

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

Rev. Rul. 96-51, page 5.

Taxes, accrual of deduction. Under the all events test of section 461 of the Code, an accrual method employer may deduct in Year 1 its otherwise deductible FICA and FUTA taxes imposed with respect to year-end wages properly accrued in Year 1, but paid in Year 2, if the requirements of the recurring item exception are met.

P.L. 104-191, page 7.

An Act to amend the Internal Revenue Code of 1996, to improve portability and continuity of health insurance coverage in the group and individual markets and to promote the use of medical savings accounts, is reproduced.

EMPLOYEE PLANS

Rev. Proc. 96-49, page 74.

Retirement plans; section 414(u); model amendments. This procedure describes how certain plan

sponsors may adopt model amendments to amend their plans to comply with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994, P. L. 103-353, and section 414(u) of the Code, which was added by section 1704(n) of the Small Business Job Protection Act of 1996, P. L. 104-188.

EXEMPT ORGANIZATIONS

Announcement 96-109, page 76.

A list is given of organizations now classified as private foundations.

ADMINISTRATIVE

Announcement 96-110, page 77.

Corporations and partnerships will not automatically receive Package 1120 or 1065 for 1996. Instead, they will receive a postcard and may order either package if necessary.

Finding Lists begin on page 79.

Announcement Relating to Court Decisions, on page 4.

Announcement of Declaratory Judgment Proceedings Under Section 7428, on page 77.

Mission of the Service

The purpose of the Internal Revenue Service is to collect the proper amount of tax revenue at the least cost; serve the public by continually improving the

quality of our products and services; and perform in a manner warranting the highest degree of public confidence in our integrity, efficiency and fairness.

Statement of Principles of Internal Revenue Tax Administration

The function of the Internal Revenue Service is to administer the Internal Revenue Code. Tax policy for raising revenue is determined by Congress.

With this in mind, it is the duty of the Service to carry out that policy by correctly applying the laws enacted by Congress; to determine the reasonable meaning of various Code provisions in light of the Congressional purpose in enacting them; and to perform this work in a fair and impartial manner, with neither a government nor a taxpayer point of view.

At the heart of administration is interpretation of the Code. It is the responsibility of each person in the Service, charged with the duty of interpreting the law, to try to find the true meaning of the statutory provision and not to adopt a strained construction in the belief that he or she is "protecting the revenue." The revenue is properly protected only when we ascertain and apply the true meaning of the statute.

The Service also has the responsibility of applying and administering the law in a reasonable, practical manner. Issues should only be raised by examining officers when they have merit, never arbitrarily or for trading purposes. At the same time, the examining officer should never hesitate to raise a meritorious issue. It is also important that care be exercised not to raise an issue or to ask a court to adopt a position inconsistent with an established Service position.

Administration should be both reasonable and vigorous. It should be conducted with as little delay as possible and with great courtesy and considerateness. It should never try to overreach, and should be reasonable within the bounds of law and sound administration. It should, however, be vigorous in requiring compliance with law and it should be relentless in its attack on unreal tax devices and fraud.

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 and may be obtained from the Superintendent of Documents on a subscription basis. Bulletin contents of a permanent nature are consolidated semi-annually into Cumulative Bulletins, which are sold on a single-copy basis.

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

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

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

court decisions, rulings, and procedures must be considered, and Service personnel and others concerned are cautioned against reaching the same conclusions in other cases unless the facts and circumstances are substantially the same.

The Bulletin is divided into four parts as follows:

Part I.—1986 Code.

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

Part II.—Treaties and Tax Legislation.

This part is divided into two subparts as follows: Subpart A, Tax Conventions, and 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.

With the exception of the Notice of Proposed Rulemaking and the disbarment and suspension list included in this part, none of these announcements are consolidated in the Cumulative Bulletins.

The first Bulletin for each month includes an index for the matters published during the preceding month. These monthly indexes are cumulated on a quarterly and semiannual basis, and are published in the first Bulletin of the succeeding quarterly and semi-annual period, respectively.

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Announcement Relating to Court Decisions

It is the policy of the Internal Revenue Service to announce at an early date whether it will follow the holdings in certain cases. An Action on Decision is the document making such an announcement. An Action on Decision will be issued at the discretion of the Service only on unappealed issues decided adverse to the government. Generally, an Action on Decision is issued where its guidance would be helpful to Service personnel working with the same or similar issues. Unlike a Treasury Regulation or a Revenue Ruling, an Action on Decision is not an affirmative statement of Service position. It is not intended to serve as public guidance and may not be cited as precedent.

Actions on Decisions shall be relied upon within the Service only as conclusions applying the law to the facts in the particular case at the time the Action on Decision was issued. Caution should be exercised in extending the recommendation of the Action on Decision to similar cases where the facts are different. Moreover, the recommendation in the Action on Decision may be superseded by new legislation, regulations, rulings, cases, or Actions on Decisions.

Prior to 1991, the Service published acquiescence or nonacquiescence only in certain regular Tax Court opinions. The Service has expanded its acquiescence program to include other civil tax cases where guidance is determined to be helpful. Accordingly, the Service now may acquiesce or nonacquiesce in the holdings of memorandum Tax Court opinions, as well as those of the United States District Courts, Claims Court, and Circuit Courts of Appeal. Regardless of the court deciding the case, the recommendation of any Action on Decision will be published in the Internal Revenue Bulletin.

The recommendation in every Action on Decision will be summarized as acquiescence, acquiescence in result only, or nonacquiescence. Both “acquiescence” and “acquiescence in result only” mean that the Service accepts the holding of the court in a case and that the Service will follow it in disposing of cases with the same controlling facts. However, “acquiescence” indicates neither approval nor disapproval of the reasons assigned by the court for its conclusions; whereas, “acquiescence in result only” indicates disagreement or concern with some or all of those reasons. Nonacquiescence signifies that, although no further review was sought, the Service does not agree with the holding of the court and, generally, will not follow the decision in disposing of cases involving other taxpayers. In reference to an opinion of a circuit court of appeals, a nonacquiescence indicates that the Service will not follow the holding on a nationwide basis. However, the Service will recognize the precedential impact of the opinion on cases arising within the venue of the deciding circuit.

The announcements published in the weekly Internal Revenue Bulletins are consolidated semiannually and annually. The semiannual consolidation appears in the first Bulletin for July and in the Cumulative Bulletin for the first half of the year, and the annual consolidation appears in the first Bulletin for the following January and in the Cumulative Bulletin for the last half of the year.

The Commissioner ACQUIESCES in the following decisions:

Burlington Northern Railroad Co. v. Commissioner,¹

82 T.C. 143 (1984)

Eastman Kodak Co. v. United States,²

534 F.2d 252 (Ct. Cl. 1976)

Velinsky v. Commissioner,³

T.C. Memo 1996-180

The Commissioner does NOT ACQUIESCE the following decision:

Brown Group, Inc. v. Commissioner,⁴

77 F.3d 217 (8th Cir. 1996)

vacating and remanding 104 T.C. 105 (1995)

¹Acquiescence and that Rev. Rul. 74-70 be reconsidered relating to whether an accrual basis taxpayer may deduct, pursuant to the all events test of section 1.461-1(a)(2) of the Treasury Regulations, the employer's portion of payroll taxes on year-end salaries where the salaries are properly accruable but unpaid at year-end and the obligation to remit the taxes does not arise until the following year when such wages are paid to employees.

²Acquiescence and that Rev. Rul. 74-70 be reconsidered relating to whether an accrual basis taxpayer may deduct, pursuant to the all events test of section 1.461-1(a)(2) of the Treasury Regulations, the employer's portion of payroll taxes on year-end salaries where the salaries are properly accruable but unpaid at year-end and the obligation to remit the taxes does not arise until the following year when such wages are paid to employees.

³Acquiescence relating to whether, for purposes of the grossly erroneous requirement of section 6013(e) of the Code, an adjustment to cost of goods sold (COGS) is an omission of gross income or an item of “deduction, credit, or basis.”

⁴Nonacquiescence relating to whether a controlled foreign corporation's (“CFC’s”) distributive share of partnership income is foreign base company sales income under section 954(d) of the Code, when the partnership income is earned under circumstances in which it would have been foreign base company sales income if earned directly by the CFC partner.

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

Section 461.—General Rule for Taxable Year of Deduction

26 CFR 1.461-1: General rule for taxable year of deduction.
(Also § 1.461-5.)

Taxes, accrual of deduction. Under the all events test of section 461 of the Code, an accrual method employer may deduct in Year 1 its otherwise deductible FICA and FUTA taxes imposed with respect to year-end wages properly accrued in Year 1, but paid in Year 2, if the requirements of the recurring item exception are met.

Rev. Rul. 96-51

ISSUE

Under the all events test of § 461 of the Internal Revenue Code, may an accrual method employer deduct in Year 1 its otherwise deductible Federal Insurance Contributions Act (FICA) and Federal Unemployment Tax Act (FUTA) taxes imposed with respect to year-end wages properly accrued in Year 1, but paid in Year 2?

FACTS

X, a corporation, employs the accrual method of accounting and uses a calendar taxable year. X pays otherwise deductible wages to its employees bi-weekly on the Friday immediately following a two-week pay period. Wages for the pay period beginning Saturday, December 23, 1995, and ending Friday, January 5, 1996, were paid to X's employees on Friday, January 12, 1996. Prior to filing its 1995 corporate federal income tax return on March 15, 1996, X paid the taxes owed under §§ 3111 (the employer's share of FICA taxes) and 3301 (FUTA taxes) with respect to the December 23-31, 1995 wages that X properly accrued in 1995. X properly adopted the recurring item exception under § 1.461-5 of the Income Tax Regulations as a method of accounting with respect to X's recurring liability for its share of FICA and FUTA taxes imposed in connection with accrued but unpaid year-end wages. On its 1995 return, X deducted the FICA and FUTA taxes it paid on the accrued year-end wages.

LAW AND ANALYSIS

Section 461(a) provides that the amount of any deduction or credit must be taken for the taxable year that is the

proper taxable year under the method of accounting used in computing taxable income.

Section 461(h) and § 1.461-1(a)(2)(i) provide that, under the accrual method of accounting, a liability is incurred, and is generally taken into account for federal income tax purposes, in the taxable year in which (1) all the events have occurred that establish the fact of the liability, (2) the amount of the liability can be determined with reasonable accuracy, and (3) economic performance has occurred with respect to the liability. The economic performance requirement applies to liabilities allowable as a deduction or otherwise incurred after July 18, 1984.

Section 1.461-4(g)(6) provides generally that, if a taxpayer is liable to pay a tax, economic performance occurs as the tax is paid to the governmental authority that imposed it.

Section 1.461-5 provides a recurring item exception to the general rule of economic performance. Under the recurring item exception, a liability is treated as incurred for a taxable year if: (1) at the end of the taxable year, all events have occurred that establish the fact of the liability and the amount can be determined with reasonable accuracy; (2) economic performance occurs on or before the earlier of (a) the date that the taxpayer timely files a return (including extensions), or (b) the 15th day of the ninth calendar month after the close of the taxable year; (3) the liability is recurring in nature; and (4) either the amount of the liability is not material or accrual of the liability in the earlier year results in a better matching of the liability against the income to which it relates.

Section 1.461-5(b)(5)(ii) provides that, in the case of a liability for taxes, the matching requirement of the recurring item exception is deemed satisfied.

Rev. Rul. 74-70, 1974-1 C.B. 116, holds that, under the all events test, an accrual basis employer generally may not deduct its share of FICA taxes payable with respect to wages accrued but unpaid at year-end until the taxable year in which those wages are actually or constructively paid.

In *Eastman Kodak Co. v. United States*, 534 F.2d 252 (Ct. Cl. 1976), *acq.*, this Bulletin, page 4, the court held that an accrual basis employer may deduct its share of FICA, FUTA, and state unemployment taxes with respect

to year-end wages in the year the wages were accrued, rather than in the following year when the wages were paid. The court held that, under the all events test, the fact of the liability may be established, and the amount thereof reasonably ascertained, even though no legally enforceable obligation to pay the taxes in issue had arisen by year-end. The court found that the fact of the employer's liability for the taxes was established as an automatic consequence of its definite and legal obligation to pay the underlying year-end accrued wages. *See also Burlington Northern R.R. v. Commissioner*, 82 T.C. 143 (1984), *acq.* this Bulletin, page 4 (reaching the same conclusion on the deductibility of the § 3221 employer tax under the Railroad Retirement Tax Act with respect to accrued year-end wages).

Similarly, X satisfied the all events test for the federal employment taxes imposed with respect to accrued year-end wages for 1995 because the fact of its liability to pay those taxes was established as an automatic consequence of its accrual of the underlying wages and the amount of those taxes was reasonably ascertainable. Further, X satisfied the requirements of the recurring item exception because the all events test was satisfied by the end of 1995, economic performance occurred within the prescribed time because the taxes were paid prior to the filing of X's 1995 return, the liability was recurring in nature, and the accrual of the tax liability in 1995 is deemed (under § 1.461-5(b)(5)(ii)) to result in a better matching of that liability against the income to which it relates. Accordingly, X may deduct on its 1995 return the FICA and FUTA taxes it paid on the accrued year-end wages.

HOLDING

Under the all events test of § 461, an accrual method employer may deduct in Year 1 its otherwise deductible FICA and FUTA taxes imposed with respect to year-end wages properly accrued in Year 1, but paid in Year 2, provided the employer satisfies the requirements of the recurring item exception with respect to these taxes.

EFFECT ON OTHER DOCUMENTS

Rev. Rul. 74-70 is revoked.

APPLICATION

The tax treatment of an employer's FICA and FUTA taxes with respect to year-end wages within the scope of this revenue ruling constitutes a method of accounting. An employer currently treating those taxes in a manner different from that provided in this revenue ruling

must seek the Commissioner's consent to change its method of accounting. A change in method of accounting for those taxes is a change in method of accounting to which §§ 446(e) and 481 apply. This change in method of accounting must be made in accordance with Rev. Proc. 92-20, 1992-1 C.B. 685.

DRAFTING INFORMATION

The principal author of this revenue ruling is Barry M. Freiman of the Office of Assistant Chief Counsel (Income Tax and Accounting). For further information regarding this revenue ruling, contact Mr. Freiman at (202) 622-4950 (not a toll-free call).

Part II. Treaties and Tax Legislation

Subpart B.—Legislation and Related Committee Reports

Public Law 104-191
104th Congress, H.R. 3103¹
August 21, 1996

An Act to amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

* * * * *

TITLE III—TAX-RELATED HEALTH PROVISIONS

SEC. 300. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

Subtitle A—Medical Savings Accounts

SEC. 301. MEDICAL SAVINGS ACCOUNTS.

(a) **IN GENERAL.**—Part VII of subchapter B of chapter 1 (relating to additional itemized deductions for individuals) is amended by redesignating section 220 as section 221 and by inserting after section 219 the following new section:

***SEC. 220. MEDICAL SAVINGS ACCOUNTS.**

“(a) **DEDUCTION ALLOWED.**—In the case of an individual who is an eligible individual for any month during the taxable year, there shall be allowed as a deduction for the taxable year an amount equal to the aggregate amount paid in cash during such taxable year by such individual to a medical savings account of such individual.

“(b) **LIMITATIONS.**—

“(1) **IN GENERAL.**—The amount allowable as a deduction under subsection (a) to an individual for the taxable year shall not exceed the sum of the monthly limitations for months during such taxable year that the individual is an eligible individual.

“(2) **MONTHLY LIMITATION.**—The monthly limitation for any month is the amount equal to $\frac{1}{12}$ of—

“(A) in the case of an individual who has self-only coverage under the high deductible health plan as of the first day of such month, 65 percent of the annual deductible under such coverage, and

“(B) in the case of an individual who has family coverage under the high deductible health plan as of the

¹This publication of the law is restricted to excerpts involving tax matters.

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first day of such month, 75 percent of the annual deductible under such coverage.

"(3) SPECIAL RULE FOR MARRIED INDIVIDUALS.—In the case of individuals who are married to each other, if either spouse has family coverage—

"(A) both spouses shall be treated as having only such family coverage (and if such spouses each have family coverage under different plans, as having the family coverage with the lowest annual deductible), and

"(B) the limitation under paragraph (1) (after the application of subparagraph (A) of this paragraph) shall be divided equally between them unless they agree on a different division.

"(4) DEDUCTION NOT TO EXCEED COMPENSATION.—

"(A) EMPLOYEES.—The deduction allowed under subsection (a) for contributions as an eligible individual described in subclause (I) of subsection (c)(1)(A)(iii) shall not exceed such individual's wages, salaries, tips, and other employee compensation which are attributable to such individual's employment by the employer referred to in such subclause.

"(B) SELF-EMPLOYED INDIVIDUALS.—The deduction allowed under subsection (a) for contributions as an eligible individual described in subclause (II) of subsection (c)(1)(A)(iii) shall not exceed such individual's earned income (as defined in section 401(c)(1)) derived by the taxpayer from the trade or business with respect to which the high deductible health plan is established.

"(C) COMMUNITY PROPERTY LAWS NOT TO APPLY.—The limitations under this paragraph shall be determined without regard to community property laws.

"(5) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—No deduction shall be allowed under this section for any amount paid for any taxable year to a medical savings account of an individual if—

"(A) any amount is contributed to any medical savings account of such individual for such year which is excludable from gross income under section 106(b), or

"(B) if such individual's spouse is covered under the high deductible health plan covering such individual, any amount is contributed for such year to any medical savings account of such spouse which is so excludable.

"(6) DENIAL OF DEDUCTION TO DEPENDENTS.—No deduction shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

"(c) DEFINITIONS.—For purposes of this section—

"(1) ELIGIBLE INDIVIDUAL.—

"(A) IN GENERAL.—The term 'eligible individual' means, with respect to any month, any individual if—

"(i) such individual is covered under a high deductible health plan as of the 1st day of such month,

"(ii) such individual is not, while covered under a high deductible health plan, covered under any health plan—

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“(I) which is not a high deductible health plan,
and

“(II) which provides coverage for any benefit
which is covered under the high deductible health
plan, and

“(iii)(I) the high deductible health plan covering
such individual is established and maintained by
the employer of such individual or of the spouse of
such individual and such employer is a small employer,
or

“(II) such individual is an employee (within the
meaning of section 401(c)(1)) or the spouse of such
an employee and the high deductible health plan cover-
ing such individual is not established or maintained
by any employer of such individual or spouse.

“(B) CERTAIN COVERAGE DISREGARDED.—Subparagraph
(A)(ii) shall be applied without regard to—

“(i) coverage for any benefit provided by permitted
insurance, and

“(ii) coverage (whether through insurance or other-
wise) for accidents, disability, dental care, vision care,
or long-term care.

“(C) CONTINUED ELIGIBILITY OF EMPLOYEE AND SPOUSE
ESTABLISHING MEDICAL SAVINGS ACCOUNTS.—If, while an
employer is a small employer—

“(i) any amount is contributed to a medical savings
account of an individual who is an employee of such
employer or the spouse of such an employee, and

“(ii) such amount is excludable from gross income
under section 106(b) or allowable as a deduction under
this section,

such individual shall not cease to meet the requirement
of subparagraph (A)(iii)(I) by reason of such employer ceas-
ing to be a small employer so long as such employee contin-
ues to be an employee of such employer.

“(D) LIMITATIONS ON ELIGIBILITY.—

“For limitations on number of taxpayers who are eligible to have
medical savings accounts, see subsection (i).

“(2) HIGH DEDUCTIBLE HEALTH PLAN.—

“(A) IN GENERAL.—The term ‘high deductible health
plan’ means a health plan—

“(i) in the case of self-only coverage, which has
an annual deductible which is not less than \$1,500
and not more than \$2,250,

“(ii) in the case of family coverage, which has
an annual deductible which is not less than \$3,000
and not more than \$4,500, and

“(iii) the annual out-of-pocket expenses required
to be paid under the plan (other than for premiums)
for covered benefits does not exceed—

“(I) \$3,000 for self-only coverage, and

“(II) \$5,500 for family coverage.

“(B) SPECIAL RULES.—

“(i) EXCLUSION OF CERTAIN PLANS.—Such term does
not include a health plan if substantially all of its
coverage is coverage described in paragraph (1)(B).

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"(ii) SAFE HARBOR FOR ABSENCE OF PREVENTIVE CARE DEDUCTIBLE.—A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care if the absence of a deductible for such care is required by State law.

"(3) PERMITTED INSURANCE.—The term 'permitted insurance' means—

"(A) Medicare supplemental insurance,

"(B) insurance if substantially all of the coverage provided under such insurance relates to—

"(i) liabilities incurred under workers' compensation laws,

"(ii) tort liabilities,

"(iii) liabilities relating to ownership or use of property, or

"(iv) such other similar liabilities as the Secretary may specify by regulations,

"(C) insurance for a specified disease or illness, and

"(D) insurance paying a fixed amount per day (or other period) of hospitalization.

"(4) SMALL EMPLOYER.—

"(A) IN GENERAL.—The term 'small employer' means, with respect to any calendar year, any employer if such employer employed an average of 50 or fewer employees on business days during either of the 2 preceding calendar years. For purposes of the preceding sentence, a preceding calendar year may be taken into account only if the employer was in existence throughout such year.

"(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the 1st preceding calendar year, the determination under subparagraph (A) shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

"(C) CERTAIN GROWING EMPLOYERS RETAIN TREATMENT AS SMALL EMPLOYER.—The term 'small employer' includes, with respect to any calendar year, any employer if—

"(i) such employer met the requirement of subparagraph (A) (determined without regard to subparagraph (B)) for any preceding calendar year after 1996,

"(ii) any amount was contributed to the medical savings account of any employee of such employer with respect to coverage of such employee under a high deductible health plan of such employer during such preceding calendar year and such amount was excludable from gross income under section 106(b) or allowable as a deduction under this section, and

"(iii) such employer employed an average of 200 or fewer employees on business days during each preceding calendar year after 1996.

"(D) SPECIAL RULES.—

"(i) CONTROLLED GROUPS.—For purposes of this paragraph, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as 1 employer.

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"(ii) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

"(5) FAMILY COVERAGE.—The term 'family coverage' means any coverage other than self-only coverage.

"(d) MEDICAL SAVINGS ACCOUNT.—For purposes of this section—

"(1) MEDICAL SAVINGS ACCOUNT.—The term 'medical savings account' means a trust created or organized in the United States exclusively for the purpose of paying the qualified medical expenses of the account holder, but only if the written governing instrument creating the trust meets the following requirements:

"(A) Except in the case of a rollover contribution described in subsection (f)(5), no contribution will be accepted—

"(i) unless it is in cash, or

"(ii) to the extent such contribution, when added to previous contributions to the trust for the calendar year, exceeds 75 percent of the highest annual limit deductible permitted under subsection (c)(2)(A)(ii) for such calendar year.

"(B) The trustee is a bank (as defined in section 408(n)), an insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

"(C) No part of the trust assets will be invested in life insurance contracts.

"(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

"(E) The interest of an individual in the balance in his account is nonforfeitable.

"(2) QUALIFIED MEDICAL EXPENSES.—

"(A) IN GENERAL.—The term 'qualified medical expenses' means, with respect to an account holder, amounts paid by such holder for medical care (as defined in section 213(d)) for such individual, the spouse of such individual, and any dependent (as defined in section 152) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise.

"(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—

"(i) IN GENERAL.—Subparagraph (A) shall not apply to any payment for insurance.

"(ii) EXCEPTIONS.—Clause (i) shall not apply to any expense for coverage under—

"(I) a health plan during any period of continuation coverage required under any Federal law,

"(II) a qualified long-term care insurance contract (as defined in section 7702B(b)), or

"(III) a health plan during a period in which the individual is receiving unemployment compensation under any Federal or State law.

"(C) MEDICAL EXPENSES OF INDIVIDUALS WHO ARE NOT ELIGIBLE INDIVIDUALS.—Subparagraph (A) shall apply to an amount paid by an account holder for medical care of an individual who is not an eligible individual for the month in which the expense for such care is incurred only if no amount is contributed (other than a rollover contribution) to any medical savings account of such account holder for the taxable year which includes such month. This subparagraph shall not apply to any expense for coverage described in subclause (I) or (III) of subparagraph (B)(ii).

"(3) ACCOUNT HOLDER.—The term 'account holder' means the individual on whose behalf the medical savings account was established.

"(4) CERTAIN RULES TO APPLY.—Rules similar to the following rules shall apply for purposes of this section:

"(A) Section 219(d)(2) (relating to no deduction for rollovers).

"(B) Section 219(f)(3) (relating to time when contributions deemed made).

"(C) Except as provided in section 106(b), section 219(f)(5) (relating to employer payments).

"(D) Section 408(g) (relating to community property laws).

"(E) Section 408(h) (relating to custodial accounts).

"(e) TAX TREATMENT OF ACCOUNTS.—

"(1) IN GENERAL.—A medical savings account is exempt from taxation under this subtitle unless such account has ceased to be a medical savings account. Notwithstanding the preceding sentence, any such account is subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

"(2) ACCOUNT TERMINATIONS.—Rules similar to the rules of paragraphs (2) and (4) of section 408(e) shall apply to medical savings accounts, and any amount treated as distributed under such rules shall be treated as not used to pay qualified medical expenses.

"(f) TAX TREATMENT OF DISTRIBUTIONS.—

"(1) AMOUNTS USED FOR QUALIFIED MEDICAL EXPENSES.—Any amount paid or distributed out of a medical savings account which is used exclusively to pay qualified medical expenses of any account holder shall not be includible in gross income.

"(2) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—Any amount paid or distributed out of a medical savings account which is not used exclusively to pay the qualified medical expenses of the account holder shall be included in the gross income of such holder.

"(3) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—

"(A) IN GENERAL.—If any excess contribution is contributed for a taxable year to any medical savings account of an individual, paragraph (2) shall not apply to distributions from the medical savings accounts of such individual (to the extent such distributions do not exceed the aggregate excess contributions to all such accounts of such individual for such year) if—

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"(i) such distribution is received by the individual on or before the last day prescribed by law (including extensions of time) for filing such individual's return for such taxable year, and

"(ii) such distribution is accompanied by the amount of net income attributable to such excess contribution.

Any net income described in clause (ii) shall be included in the gross income of the individual for the taxable year in which it is received.

"(B) EXCESS CONTRIBUTION.—For purposes of subparagraph (A), the term 'excess contribution' means any contribution (other than a rollover contribution) which is neither excludable from gross income under section 106(b) nor deductible under this section.

"(4) ADDITIONAL TAX ON DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

"(A) IN GENERAL.—The tax imposed by this chapter on the account holder for any taxable year in which there is a payment or distribution from a medical savings account of such holder which is includible in gross income under paragraph (2) shall be increased by 15 percent of the amount which is so includible.

"(B) EXCEPTION FOR DISABILITY OR DEATH.—Subparagraph (A) shall not apply if the payment or distribution is made after the account holder becomes disabled within the meaning of section 72(m)(7) or dies.

"(C) EXCEPTION FOR DISTRIBUTIONS AFTER MEDICARE ELIGIBILITY.—Subparagraph (A) shall not apply to any payment or distribution after the date on which the account holder attains the age specified in section 1811 of the Social Security Act.

"(5) ROLLOVER CONTRIBUTION.—An amount is described in this paragraph as a rollover contribution if it meets the requirements of subparagraphs (A) and (B).

"(A) IN GENERAL.—Paragraph (2) shall not apply to any amount paid or distributed from a medical savings account to the account holder to the extent the amount received is paid into a medical savings account for the benefit of such holder not later than the 60th day after the day on which the holder receives the payment or distribution.

"(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a medical savings account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a medical savings account which was not includible in the individual's gross income because of the application of this paragraph.

"(6) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of determining the amount of the deduction under section 213, any payment or distribution out of a medical savings account for qualified medical expenses shall not be treated as an expense paid for medical care.

"(7) TRANSFER OF ACCOUNT INCIDENT TO DIVORCE.—The transfer of an individual's interest in a medical savings account

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to an individual's spouse or former spouse under a divorce or separation instrument described in subparagraph (A) of section 71(b)(2) shall not be considered a taxable transfer made by such individual notwithstanding any other provision of this subtitle, and such interest shall, after such transfer, be treated as a medical savings account with respect to which such spouse is the account holder.

"(8) TREATMENT AFTER DEATH OF ACCOUNT HOLDER.—

"(A) TREATMENT IF DESIGNATED BENEFICIARY IS SPOUSE.—If the account holder's surviving spouse acquires such holder's interest in a medical savings account by reason of being the designated beneficiary of such account at the death of the account holder, such medical savings account shall be treated as if the spouse were the account holder.

"(B) OTHER CASES.—

"(i) IN GENERAL.—If, by reason of the death of the account holder, any person acquires the account holder's interest in a medical savings account in a case to which subparagraph (A) does not apply—

"(I) such account shall cease to be a medical savings account as of the date of death, and

"(II) an amount equal to the fair market value of the assets in such account on such date shall be includible if such person is not the estate of such holder, in such person's gross income for the taxable year which includes such date, or if such person is the estate of such holder, in such holder's gross income for the last taxable year of such holder.

"(ii) SPECIAL RULES.—

"(I) REDUCTION OF INCLUSION FOR PRE-DEATH EXPENSES.—The amount includible in gross income under clause (i) by any person (other than the estate) shall be reduced by the amount of qualified medical expenses which were incurred by the decedent before the date of the decedent's death and paid by such person within 1 year after such date.

"(II) DEDUCTION FOR ESTATE TAXES.—An appropriate deduction shall be allowed under section 691(c) to any person (other than the decedent or the decedent's spouse) with respect to amounts included in gross income under clause (i) by such person.

"(g) COST-OF-LIVING ADJUSTMENT.—In the case of any taxable year beginning in a calendar year after 1998, each dollar amount in subsection (c)(2) shall be increased by an amount equal to—

"(1) such dollar amount, multiplied by

"(2) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting 'calendar year 1997' for 'calendar year 1992' in subparagraph (B) thereof.

If any increase under the preceding sentence is not a multiple of \$50, such increase shall be rounded to the nearest multiple of \$50.

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"(h) **REPORTS.**—The Secretary may require the trustee of a medical savings account to make such reports regarding such account to the Secretary and to the account holder with respect to contributions, distributions, and such other matters as the Secretary determines appropriate. The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by the Secretary.

"(i) **LIMITATION ON NUMBER OF TAXPAYERS HAVING MEDICAL SAVINGS ACCOUNTS.**—

"(1) **IN GENERAL.**—Except as provided in paragraph (5), no individual shall be treated as an eligible individual for any taxable year beginning after the cut-off year unless—

"(A) such individual was an active MSA participant for any taxable year ending on or before the close of the cut-off year, or

"(B) such individual first became an active MSA participant for a taxable year ending after the cut-off year by reason of coverage under a high deductible health plan of an MSA-participating employer.

"(2) **CUT-OFF YEAR.**—For purposes of paragraph (1), the term 'cut-off year' means the earlier of—

"(A) calendar year 2000, or

"(B) the first calendar year before 2000 for which the Secretary determines under subsection (j) that the numerical limitation for such year has been exceeded.

"(3) **ACTIVE MSA PARTICIPANT.**—For purposes of this subsection—

"(A) **IN GENERAL.**—The term 'active MSA participant' means, with respect to any taxable year, any individual who is the account holder of any medical savings account into which any contribution was made which was excludable from gross income under section 106(b), or allowable as a deduction under this section, for such taxable year.

"(B) **SPECIAL RULE FOR CUT-OFF YEARS BEFORE 2000.**—In the case of a cut-off year before 2000—

"(i) an individual shall not be treated as an eligible individual for any month of such year or an active MSA participant under paragraph (1)(A) unless such individual is, on or before the cut-off date, covered under a high deductible health plan, and

"(ii) an employer shall not be treated as an MSA-participating employer unless the employer, on or before the cut-off date, offered coverage under a high deductible health plan to any employee.

"(C) **CUT-OFF DATE.**—For purposes of subparagraph (B)—

"(i) **IN GENERAL.**—Except as otherwise provided in this subparagraph, the cut-off date is October 1 of the cut-off year.

"(ii) **EMPLOYEES WITH ENROLLMENT PERIODS AFTER OCTOBER 1.**—In the case of an individual described in subclause (I) of subsection (c)(1)(A)(iii), if the regularly scheduled enrollment period for health plans of the individual's employer occurs during the last 3 months of the cut-off year, the cut-off date is December 31 of the cut-off year.

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“(iii) SELF-EMPLOYED INDIVIDUALS.—In the case of an individual described in subclause (II) of subsection (c)(1)(A)(iii), the cut-off date is November 1 of the cut-off year.

“(iv) SPECIAL RULES FOR 1997.—If 1997 is a cut-off year by reason of subsection (j)(1)(A)—

“(I) each of the cut-off dates under clauses (i) and (iii) shall be 1 month earlier than the date determined without regard to this clause, and

“(II) clause (ii) shall be applied by substituting ‘4 months’ for ‘3 months’.

“(4) MSA-PARTICIPATING EMPLOYER.—For purposes of this subsection, the term ‘MSA-participating employer’ means any small employer if—

“(A) such employer made any contribution to the medical savings account of any employee during the cut-off year or any preceding calendar year which was excludable from gross income under section 106(b), or

“(B) at least 20 percent of the employees of such employer who are eligible individuals for any month of the cut-off year by reason of coverage under a high deductible health plan of such employer each made a contribution of at least \$100 to their medical savings accounts for any taxable year ending with or within the cut-off year which was allowable as a deduction under this section.

“(5) ADDITIONAL ELIGIBILITY AFTER CUT-OFF YEAR.—If the Secretary determines under subsection (j)(2)(A) that the numerical limit for the calendar year following a cut-off year described in paragraph (2)(B) has not been exceeded—

“(A) this subsection shall not apply to any otherwise eligible individual who is covered under a high deductible health plan during the first 6 months of the second calendar year following the cut-off year (and such individual shall be treated as an active MSA participant for purposes of this subsection if a contribution is made to any medical savings account with respect to such coverage), and

“(B) any employer who offers coverage under a high deductible health plan to any employee during such 6-month period shall be treated as an MSA-participating employer for purposes of this subsection if the requirements of paragraph (4) are met with respect to such coverage.

For purposes of this paragraph, subsection (j)(2)(A) shall be applied for 1998 by substituting ‘750,000’ for ‘600,000’.

“(j) DETERMINATION OF WHETHER NUMERICAL LIMITS ARE EXCEEDED.—

“(1) DETERMINATION OF WHETHER LIMIT EXCEEDED FOR 1997.—The numerical limitation for 1997 is exceeded if, based on the reports required under paragraph (4), the number of medical savings accounts established as of—

“(A) April 30, 1997, exceeds 375,000, or

“(B) June 30, 1997, exceeds 525,000.

“(2) DETERMINATION OF WHETHER LIMIT EXCEEDED FOR 1998 OR 1999.—

“(A) IN GENERAL.—The numerical limitation for 1998 or 1999 is exceeded if the sum of—

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"(i) the number of MSA returns filed on or before April 15 of such calendar year for taxable years ending with or within the preceding calendar year, plus

"(ii) the Secretary's estimate (determined on the basis of the returns described in clause (i)) of the number of MSA returns for such taxable years which will be filed after such date,

exceeds 600,000 (750,000 in the case of 1999). For purposes of the preceding sentence, the term 'MSA return' means any return on which any exclusion is claimed under section 106(b) or any deduction is claimed under this section.

"(B) ALTERNATIVE COMPUTATION OF LIMITATION.—The numerical limitation for 1998 or 1999 is also exceeded if the sum of—

"(i) 90 percent of the sum determined under subparagraph (A) for such calendar year, plus

"(ii) the product of 2.5 and the number of medical savings accounts established during the portion of such year preceding July 1 (based on the reports required under paragraph (4)) for taxable years beginning in such year,

exceeds 750,000.

"(3) PREVIOUSLY UNINSURED INDIVIDUALS NOT INCLUDED IN DETERMINATION.—

"(A) IN GENERAL.—The determination of whether any calendar year is a cut-off year shall be made by not counting the medical savings account of any previously uninsured individual.

"(B) PREVIOUSLY UNINSURED INDIVIDUAL.—For purposes of this subsection, the term 'previously uninsured individual' means, with respect to any medical savings account, any individual who had no health plan coverage (other than coverage referred to in subsection (c)(1)(B)) at any time during the 6-month period before the date such individual's coverage under the high deductible health plan commences.

"(4) REPORTING BY MSA TRUSTEES.—

"(A) IN GENERAL.—Not later than August 1 of 1997, 1998, and 1999, each person who is the trustee of a medical savings account established before July 1 of such calendar year shall make a report to the Secretary (in such form and manner as the Secretary shall specify) which specifies—

"(i) the number of medical savings accounts established before such July 1 (for taxable years beginning in such calendar year) of which such person is the trustee,

"(ii) the name and TIN of the account holder of each such account, and

"(iii) the number of such accounts which are accounts of previously uninsured individuals.

"(B) ADDITIONAL REPORT FOR 1997.—Not later than June 1, 1997, each person who is the trustee of a medical savings account established before May 1, 1997, shall make an additional report described in subparagraph (A) but only with respect to accounts established before May 1, 1997.

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“(C) PENALTY FOR FAILURE TO FILE REPORT.—The penalty provided in section 6693(a) shall apply to any report required by this paragraph, except that—

“(i) such section shall be applied by substituting ‘\$25’ for ‘\$50’, and

“(ii) the maximum penalty imposed on any trustee shall not exceed \$5,000.

“(D) AGGREGATION OF ACCOUNTS.—To the extent practicable, in determining the number of medical savings accounts on the basis of the reports under this paragraph, all medical savings accounts of an individual shall be treated as 1 account and all accounts of individuals who are married to each other shall be treated as 1 account.

“(5) DATE OF MAKING DETERMINATIONS.—Any determination under this subsection that a calendar year is a cut-off year shall be made by the Secretary and shall be published not later than October 1 of such year.”.

(b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 is amended by inserting after paragraph (15) the following new paragraph:

“(16) MEDICAL SAVINGS ACCOUNTS.—The deduction allowed by section 220.”.

(c) EXCLUSIONS FOR EMPLOYER CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

(1) EXCLUSION FROM INCOME TAX.—The text of section 106 (relating to contributions by employer to accident and health plans) is amended to read as follows:

“(a) GENERAL RULE.—Except as otherwise provided in this section, gross income of an employee does not include employer-provided coverage under an accident or health plan.

“(b) CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

“(1) IN GENERAL.—In the case of an employee who is an eligible individual, amounts contributed by such employee's employer to any medical savings account of such employee shall be treated as employer-provided coverage for medical expenses under an accident or health plan to the extent such amounts do not exceed the limitation under section 220(b)(1) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

“(2) NO CONSTRUCTIVE RECEIPT.—No amount shall be included in the gross income of any employee solely because the employee may choose between the contributions referred to in paragraph (1) and employer contributions to another health plan of the employer.

“(3) SPECIAL RULE FOR DEDUCTION OF EMPLOYER CONTRIBUTIONS.—Any employer contribution to a medical savings account, if otherwise allowable as a deduction under this chapter, shall be allowed only for the taxable year in which paid.

“(4) EMPLOYER MSA CONTRIBUTIONS REQUIRED TO BE SHOWN ON RETURN.—Every individual required to file a return under section 6012 for the taxable year shall include on such return the aggregate amount contributed by employers to the medical savings accounts of such individual or such individual's spouse for such taxable year.

“(5) MSA CONTRIBUTIONS NOT PART OF COBRA COVERAGE.—Paragraph (1) shall not apply for purposes of section 4980B.

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"(6) DEFINITIONS.—For purposes of this subsection, the terms 'eligible individual' and 'medical savings account' have the respective meanings given to such terms by section 220.

"(7) CROSS REFERENCE.—

"For penalty on failure by employer to make comparable contributions to the medical savings accounts of comparable employees, see section 4980E."

(2) EXCLUSION FROM EMPLOYMENT TAXES.—

(A) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 is amended by adding at the end the following new paragraph:

"(10) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS.—The term 'compensation' shall not include any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b)."

(B) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 is amended by striking "or" at the end of paragraph (15), by striking the period at the end of paragraph (16) and inserting "; or", and by inserting after paragraph (16) the following new paragraph:

"(17) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b)."

(C) WITHHOLDING TAX.—Subsection (a) of section 3401 is amended by striking "or" at the end of paragraph (19), by striking the period at the end of paragraph (20) and inserting "; or", and by inserting after paragraph (20) the following new paragraph:

"(21) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b)."

(3) EMPLOYER CONTRIBUTIONS REQUIRED TO BE SHOWN ON W-2.—Subsection (a) of section 6051 is amended by striking "and" at the end of paragraph (9), by striking the period at the end of paragraph (10) and inserting ", and", and by inserting after paragraph (10) the following new paragraph:

"(11) the amount contributed to any medical savings account (as defined in section 220(d)) of such employee or such employee's spouse."

(4) PENALTY FOR FAILURE OF EMPLOYER TO MAKE COMPARABLE MSA CONTRIBUTIONS.—

(A) IN GENERAL.—Chapter 43 is amended by adding after section 4980D the following new section:

***SEC. 4980E. FAILURE OF EMPLOYER TO MAKE COMPARABLE MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS.**

"(a) GENERAL RULE.—In the case of an employer who makes a contribution to the medical savings account of any employee with respect to coverage under a high deductible health plan of the employer during a calendar year, there is hereby imposed a tax on the failure of such employer to meet the requirements of subsection (d) for such calendar year.

"(b) AMOUNT OF TAX.—The amount of the tax imposed by subsection (a) on any failure for any calendar year is the amount

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equal to 35 percent of the aggregate amount contributed by the employer to medical savings accounts of employees for taxable years of such employees ending with or within such calendar year.

“(c) **WAIVER BY SECRETARY.**—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that the payment of such tax would be excessive relative to the failure involved.

“(d) **EMPLOYER REQUIRED TO MAKE COMPARABLE MSA CONTRIBUTIONS FOR ALL PARTICIPATING EMPLOYEES.**—

“(1) **IN GENERAL.**—An employer meets the requirements of this subsection for any calendar year if the employer makes available comparable contributions to the medical savings accounts of all comparable participating employees for each coverage period during such calendar year.

“(2) **COMPARABLE CONTRIBUTIONS.**—

“(A) **IN GENERAL.**—For purposes of paragraph (1), the term ‘comparable contributions’ means contributions—

“(i) which are the same amount, or

“(ii) which are the same percentage of the annual deductible limit under the high deductible health plan covering the employees.

“(B) **PART-YEAR EMPLOYEES.**—In the case of an employee who is employed by the employer for only a portion of the calendar year, a contribution to the medical savings account of such employee shall be treated as comparable if it is an amount which bears the same ratio to the comparable amount (determined without regard to this subparagraph) as such portion bears to the entire calendar year.

“(3) **COMPARABLE PARTICIPATING EMPLOYEES.**—For purposes of paragraph (1), the term ‘comparable participating employees’ means all employees—

“(A) who are eligible individuals covered under any high deductible health plan of the employer, and

“(B) who have the same category of coverage.

For purposes of subparagraph (B), the categories of coverage are self-only and family coverage.

“(4) **PART-TIME EMPLOYEES.**—

“(A) **IN GENERAL.**—Paragraph (3) shall be applied separately with respect to part-time employees and other employees.

“(B) **PART-TIME EMPLOYEE.**—For purposes of subparagraph (A), the term ‘part-time employee’ means any employee who is customarily employed for fewer than 30 hours per week.

“(e) **CONTROLLED GROUPS.**—For purposes of this section, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as 1 employer.

“(f) **DEFINITIONS.**—Terms used in this section which are also used in section 220 have the respective meanings given such terms in section 220.”

(B) **CLERICAL AMENDMENT.**—The table of sections for chapter 43 is amended by adding after the item relating to section 4980D the following new item:

“Sec. 4980E. Failure of employer to make comparable medical savings account contributions.”

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(d) **MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS NOT AVAILABLE UNDER CAFETERIA PLANS.**—Subsection (f) of section 125 of such Code is amended by inserting “106(b),” before “117”.

(e) **TAX ON EXCESS CONTRIBUTIONS.**—Section 4973 (relating to tax on excess contributions to individual retirement accounts, certain section 403(b) contracts, and certain individual retirement annuities) is amended—

(1) by inserting “MEDICAL SAVINGS ACCOUNTS,” after “ACCOUNTS,” in the heading of such section,

(2) by striking “or” at the end of paragraph (1) of subsection (a),

(3) by redesignating paragraph (2) of subsection (a) as paragraph (3) and by inserting after paragraph (1) the following:

“(2) a medical savings account (within the meaning of section 220(d)), or”, and

(4) by adding at the end the following new subsection:

“(d) **EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.**—For purposes of this section, in the case of medical savings accounts (within the meaning of section 220(d)), the term ‘excess contributions’ means the sum of—

“(1) the aggregate amount contributed for the taxable year to the accounts (other than rollover contributions described in section 220(f)(5)) which is neither excludable from gross income under section 106(b) nor allowable as a deduction under section 220 for such year, and

“(2) the amount determined under this subsection for the preceding taxable year, reduced by the sum of—

“(A) the distributions out of the accounts which were included in gross income under section 220(f)(2), and

“(B) the excess (if any) of—

“(i) the maximum amount allowable as a deduction under section 220(b)(1) (determined without regard to section 106(b)) for the taxable year, over

“(ii) the amount contributed to the accounts for the taxable year.

For purposes of this subsection, any contribution which is distributed out of the medical savings account in a distribution to which section 220(f)(3) applies shall be treated as an amount not contributed.”

(f) **TAX ON PROHIBITED TRANSACTIONS.**—

(1) Section 4975 (relating to tax on prohibited transactions) is amended by adding at the end of subsection (c) the following new paragraph:

“(4) **SPECIAL RULE FOR MEDICAL SAVINGS ACCOUNTS.**—An individual for whose benefit a medical savings account (within the meaning of section 220(d)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a medical savings account by reason of the application of section 220(e)(2) to such account.”

(2) Paragraph (1) of section 4975(e) is amended to read as follows:

“(1) **PLAN.**—For purposes of this section, the term ‘plan’ means—

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"(A) a trust described in section 401(a) which forms a part of a plan, or a plan described in section 403(a), which trust or plan is exempt from tax under section 501(a),

"(B) an individual retirement account described in section 408(a),

"(C) an individual retirement annuity described in section 408(b),

"(D) a medical savings account described in section 220(d), or

"(E) a trust, plan, account, or annuity which, at any time, has been determined by the Secretary to be described in any preceding subparagraph of this paragraph."

(g) FAILURE TO PROVIDE REPORTS ON MEDICAL SAVINGS ACCOUNTS.—

(1) Subsection (a) of section 6693 (relating to failure to provide reports on individual retirement accounts or annuities) is amended to read as follows:

"(a) REPORTS.—

"(1) IN GENERAL.—If a person required to file a report under a provision referred to in paragraph (2) fails to file such report at the time and in the manner required by such provision, such person shall pay a penalty of \$50 for each failure unless it is shown that such failure is due to reasonable cause.

"(2) PROVISIONS.—The provisions referred to in this paragraph are—

"(A) subsections (i) and (l) of section 408 (relating to individual retirement plans), and

"(B) section 220(h) (relating to medical savings accounts)."

(h) EXCEPTION FROM CAPITALIZATION OF POLICY ACQUISITION EXPENSES.—Subparagraph (B) of section 848(e)(1) (defining specified insurance contract) is amended by striking "and" at the end of clause (ii), by striking the period at the end of clause (iii) and inserting ", and", and by adding at the end the following new clause:

"(iv) any contract which is a medical savings account (as defined in section 220(d))."

(i) CLERICAL AMENDMENT.—The table of sections for part VII of subchapter B of chapter 1 is amended by striking the last item and inserting the following:

"Sec. 220. Medical savings accounts.

"Sec. 221. Cross reference."

26 USC 62 note.

(j) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1996.

26 USC 220 note.

(k) MONITORING OF PARTICIPATION IN MEDICAL SAVINGS ACCOUNTS.—The Secretary of the Treasury or his delegate shall—

(1) during 1997, 1998, 1999, and 2000, regularly evaluate the number of individuals who are maintaining medical savings accounts and the reduction in revenues to the United States by reason of such accounts, and

(2) provide such reports of such evaluations to Congress as such Secretary determines appropriate.

26 USC 220 note.

(l) STUDY OF EFFECTS OF MEDICAL SAVINGS ACCOUNTS ON SMALL GROUP MARKET.—The Comptroller General of the United States shall enter into a contract with an organization with expertise in health economics, health insurance markets, and actuarial

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science to conduct a comprehensive study regarding the effects of medical savings accounts in the small group market on—

- (1) selection, including adverse selection,
- (2) health costs, including any impact on premiums of individuals with comprehensive coverage,
- (3) use of preventive care,
- (4) consumer choice,
- (5) the scope of coverage of high deductible plans purchased in conjunction with such accounts, and
- (6) other relevant items.

A report on the results of the study conducted under this subsection shall be submitted to the Congress no later than January 1, 1999. Reports.

Subtitle B—Increase in Deduction for Health Insurance Costs of Self-Employed Individuals

SEC. 311. INCREASE IN DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Paragraph (1) of section 162(l) is amended to read as follows:

“(1) ALLOWANCE OF DEDUCTION.—

“(A) IN GENERAL.—In the case of an individual who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to the applicable percentage of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents.

“(B) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the applicable percentage shall be determined under the following table:

“For taxable years beginning in calendar year—	The applicable percentage is—
1997	40 percent
1998 through 2002	45 percent
2003	50 percent
2004	60 percent
2005	70 percent
2006 or thereafter	80 percent.”.

(b) EXCLUSION FOR AMOUNTS RECEIVED UNDER CERTAIN SELF-INSURED PLANS.—Paragraph (3) of section 104(a) is amended by inserting “(or through an arrangement having the effect of accident or health insurance)” after “health insurance”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1996. 26 USC 104 note.

Subtitle C—Long-Term Care Services and Contracts

PART I—GENERAL PROVISIONS

SEC. 321. TREATMENT OF LONG-TERM CARE INSURANCE.

(a) GENERAL RULE.—Chapter 79 (relating to definitions) is amended by inserting after section 7702A the following new section:

“SEC. 7702B. TREATMENT OF QUALIFIED LONG-TERM CARE INSURANCE.

“(a) IN GENERAL.—For purposes of this title—

“(1) a qualified long-term care insurance contract shall be treated as an accident and health insurance contract,

“(2) amounts (other than policyholder dividends, as defined in section 808, or premium refunds) received under a qualified long-term care insurance contract shall be treated as amounts received for personal injuries and sickness and shall be treated as reimbursement for expenses actually incurred for medical care (as defined in section 213(d)),

“(3) any plan of an employer providing coverage under a qualified long-term care insurance contract shall be treated as an accident and health plan with respect to such coverage,

“(4) except as provided in subsection (e)(3), amounts paid for a qualified long-term care insurance contract providing the benefits described in subsection (b)(2)(A) shall be treated as payments made for insurance for purposes of section 213(d)(1)(D), and

“(5) a qualified long-term care insurance contract shall be treated as a guaranteed renewable contract subject to the rules of section 816(e).

“(b) QUALIFIED LONG-TERM CARE INSURANCE CONTRACT.—For purposes of this title—

“(1) IN GENERAL.—The term ‘qualified long-term care insurance contract’ means any insurance contract if—

“(A) the only insurance protection provided under such contract is coverage of qualified long-term care services,

“(B) such contract does not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount,

“(C) such contract is guaranteed renewable,

“(D) such contract does not provide for a cash surrender value or other money that can be—

“(i) paid, assigned, or pledged as collateral for a loan, or

“(ii) borrowed,

other than as provided in subparagraph (E) or paragraph (2)(C),

“(E) all refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits, and

“(F) such contract meets the requirements of subsection (g).

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“(2) SPECIAL RULES.—

“(A) PER DIEM, ETC. PAYMENTS PERMITTED.—A contract shall not fail to be described in subparagraph (A) or (B) of paragraph (1) by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

“(B) SPECIAL RULES RELATING TO MEDICARE.—

“(i) Paragraph (1)(B) shall not apply to expenses which are reimbursable under title XVIII of the Social Security Act only as a secondary payor.

“(ii) No provision of law shall be construed or applied so as to prohibit the offering of a qualified long-term care insurance contract on the basis that the contract coordinates its benefits with those provided under such title.

“(C) REFUNDS OF PREMIUMS.—Paragraph (1)(E) shall not apply to any refund on the death of the insured, or on a complete surrender or cancellation of the contract, which cannot exceed the aggregate premiums paid under the contract. Any refund on a complete surrender or cancellation of the contract shall be includible in gross income to the extent that any deduction or exclusion was allowable with respect to the premiums.

“(c) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

“(1) IN GENERAL.—The term ‘qualified long-term care services’ means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which—

“(A) are required by a chronically ill individual, and

“(B) are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

“(2) CHRONICALLY ILL INDIVIDUAL.—

“(A) IN GENERAL.—The term ‘chronically ill individual’ means any individual who has been certified by a licensed health care practitioner as—

“(i) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity,

“(ii) having a level of disability similar (as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in clause (i), or

“(iii) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the preceding 12-month period a licensed health care practitioner has certified that such individual meets such requirements.

“(B) ACTIVITIES OF DAILY LIVING.—For purposes of subparagraph (A), each of the following is an activity of daily living:

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- “(i) Eating.
- “(ii) Toileting.
- “(iii) Transferring.
- “(iv) Bathing.
- “(v) Dressing.
- “(vi) Continence.

A contract shall not be treated as a qualified long-term care insurance contract unless the determination of whether an individual is a chronically ill individual takes into account at least 5 of such activities.

“(3) MAINTENANCE OR PERSONAL CARE SERVICES.—The term ‘maintenance or personal care services’ means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

“(4) LICENSED HEALTH CARE PRACTITIONER.—The term ‘licensed health care practitioner’ means any physician (as defined in section 1861(r)(1) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.

“(d) AGGREGATE PAYMENTS IN EXCESS OF LIMITS.—

“(1) IN GENERAL.—If the aggregate of—

“(A) the periodic payments received for any period under all qualified long-term care insurance contracts which are treated as made for qualified long-term care services for an insured, and

“(B) the periodic payments received for such period which are treated under section 101(g) as paid by reason of the death of such insured,

exceeds the per diem limitation for such period, such excess shall be includible in gross income without regard to section 72. A payment shall not be taken into account under subparagraph (B) if the insured is a terminally ill individual (as defined in section 101(g)) at the time the payment is received.

“(2) PER DIEM LIMITATION.—For purposes of paragraph (1), the per diem limitation for any period is an amount equal to the excess (if any) of—

“(A) the greater of—

“(i) the dollar amount in effect for such period under paragraph (4), or

“(ii) the costs incurred for qualified long-term care services provided for the insured for such period, over

“(B) the aggregate payments received as reimbursements (through insurance or otherwise) for qualified long-term care services provided for the insured during such period.

“(3) AGGREGATION RULES.—For purposes of this subsection—

“(A) all persons receiving periodic payments described in paragraph (1) with respect to the same insured shall be treated as 1 person, and

“(B) the per diem limitation determined under paragraph (2) shall be allocated first to the insured and any remaining limitation shall be allocated among the other

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such persons in such manner as the Secretary shall prescribe.

"(4) DOLLAR AMOUNT.—The dollar amount in effect under this subsection shall be \$175 per day (or the equivalent amount in the case of payments on another periodic basis).

"(5) INFLATION ADJUSTMENT.—In the case of a calendar year after 1997, the dollar amount contained in paragraph (4) shall be increased at the same time and in the same manner as amounts are increased pursuant to section 213(d)(10).

"(6) PERIODIC PAYMENTS.—For purposes of this subsection, the term 'periodic payment' means any payment (whether on a periodic basis or otherwise) made without regard to the extent of the costs incurred by the payee for qualified long-term care services.

"(e) TREATMENT OF COVERAGE PROVIDED AS PART OF A LIFE INSURANCE CONTRACT.—Except as otherwise provided in regulations prescribed by the Secretary, in the case of any long-term care insurance coverage (whether or not qualified) provided by a rider on or as part of a life insurance contract—

"(1) IN GENERAL.—This section shall apply as if the portion of the contract providing such coverage is a separate contract.

"(2) APPLICATION OF 7702.—Section 7702(c)(2) (relating to the guideline premium limitation) shall be applied by increasing the guideline premium limitation with respect to a life insurance contract, as of any date—

"(A) by the sum of any charges (but not premium payments) against the life insurance contract's cash surrender value (within the meaning of section 7702(f)(2)(A)) for such coverage made to that date under the contract, less

"(B) any such charges the imposition of which reduces the premiums paid for the contract (within the meaning of section 7702(f)(1)).

"(3) APPLICATION OF SECTION 213.—No deduction shall be allowed under section 213(a) for charges against the life insurance contract's cash surrender value described in paragraph (2), unless such charges are includible in income as a result of the application of section 72(e)(10) and the rider is a qualified long-term care insurance contract under subsection (b).

"(4) PORTION DEFINED.—For purposes of this subsection, the term 'portion' means only the terms and benefits under a life insurance contract that are in addition to the terms and benefits under the contract without regard to long-term care insurance coverage.

"(f) TREATMENT OF CERTAIN STATE-MAINTAINED PLANS.—

"(1) IN GENERAL.—If—

"(A) an individual receives coverage for qualified long-term care services under a State long-term care plan, and

"(B) the terms of such plan would satisfy the requirements of subsection (b) were such plan an insurance contract,

such plan shall be treated as a qualified long-term care insurance contract for purposes of this title.

"(2) STATE LONG-TERM CARE PLAN.—For purposes of paragraph (1), the term 'State long-term care plan' means any plan—

"(A) which is established and maintained by a State or an instrumentality of a State,

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"(B) which provides coverage only for qualified long-term care services, and

"(C) under which such coverage is provided only to—

"(i) employees and former employees of a State (or any political subdivision or instrumentality of a State),

"(ii) the spouses of such employees, and

"(iii) individuals bearing a relationship to such employees or spouses which is described in any of paragraphs (1) through (8) of section 152(a)."

(b) RESERVE METHOD.—Clause (iii) of section 807(d)(3)(A) is amended by inserting "(other than a qualified long-term care insurance contract, as defined in section 7702B(b))" after "insurance contract".

(c) LONG-TERM CARE INSURANCE NOT PERMITTED UNDER CAFETERIA PLANS OR FLEXIBLE SPENDING ARRANGEMENTS.—

(1) CAFETERIA PLANS.—Section 125(f) is amended by adding at the end the following new sentence: "Such term shall not include any product which is advertised, marketed, or offered as long-term care insurance."

(2) FLEXIBLE SPENDING ARRANGEMENTS.—Section 106 (relating to contributions by employer to accident and health plans), as amended by section 301(c), is amended by adding at the end the following new subsection:

"(c) INCLUSION OF LONG-TERM CARE BENEFITS PROVIDED THROUGH FLEXIBLE SPENDING ARRANGEMENTS.—

"(1) IN GENERAL.—Effective on and after January 1, 1997, gross income of an employee shall include employer-provided coverage for qualified long-term care services (as defined in section 7702B(c)) to the extent that such coverage is provided through a flexible spending or similar arrangement.

"(2) FLEXIBLE SPENDING ARRANGEMENT.—For purposes of this subsection, a flexible spending arrangement is a benefit program which provides employees with coverage under which—

"(A) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and

"(B) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage. In the case of an insured plan, the maximum amount reasonably available shall be determined on the basis of the underlying coverage."

(d) CONTINUATION COVERAGE RULES NOT TO APPLY.—

(1) Paragraph (2) of section 4980B(g) is amended by adding at the end the following new sentence: "Such term shall not include any plan substantially all of the coverage under which is for qualified long-term care services (as defined in section 7702B(c))."

* * * * *

(e) CLERICAL AMENDMENT.—The table of sections for chapter 79 is amended by inserting after the item relating to section 7702A the following new item:

"Sec. 7702B. Treatment of qualified long-term care insurance."

(f) EFFECTIVE DATES.—

26 USC 1702B
note.

(1) GENERAL EFFECTIVE DATE.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this section shall apply to contracts issued after December 31, 1996.

(B) RESERVE METHOD.—The amendment made by subsection (b) shall apply to contracts issued after December 31, 1997.

(2) CONTINUATION OF EXISTING POLICIES.—In the case of any contract issued before January 1, 1997, which met the long-term care insurance requirements of the State in which the contract was situated at the time the contract was issued—

(A) such contract shall be treated for purposes of the Internal Revenue Code of 1986 as a qualified long-term care insurance contract (as defined in section 7702B(b) of such Code), and

(B) services provided under, or reimbursed by, such contract shall be treated for such purposes as qualified long-term care services (as defined in section 7702B(c) of such Code).

In the case of an individual who is covered on December 31, 1996, under a State long-term care plan (as defined in section 7702B(f)(2) of such Code), the terms of such plan on such date shall be treated for purposes of the preceding sentence as a contract issued on such date which met the long-term care insurance requirements of such State.

(3) EXCHANGES OF EXISTING POLICIES.—If, after the date of enactment of this Act and before January 1, 1998, a contract providing for long-term care insurance coverage is exchanged solely for a qualified long-term care insurance contract (as defined in section 7702B(b) of such Code), no gain or loss shall be recognized on the exchange. If, in addition to a qualified long-term care insurance contract, money or other property is received in the exchange, then any gain shall be recognized to the extent of the sum of the money and the fair market value of the other property received. For purposes of this paragraph, the cancellation of a contract providing for long-term care insurance coverage and reinvestment of the cancellation proceeds in a qualified long-term care insurance contract within 60 days thereafter shall be treated as an exchange.

(4) ISSUANCE OF CERTAIN RIDERS PERMITTED.—For purposes of applying sections 101(f), 7702, and 7702A of the Internal Revenue Code of 1986 to any contract—

(A) the issuance of a rider which is treated as a qualified long-term care insurance contract under section 7702B, and

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(B) the addition of any provision required to conform any other long-term care rider to be so treated, shall not be treated as a modification or material change of such contract.

(5) APPLICATION OF PER DIEM LIMITATION TO EXISTING CONTRACTS.—The amount of per diem payments made under a contract issued on or before July 31, 1996, with respect to an insured which are excludable from gross income by reason of section 7702B of the Internal Revenue Code of 1986 (as added by this section) shall not be reduced under subsection (d)(2)(B) thereof by reason of reimbursements received under a contract issued on or before such date. The preceding sentence shall cease to apply as of the date (after July 31, 1996) such contract is exchanged or there is any contract modification which results in an increase in the amount of such per diem payments or the amount of such reimbursements.

26 USC 7702B
note.

Reports.

(g) LONG-TERM CARE STUDY REQUEST.—The Chairman of the Committee on Ways and Means of the House of Representatives and the Chairman of the Committee on Finance of the Senate shall jointly request the National Association of Insurance Commissioners, in consultation with representatives of the insurance industry and consumer organizations, to formulate, develop, and conduct a study to determine the marketing and other effects of per diem limits on certain types of long-term care policies. If the National Association of Insurance Commissioners agrees to the study request, the National Association of Insurance Commissioners shall report the results of its study to such committees not later than 2 years after accepting the request.

SEC. 322. QUALIFIED LONG-TERM CARE SERVICES TREATED AS MEDICAL CARE.

(a) GENERAL RULE.—Paragraph (1) of section 213(d) (defining medical care) is amended by striking “or” at the end of subparagraph (B), by redesignating subparagraph (C) as subparagraph (D), and by inserting after subparagraph (B) the following new subparagraph:

“(C) for qualified long-term care services (as defined in section 7702B(c)), or”.

(b) TECHNICAL AMENDMENTS.—

(1) Subparagraph (D) of section 213(d)(1) (as redesignated by subsection (a)) is amended by inserting before the period “or for any qualified long-term care insurance contract (as defined in section 7702B(b))”.

(2)(A) Paragraph (1) of section 213(d) is amended by adding at the end the following new flush sentence:

“In the case of a qualified long-term care insurance contract (as defined in section 7702B(b)), only eligible long-term care premiums (as defined in paragraph (10)) shall be taken into account under subparagraph (D).”

(B) Paragraph (2) of section 162(l) is amended by adding at the end the following new subparagraph:

“(C) LONG-TERM CARE PREMIUMS.—In the case of a qualified long-term care insurance contract (as defined in section 7702B(b)), only eligible long-term care premiums (as defined in section 213(d)(10)) shall be taken into account under paragraph (1).”

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(C) Subsection (d) of section 213 is amended by adding at the end the following new paragraphs:

“(10) ELIGIBLE LONG-TERM CARE PREMIUMS.—

“(A) IN GENERAL.—For purposes of this section, the term ‘eligible long-term care premiums’ means the amount paid during a taxable year for any qualified long-term care insurance contract (as defined in section 7702B(b)) covering an individual, to the extent such amount does not exceed the limitation determined under the following table:

In the case of an individual with an attained age before the close of the taxable year of:	The limitation is:
40 or less	\$ 200
More than 40 but not more than 50	375
More than 50 but not more than 60	750
More than 60 but not more than 70	2,000
More than 70	2,500

“(B) INDEXING.—

“(i) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1997, each dollar amount contained in subparagraph (A) shall be increased by the medical care cost adjustment of such amount for such calendar year. If any increase determined under the preceding sentence is not a multiple of \$10, such increase shall be rounded to the nearest multiple of \$10.

“(ii) MEDICAL CARE COST ADJUSTMENT.—For purposes of clause (i), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

“(I) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

“(II) such component for August of 1996.

The Secretary shall, in consultation with the Secretary of Health and Human Services, prescribe an adjustment which the Secretary determines is more appropriate for purposes of this paragraph than the adjustment described in the preceding sentence, and the adjustment so prescribed shall apply in lieu of the adjustment described in the preceding sentence.

“(11) CERTAIN PAYMENTS TO RELATIVES TREATED AS NOT PAID FOR MEDICAL CARE.—An amount paid for a qualified long-term care service (as defined in section 7702B(c)) provided to an individual shall be treated as not paid for medical care if such service is provided—

“(A) by the spouse of the individual or by a relative (directly or through a partnership, corporation, or other entity) unless the service is provided by a licensed professional with respect to such service, or

“(B) by a corporation or partnership which is related (within the meaning of section 267(b) or 707(b)) to the individual.

For purposes of this paragraph, the term ‘relative’ means an individual bearing a relationship to the individual which is described in any of paragraphs (1) through (8) of section 152(a).

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This paragraph shall not apply for purposes of section 105(b) with respect to reimbursements through insurance.”

(3) Paragraph (6) of section 213(d) is amended—

(A) by striking “subparagraphs (A) and (B)” and inserting “subparagraphs (A), (B), and (C)”, and

(B) by striking “paragraph (1)(C)” in subparagraph (A) and inserting “paragraph (1)(D)”.

(4) Paragraph (7) of section 213(d) is amended by striking “subparagraphs (A) and (B)” and inserting “subparagraphs (A), (B), and (C)”.

26 USC 162 note.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1996.

SEC. 323. REPORTING REQUIREMENTS.

(a) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 is amended by adding at the end the following new section:

“SEC. 6050Q. CERTAIN LONG-TERM CARE BENEFITS.

“(a) REQUIREMENT OF REPORTING.—Any person who pays long-term care benefits shall make a return, according to the forms or regulations prescribed by the Secretary, setting forth—

“(1) the aggregate amount of such benefits paid by such person to any individual during any calendar year,

“(2) whether or not such benefits are paid in whole or in part on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate,

“(3) the name, address, and TIN of such individual, and

“(4) the name, address, and TIN of the chronically ill or terminally ill individual on account of whose condition such benefits are paid.

“(b) STATEMENTS TO BE FURNISHED TO PERSONS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

“(1) the name of the person making the payments, and

“(2) the aggregate amount of long-term care benefits paid to the individual which are required to be shown on such return.

The written statement required under the preceding sentence shall be furnished to the individual on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

“(c) LONG-TERM CARE BENEFITS.—For purposes of this section, the term ‘long-term care benefit’ means—

“(1) any payment under a product which is advertised, marketed, or offered as long-term care insurance, and

“(2) any payment which is excludable from gross income by reason of section 101(g).”.

(b) PENALTIES.—

(1) Subparagraph (B) of section 6724(d)(1) is amended by redesignating clauses (ix) through (xiv) as clauses (x) through (xv), respectively, and by inserting after clause (viii) the following new clause:

“(ix) section 6050Q (relating to certain long-term care benefits).”.

(2) Paragraph (2) of section 6724(d) is amended by redesignating subparagraphs (Q) through (T) as subparagraphs (R) through (U), respectively, and by inserting after subparagraph (P) the following new subparagraph:

“(Q) section 6050Q(b) (relating to certain long-term care benefits).”

(c) CLERICAL AMENDMENT.—The table of sections for subpart B of part III of subchapter A of chapter 61 is amended by adding at the end the following new item:

“Sec. 6050Q. Certain long-term care benefits.”

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to benefits paid after December 31, 1996.

26 USC 6050Q
note.

PART II—CONSUMER PROTECTION PROVISIONS

SEC. 325. POLICY REQUIREMENTS.

Section 7702B (as added by section 321) is amended by adding at the end the following new subsection:

“(g) CONSUMER PROTECTION PROVISIONS.—

“(1) IN GENERAL.—The requirements of this subsection are met with respect to any contract if the contract meets—

“(A) the requirements of the model regulation and model Act described in paragraph (2),

“(B) the disclosure requirement of paragraph (3), and

“(C) the requirements relating to nonforfeitability under paragraph (4).

“(2) REQUIREMENTS OF MODEL REGULATION AND ACT.—

“(A) IN GENERAL.—The requirements of this paragraph are met with respect to any contract if such contract meets—

“(i) MODEL REGULATION.—The following requirements of the model regulation:

“(I) Section 7A (relating to guaranteed renewal or noncancellability), and the requirements of section 6B of the model Act relating to such section 7A.

“(II) Section 7B (relating to prohibitions on limitations and exclusions).

“(III) Section 7C (relating to extension of benefits).

“(IV) Section 7D (relating to continuation or conversion of coverage).

“(V) Section 7E (relating to discontinuance and replacement of policies).

“(VI) Section 8 (relating to unintentional lapse).

“(VII) Section 9 (relating to disclosure), other than section 9F thereof.

“(VIII) Section 10 (relating to prohibitions against post-claims underwriting).

“(IX) Section 11 (relating to minimum standards).

“(X) Section 12 (relating to requirement to offer inflation protection), except that any requirement for a signature on a rejection of inflation

protection shall permit the signature to be on an application or on a separate form.

"(XI) Section 23 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

"(ii) MODEL ACT.—The following requirements of the model Act:

"(I) Section 6C (relating to preexisting conditions).

"(II) Section 6D (relating to prior hospitalization).

"(B) DEFINITIONS.—For purposes of this paragraph—

"(i) MODEL PROVISIONS.—The terms 'model regulation' and 'model Act' mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of January 1993).

"(ii) COORDINATION.—Any provision of the model regulation or model Act listed under clause (i) or (ii) of subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision.

"(iii) DETERMINATION.—For purposes of this section and section 4980C, the determination of whether any requirement of a model regulation or the model Act has been met shall be made by the Secretary.

"(3) DISCLOSURE REQUIREMENT.—The requirement of this paragraph is met with respect to any contract if such contract meets the requirements of section 4980C(d).

"(4) NONFORFEITURE REQUIREMENTS.—

"(A) IN GENERAL.—The requirements of this paragraph are met with respect to any level premium contract, if the issuer of such contract offers to the policyholder, including any group policyholder, a nonforfeiture provision meeting the requirements of subparagraph (B).

"(B) REQUIREMENTS OF PROVISION.—The nonforfeiture provision required under subparagraph (A) shall meet the following requirements:

"(i) The nonforfeiture provision shall be appropriately captioned.

"(ii) The nonforfeiture provision shall provide for a benefit available in the event of a default in the payment of any premiums and the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the Secretary for the same contract form.

"(iii) The nonforfeiture provision shall provide at least one of the following:

"(I) Reduced paid-up insurance.

"(II) Extended term insurance.

"(III) Shortened benefit period.

"(IV) Other similar offerings approved by the Secretary.

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"(5) CROSS REFERENCE.—

"For coordination of the requirements of this subsection with State requirements, see section 4980C(f)."

SEC. 326. REQUIREMENTS FOR ISSUERS OF QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

(a) IN GENERAL.—Chapter 43 is amended by adding at the end the following new section:

"SEC. 4980C. REQUIREMENTS FOR ISSUERS OF QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

"(a) GENERAL RULE.—There is hereby imposed on any person failing to meet the requirements of subsection (c) or (d) a tax in the amount determined under subsection (b).

"(b) AMOUNT.—

"(1) IN GENERAL.—The amount of the tax imposed by subsection (a) shall be \$100 per insured for each day any requirement of subsection (c) or (d) is not met with respect to each qualified long-term care insurance contract.

"(2) WAIVER.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that payment of the tax would be excessive relative to the failure involved.

"(c) RESPONSIBILITIES.—The requirements of this subsection are as follows:

"(1) REQUIREMENTS OF MODEL PROVISIONS.—

"(A) MODEL REGULATION.—The following requirements of the model regulation must be met:

"(i) Section 13 (relating to application forms and replacement coverage).

"(ii) Section 14 (relating to reporting requirements), except that the issuer shall also report at least annually the number of claims denied during the reporting period for each class of business (expressed as a percentage of claims denied), other than claims denied for failure to meet the waiting period or because of any applicable preexisting condition.

"(iii) Section 20 (relating to filing requirements for marketing).

"(iv) Section 21 (relating to standards for marketing), including inaccurate completion of medical histories, other than sections 21C(1) and 21C(6) thereof, except that—

"(I) in addition to such requirements, no person shall, in selling or offering to sell a qualified long-term care insurance contract, misrepresent a material fact; and

"(II) no such requirements shall include a requirement to inquire or identify whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance.

"(v) Section 22 (relating to appropriateness of recommended purchase).

"(vi) Section 24 (relating to standard format outline of coverage).

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"(vii) Section 25 (relating to requirement to deliver shopper's guide).

"(B) MODEL ACT.—The following requirements of the model Act must be met:

"(i) Section 6F (relating to right to return), except that such section shall also apply to denials of applications and any refund shall be made within 30 days of the return or denial.

"(ii) Section 6G (relating to outline of coverage).

"(iii) Section 6H (relating to requirements for certificates under group plans).

"(iv) Section 6I (relating to policy summary).

"(v) Section 6J (relating to monthly reports on accelerated death benefits).

"(vi) Section 7 (relating to incontestability period).

"(C) DEFINITIONS.—For purposes of this paragraph, the terms 'model regulation' and 'model Act' have the meanings given such terms by section 7702B(g)(2)(B).

"(2) DELIVERY OF POLICY.—If an application for a qualified long-term care insurance contract (or for a certificate under such a contract for a group) is approved, the issuer shall deliver to the applicant (or policyholder or certificateholder) the contract (or certificate) of insurance not later than 30 days after the date of the approval.

"(3) INFORMATION ON DENIALS OF CLAIMS.—If a claim under a qualified long-term care insurance contract is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificateholder (or representative)—

"(A) provide a written explanation of the reasons for the denial, and

"(B) make available all information directly relating to such denial.

"(d) DISCLOSURE.—The requirements of this subsection are met if the issuer of a long-term care insurance policy discloses in such policy and in the outline of coverage required under subsection (c)(1)(B)(ii) that the policy is intended to be a qualified long-term care insurance contract under section 7702B(b).

"(e) QUALIFIED LONG-TERM CARE INSURANCE CONTRACT DEFINED.—For purposes of this section, the term 'qualified long-term care insurance contract' has the meaning given such term by section 7702B.

"(f) COORDINATION WITH STATE REQUIREMENTS.—If a State imposes any requirement which is more stringent than the analogous requirement imposed by this section or section 7702B(g), the requirement imposed by this section or section 7702B(g) shall be treated as met if the more stringent State requirement is met."

(b) CONFORMING AMENDMENT.—The table of sections for chapter 43 is amended by adding at the end the following new item:

"Sec. 4980C. Requirements for issuers of qualified long-term care insurance contracts."

26 USC 4980C
note.

SEC. 327. EFFECTIVE DATES.

(a) IN GENERAL.—The provisions of, and amendments made by, this part shall apply to contracts issued after December 31, 1996. The provisions of section 321(f) (relating to transition rule) shall apply to such contracts.

(b) ISSUERS.—The amendments made by section 326 shall apply to actions taken after December 31, 1996.

Subtitle D—Treatment of Accelerated Death Benefits

SEC. 331. TREATMENT OF ACCELERATED DEATH BENEFITS BY RECIPIENT.

(a) IN GENERAL.—Section 101 (relating to certain death benefits) is amended by adding at the end the following new subsection:

“(g) TREATMENT OF CERTAIN ACCELERATED DEATH BENEFITS.—

“(1) IN GENERAL.—For purposes of this section, the following amounts shall be treated as an amount paid by reason of the death of an insured:

“(A) Any amount received under a life insurance contract on the life of an insured who is a terminally ill individual.

“(B) Any amount received under a life insurance contract on the life of an insured who is a chronically ill individual.

“(2) TREATMENT OF VIATICAL SETTLEMENTS.—

“(A) IN GENERAL.—If any portion of the death benefit under a life insurance contract on the life of an insured described in paragraph (1) is sold or assigned to a viatical settlement provider, the amount paid for the sale or assignment of such portion shall be treated as an amount paid under the life insurance contract by reason of the death of such insured.

“(B) VIATICAL SETTLEMENT PROVIDER.—

“(i) IN GENERAL.—The term ‘viatical settlement provider’ means any person regularly engaged in the trade or business of purchasing, or taking assignments of, life insurance contracts on the lives of insureds described in paragraph (1) if—

“(I) such person is licensed for such purposes (with respect to insureds described in the same subparagraph of paragraph (1) as the insured) in the State in which the insured resides, or

“(II) in the case of an insured who resides in a State not requiring the licensing of such persons for such purposes with respect to such insured, such person meets the requirements of clause (ii) or (iii), whichever applies to such insured.

“(ii) TERMINALLY ILL INSURED.—A person meets the requirements of this clause with respect to an insured who is a terminally ill individual if such person—

“(I) meets the requirements of sections 8 and 9 of the Viatical Settlements Model Act of the National Association of Insurance Commissioners, and

“(II) meets the requirements of the Model Regulations of the National Association of Insurance Commissioners (relating to standards for evaluation of reasonable payments) in determining

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amounts paid by such person in connection with such purchases or assignments.

"(iii) CHRONICALLY ILL INSUREDS.—A person meets the requirements of this clause with respect to an insured who is a chronically ill individual if such person—

"(I) meets requirements similar to the requirements referred to in clause (ii)(I), and

"(II) meets the standards (if any) of the National Association of Insurance Commissioners for evaluating the reasonableness of amounts paid by such person in connection with such purchases or assignments with respect to chronically ill individuals.

"(3) SPECIAL RULES FOR CHRONICALLY ILL INSUREDS.—In the case of an insured who is a chronically ill individual—

"(A) IN GENERAL.—Paragraphs (1) and (2) shall not apply to any payment received for any period unless—

"(i) such payment is for costs incurred by the payee (not compensated for by insurance or otherwise) for qualified long-term care services provided for the insured for such period, and

"(ii) the terms of the contract giving rise to such payment satisfy—

"(I) the requirements of section 7702B(b)(1)(B), and

"(II) the requirements (if any) applicable under subparagraph (B).

For purposes of the preceding sentence, the rule of section 7702B(b)(2)(B) shall apply.

"(B) OTHER REQUIREMENTS.—The requirements applicable under this subparagraph are—

"(i) those requirements of section 7702B(g) and section 4980C which the Secretary specifies as applying to such a purchase, assignment, or other arrangement,

"(ii) standards adopted by the National Association of Insurance Commissioners which specifically apply to chronically ill individuals (and, if such standards are adopted, the analogous requirements specified under clause (i) shall cease to apply), and

"(iii) standards adopted by the State in which the policyholder resides (and if such standards are adopted, the analogous requirements specified under clause (i) and (subject to section 4980C(f)) standards under clause (ii), shall cease to apply).

"(C) PER DIEM PAYMENTS.—A payment shall not fail to be described in subparagraph (A) by reason of being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payment relates.

"(D) LIMITATION ON EXCLUSION FOR PERIODIC PAYMENTS.—

"For limitation on amount of periodic payments which are treated as described in paragraph (1), see section 7702B(d)."

"(4) DEFINITIONS.—For purposes of this subsection—

"(A) TERMINALLY ILL INDIVIDUAL.—The term 'terminally ill individual' means an individual who has been

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certified by a physician as having an illness or physical condition which can reasonably be expected to result in death in 24 months or less after the date of the certification.

"(B) CHRONICALLY ILL INDIVIDUAL.—The term 'chronically ill individual' has the meaning given such term by section 7702B(c)(2); except that such term shall not include a terminally ill individual.

"(C) QUALIFIED LONG-TERM CARE SERVICES.—The term 'qualified long-term care services' has the meaning given such term by section 7702B(c).

"(D) PHYSICIAN.—The term 'physician' has the meaning given to such term by section 1861(r)(1) of the Social Security Act (42 U.S.C. 1395x(r)(1)).

"(5) EXCEPTION FOR BUSINESS-RELATED POLICIES.—This subsection shall not apply in the case of any amount paid to any taxpayer other than the insured if such taxpayer has an insurable interest with respect to the life of the insured by reason of the insured being a director, officer, or employee of the taxpayer or by reason of the insured being financially interested in any trade or business carried on by the taxpayer."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to amounts received after December 31, 1996.

26 USC 101 note.

SEC. 332. TAX TREATMENT OF COMPANIES ISSUING QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.

(a) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—Section 818 (relating to other definitions and special rules) is amended by adding at the end the following new subsection:

"(g) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—For purposes of this part—

"(1) IN GENERAL.—Any reference to a life insurance contract shall be treated as including a reference to a qualified accelerated death benefit rider on such contract.

"(2) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.—For purposes of this subsection, the term 'qualified accelerated death benefit rider' means any rider on a life insurance contract if the only payments under the rider are payments meeting the requirements of section 101(g).

"(3) EXCEPTION FOR LONG-TERM CARE RIDERS.—Paragraph (1) shall not apply to any rider which is treated as a long-term care insurance contract under section 7702B."

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by this section shall take effect on January 1, 1997.

(2) ISSUANCE OF RIDER NOT TREATED AS MATERIAL CHANGE.—For purposes of applying sections 101(f), 7702, and 7702A of the Internal Revenue Code of 1986 to any contract—

(A) the issuance of a qualified accelerated death benefit rider (as defined in section 818(g) of such Code (as added by this Act)), and

(B) the addition of any provision required to conform an accelerated death benefit rider to the requirements of such section 818(g),

shall not be treated as a modification or material change of such contract.

26 USC 818 note.

Subtitle E—State Insurance Pools

SEC. 341. EXEMPTION FROM INCOME TAX FOR STATE-SPONSORED ORGANIZATIONS PROVIDING HEALTH COVERAGE FOR HIGH-RISK INDIVIDUALS.

(a) IN GENERAL.—Subsection (c) of section 501 (relating to list of exempt organizations) is amended by adding at the end the following new paragraph:

“(26) Any membership organization if—

“(A) such organization is established by a State exclusively to provide coverage for medical care (as defined in section 213(d)) on a not-for-profit basis to individuals described in subparagraph (B) through—

“(i) insurance issued by the organization, or

“(ii) a health maintenance organization under an arrangement with the organization,

“(B) the only individuals receiving such coverage through the organization are individuals—

“(i) who are residents of such State, and

“(ii) who, by reason of the existence or history of a medical condition—

“(I) are unable to acquire medical care coverage for such condition through insurance or from a health maintenance organization, or

“(II) are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization,

“(C) the composition of the membership in such organization is specified by such State, and

“(D) no part of the net earnings of the organization inures to the benefit of any private shareholder or individual.”

26 USC 501 note.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1996.

SEC. 342. EXEMPTION FROM INCOME TAX FOR STATE-SPONSORED WORKMEN'S COMPENSATION REINSURANCE ORGANIZATIONS.

(a) IN GENERAL.—Subsection (c) of section 501 (relating to list of exempt organizations), as amended by section 341, is amended by adding at the end the following new paragraph:

“(27) Any membership organization if—

“(A) such organization is established before June 1, 1996, by a State exclusively to reimburse its members for losses arising under workmen's compensation acts,

“(B) such State requires that the membership of such organization consist of—

“(i) all persons who issue insurance covering workmen's compensation losses in such State, and

“(ii) all persons and governmental entities who self-insure against such losses, and

“(C) such organization operates as a non-profit organization by—

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“(i) returning surplus income to its members or workmen’s compensation policyholders on a periodic basis, and

“(ii) reducing initial premiums in anticipation of investment income.”

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years ending after the date of the enactment of this Act. 26 USC 501 note.

Subtitle F—Organizations Subject to Section 833

SEC. 351. ORGANIZATIONS SUBJECT TO SECTION 833.

(a) IN GENERAL.—Section 833(c) (relating to organization to which section applies) is amended by adding at the end the following new paragraph:

“(4) TREATMENT AS EXISTING BLUE CROSS OR BLUE SHIELD ORGANIZATION.—

“(A) IN GENERAL.—Paragraph (2) shall be applied to an organization described in subparagraph (B) as if it were a Blue Cross or Blue Shield organization.

“(B) APPLICABLE ORGANIZATION.—An organization is described in this subparagraph if it—

“(i) is organized under, and governed by, State laws which are specifically and exclusively applicable to not-for-profit health insurance or health service type organizations, and

“(ii) is not a Blue Cross or Blue Shield organization or health maintenance organization.”

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years ending after December 31, 1996. 26 USC 833 note.

Subtitle G—IRA Distributions to the Unemployed

SEC. 361. DISTRIBUTIONS FROM CERTAIN PLANS MAY BE USED WITHOUT ADDITIONAL TAX TO PAY FINANCIALLY DEVASTATING MEDICAL EXPENSES.

(a) IN GENERAL.—Section 72(t)(3)(A) is amended by striking “(B).”

(b) DISTRIBUTIONS FOR PAYMENT OF HEALTH INSURANCE PREMIUMS OF CERTAIN UNEMPLOYED INDIVIDUALS.—Paragraph (2) of section 72(t) is amended by adding at the end the following new subparagraph:

“(D) DISTRIBUTIONS TO UNEMPLOYED INDIVIDUALS FOR HEALTH INSURANCE PREMIUMS.—

“(i) IN GENERAL.—Distributions from an individual retirement plan to an individual after separation from employment—

“(I) if such individual has received unemployment compensation for 12 consecutive weeks under any Federal or State unemployment compensation law by reason of such separation,

“(II) if such distributions are made during any taxable year during which such unemployment compensation is paid or the succeeding taxable year, and

“(III) to the extent such distributions do not exceed the amount paid during the taxable year for insurance described in section 213(d)(1)(D) with respect to the individual and the individual’s spouse and dependents (as defined in section 152).

“(ii) DISTRIBUTIONS AFTER REEMPLOYMENT.—Clause (i) shall not apply to any distribution made after the individual has been employed for at least 60 days after the separation from employment to which clause (i) applies.

“(iii) SELF-EMPLOYED INDIVIDUALS.—To the extent provided in regulations, a self-employed individual shall be treated as meeting the requirements of clause (i)(I) if, under Federal or State law, the individual would have received unemployment compensation but for the fact the individual was self-employed.”

(c) CONFORMING AMENDMENT.—Subparagraph (B) of section 72(t)(2) is amended by striking “or (C)” and inserting “, (C), or (D)”.

26 USC 72 note.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions after December 31, 1996.

Subtitle H—Organ and Tissue Donation Information Included With Income Tax Refund Payments

26 USC 6042
note.

SEC. 371. ORGAN AND TISSUE DONATION INFORMATION INCLUDED WITH INCOME TAX REFUND PAYMENTS.

(a) IN GENERAL.—The Secretary of the Treasury shall, to the extent practicable, include with the mailing of any payment of a refund of individual income tax made during the period beginning on February 1, 1997, and ending on June 30, 1997, a copy of the document described in subsection (b).

(b) TEXT OF DOCUMENT.—The Secretary of the Treasury shall, after consultation with the Secretary of Health and Human Services and organizations promoting organ and tissue (including eye) donation, prepare a document suitable for inclusion with individual income tax refund payments which—

- (1) encourages organ and tissue donation;
- (2) includes a detachable organ and tissue donor card; and
- (3) urges recipients to—
 - (A) sign the organ and tissue donor card;
 - (B) discuss organ and tissue donation with family members and tell family members about the recipient’s desire to be an organ and tissue donor if the occasion arises; and
 - (C) encourage family members to request or authorize organ and tissue donation if the occasion arises.

TITLE IV—APPLICATION AND ENFORCEMENT OF GROUP HEALTH PLAN REQUIREMENTS

Subtitle A—Application and Enforcement of Group Health Plan Requirements

SEC. 401. GROUP HEALTH PLAN PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS.

(a) IN GENERAL.—The Internal Revenue Code of 1986 is amended by adding at the end the following new subtitle:

“Subtitle K—Group Health Plan Portability, Access, and Renewability Requirements

*Chapter 100. Group health plan portability, access, and renewability requirements.

“CHAPTER 100—GROUP HEALTH PLAN PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS

*Sec. 9801. Increased portability through limitation on preexisting condition exclusions.

*Sec. 9802. Prohibiting discrimination against individual participants and beneficiaries based on health status.

*Sec. 9803. Guaranteed renewability in multiemployer plans and certain multiple employer welfare arrangements.

*Sec. 9804. General exceptions.

*Sec. 9805. Definitions.

*Sec. 9806. Regulations.

“SEC. 9801. INCREASED PORTABILITY THROUGH LIMITATION ON PREEXISTING CONDITION EXCLUSIONS.

“(a) LIMITATION ON PREEXISTING CONDITION EXCLUSION PERIOD; CREDITING FOR PERIODS OF PREVIOUS COVERAGE.—Subject to subsection (d), a group health plan may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if—

“(1) such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date;

“(2) such exclusion extends for a period of not more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date; and

“(3) the period of any such preexisting condition exclusion is reduced by the length of the aggregate of the periods of creditable coverage (if any) applicable to the participant or beneficiary as of the enrollment date.

“(b) DEFINITIONS.—For purposes of this section—

“(1) PREEXISTING CONDITION EXCLUSION.—

“(A) IN GENERAL.—The term ‘preexisting condition exclusion’ means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on

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the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

“(B) TREATMENT OF GENETIC INFORMATION.—For purposes of this section, genetic information shall not be treated as a condition described in subsection (a)(1) in the absence of a diagnosis of the condition related to such information.

“(2) ENROLLMENT DATE.—The term ‘enrollment date’ means, with respect to an individual covered under a group health plan, the date of enrollment of the individual in the plan or, if earlier, the first day of the waiting period for such enrollment.

“(3) LATE ENROLLEE.—The term ‘late enrollee’ means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during—

“(A) the first period in which the individual is eligible to enroll under the plan, or

“(B) a special enrollment period under subsection (f).

“(4) WAITING PERIOD.—The term ‘waiting period’ means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

“(c) RULES RELATING TO CREDITING PREVIOUS COVERAGE.—

“(1) CREDITABLE COVERAGE DEFINED.—For purposes of this part, the term ‘creditable coverage’ means, with respect to an individual, coverage of the individual under any of the following:

“(A) A group health plan.

“(B) Health insurance coverage.

“(C) Part A or part B of title XVIII of the Social Security Act.

“(D) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.

“(E) Chapter 55 of title 10, United States Code.

“(F) A medical care program of the Indian Health Service or of a tribal organization.

“(G) A State health benefits risk pool.

“(H) A health plan offered under chapter 89 of title 5, United States Code.

“(I) A public health plan (as defined in regulations).

“(J) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

Such term does not include coverage consisting solely of coverage of excepted benefits (as defined in section 9805(c)).

“(2) NOT COUNTING PERIODS BEFORE SIGNIFICANT BREAKS IN COVERAGE.—

“(A) IN GENERAL.—A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

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“(B) WAITING PERIOD NOT TREATED AS A BREAK IN COVERAGE.—For purposes of subparagraph (A) and subsection (d)(4), any period that an individual is in a waiting period for any coverage under a group health plan or is in an affiliation period shall not be taken into account in determining the continuous period under subparagraph (A).

“(C) AFFILIATION PERIOD.—

“(i) IN GENERAL.—For purposes of this section, the term ‘affiliation period’ means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. During such an affiliation period, the organization is not required to provide health care services or benefits and no premium shall be charged to the participant or beneficiary.

“(ii) BEGINNING.—Such period shall begin on the enrollment date.

“(iii) RUNS CONCURRENTLY WITH WAITING PERIODS.—Any such affiliation period shall run concurrently with any waiting period under the plan.

“(3) METHOD OF CREDITING COVERAGE.—

“(A) STANDARD METHOD.—Except as otherwise provided under subparagraph (B), for purposes of applying subsection (a)(3), a group health plan shall count a period of creditable coverage without regard to the specific benefits for which coverage is offered during the period.

“(B) ELECTION OF ALTERNATIVE METHOD.—A group health plan may elect to apply subsection (a)(3) based on coverage of any benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subparagraph (A). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group health plan shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

“(C) PLAN NOTICE.—In the case of an election with respect to a group health plan under subparagraph (B), the plan shall—

“(i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election, and

“(ii) include in such statements a description of the effect of this election.

“(4) ESTABLISHMENT OF PERIOD.—Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (e) or in such other manner as may be specified in regulations.

“(d) EXCEPTIONS.—

“(1) EXCLUSION NOT APPLICABLE TO CERTAIN NEWBORNS.—Subject to paragraph (4), a group health plan may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

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"(2) EXCLUSION NOT APPLICABLE TO CERTAIN ADOPTED CHILDREN.—Subject to paragraph (4), a group health plan may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.

"(3) EXCLUSION NOT APPLICABLE TO PREGNANCY.—For purposes of this section, a group health plan may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

"(4) LOSS IF BREAK IN COVERAGE.—Paragraphs (1) and (2) shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

"(e) CERTIFICATIONS AND DISCLOSURE OF COVERAGE.—

"(1) REQUIREMENT FOR CERTIFICATION OF PERIOD OF CREDITABLE COVERAGE.—

"(A) IN GENERAL.—A group health plan shall provide the certification described in subparagraph (B)—

"(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision,

"(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision, and

"(iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii), whichever is later.

The certification under clause (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

"(B) CERTIFICATION.—The certification described in this subparagraph is a written certification of—

"(i) the period of creditable coverage of the individual under such plan and the coverage under such COBRA continuation provision, and

"(ii) the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under such plan.

"(C) ISSUER COMPLIANCE.—To the extent that medical care under a group health plan consists of health insurance coverage offered in connection with the plan, the plan is deemed to have satisfied the certification requirement under this paragraph if the issuer provides for such certification in accordance with this paragraph.

"(2) DISCLOSURE OF INFORMATION ON PREVIOUS BENEFITS.—

"(A) IN GENERAL.—In the case of an election described in subsection (c)(3)(B) by a group health plan, if the plan enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (1)—

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"(i) upon request of such plan, the entity which issued the certification provided by the individual shall promptly disclose to such requesting plan information on coverage of classes and categories of health benefits available under such entity's plan, and

"(ii) such entity may charge the requesting plan or issuer for the reasonable cost of disclosing such information.

"(3) REGULATIONS.—The Secretary shall establish rules to prevent an entity's failure to provide information under paragraph (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

"(f) SPECIAL ENROLLMENT PERIODS.—

"(1) INDIVIDUALS LOSING OTHER COVERAGE.—A group health plan shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

"(A) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or individual.

"(B) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor (or the health insurance issuer offering health insurance coverage in connection with the plan) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

"(C) The employee's or dependent's coverage described in subparagraph (A)—

"(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

"(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.

"(D) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (C)(i) or termination of coverage or employer contribution described in subparagraph (C)(ii).

"(2) FOR DEPENDENT BENEFICIARIES.—

"(A) IN GENERAL.—If—

"(i) a group health plan makes coverage available with respect to a dependent of an individual,

"(ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming

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a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and

"(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

the group health plan shall provide for a dependent special enrollment period described in subparagraph (B) during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

"(B) DEPENDENT SPECIAL ENROLLMENT PERIOD.—The dependent special enrollment period under this subparagraph shall be a period of not less than 30 days and shall begin on the later of—

"(i) the date dependent coverage is made available, or

"(ii) the date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subparagraph (A)(iii).

"(C) NO WAITING PERIOD.—If an individual seeks coverage of a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective—

"(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

"(ii) in the case of a dependent's birth, as of the date of such birth; or

"(iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

"SEC. 9802. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.

"(a) IN ELIGIBILITY TO ENROLL.—

"(1) IN GENERAL.—Subject to paragraph (2), a group health plan may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following factors in relation to the individual or a dependent of the individual:

"(A) Health status.

"(B) Medical condition (including both physical and mental illnesses).

"(C) Claims experience.

"(D) Receipt of health care.

"(E) Medical history.

"(F) Genetic information.

"(G) Evidence of insurability (including conditions arising out of acts of domestic violence).

"(H) Disability.

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"(2) NO APPLICATION TO BENEFITS OR EXCLUSIONS.—To the extent consistent with section 9801, paragraph (1) shall not be construed—

"(A) to require a group health plan to provide particular benefits (or benefits with respect to a specific procedure, treatment, or service) other than those provided under the terms of such plan; or

"(B) to prevent such a plan from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

"(3) CONSTRUCTION.—For purposes of paragraph (1), rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for such enrollment.

"(b) IN PREMIUM CONTRIBUTIONS.—

"(1) IN GENERAL.—A group health plan may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any factor described in subsection (a)(1) in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

"(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed—

"(A) to restrict the amount that an employer may be charged for coverage under a group health plan; or

"(B) to prevent a group health plan from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

***SEC. 9803. GUARANTEED RENEWABILITY IN MULTIEMPLOYER PLANS AND CERTAIN MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.**

"(a) IN GENERAL.—A group health plan which is a multiemployer plan (as defined in section 414(f)) or which is a multiple employer welfare arrangement may not deny an employer continued access to the same or different coverage under such plan, other than—

"(1) for nonpayment of contributions;

"(2) for fraud or other intentional misrepresentation of material fact by the employer;

"(3) for noncompliance with material plan provisions;

"(4) because the plan is ceasing to offer any coverage in a geographic area;

"(5) in the case of a plan that offers benefits through a network plan, because there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of the network plan and the plan applies this paragraph uniformly without regard to the claims experience of employers or a factor described in section 9802(a)(1) in relation to such individuals or their dependents; or

"(6) for failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other

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agreement requiring or authorizing contributions to the plan, or to employ employees covered by such an agreement.

"(b) **MULTIPLE EMPLOYER WELFARE ARRANGEMENT.**—For purposes of subsection (a), the term 'multiple employer welfare arrangement' has the meaning given such term by section 3(40) of the Employee Retirement Income Security Act of 1974, as in effect on the date of the enactment of this section.

"SEC. 9804. GENERAL EXCEPTIONS.

"(a) **EXCEPTION FOR CERTAIN PLANS.**—The requirements of this chapter shall not apply to—

"(1) any governmental plan, and

"(2) any group health plan for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees.

"(b) **EXCEPTION FOR CERTAIN BENEFITS.**—The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9805(c)(1).

"(c) **EXCEPTION FOR CERTAIN BENEFITS IF CERTAIN CONDITIONS MET.**—

"(1) **LIMITED, EXCEPTED BENEFITS.**—The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9805(c)(2) if the benefits—

"(A) are provided under a separate policy, certificate, or contract of insurance; or

"(B) are otherwise not an integral part of the plan.

"(2) **NONCOORDINATED, EXCEPTED BENEFITS.**—The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9805(c)(3) if all of the following conditions are met:

"(A) The benefits are provided under a separate policy, certificate, or contract of insurance.

"(B) 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.

"(C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

"(3) **SUPPLEMENTAL EXCEPTED BENEFITS.**—The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9805(c)(4) if the benefits are provided under a separate policy, certificate, or contract of insurance.

"SEC. 9805. DEFINITIONS.

"(a) **GROUP HEALTH PLAN.**—For purposes of this chapter, the term 'group health plan' has the meaning given to such term by section 5000(b)(1).

"(b) **DEFINITIONS RELATING TO HEALTH INSURANCE.**—For purposes of this chapter—

"(1) **HEALTH INSURANCE COVERAGE.**—

"(A) **IN GENERAL.**—Except as provided in subparagraph (B), the term 'health insurance coverage' means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical

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service plan contract, or health maintenance organization contract offered by a health insurance issuer.

"(B) NO APPLICATION TO CERTAIN EXCEPTED BENEFITS.— In applying subparagraph (A), excepted benefits described in subsection (c)(1) shall not be treated as benefits consisting of medical care.

"(2) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974, as in effect on the date of the enactment of this section). Such term does not include a group health plan.

"(3) HEALTH MAINTENANCE ORGANIZATION.—The term 'health maintenance organization' means—

"(A) a federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a))),

"(B) an organization recognized under State law as a health maintenance organization, or

"(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

"(c) EXCEPTED BENEFITS.—For purposes of this chapter, the term 'excepted benefits' means benefits under one or more (or any combination thereof) of the following:

"(1) BENEFITS NOT SUBJECT TO REQUIREMENTS.—

"(A) Coverage only for accident, or disability income insurance, or any combination thereof.

"(B) Coverage issued as a supplement to liability insurance.

"(C) Liability insurance, including general liability insurance and automobile liability insurance.

"(D) Workers' compensation or similar insurance.

"(E) Automobile medical payment insurance.

"(F) Credit-only insurance.

"(G) Coverage for on-site medical clinics.

"(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

"(2) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED SEPARATELY.—

"(A) Limited scope dental or vision benefits.

"(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

"(C) Such other similar, limited benefits as are specified in regulations.

"(3) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS.—

"(A) Coverage only for a specified disease or illness.

"(B) Hospital indemnity or other fixed indemnity insurance.

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"(4) **BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS SEPARATE INSURANCE POLICY.**—Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

"(d) **OTHER DEFINITIONS.**—For purposes of this chapter—

"(1) **COBRA CONTINUATION PROVISION.**—The term 'COBRA continuation provision' means any of the following:

"(A) Section 4980B, other than subsection (f)(1) thereof insofar as it relates to pediatric vaccines.

"(B) Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.), other than section 609 of such Act.

"(C) Title XXII of the Public Health Service Act.

"(2) **GOVERNMENTAL PLAN.**—The term 'governmental plan' has the meaning given such term by section 414(d).

"(3) **MEDICAL CARE.**—The term 'medical care' has the meaning given such term by section 213(d) determined without regard to—

"(A) paragraph (1)(C) thereof, and

"(B) so much of paragraph (1)(D) thereof as relates to qualified long-term care insurance.

"(4) **NETWORK PLAN.**—The term 'network plan' means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care are provided, in whole or in part, through a defined set of providers under contract with the issuer.

"(5) **PLACED FOR ADOPTION DEFINED.**—The term 'placement', or being 'placed', for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

"SEC. 9806. REGULATIONS.

"The Secretary, consistent with section 104 of the Health Care Portability and Accountability Act of 1996, may promulgate such regulations as may be necessary or appropriate to carry out the provisions of this chapter. The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this chapter."

(b) **CLERICAL AMENDMENT.**—The table of subtitles of such Code is amended by adding at the end the following new item:

"Subtitle K. Group health plan portability, access, and renewability requirements."

(c) **EFFECTIVE DATE.**—

(1) **IN GENERAL.**—The amendments made by this section shall apply to plan years beginning after June 30, 1997.

(2) **DETERMINATION OF CREDITABLE COVERAGE.**—

(A) **PERIOD OF COVERAGE.**—

(i) **IN GENERAL.**—Subject to clause (ii), no period before July 1, 1996, shall be taken into account under chapter 100 of the Internal Revenue Code of 1986 (as added by this section) in determining creditable coverage.

26 USC 9801
note.

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(ii) SPECIAL RULE FOR CERTAIN PERIODS.—The Secretary of the Treasury, consistent with section 104, shall provide for a process whereby individuals who need to establish creditable coverage for periods before July 1, 1996, and who would have such coverage credited but for clause (i) may be given credit for creditable coverage for such periods through the presentation of documents or other means.

(B) CERTIFICATIONS, ETC.—

(i) IN GENERAL.—Subject to clauses (ii) and (iii), subsection (e) of section 9801 of the Internal Revenue Code of 1986 (as added by this section) shall apply to events occurring after June 30, 1996.

(ii) NO CERTIFICATION REQUIRED TO BE PROVIDED BEFORE JUNE 1, 1997.—In no case is a certification required to be provided under such subsection before June 1, 1997.

(iii) CERTIFICATION ONLY ON WRITTEN REQUEST FOR EVENTS OCCURRING BEFORE OCTOBER 1, 1996.—In the case of an event occurring after June 30, 1996, and before October 1, 1996, a certification is not required to be provided under such subsection unless an individual (with respect to whom the certification is otherwise required to be made) requests such certification in writing.

(C) TRANSITIONAL RULE.—In the case of an individual who seeks to establish creditable coverage for any period for which certification is not required because it relates to an event occurring before June 30, 1996—

(i) the individual may present other credible evidence of such coverage in order to establish the period of creditable coverage; and

(ii) a group health plan and a health insurance issuer shall not be subject to any penalty or enforcement action with respect to the plan's or issuer's crediting (or not crediting) such coverage if the plan or issuer has sought to comply in good faith with the applicable requirements under the amendments made by this section.

(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—Except as provided in paragraph (2), in the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) July 1, 1997.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

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(4) **TIMELY REGULATIONS.**—The Secretary of the Treasury, consistent with section 104, shall first issue by not later than April 1, 1997, such regulations as may be necessary to carry out the amendments made by this section.

(5) **LIMITATION ON ACTIONS.**—No enforcement action shall be taken, pursuant to the amendments made by this section, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before January 1, 1998, or, if later, the date of issuance of regulations referred to in paragraph (4), if the plan or issuer has sought to comply in good faith with such requirements.

SEC. 402. PENALTY ON FAILURE TO MEET CERTAIN GROUP HEALTH PLAN REQUIREMENTS.

(a) **IN GENERAL.**—Chapter 43 of the Internal Revenue Code of 1986 (relating to qualified pension, etc., plans) is amended by adding after section 4980C the following new section:

“SEC. 4980D. FAILURE TO MEET CERTAIN GROUP HEALTH PLAN REQUIREMENTS.

“(a) **GENERAL RULE.**—There is hereby imposed a tax on any failure of a group health plan to meet the requirements of chapter 100 (relating to group health plan portability, access, and renewability requirements).

“(b) **AMOUNT OF TAX.**—

“(1) **IN GENERAL.**—The amount of the tax imposed by subsection (a) on any failure shall be \$100 for each day in the noncompliance period with respect to each individual to whom such failure relates.

“(2) **NONCOMPLIANCE PERIOD.**—For purposes of this section, the term ‘noncompliance period’ means, with respect to any failure, the period—

“(A) beginning on the date such failure first occurs, and

“(B) ending on the date such failure is corrected.

“(3) **MINIMUM TAX FOR NONCOMPLIANCE PERIOD WHERE FAILURE DISCOVERED AFTER NOTICE OF EXAMINATION.**—Notwithstanding paragraphs (1) and (2) of subsection (c)—

“(A) **IN GENERAL.**—In the case of 1 or more failures with respect to an individual—

“(i) which are not corrected before the date a notice of examination of income tax liability is sent to the employer, and

“(ii) which occurred or continued during the period under examination,

the amount of tax imposed by subsection (a) by reason of such failures with respect to such individual shall not be less than the lesser of \$2,500 or the amount of tax which would be imposed by subsection (a) without regard to such paragraphs.

“(B) **HIGHER MINIMUM TAX WHERE VIOLATIONS ARE MORE THAN DE MINIMIS.**—To the extent violations for which any person is liable under subsection (e) for any year are more than de minimis, subparagraph (A) shall be applied by substituting ‘\$15,000’ for ‘\$2,500’ with respect to such person.

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“(C) EXCEPTION FOR CHURCH PLANS.—This paragraph shall not apply to any failure under a church plan (as defined in section 414(e)).

“(c) LIMITATIONS ON AMOUNT OF TAX.—

“(1) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by subsection (a) on any failure during any period for which it is established to the satisfaction of the Secretary that the person otherwise liable for such tax did not know, and exercising reasonable diligence would not have known, that such failure existed.

“(2) TAX NOT TO APPLY TO FAILURES CORRECTED WITHIN CERTAIN PERIODS.—No tax shall be imposed by subsection (a) on any failure if—

“(A) such failure was due to reasonable cause and not to willful neglect, and

“(B)(i) in the case of a plan other than a church plan (as defined in section 414(e)), such failure is corrected during the 30-day period beginning on the first date the person otherwise liable for such tax knew, or exercising reasonable diligence would have known, that such failure existed, and

“(ii) in the case of a church plan (as so defined), such failure is corrected before the close of the correction period (determined under the rules of section 414(e)(4)(C)).

“(3) OVERALL LIMITATION FOR UNINTENTIONAL FAILURES.—In the case of failures which are due to reasonable cause and not to willful neglect—

“(A) SINGLE EMPLOYER PLANS.—

“(i) IN GENERAL.—In the case of failures with respect to plans other than specified multiple employer health plans, the tax imposed by subsection (a) for failures during the taxable year of the employer shall not exceed the amount equal to the lesser of—

“(I) 10 percent of the aggregate amount paid or incurred by the employer (or predecessor employer) during the preceding taxable year for group health plans, or

“(II) \$500,000.

“(ii) TAXABLE YEARS IN THE CASE OF CERTAIN CONTROLLED GROUPS.—For purposes of this subparagraph, if not all persons who are treated as a single employer for purposes of this section have the same taxable year, the taxable years taken into account shall be determined under principles similar to the principles of section 1561.

“(B) SPECIFIED MULTIPLE EMPLOYER HEALTH PLANS.—

“(i) IN GENERAL.—In the case of failures with respect to a specified multiple employer health plan, the tax imposed by subsection (a) for failures during the taxable year of the trust forming part of such plan shall not exceed the amount equal to the lesser of—

“(I) 10 percent of the amount paid or incurred by such trust during such taxable year to provide medical care (as defined in section 9805(d)(3))

directly or through insurance, reimbursement, or otherwise, or

“(II) \$500,000.

For purposes of the preceding sentence, all plans of which the same trust forms a part shall be treated as one plan.

“(ii) SPECIAL RULE FOR EMPLOYERS REQUIRED TO PAY TAX.—If an employer is assessed a tax imposed by subsection (a) by reason of a failure with respect to a specified multiple employer health plan, the limit shall be determined under subparagraph (A) (and not under this subparagraph) and as if such plan were not a specified multiple employer health plan.

“(4) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that the payment of such tax would be excessive relative to the failure involved.

“(d) TAX NOT TO APPLY TO CERTAIN INSURED SMALL EMPLOYER PLANS.—

“(1) IN GENERAL.—In the case of a group health plan of a small employer which provides health insurance coverage solely through a contract with a health insurance issuer, no tax shall be imposed by this section on the employer on any failure which is solely because of the health insurance coverage offered by such issuer.

“(2) SMALL EMPLOYER.—

“(A) IN GENERAL.—For purposes of paragraph (1), the term ‘small employer’ means, with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year. For purposes of the preceding sentence, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as one employer.

“(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

“(C) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

“(3) HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER.—For purposes of paragraph (1), the terms ‘health insurance coverage’ and ‘health insurance issuer’ have the respective meanings given such terms by section 9805.

“(e) LIABILITY FOR TAX.—The following shall be liable for the tax imposed by subsection (a) on a failure:

“(1) Except as otherwise provided in this subsection, the employer.

“(2) In the case of a multiemployer plan, the plan.

"(3) In the case of a failure under section 9803 (relating to guaranteed renewability) with respect to a plan described in subsection (f)(2)(B), the plan.

"(f) DEFINITIONS.—For purposes of this section—

"(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term by section 9805(a).

"(2) SPECIFIED MULTIPLE EMPLOYER HEALTH PLAN.—The term 'specified multiple employer health plan' means a group health plan which is—

"(A) any multiemployer plan, or

"(B) any multiple employer welfare arrangement (as defined in section 3(40) of the Employee Retirement Income Security Act of 1974, as in effect on the date of the enactment of this section).

"(3) CORRECTION.—A failure of a group health plan shall be treated as corrected if—

"(A) such failure is retroactively undone to the extent possible, and

"(B) the person to whom the failure relates is placed in a financial position which is as good as such person would have been in had such failure not occurred."

(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding after the item relating to section 4980C the following new item:

"Sec. 4980D. Failure to meet certain group health plan requirements."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to failures under chapter 100 of the Internal Revenue Code of 1986 (as added by section 401 of this Act).

26 USC 4980D
note.

Subtitle B—Clarification of Certain Continuation Coverage Requirements

SEC. 421. COBRA CLARIFICATIONS.

(a) PUBLIC HEALTH SERVICE ACT.—

(1) PERIOD OF COVERAGE.—Section 2202(2) of the Public Health Service Act (42 U.S.C. 300bb-2(2)) is amended—

(A) in subparagraph (A)—

(i) by transferring the sentence immediately preceding clause (iv) so as to appear immediately following such clause (iv); and

(ii) in the last sentence (as so transferred)—

(I) by striking "an individual" and inserting "a qualified beneficiary";

(II) by striking "at the time of a qualifying event described in section 2203(2)" and inserting "at any time during the first 60 days of continuation coverage under this title";

(III) by striking "with respect to such event," and

(IV) by inserting "(with respect to all qualified beneficiaries)" after "29 months";

(B) in subparagraph (D)(i), by inserting before ", or" the following: "(other than such an exclusion or limitation which does not apply to (or is satisfied by) such beneficiary by reason of chapter 100 of the Internal Revenue Code

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of 1986, part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, or title XXVII of this Act); and

(C) in subparagraph (E), by striking "at the time of a qualifying event described in section 2203(2)" and inserting "at any time during the first 60 days of continuation coverage under this title".

(2) NOTICES.—Section 2206(3) of the Public Health Service Act (42 U.S.C. 300bb-6(3)) is amended by striking "at the time of a qualifying event described in section 2203(2)" and inserting "at any time during the first 60 days of continuation coverage under this title".

(3) BIRTH OR ADOPTION OF A CHILD.—Section 2208(3)(A) of the Public Health Service Act (42 U.S.C. 300bb-8(3)(A)) is amended by adding at the end thereof the following new flush sentence:

"Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continuation coverage under this title."

(b) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) PERIOD OF COVERAGE.—Section 602(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(2)) is amended—

(A) in the last sentence of subparagraph (A)—

(i) by striking "an individual" and inserting "a qualified beneficiary";

(ii) by striking "at the time of a qualifying event described in section 603(2)" and inserting "at any time during the first 60 days of continuation coverage under this part";

(iii) by striking "with respect to such event"; and

(iv) by inserting "(with respect to all qualified beneficiaries)" after "29 months";

(B) in subparagraph (D)(i), by inserting before ", or" the following: "(other than such an exclusion or limitation which does not apply to (or is satisfied by) such beneficiary by reason of chapter 100 of the Internal Revenue Code of 1986, part 7 of this subtitle, or title XXVII of the Public Health Service Act)"; and

(C) in subparagraph (E), by striking "at the time of a qualifying event described in section 603(2)" and inserting "at any time during the first 60 days of continuation coverage under this part".

(2) NOTICES.—Section 606(a)(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1166(a)(3)) is amended by striking "at the time of a qualifying event described in section 603(2)" and inserting "at any time during the first 60 days of continuation coverage under this part".

(3) BIRTH OR ADOPTION OF A CHILD.—Section 607(3)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(3)) is amended by adding at the end thereof the following new flush sentence:

"Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continuation coverage under this part."

(c) INTERNAL REVENUE CODE OF 1986.—

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(1) PERIOD OF COVERAGE.—Section 4980B(f)(2)(B) of the Internal Revenue Code of 1986 is amended—

(A) in the last sentence of clause (i)—

(i) by striking “at the time of a qualifying event described in paragraph (3)(B)” and inserting “at any time during the first 60 days of continuation coverage under this section”;

(ii) by striking “with respect to such event”; and

(iii) by inserting “(with respect to all qualified beneficiaries)” after “29 months”;

(B) in clause (iv)(I), by inserting before “, or” the following: “(other than such an exclusion or limitation which does not apply to (or is satisfied by) such beneficiary by reason of chapter 100 of this title, part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, or title XXVII of the Public Health Service Act)”; and

(C) in clause (v), by striking “at the time of a qualifying event described in paragraph (3)(B)” and inserting “at any time during the first 60 days of continuation coverage under this section”.

(2) NOTICES.—Section 4980B(f)(6)(C) of the Internal Revenue Code of 1986 is amended by striking “at the time of a qualifying event described in paragraph (3)(B)” and inserting “at any time during the first 60 days of continuation coverage under this section”.

(3) BIRTH OR ADOPTION OF A CHILD.—Section 4980B(g)(1)(A) of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new flush sentence:

“Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continuation coverage under this section.”.

(d) EFFECTIVE DATE.—The amendments made by this section shall become effective on January 1, 1997, regardless of whether the qualifying event occurred before, on, or after such date.

26 USC 4980B
note.

(e) NOTIFICATION OF CHANGES.—Not later than November 1, 1996, each group health plan (covered under title XXII of the Public Health Service Act, part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, and section 4980B(f) of the Internal Revenue Code of 1986) shall notify each qualified beneficiary who has elected continuation coverage under such title, part or section of the amendments made by this section.

26 USC 4980B
note.

TITLE V—REVENUE OFFSETS

SEC. 500. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

Subtitle A—Company-Owned Life Insurance

SEC. 501. DENIAL OF DEDUCTION FOR INTEREST ON LOANS WITH RESPECT TO COMPANY-OWNED LIFE INSURANCE.

(a) IN GENERAL.—Paragraph (4) of section 264(a) is amended—
(1) by inserting “, or any endowment or annuity contracts owned by the taxpayer covering any individual,” after “the life of any individual”, and

(2) by striking all that follows “carried on by the taxpayer” and inserting a period.

(b) EXCEPTION FOR CONTRACTS RELATING TO KEY PERSONS; PERMISSIBLE INTEREST RATES.—Section 264 is amended—

(1) by striking “Any” in subsection (a)(4) and inserting “Except as provided in subsection (d), any”, and

(2) by adding at the end the following new subsection:

“(d) SPECIAL RULES FOR APPLICATION OF SUBSECTION (a)(4).—

“(1) EXCEPTION FOR KEY PERSONS.—Subsection (a)(4) shall not apply to any interest paid or accrued on any indebtedness with respect to policies or contracts covering an individual who is a key person to the extent that the aggregate amount of such indebtedness with respect to policies and contracts covering such individual does not exceed \$50,000.

“(2) INTEREST RATE CAP ON KEY PERSONS AND PRE-1986 CONTRACTS.—

“(A) IN GENERAL.—No deduction shall be allowed by reason of paragraph (1) or the last sentence of subsection (a) with respect to interest paid or accrued for any month beginning after December 31, 1995, to the extent the amount of such interest exceeds the amount which would have been determined if the applicable rate of interest were used for such month.

“(B) APPLICABLE RATE OF INTEREST.—For purposes of subparagraph (A)—

“(i) IN GENERAL.—The applicable rate of interest for any month is the rate of interest described as Moody's Corporate Bond Yield Average-Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto, for such month.

“(ii) PRE-1986 CONTRACTS.—In the case of indebtedness on a contract purchased on or before June 20, 1986—

“(I) which is a contract providing a fixed rate of interest, the applicable rate of interest for any month shall be the Moody's rate described in clause (i) for the month in which the contract was purchased, or

“(II) which is a contract providing a variable rate of interest, the applicable rate of interest for any month in an applicable period shall be such Moody's rate for the third month preceding the first month in such period.

For purposes of subclause (II), the taxpayer shall elect an applicable period for such contract on its return of tax imposed by this chapter for its first taxable year ending on or after October 13, 1995. Such

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applicable period shall be for any number of months (not greater than 12) specified in the election and may not be changed by the taxpayer without the consent of the Secretary.

"(3) KEY PERSON.—For purposes of paragraph (1), the term 'key person' means an officer or 20-percent owner, except that the number of individuals who may be treated as key persons with respect to any taxpayer shall not exceed the greater of—

"(A) 5 individuals, or

"(B) the lesser of 5 percent of the total officers and employees of the taxpayer or 20 individuals.

"(4) 20-PERCENT OWNER.—For purposes of this subsection, the term '20-percent owner' means—

"(A) if the taxpayer is a corporation, any person who owns directly 20 percent or more of the outstanding stock of the corporation or stock possessing 20 percent or more of the total combined voting power of all stock of the corporation, or

"(B) if the taxpayer is not a corporation, any person who owns 20 percent or more of the capital or profits interest in the employer.

"(5) AGGREGATION RULES.—

"(A) IN GENERAL.—For purposes of paragraph (4)(A) and applying the \$50,000 limitation in paragraph (1)—

"(i) all members of a controlled group shall be treated as one taxpayer, and

"(ii) such limitation shall be allocated among the members of such group in such manner as the Secretary may prescribe.

"(B) CONTROLLED GROUP.—For purposes of this paragraph, all persons treated as a single employer under subsection (a) or (b) of section 52 or subsection (m) or (o) of section 414 shall be treated as members of a controlled group."

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section shall apply to interest paid or accrued after October 13, 1995.

(2) TRANSITION RULE FOR EXISTING INDEBTEDNESS.—

(A) IN GENERAL.—In the case of—

(i) indebtedness incurred before January 1, 1996, or

(ii) indebtedness incurred before January 1, 1997 with respect to any contract or policy entered into in 1994 or 1995,

the amendments made by this section shall not apply to qualified interest paid or accrued on such indebtedness after October 13, 1995, and before January 1, 1999.

(B) QUALIFIED INTEREST.—For purposes of subparagraph (A), the qualified interest with respect to any indebtedness for any month is the amount of interest (otherwise deductible) which would be paid or accrued for such month on such indebtedness if—

(i) in the case of any interest paid or accrued after December 31, 1995, indebtedness with respect to no more than 20,000 insured individuals were taken into account, and

26 USC 264 note.

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(ii) the lesser of the following rates of interest were used for such month:

(I) The rate of interest specified under the terms of the indebtedness as in effect on October 13, 1995 (and without regard to modification of such terms after such date).

(II) The applicable percentage of the rate of interest described as Moody's Corporate Bond Yield Average-Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto, for such month.

For purposes of clause (i), all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as 1 person. Subclause (II) of clause (ii) shall not apply to any month before January 1, 1996.

(C) APPLICABLE PERCENTAGE.—For purposes of subparagraph (B), the applicable percentage is as follows:

For calendar year:	The percentage is:
1996	100 percent
1997	90 percent
1998	80 percent

(3) SPECIAL RULE FOR GRANDFATHERED CONTRACTS.—This section shall not apply to any contract purchased on or before June 20, 1986, except that section 264(d)(2) of the Internal Revenue Code of 1986 shall apply to interest paid or accrued after October 13, 1995.

26 USC 264 note.

(d) SPREAD OF INCOME INCLUSION ON SURRENDER, ETC. OF CONTRACTS.—

(1) IN GENERAL.—If any amount is received under any life insurance policy or endowment or annuity contract described in paragraph (4) of section 264(a) of the Internal Revenue Code of 1986—

(A) on the complete surrender, redemption, or maturity of such policy or contract during calendar year 1996, 1997, or 1998, or

(B) in full discharge during any such calendar year of the obligation under the policy or contract which is in the nature of a refund of the consideration paid for the policy or contract,

then (in lieu of any other inclusion in gross income) such amount shall be includible in gross income ratably over the 4-taxable year period beginning with the taxable year such amount would (but for this paragraph) be includible. The preceding sentence shall only apply to the extent the amount is includible in gross income for the taxable year in which the event described in subparagraph (A) or (B) occurs.

(2) SPECIAL RULES FOR APPLYING SECTION 264.—A contract shall not be treated as—

(A) failing to meet the requirement of section 264(c)(1) of the Internal Revenue Code of 1986, or

(B) a single premium contract under section 264(b)(1) of such Code,

solely by reason of an occurrence described in subparagraph (A) or (B) of paragraph (1) of this subsection or solely by

reason of no additional premiums being received under the contract by reason of a lapse occurring after October 13, 1995.

(3) SPECIAL RULE FOR DEFERRED ACQUISITION COSTS.—In the case of the occurrence of any event described in subparagraph (A) or (B) of paragraph (1) of this subsection with respect to any policy or contract—

(A) section 848 of the Internal Revenue Code of 1986 shall not apply to the unamortized balance (if any) of the specified policy acquisition expenses attributable to such policy or contract immediately before the insurance company's taxable year in which such event occurs, and

(B) there shall be allowed as a deduction to such company for such taxable year under chapter 1 of such Code an amount equal to such unamortized balance.

Subtitle B—Treatment of Individuals Who Lose United States Citizenship

SEC. 511. REVISION OF INCOME, ESTATE, AND GIFT TAXES ON INDIVIDUALS WHO LOSE UNITED STATES CITIZENSHIP.

(a) IN GENERAL.—Subsection (a) of section 877 is amended to read as follows:

“(a) TREATMENT OF EXPATRIATES.—

“(1) IN GENERAL.—Every nonresident alien individual who, within the 10-year period immediately preceding the close of the taxable year, lost United States citizenship, unless such loss did not have for one of its principal purposes the avoidance of taxes under this subtitle or subtitle B, shall be taxable for such taxable year in the manner provided in subsection (b) if the tax imposed pursuant to such subsection exceeds the tax which, without regard to this section, is imposed pursuant to section 871.

“(2) CERTAIN INDIVIDUALS TREATED AS HAVING TAX AVOIDANCE PURPOSE.—For purposes of paragraph (1), an individual shall be treated as having a principal purpose to avoid such taxes if—

“(A) the average annual net income tax (as defined in section 38(c)(1)) of such individual for the period of 5 taxable years ending before the date of the loss of United States citizenship is greater than \$100,000, or

“(B) the net worth of the individual as of such date is \$500,000 or more.

In the case of the loss of United States citizenship in any calendar year after 1996, such \$100,000 and \$500,000 amounts shall be increased by an amount equal to such dollar amount multiplied by the cost-of-living adjustment determined under section 1(f)(3) for such calendar year by substituting ‘1994’ for ‘1992’ in subparagraph (B) thereof. Any increase under the preceding sentence shall be rounded to the nearest multiple of \$1,000.”

(b) EXCEPTIONS.—

(1) IN GENERAL.—Section 877 is amended by striking subsection (d), by redesignating subsection (c) as subsection (d), and by inserting after subsection (b) the following new subsection:

“(c) TAX AVOIDANCE NOT PRESUMED IN CERTAIN CASES.—

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“(1) IN GENERAL.—Subsection (a)(2) shall not apply to an individual if—

“(A) such individual is described in a subparagraph of paragraph (2) of this subsection, and

“(B) within the 1-year period beginning on the date of the loss of United States citizenship, such individual submits a ruling request for the Secretary’s determination as to whether such loss has for one of its principal purposes the avoidance of taxes under this subtitle or subtitle B.

“(2) INDIVIDUALS DESCRIBED.—

“(A) DUAL CITIZENSHIP, ETC.—An individual is described in this subparagraph if—

“(i) the individual became at birth a citizen of the United States and a citizen of another country and continues to be a citizen of such other country, or

“(ii) the individual becomes (not later than the close of a reasonable period after loss of United States citizenship) a citizen of the country in which—

“(I) such individual was born,

“(II) if such individual is married, such individual’s spouse was born, or

“(III) either of such individual’s parents were born.

“(B) LONG-TERM FOREIGN RESIDENTS.—An individual is described in this subparagraph if, for each year in the 10-year period ending on the date of loss of United States citizenship, the individual was present in the United States for 30 days or less. The rule of section 7701(b)(3)(D)(ii) shall apply for purposes of this subparagraph.

“(C) RENUNCIATION UPON REACHING AGE OF MAJORITY.—An individual is described in this subparagraph if the individual’s loss of United States citizenship occurs before such individual attains age 18½.

“(D) INDIVIDUALS SPECIFIED IN REGULATIONS.—An individual is described in this subparagraph if the individual is described in a category of individuals prescribed by regulation by the Secretary.”.

(2) TECHNICAL AMENDMENT.—Paragraph (1) of section 877(b) of such Code is amended by striking “subsection (c)” and inserting “subsection (d)”.

(c) TREATMENT OF PROPERTY DISPOSED OF IN NONRECOGNITION TRANSACTIONS; TREATMENT OF DISTRIBUTIONS FROM CERTAIN CONTROLLED FOREIGN CORPORATIONS.—Subsection (d) of section 877, as redesignated by subsection (b), is amended to read as follows:

“(d) SPECIAL RULES FOR SOURCE, ETC.—For purposes of subsection (b)—

“(1) SOURCE RULES.—The following items of gross income shall be treated as income from sources within the United States:

“(A) SALE OF PROPERTY.—Gains on the sale or exchange of property (other than stock or debt obligations) located in the United States.

“(B) STOCK OR DEBT OBLIGATIONS.—Gains on the sale or exchange of stock issued by a domestic corporation or debt obligations of United States persons or of the United

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States, a State or political subdivision thereof, or the District of Columbia.

"(C) INCOME OR GAIN DERIVED FROM CONTROLLED FOREIGN CORPORATION.—Any income or gain derived from stock in a foreign corporation but only—

"(i) if the individual losing United States citizenship owned (within the meaning of section 958(a)), or is considered as owning (by applying the ownership rules of section 958(b)), at any time during the 2-year period ending on the date of the loss of United States citizenship, more than 50 percent of—

"(I) the total combined voting power of all classes of stock entitled to vote of such corporation, or

"(II) the total value of the stock of such corporation, and

"(ii) to the extent such income or gain does not exceed the earnings and profits attributable to such stock which were earned or accumulated before the loss of citizenship and during periods that the ownership requirements of clause (i) are met.

"(2) GAIN RECOGNITION ON CERTAIN EXCHANGES.—

"(A) IN GENERAL.—In the case of any exchange of property to which this paragraph applies, notwithstanding any other provision of this title, such property shall be treated as sold for its fair market value on the date of such exchange, and any gain shall be recognized for the taxable year which includes such date.

"(B) EXCHANGES TO WHICH PARAGRAPH APPLIES.—This paragraph shall apply to any exchange during the 10-year period described in subsection (a) if—

"(i) gain would not (but for this paragraph) be recognized on such exchange in whole or in part for purposes of this subtitle,

"(ii) income derived from such property was from sources within the United States (or, if no income was so derived, would have been from such sources), and

"(iii) income derived from the property acquired in the exchange would be from sources outside the United States.

"(C) EXCEPTION.—Subparagraph (A) shall not apply if the individual enters into an agreement with the Secretary which specifies that any income or gain derived from the property acquired in the exchange (or any other property which has a basis determined in whole or part by reference to such property) during such 10-year period shall be treated as from sources within the United States. If the property transferred in the exchange is disposed of by the person acquiring such property, such agreement shall terminate and any gain which was not recognized by reason of such agreement shall be recognized as of the date of such disposition.

"(D) SECRETARY MAY EXTEND PERIOD.—To the extent provided in regulations prescribed by the Secretary, subparagraph (B) shall be applied by substituting the 15-

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year period beginning 5 years before the loss of United States citizenship for the 10-year period referred to therein.

"(E) SECRETARY MAY REQUIRE RECOGNITION OF GAIN IN CERTAIN CASES.—To the extent provided in regulations prescribed by the Secretary—

"(i) the removal of appreciated tangible personal property from the United States, and

"(ii) any other occurrence which (without recognition of gain) results in a change in the source of the income or gain from property from sources within the United States to sources outside the United States, shall be treated as an exchange to which this paragraph applies.

"(3) SUBSTANTIAL DIMINISHING OF RISKS OF OWNERSHIP.—

For purposes of determining whether this section applies to any gain on the sale or exchange of any property, the running of the 10-year period described in subsection (a) shall be suspended for any period during which the individual's risk of loss with respect to the property is substantially diminished by—

"(A) the holding of a put with respect to such property (or similar property),

"(B) the holding by another person of a right to acquire the property, or

"(C) a short sale or any other transaction.

"(4) TREATMENT OF PROPERTY CONTRIBUTED TO CONTROLLED FOREIGN CORPORATIONS.—

"(A) IN GENERAL.—If—

"(i) an individual losing United States citizenship contributes property to any corporation which, at the time of the contribution, is described in subparagraph (B), and

"(ii) income derived from such property was from sources within the United States (or, if no income was so derived, would have been from such sources), during the 10-year period referred to in subsection (a), any income or gain on such property (or any other property which has a basis determined in whole or part by reference to such property) received or accrued by the corporation shall be treated as received or accrued directly by such individual and not by such corporation. The preceding sentence shall not apply to the extent the property has been treated under subparagraph (C) as having been sold by such corporation.

"(B) CORPORATION DESCRIBED.—A corporation is described in this subparagraph with respect to an individual if, were such individual a United States citizen—

"(i) such corporation would be a controlled foreign corporation (as defined in 957), and

"(ii) such individual would be a United States shareholder (as defined in section 951(b)) with respect to such corporation.

"(C) DISPOSITION OF STOCK IN CORPORATION.—If stock in the corporation referred to in subparagraph (A) (or any other stock which has a basis determined in whole or part by reference to such stock) is disposed of during the 10-year period referred to in subsection (a) and while the

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property referred to in subparagraph (A) is held by such corporation, a pro rata share of such property (determined on the basis of the value of such stock) shall be treated as sold by the corporation immediately before such disposition.

“(D) ANTI-ABUSE RULES.—The Secretary shall prescribe such regulations as may be necessary to prevent the avoidance of the purposes of this paragraph, including where—

“(i) the property is sold to the corporation, and

“(ii) the property taken into account under subparagraph (A) is sold by the corporation.

“(E) INFORMATION REPORTING.—The Secretary shall require such information reporting as is necessary to carry out the purposes of this paragraph.”.

(d) CREDIT FOR FOREIGN TAXES IMPOSED ON UNITED STATES SOURCE INCOME.—

(1) Subsection (b) of section 877 is amended by adding at the end the following new sentence: “The tax imposed solely by reason of this section shall be reduced (but not below zero) by the amount of any income, war profits, and excess profits taxes (within the meaning of section 903) paid to any foreign country or possession of the United States on any income of the taxpayer on which tax is imposed solely by reason of this section.”

(2) Subsection (a) of section 877, as amended by subsection (a), is amended by inserting “(after any reduction in such tax under the last sentence of such subsection)” after “such subsection”.

(e) COMPARABLE ESTATE AND GIFT TAX TREATMENT.—

(1) ESTATE TAX.—

(A) IN GENERAL.—Subsection (a) of section 2107 is amended to read as follows:

“(a) TREATMENT OF EXPATRIATES.—

“(1) RATE OF TAX.—A tax computed in accordance with the table contained in section 2001 is hereby imposed on the transfer of the taxable estate, determined as provided in section 2106, of every decedent nonresident not a citizen of the United States if, within the 10-year period ending with the date of death, such decedent lost United States citizenship, unless such loss did not have for one of its principal purposes the avoidance of taxes under this subtitle or subtitle A.

“(2) CERTAIN INDIVIDUALS TREATED AS HAVING TAX AVOIDANCE PURPOSE.—

“(A) IN GENERAL.—For purposes of paragraph (1), an individual shall be treated as having a principal purpose to avoid such taxes if such individual is so treated under section 877(a)(2).

“(B) EXCEPTION.—Subparagraph (A) shall not apply to a decedent meeting the requirements of section 877(c)(1).”.

(B) CREDIT FOR FOREIGN DEATH TAXES.—Subsection (c) of section 2107 is amended by redesignating paragraph (2) as paragraph (3) and by inserting after paragraph (1) the following new paragraph:

“(2) CREDIT FOR FOREIGN DEATH TAXES.—

“(A) IN GENERAL.—The tax imposed by subsection (a) shall be credited with the amount of any estate, inherit-

ance, legacy, or succession taxes actually paid to any foreign country in respect of any property which is included in the gross estate solely by reason of subsection (b).

"(B) LIMITATION ON CREDIT.—The credit allowed by subparagraph (A) for such taxes paid to a foreign country shall not exceed the lesser of—

"(i) the amount which bears the same ratio to the amount of such taxes actually paid to such foreign country in respect of property included in the gross estate as the value of the property included in the gross estate solely by reason of subsection (b) bears to the value of all property subjected to such taxes by such foreign country, or

"(ii) such property's proportionate share of the excess of—

"(I) the tax imposed by subsection (a), over

"(II) the tax which would be imposed by section 2101 but for this section.

"(C) PROPORTIONATE SHARE.—For purposes of subparagraph (B), a property's proportionate share is the percentage of the value of the property which is included in the gross estate solely by reason of subsection (b) bears to the total value of the gross estate."

(C) EXPANSION OF INCLUSION IN GROSS ESTATE OF STOCK OF FOREIGN CORPORATIONS.—Paragraph (2) of section 2107(b) is amended by striking "more than 50 percent of" and all that follows and inserting "more than 50 percent of—

"(A) the total combined voting power of all classes of stock entitled to vote of such corporation, or

"(B) the total value of the stock of such corporation,".

(2) GIFT TAX.—

(A) IN GENERAL.—Paragraph (3) of section 2501(a) is amended to read as follows:

"(3) EXCEPTION.—

"(A) CERTAIN INDIVIDUALS.—Paragraph (2) shall not apply in the case of a donor who, within the 10-year period ending with the date of transfer, lost United States citizenship, unless such loss did not have for one of its principal purposes the avoidance of taxes under this subtitle or subtitle A.

"(B) CERTAIN INDIVIDUALS TREATED AS HAVING TAX AVOIDANCE PURPOSE.—For purposes of subparagraph (A), an individual shall be treated as having a principal purpose to avoid such taxes if such individual is so treated under section 877(a)(2).

"(C) EXCEPTION FOR CERTAIN INDIVIDUALS.—Subparagraph (B) shall not apply to a decedent meeting the requirements of section 877(c)(1).

"(D) CREDIT FOR FOREIGN GIFT TAXES.—The tax imposed by this section solely by reason of this paragraph shall be credited with the amount of any gift tax actually paid to any foreign country in respect of any gift which is taxable under this section solely by reason of this paragraph."

(f) COMPARABLE TREATMENT OF LAWFUL PERMANENT RESIDENTS WHO CEASE TO BE TAXED AS RESIDENTS.—

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(1) IN GENERAL.—Section 877 is amended by redesignating subsection (e) as subsection (f) and by inserting after subsection (d) the following new subsection:

“(e) COMPARABLE TREATMENT OF LAWFUL PERMANENT RESIDENTS WHO CEASE TO BE TAXED AS RESIDENTS.—

“(1) IN GENERAL.—Any long-term resident of the United States who—

“(A) ceases to be a lawful permanent resident of the United States (within the meaning of section 7701(b)(6)), or

“(B) commences to be treated as a resident of a foreign country under the provisions of a tax treaty between the United States and the foreign country and who does not waive the benefits of such treaty applicable to residents of the foreign country,

shall be treated for purposes of this section and sections 2107, 2501, and 6039F in the same manner as if such resident were a citizen of the United States who lost United States citizenship on the date of such cessation or commencement.

“(2) LONG-TERM RESIDENT.—For purposes of this subsection, the term ‘long-term resident’ means any individual (other than a citizen of the United States) who is a lawful permanent resident of the United States in at least 8 taxable years during the period of 15 taxable years ending with the taxable year during which the event described in subparagraph (A) or (B) of paragraph (1) occurs. For purposes of the preceding sentence, an individual shall not be treated as a lawful permanent resident for any taxable year if such individual is treated as a resident of a foreign country for the taxable year under the provisions of a tax treaty between the United States and the foreign country and does not waive the benefits of such treaty applicable to residents of the foreign country.

“(3) SPECIAL RULES.—

“(A) EXCEPTIONS NOT TO APPLY.—Subsection (c) shall not apply to an individual who is treated as provided in paragraph (1).

“(B) STEP-UP IN BASIS.—Solely for purposes of determining any tax imposed by reason of this subsection, property which was held by the long-term resident on the date the individual first became a resident of the United States shall be treated as having a basis on such date of not less than the fair market value of such property on such date. The preceding sentence shall not apply if the individual elects not to have such sentence apply. Such an election, once made, shall be irrevocable.

“(4) AUTHORITY TO EXEMPT INDIVIDUALS.—This subsection shall not apply to an individual who is described in a category of individuals prescribed by regulation by the Secretary.

“(5) REGULATIONS.—The Secretary shall prescribe such regulations as may be appropriate to carry out this subsection, including regulations providing for the application of this subsection in cases where an alien individual becomes a resident of the United States during the 10-year period after being treated as provided in paragraph (1).”

(2) CONFORMING AMENDMENTS.—

(A) Section 2107 is amended by striking subsection (d), by redesignating subsection (e) as subsection (d), and

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by inserting after subsection (d) (as so redesignated) the following new subsection:

“(e) CROSS REFERENCE.—

“For comparable treatment of long-term lawful permanent residents who ceased to be taxed as residents, see section 877(e).”.

(B) Paragraph (3) of section 2501(a) (as amended by subsection (e)) is amended by adding at the end the following new subparagraph:

“(E) CROSS REFERENCE.—

“For comparable treatment of long-term lawful permanent residents who ceased to be taxed as residents, see section 877(e).”.

26 USC 877 note.

(g) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to—

(A) individuals losing United States citizenship (within the meaning of section 877 of the Internal Revenue Code of 1986) on or after February 6, 1995, and

(B) long-term residents of the United States with respect to whom an event described in subparagraph (A) or (B) of section 877(e)(1) of such Code occurs on or after February 6, 1995.

(2) RULING REQUESTS.—In no event shall the 1-year period referred to in section 877(c)(1)(B) of such Code, as amended by this section, expire before the date which is 90 days after the date of the enactment of this Act.

(3) SPECIAL RULE.—

(A) IN GENERAL.—In the case of an individual who performed an act of expatriation specified in paragraph (1), (2), (3), or (4) of section 349(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a)(1)–(4)) before February 6, 1995, but who did not, on or before such date, furnish to the United States Department of State a signed statement of voluntary relinquishment of United States nationality confirming the performance of such act, the amendments made by this section and section 512 shall apply to such individual except that the 10-year period described in section 877(a) of such Code shall not expire before the end of the 10-year period beginning on the date such statement is so furnished.

(B) EXCEPTION.—Subparagraph (A) shall not apply if the individual establishes to the satisfaction of the Secretary of the Treasury that such loss of United States citizenship occurred before February 6, 1994.

SEC. 512. INFORMATION ON INDIVIDUALS LOSING UNITED STATES CITIZENSHIP.

(a) IN GENERAL.—Subpart A of part III of subchapter A of chapter 61 is amended by inserting after section 6039E the following new section:

“SEC. 6039F. INFORMATION ON INDIVIDUALS LOSING UNITED STATES CITIZENSHIP.

“(a) IN GENERAL.—Notwithstanding any other provision of law, any individual who loses United States citizenship (within the meaning of section 877(a)) shall provide a statement which

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includes the information described in subsection (b). Such statement shall be—

“(1) provided not later than the earliest date of any act referred to in subsection (c), and

“(2) provided to the person or court referred to in subsection (c) with respect to such act.

“(b) INFORMATION TO BE PROVIDED.—Information required under subsection (a) shall include—

“(1) the taxpayer’s TIN,

“(2) the mailing address of such individual’s principal foreign residence,

“(3) the foreign country in which such individual is residing,

“(4) the foreign country of which such individual is a citizen,

“(5) in the case of an individual having a net worth of at least the dollar amount applicable under section 877(a)(2)(B), information detailing the assets and liabilities of such individual, and

“(6) such other information as the Secretary may prescribe.

“(c) ACTS DESCRIBED.—For purposes of this section, the acts referred to in this subsection are—

“(1) the individual’s renunciation of his United States nationality before a diplomatic or consular officer of the United States pursuant to paragraph (5) of section 349(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a)(5)),

“(2) the individual’s furnishing to the United States Department of State a signed statement of voluntary relinquishment of United States nationality confirming the performance of an act of expatriation specified in paragraph (1), (2), (3), or (4) of section 349(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a)(1)–(4)),

“(3) the issuance by the United States Department of State of a certificate of loss of nationality to the individual, or

“(4) the cancellation by a court of the United States of a naturalized citizen’s certificate of naturalization.

“(d) PENALTY.—Any individual failing to provide a statement required under subsection (a) shall be subject to a penalty for each year (of the 10-year period beginning on the date of loss of United States citizenship) during any portion of which such failure continues in an amount equal to the greater of—

“(1) 5 percent of the tax required to be paid under section 877 for the taxable year ending during such year, or

“(2) \$1,000,

unless it is shown that such failure is due to reasonable cause and not to willful neglect.

“(e) INFORMATION TO BE PROVIDED TO SECRETARY.—Notwithstanding any other provision of law—

“(1) any Federal agency or court which collects (or is required to collect) the statement under subsection (a) shall provide to the Secretary—

“(A) a copy of any such statement, and

“(B) the name (and any other identifying information) of any individual refusing to comply with the provisions of subsection (a),

“(2) the Secretary of State shall provide to the Secretary a copy of each certificate as to the loss of American nationality under section 358 of the Immigration and Nationality Act which is approved by the Secretary of State, and

"(3) the Federal agency primarily responsible for administering the immigration laws shall provide to the Secretary the name of each lawful permanent resident of the United States (within the meaning of section 7701(b)(6)) whose status as such has been revoked or has been administratively or judicially determined to have been abandoned.

Notwithstanding any other provision of law, not later than 30 days after the close of each calendar quarter, the Secretary shall publish in the Federal Register the name of each individual losing United States citizenship (within the meaning of section 877(a)) with respect to whom the Secretary receives information under the preceding sentence during such quarter.

"(f) REPORTING BY LONG-TERM LAWFUL PERMANENT RESIDENTS WHO CEASE TO BE TAXED AS RESIDENTS.—In lieu of applying the last sentence of subsection (a), any individual who is required to provide a statement under this section by reason of section 877(e)(1) shall provide such statement with the return of tax imposed by chapter 1 for the taxable year during which the event described in such section occurs.

"(g) EXEMPTION.—The Secretary may by regulations exempt any class of individuals from the requirements of this section if he determines that applying this section to such individuals is not necessary to carry out the purposes of this section."

(b) CLERICAL AMENDMENT.—The table of sections for such subpart A is amended by inserting after the item relating to section 6039E the following new item:

"Sec. 6039F. Information on individuals losing United States citizenship."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to—

(1) individuals losing United States citizenship (within the meaning of section 877 of the Internal Revenue Code of 1986) on or after February 6, 1995, and

(2) long-term residents of the United States with respect to whom an event described in subparagraph (A) or (B) of section 877(e)(1) of such Code occurs on or after such date.

In no event shall any statement required by such amendments be due before the 90th day after the date of the enactment of this Act.

SEC. 513. REPORT ON TAX COMPLIANCE BY UNITED STATES CITIZENS AND RESIDENTS LIVING ABROAD.

Not later than 90 days after the date of the enactment of this Act, the Secretary of the Treasury shall prepare and submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report—

(1) describing the compliance with subtitle A of the Internal Revenue Code of 1986 by citizens and lawful permanent residents of the United States (within the meaning of section 7701(b)(6) of such Code) residing outside the United States, and

(2) recommending measures to improve such compliance (including improved coordination between executive branch agencies).

26 USC 6039F
note.

**Subtitle C—Repeal of Financial Institution
Transition Rule to Interest Allocation
Rules**

**SEC. 521. REPEAL OF FINANCIAL INSTITUTION TRANSITION RULE TO
INTEREST ALLOCATION RULES.**

(a) **IN GENERAL.**—Paragraph (5) of section 1215(c) of the Tax Reform Act of 1986 (Public Law 99-514, 100 Stat. 2548) is hereby repealed.

26 USC 864 note.

(b) **EFFECTIVE DATE.**—

26 USC 864 note.

(1) **IN GENERAL.**—The amendment made by this section shall apply to taxable years beginning after December 31, 1995.

(2) **SPECIAL RULE.**—In the case of the first taxable year beginning after December 31, 1995, the pre-effective date portion of the interest expense of the corporation referred to in such paragraph (5) of such section 1215(c) for such taxable year shall be allocated and apportioned without regard to such amendment. For purposes of the preceding sentence, the pre-effective date portion is the amount which bears the same ratio to the interest expense for such taxable year as the number of days during such taxable year before the date of the enactment of this Act bears to 366.

Approved August 21, 1996.

Part III. Administrative, Procedural, and Miscellaneous

26 CFR 601.201: Rulings and determination letters.

Rev. Proc. 96-49

SECTION 1. PURPOSE

This revenue procedure provides a model amendment that will give plan sponsors a streamlined way to amend their plans to comply with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994, Pub. L. No. 103-353 ("USERRA"), and § 414(u) of the Internal Revenue Code. The revenue procedure also provides that plan amendments to reflect the provisions of USERRA and § 414(u) generally will not be required to be made before 1998. Section 414(u) was added by § 1704(n) of the Small Business Job Protection Act of 1996, Pub. L. No. 104-188 ("SBJPA"). The model amendment is available for use by sponsors of master or prototype ("M&P"), regional prototype, volume submitter specimen, individually designed, and simplified employee pension ("SEP") plans that have received favorable opinion, notification, advisory, ruling, or determination letters that take into account the requirements of the Tax Reform Act of 1986, Pub. L. No. 99-514 ("TRA '86").

SECTION 2. BACKGROUND AND GENERAL INFORMATION

.01 USERRA, codified at 38 U.S.C. §§ 4301-4333, revised and restated the federal law protecting veterans' reemployment rights. Under USERRA, which is interpreted and enforced by the Veterans' Employment and Training Service of the U.S. Department of Labor, an employee who is absent from a position with an employer because of military service generally is entitled to reemployment with that employer, subject to certain limits and exceptions. USERRA also requires certain other rights and benefits to be provided or made available, including, in certain circumstances, coverage under the employer's health plan. In addition, on reemployment, an employee is entitled to receive certain pension, profit-sharing and similar benefits (under defined benefit or defined contribution plans) that would have been received but for the employee's absence during military service. USERRA sets forth various rules relating to the em-

ployee's reemployment and other rights and benefits, including—

- the types of military service covered,
- advance notice of military service to be given to an employer,
- documentation of reemployment eligibility,
- exceptions for dishonorable discharge and employer hardship,
- the position in which an individual must be reemployed, and
- enforcement procedures.

.02 Section 414(u) generally provides that a contribution that is made by an employer or employee to an individual account plan or by an employee to a contributory defined benefit plan, and that is required under USERRA, is taken into account for purposes of the limitations of § 402(g), 402(h), 403(b), 404(a), 404(h), 408, 415 or 457 in the year to which the contribution relates, not the year in which the contribution is made. In addition, § 414(u) provides that a plan is not treated as failing to meet the requirements of § 401(a)(4), 401(a)(26), 401(k)(3), 401(k)(11), 401(k)(12), 401(m), 403(b)(12), 408(k)(3), 408(k)(6), 408(p), 410(b), or 416 because of the contribution (or the right to make the contribution).

.03 Section 414(u) generally provides that an employer maintaining a plan shall be treated as meeting the requirements of USERRA only if an employee reemployed under USERRA is treated as not having incurred a break in service because of the period of military service, the employee's military service is treated as service with the employer for vesting and benefit accrual purposes, the employee is permitted to make additional elective deferrals and employee contributions in an amount not exceeding the maximum amount the employee would have been permitted or required to contribute during the period of military service if the employee had actually been employed by the employer during that period ("make-up contributions"), and the employee is entitled to any accrued benefits that are contingent on employee contributions or elective deferrals to the extent the employee pays the contributions or elective deferrals to the plan. Make-up contributions must be permitted during the period that begins on the date of reemployment and continues for five years or, if less, three times the period of military service. With respect to make-up contributions, the

employer must make matching contributions that would have been required if the make-up contributions had actually been made during the period of military service.

.04 Section 414(u) provides that an employee is treated as receiving compensation from the employer during the period of military service equal to the compensation the employee otherwise would have received from the employer during that period, or, if the compensation the employee otherwise would have received is not reasonably certain, the employee's average compensation from the employer during the period immediately preceding the period of military service. For purposes of § 414(u), USERRA is not treated as requiring the crediting of earnings to an employee with respect to any contribution before the contribution is actually made or requiring any allocation of forfeitures to the employee for the period of military service. Section 414(u) also provides that, if a plan provides for the suspension of an employee's obligation to repay a loan for any part of any period of military service, the suspension is not taken into account for purposes of § 72(p), 401(a) or 4975(d)(1).

.05 USERRA provides generally that it is effective with respect to reemployments initiated 60 days or more after the October 13, 1994, enactment date of USERRA, that is, reemployments initiated on or after December 12, 1994. USERRA provides that an employee pension benefit plan has two years from the date of enactment, that is, until October 13, 1996, to come into compliance. Section 1704(n)(3) of SBJPA provides that § 414(u) is effective as of December 12, 1994. The relief provided by § 414(u) extends to plans that are not operated in compliance with the requirements of USERRA specified in § 414(u) until after October 12, 1996, as well as to plans that were operated in compliance with those requirements before October 13, 1996.

.06 Provisions of SBJPA that are unrelated to USERRA changed various qualification requirements for plans. Section 1465 of SBJPA provides that, if a plan amendment is required by certain changes under SBJPA ("SBJPA change"), the amendment is not required to be made before the first day of the first plan year beginning on or after January 1, 1998 (January 1, 2000, for a governmental plan as defined in

§ 414(d) of the Code), if the plan is operated in accordance with the SBJPA change during the period from the effective date of the SBJPA change to the time the plan amendment is required and if the plan amendment reflecting the SBJPA change applies retroactively to that period.

.07 Plan amendments to reflect the provisions of USERRA and § 414(u) will not be required to be made before the date plan amendments will be required to be made under § 1465 of SBJPA.

SECTION 3. MODEL AMENDMENT

.01 All plans—Sponsors described in subsection .02 may amend their plans by adopting, word-for-word, the model language in the appendix to this revenue procedure in accordance with the instructions in this revenue procedure. If a sponsor to whom the model language is available pursuant to subsection .02 adopts the model language, neither application to the Service nor a user fee is required. The Service will not issue new opinion, notification, advisory, ruling, or determination letters for plans that are amended solely to add the model language described in this section.

.02 The model language is available only to sponsors of M&P, regional prototype, volume submitter specimen, and individually designed (including volume submitter and SEP) plans that, as of the date of the adoption of the model amendment, have reliance on a favorable opinion, notification, advisory, ruling, or determination letter that takes

into account the requirements of TRA '86 under Rev. Proc. 87-50, 1987-2 C.B. 647, as modified; Rev. Proc. 89-9, 1989-1 C.B. 780, as modified; Rev. Proc. 89-13, 1989-1 C.B. 801, as modified; Rev. Proc. 90-20, 1990-1 C.B. 495; Rev. Proc. 91-41, 1991-2 C.B. 697; Rev. Proc. 91-66, 1991-2 C.B. 870; Rev. Proc. 93-39, 1993-2 C.B. 513; or Rev. Proc. 96-6, 1996-1 I.R.B. 151.

.03 M&P, Regional Prototype and Volume Submitter Plans—M&P, regional prototype and volume submitter plan sponsors that use the model language must file Form 8837, Notice of Adoption of Revenue Procedure Model Amendments.

SECTION 4. RELIANCE

An employer entitled to rely on an opinion, notification, ruling, or determination letter will not lose reliance on the letter merely because of this amendment. Plan amendments made in accordance with section 2.07 and section 3 of this revenue procedure will not cause the plan to lose its otherwise applicable extended reliance period under Rev. Procs. 89-9 and 89-13, as modified by Rev. Proc. 93-9, 1993-1 C.B. 474, or section 13 of Rev. Proc. 93-39.

DRAFTING INFORMATION

The principal author of this revenue procedure is Richard Wright of the Employee Plans Division. For further information regarding this revenue procedure, contact the Employee Plans Division's telephone assistance service be-

tween 1:30 and 4:00 p.m., Eastern Time, Monday through Thursday at (202) 622-6074/6075 or Mr. Wright at (202) 622-6214. (These telephone numbers are not toll-free numbers.)

For further information regarding USERRA, contact the local office of the Veterans' Employment and Training Service ("VETS") of the U.S. Department of Labor or contact the VETS National Office at 1-202-219-8611.

APPENDIX

MODEL AMENDMENTS

AMENDMENT 1

(Note to Sponsor: The following model amendment may be used to amend plans to provide for the requirements of USERRA and § 414(u) of the Code.)

"Notwithstanding any provision of this plan to the contrary, contributions, benefits and service credit with respect to qualified military service will be provided in accordance with § 414(u) of the Internal Revenue Code."

AMENDMENT 2

(Note to Sponsor: The following model amendment may be used to amend plans that provide for loans to participants, if the sponsor chooses to suspend loan repayments during participants' periods of military service.)

"Loan repayments will be suspended under this plan as permitted under § 414(u)(4) of the Internal Revenue Code."

Part IV. Items of General Interest

Foundations Status of Certain Organizations

Announcement 96-109

The following organizations have failed to establish or have been unable to maintain their status as public charities or as operating foundations. Accordingly, grantors and contributors may not, after this date, rely on previous rulings or designations in the Cumulative List of Organizations (Publication 78), or on the presumption arising from the filing of notices under section 508(b) of the Code. This listing does *not* indicate that the organizations have lost their status as organizations described in section 501(c)(3), eligible to receive deductible contributions.

Former Public Charities. The following organizations (which have been treated as organizations that are not private foundations described in section 509(a) of the Code) are now classified as private foundations:

Accessibly Fun Resort and Campground Inc., Bloomington, MN
Ambulance Rescue 33 LTD, Chillicothe, IL
American Association of University Women North Shore Memorial, Chicago, IL
American Export Worldwide, Washington, DC
Androy Project Committee, Hibbing, MN
Anxiety Control Techniques, Tinley Park, IL
Apple Retreat Ministries, New Prague, MN
Archeological Institute of America Minn Society Inc., Minneapolis, MN
Arrowhead Wilderness Camps Inc., Highland Park, IL
ASI-Jamestown Inc., St. Paul, MN
Aspects and Expectations Inc., Madison, WI
Big Bend Vernon Historical Society Inc., Big Bend, WI
Bonduel Community Archives Inc., Bonduel, WI
Bradley Sigma Phi Historical Landmark, Madison, WI
California Acupuncture Resources Inc., San Leandro, CA
Cambridge Productions, Chicago, IL
Cameron Senior Citizens, Cameron, WI
Carbondale Community Orchestra Inc., Carbondale, IL
Casa Guatemala, Chicago, IL

Cascade Community Food Cupboard, Cascade, MT
Center for Development of Hardy Landscape Plants Inc., Chanhassen MN
Charles Restoration Mission, Detroit, MI
Chicago Numismatic Foundation Rare Coin Museum & Library Inc., Chicago, IL
Childrens Kidney Disease Society CKDS, Minneapolis, MN
Christian Bridge, Palos Heights, IL
Christian Health Association of Liberia Support Group, Aurora, IL
Christy Lynn Schaeffer Memorial Scholarship Fund LTD, Wolf Lake, IL
Columbia Park Tower Fund Inc., Malone, WI
Commonwealth Development Corporation, Inc., Detroit, MI
Community Support Systems, Chicago, IL
Concern for Car Owners Inc., Okemos, MI
Cultural & Educational Productions Association, Homewood, IL
Dale Mahnke Musical Ministries, Shelbyville, IL
Diocese of Chicago Housing Development Corporation, Chicago, IL
District 637 Foundation, Redwood Falls, MN
Don Irwin Ministries Inc., Minneapolis, MN
Douglas Mental Health Foundation Inc., Viroqua, WI
Dr. Jakob G. Schlichter Research Foundation, Chicago, IL
E. F. Jablonski Family Foundation Inc., Wausau, WI
Employment Awareness Resources, Broadview, IL
Environmental Advisory Group, Inc., Florence, AL
Evensong Foundation, Chicago, IL
Express Learning Center Inc., Chicago, IL
Family Drozd-Czerkowski Foundation, Chicago, IL
Farrington Company, Inc., New York, NY
Illinois Association for Gifted Children, Glenview, IL
Illinois Society of Fire Service Instructors, Oak Lawn, IL
Institute for Child and Family, Milwaukee, WI
Institute for World Resource Research, Woodbridge, IL
Janesville Youth Football Inc., Janesville, WI
J. Hawk Aquatic Club Inc., Whitewater, WI
Joan Vaala Memorial Trust, Madison, MN
John P. Loftus Scholarship Fund, Chicago, IL
Lake County Knights Inc., Wildwood, IL
Lee County Drug Dependency Rehabilitation Center, Inc., Tupelo, MS
Lewis and Clark International Ayn Hostel, St. Charles, MO
Marbleworks Theatre, Chicago, IL
Mather Health Care Inc., Evanston, IL
Maumee Valley-Wabash & Erie Canal Historical Society Incorporated, Woodburn, IN
Maywood Renaissance Center Inc., Maywood, IL
Mt. Pulaski Community Unit District No. 23 Education FDTN, Mt. Pulaski, IL
National Black Caucus of Special Educators, Chicago, IL
National Writers Uplink, Danville, IL
New Vision of Faith Development Corporation, Chicago, IL
New World Repertory Company, Chicago, IL
Orpheus of America, Chicago, IL
Pace Group, Inc., Wisconsin Rapids, WI
Pro Education Inc., Palos Hills, IL
Pro Hispanic Political Educational Project Inc., Paoli, PA
Projected Images of Hudson County, Hoboken, NJ
Project Redemption, Reamstown, PA
Project 2000 Plus Inc., Frederick, MD
Quantum Group, Minneapolis, MN
Rabbi Benjamin Steinberg Education Fund Inc., Baltimore, MD
Raft Inc., Washington, PA
Reach Out 56 Inc., Philadelphia, PA
Sakhisizwe Christian Ministries of South Africa Inc., Westminster, MD
San Pedro Maritime Heritage Museum, Wilmington, CA
Schuyler Jail Museum Inc., Rushville, IL
Search and Rescue Dogs of Maryland Inc., Waldorf, MD
Senri International School Foundation Inc., Princeton, NJ
Serenity House Inter-Island Neighborhood Endowment, St. Thomas, VI
Sexual Abuse & Addiction Treatment Foundation Inc., Frederick, MD
Shakespeare Guild Incorporated, Washington, DC
Shelter Project, Alexandria, VA

Shenandoah Fellowship Ministries,
McLean, VA
Tri City Tennis Association Inc.,
Marinette, WI
Union City Volunteer Fire Department,
Union City, PA
United Filipino Americans of Lake
County, Winthrop Harbor, IL
United States Chinese Kuoshu
Federation Inc., Towson, MD
United States Go Foundation, Inc., New
York, NY
University of Hull American
Foundation, Washington, DC
U.S. Council for International
Rehabilitation, Washington, DC
U.S. Knowhow Inc., Elmhurst, IL
Utilization Review Accreditation
Commission Inc., Washington, DC
Vesta Foundation Inc., Adelphi, MD
Vietnam Era Veterans Inter-Tribal
Assoc-Womens Auxiliary Inc.,
Germantown, MD
Village Theatre Company, Inc., New
York, NY
Virginia Center for Public Press Inc.,
Richmond, VA
Virginia Network for Victims and
Witnesses of Crime Inc., Alexandria,
VA
Virginians in Partnership for Housing
Inc., Mt. Vernon, VA
Vital Foundation, Pittsburgh, PA

Vivant Institute, Inc., New York, NY
Ward 8 Forum on Education,
Washington, DC
Warrior Run Lady Defender Basketball
Parents and Boosters AS, Turbotville,
PA
Washingtons Child Project, Washington,
DC

If an organization listed above sub-
mits information that warrants the re-
newal of its classification as a public
charity or as a private operating founda-
tion, the Internal Revenue Service will
issue a ruling or determination letter
with the revised classification as to
foundation status. Grantors and contribu-
tors may thereafter rely upon such rul-
ing or determination letter as provided
in section 1.509(a)-7 of the Income Tax
Regulations. It is not the practice of the
Service to announce such revised classi-
fication of foundation status in the Inter-
nal Revenue Bulletin.

**New Form 8160-A, Form
1120/1120-A Tax Package
Postcard, and New Form 8160-C,
Form 1065 Package Postcard**

Announcement 96-110

The 1996 Package 1120 (U.S. Corpo-
ration Income Tax Package) and the

1996 Package 1065 (U.S. Partnership
Return of Income) will not be mailed
automatically to prior year filers of
Forms 1120, 1120-A, or 1065 with U.S.
addresses. Instead, filers of these returns
for 1995 will be sent a postcard (Form
8160-A for corporations or Form
8160-C for partnerships), which will
include the pre-printed label to be used
with the 1996 return. Corporations or
partnerships that need a 1996 package
can order it by returning the postpaid
reply portion of the postcard.

**Notice of Disposition of Declaratory
Judgment Proceedings Under
Section 7428**

This announcement serves notice to
potential donors that on August 20,
1996, the United States Tax Court en-
tered an Order of Dismissal in reponse
to the parties' Joint Motion to Dismiss
for Mootness. The Court agreed that the
revocation notice is null and void and
the organizations listed below are to be
recognized as tax exempt under section
501(c)(3) of the Internal Revenue Code.
Greater Damascus Baptist Church
Dayton, OH
Philippi Missionary Baptist Church
Dayton, OH

Definition of Terms

Revenue rulings and revenue procedures (hereinafter referred to as "rulings") that have an effect on previous rulings use the following defined terms to describe the effect:

Amplified describes a situation where no change is being made in a prior published position, but the prior position is being extended to apply to a variation of the fact situation set forth therein. Thus, if an earlier ruling held that a principle applied to A, and the new ruling holds that the same principle also applies to B, the earlier ruling is amplified. (Compare with *modified*, below).

Clarified is used in those instances where the language in a prior ruling is being made clear because the language has caused, or may cause, some confusion. It is not used where a position in a prior ruling is being changed.

Distinguished describes a situation where a ruling mentions a previously published ruling and points out an essential difference between them.

Modified is used where the substance of a previously published position is being changed. Thus, if a prior ruling held that a principle applied to A but not to B, and the new ruling holds that it applies to both A and B, the prior ruling

is modified because it corrects a published position. (Compare with *amplified* and *clarified*, above).

Obsoleted describes a previously published ruling that is not considered determinative with respect to future transactions. This term is most commonly used in a ruling that lists previously published rulings that are obsoleted because of changes in law 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 the 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.

C.B.—Cumulative Bulletin.

CFR—Code of Federal Regulations.

CI—City.

COOP—Cooperative.

Ct.D.—Court Decision.

CY—County.

D—Decedent.

DC—Dummy Corporation.

DE—Donee.

Del. Order—Delegation Order.

DISC—Domestic International Sales Corporation.

DR—Donor.

E—Estate.

EE—Employee.

E.O.—Executive Order.

ER—Employer.

ERISA—Employee Retirement Income Security Act.

EX—Executor.

F—Fiduciary.

FC—Foreign Country.

FICA—Federal Insurance Contribution Act.

FISC—Foreign International Sales Company.

FPH—Foreign Personal Holding Company.

F.R.—Federal Register.

FUTA—Federal Unemployment Tax Act.

FX—Foreign Corporation.

G.C.M.—Chief Counsel's Memorandum.

GE—Grantee.

GP—General Partner.

GR—Grantor.

IC—Insurance Company.

I.R.B.—Internal Revenue Bulletin.

LE—Lessee.

LP—Limited Partner.

LR—Lessor.

M—Minor.

Nonacq.—Nonacquiescence.

O—Organization.

P—Parent Corporation.

PHC—Personal Holding Company.

PO—Possession of the U.S.

PR—Partner.

PRS—Partnership.

PTE—Prohibited Transaction Exemption.

Pub. L.—Public Law.

REIT—Real Estate Investment Trust.

Rev. Proc.—Revenue Procedure.

Rev. Rul.—Revenue Ruling.

S—Subsidiary.

S.P.R.—Statements of Procedural Rules.

Stat.—Statutes at Large.

T—Target Corporation.

T.C.—Tax Court.

T.D.—Treasury Decision.

TFE—Transferee.

TFR—Transferor.

T.I.R.—Technical Information Release.

TP—Taxpayer.

TR—Trust.

TT—Trustee.

U.S.C.—United States Code.

X—Corporation.

Y—Corporation.

Z—Corporation.

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¹A cumulative list of all Revenue Rulings, Revenue Procedures, Treasury Decisions, etc., published in Internal Revenue Bulletins 1996–1 through 1996–26 will be found in Internal Revenue Bulletin 1996–27, dated July 1, 1996.

Finding List of Current Action on Previously Published Items¹

Bulletins 1996–27 through 1996–42

*Denotes entry since last publication

Revenue Procedures:

80–27

Modified by
96–40, 1996–32 I.R.B. 8

87–32

Modified by
TD 8680, 1996–33 I.R.B. 5

92–20

Modified by
TD 8680, 1996–33 I.R.B. 5

95–29

Superseded by
96–36, 1996–27 I.R.B. 11

95–29A

Superseded by
96–36, 1996–27 I.R.B. 11

95–30

Superseded by
96–42, 1996–32 I.R.B. 14

¹A cumulative finding list for previously published items mentioned in Internal Revenue Bulletins 1996–1 through 1996–26 will be found in Internal Revenue Bulletin 1996–27, dated July 1, 1996.