HIGHLIGHTS OF THIS ISSUE

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

INCOME TAX

This notice identifies certain “micro-captive transactions” and substantially similar transactions as transactions of interest for purposes of § 1.6011–4(b)(6) of the Income Tax Regulations and §§ 6111 and 6112 of the Internal Revenue Code. This notice also alerts persons involved in such transactions to certain responsibilities and penalties that may arise from their involvement with these transactions.

EMPLOYEE PLANS

Notice 2016–67, page 748.
The notice addresses the application of the market rate of return limitation of §411(b)(5)(B)(i) and §1.411(b)(5)–1(d) to a pension equity plan (PEP) that provides for implicit interest. In addition, this notice requests comments on potential proposed regulations that would subject implicit interest PEPs to the market rate of return limitation.

T.D. 9791, page 734.
This document contains final regulations regarding the definition of short-term, limited-duration insurance for purposes of the exclusion from the definition of individual health insurance coverage, and standards for travel insurance and supplemental health insurance coverage to be considered excepted benefits. This document also amends a reference in the final regulations relating to the prohibition on lifetime and annual dollar limits.

EXCISE TAX

T.D. 9791, page 734.
This document contains final regulations regarding the definition of short-term, limited-duration insurance for purposes of the exclusion from the definition of individual health insurance coverage, and standards for travel insurance and supplemental health insurance coverage to be considered excepted benefits. This document also amends a reference in the final regulations relating to the prohibition on lifetime and annual dollar limits.
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:

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

T.D. 9791
DEPARTMENT OF THE TREASURY
Internal Revenue Service
26 CFR Part 54
DEPARTMENT OF LABOR
Employee Benefits Security Administration
29 CFR Part 2590
DEPARTMENT OF HEALTH AND HUMAN SERVICES
45 CFR Parts 144, 146, 147, and 148
CMS–9932–F
Exempted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance

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 the definition of short-term, limited-duration insurance for purposes of the exclusion from the definition of individual health insurance coverage, and standards for travel insurance and supplemental health insurance coverage to be considered excepted benefits. This document also amends a reference in the final regulations relating to the prohibition on lifetime and annual dollar limits.

DATES: Effective date. These final regulations are effective on December 30, 2016.
Applicability date. These final regulations apply to group health plans and health insurance issuers beginning on the first day of the first plan year (or, in the individual market, the first day of the first policy year) beginning on or after January 1, 2017.

FOR FURTHER INFORMATION CONTACT: Elizabeth Schumacher or Matthew Litton of the Department of Labor, at 202-693-8335, Karen Levin, Internal Revenue Service, Department of the Treasury, at (202) 317-5500, David Mlawsky or Cam Clemmons, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at 410-786-1565.

Supplementary Information:

I. Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104–191 (110 Stat. 396), added title XXVII of the Public Health Service Act (PHS Act), part 7 of the Employee Retirement Income Security Act of 1974 (ERISA), and Chapter 100 of the Internal Revenue Code (the Code), providing portability and nondiscrimination rules with respect to health coverage. These provisions of the PHS Act, ERISA, and the Code were later augmented by other consumer protection laws, including the Mental Health Parity Act of 1996,1 the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008,2 the Newborns’ and Mothers’ Health Protection Act,3 the Women’s Health and Cancer Rights Act,4 the Genetic Information Nondiscrimination Act of 2008,5 the Children’s Health Insurance Program Reauthorization Act of 2009,6 Michelle’s Law,7 and the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (Affordable Care Act).8

The Affordable Care Act reorganizes, amends, and adds to the provisions of part A of title XXVII of the PHS Act relating to group health plans and health insurance issuers in the group and individual markets. For this purpose, the term “group health plan” includes both insured and

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1Public Law 104–204, 110 Stat. 2944 (September 26, 1996).
3Public Law 104–204, 110 Stat. 2935 (September 26, 1996).
7Public Law 110–381, 122 Stat. 4081 (October 9, 2008).
8The Patient Protection and Affordable Care Act, Public Law 111–148, was enacted on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010, Public Law 111–152, was enacted on March 30, 2010. (These statutes are collectively known as the “Affordable Care Act”.)
self-insured group health plans. The Affordable Care Act added section 715(a)(1) of ERISA and section 9815(a)(1) of the Code to incorporate the provisions of part A of title XXVII of the PHS Act (generally, sections 2701 through 2728 of the PHS Act) into ERISA and the Code to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans.

II. Overview of the Final Regulations

On June 10, 2016, the Departments of Labor, Health and Human Services and the Treasury (the Departments) issued proposed regulations with respect to expatriate health plans, expatriate health plan issuers, and qualified expatriates; requirements for travel insurance, similar supplemental coverage, and hospital indemnity or other fixed indemnity insurance to be excepted benefits; the prohibition on lifetime and annual limits; and short-term, limited-duration insurance. After consideration of comments on the proposed regulations, the Departments are publishing final regulations regarding short-term, limited duration insurance, travel insurance, similar supplemental coverage, and lifetime and annual limits. The Departments intend to address hospital indemnity or other fixed indemnity insurance and expatriate health plans in future rulemaking, taking into account comments received on these issues.

On July 20, 2015, the Internal Revenue Service published Notice 2015–43, 2015–29 IRB 73, to provide interim guidance with respect to the treatment of expatriate health plans, expatriate health plan issuers, and employers in their capacity as plan sponsors of expatriate health plans, as defined in the Expatriate Health Coverage Clarification Act of 2014 (EHCCA). The interim guidance in Notice 2015–43 generally allows a taxpayer to apply the requirements of the EHCCA using a reasonable good faith interpretation of the EHCCA until further guidance is issued, except as otherwise specifically provided with respect to the health insurance providers fee under section 9010 of the Affordable Care Act. Notice 2015–29 provided interim guidance pertaining to the fee under section 9010 for calendar years 2014 and 2015, and Notice 2016–14 provided guidance pertaining to the fee for calendar year 2016. Additionally, the preamble to the Departments’ proposed regulations provides that issuers, employers, administrators, and individuals are permitted to rely on the proposed regulations pending the applicability date of final regulations in the Federal Register. Until final regulations are issued and effective, this reliance rule as well as the interim guidance in Notice 2015–43 remain in effect.

A. Short-Term, Limited-Duration Insurance

Short-term, limited-duration insurance is a type of health insurance coverage that is designed to fill temporary gaps in coverage when an individual is transitioning from one plan or coverage to another plan or coverage. Although short-term, limited-duration insurance is not an excepted benefit, it is similarly exempt from PHS Act requirements because it is not individual health insurance coverage. Section 2791(b)(5) of the PHS Act provides that the term “individual health insurance coverage” means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited-duration insurance. The PHS Act does not define short-term, limited-duration insurance. Under current regulations, short-term, limited-duration insurance means “health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer’s consent) that is less than 12 months after the original effective date of the contract.”

Before enactment of the Affordable Care Act, short-term, limited-duration insurance was an important means for individuals to obtain health coverage when transitioning from one job to another (and from one group health plan to another) or when faced with other similar situations. However, with guaranteed availability of coverage and special enrollment period requirements in the individual health insurance market under the Affordable Care Act, individuals can purchase coverage with the protections of the Affordable Care Act to fill in the gaps in coverage. The Departments have become aware that short-term, limited-duration insurance is being sold in situations other than those that the exception from the definition of individual health insurance coverage was initially intended to address. In some instances, individuals are purchasing this coverage as their primary form of health coverage and, contrary to the intent of the 12-month coverage limitation in the current definition of short-term, limited-duration insurance, some issuers are providing renewals of the coverage that extend the duration beyond 12 months. Because short-term, limited-duration insurance is exempt from certain consumer protections, the Departments are concerned that these policies may have significant limitations, such as lifetime and annual dollar limits on essential health benefits (EHB) and pre-existing condition...
exclusions, and therefore may not provide meaningful health coverage. Further, because these policies can be medically underwritten based on health status, healthier individuals may be targeted for this type of coverage, thus adversely impacting the risk pool for Affordable Care Act–compliant coverage.

To address the issue of short-term, limited-duration insurance being sold as a type of primary coverage, the Departments proposed regulations to revise the definition of short-term, limited-duration insurance so that the coverage must be less than three months in duration, including any period for which the policy may be renewed. The proposed regulations also included a requirement that a notice must be prominently displayed in the contract and in any application materials provided in connection with enrollment in such coverage with the following language: THIS IS NOT QUALIFYING HEALTH COVERAGE (“MINIMUM ESSENTIAL COVERAGE”) THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON’T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

In addition to proposing to reduce the length of short-term, limited-duration insurance to less than three months, the proposed regulations modified the permitted coverage period to take into account extensions made by the policyholder “with or without the issuer’s consent.” This modification was intended to address the Departments’ concern that some issuers are taking liberty with the current definition of short-term, limited-duration insurance—either by automatically renewing such policies or having a simplified reapplication process with the result being that such coverage, which does not contain the important protections of the Affordable Care Act, lasts longer than 12 months and serves as an individual’s primary health coverage.

The Departments received a number of comments relating to the treatment of short-term, limited-duration insurance. Several commenters supported the proposed rules and the reasoning behind them, noting that short-term, limited-duration insurance is not subject to the same consumer protections as major medical coverage and can discriminate based on health status by recruiting healthier consumers to the exclusion of sicker consumers. These commenters suggested the proposed rules would limit the number of consumers relying on short-term, limited-duration insurance as their primary form of coverage and improve the Affordable Care Act’s single risk pool.

Some commenters requested that the Departments go further and prohibit issuers from offering short-term, limited-duration insurance to consumers who have previously purchased this type of coverage to prevent consumers from straining together coverage under policies offered by the same or different issuers. However, in the Departments’ view, such a restriction is not warranted. The individual shared responsibility provision of the Code, which generally requires individuals to obtain minimum essential coverage in order to avoid an additional payment with their taxes, provides sufficient incentive to discourage consumers from purchasing multiple successive short-term, limited-duration insurance policies. The added notice requirement ensures that individuals purchasing such policies are aware of the individual shared responsibility requirement and its potential implications. Furthermore, such a prohibition would be difficult for State regulators to enforce, since prior coverage of a consumer would have to be tracked.

Other commenters expressed general opposition to the proposed rules or requested that short-term, limited-duration insurance be allowed to provide coverage for a longer period. Several commenters stated that some individuals who lose their employer–sponsored coverage may not be able to obtain COBRA continuation coverage and that a job search can often take longer than three months. One commenter suggested alignment of short-term, limited-duration insurance with the employer waiting period rules by permitting a coverage period of up to four months. Another commenter asked that issuers be allowed to renew coverage beyond the three-month period in certain situations, such as when an individual experiences a triggering event for a special enrollment period. The Departments decline to adopt these suggestions. Short-term, limited-duration insurance allows for coverage to fill temporary coverage gaps when an individual transitions between sources of primary coverage. As explained above, for longer gaps in coverage, guaranteed availability of coverage and special enrollment period requirements in the individual health insurance market under the Affordable Care Act ensure that individuals can purchase individual market coverage through or outside of the Exchange that is minimum essential coverage and includes the consumer protections of the Affordable Care Act. Further, limiting the coverage of short-term, limited-duration insurance to less than three months is consistent with the exemption from the individual shared responsibility provision for gaps in coverage of less than three months (the short coverage gap exemption). Under current law, an individual who is not enrolled in minimum essential coverage (whether enrolled in short-term, limited-duration coverage or otherwise) for a period of three months or more generally cannot claim the short coverage gap exemption for any of those months. The final regulations help ensure that individuals who purchase a short-term, limited-duration insurance policy will be eligible for the short coverage gap exemption (assuming other requirements are met) during the temporary coverage period.

17See Code section 5000A.
18COBRA continuation coverage means coverage that satisfies an applicable COBRA continuation provision. These provisions are sections 601–608 of ERISA, section 4980B of the Code (other than paragraph (f)(1) of such section 4980B as insofar as it relates to pediatric vaccines), or Title XXII of the PHS Act.
2126 CFR 1.5000A–3(j).
After consideration of the comments and feedback received from stakeholders, the Departments are finalizing the proposed regulations without change.

The revised definition of short-term, limited-duration insurance applies for policy years beginning on or after January 1, 2017. The Departments recognize, however, that State regulators may have approved short-term, limited-duration insurance products for sale in 2017 that met the definition in effect prior to January 1, 2017. Accordingly, the Department of Health and Human Services (HHS) will not take enforcement action against an issuer with respect to the issuer’s sale of a short-term, limited-duration insurance product before April 1, 2017 on the ground that the coverage period is three months or more, provided that the coverage ends on or before December 31, 2017 and otherwise complies with the definition of short-term, limited-duration insurance in effect under the regulations. States may also elect not to take enforcement actions against issuers with respect to such coverage sold before April 1, 2017.

B. Excepted Benefits

Sections 2722 and 2763 of the PHS Act, section 732 of ERISA, and section 9831 of the Code provide that the respective requirements of title XXVII of the PHS Act, part 7 of ERISA, and Chapter 100 of the Code generally do not apply to the provision of certain types of benefits, known as “excepted benefits.” Excepted benefits are described in section 2791(c) of the PHS Act, section 733(c) of ERISA, and section 9832(c) of the Code.

The parallel statutory provisions establish four categories of excepted benefits. The first category, under section 2791(c)(1) of the PHS Act, section 733(c)(1) of ERISA and section 9832(c)(1) of the Code, includes benefits that are generally not health coverage (such as automobile insurance, liability insurance, workers compensation, and accidental death and dismemberment coverage). The benefits in this category are excepted in all circumstances. In contrast, the benefits in the second, third, and fourth categories are types of health coverage that are excepted only if certain conditions are met.

The second category of excepted benefits is limited excepted benefits, which may include limited scope vision or dental benefits, and benefits for long-term care, nursing home care, home health care, or community-based care. Section 2791(c)(2)(C) of the PHS Act, section 733(c)(2)(C) of ERISA, and section 9832(c)(2)(C) of the Code authorize the Secretaries of HHS, Labor, and the Treasury (collectively, the Secretaries) to issue regulations establishing other, similar limited benefits as excepted benefits. The Secretaries exercised this authority previously with respect to certain health flexible spending arrangements. To be excepted under this second category, the benefits must either: (1) be provided under a separate policy, certificate, or contract of insurance; or (2) otherwise not be an integral part of a group health plan, whether insured or self-insured.

The third category of excepted benefits, referred to as “noncoordinated excepted benefits,” includes both coverage for only a specified disease or illness (such as cancer-only policies), and hospital indemnity or other fixed indemnity insurance. These benefits are excepted under section 2722(c)(2) of the PHS Act, section 732(c)(2) of ERISA, and section 9831(c)(2) of the Code only if all of the following conditions are met: (1) the benefits are provided under a separate policy, certificate, or contract of insurance; (2) there is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and (3) the benefits are paid with respect to any event without regard to whether benefits are provided under any group health plan maintained by the same plan sponsor.

The fourth category, under section 2791(c)(4) of the PHS Act, section 733(c)(4) of ERISA, and section 9832(c)(4) of the Code, is supplemental excepted benefits. These benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance and are Medicare supplemental health insurance (also known as Medigap), TRICARE supplemental programs, or “similar supplemental coverage provided to coverage under a group health plan.” The phrase “similar supplemental coverage provided to coverage under a group health plan” is not defined in the statute or regulations. However, the Departments issued regulations clarifying that one requirement to be similar supplemental coverage is that the coverage “must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles.”

In 2007 and 2008, the Departments issued guidance on the circumstances under which supplemental health insurance would be considered excepted benefits under section 2791(c)(4) of the PHS Act (and the parallel provisions of ERISA and the Code). The guidance identifies several factors the Departments will apply when evaluating whether supplemental health insurance will be considered to be “similar supplemental coverage provided to coverage under a group health plan.” The guidance provides a safe harbor that supplemental health insurance will be considered an excepted benefit if it is provided through a policy, certificate, or contract of insurance separate from the primary coverage under the plan and meets all of the following requirements: (1) the supplemental policy, certificate, or contract of insurance is issued by an entity that does not provide the primary coverage under the plan; (2) the supplemental policy, certificate, or contract of insurance is specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles, but does not become secondary or supplemental only under a coordi-

22This non-enforcement policy is limited to the requirement that short-term, limited-duration insurance must be less than three months. It does not relieve issuers of short-term, limited-duration insurance of the notice requirement, which applies for policy years beginning on or after January 1, 2017.


24PHS Act section 2722(c)(1), ERISA section 733(c)(1), Code section 9831(c)(1).

2526 CFR 54.9831–1(c)(5)(i)(C), 29 CFR 2590.732(c)(5)(i)(C), and 45 CFR 146.145(b)(5)(i)(C).

nation of benefits provision; (3) the cost of the supplemental coverage is 15 percent or less of the cost of primary coverage (determined in the same manner as the applicable premium is calculated under a COBRA continuation provision); and (4) the supplemental coverage sold in the group health insurance market does not differentiate among individuals in eligibility, benefits, or premiums based upon any health factor of the individual (or any dependents of the individual).

On February 13, 2015, the Departments issued Affordable Care Act Implementation FAQs Part XXIII, providing additional guidance on the circumstances under which health insurance coverage that supplements group health plan coverage may be considered supplemental excepted benefits. The FAQ states that the Departments intend to propose regulations clarifying the circumstances under which supplemental insurance products that do not fill in cost-sharing gaps under the primary plan are considered to be specifically designed to fill gaps in primary coverage. Specifically, the FAQ provides that health insurance coverage that supplements group health coverage by providing coverage of additional categories of benefits (as opposed to filling in cost–sharing gaps under the primary plan) would be considered to be designed to “fill in the gaps” of the primary coverage only if the benefits covered by the supplemental insurance product are not EHB, as defined under section 1302(b) of the Affordable Care Act, in the State in which the coverage is issued. Thus, if any benefit provided by the supplemental policy is either included in the primary coverage or is an EHB in the State where the coverage is issued, the insurance coverage would not be supplemental excepted benefits under the proposed regulations. Furthermore, supplemental health insurance products that both fill in cost sharing in the primary coverage, such as coinsurance or deductibles, and cover additional categories of benefits that are not EHB, would be considered supplemental excepted benefits under the proposed regulations provided all other criteria are met.

The Departments received several comments in support of the proposed regulations. One commenter expressed support but requested that the Departments provide additional examples in the regulations. Another commenter requested clarification regarding the application of the standards for similar supplemental coverage that provides benefits outside of the United States, noting that no State’s EHB rules require coverage for services outside of the United States. If any benefit provided by the supplemental policy is a type of service that is an EHB in the State where the coverage is issued, the coverage would not be supplemental excepted benefits under the final regulations, even if the supplemental coverage was limited to covering the benefit in a location or setting where it would not be covered as an EHB.

After consideration of the comments, the Departments are finalizing the proposed regulations on similar supplemental coverage without substantive change. For purposes of consistency and clarity, HHS is also including a cross reference in the individual market excepted benefits regulations at 45 CFR 148.220 to reflect the standard for similar supplemental coverage under the group market regulations at 45 CFR 146.145(b)(5)(i)(C). The Departments may provide additional guidance on similar supplemental coverage that meets the criteria to be excepted benefits in the future.

2. Travel Insurance

The Departments are aware that certain travel insurance products may include limited health benefits. However, these products typically are not designed as major medical coverage. Instead, the risks being insured relate primarily to: (1) the interruption or cancellation of a trip; (2) the loss of baggage or personal effects; (3) damages to accommodations or rental vehicles; or (4) sickness, accident, disability, or death occurring during travel, with any health benefits usually incidental to other coverage.

Section 2791(c)(1)(H) of the PHS Act, section 733(c)(1)(H) of ERISA, and section 9832(c)(1)(H) of the Code provide that the Departments may, in regulations, designate as excepted benefits “benefits for medical care [that] are secondary or incidental to other insurance benefits.” Pursuant to this authority, and to clarify which types of travel-related insurance products are excepted benefits under the PHS Act, ERISA, and the Code, the Departments’ proposed regulations identified travel insurance as an excepted benefit under the first category of excepted benefits and proposed a definition of travel insurance consistent with the definition of

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28 For this purpose, a supplemental plan would determine what benefits are EHB based on the EHB–benchmark plan applicable in the State, along with any additional benefits that are considered EHB consistent with 45 CFR 155.170(a)(2).

November 21, 2016

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Bulletin No. 2016–47
travel insurance under final regulations issued by the Treasury Department and the IRS for the health insurance providers fee imposed by section 9010 of the Affordable Care Act, which uses a modified version of the National Association of Insurance Commissioners definition of travel insurance.

The proposed regulations defined the term “travel insurance” as insurance coverage for personal risks incident to planned travel, which may include, but are not limited to, interruption or cancellation of a trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability, or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverage. For this purpose, travel insurance does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting six months or longer, including, for example, those working overseas as an expatriate or military personnel being deployed.

The Departments received a number of comments in favor of the treatment of travel insurance as an excepted benefit, as well as the proposed definition of travel insurance. Several comments expressed support for the proposed definition’s consistency with regulations governing the health insurance providers fee. One commenter requested clarification that the requirement that health benefits are incidental to other coverage be determined based solely on coverage under the travel insurance policy, without regard to other coverage provided by an employer or plan sponsor; the Departments agree that this is correct. The Departments are finalizing without change the proposed regulations defining travel insurance and treating such coverage as an excepted benefit.

C. Definition of EHB for Purposes of the Prohibition on Lifetime and Annual Limits

Section 2711 of the PHS Act, as added by the Affordable Care Act, generally prohibits group health plans and health insurance issuers offering group or individual health insurance coverage from imposing lifetime and annual dollar limits on EHB, as defined under section 1302(b) of the Affordable Care Act. These prohibitions apply to both grandfathered and non-grandfathered health plans, except the annual limits prohibition does not apply to grandfathered individual health insurance coverage.

Under the Affordable Care Act, self-insured group health plans, large group market health plans, and grandfathered health plans are not required to offer EHB, but they generally cannot place lifetime or annual dollar limits on services they cover that are considered EHB. On November 18, 2015, the Departments issued final regulations implementing section 2711 of the PHS Act. The final regulations provide that, for plan years (in the individual market, policy years) beginning on or after January 1, 2017, a plan or issuer that is not required to provide EHB must define EHB, for purposes of the prohibition on lifetime and annual dollar limits, in a manner consistent with any of the 51 EHB base-benchmark plans applicable in a State or the District of Columbia, or one of the three Federal Employees Health Benefits Program (FEHBP) EHB base-benchmark plans, as specified under 45 CFR 156.100.

The final regulations under section 2711 of the PHS Act include a reference to selecting a “base-benchmark” plan, as specified under 45 CFR 156.100, for purposes of determining which benefits cannot be subject to lifetime or annual dollar limits. The base-benchmark plan selected by a State or applied by default under 45 CFR 156.100, however, may not reflect the complete definition of EHB in the applicable State. For that reason, the Departments are amending the regulations at 26 CFR 54.9815–2711(c), 29 CFR 2590.715–2711(c), and 45 CFR 147.126(c) to refer to the provisions that capture the complete definition of EHB in a State.

Specifically, in these final regulations, the Departments replace the phrase “in a manner consistent with one of the three Federal Employees Health Benefit Program (FEHBP) options as defined by 45 CFR 156.100(a)(3) or one of the base-benchmark plans selected by a State or applied by default pursuant to 45 CFR 156.100” in each of the regulations with the following: “in a manner that is consistent with (1) one of the EHB-benchmark plans applicable in a State under 45 CFR 156.110, and includes coverage of any additional required benefits that are considered EHB consistent with 45 CFR 155.170(a)(2); or (2) one of the three Federal Employees Health Benefit Program (FEHBP) plan options as defined by 45 CFR 156.100(a)(3), supplemented, as necessary, to meet the standards in 45 CFR 156.110.” This change reflects the possibility that base-benchmark plans, including the FEHBP plan options, could require supplementation under 45 CFR 156.110, and ensures the inclusion of State–required benefit mandates enacted on or before December 31, 2011 in accordance with 45 CFR 155.170, which when coupled with a State’s EHB–benchmark plan, establish the definition of EHB in that State under regulations implementing section 1302(b) of the Affordable Care Act.

Some commenters requested clarification that self-insured group health plans, large group market health plans and grandfathered plans are not required to include as covered benefits any specific items and services covered by the State–EHB benchmark plan, including any additional State–required benefits consider-

26 CFR 54.9815–2711(c), 29 CFR 2590.715–2711(c), 45 CFR 147.126(c).

80 FR 72192.

In the HHS Notice of Benefit and Payment Parameters for 2016 published February 27, 2015 (80 FR 10750), HHS instructed States to select a new base-benchmark plan to take effect beginning with plan or policy years beginning in 2017. The new final EHB base-benchmark plans selected as a result of this process are publicly available at downloads.cms.gov/ccio/Final%20List%20of%20BMPs_15_10_21.pdf. Additional information about the new base-benchmark plans, including plan documents and summaries of benefits, is available at www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html. The definition of EHB in each of the 50 states and the District of Columbia is based on the base-benchmark plan, and takes into account any additions to the base–benchmark plan, such as supplementation under 45 CFR 156.110, and State–required benefit mandates in accordance with 45 CFR 155.170.
ered EHB under 45 CFR 155.170(a)(2). The requirement in section 2707(a) of the PHS Act to provide the EHB package required under section 1302(a) of the Affordable Care Act applies only to non-grandfathered health insurance coverage in the individual and small group markets. Self--insured group health plans, large group market health plans and grandfathered health plans are not required to include coverage of EHB, but cannot place lifetime or annual dollar limits on any EHB covered by these plans. These plans are permitted to impose limits other than dollar limits on EHB, as long as they comply with other applicable statutory provisions. In addition, these plans can continue to impose annual and lifetime dollar limits on benefits that do not fall within the definition of EHB.

One commenter urged the Departments to eliminate the option for large group market health plans to define EHB based on one of the three largest nationally available FEHBP benchmark plan options to ensure consistency with the definition of EHB in the individual and small group markets. However, these FEHBP plan options are unique among benchmark plans in that they are available nationally, and thus can more appropriately be utilized to determine what benefits would be categorized as EHB for those employers that provide health coverage to employees throughout the United States and are not situated only in a single State. The Departments are finalizing the proposed clarification to the lifetime and annual limit regulations without change.

D. Applicability Date

These final regulations are applicable for plan years (or, in the individual market, policy years) beginning on or after January 1, 2017. The HHS final regulations specify the applicability dates in the group market regulations at 45 CFR 146.125 and in the individual market regulations at 45 CFR 148.102.

III. Economic Impact and Paperwork Burden

A. Summary — Department of Labor and Department of Health and Human Services

These final regulations specify the conditions for similar supplemental coverage products that are designed to fill gaps in primary coverage by providing coverage of additional categories of benefits (as opposed to filling in gaps in cost sharing) to constitute supplemental excepted benefits, and clarify that certain travel-related insurance products that provide only incidental health benefits constitute excepted benefits.

These final regulations also revise the definition of short-term, limited-duration insurance so that the coverage (including renewals) has to be less than three months in total duration (as opposed to the current definition of less than 12 months in duration), and provide that a notice must be prominently displayed in the contract and in any application materials provided in connection with enrollment in the coverage indicating that such coverage is not minimum essential coverage.

Finally, the regulations amend the definition of “essential health benefits” for purposes of the prohibition on lifetime and annual dollar limits with respect to group health plans and health insurance issuers that are not required to provide essential health benefits, including self--insured group health plans, large group market health plans, and grandfathered health plans.

The Departments are publishing these final regulations to implement the protections intended by the Congress in the most economically efficient manner possible. The Departments have examined the effects of this rule as required by Executive Order 13563 (76 FR 3821, January 21, 2011), Executive Order 12866 (58 FR 51735, September 19, 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (September 19, 1980, Pub. L. 96–354), the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)).

B. Executive Orders 12866 and 13563—Department of Labor and Department of Health and Human Services

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 final 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 must be prepared for rules with economically significant effects (for example, $100 million or more in any 1 year), and a “significant” regulatory action is subject to review by the Office of Management and Budget. The Departments have determined that this regulatory action is not likely to have economic impacts of $100 million or more in any one year, and is not significant within the meaning of Executive Or-
der 12866. However, the Departments are nonetheless providing a discussion of the benefits and costs that might stem from these final regulations in the Summary of Impacts section below.

1. Need for Regulatory Action

These final regulations clarify the conditions for similar supplemental coverage and travel insurance to be recognized as excepted benefits. These clarifications are necessary to provide health insurance issuers offering supplemental coverage and travel insurance products with a clearer understanding of the Federal standards that apply to these types of coverage. These final regulations also amend the definition of short-term, limited-duration insurance for purposes of the exclusion from the definition of individual health insurance coverage and impose a new notice requirement in response to reports that short-term, limited-duration insurance coverage is being sold to individuals as primary coverage.

2. Summary of Impacts

The final regulations outline the conditions for travel insurance and similar supplemental health insurance coverage to be considered excepted benefits, and revise the definition of short-term, limited-duration insurance.

The Departments received comments suggesting that the majority of travel insurance policies are issued for trips of short duration, with the average policy length being approximately three months, and these policies generally provide limited medical coverage and property and casualty coverage to protect against risks related to travel. The Departments believe that the designation of certain travel insurance products (as defined by the regulations) as excepted benefits is consistent with prevailing industry practices, and therefore, will not result in significant cost to issuers of these products or consumers who purchase them.

Short-term, limited-duration policies represent a very small fraction of the health insurance market, though their use is increasing. In 2015, total premiums earned for short-term, limited-duration insurance was approximately $160 million for approximately 1,517,000 member months and with approximately 148,000 covered lives at the end of the year, while in 2013, total premiums were approximately $98 million for 1,031,000 member months with approximately 80,400 covered lives at the end of the year.

The Departments received comments indicating that a large majority of the short-term, limited-duration insurance plans are sold as transitional coverage, particularly for individuals seeking to cover periods of unemployment or gaps between employer-sponsored coverage, and typically provide coverage for less than three months. Therefore, the Departments believe that the final regulations will have no effect on the majority of consumers who purchase such coverage and issuers of those policies. The small fraction of consumers who purchase such policies for longer periods and who may have to transition to individual market coverage will benefit from the protections afforded by the Affordable Care Act, such as no preexisting condition exclusions, essential health benefits without annual or lifetime dollar limits, and guaranteed renewability. While some of these consumers may experience an increase in costs due to higher premiums compared with short-term, limited-duration coverage, they will also avoid potential tax liability by having minimum essential coverage. Some consumers may also be eligible for premium tax credits and cost-sharing reductions for coverage offered through the Exchanges. Finally, inclusion of these individuals, often relatively healthier individuals, in the individual market will help strengthen the individual market’s single risk pool. The notice requirement will help ensure that consumers do not inadvertently purchase these products expecting them to be minimum essential coverage. Further, the Departments believe that any costs incurred by issuers of short-term, limited-duration insurance to include the required notice in application or enrollment materials will be negligible since the Departments have provided the exact text for the notice.

As a result, the Departments have concluded that the impacts of these final regulations are not economically significant.

C. Paperwork Reduction Act – Department of Health and Human Services

The final regulations provide that to be considered short-term, limited-duration insurance for policy years beginning on or after January 1, 2017, a notice must be prominently displayed in the contract and in any application materials, stating that the coverage is not minimum essential coverage and that failure to have minimum essential coverage may result in an additional tax payment. The Departments have provided the exact text for these notice requirements and the language will not need to be customized. The burden associated with these notices is not subject to the Paperwork Reduction Act of 1995 in accordance with 5 CFR 1320.3(c)(2) because they do not contain a “collection of information” as defined in 44 U.S.C. 3502(3).

D. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) (RFA) imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 et seq.) and that are likely to have a significant economic impact on a substantial number of small entities. Unless an agency certifies that a proposed rule is not likely to have a significant economic impact on a substantial number of small entities, section 603 of RFA requires that the agency present an initial regulatory flexibility analysis at the time of the publication of the notice of proposed rulemaking describing the impact of the rule on small entities and seeking public comment on such impact. Small entities include small businesses, organizations and governmental jurisdictions.


The RFA generally defines a “small entity” as (1) a proprietary firm meeting the size standards of the Small Business Administration (13 CFR 121.201); (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 to 5 percent.

The Departments expect the impact of these final regulations to be limited because the provisions are generally consistent with current industry practices and impact only a small fraction of the health insurance market. Therefore, the Departments certify that the final regulations will not have a significant impact on a substantial number of small entities. In addition, section 1102(b) of the Social Security Act requires agencies to prepare a regulatory impact analysis if a rule may have a significant economic impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. These final regulations will not affect small rural hospitals. Therefore, the Departments have determined that these final regulations will not have a significant impact on the operations of a substantial number of small rural hospitals.

E. Special Analysis – Department of the Treasury

Certain IRS regulations, including this one, are exempt from the requirements of Executive Order 12866, as supplemented and reaffirmed by Executive Order 13563. Therefore, a regulatory impact assessment is not required. For applicability of RFA, see paragraph D of this section III.

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.

F. Unfunded Mandates Reform Act

For purposes of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1501 et seq.), as well as Executive Order 12875, these final regulations do not include any Federal mandate that may result in expenditures by State, local, or tribal governments, or the private sector, which may impose an annual burden of $146 million adjusted for inflation since 1995.

G. Federalism – Department of Labor and Department of Health and Human Services

Executive Order 13132 outlines fundamental principles of federalism. It requires adherence to specific criteria by Federal agencies in formulating and implementing policies that have “substantial direct effects” on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have these federalism implications must consult with State and local officials, and describe the extent of their consultation and the nature of the concerns of State and local officials in the preamble to the final regulation.

In the Departments’ view, these final regulations have federalism implications because they would have direct effects on the States, the relationship between the national government and the States, or on the distribution of power and responsibilities among various levels of government. Under these final regulations, health insurance issuers offering short-term, limited-duration insurance, travel insurance and similar supplemental coverage will be required to follow the minimum Federal standards to not be subject to the market reform provisions under the PHS Act, ERISA and the Code. However, in the Departments’ view, the federalism implications of these final regulations are substantially mitigated because, with respect to health insurance issuers, the Departments expect that the majority of States will enact laws or take other appropriate action resulting in their meeting or exceeding the Federal standards.

In general, through section 514, ERISA supersedes State laws to the extent that they relate to any covered employee benefit plan, and preserves State laws that regulate insurance, banking, or securities. While ERISA prohibits States from regulating an employee benefit plan as an insurance or investment company or bank, the preemption provisions of section 731 of ERISA and section 2724 of the PHS Act (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a) and 148.210(b)) apply so that the requirements in title XXVII of the PHS Act (including those added by the Affordable Care Act) are not to be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with individual or group health insurance coverage except to the extent that such standard or requirement prevents the application of a Federal requirement. The conference report accompanying HIPAA indicates that this is intended to be the “narrowest” preemption of State laws (See House Conf. Rep. No. 104-736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018).

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

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

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

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

H. Congressional Review Act

These final regulations are subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.) and will be transmitted to the Congress and to the Comptroller General for review in accordance with such provisions.

I. Statement of Availability of IRS Documents


IV. Statutory Authority

The Department of the Treasury regulations are adopted pursuant to the authority 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. 1135 and 1191c; and 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.

§ 54.9801–2 Definitions.

* * * * *

Short-term, limited-duration insurance means health insurance coverage provided pursuant to a contract with an issuer that:

(1) Has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder with or without the issuer’s consent) that is less than 3 months after the original effective date of the contract; and

(2) Displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the following: “THIS IS NOT QUALIFYING HEALTH COVERAGE (“MINIMUM ESSENTIAL COVERAGE”) THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON’T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.”

* * * * *

Travel insurance means insurance coverage for personal risks incident to planned travel, which may include, but is not limited to, interruption or cancellation of trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability, or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverage. For this purpose, the term travel insurance does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting 6 months or longer, including, for example, those working overseas as an expatriate or military personnel being deployed.

* * * * *

Par. 3. Section 54.9815–2711 is amended by revising paragraph (c) to read as follows:

§ 54.9815–2711 No lifetime or annual limits.

* * * * *
(c) Definition of essential health benefits. The term “essential health benefits” means essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations. For this purpose, a group health plan or a health insurance issuer that is not required to provide essential health benefits under section 1302(b) must define “essential health benefits” in a manner that is consistent with—

(1) One of the EHB–benchmark plans applicable in a State under 45 CFR 156.110, and includes coverage of any additional required benefits that are considered essential health benefits consistent with 45 CFR 155.170(a)(2); or

(2) One of the three Federal Employees Health Benefits Program (FEHBP) plan options as defined by 45 CFR 156.100(a)(3), supplemented, as necessary, to meet the standards in 45 CFR 156.110.

Par. 4. Section 54.9831–1 is amended:

a. In paragraph (b)(1) by removing the reference “54.9812–1T” and adding in its place the phrase “54.9811–1T, 54.9812–1T” and adding in its place the phrase “54.9811–1, 54.9812–1, 54.9815–1251 through 54.9815–2719A”; and
b. In paragraph (c)(2)(vii) by removing “and” at the end;
c. In paragraph (c)(2)(viii) by removing the period and adding “; and” at the end;
d. Adding paragraph (c)(2)(ix); and
e. Revising paragraph (c)(5)(i)(C).

The revisions and additions are as follows:

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

(c) * * *
(2) * * *
(ix) Travel insurance, within the meaning of § 54.9801–2.

§ 54.9833–1 Effective dates.

* * * Notwithstanding the previous sentence, the definition of “short–term, limited–duration insurance” in § 54.9801–2 and paragraph (c)(5)(i)(C) of § 54.9831–1 apply for plan years beginning on or after January 1, 2017.
***Part III. Administrative, Procedural, and Miscellaneous***

**Transaction of Interest — Section 831(b) Micro-Captive Transactions**

**Notice 2016–66**

The Department of the Treasury (“Treasury Department”) and the Internal Revenue Service (the “IRS”) are aware of a type of transaction, described below, in which a taxpayer attempts to reduce the aggregate taxable income of the taxpayer, related persons, or both, using contracts that appear to treat the parties as insurance contracts and a related company that the parties treat as a captive insurance company. Each entity that the parties treat as an insured entity under the contracts claims deductions for premiums for insurance coverage. The related company that the parties treat as a captive insurance company may lack sufficient information to identify the payments directly or indirectly received under the contracts from its taxable income. The manner in which the contracts are interpreted, administered, and applied is inconsistent with arm’s length transactions and sound business practices.

The Treasury Department and the IRS believe this transaction (“micro-captive transaction”) has a potential for tax avoidance or evasion. See IR-2016–25 (discussing characteristics of an abusive micro-captive insurance structure). However, the Treasury Department and the IRS lack sufficient information to identify which § 831(b) arrangements should be identified specifically as a tax avoidance transaction and may lack sufficient information to define the characteristics that distinguish the tax avoidance transactions from other § 831(b) related-party transactions. This notice identifies the transaction described in section 2.01 of this notice and substantially similar transactions as transactions of interest for purposes of § 1.6011–4(b)(6) of the Income Tax Regulations and §§ 6111 and 6112 of the Code. This notice also alerts persons involved in such transactions to certain responsibilities and penalties that may arise from their involvement with these transactions.

**SECTION 1. BACKGROUND**

**.01 Overview of Transaction**

In the micro-captive transaction, A, a person, directly or indirectly owns an interest in an entity (or entities) (“Insured”) conducting a trade or business. A, persons related to A, or both, also directly or indirectly own another entity (or entities) (“Captive”).

In some cases, Captive enters into a contract (or contracts) (the “Contract”) with Insured as discussed below in section 1.02 of this notice. In these cases, Captive may enter into a reinsurance or pooling agreement under which a portion of the risks covered under the Contract are treated as pooled with risks of other entities, and Captive assumes risks from other entities as also discussed below in section 1.02 of this notice.

In other cases, Captive indirectly enters into the Contract by reinsuring risks that Insured has initially insured with an intermediary, Company C, as discussed below in section 1.03 of this notice.

**.02 Cases in Which Captive Enters into the Contract with Insured**

(a) **In general.** In cases in which Captive enters into the Contract with Insured, Captive and Insured treat the Contract as an insurance contract for federal income tax purposes. Captive provides coverage for Insured. Captive may offer coverage only to persons related to or affiliated with Insured. If Captive also offers coverage to persons that are not related to or affiliated with Insured, Captive typically offers coverage only to other entities represented by a person who promotes the micro-captive transaction. Captive may enter into a reinsurance or pooling agreement under which a portion of the risks covered under the Contract are treated as pooled with risks of other entities and Captive assumes risks from other entities. Typically, the other entities participating in the reinsurance or pooling agreement are also represented by a person who promotes the micro-captive transaction.

Insured makes payments to Captive under the Contract, treats the payments as insurance premiums that are within the scope of § 1.162–1(a), and deducts the payments as ordinary and necessary business expenses under § 162. Captive treats the payments received from Insured under the Contract as premiums for insurance coverage. If Captive is not a domestic corporation, Captive makes an election under § 831(b) to be treated as a domestic corporation. The micro-captive transaction is structured so that Captive has no more than $2,200,000 in net premiums written (or, if greater, direct premiums written) for each taxable year ($2,200,000 for taxable years beginning after December 31, 2016) in which the transaction is in effect. Captive makes an election under § 831(b) to be taxed only on taxable investment income and excludes the premiums from taxable income.

(b) **Promoter.** A promoter (“Promoter”) typically markets the micro-captive transaction structure to A. Promoter, persons related to Promoter, or both, typically provide continuing services to Captive, including:

1. providing the forms used for the Contract;
2. management of Captive; and
3. administrative, accounting, or legal services, including the filing of tax forms.

(c) **Contract coverage.** The coverage provided by Captive under the Contract has one or more of the following characteristics:

1. the coverage involves an implausible risk;
2. the coverage does not match a business need or risk of Insured;
3. the description of the scope of the coverage in the Contract is vague, ambiguous, or illusory; or
4. the coverage duplicates coverage provided to Insured by an unrelated, commercial insurance company, and the policy with the commercial insurer often has a far smaller premium.

(d) **Amounts paid to Captive.** The payments made by Insured to Captive under the Contract have one or more of the following characteristics:
(1) the amounts of Insured’s payments under the Contract are designed to provide Insured with a deduction under § 162 of a particular amount;
(2) the payments are determined without an underwriting or actuarial analysis that conforms to insurance industry standards;
(3) the payments are not made consistently with the schedule in the Contract;
(4) the payments are agreed to by Insured and Captive without comparing the amounts of the payments to payments that would be made under alternative insurance arrangements providing the same or similar coverage;
(5) the payments significantly exceed the premium prevailing for coverage offered by unrelated, commercial insurance companies for risks with similar loss profiles; or
(6) if Insured includes multiple entities, the allocation of amounts paid to Captive among the insured entities does not reflect the actuarial or economic measure of the risk of each entity.

(e) Claims procedures and management of Captive. Captive, Insured, or both does one or more of the following:
(1) Captive fails to comply with some or all of the laws or regulations applicable to insurance companies in the jurisdiction in which Captive is chartered, the jurisdiction(s) in which Captive is subject to regulation because of the nature of its business, or both;
(2) Captive does not issue policies or binders in a timely manner consistent with industry standards;
(3) Captive does not have defined claims administration procedures that are consistent with insurance industry standards;
(4) Insured does not file claims for each loss event covered by the Contract.

(f) Captive’s capital. Captive’s capital has one or more of the following characteristics:
(1) Captive does not have capital adequate to assume the risks that the Contract transfers from Insured;
(2) Captive invests its capital in illiquid or speculative assets usually not held by insurance companies; or
(3) Captive loans or otherwise transfers its capital to Insured, entities affiliated with Insured, A, or persons related to A.

.03 Cases in Which Insured and Captive Use an Intermediary Company

In certain cases, Captive indirectly enters into the Contract by reinsuring risks that Insured has initially insured with an intermediary, Company C. In these cases, Insured enters into a contract with Company C that the parties treat as an insurance contract. Company C also enters into a reinsurance contract with Captive to reinsure risks under the contract between Insured and Company C. In cases in which Captive reinsures risks that Insured has initially insured with an intermediary, Company C, the reinsurance agreement between Company C and Captive is the Contract for purposes of this notice and the disclosures required in section 3.05 of this notice.

In these cases, the coverage provided by Captive under the Contract, the payments made to Captive by Company C, and Captive’s capital each has one or more of the characteristics described in section 1.02(c), (d) or (f) of this notice, as applicable; also, Captive, Insured or both do one or more of the items described in section 1.02(e) of this notice. In addition, a Promoter typically markets the transaction to A.

Moreover, in these cases, Company C is unrelated to A or Insured but may be related to Promoter. Company C enters into similar arrangements with other entities, which usually are also represented by Promoter. Company C reinsures with Captive a portion of the risks, commonly in layers. For example, the first layer might cover losses from $1 up to $10,000; the second layer might cover losses greater than $10,000, but not more than $100,000; and the third layer might cover losses greater than $100,000. Captive might assume from Company C 100 percent of one layer of Insured’s risks and in another layer a proportionate share of the aggregate risk of Insured and other entities. The allocation among the layers of amounts paid to Captive as premiums typically does not reflect the actuarial or economic measures of the risks associated with the particular layers. In addition, any claims filed generally fall within the layer or layers that only cover risks of Insured.

.04 Claimed Tax Treatment and Benefits

In the micro–captive transaction, Insured, Captive, and, if applicable, Company C, treat the Contract as an insurance contract for federal income tax purposes. Insured claims a deduction for the premiums paid under § 162. Captive excludes the premium income from its taxable income by electing under § 831(b) to be taxed only on its investment income. Captive uses the premium income for purposes other than administering and paying claims under the Contract, generally benefitting Insured or a party related to Insured. For instance, Captive may use premium income to provide a loan to Insured.

However, if the transaction does not constitute insurance, Insured is not entitled to deduct the amount of that payment under § 162 as an insurance premium. In addition, if Captive does not provide insurance, Captive does not qualify as an insurance company and Captive’s elections to be taxed only on its investment income under § 831(b) and to be treated as a domestic insurance company under § 953(d) are invalid.

The Treasury Department and the IRS recognize that related parties may use captive insurance companies that make elections under § 831(b) for risk management purposes that do not involve tax avoidance, but believe that there are cases in which the use of such arrangements to claim the tax benefits of treating the Contract as an insurance contract is improper. Therefore, the Treasury Department and the IRS are identifying transactions described in section 2.01 of this notice (and transactions substantially similar to such transactions) as transactions of interest for purposes of § 1.6011–4(b)(6) and §§ 6111 and 6112 of the Code.

SECTION 2. TRANSACTIONS OF INTEREST

.01 Transactions Identified as Transactions of Interest

The following transaction is identified as a transaction of interest under this notice:
(a) A, a person, directly or indirectly owns an interest in an entity (or entities) (“Insured”) conducting a trade or business;
(b) an entity (or entities) directly or indirectly owned by A, Insured, or persons related to A or Insured (“Captive”) enters into a contract (or contracts) (the “Contracts”) with Insured that Captive and Insured treat as insurance, or reinsures risks that Insured has initially insured with an intermediary, Company C;
(c) Captive makes an election under § 831(b) to be taxed only on taxable investment income;
(d) A, Insured, or one or more persons related (within the meaning of § 267(b) or 707(b)) to A or Insured directly or indirectly own at least 20 percent of the voting power or value of the outstanding stock of Captive; and
(e) one or both of the following apply:
(1) the amount of the liabilities incurred by Captive for insured losses and claim administration expenses during the Computation Period (defined in section 2.02 of this notice) is less than 70 percent of the following:
(A) premiums earned by Captive during the Computation Period, less
(B) policyholder dividends paid by Captive during the Computation Period; or
(2) Captive has at any time during the Computation Period directly or indirectly made available as financing or otherwise conveyed or agreed to make available or convey to A, Insured, or a person related (within the meaning of § 267(b) or 707(b)) to A or Insured (collectively, the “Recipient”) in a transaction that did not result in taxable income or gain to Recipient, any portion of the payments under the Contract, such as through a guarantee, a loan, or other transfer of Captive’s capital.
A transaction described in this section 2.01 is identified as a transaction of interest regardless of whether the transaction has the characteristics described in section 1 of this notice.

.02 The Computation Period

The Computation Period is (a) the most recent five taxable years of Captive or (b) if Captive has been in existence for less than five taxable years, the entire period of Captive’s existence. For purposes of the preceding sentence, if Captive has been in existence for less than five taxable years and Captive is a successor to one or more Captives created or availed of in connection with a transaction described in this notice, taxable years of such predecessor entities are treated as taxable years of Captive. For purposes of this section 2.02, a short taxable year is treated as a taxable year.

.03 Exception for Compensatory Arrangements with Prohibited Transaction Exemption

There may be limited circumstances in which a captive insurance company arrangement that provides insurance for employee compensation or benefits is described in this section and accordingly is identified as a transaction of interest under this notice. However, if such an arrangement is one for which the Employee Benefits Security Administration of the U.S. Department of Labor has issued a Prohibited Transaction Exemption, it is not treated as an arrangement identified as a transaction of interest under this notice.

SECTION 3. RULES OF APPLICATION

.01 Effective Date

Transactions that are the same as, or substantially similar to, the transaction described in section 2.01 of this notice are identified as “transactions of interest” for purposes of § 1.6011–4(b)(6) and §§ 6111 and 6112 effective November 1, 2016. Persons entering into these transactions on or after November 2, 2006, must disclose the transaction as described in § 1.6011–4.

.02 Participation

Under § 1.6011–4(c)(3)(i)(E), A, Insured, Captive, and, if applicable, Company C are participants in a transaction for each year in which their respective tax returns reflect tax consequences or a tax strategy of a transaction of interest described in section 2.01 of this notice.

.03 Time for Disclosure

For rules regarding the time for providing disclosure of a transaction described in section 2.01 of this notice, see § 1.6011–4(e) and § 301.6111–3(e). However, if, under § 1.6011–4(e), a taxpayer is required to file a disclosure statement with respect to a transaction described in section 2.01 of this notice after November 1, 2016, and prior to January 30, 2017, that disclosure statement will be considered to be timely filed if the taxpayer alternatively files the disclosure with the Office of Tax Shelter Analysis by January 30, 2017.

.04 Material Advisor Threshold Amount

The threshold amounts are the same as those for listed transactions. See § 301.6111–3(b)(3)(i)(B).

.05 Disclosure

(a) General rule. Under § 1.6011–4(d) and the Instructions to Form 8886, Reportable Transaction Disclosure State-
ment, the required disclosure must identify and describe the transaction in sufficient detail for the IRS to be able to understand the tax structure of the reportable transaction and the identity of all parties involved in the transaction.

(b) Information required of all participants. For all participants, describing the transaction in sufficient detail includes, but is not limited to, describing on Form 8886 how and when the taxpayer became aware of the transaction.

(c) Information required of Captive. For Captive, describing the transaction in sufficient detail includes, but is not limited to, describing the following on Form 8886:

(1) whether Captive is reporting because (i) the amount of the liabilities incurred by Captive for insured losses and claim administration expenses during the Computation Period is less than 70 percent of the amount specified in section 2.01(e)(1) of this notice; (ii) Captive has at any time during the Computation Period made available as financing or otherwise conveyed any portion of the payments under the Contract to A, Insured, or a person related (within the meaning of § 267(b) or 707(b)) to A or Insured through a separate transaction, such as a guarantee, a loan, or other transfer; or (iii) both (i) and (ii);

(2) under what authority Captive is chartered;

(3) a description of all the type(s) of coverage provided by Captive during the year or years of participation (if disclosure pertains to multiple years);

(4) a description of how the amounts treated as premiums for coverage provided by Captive during the year or years of participation (if disclosure pertains to multiple years) were determined, including the name and contact information of any actuary or underwriter who assisted in these determinations;

(5) a description of any claims paid by Captive during the year or years of participation (if disclosure pertains to multiple years), and of the amount of, and reason for, any reserves reported by Captive on the annual statement; and

(6) a description of the assets held by Captive during the year or years of participation (if disclosure pertains to multiple years); that is, the use Captive has made of its premium and investment income, including but not limited to, securities (whether or not registered), loans, real estate, or partnerships or other joint ventures, and an identification of the related parties involved in any transactions with respect to those assets.

.06 Penalties

Persons required to disclose these transactions under § 1.6011–4 who fail to do so may be subject to the penalty under § 6707A. Persons required to disclose these transactions under § 6111 who fail to do so may be subject to the penalty under § 6707(a). Persons required to maintain lists of advisees under § 6112 who fail to do so (or who fail to provide such lists when requested by the IRS) may be subject to the penalty under § 6708(a).

In addition, the IRS may impose other penalties on parties involved in these transactions, including the accuracy-related penalty under § 6662 or § 6662A.

SECTION 4. REQUEST FOR COMMENTS

The Treasury Department and the IRS request comments on how the transaction might be addressed in published guidance.

Comments should be submitted in writing on or before January 30, 2017. Send submissions to CC:PA:LPD:PR (Notice 2016–66), Room 5203, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand–delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (Notice 2016–66), Courier’s Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington, DC 20224. Comments may also be sent electronically, via the following e-mail address: Notice.comments@irs.counsel.treas.gov. Please include “Notice 2016–66” in the subject line of any electronic communications. All comments submitted will be available for public inspection and copying.

SECTION 5. DRAFTING INFORMATION

The principal author of this notice is John E. Glover of the Office of Associate Chief Counsel (Financial Institutions & Products). For further information regarding this notice contact Mr. Glover at (202) 317–6995 (not a toll-free number).

Notice 2016–67

I. PURPOSE

This notice describes the applicability of the market rate of return limitation rules of § 411(b)(5)(B)(i) and § 1.411(b)(5)–1(d) to a defined benefit plan that expresses a participant’s accumulated benefit as the current value of an accumulated percentage of the participant’s final average compensation, highest average compensation, or highest average compensation during a limited period of years (a type of plan often referred to as a “pension equity plan” or “PEP”). In particular, this notice addresses the applicability of the market rate of return limitation rules to a type of PEP that applies a deferred annuity factor to the participant’s accumulated benefit in order to determine deferred benefits (a type of PEP often referred to as an “implicit interest PEP”). In addition, this notice requests comments on potential proposed regulations that would subject implicit interest PEPs to the market rate of return limitation.

II. BACKGROUND

Section 411(a) provides that, in order to be a qualified plan, a defined benefit plan must satisfy the benefit accrual requirements of § 411(b). Under § 411(b)(1)(H), a defined benefit plan fails to comply with § 411(b) if, under the plan, an employee’s benefit accrual ceases, or the employee’s rate of benefit accrual is reduced, because of the attainment of any age.

Section 411(b)(5) contains a number of special rules that apply to an applicable defined benefit plan for purposes of section 411(b)(1)(H). The term “applicable defined benefit plan” is defined in § 411(a)(13)(C) and includes a cash balance plan, a PEP, or another plan that has been designated in regulations as an applicable defined benefit plan because it has a similar effect to a cash balance plan or PEP. Final regulations under §§ 411(a)(13) and 411(b)(5) relating to applicable defined benefit plans were published in the Federal Register on October 19, 2010 (75 FR 64123) and on September 19, 2014 (79 FR 56442). These regulations are referred to in this notice as
“the hybrid plan regulations.” The hybrid plan regulations refer to cash balance plans, PEPs, and other applicable defined benefit plans under § 411(a)(13)(C) as “statutory hybrid plans.”

Section 411(b)(5)(B) states that an applicable defined benefit plan is treated as failing to meet § 411(b)(1)(H) unless certain requirements are satisfied. Among these requirements is § 411(b)(5)(B)(i), which provides that an applicable defined benefit plan is treated as failing to meet the age discrimination requirements of § 411(b)(1)(H) if the terms of the plan provide for any interest credit (or equivalent amount) for any plan year at a rate that is greater than a market rate of return.

Under § 1.411(b)(5)–1(d)(1)(i)(A), an interest credit generally means any of the following adjustments to a participant’s accumulated benefit under a statutory hybrid benefit formula, to the extent not conditioned on current service and not made on account of imputed service: “(1) [a]ny increase or decrease for a period, under the terms of the plan at the beginning of the period, that is calculated by applying a rate of interest or rate of return (including a rate of increase or decrease under an index) to the participant’s accumulated benefit (or portion thereof) as of the beginning of the period; and (2) [a]ny other increase for a period, under the terms of the plan at the beginning of the period.”

Under § 1.411(b)(5)–1(d)(1)(ii)(D), a principal credit means any increase to a participant’s accumulated benefit under a statutory hybrid benefit formula that is not an interest credit. Thus, for example, an increase in the accumulated benefit under a PEP formula that is made on account of current service (including an increase on account of higher average compensation) constitutes a principal credit.

Additional final regulations amending the hybrid plan regulations under §§ 411(a)(13) and 411(b)(5) were published in the Federal Register on November 16, 2015 (80 FR 70680). These regulations (referred to in this notice as the “transition regulations”) provide an exception from the requirements of § 411(d)(6) to permit a plan to reduce, with respect to benefits that have already accrued, its interest crediting rate from a rate that is impermissible under the hybrid plan regulations to a permissible rate. In addition, the transition regulations delay the applicability date of certain provisions under §§ 411(a)(13) and 411(b)(5) in the final hybrid plan regulations that were scheduled to become effective for plan years beginning on or after January 1, 2016. Under the transition regulations, those provisions generally are first effective for plan years beginning on or after January 1, 2017. This delay in effective date applies to the provisions in § 1.411(b)(5)–1(d) that set forth the list of interest crediting rates and combinations of rates that satisfy the requirement of § 411(b)(5)(B)(i) that a plan not provide an effective rate of return in excess of a market rate of return. See § 1.411(b)(5)–1(f)(2)(i)(B)(7).

III. PEP DESIGNS – DETERMINATION OF BENEFIT PAYABLE AT ANNUITY STARTING DATE

PEPs typically are designed to provide a single–sum distribution equal to the accumulated benefit (that is, the current value of an accumulated percentage of the participant’s average compensation) at the time principal credits cease. In addition, for annuity starting dates after principal credits cease, PEPs often provide for increases in the amount of benefits that are payable in order to reflect the time value of money. Some PEPs provide for this increase by explicitly crediting interest on the accumulated benefit after principal credits cease. In the case of such a PEP (“an explicit interest PEP”), a participant is entitled to benefits at an annuity starting date based on the participant’s accumulated benefit as of the date principal credits cease, increased by interest credits through the annuity starting date.

Other PEPs provide for increases in annuity benefits for annuity starting dates after principal credits cease by applying a deferred annuity factor to the participant’s accumulated benefit as of the date principal credits cease. Such a PEP is often referred to as an “implicit interest PEP” because preretirement interest is implicitly reflected in the deferred annuity factor. One example of an implicit interest PEP is a PEP that defines the accrued benefit (that is, the annual benefit payable at a participant’s normal retirement age) as the actuarial equivalent of the accumulated benefit determined as of the date principal credits cease (or the current date, if principal credits have not yet ceased), and determines actuarial equivalence using a deferred annuity factor that reflects preretirement interest.1

IV. APPLICATION OF EXISTING REGULATIONS

Under an explicit interest PEP, because the accumulated benefit is adjusted with interest credits to determine the benefit payable at annuity starting dates after principal credits cease, those interest credits are subject to the market rate of return limitation rules under the hybrid plan regulations must be made by the applicable deadline in § 411(b)(5)–1(e)(3)(vi)(B)(3) of the transition regulations (generally before the beginning of the first plan year that begins on or after January 1, 2017) in order for the amendments to be eligible for the exception from § 411(d)(6) provided by the transition regulations.

By contrast, under an implicit interest PEP, the preretirement interest that is implicit in applying a deferred annuity factor to the accumulated benefit is not included in the definition of an interest credit under § 411(b)(5)–1(d)(1)(ii)(A). This is because the accumulated benefit remains a constant percentage of average compensation and is not adjusted with interest credits after principal credits cease. Thus, under the hybrid plan regulations, no amendment is required to the deferred annuity factors under an implicit interest PEP in order to reduce the preretirement interest that is implicit in those factors to a rate that does not exceed a market rate of return and the exception from § 411(d)(6) under the transition regulations does not apply to such an amendment.

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1The deferred annuity factor applied under an implicit interest PEP may also reflect preretirement mortality. For purposes of sections IV and V of this notice, references to preretirement interest include any adjustments for preretirement mortality reflected in a deferred annuity factor.
Stakeholders have expressed uncertainty as to whether the market rate of return limitation rules under § 1.411(b)(5)–1(d) of the final hybrid plan regulations apply to implicit interest PEPs. Due to this uncertainty, some plan sponsors of implicit interest PEPs might have believed that the preretirement interest that is implicit in a deferred annuity factor was subject to the market rate of return limitation rules under § 1.411(b)(5)–1(d). As a result, some plan sponsors might have already adopted plan amendments to reduce that interest in accordance with the rules under the transition regulations that apply to amendments reducing interest crediting rates that exceed a market rate of return. For a discussion of the consequences of such a change and the impact of potential future regulations, see section V of this notice.

V. POTENTIAL FUTURE AMENDMENTS TO THE REGULATIONS

Even though the preretirement interest that is implicit in a deferred annuity factor under an implicit interest PEP is not subject to the market rate of return limitation rules in the final hybrid plan regulations, the Treasury Department and the IRS are considering whether to propose amendments to those regulations that would subject implicit preretirement interest to the market rate of return limitation. Comments are requested as to whether such a rule should be proposed. Comments should take into account the statutory intent of § 411(b)(5) to subject interest credits and equivalent amounts to a market rate of return, as well as the difference between interest credits and the interest that is implicit in deferred annuity factors.

If final regulations are ultimately adopted to subject the preretirement interest that is implicit in a deferred annuity factor under an implicit interest PEP to the market rate of return limitation, it is expected that plan sponsors will be given an adequate period of time, after publication of those regulations and before the regulations become applicable, to amend plans to comply with the rule and that in no event will the final rule apply earlier than for plan years that begin on or after January 1, 2018. In addition, it is expected that, if such a final rule is ultimately adopted, the exception to § 411(d)(6) provided in the transition regulations will be expanded to cover required changes in the deferred annuity factor made during the period covered by the existing transition regulations and after that period ends but prior to the applicability date of the new final rule. Thus, if such a rule is adopted and a plan sponsor has already reduced the implicit interest rate in a PEP to a market rate of return under an amendment that would satisfy the existing transition regulations, no further action would be necessary.

However, if no such final rule is adopted to subject the preretirement interest that is implicit in deferred annuity factors to the market rate of return limitation, then any amendment that has already been adopted to change a plan’s deferred annuity factors in order to reduce the interest implicit in those factors to a market rate of return would not be eligible for the exception from § 411(d)(6) under the transition regulations. In such a case, a correction would be needed to the extent that the prior amendment violates § 411(d)(6), and guidance relating to permissible corrections would be provided. The Treasury Department and the IRS request comments as to corrections that would appropriately restore benefits that have been reduced by such an amendment but that would not be overly burdensome.

Comments may be submitted in writing on or before February 21, 2017. Comments should be mailed to Internal Revenue Service, CC:PA:LPD:PR (Notice 2016–67), Room 5203, P.O. Box 7604, Ben Franklin Station, Washington, D.C. 20044, or sent electronically to notice.comments@irs.counsel.treas.gov. Please include “Notice 2016–67” in the subject line of any electronic communications. Alternatively, comments may be hand delivered Monday through Friday between the hours of 8:00 a.m. and 4:00 p.m. to CC:PA:LPD:PR (Notice 2016–67), Courier’s Desk, Internal Revenue Service, 1111 Constitution Ave., NW, Washington, D.C. All comments will be available for public inspection and copying.

VI. DRAFTING INFORMATION

The principal author of this notice is Neil Sandhu of the Office of Associate Chief Counsel (Tax Exempt and Government Entities). For further information regarding this notice, contact Neil Sandhu at (202) 317-6700 (not a toll-free number).
**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 but not to B, 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 substance 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.
- CB.—Cumulative Bulletin.
- CI—City.
- COOP—Cooperative.
- C.D.—Court Decision.
- C.Y.—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.
- EX—Executor.
- F—Fiduciary.
- FC—Foreign Country.
- FISC—Foreign International Sales Company.
- FPH—Foreign Personal Holding Company.
- F.R.—Federal Register.
- FX—Foreign corporation.
- G.C.M.—Chief Counsel’s Memorandum.
- GE—Grantee.
- GP—General Partner.
- GR—Grantor.
- IC—Insurance Company.
- 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. Rul.—Revenue Ruling.
- S.—Subsidiary.
- Stat.—Statutes at Large.
- T.—Target Corporation.
- T.C.—Tax Court.
- TFE—Transferor.
- TFR—Transferor.
- TP—Taxpayer.
- TR—Trust.
- TT—Trustee.
- 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 2016–01 through 2016–26 is in Internal Revenue Bulletin 2016–26, dated June 27, 2016.
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A cumulative list of all revenue rulings, revenue procedures, Treasury decisions, etc., published in Internal Revenue Bulletins 2016–01 through 2016–26 is in Internal Revenue Bulletin 2016–26, dated June 27, 2016.
The Introduction at the beginning of this issue describes the purpose and content of this publication. The weekly Internal Revenue Bulletins are available at www.irs.gov/irb/.

We Welcome Comments About the Internal Revenue Bulletin

If you have comments concerning the format or production of the Internal Revenue Bulletin or suggestions for improving it, we would be pleased to hear from you. You can email us your suggestions or comments through the IRS Internet Home Page (www.irs.gov) or write to the Internal Revenue Service, Publishing Division, IRB Publishing Program Desk, 1111 Constitution Ave. NW, IR-6230 Washington, DC 20224.