a copy of the self-certification from the eligible organization or notification from the Department of Labor described in paragraph (b)(1)(ii) of this section.

(c) * * *

(1) *General rule.* A group health plan established or maintained by an eligible organization that provides benefits through one or more group health insurance issuers complies for one or more plan years with any requirement under § 54.9815-2713(a)(1)(iv) to provide contraceptive coverage if the eligible organization or group health plan provides either a copy of the self-certification to each issuer providing coverage in connection with the plan or a notice to the Secretary of Health and Human Services that it is an eligible organization and of its religious objection to coverage for all or a subset of contraceptive services.

(i) When a copy of the self-certification is provided directly to an issuer, the issuer has sole responsibility for providing such coverage in accordance with § 54.9815-2713. An issuer may not require any further documentation from the eligible organization regarding its status as such.

(ii) When a notice is provided to the Secretary of Health and Human Services, the notice must include the name of the eligible organization and the basis on which it qualifies for an accommodation; its objection based on its sincerely held religious beliefs to coverage of some or all contraceptive services, as applicable (including an identification of the subset of contraceptive services to which coverage the eligible organization objects, if applicable); the plan name and type (that is, whether it is a student health insurance plan within the meaning of 45 CFR 147.145(a) or a church plan within the meaning of ERISA section 3(33)); and the name and contact information for any of the plan's third party administrators and health insurance issuers. If there is a change in any of the information required to be included in the notice, the organization must provide updated information to the Secretary of Health and Human Services. The Department of Health and Human Services will send a separate notification to each of the plan's health insurance issuers informing the issuer that

the Secretary of Health and Human Services has received a notice under paragraph (c)(1) of this section and describing the obligations of the issuer under this section.

(2) * * *

(i) A group health insurance issuer that receives a copy of the self-certification or notification described in paragraph (c)(1)(ii) of this section with respect to a group health plan established or maintained by an eligible organization in connection with which the issuer would otherwise provide contraceptive coverage under § 54.9815-2713(a)(1)(iv) must—

* * * * *

§ 54.9815-2713AT [REMOVED]

Par. 4. Section 54.9815-2713AT is removed.

§ 54.9815-2713T [REMOVED]

Par. 5. Section 54.9815-2713T is removed.

(Filed by the Office of the federal register on July 10, 2015, 11:15 a.m., and published in the issue of the Federal Register for July 14, 2015, 80 F.R. 41318)

Section 42.—Low-Income Housing Credit

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2015. See Rev. Rul. 2015-16, page 130.

Section 280G.—Golden Parachute Payments

Federal short-term, mid-term, and long-term rates are set forth for the month August 2015. See Rev. Rul. 2015-16, page 130.

Section 382.—Limitation on Net Operating Loss Carryforwards and Certain Built-In Losses Following Ownership Change

The adjusted applicable federal long-term rate is set forth for the month August 2015. See Rev. Rul. 2015-16, page 130.

Section 412.—Minimum Funding Standards

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2015. See Rev. Rul. 2015–16, page 130.

Section 467.—Certain Payments for the Use of Property or Services

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2015. See Rev. Rul. 2015–16, page 130.

Section 468.—Special Rules for Mining and Solid Waste Reclamation and Closing Costs

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2015. See Rev. Rul. 2015–16, page 130.

Section 482.—Allocation of Income and Deductions Among Taxpayers

Federal short-term, mid-term, and long-term rates are set forth for the month August 2015. See Rev. Rul. 2015–16, page 130.

Section 483.—Interest on Certain Deferred Payments

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2015. See Rev. Rul. 2015–16, page 130.

Section 642.—Special Rules for Credits and Deductions

Federal short-term, mid-term, and long-term rates are set forth for the month August 2015. See Rev. Rul. 2015–16, page 130.

Section 807.—Rules for Certain Reserves

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2015. See Rev. Rul. 2015–16, page 130.

Section 846.—Discounted Unpaid Losses Defined

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2015. See Rev. Rul. 2015–16, page 130.

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

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

Rev. Rul. 2015–16

This revenue ruling provides various prescribed rates for federal income tax purposes for August 2015 (the current month). Table 1 contains the short-term, mid-term, and long-term applicable federal rates (AFR) for the current month for purposes of section 1274(d) of the Internal Revenue Code. Table 2 contains the short-term, mid-term, and long-term adjusted applicable federal rates (adjusted AFR) for the current month for purposes of section 1288(b). Table 3 sets forth the adjusted federal long-term rate and the long-term tax-exempt rate described in section 382(f). Table 4 contains the appropriate percentages for determining the low-income housing credit described in section 42(b)(1) for buildings placed in service during the current month. However, under section 42(b)(2), the applicable percentage for non-federally subsidized new buildings placed in service after July 30, 2008, with respect to housing credit dollar amount allocations made before January 1, 2015, shall not be less than 9%.

Finally, Table 5 contains the federal rate for determining the present value of an annuity, an interest for life or for a term of years, or a remainder or a reversionary interest for purposes of section 7520.

REV. RUL. 2015–16 TABLE 1
Applicable Federal Rates (AFR) for August 2015

	Annual	Period for Compounding		
		Semiannual	Quarterly	Monthly
<i>Short-term</i>				
AFR	.48%	.48%	.48%	.48%
110% AFR	.53%	.53%	.53%	.53%
120% AFR	.58%	.58%	.58%	.58%
130% AFR	.62%	.62%	.62%	.62%
<i>Mid-term</i>				
AFR	1.82%	1.81%	1.81%	1.80%
110% AFR	2.00%	1.99%	1.99%	1.98%

REV. RUL. 2015–16 TABLE 1
Applicable Federal Rates (AFR) for August 2015

	<i>Period for Compounding</i>			
	<i>Annual</i>	<i>Semiannual</i>	<i>Quarterly</i>	<i>Monthly</i>
120% AFR	2.18%	2.17%	2.16%	2.16%
130% AFR	2.36%	2.35%	2.34%	2.34%
150% AFR	2.74%	2.72%	2.71%	2.70%
175% AFR	3.20%	3.17%	3.16%	3.15%
		<i>Long-term</i>		
AFR	2.82%	2.80%	2.79%	2.78%
110% AFR	3.10%	3.08%	3.07%	3.06%
120% AFR	3.39%	3.36%	3.35%	3.34%
130% AFR	3.67%	3.64%	3.62%	3.61%

REV. RUL. 2015–16 TABLE 2
Adjusted AFR for August 2015

	<i>Period for Compounding</i>			
	<i>Annual</i>	<i>Semiannual</i>	<i>Quarterly</i>	<i>Monthly</i>
Short-term adjusted AFR	.48%	.48%	.48%	.48%
Mid-term adjusted AFR	1.58%	1.57%	1.57%	1.56%
Long-term adjusted AFR	2.82%	2.80%	2.79%	2.78%

REV. RUL. 2015–16 TABLE 3
Rates Under Section 382 for August 2015

Adjusted federal long-term rate for the current month	2.82%
Long-term tax-exempt rate for ownership changes during the current month (the highest of the adjusted federal long-term rates for the current month and the prior two months.)	2.82%

REV. RUL. 2015–16 TABLE 4
Appropriate Percentages Under Section 42(b)(1) for August 2015

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

Appropriate percentage for the 70% present value low-income housing credit	7.53%
Appropriate percentage for the 30% present value low-income housing credit	3.23%

REV. RUL. 2015–16 TABLE 5
Rate Under Section 7520 for August 2015

Applicable federal rate for determining the present value of an annuity, an interest for life or a term of years, or a remainder or reversionary interest	2.2%
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Section 1288.—Treatment of Original Issue Discount on Tax-Exempt Obligations

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2015. See Rev. Rul. 2015–16, page 130.

Section 7520.—Valuation Tables

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2015. See Rev. Rul. 2015–16, page 130.

Section 7872.—Treatment of Loans With Below-Market Interest Rates

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2015. See Rev. Rul. 2015–16, page 130.

Part III. Administrative, Procedural, and Miscellaneous

Notice 2015-51

SECTION 1: PURPOSE

On February 2, 2015, the Treasury Department and IRS published Notice 2015-4, which provides guidance on the energy credit under section 48 of the Internal Revenue Code (Code). Specifically, that notice provides performance and quality standards that small wind energy property must meet to qualify for the energy credit under section 48. Notice 2015-4 is effective for small wind energy property acquired or placed in service (in the case of property constructed, reconstructed, or erected by the taxpayer) after February 2, 2015. This notice modifies Notice 2015-4 by providing a revised effective date for certain small wind energy property that meets the performance and quality standards of International Electrotechnical Commission 61400-1, 61400-12, and 61400-11. Except as otherwise specified in this notice, the guidance provided in Notice 2015-4 continues to apply.

SECTION 2: SMALL WIND ENERGY PROPERTY STANDARDS

.01 Section 3.01 of Notice 2015-4 provides that to qualify as small wind energy

property under section 48, the property must use a wind turbine that has a nameplate capacity of not more than 100 kW and meets the performance and quality standards as set forth in either of the following:

(1) American Wind Energy Association Small Wind Turbine Performance and Safety Standard 9.1-2009 (AWEA); or

(2) International Electrotechnical Commission 61400-1, 61400-12, and 61400-11 (IEC).

.02 The performance and quality standards under AWEA apply only to wind turbines having a rotor swept area of 200m² or less. All other wind turbines having a rotor swept area of more than 200m² must meet the performance and quality standards as set forth in IEC.

SECTION 3: MODIFICATION OF NOTICE 2015-4

In response to information that has come to the attention of Treasury and the IRS about the ability of manufacturers of certain property to immediately complete the certification process relating to the performance and quality standards as set forth in IEC, this Notice delays the effective

date in Notice 2015-4 with respect to such property. Accordingly, this notice modifies Notice 2015-4 by replacing section 5 of the notice with the following language:

This notice is effective for small wind energy property acquired or placed in service (in the case of property constructed, reconstructed, or erected by the taxpayer) after February 2, 2015, if the small wind energy property uses a wind turbine having a rotor swept area of 200m² or less, and after December 31, 2015, if the small wind energy property uses a wind turbine having a rotor swept area of more than 200m².

SECTION 4: DRAFTING INFORMATION

The principal author of this notice is Martha M. Garcia of the Office of Associate Chief Counsel (Passthroughs and Special Industries). For further information regarding this notice, contact Ms. Garcia on 202-317-6853 (not a toll-free number).

Part IV. Items of General Interest

Suspension of Benefits under the Multiemployer Pension Reform Act of 2014

REG-102648-15

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking, notice of proposed rulemaking by cross-reference to temporary regulations, and notice of public hearing.

SUMMARY: This document contains proposed regulations relating to multiemployer pension plans that are projected to have insufficient funds, at some point in the future, to pay the full benefits to which individuals will be entitled under the plans (referred to as plans in “critical and declining status”). The Multiemployer Pension Reform Act of 2014 (“MPRA”) amended the Internal Revenue Code to incorporate suspension of benefits provisions that permit these multiemployer plans to reduce pension benefits payable to participants and beneficiaries if certain conditions are satisfied. MPRA requires the Secretary of the Treasury, in consultation with the Pension Benefit Guaranty Corporation and the Secretary of Labor, to approve or deny applications by these plans to reduce benefits. As required by MPRA, these proposed regulations, together with temporary regulations being published at the same time, provide guidance implementing these statutory provisions. These proposed regulations would affect active, retired, and deferred vested participants and beneficiaries of multiemployer plans that are in critical and declining status as well as employers contributing to, and sponsors and administrators of, those plans.

DATES: Comments must be received by August 18, 2015. Outlines of topics to be discussed at the public hearing scheduled for September 10, 2015 must be received by August 18, 2015.

ADDRESSES: Send submissions to: CC:PA:LPD:PR (REG-102648-15), room

5205, Internal Revenue Service, PO Box 7604, Ben Franklin Station, Washington D.C. 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-102648-15), Courier’s Desk, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, D.C., or sent electronically via the Federal eRulemaking Portal at <http://www.regulations.gov> (IRS REG-102648-15). The public hearing will be held in the Amphitheater of the Ronald Reagan Building and International Trade Center, 1300 Pennsylvania Ave., NW., Washington, D.C.

FOR FURTHER INFORMATION

CONTACT: Concerning the regulations, the Department of the Treasury MPRA guidance information line at (202) 622-1559; concerning submission of comments or the hearing, Regina Johnson at (202) 317-6901 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collection of information contained in this notice of proposed rulemaking has been submitted to the Office of Management and Budget for review in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)).

The collection of information in the paragraphs of these proposed regulations that cross-reference the temporary regulations that are being published elsewhere in this issue of the **Federal Register** is required for a multiemployer defined benefit plan in critical and declining status to satisfy the criteria for approval of an application for a suspension of benefits, including providing notice of the application to specified individuals (containing an individualized estimate of the size of the benefit suspension) and other interested parties. The collection is also required for a plan sponsor to obtain approval of the ballot for the vote on the suspension of benefits that follows approval of the application.

The collection of information in the paragraphs of these proposed regulations that do not cross-reference the temporary regulations is required for a multiem-

ployer defined benefit plan in critical and declining status to maintain an annual written record of its determinations that all reasonable measures to avoid insolvency have been taken and that the plan is not projected to avoid insolvency without a suspension of benefits.

Comments on the collection of information should be sent to the **Office of Management and Budget**, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the Internal Revenue Service, Attn: IRS Reports Clearance Officer, SE:W:CAR:MP:T:T:SP, Washington, DC 20224. Comments on the collection of information should be received by August 18, 2015. Comments are specifically requested concerning:

Whether the proposed collection of information is necessary for the proper performance of the functions of the IRS, including whether the information will have practical utility;

The accuracy of the estimated burden associated with the proposed collection of information;

How the quality, utility, and clarity of the information to be collected may be enhanced;

How the burden of complying with the proposed collections of information may be minimized, including through the application of automated collection techniques or other forms of information technology; and

Estimates of capital or start-up costs and costs of operation, maintenance, and purchase of service to provide information.

For the paragraphs of the proposed regulations that cross-reference the temporary regulations:

Estimated total average annual reporting or recordkeeping burden: 13,888 hours.

Estimated average annual burden per recordkeeper: 496 hours.

Estimated number of recordkeepers: 28.

For the paragraphs of the proposed regulations that do not cross-reference the temporary regulations:

Estimated total average annual reporting or recordkeeping burden: 140 hours.

Estimated average annual burden per recordkeeper: 5 hours.

Estimated number of recordkeepers: 28.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number assigned by the Office of Management and Budget.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Background

Section 432(e)(9)¹ of the Internal Revenue Code (Code) permits the plan sponsor of a multiemployer plan that is projected to have insufficient funds, at some point in the future, to pay the full benefits to which individuals will be entitled under the plan (referred to as a plan in “critical and declining status”) to reduce the pension benefits payable to participants and beneficiaries under the plan if certain conditions are satisfied (referred to as a “suspension of benefits”). MPRA requires the Secretary of the Treasury, in consultation with the Pension Benefit Guaranty Corporation (PBGC) and the Secretary of Labor (generally referred to in this preamble as the Treasury Department, PBGC, and Labor Department, respectively), to issue appropriate guidance to implement the provisions of section 432(e)(9). This document contains proposed regulations under section 432(e)(9) that, together with temporary regulations that are being published elsewhere in this issue of the **Federal Register** and a revenue procedure being published in the Internal Revenue Bulletin, Rev. Proc. 2015–34, implement section 432(e)(9), as required by the statute. The Treasury Department consulted with the PBGC and the Labor Department on these proposed regulations.

The temporary regulations, which are applicable immediately, provide sufficient guidance to enable a plan sponsor that wishes to apply for approval of a suspension of benefits to prepare and submit such an application, and to enable the Department of the Treasury to begin the processing of such an application. The temporary regulations provide general guidance regarding section 432(e)(9), including guidance regarding the meaning of the term “suspension of benefits,” the general conditions for a suspension of benefits, and the implementation of a suspension after a participant vote. This notice of proposed rulemaking requests comments on the provisions of the temporary regulations, and the provisions of the temporary regulations and proposed regulations are expected to be integrated and issued as a single set of final regulations with any changes that are made following consideration of the comments.

The proposed regulations included in this document are not applicable immediately. The proposed regulations provide additional guidance regarding section 432(e)(9), including guidance relating to the standards that will be applied in reviewing an application for suspension of benefits and the statutory limitations on a suspension of benefits. For further background on the statutory provisions that these proposed regulations and the temporary regulations that are incorporated by cross-reference into these proposed regulations are designed to implement, see the preamble to the temporary regulations in the Rules and Regulations section of this issue of the **Federal Register**.

The regulations implementing the statutory suspension of benefits provisions have been divided, as described, into proposed regulations and temporary regulations in order to balance the interest in considering public comments on rules before they apply with the evident statutory intent, reflected in MPRA, to implement the statutory provisions without undue delay. Although the Treasury Department

has issued proposed and temporary regulations under section 432(e)(9), it is expected that no application proposing a benefit suspension will be approved prior to the issuance of final regulations. If a plan sponsor chooses to submit an application for approval of a proposed benefit suspension in accordance with the proposed and temporary regulations before the issuance of final regulations, then the plan sponsor may need to revise the proposed suspension (and potentially the related notices to plan participants) or supplement the application to take into account any differences in the requirements relating to suspensions of benefits that might be included in the final regulations.

Rev. Proc. 2015–34 prescribes the specifics of the application process for approval of a proposed benefit suspension. The revenue procedure also provides a model notice that a plan sponsor proposing a benefit suspension may use to satisfy the statutory notice requirement.

Conditions for suspensions

As a condition for suspension of benefits, the statute requires a plan sponsor to determine, in a written record to be maintained throughout the period of the benefit suspension, that although all reasonable measures to avoid insolvency have been taken (and continue to be taken during the period of the benefit suspension), the plan is still projected to become insolvent unless benefits are suspended. In making this determination, the plan sponsor may take into account factors including a specified list of 10 statutory factors.² See section 432(e)(9)(C)(ii).

Limitations on suspensions

Section 432(e)(9)(D) contains limitations on the benefits that may be suspended, some of which apply to plan participants and beneficiaries on an individual basis and some of which apply on an aggregate basis. Under the statute,

¹Section 432(e)(9) was added to the Internal Revenue Code by the Pension Protection Act of 2006, Public Law 109–280 (120 Stat. 780 (2006)) (PPA ‘06) and amended by the Multiemployer Pension Reform Act of 2014, Division O of the Consolidated and Further Continuing Appropriations Act, 2015, Public Law 113–235 (128 Stat. 2130 (2014)) (MPRA).

²These 10 factors are current and past contribution levels; levels of benefit accruals (including prior reductions in the rate of benefit accruals); prior adjustable benefit reductions and suspensions of benefits; the impact on plan solvency of the subsidies and ancillary benefits available to active participants; compensation levels of active participants relative to employees in the participants’ industry generally; competitive and other economic factors facing contributing employers; the impact of benefit and contribution levels on retaining active participants and bargaining groups under the plan; the impact of past and anticipated contribution increases under the plan on employer attrition and retention levels; and measures undertaken by the plan sponsor to retain or attract contributing employers.

an individual's monthly benefit may not be reduced below 110 percent of the monthly benefit that is guaranteed by the PBGC under section 4022A of the Employee Retirement Income Security Act of 1974, Public Law 93-406 (88 Stat. 829 (1974)), as amended (ERISA) on the date of the suspension. In addition, no benefits based on disability (as defined under the plan) may be suspended.

In the case of a participant or beneficiary who has attained age 75 as of the effective date of a suspension, the statute provides that the suspension may not exceed the applicable percentage of the individual's maximum suspendable benefit (the age-based limitation). The maximum suspendable benefit is the maximum amount of an individual's benefit that would be suspended without regard to the age-based limitation. The applicable percentage is a percentage that is determined by dividing (i) the number of months during the period that begins with the month after the month in which the suspension is effective and ends with the month in which that participant or beneficiary attains the age of 80 by (ii) 60 months.

Section 432(e)(9)(D) also requires the aggregate benefit suspensions (considered, if applicable, in connection with a plan partition under section 4233 of ERISA (partition)) to be reasonably estimated to achieve, but not materially exceed, the level that is needed to avoid insolvency.

Under the statute, any suspension of benefits must be equitably distributed across the participant and beneficiary population, taking into account factors that may include one or more of a list of 11 statutory factors.³ See section 432(e)(9)(D)(vi). Finally, with regard to a suspension of benefits that is made in combination with a plan partition, the suspension may not occur before the effective date of the partition.

Benefit improvements

Section 432(e)(9)(E) sets forth rules relating to benefit improvements made while a suspension of benefits is in effect. Under this provision, a benefit improvement is defined as a resumption of suspended benefits, an increase in benefits, an increase in the rate at which benefits accrue, or an increase in the rate at which benefits become nonforfeitable under the plan.

The statute also provides that, while a suspension of benefits is in effect, a plan sponsor generally has discretion to provide benefit improvements. However, a sponsor may not increase plan liabilities by reason of any benefit improvement for any participant or beneficiary who is not in pay status (in other words, those who are not yet receiving benefits, such as active employees or deferred vested employees) unless (1) this benefit improvement is accompanied by an equitable distribution of benefit improvements for those who have begun to receive benefits (typically, retirees), and (2) the plan actuary certifies that, after taking those benefit improvements into account, the plan is projected to avoid insolvency indefinitely.⁴ Whether an individual is in pay status for this purpose is generally based on whether the individual's benefits began before the first day of the plan year for which the benefit improvement took effect.

In order for benefit improvements to be equitably distributed, the projected value of the total liabilities attributable to benefit improvements for participants and beneficiaries who are not in pay status may not exceed the projected value of the liabilities attributable to benefit improvements for participants and beneficiaries who are in pay status. See section 432(e)(9)(E)(ii). The plan sponsor must equitably distribute any increase in total liabilities attributable to the benefit improvements among the participants and beneficiaries who are in pay status, taking

into account the factors relevant to the equitable distribution of benefit suspensions among participants and beneficiaries (described in section 432(e)(9)(D)(vi)) and the extent to which their benefits were suspended.

The statute allows a plan sponsor to increase plan liabilities through a resumption of benefits for participants and beneficiaries in pay status without providing any benefit improvements for those who are not yet in pay status, but only if it equitably distributes the value of resumed benefits among participants and beneficiaries in pay status, taking into account the factors relevant to the equitable distribution of benefit suspensions.

The restrictions on benefit improvements in section 432(e)(9)(E) apply in addition to any other applicable limitations on increases in benefits that apply to a plan, except with respect to resumptions of suspended benefits only for participants and beneficiaries in pay status (described in the preceding sentence).

Suspension applications

Section 432(e)(9)(G) describes the process for approval or rejection of a plan sponsor's application for a suspension of benefits. Under the statute, the Treasury Department, in consultation with the PBGC and the Labor Department, must approve an application upon finding that the plan is eligible for the suspensions and has satisfied the criteria of sections 432(e)(9)(C), (D), (E), and (F). In evaluating whether a plan sponsor has met the criteria in section 432(e)(9)(C)(ii) (a plan sponsor's determination that, although all reasonable measures have been taken, the plan will become insolvent if benefits are not suspended), the plan sponsor's consideration of factors under that clause must be reviewed. The statute also requires that the plan sponsor's determinations in an application for a suspension of benefits be accepted unless they are clearly erroneous.

³These 11 factors are age and life expectancy; length of time in pay status; amount of benefit; type of benefit; extent of a subsidized benefit; extent of post-retirement benefit increases; history of benefit increases and reductions; years to retirement for active employees; any discrepancies between active employees and retirees; extent to which participants are reasonably likely to withdraw support for the plan, resulting in accelerated employer withdrawal; and the extent to which the benefits are attributed to service with an employer that failed to pay its withdrawal liability.

⁴Avoidance of insolvency is determined by reference to section 418E under which a plan is insolvent if it is unable to pay scheduled benefits for a year. Pursuant to section 432(e)(9)(E)(iv), this restriction does not apply to certain benefit improvements if the Treasury Department determines either that the benefit improvements are reasonable and provide for only de minimis increases in plan liabilities or that the benefit improvements are required as a condition of qualification or to comply with other applicable law.

Participant vote on proposed benefit reduction

If a suspension application is approved, the proposed suspension then goes to a vote of plan participants and beneficiaries. See section 432(e)(9)(H). The vote will be administered by the Treasury Department, in consultation with the PBGC and the Labor Department, within 30 days after approval of the suspension application. The plan sponsor is required to provide a ballot for a vote (subject to approval by the Treasury Department, in consultation with the PBGC and the Labor Department). The statute specifies information that the ballot must include.⁵ If a majority of plan participants and beneficiaries do not vote to reject the suspension, the statute requires the Treasury Department to issue a final authorization to suspend benefits within seven days after the vote.

Explanation of Provisions

I. Overview

These proposed regulations provide guidance on certain requirements under section 432(e)(9) regarding suspension of benefits for multiemployer defined benefit plans in critical and declining status. The proposed regulations cross-reference certain requirements that are addressed in the temporary regulations issued in the Rules and Regulations section of this issue of the **Federal Register**. In addition to the proposed and temporary regulations, the procedural requirements for submitting an application to suspend benefits, as well as a model notice, are provided in Rev. Proc. 2015-34.

II. General rules on suspension of benefits

Under the temporary regulations, once a plan is amended to suspend benefits, a plan may pay or continue to pay a reduced level of benefits pursuant to the suspension only if the terms of the plan are consistent with the requirements of section 432(e)(9) and the regulations. The

proposed regulations would provide that a plan's terms are consistent with the requirements of section 432(e)(9) even if they provide that, instead of a suspension of benefits occurring in full on a specified effective date, the amount of a suspension will phase in or otherwise change in a definite, pre-determined manner as of a specified future effective date or dates. However, the proposed regulations would provide that a plan's terms are inconsistent with the statutory requirements if they provide that the amount of a suspension will change contingent upon the occurrence of any other specified future event, condition, or development. For example, a plan is not permitted to provide that an additional or larger suspension of benefits is triggered if the plan's funded status deteriorates. Similarly, a plan is not permitted to provide that, contingent upon a specified future event, condition, or development, a suspension of benefits will be automatically reduced (except upon a failure to satisfy the annual requirement, described in the proposed regulations, that the plan sponsor determine that the plan is projected to become insolvent unless benefits are suspended).

In the case of an individual who has commenced benefits, the proposed regulations provide that the effective date of a suspension of benefits is the first date as of which a portion of the individual's benefits are not paid as a result of the suspension. In the case of an individual who has not yet commenced benefits, the effective date of a suspension of benefits is the first date as of which the participant's accrued benefit is reduced as a result of the suspension. The effective date of a suspension may not precede the date on which a final authorization to suspend benefits is issued.

If a suspension of benefits provides for more than one reduction in benefits over time, such that benefits are scheduled to be reduced by an additional amount after benefits are first reduced pursuant to the suspension, then each date as of which benefits are reduced is treated as a separate effective date of the suspension,

which would require, for example, that the age-based limitation be separately applied as of each effective date. However, if the effective date of the final scheduled reduction in benefits in a series of reductions pursuant to a suspension is less than three years after the effective date of the first reduction, the effective date of the first reduction will be treated as the effective date of all subsequent reductions pursuant to that suspension. For example, if a suspension provides that benefits will be reduced by a specified percentage effective January 1, 2017, by an additional percentage effective January 1, 2018, and by an additional percentage effective January 1, 2019, with no subsequent changes scheduled, it would meet the three-year condition to treat January 1, 2017 as the effective date for all three reductions. However, if the suspension provided for a further reduction effective January 1, 2020, the suspension would not be treated as satisfying the three-year condition and therefore would be treated under the proposed regulations as having four separate effective dates.

III. Conditions for suspensions

The regulations provide that a plan may not suspend benefits unless the plan sponsor makes initial and annual determinations that the plan is projected to become insolvent unless benefits are suspended, although all reasonable measures to avoid insolvency have been taken. These determinations are based on the nonexclusive list of factors described in section 432(e)(9)(C)(ii).

Under the proposed regulations, a plan sponsor satisfies the annual-plan-sponsor determinations requirement for a plan year only if the plan sponsor determines, no later than the last day of the plan year, that (1) all reasonable measures to avoid insolvency have been taken, and (2) the plan is projected to become insolvent unless the suspension of benefits continues (or another suspension of benefits under section 432(e)(9) is implemented) for the plan. For this purpose, the projection of

⁵This information includes a statement from the plan sponsor in support of the suspension; a statement in opposition to the suspension compiled from comments received in response to the **Federal Register** notice issued by Treasury within 30 days of receiving the suspension application; a statement that the suspension has been approved by the Secretary of the Treasury, in consultation with the PBGC and the Secretary of Labor; a statement that the plan sponsor has determined that the plan will become insolvent unless the suspension takes effect; a statement that insolvency of the plan could result in benefits lower than benefits paid under the suspension; and a statement that insolvency of the PBGC would result in benefits lower than benefits otherwise paid in the case of plan insolvency.

the plan's insolvency must be made using the standards that apply for purposes of determining whether a suspension is sufficient to avoid insolvency and not materially in excess of the level needed to avoid insolvency that are described in paragraph IV.B.1 of this preamble.

If there is favorable actuarial experience so that the plan could avoid insolvency even if the benefit suspension were reduced (but not eliminated), the plan sponsor may wish to adopt a benefit increase that partially restores suspended benefits in order to share that favorable experience with the participants. The statute contemplates this circumstance by providing in section 432(e)(9)(E) the requirements for such a partial restoration of suspended benefits and for other benefit improvements. Moreover, if favorable actuarial experience would allow the plan to avoid insolvency if the benefit suspension were eliminated entirely, the proposed regulations would require the plan sponsor to eliminate the suspension.

The proposed regulations provide that, in order to satisfy the annual-plan-sponsor determinations requirement, the plan sponsor must maintain a written record of its annual determinations. The written record must be included in an update to the rehabilitation plan, whether or not there is otherwise an update for that year or, if the plan is no longer in critical status, in the documents under which the plan is maintained (so that it is available to plan participants and beneficiaries). The plan sponsor's consideration of factors required for its determination of whether all reasonable measures have been taken must be reflected in that determination.

If a plan sponsor fails to satisfy the annual-plan-sponsor determinations requirement for a plan year (including maintaining the written record), then the suspension of benefits expires as of the first day of the next plan year. For example, if in a plan year the plan sponsor is unable to determine that all reasonable measures to avoid insolvency have been taken, then the plan sponsor must take those additional reasonable measures before the end of the plan year in order to avoid the expiration of the suspension as of the first day of the next plan year.

IV. *Limitations on suspensions*

The proposed and temporary regulations reflect the individual and aggregate limitations on a suspension of benefits under section 432(e)(9)(D).⁶ The temporary regulations provide that after applying the individual limitations, the overall size and distribution of the suspension is subject to the aggregate limitations.

A. *Individual limitations*

1. *Guarantee-based limitation*

The temporary regulations provide that benefits may not be suspended below 110 percent of the monthly benefit payable to a participant, beneficiaries, or alternate payee that would be guaranteed by the PBGC under section 4022A of ERISA if the plan were to become insolvent as of the effective date of the suspension.

The proposed regulations provide that under section 4022A of ERISA, the monthly benefit of a participant or beneficiary that would be guaranteed by the PBGC with respect to a plan if the plan were to become insolvent as of the effective date of the suspension is generally based on section 4022A(c)(1) of ERISA. Under section 4022A(c)(1) of ERISA, that guaranteed amount is a dollar amount multiplied by the participant's years and months of credited service as of the date as of which the guarantee is determined. The dollar amount is 100 percent of the accrual rate up to \$11, plus 75 percent of the lesser of (1) \$33, or (2) the accrual rate, if any, in excess of \$11. The accrual rate is a participant's or beneficiary's monthly benefit (described in section 4022A(c)(2)(A) of ERISA) by the participant's years of credited service (described in section 4022A(c)(3) of ERISA) as of the effective date of the suspension.

The proposed regulations provide a number of examples of how the PBGC guarantee is calculated. These examples reflect the interpretation of section 4022A of ERISA provided by the PBGC.

In determining the participant's monthly benefit for purposes of the accrual rate, only nonforfeitable benefits (other than benefits that become nonfor-

feitable on account of plan termination) are taken into account, pursuant to section 4022A(a) of ERISA. The proposed regulations treat benefits that are forfeitable on the effective date of a suspension as nonforfeitable, provided that the participant is in covered employment on that date and would have a nonforfeitable right to those benefits upon completion of vesting service following that date. For example, if an active participant had only three out of five years necessary for the participant's benefit to become 100 percent vested under a plan as of the effective date of a suspension, the participant's accrued benefit will be treated as 100 percent vested as of that date.

2. *Disability-based limitation*

The temporary regulations incorporate the statutory requirement that benefits based on disability may not be suspended. For this purpose, disability is defined in accordance with the definition of that term in the plan. The proposed regulations would provide rules for implementing this limitation.

The proposed regulations provide that benefits based on disability means the entire amount paid to a participant pursuant to the participant becoming disabled, regardless of whether a portion of that amount would have been paid if the participant had not become disabled. For example, assume that a participant with an accrued benefit of \$1,000 per month, payable at age 65, becomes entitled under the plan to an early retirement benefit at age 55 on account of a disability (as defined in the plan). Under the plan, the participant (absent disability) would be entitled to a reduced early retirement benefit of \$600 per month commencing at age 55, but the reduction for early retirement does not apply because the participant became entitled to a benefit on account of a disability. The participant's disability benefit payment of \$1,000 per month commencing at age 55 is a benefit based on disability, even though the participant would have received a portion of these benefits at retirement regardless of the disability.

The proposed regulations also provide that if a participant begins receiving an

⁶The temporary regulations refer to section 432(e)(9)(D)(vii) for additional rules applicable to certain plans.

auxiliary or other temporary disability benefit and the sole reason the participant ceases receiving that benefit is commencement of retirement benefits, the benefit based on disability after commencement of retirement benefits is the lesser of (1) the periodic payment the participant was receiving immediately before the participant's retirement benefits commenced, or (2) the total periodic payments to the participant under the plan.

For example, assume that a participant begins receiving a disability pension of \$1,000 per month payable at age 55. When the participant reaches age 65, the participant's disability pension is discontinued and the participant elects to commence payment of the participant's accrued benefit in the form of an actuarially equivalent joint and survivor annuity payable in the amount of \$850 per month. Before age 65, the participant's benefit based on disability is \$1,000 per month. After age 65, the participant's benefit based on disability is \$850 per month. (Alternatively, if the participant had elected to commence payment of the participant's accrued benefit in the form of a single life annuity payable in the amount of \$1,000 per month, the participant's benefit based on disability after age 65 would be \$1,000 per month.) A suspension of benefits is not permitted to apply to any portion of those benefits at any time.

3. Age-based limitation

The proposed regulations would provide that no suspension of benefits is permitted to apply to a participant, beneficiary, or alternate payee who has commenced receiving benefits as of the effective date of the suspension and has reached age 80 no later than the end of the month that includes the effective date of the suspension. For example, assume that a suspension of benefits has an effective date of December 1, 2017. If a retiree is 79 years old on December 1, 2017, and turns 80 on December 15, 2017, a suspension of benefits is not permitted to apply to the retiree's monthly benefit.

In addition, no more than the applicable percentage of the maximum suspendable benefit may be suspended for a participant, beneficiary, or alternate payee

who has commenced receiving benefits as of the effective date of the suspension and has reached age 75 by the end of the month that includes the effective date of the suspension.

The maximum suspendable benefit is the portion of an individual's benefits that would be suspended without regard to the age-based limitation, after the application of the guarantee-based limitation and the disability-based limitation, described earlier in paragraphs IV.A.1 and IV.A.2 of this preamble.

The applicable percentage is the percentage obtained by dividing: (1) the number of months during the period beginning with the month after the month in which the suspension of benefits is effective and ending with the month during which the participant or beneficiary attains the age of 80, by (2) 60.

The proposed regulations explain how to apply the age-based limitation if benefits have not commenced to either a participant or beneficiary as of the effective date of the suspension. If the participant is alive on the effective date, the participant is treated as having commenced benefits on that date. If the participant is deceased on the effective date, the beneficiary is treated as having commenced benefits on that date.

The age-based limitation applies to a suspension of benefits in which an alternate payee has an interest, whether or not the alternate payee has commenced benefits as of the effective date of the suspension. If the alternate payee's right to the suspended benefits derives from a qualified domestic relations order within the meaning of section 414(p)(1)(A) (QDRO) under which the alternate payee shares in each benefit payment but the participant retains the right to choose the time and form of payment with respect to the benefit to which the suspension applies (shared payment QDRO), the applicable percentage for the alternate payee is calculated by using the participant's age as of the effective date of the suspension. If the alternate payee's right to the suspended benefits derives from a QDRO under which the alternate payee has a separate right to receive a portion of the participant's retirement benefit to be paid at a time and in a form different from that chosen by the participant (separate inter-

est QDRO), the applicable percentage for the alternate payee is calculated by substituting the alternate payee's age as of the effective date of the suspension for the participant's age.

If the age-based limitation applies to a participant on the effective date of the suspension, then the age-based limitation also applies to the beneficiary of the participant, based on the age of the participant on the effective date of the suspension.

B. Aggregate limitations

1. Avoidance of insolvency

The proposed regulations reflect the requirement in section 432(e)(9)(D)(iv) that any suspension of benefits, in the aggregate (considered, if applicable, in combination with a partition of the plan), must be at a level that is reasonably estimated to enable the plan to avoid insolvency and not materially exceed the level that is necessary to enable the plan to avoid insolvency.

A suspension of benefits (considered, if applicable, in combination with a partition of the plan) will satisfy the requirement that it is at a level that is reasonably estimated to enable the plan to avoid insolvency if: (1) for each plan year throughout an extended period beginning on the first day of the plan year that includes the effective date of the suspension, the plan's solvency ratio is projected on a deterministic basis to be at least 1.0; (2) based on stochastic projections reflecting variance in investment return, the probability that the plan will avoid insolvency throughout the extended period is more than 50 percent; and (3) unless the plan's projected funded percentage (within the meaning of section 432(j)(2)) at the end of the extended period using a deterministic projection exceeds 100 percent, then the projection shows that at all times during the last five plan years of that period, there is no projected decrease in either the plan's solvency ratio or its available resources (as defined in section 418E(b)(3)). In the case of a plan that is not large enough to be required to select a retiree representative, the determination of whether a benefit suspension (considered, if applicable, in combination with a plan partition) will

satisfy the requirement that it is at a level that is reasonably estimated to enable the plan to avoid insolvency is permitted to be made without regard to clause (2).

A plan's solvency ratio for a plan year means the ratio of the plan's available resources (as defined in section 418E(b)(3)) for the plan year to the scheduled benefit payments under the plan for the plan year. An extended period means a period of at least 30 plan years. However, in the case of a temporary suspension of benefits that is scheduled to cease as of a date that is more than 25 years after the effective date of the suspension, the extended period must be lengthened so that it ends no earlier than five plan years after the cessation of the suspension.

Under the proposed regulations, a suspension of benefits will satisfy the requirement that the suspension be at a level that is reasonably estimated to not materially exceed the level necessary for the plan to avoid insolvency if an alternative, similar but smaller suspension of benefits, under which the dollar amount of the suspension for each participant and beneficiary were reduced by five percent, would not be sufficient to enable the plan to satisfy the requirement that the suspension be at a level that is reasonably estimated to enable the plan to avoid insolvency. In addition, if the PBGC issues an order partitioning the plan, then a suspension of benefits with respect to the plan will be deemed to satisfy this requirement. This test based on a five percent reduction of a suspension is roughly comparable to the common use in accounting standards of a five-percent threshold for materiality.

The proposed regulations would require the actuarial projections used for purposes of these requirements to reflect the assumption that the suspension of benefits continues indefinitely (or, if the suspension expires on a specified date by its own terms, until that date). The actuarial assumptions and methods used for the actuarial projections must be reasonable in accordance with the rules of section 431(c)(3). The actuary's selection of assumptions about future covered employment and contribution levels (including contribution base units and average contribution rate) is permitted to be based on information provided by the plan sponsor, which must act in good faith in providing

the information. In addition, to the extent that the actuarial assumptions used for the projections differ from those used to certify whether the plan is in critical and declining status pursuant to section 432(b)(3)(B)(iv), a justification for that difference generally must be provided.

The cash flow projections must be based on the fair market value of assets as of the end of the most recent calendar quarter, projected benefit payments that are consistent with the projected benefit payments under the most recent actuarial valuation, and appropriate adjustments to projected benefit payments to include benefits for new hires who are reflected in the projected contribution amounts. The projected cash flows relating to contributions, withdrawal liability payments, and benefit payments must also be adjusted to reflect significant events that occurred after the most recent actuarial valuation. Significant events include: (1) a plan merger or transfer; (2) the withdrawal or the addition of employers that changed projected cash flows relating to contributions, withdrawal liability payments, or benefit payments by more than five percent; (3) a plan amendment, a change in a collective bargaining agreement, or a change in a rehabilitation plan that changed projected cash flows relating to contributions, withdrawal liability, or benefit payments by more than five percent; or (4) any other event or trend that resulted in a material change in the projected cash flows.

The application for suspension must include a disclosure of the total contributions, total contribution base units and average contribution rate, withdrawal liability payments, and the rate of return on plan assets for each of the 10 plan years preceding the plan year in which the application is submitted. In addition, the application must include deterministic projections of the plan's solvency ratio over the extended period using two alternative assumptions that the plan's future rate of return was lower than the assumed rate of return by (1) one percentage point and (2) two percentage points.

The application must include deterministic projections of the plan's solvency ratio over the extended period using two alternative assumptions for the future contribution base units. These alternatives are that the future contribution base units (1)

continue under the same trend as the plan experienced over the past 10 years, and (2) continue under that 10-year trend reduced by one percentage point.

The application must include an illustration, prepared on a deterministic basis, of the projected value of plan assets, the accrued liability of the plan (calculated using the unit credit funding method), and the funded percentage for each year in the extended period.

2. *Equitable distribution*

The proposed regulations would require any suspension of benefits to be equitably distributed across the participant and beneficiary population. If a suspension of benefits applies differently to different categories or groups of participants and beneficiaries, then the suspension of benefits is equitably distributed across the participant and beneficiary population only if under the suspension: (1) within each such category or group, the individuals are treated consistently; (2) any difference in treatment among the different categories or groups is based on relevant factors reasonably selected by the plan sponsor; and (3) any such difference in treatment is based on a reasonable application of the relevant factors.

The proposed regulations contain examples illustrating the equitable distribution rules.

V. *Benefit improvements*

The proposed regulations set forth rules for the application of section 432(e)(9)(E), regarding benefit improvements. The proposed regulations provide that a plan satisfies the criteria in section 432(e)(9)(E) only if, during the period that any suspension of benefits remains in effect, the plan sponsor does not implement any benefit improvement except as provided in the proposed regulations.

Section 432(e)(9)(E)(vi) and the proposed regulations define the term benefit improvement to mean, with respect to a plan, a resumption of suspended benefits, an increase in benefits, an increase in the rate at which benefits accrue, or an increase in the rate at which benefits become nonforfeitable under the plan. In the case of a suspension of benefits that ex-

pires as of a date that is specified in the original plan amendment providing for the suspension, the resumption of benefits solely from the expiration of that period is not treated as a benefit improvement.

A. Limitations on benefit improvements for those not in pay status

The proposed regulations provide that, during the period any suspension of benefits under a plan remains in effect, the plan sponsor may not increase the liabilities of the plan by reason of any benefit improvement for any participant or beneficiary who was not in pay status for any plan year before the plan year for which the benefit improvement takes effect, unless several conditions are satisfied.

One condition is that the present value of the total liabilities for a benefit improvement for participants and beneficiaries whose benefit commencement dates occurred before the first day of the plan year for which the benefit improvement takes effect is not less than the present value of the total liabilities for a benefit improvement for participants and beneficiaries who were not in pay status by that date. For this purpose, present value is the present value as of the first day of the plan year in which the benefit improvement is proposed to take effect, using actuarial assumptions in accordance with section 431.

The plan sponsor must also equitably distribute the benefit improvement among participants and beneficiaries whose benefit commencement dates occurred before the first day of the plan year in which the benefit improvement is proposed to take effect. The evaluation of whether a benefit improvement is equitably distributed must take into account the factors relevant to whether a suspension of benefits is equitably distributed, described in paragraph IV.B.2 of this preamble, and the extent to which the benefits of the participants and beneficiaries were suspended.

In addition, the plan actuary must certify that, after taking into account the benefit improvement, the plan is projected to avoid insolvency indefinitely. This certification must be made using the standards that apply for purposes of determining whether a suspension is sufficient to avoid

insolvency that are described in paragraph IV.B.1 of this preamble.

These limitations do not apply to a resumption of suspended benefits or plan amendment that increases liabilities with respect to participants and beneficiaries not in pay status by the first day of the plan year in which the benefit improvement took effect that: (1) the Treasury Department, in consultation with the PBGC and the Labor Department, determines to be reasonable and which provides for only de minimis increases in plan liabilities, or (2) is required as a condition of qualification under section 401 or to comply with other applicable law, as determined by the Treasury Department.

B. Limitations on benefit improvements for those in pay status

Under the proposed regulations, the plan sponsor may increase liabilities of the plan by eliminating some or all of the suspension that applies solely to participants and beneficiaries in pay status at the time of the resumption, provided that the plan sponsor equitably distributes the value of those resumed benefits among participants and beneficiaries in pay status, taking into account factors relevant to whether a suspension of benefits is equitably distributed. Such a resumption of benefits is not subject to the limitations on a benefit improvement under section 432(f) (relating to restrictions on benefit increases for plans in critical status).

C. Other limitations on benefit increases

The proposed regulations would provide that the limitations on benefit improvements generally apply in addition to other limitations on benefit increases that apply to a plan. Except for a resumption of suspended benefits described in paragraph V.B. of this preamble, the limitations on a benefit improvement are in addition to the limitations in section 432(f) and any other applicable limitations on increases in benefits imposed on a plan.

VI. Notice of proposed suspension

Section 432(e)(9)(F)(iii) states that notice must be provided in a form and man-

ner prescribed in guidance and that notice may be provided in written, electronic, or other appropriate form to the extent such form is reasonably accessible to persons to whom the notice is required to be provided. The temporary regulations include rules implementing the statutory notice requirements in section 432(e)(9)(F). The proposed regulations would provide that notice must exclusively be provided in written or electronic form (that is, there is no other appropriate form).

VII. Approval or denial of an application for suspension of benefits

A plan sponsor cannot implement a suspension of benefits unless, among other things, its application for a proposed suspension of benefits is approved. The temporary regulations contain rules regarding the submission and review of an application, and related guidelines and procedures are set forth in Rev. Proc. 2015-34. The temporary regulations provide that a complete application will be deemed approved unless, within 225 days after a complete application is received, the Treasury Department notifies the plan sponsor that its application does not satisfy one or more of the requirements for approval. The proposed regulations would provide that, if necessary under the circumstances, the Treasury Department and the plan sponsor may mutually agree in writing to stay the 225-day period. Any such agreement would be expected to be used only in unusual circumstances.

As required by section 432(e)(9)(G)(iv), the proposed regulations provide that in evaluating whether the plan sponsor has satisfied the condition (in section 432(e)(9)(C)(ii)) that it determine that all reasonable measures to avoid insolvency within the meaning of section 418E have been taken, the Treasury Department, in consultation with the PBGC and the Labor Department, will review the plan sponsor's consideration of each of the factors enumerated in section 432(e)(9)(C)(ii) and each other factor it took into account in making that determination. The proposed regulations, like the statute, do not require the plan sponsor to take any particular measure or measures to avoid insolvency but do require, in the aggregate, that the plan sponsor take all reasonable

measures to avoid insolvency. In accordance with section 432(e)(9)(G)(v), the proposed regulations provide that, in evaluating the plan sponsor's application, the Treasury Department will accept the plan sponsor's determinations under section 432(e)(9)(C)(ii) unless the Treasury Department concludes, in consultation with the PBGC and the Labor Department, that the determinations were clearly erroneous. This statutory structure reflects the view that particular measures to avoid insolvency may be inappropriate for some plans and requires the Treasury Department to review the plan sponsor's consideration of the appropriateness of each of the statutory factors, but recognizes that the plan sponsor is generally in a better position than the Treasury Department to determine the most effective measures that a particular plan should take to avoid insolvency.

The proposed regulations provide that an application to suspend benefits will not be approved unless the plan sponsor certifies that, if it receives final authorization to suspend benefits (described in paragraph VIII. of this preamble), chooses to implement the suspension, and adopts a plan amendment to implement the suspension, it will timely amend the plan to provide that (1) the suspension of benefits will cease as of the first day of the first plan year following the first plan year in which the plan sponsor fails to make the annual determinations in section 432(e)(9)(C)(ii); and (2) any future benefit improvement must satisfy the section 432(e)(9)(E) rules for benefit improvements.

VIII. *Participant vote on proposed benefit reduction*

Section 432(e)(9)(H)(ii) provides that if an application for a suspension of benefits is approved, then the Treasury Department, in consultation with the PBGC and the Labor Department, will administer a vote of all plan participants and all beneficiaries of deceased participants (eligible voters). Any suspension of benefits will take effect only after the vote and after a final authorization to suspend benefits. Many of the rules relating to the vote

are set forth in the temporary regulations. However, both the temporary and the proposed regulations reserve, for later issuance, provisions on the administration of the vote.

The proposed regulations would provide that if an application for suspension is approved, the plan sponsor must take reasonable steps to inform eligible voters about the proposed suspension and the vote. This includes all eligible voters who can be contacted by reasonable efforts pursuant to section 432(e)(9)(F). Anyone whom the plan sponsor has been able to locate through these means (or who has otherwise been located by the plan sponsor) must be sent a ballot.

The proposed regulations would require the plan sponsor to provide a ballot for the vote⁷ that includes the following:

- A description of the proposed suspension and its effect, including the effect of the suspension on each category or group of individuals affected by the suspension and the extent to which they are affected;
- A description of the factors considered by the plan sponsor in designing the benefit suspension, including but not limited to the factors in section 432(e)(9)(D)(vi);
- A description of whether the suspension will remain in effect indefinitely or will expire by its own terms (and, if it will expire by its own terms, when that will occur);
- A statement from the plan sponsor in support of the proposed suspension;
- A statement in opposition to the proposed suspension compiled from comments received pursuant to the solicitation of comments in the **Federal Register** notice with respect to the application;
- A statement that the proposed suspension has been approved by the Secretary of the Treasury, in consultation with the PBGC and the Secretary of Labor;
- A statement that the plan sponsor has determined that the plan will become insolvent unless the proposed suspension takes effect (including the year in which insolvency is projected to occur

without a suspension of benefits), and an accompanying statement that this determination is subject to uncertainty;

- A statement that insolvency of the plan could result in benefits lower than benefits paid under the proposed suspension and a description of the projected benefit payments in the event of plan insolvency;
- A statement that insolvency of the PBGC would result in benefits lower than benefits otherwise paid in the case of plan insolvency;
- A statement that the plan's actuary has certified that the plan is projected to avoid insolvency, taking into account the proposed suspension of benefits (and, if applicable, a proposed partition plan), and an accompanying statement that the actuary's projection is subject to uncertainty;
- A statement that the suspension will go into effect unless a majority of eligible voters vote to reject the suspension and that, therefore, a failure to vote has the same effect on the outcome of the vote as a vote in favor of the suspension;
- A copy of the individualized estimate that was provided as part of the earlier notice described in section 432(e)(9)(F) (or, if that individualized estimate is no longer accurate, a corrected version of that estimate); and
- A description of the voting procedures, including the deadline for voting.

A proposed suspension is generally permitted to be implemented unless rejected by a majority vote of all eligible voters. In determining whether a majority of all eligible voters have voted to reject the suspension under section 432(e)(9)(H)(ii), the proposed regulations would treat any eligible voters to whom ballots have not been provided (because the individuals could not be located) as voting to reject the suspension at the same rate (in other words, in the same percentage) as those to whom ballots have been provided.

Proposed Effective Date

These regulations are proposed to be effective on and after the date of publica-

⁷The ballot is subject to approval by the Treasury Department, in consultation with the PBGC and the Labor Department. See section 432(e)(9)(H) and § 1.432(e)(9)-1T(h).

tion in the **Federal Register** of the Treasury decision adopting these rules as final regulations. Until regulations finalizing these proposed regulations are issued, taxpayers may not rely on the rules set forth in these proposed regulations.

Availability of IRS Documents

For copies of recently issued revenue procedures, revenue rulings, notices and other guidance published in the Internal Revenue Bulletin, please visit the IRS Web site at <http://www.irs.gov> or contact the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

Special Analyses

Certain IRS regulations, including this one, are exempt from the requirements of Executive Order 12866, as supplemented and reaffirmed by Executive Order 13563. Therefore, a regulatory impact assessment is not required. It 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.

The Regulatory Flexibility Act (RFA) (5 U.S.C. chapter 6) requires an agency to consider whether the rules it proposes will have a significant economic impact on a substantial number of small entities. In this case, the IRS and Treasury believe that the regulations likely would not have a “significant economic impact on a substantial number of small entities.” 5 U.S.C. 605. This certification is based on the fact that the number of small entities affected by this rule is unlikely to be substantial because it is unlikely that a substantial number of small multiemployer plans in critical and declining status will suspend benefits under section 432(e)(9). Pursuant to section 7805(f) of the Code, this notice of proposed rulemaking has been submitted to the Chief Counsel of Advocacy of the Small Business Administration for comment on its impact on small business.

Comments and Public Hearing

Before these proposed regulations are adopted as final regulations, consideration will be given to any comments that are submitted timely to the Treasury Department and the IRS as prescribed in this

preamble under the “Addresses” heading. The Treasury Department and the IRS request comments on all aspects of the proposed rules (including both the provisions set forth in this notice of proposed rulemaking and the provisions set forth in the cross-referenced temporary regulations). Comments are specifically requested on the demonstration of avoidance of insolvency, including the rules related to the use of the extended period for this purpose. In addition, comments are requested on the rules relating to the demonstration that the suspension is not materially in excess of the level necessary to avoid insolvency.

All comments will be available for public inspection and copying at www.regulations.gov or upon request. **Please Note:** All comments will be made available to the public. Do not include any personally identifiable information (such as Social Security number, 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.

A public hearing on these proposed regulations has been scheduled for September 10, 2015, beginning at 9:00 a.m. in the Amphitheater of the Ronald Reagan Building and International Trade Center, 1300 Pennsylvania Ave., NW., Washington, D.C.

The rules of 26 CFR 601.601(a)(3) apply to the hearing. Persons who wish to present oral comments at the hearing must submit written or electronic comments by August 18, 2015, and an outline of topics to be discussed and the amount of time to be devoted to each topic (a signed original and eight (8) copies) by August 18, 2015. A period of up to 10 minutes will be allotted to each person for making comments. An agenda showing the scheduling of the speakers will be prepared after the deadline for receiving outlines has passed. Copies of the agenda will be available free of charge at the hearing.

For information about the hearing, see the **FOR FURTHER INFORMATION CONTACT** section of this preamble.

Contact Information

For general questions regarding these regulations, please contact the Depart-

ment of the Treasury at (202) 622-1559 (not a toll-free number). For information regarding a specific application for a suspension of benefits, please contact the Department of the Treasury at (202) 622-1534 (not a toll-free number).

* * * * *

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 1.432(e)(9)–1 is added to read as follows:

§ 1.432(e)(9)–1 Benefit suspensions for multiemployer plans in critical and declining status.

(a) *General rules on suspension of benefits—(1) General rule.* [The text of the proposed amendments to § 1.432(e)(9)–1(a)(1) is the same as § 1.432(e)(9)–1T(a)(1) published elsewhere in this issue of the **Federal Register**.]

(2) *Adoption of plan terms inconsistent with suspension requirements—(i) General rule.* [The text of the proposed amendments to § 1.432(e)(9)–1(a)(2)(i) is the same as § 1.432(e)(9)–1T(a)(2)(i) published elsewhere in this issue of the **Federal Register**.]

(ii) *Changes in level of suspension.* A plan’s terms are consistent with the requirements of section 432(e)(9) even if the plan provides that, instead of a suspension of benefits occurring in full on a specified effective date, the amount of a suspension will phase in or otherwise change in a definite, pre-determined manner as of a specified future effective date or dates. However, a plan’s terms are inconsistent with the requirements of section 432(e)(9) if they provide that the amount of a suspension will change contingent upon the occurrence of any other specified future event, condition, or development. For example, a plan is not permitted to provide that an additional or larger suspension of benefits is triggered if the plan’s funded status deteriorates. Sim-

ilarly, a plan is not permitted to provide that, contingent upon a specified future event, condition, or development, a suspension of benefits will be automatically reduced (except upon a failure to satisfy the annual requirement, described in paragraph (c)(4) of this section, that the plan sponsor make determinations that the plan is projected to avoid insolvency unless benefits are suspended).

(3) *Organization of the regulation.* This paragraph (a) contains definitions and general rules relating to a suspension of benefits by a multiemployer plan under section 432(e)(9). Paragraph (b) of this section defines a suspension of benefits and describes the length of a suspension, the treatment of beneficiaries and alternate payees under this section, and the requirement to select a retiree representative. Paragraph (c) of this section contains rules for the actuarial certification and plan-sponsor determinations that must be made in order for a plan to suspend benefits. Paragraph (d) of this section describes limitations on suspensions of benefits. Paragraph (e) of this section describes limitations on benefit improvements that may be made while a suspension of benefits is in effect. Paragraph (f) of this section describes the requirement to provide notice in connection with an application to suspend benefits. Paragraph (g) of this section describes the approval or denial of an application for a suspension of benefits. Paragraph (h) of this section contains certain rules relating to the vote on an approved suspension, systemically important plans, and the issuance of a final authorization to suspend benefits.

(4) *Definitions.* The following definitions apply for purposes of this section—
(i) *Pay status.* [The text of the proposed amendments to § 1.432(e)(9)–1(a)(4)(i) is the same as § 1.432(e)(9)–1T(a)(4)(i) published elsewhere in this issue of the **Federal Register**.]

(ii) *Plan sponsor.* [The text of the proposed amendments to § 1.432(e)(9)–1(a)(4)(ii) is the same as § 1.432(e)(9)–1T(a)(4)(ii) published elsewhere in this issue of the **Federal Register**.]

(iii) *Effective date of suspension of benefits—(A) In general.* In the case of an individual who has commenced benefits, the effective date of a suspension of benefits is the first date as of which a portion

of the individual's benefits are not paid as a result of the suspension. In the case of an individual who has not yet commenced benefits, the effective date of a suspension of benefits is the first date as of which the individual's accrued benefit is reduced as a result of the suspension.

(B) *Phased-in suspension.* If a suspension of benefits provides for more than one reduction in benefits over time, such that benefits are scheduled to be reduced by an additional amount after benefits are first reduced pursuant to the suspension, then each date as of which benefits are reduced is treated as a separate effective date of the suspension. However, if the effective date of the final scheduled reduction in benefits in a series of reductions pursuant to a suspension is less than three years later than the effective date of the first reduction, the effective date of the first reduction will be treated as the effective date of all subsequent reductions pursuant to that suspension.

(C) *Effective date may not be retroactive.* The effective date of a suspension may not precede the date on which a final authorization to suspend benefits is issued pursuant to paragraph (h)(6) of this section.

(b) *Definition of suspension of benefits and related rules.* [The text of the proposed amendments to § 1.432(e)(9)–1(b) is the same as § 1.432(e)(9)–1T(b) published elsewhere in this issue of the **Federal Register**.]

(c) *Conditions for suspension—(1) In general—(i) Actuarial certification and initial-plan-sponsor determinations.* [The text of the proposed amendments to § 1.432(e)(9)–1(c)(1)(i) is the same as § 1.432(e)(9)–1T(c)(1)(i) published elsewhere in this issue of the **Federal Register**.]

(ii) *Annual requirement to make plan-sponsor determinations.* As provided in paragraph (c)(5) of this section, the suspension will continue only if the plan sponsor continues to make the annual-plan-sponsor determinations described in paragraph (c)(4) of this section.

(2) *Actuarial certification.* [The text of the proposed amendments to § 1.432(e)(9)–1(c)(2) is the same as § 1.432(e)(9)–1T(c)(2) published elsewhere in this issue of the **Federal Register**.]

(3) *Initial-plan-sponsor determinations.* [The text of the proposed amendments to § 1.432(e)(9)–1(c)(3) is the same as § 1.432(e)(9)–1T(c)(3) published elsewhere in this issue of the **Federal Register**.]

(4) *Annual-plan-sponsor determinations—(i) General rule.* A plan satisfies the annual-plan-sponsor determinations requirement of this paragraph (c)(4) for a plan year only if the plan sponsor determines, no later than the last day of the plan year, that—

(A) All reasonable measures to avoid insolvency have been and continue to be taken; and

(B) The plan is not projected to avoid insolvency (determined using the standards described in paragraphs (d)(5)(ii), (iv), and (v) of this section, substituting the current plan year for the plan year that includes the effective date of the suspension) unless the suspension of benefits continues (or another suspension of benefits under section 432(e)(9) is implemented) for the plan.

(ii) *Factors.* In making its determination that all reasonable measures to avoid insolvency have been and continue to be taken, the plan sponsor may take into account the non-exclusive list of factors in paragraph (c)(3)(ii) of this section.

(iii) *Requirement to maintain written record.* The plan sponsor must maintain a written record of the annual-plan-sponsor determinations made under this paragraph (c)(4). The written record must be included in an update to the rehabilitation plan, whether or not there is otherwise an update for that year (or, if the plan is no longer in critical status, must be included in the documents under which the plan is maintained). The written record of the determinations must describe the plan sponsor's consideration of factors, as described in paragraph (c)(4)(ii) of this section.

(5) *Failure to make annual-plan-sponsor determinations.* If a plan sponsor fails to satisfy the annual-plan-sponsor determinations requirement of paragraph (c)(4) of this section for a plan year (including maintaining the written record described in paragraph (c)(4)(iii) of this section), then the suspension of benefits will cease to be in effect beginning as of the first day of the next plan year.

(d) *Limitations on suspension*—(1) *In general.* [The text of the proposed amendments to § 1.432(e)(9)–1(d)(1) is the same as § 1.432(e)(9)–1T(d)(1) published elsewhere in this issue of the **Federal Register**.]

(2) *Guarantee-based limitation*—(i) *General rule.* [The text of the proposed amendments to § 1.432(e)(9)–1(d)(2)(i) is the same as § 1.432(e)(9)–1T(d)(2)(i) published elsewhere in this issue of the **Federal Register**.]

(ii) *PBGC guarantee.* Under section 4022A of the Employee Retirement Income Security Act of 1974, Public Law 93–406 (88 Stat. 829 (1974)), as amended (ERISA), the monthly benefit of a participant or beneficiary that would be guaranteed by the Pension Benefit Guaranty Corporation (PBGC) with respect to a plan if the plan were to become insolvent as of the effective date of the suspension is generally based on section 4022A(c)(1) of ERISA. Under that section, the monthly benefit that would be guaranteed if the plan were to become insolvent as of the date as of which the guarantee is determined is the product of—

(A) 100 percent of the accrual rate up to \$11, plus 75 percent of the lesser of—

(1) \$33; or

(2) The accrual rate, if any, in excess of \$11; and

(B) The number of the participant's years and months of credited service as of that date.

(iii) *Calculation of accrual rate.* The accrual rate, as defined in section 4022A(c)(2) of ERISA, is calculated by dividing—

(A) The participant's or beneficiary's monthly benefit, described in section 4022A(c)(2)(A) of ERISA; by

(B) The participant's years of credited service, described in section 4022A(c)(3) of ERISA, as of the effective date of the suspension.

(iv) *Special rule for non-vested participants.* For purposes of this paragraph (d)(2), a participant's nonforfeitable benefits under section 4022A(a) of ERISA include benefits that are forfeitable as of the effective date of the suspension, provided that the participant would have a nonforfeitable right to those benefits if the participant continued to earn vesting service following that date.

(v) *Examples.* The following examples illustrate the limitation on a suspension of benefits in this paragraph (d)(2). Unless otherwise stated, the amount of guarantee payable by PBGC in these examples is based on section 4022A(c) of ERISA, and the rules under section 4022A(d) of ERISA (guarantee for benefits reduced under section 411(a)(3)(E)), section 4022A(e) of ERISA (benefits ineligible for guarantee), and section 4022A(h) of ERISA (guarantee for benefits accrued as of July 30, 1980) do not apply. In these examples, unless otherwise stated, the monthly benefits are nonforfeitable, are based on benefits that have been in effect for at least 60 months as of the effective date of the suspension, and are no greater than the monthly benefit that would be payable at normal retirement age in the form of a single life annuity.

Example 1. (i) *Facts.* A participant is receiving a benefit of \$1,500 per month. The participant has 30 years of credited service under the plan.

(ii) *Calculation of accrual rate.* The participant's accrual rate is \$50, calculated by dividing the participant's monthly benefit payment (\$1,500) by the participant's years of credited service (30).

(iii) *Calculation of monthly PBGC-guaranteed benefit.* The first \$11 of the accrual rate is fully guaranteed, and the next \$33 of the accrual rate is 75% guaranteed ($\$33 \times .75 = \24.75). The participant's monthly guaranteed benefit per year of credited service is \$35.75 ($\$11 + \$24.75 = \35.75). The PBGC guarantee formula is then applied to produce the amount of guarantee payable by PBGC, which is \$1,072.50 ($\$35.75 \times 30 \text{ years} = \$1,072.50$).

(iv) *Calculation of guarantee-based limitation.* A suspension of benefits may not reduce the participant's benefits below the guarantee-based limitation, which is equal to 110% of the amount of guarantee payable by PBGC. That monthly amount is \$1,179.75 ($\$1,072.50 \times 1.1 = \$1,179.75$).

Example 2. (i) *Facts.* The facts are the same as in *Example 1*, except that the participant is deceased and the participant's beneficiary is receiving a monthly benefit of \$750 under a 50% joint and survivor annuity.

(ii) *Calculation of accrual rate.* The beneficiary's accrual rate is \$25, calculated by dividing the beneficiary's monthly benefit payment (\$750) by the participant's years of credited service (30).

(iii) *Calculation of monthly PBGC-guaranteed benefit.* The first \$11 of the accrual rate is fully guaranteed, and the next \$14 ($\$25 - \$11 = \14) of the accrual rate is 75% guaranteed ($\$14 \times .75 = \10.50). The beneficiary's monthly guaranteed benefit is \$21.50 per year of credited service ($\$11 + \$10.50 = \$21.50$). The PBGC guarantee formula is then applied to produce the amount of guarantee payable by PBGC, which is \$645 ($\$21.50 \times 30 \text{ years} = \645).

(iv) *Calculation of guarantee-based limitation.* A suspension of benefits may not reduce the beneficia-

ry's benefits below the guarantee-based limitation, which is equal to 110% of the monthly amount of guarantee payable by PBGC. That monthly guarantee-based limitation amount is \$709.50 ($\$645 \times 1.1 = \709.50).

Example 3. (i) *Facts.* A participant would be eligible for a monthly benefit of \$1,000 payable as a single life annuity at normal retirement age, based on the participant's 25 years of credited service. The plan also permits a participant to receive a benefit on an unreduced basis as a single life annuity at early retirement age and permits participants to receive an early retirement benefit in the form of a Social Security level income option. Under the Social Security level income option, the participant receives a monthly benefit of \$1,600 prior to normal retirement age (which is the plan's assumed Social Security retirement age) and \$900 after normal retirement age.

(ii) *Calculation of accrual rate.* For purposes of calculating the accrual rate, the monthly benefit that is used to calculate the PBGC guarantee does not exceed the monthly benefit of \$1,000 that would be payable at normal retirement age. In calculating the accrual rate, the amount of guarantee payable by PBGC would be based on a monthly benefit of \$1,000 prior to normal retirement age and \$900 after normal retirement age. Before normal retirement age, the participant's accrual rate is \$40, determined by dividing the participant's monthly benefit payment (\$1,000) by years of credited service (25). After normal retirement age, the participant's accrual rate is \$36, calculated by dividing the participant's monthly benefit payment (\$900) by the participant's years of credited service (25).

(iii) *Calculation of monthly PBGC-guaranteed benefit.* Before normal retirement age, the first \$11 of the accrual rate is fully guaranteed, and the next \$29 of the accrual rate is 75% guaranteed ($\$29 \times .75 = \21.75). The participant's monthly guaranteed benefit per year of credited service is \$32.75 ($\$11 + \$21.75 = \32.75). The PBGC guarantee formula is then applied to produce the amount of guarantee payable by PBGC, which is \$818.75 ($\$32.75 \times 25 \text{ years} = \818.75). After normal retirement age, the first \$11 of the accrual rate is fully guaranteed, and the next \$25 of the accrual rate is 75% guaranteed ($\$25 \times .75 = \18.75). The participant's monthly guaranteed benefit per year of credited service is \$29.75 ($\$11 + \$18.75 = \29.75). The PBGC guarantee formula is then applied to produce the amount of guarantee payable by PBGC, which is \$743.75 after normal retirement age ($\$29.75 \times 25 \text{ years} = \743.75).

(iv) *Calculation of guarantee-based limitation.* A suspension of benefits may not reduce the participant's benefits below the guarantee-based limitation, which is equal to 110% of the monthly amount of guarantee payable by PBGC. That monthly guarantee-based limitation amount is \$900.63 ($\$818.75 \times 1.1 = \900.63) before normal retirement age and \$818.13 ($\$743.75 \times 1.1 = \818.13) after normal retirement age.

Example 4. (i) *Facts.* A participant would be eligible for a monthly benefit of \$1,000 payable as a single life annuity at normal retirement age, based on the participant's 20 years of credited service. The plan provides an actuarial increase for delaying ben-

efits until after normal retirement age. The participant delays commencement of benefits until after normal retirement age and the participant's monthly benefit is \$1,200 instead of \$1,000.

(ii) *Calculation of accrual rate.* For purposes of calculating the accrual rate, the monthly benefit that is used to calculate the PBGC guarantee does not exceed the monthly benefit of \$1,000 that would be payable at normal retirement age. Thus, in determining the accrual rate, the PBGC guarantee would be based on a monthly benefit of \$1,000, whether benefits are paid at or after normal retirement age. The participant's accrual rate is \$50, calculated by dividing the participant's monthly benefit payment (\$1,000) by the participant's years of credited service (20).

(iii) *Calculation of monthly PBGC-guaranteed benefit.* The first \$11 of the accrual rate is fully guaranteed, and the next \$33 of the accrual rate is 75% guaranteed ($\$33 \times .75 = \24.75). The participant's monthly guaranteed benefit per year of credited service is \$35.75 ($\$11 + \$24.75 = \35.75). The PBGC guarantee formula is then applied to produce the amount of guarantee payable by PBGC, which is $\$715 (\$35.75 \times 20 \text{ years} = \$715)$.

(iv) *Calculation of guarantee-based limitation.* A suspension of benefits may not reduce the participant's benefits below the guarantee-based limitation, which is equal to 110% of the monthly amount of guarantee payable by PBGC. That monthly guarantee-based limitation amount is $\$786.50 (\$715 \times 1.1 = \$786.50)$.

Example 5. (i) Facts. A plan provides that a participant who has completed at least five years of service will have a nonforfeitable right to 100% of an accrued benefit (and will not have a nonforfeitable right to any portion of the accrued benefit prior to completing five years of service). The plan implements a suspension of benefits on January 1, 2017. As of that date, a participant has three years of vesting service, and none of the participant's benefits are nonforfeitable under the terms of the plan.

(ii) *Calculation of nonforfeitable benefits.* For purposes of applying the guarantee-based limitation, the participant is considered to have a nonforfeitable right to 100% of the accrued benefit under the plan as of January 1, 2017.

(3) *Age-based limitation—(i) No suspension for participants or beneficiaries who are age 80 and older.* No suspension of benefits is permitted to apply to a participant, beneficiary, or alternate payee who—

(A) Has commenced benefits as of the effective date of the suspension; and

(B) Has attained 80 years of age no later than the end of the month that includes the effective date of the suspension.

(ii) *Limited suspension for participants and beneficiaries between ages 75 and 80.* No more than the applicable percentage of the maximum suspendable benefit may be suspended for a participant, beneficiary, or alternate payee who—

(A) Has commenced benefits as of the effective date of the suspension; and

(B) Has attained 75 years of age no later than the end of the month that includes the effective date of the suspension.

(iii) *Maximum suspendable benefit—(A) In general.* For purposes of this paragraph (d)(3), the maximum suspendable benefit with respect to a participant, beneficiary, or alternate payee is the portion of the individual's benefits that would otherwise be suspended pursuant to this section (that is, the amount that would be suspended without regard to the limitation in this paragraph (d)(3)).

(B) *Coordination of limitations.* An individual's maximum suspendable benefit is calculated after the application of the guarantee-based limitation under paragraph (d)(2) of this section and the disability-based limitation under paragraph (d)(4) of this section.

(iv) *Applicable percentage.* For purposes of this paragraph (d)(3), the applicable percentage is the percentage obtained by dividing—

(A) The number of months during the period beginning with the month after the month in which the suspension of benefits is effective and ending with the month during which the participant or beneficiary attains the age of 80, by

(B) 60.

(v) *Applicability of age-based limitation to benefits paid to beneficiaries.* If the age-based limitation in this paragraph (d)(3) applies to a participant on the effective date of the suspension, then the age-based limitation also applies to the beneficiary of the participant, based on the age of the participant on the effective date of the suspension.

(vi) *Rule for benefits that have not commenced at the time of the suspension.* If benefits have not commenced to either a participant or beneficiary as of the effective date of the suspension, then in applying this paragraph (d)(3)—

(A) If the participant is alive on the effective date of the suspension, the participant is treated as having commenced benefits on that date; and

(B) If the participant is deceased on effective date of the suspension, the beneficiary is treated as having commenced benefits on that date.

(vii) *Rules for alternate payees.* The age-based limitation in this paragraph (d)(3) applies to a suspension of benefits in which an alternate payee has an interest, whether or not the alternate payee has commenced benefits as of the effective date of the suspension. For purposes of this paragraph (d)(3), the applicable percentage for an alternate payee is calculated by—

(A) Using the participant's age as of the effective date of the suspension, if the alternate payee's right to the suspended benefits derives from a qualified domestic relations order within the meaning of section 414(p)(1)(A) (QDRO) under which the alternate payee shares in each benefit payment but the participant retains the right to choose the time and form of payment with respect to the benefit to which the suspension applies (shared payment QDRO); or

(B) Substituting the alternate payee's age as of the effective date of the suspension for the participant's age, if the alternate payee's right to the suspended benefits derives from a QDRO under which the alternate payee has a separate right to receive a portion of the participant's retirement benefit to be paid at a time and in a form different from that chosen by the participant (separate interest QDRO).

(viii) *Examples.* The following examples illustrate the rules of this paragraph (d)(3):

Example 1. (i) Facts. The plan sponsor of a plan in critical and declining status is implementing a suspension of benefits, effective December 1, 2017, that would reduce all benefit payments under the plan by 30%. On that date, a retiree is receiving a monthly benefit of \$1,500 (which is not a benefit based on disability) and has 28 years of credited service under the plan. If none of the limitations in section 432(e)(9)(D)(i), (ii), and (iii) were to apply, a 30% suspension would reduce the retiree's monthly benefit by \$450, to \$1,050. Under the guarantee-based limitation in section 432(e)(9)(D)(i), the retiree's monthly benefit could not be reduced by more than $\$398.90$, to $\$1,101.10 (1.1 \times (28 \times (\$11 + (.75 \times \$33))))$. The retiree is 77 years old on the effective date of the suspension, turns 78 on December 15, 2017, and turns 80 on December 15, 2019.

(ii) *Maximum suspendable benefit.* Because the retiree is not receiving a benefit based on disability under section 432(e)(9)(D)(iii), the retiree's maximum suspendable benefit is $\$398.90$ (which is equal to the lesser of reduction that would apply pursuant to the 30% suspension (\$450) or the amount of reduction that would be permitted under the guarantee-based limitation (\$398.90)).

(iii) *Applicable percentage.* Because the retiree is between ages 75 and 80 on the effective date of the suspension, the reduction is not permitted to exceed the applicable percentage of the retiree's maximum suspendable benefit. The number of months during the period beginning with January 2018 (the month after the month that includes the effective date of the suspension) and ending with December 2019 (the month in which the retiree turns 80) is 24. The applicable percentage is equal to 40% (24 months divided by 60).

(iv) *Age-based limitation.* The retiree's maximum suspendable benefit is \$398.90 and the applicable percentage is 40%. Thus, under the age-based limitation, the retiree's benefit may not be reduced by more than \$159.56 ($\$398.90 \times .40 = \159.56). Because the retiree was receiving a monthly benefit of \$1,500, the suspension of benefits may not reduce the retiree's monthly benefit below \$1,340.44 ($\$1,500 - \$159.56 = \$1,340.44$).

Example 2. (i) Facts. The facts are the same as *Example 1*, except that the retiree is 79 years old on December 1, 2017, and turns 80 on December 15, 2017.

(ii) *Age-based limitation.* The suspension is not permitted to apply to the retiree because the retiree will turn 80 by the end of the month (December 2017) in which the suspension is effective.

Example 3. (i) Facts. The facts are the same as *Example 1*, but on the effective date of the suspension, the retiree is receiving a benefit in the form of a 50% joint and survivor annuity for himself and a contingent beneficiary who is age 71. The retiree dies in October 2018.

(ii) *Application of age-based limitation to contingent beneficiary.* Because the retiree had attained age 78 in the month that included the effective date of the suspension, the age-based limitation on the suspension of benefits for a 78-year-old individual applies to the retiree. The age-based limitation also applies to the contingent beneficiary, even though the contingent beneficiary had not commenced benefits under the plan as of the effective date of the suspension and had not attained age 75 by the end of the month containing the effective date of the suspension.

(iii) *Maximum suspendable benefit.* The contingent beneficiary's amount of guarantee payable by PBGC is based on the benefit the beneficiary would have received from the plan before the suspension (\$750). The beneficiary's accrual rate is \$26.7857 (calculated by dividing the monthly benefit payment (\$750) by years of credited service (28)) and the beneficiary's amount of guarantee payable by PBGC is \$639.50 ($28 \times (\$11 + (.75 \times \$15.7857))$). The beneficiary's maximum suspendable benefit is \$46.55 (which is equal to the lesser of reduction that would apply pursuant to the 30% suspension (\$225) or the amount of reduction that would be permitted under the guarantee-based limitation (\$46.55, which is equal to $(\$750 - 1.1 \times 639.50)$).

(iv) *Applicable percentage.* The applicable percentage for the beneficiary is based on the retiree's age of 78 on the effective date of the suspension. Accordingly, the applicable percentage for the beneficiary is 40%.

(v) *Age-based limitation.* The beneficiary's maximum suspendable benefit is \$46.55 and the appli-

cable percentage is 40%. Thus, under the age-based limitation, the beneficiary's benefit may not be reduced by more than \$18.62 ($\$46.55 \times .40 = \18.62). Therefore, as a result of the retiree's age-based limitation, the suspension of benefits may not reduce the beneficiary's monthly benefit below \$731.38 ($\$750 - \$18.62 = \731.38).

Example 4. (i) Facts. The facts are the same as *Example 3*, except that on the effective date of the suspension the retiree is age 71 and the retiree's contingent beneficiary is age 77.

(ii) *Application of age-based limitation to contingent beneficiary.* Because the retiree had not reached age 75 as of the effective date of the suspension, the age-based limitation on the suspension of benefits does not apply to the retiree. The age-based limitation also does not apply to the retiree's contingent beneficiary, even though the contingent beneficiary had attained age 77 as of the effective date of the suspension, because the contingent beneficiary had not yet commenced benefits on that date. The beneficiary's post-suspension benefit may not be less than minimum benefit payable pursuant to the guarantee-based limitation, which is \$703.45 ($\$639.50 \times 1.1 = \703.45).

Example 5. (i) Facts. The facts are the same as in *Example 4*, except that the retiree died in October 2017, prior to the December 1, 2017 effective date of the suspension of benefits. The retiree's beneficiary commenced benefits on November 1, 2017.

(ii) *Application of age-based limitation to contingent beneficiary.* Because the retiree's beneficiary had commenced benefits before the effective date of the suspension and had reached age 75 by the end of the month that includes the effective date of the suspension, the age-based limitation applies to the beneficiary based on the beneficiary's age on the effective date of the suspension.

(4) *Disability-based limitation—(i) General rule* [The text of the proposed amendments to § 1.432(e)(9)–1(d)(4)(i) is the same as § 1.432(e)(9)–1T(d)(4)(i) published elsewhere in this issue of the **Federal Register**.]

(ii) *Benefits based on disability—(A) In general.* For purposes of this section, benefits based on disability means the entire amount paid to a participant pursuant to the participant becoming disabled, without regard to whether a portion of that amount would have been paid if the participant had not become disabled.

(B) *Rule for auxiliary or other temporary disability benefits.* If a participant begins receiving an auxiliary or other temporary disability benefit and the sole reason the participant ceases receiving that benefit is commencement of retirement benefits, the benefit based on disability after commencement of retirement benefits is the lesser of—

(1) The periodic payment the participant was receiving immediately before the

participant's retirement benefits commenced; or

(2) The total periodic payments to the participant under the plan.

(C) *Examples.* The following examples illustrate the disability-based limitation on a suspension of benefits under this paragraph (d)(4):

Example 1. (i) Facts. A participant with a vested accrued benefit of \$1,000 per month, payable at age 65, becomes disabled at age 55. The plan applies a reduction to the monthly benefit for early commencement if the participant commences benefits before age 65. For a participant who commences receiving benefits at age 55, the actuarially adjusted early retirement benefit is 60% of the accrued benefit. However, the plan also provides that if a participant becomes entitled to an early retirement benefit on account of disability, as defined in the plan, the benefit is not reduced. On account of a disability, the participant commences an unreduced early retirement benefit of \$1,000 per month at age 55 (instead of the \$600 monthly benefit the participant would receive if the participant were not disabled). The participant continues to receive \$1,000 per month after reaching age 65.

(ii) *Conclusion.* The participant's disability benefit payment of \$1,000 per month commencing at age 55 is a benefit based on disability, even though the participant would have received a portion of these benefits at retirement regardless of the disability. Thus, both before and after attaining age 65, the participant's entire monthly payment amount (\$1,000) is a benefit based on disability. A suspension of benefits is not permitted to apply to any portion of the participant's benefit at any time.

Example 2. (i) Facts. The facts are the same as *Example 1*, except that the terms of the plan provide that when a disabled participant reaches age 65, the disability pension is discontinued by reason of reaching age 65, and the retirement benefits commence. In this case, the amount of the participant's retirement benefits is the same as the amount that the participant was receiving immediately before commencing retirement benefits, or \$1,000.

(ii) *Conclusion.* Before age 65, the participant's disability benefit payment of \$1,000 per month commencing at age 55 is a benefit based on disability. After age 65, the periodic payment of \$1,000 per month that the participant was receiving immediately before commencing retirement benefits is a benefit based on disability. Thus, both before and after attaining age 65, the participant's entire monthly payment amount (\$1,000) is a benefit based on disability. A suspension of benefits is not permitted to apply to any portion of the participant's benefit at any time.

Example 3. (i) Facts. The facts are the same as *Example 2*, except that upon reaching age 65, the participant elects to commence payment of retirement benefits not in the form of a single life annuity payable in the amount of \$1,000 per month but instead in the form of an actuarially equivalent joint and survivor annuity payable in the amount of \$850 per month.

(ii) *Conclusion.* Before age 65, the participant's benefit based on disability is \$1,000 per month. After

age 65, the participant's benefit based on disability is \$850 per month. Thus, a suspension of benefits is not permitted to apply to any portion of those benefits at any time.

Example 4. (i) Facts. A participant's disability pension is a specified amount unrelated to the participant's accrued benefit. The participant's disability benefit commencing at age 55 is \$750 per month. Upon reaching age 65, the participant's disability pension is discontinued by reason of reaching age 65 and the participant elects to receive an accrued benefit payable in the amount of \$1,000 per month.

(ii) Conclusion. Before age 65, the participant's benefit based on disability is \$750 per month. After age 65, the participant's benefit based on disability continues to be \$750 per month (even though the participant's payment is \$1,000 per month), because the benefit based on disability is the lesser of the periodic disability pension the participant was receiving immediately before retirement benefits commenced (\$750) and the periodic payment to the participant under the plan (\$1,000). Thus, a suspension of benefits is not permitted to reduce the participant's benefit based on disability (\$750 per month) at any time.

Example 5. (i) Facts. The facts are the same as *Example 2*, except that when the participant attains age 65, the participant's monthly benefit payment increases from \$1,000 to \$1,300 as a result of the plan providing additional accruals during the period of disability, as if the participant was not disabled.

(ii) Conclusion. As in *Example 2*, before age 65, the participant's benefit payment of \$1,000 per month commencing at age 55 is a benefit based on disability. After age 65, the participant's benefit payment of \$1,300 per month is a benefit based on disability because the \$1,300 is payable based on additional accruals earned pursuant to the participant becoming disabled. Thus, both before and after attaining age 65, the participant's entire monthly payment amount is a benefit based on disability. A suspension of benefits is not permitted to apply to any portion of the participant's benefit at any time.

Example 6. (i) Facts. The facts are the same as *Example 3* of paragraph (d)(2)(v) of this section, except that the Social Security level income option is only available to a participant who incurs a disability as defined in the plan.

(ii) Conclusion. Before normal retirement age, the participant's benefit payment of \$1,600 per month is a benefit based on disability. After normal retirement age, the participant's benefit based on disability is \$900, which is the lesser of the \$1,600 periodic payment that the participant was receiving immediately before the participant's normal retirement benefit commenced and the participant's \$900 normal retirement benefit. Thus, a suspension of benefits is not permitted to apply to any portion of those benefits (\$1,600 per month before and \$900 per month after normal retirement age) at any time.

Example 7. (i) Facts. A plan applies a reduction to the monthly benefit for early commencement if a participant commences benefits before age 65. The plan also provides that if a participant becomes disabled, as defined in the plan, the benefit that is paid before normal retirement age is not reduced for early retirement. Under the plan, when a disabled participant reaches age 65, the disability pension is discon-

tinued by reason of reaching age 65 and the retirement benefits commence. A participant with a vested accrued benefit of \$1,000 per month, payable at age 65, becomes disabled at age 55. On account of the disability, the participant commences benefits at age 55 in the amount of \$1,000 per month (instead of the \$600 monthly benefit the participant could have received at that age if the participant were not disabled). The participant recovers from the disability at age 60, and the participant's disability benefits cease. At age 60, the participant immediately elects to begin an early retirement benefit of \$800.

(ii) Conclusion. The participant's disability benefit payment of \$1,000 per month commencing at age 55 is a benefit based on disability, even though the participant would have received a portion of these benefits at retirement regardless of the disability. Because the participant ceased receiving disability benefits on account of the participant no longer being disabled (and not solely on account of commencing retirement benefits), the participant's early retirement benefit of \$800 per month that began after the disability benefit ended is not a benefit based on disability.

(5) Limitation on aggregate size of suspension—(i) General rule. Any suspension of benefits (considered, if applicable, in combination with a partition of the plan under section 4233 of ERISA (partition)) must be at a level that is reasonably estimated to—

(A) Enable the plan to avoid insolvency; and

(B) Not materially exceed the level that is necessary to enable the plan to avoid insolvency.

(ii) Suspension sufficient to avoid insolvency—(A) General rule. A suspension of benefits (considered, if applicable, in combination with a partition of the plan) will satisfy the requirement that it is at a level that is reasonably estimated to enable the plan to avoid insolvency if—

(1) For each plan year throughout an extended period (as described in paragraph (d)(5)(ii)(C) of this section) beginning on the first day of the plan year that includes the effective date of the suspension, the plan's solvency ratio is projected on a deterministic basis to be at least 1.0;

(2) Based on stochastic projections reflecting variance in investment return, the probability that the plan will avoid insolvency throughout the extended period is more than 50 percent; and

(3) Unless the plan's projected funded percentage (within the meaning of section 432(j)(2)) at the end of the extended period using a deterministic projection exceeds 100 percent, then the projection shows that at all times during the last five

plan years of that period, there is no projected decrease in either the plan's solvency ratio or its available resources (as defined in section 418E(b)(3)).

(B) *Solvency ratio.* For purposes of this section, a plan's solvency ratio for a plan year means the ratio of—

(1) The plan's available resources (as defined in section 418E(b)(3)) for the plan year; to

(2) The scheduled benefit payments under the plan for the plan year.

(C) *Extended period.* For purposes of this section, an extended period means a period of at least 30 plan years. However, in the case of a temporary suspension of benefits that is scheduled to cease as of a date that is more than 25 years after the effective date, the extended period must be lengthened so that it ends no earlier than five plan years after the cessation of the suspension.

(iii) Suspension not materially in excess of level necessary to avoid insolvency—(A) General rule. A suspension of benefits will satisfy the requirement under paragraph (d)(5)(i)(B) of this section that the suspension be at a level that is reasonably estimated to not materially exceed the level necessary for the plan to avoid insolvency only if an alternative, similar but smaller suspension of benefits, under which the dollar amount of the suspension for each participant and beneficiary is reduced by five percent would not be sufficient to enable the plan to satisfy the requirement to avoid insolvency under paragraph (d)(5)(i)(A) of this section.

(B) *Special rule for partitions.* If the PBGC issues an order partitioning the plan, then a suspension of benefits with respect to the plan will be deemed to satisfy the requirement under paragraph (d)(5)(i)(B) of this section that the suspension be at a level that is reasonably estimated to not materially exceed the level necessary for the plan to avoid insolvency.

(iv) Actuarial basis for projections—(A) In general. This paragraph (d)(5)(iv) sets forth rules for the actuarial projections that are required under this paragraph (d)(5). The projections must reflect the assumption that the suspension of benefits continues indefinitely (or, if the suspension expires on a specified date by its own terms, until that date).

(B) *Reasonable actuarial assumptions and methods.* The actuarial assumptions and methods used for the actuarial projections must be reasonable, in accordance with the rules of section 431(c)(3). The actuary's selection of assumptions about future covered employment and contribution levels (including contribution base units and average contribution rate) may be based on information provided by the plan sponsor, which must act in good faith in providing the information. In addition, to the extent that the actuarial assumptions used for the deterministic projection differ from those used to certify whether the plan is in critical and declining status pursuant to section 432(b)(3)(B)(iv), a justification for that difference must be provided. Similarly, to the extent that the actuarial assumptions used for the stochastic projection differ from those used for the deterministic projection (other than the rate of investment return), a justification for that difference must be provided.

(C) *Initial value of plan assets and cash flow projections.* Except as provided in paragraph (d)(5)(iv)(D) of this section, the cash flow projections must be based on—

(1) The fair market value of assets as of end of the most recent calendar quarter;

(2) Projected benefit payments that are consistent with the projected benefit payments under the most recent actuarial valuation; and

(3) Appropriate adjustments to projected benefit payments to include benefits for new hires who are reflected in the projected contribution amounts.

(D) *Requirement to reflect significant events.* The projected cash flows relating to contributions, withdrawal liability payments, and benefit payments must also be adjusted to reflect significant events that occurred after the most recent actuarial valuation. Significant events include—

(1) A plan merger or transfer;

(2) The withdrawal or the addition of employers that changed projected cash flows relating to contributions, withdrawal liability payments, or benefit payments by more than five percent;

(3) A plan amendment, a change in a collective bargaining agreement, or a change in a rehabilitation plan that changed projected cash flows relating to contributions, withdrawal liability pay-

ments, or benefit payments by more than five percent; or

(4) Any other event or trend that resulted in a material change in the projected cash flows.

(v) *Simplified determination for smaller plans.* In the case of a plan that is not large enough to be required to select a retiree representative under paragraph (b)(4) of this section, the determination of whether the benefit suspension (or a benefit suspension in combination with a partition of the plan) will satisfy the requirement that it is at a level that is reasonably estimated to enable the plan to avoid insolvency is permitted to be made without regard to paragraph (d)(5)(ii)(A)(2) of this section.

(vi) *Additional disclosure—(A) Disclosure of past experience for critical assumptions.* The application for suspension must include a disclosure of the total contributions, total contribution base units and average contribution rate, withdrawal liability payments, and the rate of return on plan assets for each of the 10 plan years preceding the plan year in which the application is submitted.

(B) *Sensitivity of results to investment return assumptions.* The application must include deterministic projections of the plan's solvency ratio over the extended period using two alternative assumptions for the plan's rate of return. These alternatives are that the plan's future rate of return will be lower than the assumed rate of return used under paragraph (d)(5)(iv)(B) of this section by—

(1) One percentage point; and

(2) Two percentage points.

(C) *Sensitivity of results to industry level assumptions.* The application must include deterministic projections of the plan's solvency ratio over the extended period using two alternative assumptions for the future contribution base units. These alternatives are that the future contribution base units—

(1) Continue under the same trend as the plan experienced over the past 10 years; and

(2) Continue under the trend identified in paragraph (d)(5)(vi)(C)(1) of this section reduced by one percentage point.

(D) *Projection of funded percentage.* The application must include an illustration, prepared on a deterministic basis, of

the projected value of plan assets, the accrued liability of the plan (calculated using the unit credit funding method), and the funded percentage for each year in the extended period.

(6) *Equitable distribution—(i) In general.* Any suspension of benefits must be equitably distributed across the participant and beneficiary population, taking into account factors, with respect to participants and beneficiaries and their benefits, that may include one or more of the factors described in paragraph (d)(6)(ii) of this section. If a suspension of benefits applies differently to different categories or groups of participants and beneficiaries, then the suspension of benefits is equitably distributed across the participant and beneficiary population only if under the suspension—

(A) Within each such category or group, the individuals are treated consistently;

(B) Any difference in treatment among the different categories or groups is based on relevant factors reasonably selected by the plan sponsor, such as the factors described in paragraph (d)(6)(ii) of this section; and

(C) Any such difference in treatment is based on a reasonable application of the relevant factors.

(ii) *Factors that may be considered—(A) In general.* In accordance with paragraph (d)(6)(i)(B) of this section, if there is any difference in the application of the suspension of benefits between one classification of participants and beneficiaries and another classification of participants and beneficiaries, that difference must be based reasonably on the statutory factors (described in paragraph (d)(6)(ii)(B) of this section) and any other factors reasonably selected by the plan sponsor. For example, it would be reasonable for a plan sponsor to conclude that the statutory factor described in paragraph (d)(6)(ii)(B)(3) of this section (amount of benefit) is a factor that should be taken into account as justifying a lesser benefit reduction for participants or beneficiaries whose benefits are closer to the level of the PBGC guarantee than for others. In addition, it would be reasonable for a plan sponsor to conclude that the presumed financial vulnerability of certain participants or beneficiaries who are reasonably deemed to be

in greater need of protection than other participants or beneficiaries is a factor that should be taken into account as justifying a lesser benefit reduction (as a percentage or otherwise) for those participants or beneficiaries than for others.

(B) *Statutory factors.* Factors that may be selected as a basis for differences in the application of a suspension of benefits include, when reasonable under the circumstances, the following statutory factors:

(1) The age and life expectancy of the participant and/or beneficiary;

(2) The length of time that benefits have been in pay status;

(3) The amount of benefits;

(4) The type of benefit, such as survivor benefit, normal retirement benefit, or early retirement benefit;

(5) The extent to which a participant or beneficiary is receiving a subsidized benefit;

(6) The extent to which a participant or beneficiary has received post-retirement benefit increases;

(7) The history of benefit increases and reductions for participants and beneficiaries;

(8) The number of years to retirement for active employees;

(9) Any differences between active and retiree benefits;

(10) The extent to which active participants are reasonably likely to withdraw support for the plan, accelerating employer withdrawals from the plan and increasing the risk of additional benefit reductions for participants in and out of pay status; and

(11) The extent to which a participant's or beneficiary's benefits are attributable to service with an employer that failed to pay its full withdrawal liability.

(iii) *Reasonable application of factors.* A suspension of benefits will not satisfy the requirement to be equitably distributed if it is based on an unreasonable application of the factors referred to in paragraph (d)(6)(ii) of this section. For example, it would constitute an unreasonable application of the factor described in paragraph (d)(6)(ii)(B)(3) of this section (amount of benefit) if that factor were used to justify a larger suspension for participants with smaller benefits.

(iv) *Examples.* The following examples illustrate the rules on equitable distribu-

tion of a suspension of benefits in this paragraph (d)(6). As a simplifying assumption for purposes of these examples, it is assumed that the facts of each example describe all of the factors that are included in the application discussed in the example (provided, however, that, in the case of a plan described in section 432(e)(9)(D)(vii), the examples are not intended to illustrate the application of section 432(e)(9)(D)(vii) or its effect on the analysis or conclusions in the examples). Throughout these examples, the guarantee-based, age-based, and disability-based limitations of section 432(e)(9)(D)(i), (ii), and (iii) are referred to as the individual limitations on benefit suspensions.

Example 1. (i) *Facts.* A suspension of benefits provides that, subject to the individual limitations on benefit suspensions, benefits for all participants and beneficiaries are reduced by the same percentage, and explains the rationale for this reduction.

(ii) *Conclusion.* The suspension of benefits is equitably distributed across the participant and beneficiary populations.

Example 2. (i) *Facts.* A suspension of benefits provides that, subject to the age-based and disability-based limitations of section 432(e)(9)(D)(ii) and (iii), the portion of each participant's and beneficiary's benefit that exceeds the guarantee-based limitation of section 432(e)(9)(D)(i) is reduced by the same percentage, and explains the rationale for this reduction.

(ii) *Conclusion.* The suspension of benefits is equitably distributed across the participant and beneficiary populations. The result would be the same if, instead, the suspension of benefits applies only to benefits that exceed a multiple (in excess of 100%) of the guarantee-based limitation.

Example 3. (i) *Facts.* A plan was previously amended to provide an ad hoc 15% increase to the benefits of all participants and beneficiaries (including participants who, at the time, were no longer earning service under the plan, which therefore included retirees and deferred vested participants). The plan sponsor applies for a suspension of benefits. Under the suspension of benefits, subject to the individual limitations on benefit suspensions, benefits for all participants and beneficiaries who were no longer earning service under the plan at the time of the ad hoc amendment are reduced by eliminating the amendment for those individuals. The suspension application explains why the benefit reduction is based on the statutory factors in paragraph (d)(6)(ii)(B)(6) of this section (the extent to which a participant or beneficiary has received post-retirement benefit increases), including application of the reduction to those who, at the time of the previous benefit increase, were either retired participants or deferred vested participants, and in paragraph (d)(6)(ii)(B)(7) of this section (the history of benefit increases and reductions), and why it is reasonable to apply the factors in this manner.

(ii) *Conclusion.* The suspension of benefits is equitably distributed across the participant and ben-

eficiary populations. This is because the difference in treatment among the different groups of participants is based on whether a participant has received post-retirement benefit increases (in this case, whether a participant was earning service under the plan at the time of the benefit increase amendment), which under these facts is a relevant factor that may be reasonably selected by the plan sponsor, and the difference in treatment between the groups of participants (eliminating the amendment only for benefits with respect to participants who were no longer earning service at the time of the amendment) is based on a reasonable application of that factor.

Example 4. (i) *Facts.* A plan contains a provision that provides a "thirteenth check" in plan years for which the investment return is greater than 7% (which was the assumed rate of return under the plan's actuarial valuation). The plan sponsor applies for a suspension of benefits. Under the suspension of benefits, subject to the individual limitations on benefit suspensions, benefits for all participants and beneficiaries are reduced by eliminating the "thirteenth check" for all those individuals. The suspension application explains why the benefit reduction is based on the statutory factors in paragraph (d)(6)(ii)(B)(6) of this section (the extent to which a participant or beneficiary has received post-retirement benefit increases) and in paragraph (d)(6)(ii)(B)(7) of this section (the history of benefit increases and reductions), and why it is reasonable to apply the factors in this manner.

(ii) *Conclusion.* The suspension of benefits is equitably distributed across the participant and beneficiary populations.

Example 5. (i) *Facts.* A plan was previously amended to reduce future accruals from \$60 per year of service to \$50 per year of service. The plan sponsor applies for a suspension of benefits. Under the suspension of benefits, subject to the individual limitations on benefit suspensions, the accrued benefits for all participants and beneficiaries are reduced to \$50 per year of service (and applies the plan's generally applicable adjustments for early retirement and form of benefit). The suspension application explains why the benefit reduction is based on the statutory factor in paragraph (d)(6)(ii)(B)(7) of this section (the history of benefit increases and reductions), and why it is reasonable to apply the factors in this manner.

(ii) *Conclusion.* The suspension of benefits is equitably distributed across the participant and beneficiary populations. This is because the difference in treatment among the different groups of participants is based on the history of benefit reductions and a discrepancy between active and retiree benefits, which under these facts are relevant factors that may be reasonably selected by the plan sponsor, and the difference in treatment between the groups of participants (reducing the \$60 benefit multiplier to \$50 per year of service for those participants who had accrued any benefits under the \$60 multiplier) is based on a reasonable application of those factors.

Example 6. (i) *Facts.* The facts are the same as in *Example 5*, except that no plan amendments have previously reduced future accruals or other benefits for active participants. Under the suspension of benefits, subject to the individual limitations on benefit suspensions, benefits for deferred vested partici-

pants, retirees and beneficiaries who have commenced benefits are reduced, but no reduction applies to active participants. The suspension of benefits is not accompanied by any reductions in future accruals or other benefits for active participants.

(ii) *Conclusion.* The suspension of benefits is not equitably distributed across the participant and beneficiary populations. This is because, under these facts, no relevant factor (such as a previous reduction in benefits applicable only to active participants) has been reasonably selected by the plan sponsor to justify the proposed difference in treatment among the categories.

Example 7. (i) Facts. The facts are the same as in *Example 6*, except that the suspension of benefits provides for a reduction that applies to both active and inactive participants. However, the reduction that applies to active participants is smaller than the reduction that applies to inactive participants because the plan sponsor concludes, as explained and supported in the application for suspension, that active participants are reasonably likely to withdraw support for the plan if any larger reduction is applied.

(ii) *Conclusion.* The suspension of benefits is equitably distributed across the participant and beneficiary populations. This is because the difference in treatment among the different groups of participants is based on the extent to which active participants are reasonably likely to withdraw support for the plan, which under these facts is a relevant factor that may reasonably be selected by the plan sponsor, and the difference in treatment between the two groups of participants (applying a greater suspension to inactive than to active participants) is based on a reasonable application of that factor.

Example 8. (i) Facts. A suspension of benefits provides that, subject to the individual limitations on benefit suspensions, the benefits for participants and beneficiaries attributable to service with an employer that failed to pay its full withdrawal liability are reduced by 50%. The plan sponsor applies for a suspension of benefits. As explained in the suspension application, the present value of the benefit reduction with respect to the former employees of one such employer is significantly greater than the unpaid withdrawal liability for that employer. Benefits for participants and beneficiaries attributable to service with all other employers are reduced by 10%.

(ii) *Conclusion.* The suspension of benefits is not equitably distributed across the participant and beneficiary populations. This is because although the difference in treatment among the different groups of participants is based on a relevant factor that may reasonably be selected by the plan sponsor, the difference in treatment between the groups of participants is not based on a reasonable application of that factor.

Example 9. (i) Facts. A suspension of benefits provides that, subject to the individual limitations on benefit suspensions, the benefits for all participants and beneficiaries are reduced by the same percentage, except that the benefits for employees and former employees of a particular employer that is actively represented on the plan's Board of Trustees are reduced by a specified lesser percentage.

(ii) *Conclusion.* The suspension of benefits is not equitably distributed across the participant and ben-

eficiary populations. This is because, under these facts, no relevant factor has been reasonably selected by the plan sponsor to justify the difference in treatment among the groups of employees.

Example 10. (i) Facts. The facts are the same as in *Example 9*, except that the particular employer whose employees and former employees are subject to the lesser benefit reduction is the union that also participates in the plan.

(ii) *Conclusion.* The suspension of benefits is not equitably distributed across the participant and beneficiary populations. This is because, under these facts, no relevant factor has been reasonably selected by the plan sponsor to justify the difference in treatment among the groups of employees.

Example 11. (i) Facts. A suspension of benefits provides that, subject to the individual limitations on benefit suspensions, the monthly benefit of all participants and beneficiaries is reduced to 110% of the monthly benefit that is guaranteed by the PBGC under section 4022A of ERISA. The plan sponsor applies for a suspension of benefits. As explained in the suspension application, this is because the plan sponsor is applying to the PBGC for a partition of the plan, which requires the plan sponsor to have implemented the maximum benefit suspensions under section 432(e)(9).

(ii) *Conclusion.* The suspension of benefits is equitably distributed across the participant and beneficiary populations.

Example 12. (i) Facts. The facts are the same as in *Example 1*, except that the suspension of benefits provides that the protection for benefits based on disability also includes payments to a beneficiary of a participant who had been receiving benefits based on disability at the time of death.

(ii) *Conclusion.* The suspension of benefits is equitably distributed across the participant and beneficiary populations because this suspension design is a reasonable application of the statutory factor in paragraph (d)(6)(ii)(B)(4) of this section (type of benefit).

(7) *Effective date of suspension made in combination with partition.* [The text of the proposed amendments to § 1.432(e)(9)–1(d)(7) is the same as § 1.432(e)(9)–1T(d)(7) published elsewhere in this issue of the Federal Register.]

(e) *Benefit improvements—(1) Limitations on benefit improvements.* This paragraph (e) sets forth rules for the application of section 432(e)(9)(E). A plan satisfies the criteria in section 432(e)(9)(E) only if, during the period that any suspension of benefits remains in effect, the plan sponsor does not implement any benefit improvement except as provided in this paragraph (e). Paragraph (e)(2) of this section describes limitations on a benefit improvement for participants and beneficiaries who are not yet in pay status. Paragraph (e)(3) of this section describes limitations on a benefit improvement for participants and beneficiaries

who are in pay status. Paragraph (e)(4) of this section provides that the limitations in this paragraph (e) generally apply in addition to other limitations on benefit increases that apply to a plan. Paragraph (e)(5) of this section defines benefit improvement.

(2) *Limitations on benefit improvements for those not in pay status—(i) Equitable distribution for those in pay status and solvency projection.* During the period that any suspension of benefits under a plan remains in effect, the plan sponsor may not increase the liabilities of the plan by reason of any benefit improvement for any participant or beneficiary who was not in pay status for any plan year before the plan year for which the benefit improvement takes effect, unless—

(A) The present value of the total liabilities for a benefit improvement for participants and beneficiaries whose benefit commencement dates were before the first day of the plan year for which the benefit improvement takes effect is not less than the present value of the total liabilities for a benefit improvement for participants and beneficiaries who were not in pay status by that date;

(B) The plan sponsor equitably distributes the benefit improvement among the participants and beneficiaries whose benefit commencement dates were before the first day of the plan year in which the benefit improvement is proposed to take effect; and

(C) The plan actuary certifies that after taking into account the benefit improvement, the plan is projected to avoid insolvency indefinitely.

(ii) *Rules of application—(A) Present value determination.* For purposes of paragraph (e)(2)(i)(A) of this section, the present value of the total liabilities for a benefit improvement is the present value as of the first day of the plan year in which the benefit improvement is proposed to take effect, using actuarial assumptions in accordance with section 431.

(B) *Factors relevant to equitable distribution.* The evaluation of whether a benefit improvement is equitably distributed for purposes of paragraph (e)(2)(i)(B) of this section must take into account the relevant factors described in paragraph (d)(6)(ii)(B) of this section and the extent to which the benefits of the

participants and beneficiaries were suspended.

(C) *Actuarial certification.* The certification in paragraph (e)(2)(i)(C) of this section must be made using the standards described in paragraphs (d)(5)(ii), (iv), and (v) of this section, substituting the plan year that includes the effective date of the benefit improvement for the plan year that includes the effective date of the suspension.

(iii) *Special rule for certain benefit increases.* The limitations of this paragraph (e) do not apply to a resumption of suspended benefits or plan amendment that increases liabilities with respect to participants and beneficiaries not in pay status by the first day of the plan year in which the benefit improvement took effect that—

(A) The Secretary of the Treasury, in consultation with the PBGC and the Secretary of Labor, determines to be reasonable and which provides for only de minimis increases in the liabilities of the plan; or

(B) Is required as a condition of qualification under section 401 or to comply with other applicable law, as determined by the Secretary of the Treasury.

(3) *Limitation on resumption of suspended benefits only for those in pay status.* The plan sponsor may increase liabilities of the plan by eliminating some or all of the suspension that applies solely to participants and beneficiaries in pay status at the time of the resumption, provided that the plan sponsor equitably distributes the value of those resumed benefits among participants and beneficiaries in pay status, taking into account the relevant factors described in paragraph (d)(6)(ii)(B) of this section. A resumption of benefits that is described in this paragraph (e)(3) is not subject to the limitations on a benefit improvement under section 432(f) (relating to restrictions on benefit increases for plans in critical status).

(4) *Additional limitations.* Except as provided in paragraph (e)(3) of this section, the limitations on a benefit improvement under this paragraph (e) are in addition to the limitations in section 432(f) and any other applicable limitations on increases in benefits imposed on a plan.

(5) *Definition of benefit improvement—(i) In general.* For purposes of this paragraph (e), the term benefit improvement means, with respect to a plan, a

resumption of suspended benefits, an increase in benefits, an increase in the rate at which benefits accrue, or an increase in the rate at which benefits become nonforfeitable under the plan.

(ii) *Effect of expiration of suspension.* In the case of a suspension of benefits that expires as of a date that is specified in the plan amendment implementing the suspension, the resumption of benefits solely from the expiration of that period is not treated as a benefit improvement.

(f) *Notice requirements—(1) In general.* [The text of the proposed amendments to § 1.432(e)(9)–1(f)(1) is the same as § 1.432(e)(9)–1T(f)(1) published elsewhere in this issue of the **Federal Register**.]

(2) *Content of notice.* [The text of the proposed amendments to § 1.432(e)(9)–1(f)(2) is the same as § 1.432(e)(9)–1T(f)(2) published elsewhere in this issue of the **Federal Register**.]

(3) *Form and manner—(i) Timing.* [The text of the proposed amendments to § 1.432(e)(9)–1(f)(3)(i) is the same as § 1.432(e)(9)–1T(f)(3)(i) published elsewhere in this issue of the **Federal Register**.]

(ii) *Method of delivery of notice—(A) Written or electronic delivery.* [The text of the proposed amendments to § 1.432(e)(9)–1(f)(3)(ii)(A) is the same as § 1.432(e)(9)–1T(f)(3)(ii)(A) published elsewhere in this issue of the **Federal Register**.]

(B) *No alternative method of delivery.* A notice under this paragraph (f) must be provided in written or electronic form.

(iii) *Additional information in notice.* [The text of the proposed amendments to § 1.432(e)(9)–1(f)(3)(iii) is the same as § 1.432(e)(9)–1T(f)(3)(iii) published elsewhere in this issue of the **Federal Register**.]

(iv) *No false or misleading information.* [The text of the proposed amendments to § 1.432(e)(9)–1(f)(3)(iv) is the same as § 1.432(e)(9)–1T(f)(3)(iv) published elsewhere in this issue of the **Federal Register**.]

(4) *Other notice requirement.* [The text of the proposed amendments to § 1.432(e)(9)–1(f)(4) is the same as § 1.432(e)(9)–1T(f)(4) published elsewhere in this issue of the **Federal Register**.]

(5) *Examples.* [The text of the proposed amendments to § 1.432(e)(9)–1(f)(5) is the same as § 1.432(e)(9)–

1T(f)(5) published elsewhere in this issue of the **Federal Register**.]

(g) *Approval or denial of an application for suspension of benefits—(1) Application.* [The text of the proposed amendments to § 1.432(e)(9)–1(g)(1) is the same as § 1.432(e)(9)–1T(g)(1) published elsewhere in this issue of the **Federal Register**.]

(2) *Solicitation of comments.* [The text of the proposed amendments to § 1.432(e)(9)–1(g)(2) is the same as § 1.432(e)(9)–1T(g)(2) published elsewhere in this issue of the **Federal Register**.]

(3) *Approval or denial—(i) Deemed approval.* [The text of the proposed amendments to § 1.432(e)(9)–1(g)(3)(i) is the same as § 1.432(e)(9)–1T(g)(3)(i) published elsewhere in this issue of the **Federal Register**.]

(ii) *Notice of denial.* [The text of the proposed amendments to § 1.432(e)(9)–1(g)(3)(ii) is the same as § 1.432(e)(9)–1T(g)(3)(ii) published elsewhere in this issue of the **Federal Register**.]

(iii) *Special rules for systemically important plans.* [The text of the proposed amendments to § 1.432(e)(9)–1(g)(3)(iii) is the same as § 1.432(e)(9)–1T(g)(3)(iii) published elsewhere in this issue of the **Federal Register**.]

(iv) *Agreement to stay 225-day period.* The Secretary of the Treasury and the plan sponsor may mutually agree in writing to stay the 225-day period described in paragraph (g)(3)(i) of this section.

(4) *Consideration of certain factors.* In evaluating whether the plan sponsor has satisfied the requirement of paragraph (c)(3)(i)(A) of this section, the Secretary of the Treasury, in consultation with the PBGC and the Secretary of Labor, will review the plan sponsor's consideration of each of the factors under paragraph (c)(3)(ii) of this section (and any other factor that the plan sponsor considered).

(5) *Standard for accepting plan sponsor determinations.* In evaluating the plan sponsor's application, the Secretary of the Treasury will accept the plan sponsor's determinations in paragraph (c)(3) of this section unless the Secretary concludes, in consultation with the PBGC and the Secretary of Labor, that the determinations were clearly erroneous.

(6) *Plan-sponsor certifications with respect to plan amendments.* The plan sponsor's application described in paragraph

(g)(1) of this section will not be approved unless the plan sponsor certifies that if the plan sponsor receives final authorization to suspend as described in paragraph (h)(6) of this section with respect to the proposed benefit suspension (or, in the case of a systemically important plan, a proposed or modified benefit suspension), the plan sponsor chooses to implement the suspension, and the plan sponsor adopts the amendment described in paragraph (a)(1) of this section, then it will timely amend the plan to provide that—

(i) If the plan sponsor fails to make the annual determinations under section 432(e)(9)(C)(ii), then the suspension of benefits will cease as of the first day of the first plan year following the plan year in which the plan sponsor fails to make the annual-plan-sponsor determinations in paragraph (c)(4) of this section; and

(ii) Any future benefit improvement must satisfy the requirements of section 432(e)(9)(E).

(7) *Special Master.* [The text of the proposed amendments to § 1.432(e)(9)–1(g)(7) is the same as § 1.432(e)(9)–1T(g)(7) published elsewhere in this issue of the **Federal Register**.]

(h) *Participant vote on proposed benefit reduction—(1) Requirement for vote—(i) In general.* [The text of the proposed amendments to § 1.432(e)(9)–1(h)(1)(i) is the same as § 1.432(e)(9)–1T(h)(1)(i) published elsewhere in this issue of the **Federal Register**.]

(ii) *Communication by plan sponsor.* The plan sponsor must take reasonable steps to inform eligible voters about the proposed suspension and the vote. This includes all eligible voters who may be contacted by reasonable efforts in accordance with paragraph (f)(1) of this section. Anyone whom the plan sponsor has been able to locate through these means (or who has otherwise been located by the plan sponsor) must be sent a ballot described in paragraph (h)(3) of this section.

(2) *Administration of vote.* [Reserved]

(3) *Ballots—(i) In general.* The plan sponsor must provide a ballot for the vote that includes the following—

(A) A description of the proposed suspension and its effect, including the effect of the suspension on each category or

group of individuals affected by the suspension and the extent to which they are affected;

(B) A description of the factors considered by the plan sponsor in designing the benefit suspension, including but not limited to the factors in paragraph (d)(6)(ii) of this section;

(C) A description of whether the suspension will remain in effect indefinitely or will expire by its own terms (and, if it will expire by its own terms, when that will occur);

(D) A statement from the plan sponsor in support of the proposed suspension;

(E) A statement in opposition to the proposed suspension compiled from comments received pursuant to the solicitation of comments pursuant to paragraph (g)(2) of this section;

(F) A statement that the proposed suspension has been approved by the Secretary of the Treasury, in consultation with the PBGC and the Secretary of Labor;

(G) A statement that the plan sponsor has determined that the plan will become insolvent unless the proposed suspension takes effect (including the year in which insolvency is projected to occur without a suspension of benefits), and an accompanying statement that this determination is subject to uncertainty;

(H) A statement that insolvency of the plan could result in benefits lower than benefits paid under the proposed suspension and a description of the projected benefit payments in the event of plan insolvency;

(I) A statement that insolvency of the PBGC would result in benefits lower than benefits otherwise paid in the case of plan insolvency;

(J) A statement that the plan's actuary has certified that the plan is projected to avoid insolvency, taking into account the proposed suspension of benefits (and, if applicable, a proposed partition plan), and an accompanying statement that the actuary's projection is subject to uncertainty;

(K) A statement that the suspension will go into effect unless a majority of all eligible voters vote to reject the suspension and that, therefore, a failure to vote has the same effect on the outcome of the vote as a vote in favor of the suspension;

(L) A copy of the individualized estimate that was provided as part of the earlier notice described in section 432(e)(9)(F) (or, if that individualized estimate is no longer accurate, a corrected version of that estimate); and

(M) A description of the voting procedures, including the deadline for voting.

(ii) *Additional rules.* [The text of the proposed amendments to § 1.432(e)(9)–1(h)(3)(ii) is the same as § 1.432(e)(9)–1T(h)(3)(ii) published elsewhere in this issue of the **Federal Register**.]

(iii) *Ballot must be approved.* [The text of the proposed amendments to § 1.432(e)(9)–1(h)(3)(iii) is the same as § 1.432(e)(9)–1T(h)(3)(iii) published elsewhere in this issue of the **Federal Register**.]

(4) *Implementing suspension following vote—(i) In general.* [The text of the proposed amendments to § 1.432(e)(9)–1(h)(4)(i) is the same as § 1.432(e)(9)–1T(h)(4)(i) published elsewhere in this issue of the **Federal Register**.]

(ii) *Effect of not sending ballot.* Any eligible voters to whom ballots have not been provided (because the individuals could not be located) will be treated as voting to reject the suspension at the same rate (in other words, in the same percentage) as those to whom ballots have been provided.

(5) *Systemically important plans.* [The text of the proposed amendments to § 1.432(e)(9)–1(h)(5) is the same as § 1.432(e)(9)–1T(h)(5) published elsewhere in this issue of the **Federal Register**.]

(6) *Final authorization to suspend.* [The text of the proposed amendments to § 1.432(e)(9)–1(h)(6) is the same as § 1.432(e)(9)–1T(h)(6) published elsewhere in this issue of the **Federal Register**.]

(i) [Reserved].

John Dalrymple
Deputy Commissioner for
Services and Enforcement.

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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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¹A cumulative list of all revenue rulings, revenue procedures, Treasury decisions, etc., published in Internal Revenue Bulletins 2015–01 through 2015–26 is in Internal Revenue Bulletin 2015–26, dated June 29, 2015.

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