

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.

EMPLOYEE PLANS

Notice 98-1, page 42.

Nondiscrimination testing; section 401(k) and section 401(m). This notice describes nondiscrimination testing with respect to cash or deferred arrangements under section 401(k) as well as employer matching and employee contributions under section 401(m) of the Code.

EXCISE TAX

T.D. 8740, page 4.

REG-102894-97, page 59.

Temporary and proposed regulations under section 6302 of the Code relate to the availability of the safe harbor deposit rule based on look-back quarter liability and affect persons required to make deposits of excise taxes.

T.D. 8741, page 6.

REG-109704-97, page 60.

Temporary and proposed regulations under section 9812 of the Code relate to mental health parity requirements imposed on group health plans.

ADMINISTRATIVE

Rev. Proc. 98-9, page 56.

This procedure sets forth the maximum face amount of Qualified Zone Academy Bonds that may be issued for each

state in 1998. For this purpose, "state" includes the District of Columbia and the possessions of the United States.

Notice 98-3, page 48.

Elections under section 7704(g). This notice provides the requirements for making and revoking an election under section 7704(g) of the Code. This election allows grandfathered publicly traded partnerships to avoid being treated as corporations for federal tax purposes.

Notice 98-5, page 49.

Foreign tax credit abuse. Treasury and the Service expect to issue regulations that will disallow foreign tax credits for foreign taxes paid or accrued in connection with certain abusive transactions.

Notice 98-6, page 52.

Notice on section 685. Guidance is provided on Qualified Funeral Trust (QFT) eligibility requirements, election procedures, and simplified reporting requirements.

Notice 98-7, page 54.

Information reporting; interest on education loans. Payees of interest that may be deductible by the payor as qualified education loan interest are informed of their information reporting requirements for 1998 under section 6050S of the Code, as added by the Taxpayer Relief Act of 1997.

Finding Lists begin on page 63.



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 prod-

ucts 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 semiannually 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 proce-

dures 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 a cumulative index for the matters published during the preceding months. These monthly indexes are cumulated on a quarterly and semiannual basis, and are published in the first Bulletin of the succeeding quarterly and semiannual period, respectively.

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

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

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

Section 901.—Taxes of Foreign Countries and of Possessions of United States

Guidance is provided as to whether a foreign tax credit is allowed with respect to foreign taxes paid or accrued in connection with certain abusive transactions. See Notice 98-5, page 49.

Section 1397E.—Credit to Holders of Qualified Zone Academy Bonds

What is the 1998 qualified zone academy bond national limitation for each State, the District of Columbia, and the possessions of the United States? See Rev. Proc. 98-9, page 56.

Section 6011.—General Requirement of Return, Statement, or List

26 CFR 301.6011-2T: Required use of magnetic media (temporary).

What information reporting requirements apply to payees of education loan interest for 1998 under § 6050S of the Code, as added by the Taxpayer Relief Act of 1997. See Notice 98-7, page 54.

Section 6050H.—Returns Relating to Mortgage Interest Received in Trade or Business From Individuals

26 CFR 1.6050H-1: Information reporting of mortgage interest received in a trade or business from an individual.

What information reporting requirements apply to payees of education loan interest for 1998 (including those secured by real property) under § 6050S of the Code, as added by the Taxpayer Relief Act of 1997. See Notice 98-7, page 54.

Section 6302.—Mode or Time of Collection

26 CFR 40.6302(c)-1T: Use of government depositories (temporary).

T.D. 8740

DEPARTMENT OF THE TREASURY
Internal Revenue Service
26 CFR Part 40

Deposits of Excise Taxes

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Temporary regulations.

SUMMARY: This document contains temporary regulations relating to the availability of the safe harbor deposit rule based on look-back quarter liability and affects persons required to make deposits of excise taxes. This document also contains temporary regulations relating to floor stocks taxes and affects persons liable for those taxes. The regulations implement certain changes made by the Small Business Job Protection Act of 1996 (the 1996 Act) and the Airport and Airway Trust Fund Tax Reinstatement Act of 1997 (the 1997 Act). The text of these regulations also serves as the text of REG-102894-97, page 59.

DATES: These regulations are effective December 29, 1997. For dates of applicability, see §§40.6302(c)-1T and 40.6302(c)-2T.

FOR FURTHER INFORMATION CONTACT: Ruth Hoffman (202) 622-3130 (not a toll-free call).

SUPPLEMENTARY INFORMATION:

Background

This document contains amendments to the Excise Tax Procedural Regulations (26 CFR part 40) that implement certain changes made by the 1996 Act and the 1997 Act.

The aviation excise taxes that expired on December 31, 1995, were reinstated by the 1996 Act for the period from August 27 through December 31, 1996, by the 1997 Act for the period from March 7 through September 30, 1997, and were extended, with modifications, for the period from October 1, 1997, through September 30, 2007.

Deposit Safe Harbor Rules

Sections 40.6302(c)-1(c)(2) and 40.6302(c)-2(b)(2) (relating to deposit safe harbors) currently provide, generally, that a person can satisfy excise tax deposit

obligations for a calendar quarter by depositing an amount equal to the person's excise tax liability reported on the return for the second preceding quarter (the look-back quarter). For this purpose, the tax liability for the look-back quarter must be modified to take into account any increase in rates in the current quarter, but the safe harbor does not specifically address the effect of the enactment of a new tax or the reinstatement of an expired tax. Notice 97-15, 1997-8 I.R.B. 23, and section 2(f) of the 1997 Act provide that the look-back safe harbor shall not apply with respect to any tax unless the tax was imposed throughout the look-back period.

The temporary regulations modify the look-back safe harbor rules to reflect this change. Under the temporary regulations, the general look-back safe harbor of §40.6302(c)-1(c)(2) is modified for a class of tax that includes a tax that was not in effect at all times during the look-back quarter (or, in the case of an alternative method tax, that was not in effect at all times during the look-back quarter and the month preceding the look-back quarter). The safe harbor does not apply to that class of tax unless, for each semi-monthly period, the deposit is not less than the greater of (1) 1/6 of the net tax liability reported for the class of tax for the look-back quarter, or (2) the sum of (i) 95 percent of the net tax liability incurred with respect to new or reinstated taxes during the semimonthly period, and (ii) 1/6 of the net tax liability reported for all other taxes in the class for the look-back quarter. Also, the section 4681 tax (ozone-depleting chemicals) look-back safe harbor provided under §40.6302(c)-2(b)(2) is modified in a similar manner if the tax liability for the quarter includes liability for any chemical that was not subject to tax at all times during the look-back quarter.

The new rules apply to liabilities for new or reinstated taxes incurred after February 28, 1997.

Fuel Floor Stocks Taxes

Section 1609(h) of the 1996 Act imposes a floor stocks tax on aviation fuel (other than gasoline) on which tax was imposed by section 4091 before August 27, 1996, and that is held on the first moment

of that date by any person. Section 2(d) of the 1997 Act imposes a floor stocks tax on aviation gasoline and aviation fuel (other than gasoline) on which tax was imposed by section 4081 or 4091 before March 7, 1997, and that is held on the first moment of that date by any person.

The temporary regulations provide that the rules set forth in 26 CFR part 40 (relating to administrative provisions for certain excise taxes, including the excise taxes on aviation fuels) also apply to related floor stocks taxes. Thus, persons liable for floor stocks taxes on aviation fuels must file returns reporting those taxes in accordance with the provisions of 26 CFR part 40.

Special Analyses

It has been determined that this Treasury decision is not a significant regulatory action as defined in EO 12866. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations and, because these regulations do not impose on small entities a collection of information requirement, the Regulatory Flexibility Act (5 U.S.C. chapter 6) does not apply. Therefore, a Regulatory Flexibility Analysis is not required. Pursuant to section 7805(f) of the Internal Revenue Code, these temporary regulations will be submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on their impact on small business.

Drafting Information

The principal author of these regulations is Ruth Hoffman, Office of Assistant Chief Counsel (Passthroughs and Special Industries). However, other personnel from the IRS and Treasury Department participated in their development.

* * * * *

Adoption of Amendments to the Regulations

Accordingly, 26 CFR part 40 is amended as follows:

PART 40—EXCISE TAX PROCEDURAL REGULATIONS

Paragraph 1. The authority citation for part 40 continues to read in part as follows:

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

Par. 2. Section 40.0–1T is added to read as follows:

§40.0–1T Introduction (temporary).

(a) through (f). [Reserved]

(g) *Applicability to floor stocks taxes.*

The regulations in this part 40 also apply with respect to floor stocks taxes imposed on articles subject to a tax described in §40.0–1(a), beginning April 1, 1991.

Par. 3. Section 40.6011(a)–1T is added to read as follows:

§40.6011(a)–1T Returns (temporary).

(a)(1) through (a)(2)(ii). [Reserved]

(a)(2)(iii) *Floor stocks tax return.* A return reporting liability for a floor stocks tax described in §40.0–1T(g) is a return for the calendar quarter in which the tax payment is due and not for the calendar quarter in which the liability for tax is incurred, beginning April 1, 1991.

Par. 4. Section 40.6302(c)–1T is added to read as follows:

§40.6302(c)–1T Use of Government depositaries (temporary).

(a) through (c)(2)(iii). [Reserved]

(c)(2)(iv) *Modification for new or reinstated taxes—(A) Applicability.* The safe harbor rule of §40.6302(c)–1(c)(2)(i) is modified for any calendar quarter in which a person's liability for a class of tax includes liability for any new or reinstated tax. For this purpose, a new or reinstated tax is—

(1) Any tax (including an alternative method tax) that was not in effect at all times during the look-back quarter; and

(2) Any alternative method tax that was not in effect at all times during the month preceding the look-back quarter.

(B) *Modification.* The safe harbor rule of §40.6302(c)–1(c)(2)(i) does not apply to a class of tax unless the deposit of taxes in that class for each semimonthly period in the calendar quarter is not less than the greater of—

(1) 1/6 of the net tax liability reported for the class of tax for the look-back quarter; or

(2) The sum of—

(i) 95 percent of the net tax liability incurred with respect to new or reinstated taxes during the semimonthly period; and

(ii) 1/6 of the net tax liability reported

for all other taxes in the class for the look-back quarter.

(C) *Effective date.* This paragraph (c)(2)(iv) applies to tax liabilities for new or reinstated taxes incurred after February 28, 1997, except that paragraph (c)(2)(iv)-(A)(2) of this section applies only for calendar quarters beginning after December 31, 1997.

(c)(3) through (f)(4). [Reserved]

(f)(5) *Taxes excluded; floor stocks taxes.* No deposit is required in the case of any floor stocks tax described in §40.0–1T(g), beginning April 1, 1991.

Par. 5. Section 40.6302(c)-2T is added to read as follows:

§40.6302(c)-2T Special rule for use of Government depositaries under section 4681 (temporary).

(a) through (b)(2)(ii). [Reserved]

(b)(2)(iii) *Modification for new chemicals—(A) Applicability.* The safe harbor rule of §40.6302(c)-2(b)(2)(i) is modified for any calendar quarter in which a person's liability for section 4681 tax includes liability with respect to any new chemical. For this purpose, a new chemical is any chemical that was not subject to tax at all times during the look-back quarter.

(B) *Modification.* The safe harbor rule of §40.6302(c)-2(b)(2)(i) does not apply unless the deposit of section 4681 taxes for each semimonthly period in the calendar quarter is not less than the greater of—

(1) 1/6 of the net tax liability reported under section 4681 for the look-back quarter; or

(2) The sum of—

(i) 95 percent of the net tax liability incurred under section 4681 with respect to the new chemical during the semimonthly period; and

(ii) 1/6 of the net tax liability reported under section 4681 with respect to all other chemicals for the look-back quarter.

(C) *Effective date.* This paragraph (b)(2)(iii) applies to tax liabilities for new chemicals incurred after February 28, 1997.

Michael P. Dolan,
Acting Commissioner of
Internal Revenue.

Approved November 6, 1997.

Donald C. Lubick,
Acting Assistant Secretary of
the Treasury.

Section 6721.—Failure to File Correct Information Returns

26 CFR 301.6721-1: Failure to file correct information returns.

What information reporting requirements apply to payees of education loan interest for 1998 under § 6050S of the Code, as added by the Taxpayer Relief Act in 1997. See Notice 98-7, page 54.

Section 6722.—Failure to Furnish Correct Payee Statements

26 CFR 301.6722-1: Failure to furnish correct payee statements.

What information reporting requirements apply to payees of education loan interest for 1998 under § 6050S of the Code, as added by the Taxpayer Relief Act of 1997. See Notice 98-7, page 54.

Section 9812.—Parity in Application of Certain Limits to Mental Health Benefits

26 CFR 54.9812-1T: Parity in the application of certain limits to mental health benefits (temporary).

T.D. 8741

DEPARTMENT OF THE TREASURY
Internal Revenue Service
26 CFR Part 54

DEPARTMENT OF LABOR
Pension and Welfare Benefits Administration
29 CFR Part 2590

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Care Financing Administration
45 CFR Part 146

Interim Rules for Mental Health Parity

AGENCIES: Internal Revenue Service, Department of the Treasury; Pension and Welfare Benefits Administration, Depart-

ment of Labor; Health Care Financing Administration, Department of Health and Human Services.

ACTION: Interim rules with request for comments.

SUMMARY: This document contains interim rules governing parity between medical/surgical benefits and mental health benefits in group health plans and health insurance coverage offered by issuers in connection with a group health plan. The rules contained in this document implement changes made to certain provisions of the Internal Revenue Code of 1986 (Code), the Employee Retirement Income Security Act of 1974 (ERISA or Act), and the Public Health Service Act (PHS Act) enacted as part of the Mental Health Parity Act of 1996 (MHPA) and the Taxpayer Relief Act of 1997. Interested persons are invited to submit comments on the interim rules for consideration by the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services (Departments) in developing final rules. The rules contained in this document are being adopted on an interim basis to ensure that sponsors and administrators of group health plans, participants and beneficiaries, States, and issuers of group health insurance coverage have timely guidance concerning compliance with the requirements of MHPA.

DATES: *Effective date.* The interim rules are effective January 1, 1998.

Applicability dates. The requirements of MHPA and the interim rules apply to group health plans and health insurance issuers offering health insurance coverage in connection with a group health plan for plan years beginning on or after January 1, 1998. MHPA includes a sunset provision under which the MHPA requirements do not apply to benefits for services furnished on or after September 30, 2001.

Information collection. Affected parties are not required to comply with the information collection requirements in these interim rules until the Departments publish in the Federal Register the control numbers assigned to these information collection requirements by the Office of Management and Budget (OMB). Publication of the control numbers notifies the

public that OMB has approved these information collection requirements under the Paperwork Reduction Act of 1995. The Departments have submitted a copy of this rule to OMB for its review of the information collections. Interested persons are invited to send comments regarding these burdens or any other aspect of these collections of information on or before February 23, 1998.

Comments. Written comments on these interim rules are invited and must be received by the Departments on or before March 23, 1998.

ADDRESSES: Comments on the information collection requirements should be sent directly to:

Office of Information and Regulatory Affairs

Office of Management and Budget
Room 10235

New Executive Office Building
Washington, DC 20503

Attention: HCFA Desk Officer

Health Care Financing Administration
Office of Financial and Human Resources

Management Planning and Analysis Staff
Room C2-26-17

7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: John Burke

Written comments on other aspects of the interim rules should be submitted with a signed original and three copies (except for electronic submissions sent to the Internal Revenue Service (IRS)) to any of the addresses specified below. For convenience, comments may be addressed to any of the Departments. Comments addressed to any Department will be shared with the other Departments.

Comments to the IRS can be addressed to:

CC:DOM:CORP:R (REG-109704-97)
Room 5228

Internal Revenue Service
POB 7604, Ben Franklin Station
Washington, DC 20044.

In the alternative, comments may be hand-delivered between the hours of 8 a.m. and 5 p.m. to:

CC:DOM:CORP:R (REG-109704-97)

Courier's Desk

Internal Revenue Service

1111 Constitution Avenue, NW
Washington DC 20224

Alternatively, taxpayers may transmit comments electronically via the IRS Internet site at: http://www.irs.ustreas.gov/prod/tax_regs/comments.html

Comments to the Department of Labor can be addressed to:

U.S. Department of Labor
Pension and Welfare Benefits
Administration
200 Constitution Avenue, NW
Room N-5669
Washington, DC 20210
Attention: MHPA Comments

Alternatively, comments may be hand-delivered between the hours of 9 a.m. and 5 p.m. to the same address.

Comments to the Department of Health and Human Services can be addressed to:

Health Care Financing Administration
Department of Health and Human
Services
Attention: HCFA-2891-IFC
P.O. Box 26688
Baltimore, MD 21207

In the alternative, comments may be hand-delivered between the hours of 8:30 a.m. and 5:00 p.m. to either:

Room 309-G
Hubert Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

or

Room C5-09-26
7500 Security Boulevard
Baltimore, MD 21244-1850

All submissions to the Internal Revenue Service will be open to public inspection and copying in Room 1621, 1111 Constitution Avenue, NW, Washington, DC from 9:00 a.m. to 4:00 p.m.

All submissions to the Department of Labor will be open to public inspection and copying in the Public Documents Room, Pension and Welfare Benefits Administration, U.S. Department of Labor, Room N-5638, 200 Constitution Avenue, NW, Washington, DC from 8:30 a.m. to 5:30 p.m.

All submissions to the Department of Health and Human Services will be open to public inspection and copying in Room 309-G of the Department of Health and

Human Services offices at 200 Independence Avenue, SW, Washington, DC from 8:30 a.m. to 5:00 p.m.

FOR FURTHER INFORMATION CONTACT: Terese Klitenic, Health Care Financing Administration, Department of Health and Human Services, at (410) 786-1565; Mark Connor, Pension and Welfare Benefits Administration, Department of Labor, at (202) 219-4377; or Russ Weinheimer, Internal Revenue Service, Department of the Treasury, at (202) 622-4695.

Customer service information. Individuals interested in obtaining a copy of the Department of Labor's booklet entitled "Questions and Answers: Recent Changes in Health Care Law," which includes information on MHPA, may call the following toll-free number: 1-800-998-7542.

SUPPLEMENTARY INFORMATION:

A. Background

The Mental Health Parity Act of 1996 (MHPA) was enacted on September 26, 1996 (Pub. L. 104-204, 110 Stat. 2944). MHPA amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act (PHS Act) to provide for parity in the application of certain dollar limits on mental health benefits with dollar limits on medical/surgical benefits. Provisions implementing MHPA were later added to the Internal Revenue Code of 1986 (Code) under the Taxpayer Relief Act of 1997 (Pub. L. 105-34).

1. *Regulatory Responsibility*

The provisions of MHPA are set forth in Chapter 100 of Subtitle K of the Code, Part 7 of Subtitle B of Title I of ERISA, and Title XXVII of the PHS Act.¹ The Secretaries of the Treasury, Labor, and Health and Human Services share jurisdiction over the MHPA provisions. These provisions are substantially similar, except as follows:

- The MHPA provisions in the Code generally apply to all group health plans other than governmental plans, but they do not

apply to health insurance issuers. A taxpayer that fails to comply with these provisions may be subject to an excise tax under section 4980D of the Code.

- The MHPA provisions in ERISA generally apply to all group health plans other than governmental plans, church plans, and certain other plans. These provisions also apply to health insurance issuers that offer health insurance coverage in connection with such group health plans. Generally, the Secretary of Labor enforces the MHPA provisions in ERISA, except that no enforcement action may be taken by the Secretary against issuers. However, individuals may generally pursue actions against issuers under ERISA and, in some circumstances, under State law.
- The MHPA provisions in the PHS Act generally apply to health insurance issuers that offer health insurance coverage in connection with group health plans and to certain State and local governmental plans. States, in the first instance, enforce the PHS Act with respect to issuers. Only if a State does not substantially enforce any provisions under its insurance laws will the Department of Health and Human Services enforce the provisions, through the imposition of civil money penalties. Moreover, no enforcement action may be taken by the Secretary of Health and Human Services against any group health plan except certain State and local governmental plans.

The interim rules being issued today by the Secretaries of the Treasury, Labor, and Health and Human Services have been developed on a coordinated basis by the Departments. In addition, these interim rules take into account comments received by the Departments in response to the request for public comments on MHPA published in the **Federal Register** on June 26, 1997 (62 FR 34604). Except to the extent needed to reflect the statutory differences described above, the interim rules of each Department are substantively identical. However, there are certain non-substantive differences. The interim rules reflect certain stylistic differences in language and structure to conform to conventions used by a particular Department. These differences have been minimized and any differences in word-

¹Chapter 100 of Subtitle K of the Code, Part 7 of Subtitle B of Title I of ERISA, and Title XXVII of the PHS Act were added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. 104-191.

ing are not intended to create any substantive difference.

2. Preemption of State Laws

The McCarran-Ferguson Act of 1945 (Pub. L. 79-15) exempts the business of insurance from federal antitrust regulation to the extent that it is regulated by the States and indicates that no federal law should be interpreted as overriding State insurance regulation unless it does so explicitly. Section 514(a) of ERISA preempts State laws relating to employee benefit plans (including group health plans). Section 731 of ERISA and section 2723 of the PHS Act provide that Part 7 of Subtitle B of Title I of ERISA and Part A of Title XXVII of the PHS Act (including the MHPA provisions) do not in any way affect or modify section 514 of ERISA with respect to group health plans.

Section 514(b)(2) of ERISA saves from preemption any State law that regulates insurance. However, section 731(a) of ERISA and section 2723(a) of the PHS Act preempt State insurance laws relating to health insurance issuers in connection with group health insurance coverage to the extent such laws “prevent the application of” Part 7 of Subtitle B of Title I of ERISA or Part A of Title XXVII of the PHS Act, including the MHPA provisions. (There is no corresponding provision in the Code.) In this regard, the conference report to HIPAA states that the conferees generally intended the narrowest preemption of State laws with regard to health insurance issuers (not group health plans) with respect to the provisions of Part 7 of Subtitle B of Title I of ERISA and Part A of Title XXVII of the PHS Act.² Consequently, the conference report to HIPAA states that State laws with regard to health insurance issuers that are broader than federal requirements in certain areas would not “prevent the application of” the provisions of Part 7 of Subtitle B of Title I of ERISA or Part A of Title XXVII

²However, the preemption is broader for the statutory requirements of section 701 of ERISA and section 2701 of the PHS Act that limit the application of preexisting condition exclusions. Under these broader provisions, State laws cannot “differ” from the preexisting condition exclusion requirements of section 701 of ERISA or section 2701 of the PHS Act except as specifically permitted by section 721(b)(2) of ERISA and section 2723(b)(2) of the PHS Act. These provisions permit a State to impose on health insurance issuers certain stricter limitations relating to preexisting condition exclusions.

of the PHS Act. Further, the conference report to MHPA states that the application of these preemption provisions should permit the operation of any State law or provision that requires more favorable treatment of mental health benefits under health insurance coverage than that required under the MHPA provisions.

Thus, generally, a State law that requires more favorable treatment of mental health benefits under health insurance coverage offered by issuers would not be preempted by the provisions of MHPA and the interim rules.

B. Overview of MHPA and the Interim Rules

The MHPA provisions are set forth in section 9812 of the Code, section 712 of ERISA, and section 2705 of the PHS Act. MHPA and the interim rules apply to a group health plan (or health insurance coverage offered by issuers in connection with a group health plan) that provides both medical/surgical benefits and mental health benefits.

The MHPA provisions provide for parity in the application of aggregate lifetime dollar limits, and annual dollar limits, between mental health benefits and medical/surgical benefits. If a group health plan offers two or more benefit packages under the plan, the requirements of MHPA and the interim rules apply separately to each package. The interim rules make clear that the MHPA requirements apply regardless of whether the mental health benefits are administered separately under the plan. In addition, the interim rules make clear that the MHPA requirements in ERISA and the PHS Act apply both to group health plans and to health insurance issuers offering coverage in connection with a group health plan.

MHPA and the interim rules do not require a group health plan (or health insurance coverage offered in connection with a group health plan) to provide mental health benefits. In addition, MHPA and the interim rules do not affect the terms and conditions (including cost sharing, limits on the number of visits or days of coverage, requirements relating to medical necessity, requirements that patients or providers obtain prior authorization for treatment, and requirements relating to primary care physicians’ referrals for treatment) relating to the amount, dura-

tion, or scope of mental health benefits under a plan (or coverage) except as specifically provided in regard to parity of aggregate lifetime dollar limits and annual dollar limits.³

1. Aggregate Lifetime Limits and Annual Limits

Under MHPA and the interim rules, a group health plan (or health insurance coverage offered in connection with a group health plan) providing both medical/surgical benefits and mental health benefits may comply with the MHPA parity requirements in any of the following general ways:

- The plan (or coverage) may comply by not including any aggregate lifetime dollar limit or annual dollar limit on mental health benefits.
- The plan (or coverage) may comply by imposing a single aggregate lifetime or annual dollar limit on both medical/surgical benefits and mental health benefits in a way that does not distinguish between the two.
- The plan (or coverage) may comply by imposing an aggregate lifetime dollar limit or annual dollar limit on mental health benefits that is not less than the aggregate lifetime dollar limit or annual dollar limit on medical/surgical benefits.
- In the case of a plan (or coverage) under which aggregate lifetime dollar limits or annual dollar limits differ for categories of medical/surgical benefits, the plan (or coverage) may comply by calculating a weighted average aggregate lifetime dollar limit or weighted average annual dollar limit for mental health benefits. The weighted average must be based on a formula in the interim rules that takes into account the limits on different categories of medical/surgical benefits.

In addition, under MHPA and the interim rules, benefits for treatment of substance abuse or chemical dependency may not be

³In response to the Departments’ request for public comments on MHPA published in the **Federal Register** (62 FR 34604), the Equal Employment Opportunity Commission (EEOC) noted that the Americans with Disabilities Act (ADA) prohibits disability-based distinctions (including such distinctions relating to the provision of mental health benefits) in employer-provided health insurance plans unless the plan otherwise falls within the protections of section 501(c) of the ADA. The ADA is within the regulatory jurisdiction of the EEOC.

counted in applying an aggregate lifetime or annual dollar limit that applies separately to mental health benefits.

2. Exemptions from the Requirements of MHPA

(a) Small Employer Exemption

The parity requirements under MHPA and the interim rules do not apply to any group health plan (or health insurance coverage offered in connection with a group health plan) for any plan year of a small employer. The term “small employer” is defined as 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.⁴

For purposes of the small employer exemption, all persons treated as a single employer under subsections (b), (c), (m), and (o) of section 414 of the Code (26 U.S.C. 414) are treated as one employer. In addition, if an employer was not in existence throughout the preceding calendar year, whether the employer is a small employer is determined on the average number of employees the employer reasonably expects to employ on business days during the current calendar year. Finally, any reference to an employer in the small employer exemption includes a reference to a predecessor of the employer.

(b) Increased Cost Exemption

The second exemption from the MHPA requirements applies to group health plans (or health insurance coverage offered in connection with a group health plan) if the application of the MHPA parity requirements described in paragraph (b)(1)(i)⁵ results in an increase in the cost under the plan (or coverage) of at least

one percent. This exemption is available only if the requirements of paragraph (f) are met. If a plan offers more than one benefit package, the exemption is applied separately to each benefit package. Except as provided in the transition period described in paragraph (h), a plan must implement the parity requirements for the first plan year beginning on or after January 1, 1998, and must continue to comply with the parity requirements until September 30, 2001 (the sunset date in paragraph (i)) unless the plan satisfies the exemption described in paragraph (f). However, the exemption is not effective until 30 days after the notice requirements in paragraph (f)(3) are satisfied.

The interim rules, in paragraph (f)(2), describe the ratio of two terms used to determine if a plan (or coverage) has experienced a cost increase of one percent or more. The first term is the total cost incurred under parity (including both mental health costs and medical/surgical costs). The second term is the total cost incurred under parity reduced by the costs required solely to comply with parity. Costs required solely to comply with parity include mental health claims that would have been denied absent amendments required to comply with parity, the administrative costs related to those claims, and other administrative costs attributable to complying with the parity requirements. Premium payments are not considered in this calculation. The ratio is expressed by the following formula:

$$\frac{IE}{IE - (CE + AE)} \geq 1.01000$$

IE represents the incurred expenditures during the base period. *CE* represents the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with the parity requirements of paragraph (b)(1)(i). *AE* represents administrative costs related to claims in *CE* and other administrative costs attributable to complying with the parity requirements of paragraph (b)(1)(i).

Examples illustrate how the rule is applied in the case of a self-funded plan, a fully insured plan, and a partially insured plan. Moreover, in the case of a partially

insured plan in which the partially insured portion is pooled for rating purposes, the costs of the pool should be allocated proportionally among the pool members by reasonable methods, including proportional enrollment. Additional provisions in paragraph (f) describe the baseline for determining those costs that are attributable solely to compliance with the parity requirements, the base period used to calculate whether a plan may claim the exemption, and how long the exemption applies once it is claimed. The base period must begin on the first day in any plan year that the plan complies with the requirements of paragraph (b)(1)(i) of this section and must extend for a period of at least six consecutive calendar months. However, in no event may the base period begin prior to September 26, 1996 (the date of enactment of the Mental Health Parity Act (Pub. L. 104–204, 110 Stat. 2944)).

Before a group health plan may claim the one-percent increased cost exemption, it must furnish participants and beneficiaries with a notice of the plan’s exemption from the parity requirements that includes the information described in paragraph (f)(3)(i). A plan may satisfy this requirement by providing participants and beneficiaries with a summary of material reductions in covered services or benefits, under 29 CFR 2520.104b–3(d), if it includes all the information required by paragraph (f)(3)(i). However, this exemption under MHPA is not effective until at least 30 days after the notice is sent to the participants and beneficiaries and the appropriate federal agency even if the notice is incorporated into a summary of material reductions in covered services or benefits.

A group health plan that is not subject to Part 7 of Subtitle B of Title I of ERISA, and a plan subject to Part 7 of Subtitle B of Title I of ERISA that chooses not to incorporate the information in paragraph (f)(3)(i) into a summary of material reductions in covered services or benefits (which must be furnished to participants and beneficiaries and the appropriate federal agency), may use the following model to satisfy the notice requirement under paragraph (f)(3) of the interim rules:

⁴Section 9831(a) of the Code, section 732(a) of ERISA, and section 2721(a) of the PHS Act provide an exception that applies under the MHPA provisions as well as under provisions added by HIPAA and the Newborns’ and Mothers’ Health Protection Act of 1996. The exception applies to any group health plan (and health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of the plan year, the plan has fewer than 2 participants who are current employees.

⁵Any reference to a particular paragraph in this preamble to the interim rules is a reference to the corresponding paragraphs in each of the Departments’ interim rules.

NOTICE OF GROUP HEALTH PLAN'S EXEMPTION FROM THE MENTAL HEALTH PARITY ACT

*** DESCRIPTION OF THE ONE PERCENT INCREASED COST EXEMPTION — This notice is required to be provided to you under the requirements of the Mental Health Parity Act of 1996 (MHPA) because the group health plan identified in Line 1 below is claiming the one percent increased cost exemption from the requirements of MHPA. Under MHPA, a group health plan offering both medical/surgical and mental health benefits generally can no longer set annual or aggregate lifetime dollar limits on mental health benefits that are lower than any such dollar limits for medical/surgical benefits. In addition, a plan that does not impose an annual or aggregate lifetime dollar limit on medical/surgical benefits generally may not impose such a limit on mental health benefits. However, a group health plan can claim an exemption from these requirements if the plan's costs increase one percent or more due to the application of MHPA's requirements.**

This notice is to inform you that the group health plan identified in Line 1 below is claiming the exemption from the requirements of MHPA. The exemption is effective as of the date identified in Line 4 below. Since benefits under your group health plan may change as of the date identified in Line 4 it is important that you contact your plan administrator or the plan representative identified in Line 5 below to see how your benefits may be affected as a result of your group health plan's election of this exemption from the requirements of MHPA.

Upon submission of this notice by you (or your representative) to the plan administrator or the person identified in Line 5 below, the plan will provide you or your representative, free of charge, a summary of the information upon which the plan's exemption is based.

1. Name of the group health plan and the plan number (PN): _____

2. Name, address, and telephone number of plan administrator responsible for providing this notice:

3. For single-employer plans, the name, address, telephone number, (if different from Line 2) and employer identification number (EIN) of the employer sponsoring the group health plan:

4. Effective date of the exemption (at least 30 days after the notices are sent): _____

5. For further information, call: _____

To claim the one-percent increased cost exemption, a group health plan that is a church plan (as defined in section 414(e) of the Code) also must furnish to the Department of the Treasury a copy of the notice sent to participants and beneficiaries that satisfies the requirements of paragraph (f)(3)(i). To claim the one percent increased cost exemption, a group health plan subject to Part 7 of Subtitle B of Title I of ERISA also must furnish to the Department of Labor a copy of the notice sent to participants and beneficiaries that satisfies the requirements of paragraph (f)(3)(i). To claim the one percent increased cost exemption, a group health

plan that is a nonfederal governmental plan also must furnish to the Department of Health and Human Services a copy of the notice sent to participants and beneficiaries that satisfies the requirements of paragraph (f)(3)(i). In all cases, the exemption is not effective until 30 days after notice has been sent both to participants and beneficiaries and to the appropriate federal agency. Any notice submitted to the Department of Labor or Health and Human Services will be available for public inspection.

The Secretaries have designated the following addresses for delivery of these notices:

For notices to the Department of the Treasury, church plans should mail the notice to:

Office of the Assistant Commissioner,
Examination
Examination Programs CP:EX:E
1111 Constitution Avenue, NW
Washington, DC 20224
Attention: MHPA one-percent cost
exemption notice

For notices to the Department of Labor, plans should mail the notice to:

Public Documents Room
Pension and Welfare Benefits
Administration

U.S. Department of Labor
Room N-5638
200 Constitution Avenue, NW
Washington, DC 20210
Attention: MHPA one-percent cost
exemption notice

For notices to the Department of Health
and Human Services, plans should mail
the notice to:

Health Care Financing Administration
7500 Security Boulevard
Baltimore, MD 21244-1850
Attention: Insurance Standards:
Exemptions

Finally, to claim the one percent increased cost exemption, a plan (or issuer) must make available to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information described in paragraph (f)(4). An individual who is not a participant or beneficiary and who presents a notice described in paragraph (f)(3)(i) is considered to be a representative. For this purpose, individually identifiable information in the notice may be redacted. The summary of information must include the incurred expenditures, the base period, the dollar amount of claims incurred during the base period that would have been denied under the terms of the plan absent amendments required to comply with parity, and the administrative expenses attributable to complying with the parity requirements. In no event should a summary of information include individually identifiable information.

Civil money penalties as described in regulations at 45 CFR 146.184(d) apply to an issuer or nonfederal governmental plan that fails to satisfy the requirements of paragraph (f).

3. MHPA's Effective Date and Sunset Provision

The MHPA provisions are generally effective for group health plans (and

health insurance issuers offering health insurance coverage in connection with a group health plan) for plan years beginning on or after January 1, 1998. MHPA includes a sunset provision under which the MHPA requirements do not apply to benefits for services furnished on or after September 30, 2001.

However, for requirements of this section other than the one-percent increased cost exemption, the interim rules provide a limitation on enforcement actions in paragraph (h)(2). Under that paragraph, no enforcement action can be taken by any of the Secretaries against a group health plan (or issuer) that has sought to comply in good faith with the requirements of section 9812 of the Code, section 712 of ERISA, and section 2705 of the PHS Act with respect to a violation that occurs before the earlier of the first day of the first plan year beginning on or after April 1, 1998, or January 1, 1999. Compliance with the requirements of the interim rules is deemed to be good faith compliance with the requirements of section 9812 of the Code, section 712 of ERISA, and section 2705 of the PHS Act.

With respect to the increased cost exemption, the interim rules provide in paragraph (h)(3) a transition period for compliance with the requirements of paragraph (f). Under paragraph (h)(3), no enforcement action will be taken against a group health plan (or issuer) that is subject to the MHPA requirements prior to April 1, 1998 solely because the plan has claimed the increased cost exemption under section 9812(c)(2) of the Code, section 712(c)(2) of ERISA, or section 2705(c)(2) of the PHS Act based on assumptions inconsistent with the rules under paragraph (f) of the interim rules, provided that the plan is amended to comply with the parity requirements no later than March 31, 1998 and the plan complies with the notice requirements in paragraph (h)(3)(ii).

A group health plan satisfies this transition period notice requirement only if the plan provides notice to the applicable federal agency and posts such notice at the location(s) where documents must be made available for examination under section 104(b)(2) of ERISA and the regulations thereunder (§2520.104b-1(b)(3)). The notice must indicate the plan's intent to use the transition period by 30 days after the first day of the plan year beginning on or after January 1, 1998, but in no event later than March 31, 1998. For a group health plan that is a church plan, the applicable federal agency is the Department of the Treasury. For a group health plan that is subject to Part 7 of Subtitle B of Title I of ERISA, the applicable federal agency is the Department of Labor. For a group health plan that is a nonfederal governmental plan, the applicable federal agency is the Department of Health and Human Services. In all cases, the notice must include the date; the name of the plan and the plan number; the name, address, and telephone number of the plan sponsor or plan administrator; the employer identification number (in the case of single-employer plans only); the individual to contact for further information; the signature of the plan administrator; and the date signed. In addition, the notice must be provided at no charge to participants and beneficiaries (or their representatives) within 15 days after receipt of a written or oral request for such notification, but in no event does the notice have to be provided before it has been sent to the applicable federal agency. For this purpose, plans may use the following model:

NOTICE OF GROUP HEALTH PLAN'S USE OF TRANSITION PERIOD

*** IMPORTANT — This notice is required to be provided if a group health plan uses the transition period under the requirements of the Mental Health Parity Act (MHPA). Under MHPA, a group health plan offering both medical/surgical and mental health benefits generally can no longer set annual or aggregate lifetime dollar limits on mental health benefits that are lower than any such dollar limits for medical/surgical benefits. In addition, a plan that does not impose an annual or aggregate lifetime dollar limit on medical/surgical benefits generally may not impose such a limit on mental health benefits. However, a group health plan can claim an exemption from these requirements if the plan's costs increase one percent or more due to the application of MHPA's requirements. Under MHPA, a plan that claimed the one percent increased cost exemption prior to the issuance of the MHPA interim regulations based on assumptions inconsistent with the MHPA interim regulations may delay compliance with the parity requirements of MHPA until a date no later than March 31, 1998.**

This notice is to inform you that the plan is utilizing the MHPA transition period and that the plan is delaying compliance with the parity requirements of MHPA until a time no later than March 31, 1998.

1. Name of the group health plan and the plan number (PN): _____

2. Name, address, and telephone number of plan administrator responsible for providing this notice:

3. For single-employer plans, the name, address, telephone number, (if different from Line 2), and employer identification number (EIN) of the employer sponsoring the group health plan:

4. For further information, call: _____

5. Signature of plan administrator: _____ Date: _____

The Secretaries have designated the following addresses for delivery of the notices:

For notices to the Department of the Treasury, plans should mail the notice to:

Office of the Assistant Commissioner,
Examination
Examination Programs CP:EX:E
1111 Constitution Avenue, NW
Washington, DC 20224

Attention: MHPA transition period notice

For notices to the Department of the Labor, plans should mail the notice to:

Public Documents Room
Pension and Welfare Benefits
Administration
U.S. Department of Labor
Room N-5638
200 Constitution Avenue, NW
Washington, DC 20210

Attention: MHPA transition period notice
For notices to the Department of Health and Human Services, plans should mail the notice to:

Health Care Financing Administration
7500 Security Boulevard
Baltimore, MD 21244-1850
Attention: Insurance Standards:
Exemptions

C. Interim Rules and Request for Comments

Section 9833 of the Code (formerly section 9806), section 734 of ERISA (formerly section 707), and section 2792 of the PHS Act provide, in part, that the Secretaries of the Treasury, Labor, and Health and Human Services may promulgate any interim final rules as they determine are appropriate to carry out the provisions of Chapter 100 of Subtitle K of the Code,

Part 7 of Subtitle B of Title I of ERISA, and Part A of Title XXVII of the PHS Act, including the MHPA provisions.

Under Section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 *et seq.*) a general notice of proposed rule-making is not required when an agency, for good cause, finds that notice and public comment thereon are impracticable, unnecessary, or contrary to the public interest.

These rules are being adopted on an interim final basis because the Secretaries have determined that without prompt guidance some members of the regulated community may not know what steps to take to comply with the MHPA requirements, which may result in an adverse impact on participants and beneficiaries with regard to their mental health benefits under group health plans and the protections provided under MHPA. Moreover,

MHPA's requirements will affect the regulated community in the immediate future.

MHPA's requirements are effective for all group health plans and for health insurance issuers offering coverage in connection with such plans for plan years beginning on or after January 1, 1998. Plan administrators and sponsors, issuers, and participants and beneficiaries, will need guidance on the new statutory provisions before MHPA's effective date. As noted earlier, these interim rules take into account comments received by the Departments in response to the request for public comments on MHPA published in the **Federal Register** on June 26, 1997 (62 FR 34604). For the foregoing reasons, the Departments find that the publication of a proposed regulation, for the purpose of notice and public comment thereon, would be impracticable, unnecessary, and contrary to the public interest.

D. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 *et. seq.*)(RFA) requires an agency to publish a regulatory flexibility analysis describing the impact of a proposed rule which the agency determines would have a significant impact on a substantial number of small entities. The RFA requires that the agency present an initial regulatory flexibility analysis and seek public comment on its analysis when the agency publishes a general notice of proposed rulemaking (NPRM) under section 553 of the Administrative Procedures Act (5 U.S.C. 553 *et seq.*) (APA). Under the RFA, small entities include small businesses, non-profit organizations and governmental agencies. For our purposes, under the RFA, States and individuals are not considered small entities. However, small employers and small group health plans are considered small entities.

Since these rules are issued as interim final rules, and not as an NPRM, a formal regulatory flexibility analysis has not been prepared. Nonetheless, in the discussion below on the rule's impact on the regulated community, the Departments present an analysis addressing many of the same issues otherwise required by the RFA, including the likely impact of the interim rule on small entities, and a discussion of regulatory alternatives consid-

ered in crafting the rule. The Departments invite interested persons to submit comments for consideration in the development of the final rules implementing the MHPA. Consistent with the RFA, the Departments encourage the public to submit comments that accomplish the stated purpose of the MHPA and minimize the impact on small entities. Specifically, we welcome comments addressing the impact of the MHPA's 1 percent cost exemption for plans and issuers that can demonstrate that implementation of the parity rules would raise their expenditures by more than one percent. We also welcome comments addressing the operation of the MHPA provision requiring that plans using differential aggregate lifetime or annual limits for various categories of benefits use a weighted average of such differential limits to calculate the overall aggregate lifetime and annual limits for the plan.

E. Executive Order 12866 — Departments of Labor and Health and Human Services

The Office of Management and Budget has determined this rule to be a major rule, as well as an economically significant regulatory action under Section 3(f) of Executive Order 12866. The following analysis fulfils the requirement under the Executive Order to assess the economic impact of major and economically significant regulatory actions.

Executive Order 12866 requires agencies to assess the costs and benefits of available regulatory alternatives, and when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). Section 3(f) of the Executive Order 12866 requires agencies to prepare a regulatory impact analysis for any rule which is deemed a "significant regulatory action" according to specified criteria, including whether the rule may have an annual effect on the economy of \$100 million or more or certain other specified effects; or whether the rules raise novel legal or policy issues arising out of the President's priorities.

This analysis was conducted by the Departments of Labor and Health and Human Services. It discusses the eco-

nomical impact of the MHPA, which this rule implements, with special emphasis on the one percent cost exemption. It quantifies the number of plans and individuals who might be affected by the exemption rule, illustrating the exemption's effect in the context of other statutory MHPA provisions. It separately considers the impact of regulatory discretion exercised by the Departments in connection with this rule.

a. Overall Impact of the MHPA

In general, the MHPA may have both direct and indirect effects on group health plans, plan sponsors, and plan participants. Direct effects may include broader coverage of mental health treatments and associated increases in mental health benefit payments. Indirect effects may include the steps employers who sponsor plans may take to reduce or offset their expenditures attributable to compliance with the MHPA, such as amending, curtailing or dropping mental health benefits or other components of compensation, as well as participants' responses to any expenditure increases that are passed to them.

Direct Effects

The most direct effect of the MHPA is broader health insurance coverage for mental health treatment. In many health plans, mental health coverage is more restrictive than medical/surgical coverage due to lower annual and/or lifetime dollar limits, more restrictive limits on visits and stays, and other plan provisions. For example, a recent survey of employee benefit plans by Hay/Huggins illustrates the differences in plan terms and lower dollar limits of mental health services and medical/surgical services. The survey reported that indemnity plans typically impose a lifetime limit of \$50,000 for mental health benefits. On the other hand, medical/surgical benefits of a typical indemnity plan provide a lifetime limit of \$1,000,000.

Requiring fuller coverage of mental health treatment will increase mental health benefit payments and associated plan expenditures. Some of this increase will be paid by plan sponsors, and some will be paid by participants in the form of increased premiums and/or reductions in

other compensation. Aside from any increased administrative costs involved, these plan expenditure increases generally represent one side of transfer payments rather than erosion in overall social welfare. In other words, additional plan expenditures arising from the MHPA are balanced by additional benefits paid for mental health services. One result will be that some money that would have been spent on other goods or services will be spent instead on mental health services.

The direct effects of the MHPA will in turn cause other effects due to subsequent responses by affected employers (in their capacity as plans sponsors) and participants.

Indirect Effects of the MHPA

There are numerous ways in which plan sponsors affected by the MHPA might react. Some might take no action other than to remove or increase dollar limits on mental health benefits. Others might make other changes to their mental health benefits in order to reduce or offset expenditure increases from compliance with MHPA. The statute explicitly preserves plan sponsors' right to provide no mental health benefits, or to set the "terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits," except with respect to annual or lifetime dollar limits. Some plan design options would be associated with lower plan expenditure increases from compliance with the MHPA. The statute also provides an "increased cost exemption" under which the statute "shall not apply" if its application "results in an increase in the cost . . . of at least 1 percent" (ERISA Section 712(c)(2)). Plan sponsors' responses to the MHPA may lessen their expenditures associated with compliance; that is, their responses may reduce the amount of transfers arising from the MHPA.

For example, many mental health plans currently have non-dollar limits. According to the U.S. Bureau of Labor Statistics, among full-time participants at private establishments with 100 or more employees in 1993, 55 percent were subject to separate day limits for inpatient mental health treatment, and 43 percent were subject to

separate visit limits for outpatient mental health treatment (U.S. Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments*, 1993). Plans that impose non-dollar limits on mental health benefits may face smaller expenditures increases from the MHPA.

Many plans currently subject mental health benefits to separate cost sharing provisions. Among full-time participants in medium and large private establishments in 1993, 15 percent were subject to separate coinsurance rates and 4 percent were subject to separate copayment rates for inpatient mental health care, while 53 percent and 18 percent were respectively subject to separate coinsurance and copayment rates for outpatient mental health care. Cost sharing generally affects plan expenditures in two ways. First, by shifting some payments for services to participants, cost sharing directly reduces the expenditures borne by plans. Second, by increasing the price of services faced by participants, cost sharing reduces the quantity of services that participants demand. Because of both of these mechanisms, plans that have more cost sharing for mental health benefits will not be impacted as much by the MHPA as plans that have parity in cost sharing.

Many plans use HMO-style management techniques to control mental health benefit expenditures. Plans that have HMO-style mental health "carve-outs" but no mental health limits are likely to pay less for mental health benefits than fee-for-service plans with low dollar limits that are impermissible under the MHPA. For example, a FFS plan with utilization review and an annual mental health limit of \$10,000 averages \$6.51 per member per month, while an unlimited "carve out" plan pays \$6.12, according to a Price Waterhouse LLP actuarial model developed for the Departments based on the same data as above.

There are a number of reasons why the permissible plan designs outlined here should have little negative effect on existing mental health coverage. First, the modest expenditure increases necessitated by the MHPA would be unlikely to prompt many major design changes. As noted below, approximately 10 percent of affected plans will face increased expenditures under the MHPA of at least one percent, according to the Price Water-

house, LLP analysis conducted for the Departments. Only 4 percent of affected plans are expected to be faced with increases from the MHPA of 1.5 percent or more, according to the same analysis. Second, the largest expenditure increases and therefore the most aggressive responses will be associated with plans that have the tightest dollar caps today—that is, with plans that would have provided the most restrictive coverage anyway.

Other effects resulting from the MHPA may include plan sponsors dropping mental health coverage altogether, or dropping or curtailing other health benefits or components of compensation. Such curtailments could include shifting some of the cost of benefits to employees, for example in the form of increased participant premium contributions for health benefits. Participants, in turn, might respond to premium increases by dropping their health benefits or electing less expensive plans. As with plan sponsor amendments to mental health benefits, such responses by plan sponsors and participants are expected to be modest and/or rare, given the generally small direct effects of the MHPA on plan expenditures.

b. Review of Quantitative Estimates

The Congressional Budget Office (CBO) estimated that the MHPA's direct effect would be to increase health plan expenditures by 0.4 percent on aggregate. (See Congressional Budget Office, "CBO's Estimates of the Mental Health Parity Amendments to the VA/HUD Appropriation Bill, as Passed in the Senate," September 10, 1996.) This assumes that plan sponsors make no changes to their plans other than to raise or eliminate dollar limits on mental health benefits consistent with the MHPA's parity requirements. However, some plan sponsors may make other changes to their plans in order to reduce or offset the impact of the MHPA on their expenditures. For example, some plan sponsors might amend, curtail, or drop mental health benefits or health benefits in general. Taking into account the likely incidence of such plan sponsor responses to the MHPA, CBO estimated that the true aggregate increase in health plan expenditures attributable to the MHPA would only be 0.16 percent.

Combining these figures with those from an earlier CBO analysis, the Depart-

ments calculate that, in dollar terms, the total annual direct impact of the MHPA would be to increase aggregate health plan expenditures by \$1.16 billion, not accounting for plan sponsor responses to reduce that impact. Accounting for those responses, the actual increase in annual aggregate health plan expenditures would be \$464 million. It should be noted that these figures do not account for the MHPA's increased cost exemption, its exemption of firms with 50 or fewer employees, the incidence of managed care plans whose added cost under the MHPA would be smaller than those of managed fee for service plans, or for plans that are separately subject to state requirements equal or greater than the MHPA's. The Departments' estimates, reported below, incorporate these adjustments.

CBO also reports the Joint Committee on Taxation's estimate that the MHPA will reduce federal revenues by \$560 million over six years. CBO explains that most of the 0.16 percent increase in plan expenditures would be shifted back to employees as lower pay, thus eroding the income and payroll tax bases. On an annual basis, the MHPA would increase expenditures for federal annuitants' health benefits by \$30 million, CBO reports. Finally, the MHPA's impact on nonfederal governmental entities would amount to \$50 million, while its impact on the private sector would probably exceed \$100 million, according to CBO.

The CBO estimates were based on a typical fee-for-service indemnity plan with customary management techniques to control expenditures, and not on plans with other types of delivery systems, such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), or Point-of-Service (POS) plans. In fact, plans using different delivery systems will face different expenditure increases under the MHPA. For example, HMOs, which typically contract with health care providers at discounted rates and tightly manage utilization, will face smaller increases under the MHPA.

Coopers & Lybrand (C&L) also estimated the impact of the MHPA (Ronald E. Bachman, "An Actuarial Analysis of S. 2031, The Mental Health Parity Act of 1996," prepared for the American Psychological Association. Coopers & Ly-

brand LLP, September 1996). C&L estimated that the MHPA would increase plan expenditures by 0.12 percent per plan on average before taking into account any responses by plan sponsors. Taking plans sponsors' responses into account and using the same response assumption as CBO, C&L estimated that plan expenditures would increase by less than 0.05 percent. In dollar terms, these increases would amount to \$348 million and \$139 million respectively.

Unlike CBO, C&L considered four different delivery systems: fee-for-service with standard utilization review on typical medical services, fee-for-service with specialized mental health utilization review, PPO and POS plans with specialized mental health utilization review, and HMO and carve-out mental health plans. Under each delivery system, C&L also considered a variety of annual dollar limits ranging from \$10,000 to unlimited amounts, rather than assuming that all plans in the delivery system provided the same level of benefits.

The Departments performed additional quantitative analysis, generally analogous to CBO's, in the course of assessing the impact of the regulatory discretion reflected in this rule. The additional analysis suggests that the direct impact of the MHPA, not accounting for plan sponsors' responses, would be to increase annual aggregate health plans expenditures by 0.29 percent or \$653 million. Under CBO's assumption regarding plan sponsor responses to reduce the added expenditure, actual added expenditures would amount to \$261 million. The Departments did not attempt to independently quantify such responses. However, the Departments estimate that if all plans eligible for the one percent cost exemption exercise it, the increase in plan expenditures would be reduced from 0.29 percent to 0.14 percent or \$310 million. The Departments' analysis is detailed below.

c. Exercise of Regulatory Discretion One Percent Cost Exemption

The main area in which the agencies exercised regulatory discretion is in connection with the one percent cost increase exemption. Alternative regulatory interpretations can impact the outcome of the number of plans, firms, policyholders,

and covered lives that would be exempted from the MHPA.

The Departments considered options concerning the interpretation of the one-percent cost exemption and how it should be implemented. In general, they considered (1) whether the eligibility for the exemption should be determined retrospectively or prospectively, and what, if any, rules should be established with respect to how eligibility should be determined, (2) whether eligibility should be contingent on affirmative approval from an enforcement agency or simply subject to possible review by such an agency, and (3) whether plan sponsors electing exemptions should be required to notify participants and/or enforcement agencies of this action and/or to disclose to these parties evidence documenting eligibility for the exemption. They also considered the administrability of each option, seeking to balance the costs and benefits to plans and participants, as well as the benefits and burdens of the regulatory scheme on the federal government.

Retro/prospective Determination

The options considered ranged from a purely retrospective interpretation to a purely prospective one, and included intermediate interpretations that blend these two approaches.

Under a purely retrospective interpretation, the one percent increased cost exemption would be based on actually incurred expenditures increases, measured retrospectively after implementation of the statute. In other words, all plans must comply and provide parity of annual and/or lifetime dollar limits of mental health and medical services for the first year beginning with the start of a plan year on or after January 1, 1998. If during the first year, a plan experiences increases in expenditures equal to one percent or more as a result of complying with the statute, that plan would then be eligible to exercise an exemption from the MHPA for subsequent plan years.

The calculation for determining the percent increase would be based on the ratio of the increase in plan expenditures to the total plan expenditures, that is, both medical and mental health expenditures. For self-insured plans, the numerator would be the actual value of mental health claims paid in excess of the previous plan

limits. For example, if the annual mental health limit were \$10,000 and the medical/surgical were \$1,000,000, then the sum of all mental health claims paid in excess of \$10,000 would be included in the numerator of the ratio used for that plan in calculations related to the one percent exemption. The denominator for self-insured plans would be the total value of medical and mental health claims excluding mental health claims in excess of \$10,000. If the result is an increase of one or more percent, the plan would be exempt from complying with the statute in any other year until the statute sunsets in 2001. Because there is a lag between the time that claims are incurred and the time they are reported, complete data needed for the calculation might not be available until three or six months after the end of the first plan year under the MHPA. With respect to fully insured plans, the calculation would be slightly different. To the extent that different plans' experiences are pooled for purposes of setting premiums, their eligibility for the exemption would depend on their pooled experience under MHPA, rather than on each plan's individual experience.

The purely retrospective interpretation would minimize the availability of the exemption, and therefore might result in both the greatest incidence of parity in lifetime and annual dollar limits and the greatest incidence of other plan actions to reduce or offset the increase in expenditures arising from the MHPA. It would also assure that all plan elections to exercise the one percent increased cost exemption are based on actual experience under the MHPA's parity requirements and not on projections or estimates of such experience.

Under a purely prospective interpretation, the a plan would be eligible for the exemption prospectively if its expected additional expenditures from the MHPA act equaled or exceeded one percent of its expected total expenditures absent the MHPA. A self-insured plan would project these figures, relying on available data and actuarial projection methods. A fully insured plan would compare legitimate premium quotes with and without the exemption to determine if the difference equals or exceeds one percent. The purely prospective interpretation would

maximize the availability of the exemption, and therefore might result in both the least incidence of parity in lifetime and annual dollar limits and the least incidence of other plan actions to reduce or offset expenditure increases arising from the MHPA.

Other interpretations were also considered, some closer to a purely retrospective interpretation and others closer to a purely prospective one. For example, one interpretation might allow plans to prospectively determine their eligibility and exercise the exemption, but only based upon a narrowly constrained analysis of their own prior experience, taking into account only the potential added expenditure from the MHPA associated with participants whose past mental health claims reached or nearly reached MHPA-prohibited dollar limits. Interpretations closer to the purely retrospective view would lessen the availability of the exemption, and therefore might result in both greater incidence of parity in lifetime and annual dollar limits and lesser incidence of other plan actions to reduce or offset expenditure increases arising from the MHPA; those closer to the purely prospective view would do the opposite.

The approach adopted under this rule, referenced above, can be characterized as modified retrospective approach, based on a relatively brief base period. It is intended to assure the accurate measurement of increased costs while minimizing the burden on plan sponsors who wish to exercise the exemption as soon as accurate measurements can be made. It also assures that all plan elections to exercise the one percent increased cost exemption are based on actual experience under the MHPA's parity requirements and not on projections or estimates of such experience. The rule eases compliance burdens by providing a transition period under which certain plans whose plan years begin during the first quarter of 1998 can exercise the exemption until April 1, 1998.

Exemption Authority

This rule provides that plans may determine their own eligibility for the exemption and, if eligible, exercise the exemption, without affirmative approval from any enforcement agency.

Notification and Disclosure

The Departments also exercised discretion in requiring notice and disclosure in connection with the one percent increased cost exemption. The rule requires plans exercising the one percent increased cost exemption during all or part of the first quarter of 1998 under the rule's transition provisions to notify the federal government, and to post a copy of this notice at the workplace. It further requires plans otherwise exercising the exemption to notify participants and the federal government, and to disclose on request to these parties summary documentation of the plans' eligibility for the exemption.

Notifications and disclosures will be of benefit to participants. They will help assure plans' compliance with the MHPA, and will promote participants' understanding of their and their plans' status under the MHPA. Moreover, by promoting participants' understanding, notifications and disclosures will inform participants' choices among plans and their feedback to plan sponsors, thereby fostering more vigorous competition among plan sponsors and issuers to provide benefits attractive to participants at competitive prices. The cost of these notifications and disclosures is outlined below.

Weighted Average Limits

The Departments also exercised discretion in developing rules that specify when plans may impose separate dollar limits on mental health benefits equal to the weighted average of limits imposed on other benefit categories, and in how this weighted average may be calculated. In general, the rules provide that such mental health limits may be imposed if the benefit categories to which separate limits apply account for at least one-third of total plan expenditures and are comparable in scope to mental health benefits. The average is calculated by weighting each applicable limit to reflect its share of total plan expenditures. Any unlimited categories are figured into the average by using in place of a limit a reasonable estimate of the maximum plan expenditure that could possibly be incurred in connection with all such categories, and weighting this estimate to reflect the proportion of total plan expenditures attributable to all such categories.

Alternative rules might have permitted more, fewer, or different plans to impose such limits on mental health benefits, and/or resulted in calculated averages that were higher or lower. For example, if unlimited categories were treated as having infinite limits, then the weighted average of category limits would equal infinity and the option of imposing a weighted average limit on mental health benefits effectively would be foreclosed. In contrast, if limits applicable to benefit categories narrower in scope than mental health benefits could be averaged to arrive at the permissible mental health limit, plans might be able to impose very low limits on very narrow benefit categories, with little effect on coverage of these categories but with the result of a lower permissible mental health benefit limit.

d. Impact of Regulatory Discretion

Because the Departments exercised regulatory discretion in connection with the one percent cost exemption, it is necessary to quantify the number of plans eligible for the exemption. This requires both estimates of the affected universe and estimates of the distribution of impacts within that universe. CBO reported universe estimates but did not estimate the distribution of impacts. C&L provided a distribution but not universe estimates. Thus, neither source provides the necessary basis for estimating the reach of the one percent cost exemption. To address this gap, the Departments, assisted by Price Waterhouse LLP, combined the CBO and C&L analyses with other data to produce relevant national estimates, as follows.

First, the Departments estimated the relevant universe at 3.0 million plans sponsored by 2.8 million employers covering 145 million individuals. To derive these estimates, we tallied the number of group health plan policyholders and dependents by firm size from the Census Bureau's March 1996 Current Population Survey. Census enterprise data provided average firm sizes in each size category, allowing us to estimate the number of employers covering these individuals. KPMG Peat Marwick's 1997 survey provided the average number of plans per firm in each size group, supporting estimates of the number of plans. Data from the Bureau of Labor Statistics' Employee

Benefits Survey and the Health and Retirement Study provided a proportionate breakdown of plans and individuals in each firm size group across plan types (HMO, PPO, and fee for service). Likewise, data from KPMG and Foster Higgins surveys were used to divide insured from self-insured plans.

Second, the Departments narrowed the focus to plans affected by the MHPA. Approximately 296,000 plans, sponsored by 136,000 employers and covering 113 million individuals, would be directly affected by the MHPA. This excludes firms with fewer than 50 employees (which are exempt under ERISA Section 712 (c)(1)), plans already covered by state mandates to provide parity in annual and lifetime dollar limits (based on C&L and Hay Huggins reports of the incidence of differential limits—roughly 29,000 plans were excluded here), and insured plans in 13 states that, independent of the MHPA, as of January 1, 1998 will require parity equivalent to or surpassing that required by the MHPA. (Those 13 states are: Indiana, Maryland, Minnesota, Montana, Arkansas, Colorado, Connecticut, Maine, Missouri, New Hampshire, North Carolina, Rhode Island, and Texas.) Some of the plans identified here as affected may not be affected. The MHPA permits self-insured nonfederal governmental plans to opt out of compliance. This includes roughly 22,000 plans covering about 18 million individuals. It also exempts plans whose costs increase by one percent or more, as enumerated below.

Third, the Departments estimated the overall impact of the MHPA as follows: affected plans' potential increases in mental health expenditures under the MHPA equal \$653 million, or 0.29 percent of affected plans' \$226 billion in total expenditures. (The 0.29 percent figure is benchmarked to CBO's estimate that the average cost increase for indemnity plans would be 0.4 percent, but it is adjusted to reflect C&L's assessment of the relative magnitude of cost increases for different plan types. The \$226 billion figure is benchmarked to CBO's \$290 billion universe, but reduced proportionately to reflect the Department's estimate of the proportion of the total universe that is affected by the MHPA.) Under CBO's assumption regarding plan sponsor actions to reduce the added expenditure, actual

added expenditures would amount to \$261 million. Expenditures could be smaller still as a result of self-insured nonfederal governmental plans' right to opt out of compliance and the MHPA's one percent increased cost exemption, which are not accounted for in the foregoing estimates. Recall also that these expenditures represent transfer payments and not social costs.

One Percent Cost Exemption

The effect of this rule will be to prohibit all covered plans from imposing annual or lifetime dollar limits on mental health benefits that are lower than limits imposed on medical and surgical benefits during at least seven months of the first plan year beginning on or after January 1, 1998. Specifically, after six months, the rule permits plans to exercise an exemption as soon as they document a cost increase of one percent or more and provide 30 days notice to participants and the federal government.

Exactly when a given plan will become eligible to elect the one percent increased cost exemption will depend on the timing of its increased costs and its documentation of those costs. In many cases, plans' increased costs under the MHPA will not equal or exceed one percent until more than the initial six months have elapsed. For example, added costs from the MHPA's provision restricting the use of annual dollar limits on mental health benefits would likely be concentrated late in the plans year, when some participants would otherwise have reached these limits. In addition, plans that utilize this rule's transition period may not be affected by the MHPA's provisions until after the first three months of the plan year have elapsed. Therefore, these may be less likely to incur added costs of one percent or more until later in the plan year, or until a subsequent plan year (in which they would be affected by the MHPA beginning on the first day of the plan year).

Whether eligible plans wishing to reduce the direct impact of the MHPA will opt to pursue the exemption or opt for alternative responses will depend on each plan's particular circumstances and priorities.

The Departments estimated the number of affected plans with potential increases of at least one percent. Roughly 30,000

plans, or about 10 percent of a plans affected by MHPA, potentially would be eligible for the one-percent increased cost exemption. That is, all else being equal, complying with the MHPA would increase 30,000 plans' expenditures by at least one percent. These plans cover about 5 million policyholders and 11 million individuals. This is the universe potentially affected by the provisions of this rule that address the one percent increased cost exemption.

In assessing the impact of this rule, the Departments considered the economic consequences of its provisions implementing the one percent cost exemption. Several factors are likely to affect the magnitude of those consequences.

First, under any interpretation, only 10 percent of MHPA-affected plans (or 30,000 plans) could become eligible for the exemption, and only some of those would elect to exercise it. The estimated 30,000 plans that would could become eligible for the one-percent cost exemption represents the upper limit of the number of plans that would actually exercise the exemption. Many of the potentially eligible plans are likely to forego the exemption in favor of other permitted actions. A survey of 300 large firms conducted by William M. Mercer, Inc., found that fewer than 2 percent intended to pursue the one percent increased cost exemption. Extrapolated to the Departments' estimated plan universe, this suggests that 6,000 plans, or 22 percent of the 30,000 that are potentially eligible, would pursue the exemption.

Second, expenditure increases from the MHPA will generally be modest, even for plans potentially eligible for the one percent cost exemption. Their potential expenditure increase would be \$332 million on a base of \$23 billion in total expenditures, or 1.47 percent overall.

Third, as noted above, plans can be designed in ways that lessen these expenditure increases.

Fourth, the 2,215 self-insured nonfederal governmental plans that might become eligible for the one percent cost exemption are separately permitted to opt out of the MHPA entirely, thereby exercising an alternative exemption with equivalent effect. These plans cover 1.8 million individuals, or 16 percent of individuals in potentially eligible plans.

Fifth, the estimates presented in this analysis are conservative; actual expenditures arising from compliance with the MHPA are likely to be less than reported here. In particular, the estimates may understate the reach and cost-effectiveness of managed mental health programs that will exist during the years that the MHPA is in effect (See Roland Sturm, "How Expensive is Unlimited Mental Health Care Coverage Under Managed Care?" *JAMA*, Nov. 12, 1997—Vol. 278 No. 18).

Sixth, because plan expenditure increases under the MHPA (aside from increases in administrative expenses) are transfers, the availability and use of the exemption does not change aggregate social welfare. However, the availability and use of the exemption does affect the size and incidence of transfers across affected parties.

Finally, this rule preserves the availability of most of this savings under the one percent exemption—certain eligible plans are permitted to exercise the exemption after seven months, thereby operating under the exemption for up to 38 of the 45 months during which the MHPA is in effect.

This rule also requires certain notices and disclosures by plans exercising the one percent increased cost exemption. The Departments undertook to estimate the paperwork burdens associated with these provisions, as well as the burden associated with determining whether a plan is eligible for the exemption. These estimates are summarized below.

The estimates reported immediately below are for all plans affected by the notice and disclosure provisions of this rule. The Paperwork Reduction Act (PRA) analysis that follows is presented separately for affected private-sector plans and for plans sponsored by nonfederal governmental employers, which are under the jurisdictions of the Departments of Labor and of Health and Human Services, respectively.

With respect to the notice to participants and beneficiaries and to the federal government by plans exercising the one percent cost exemption, the maximum possible number of such notices is approximately 5.0 million (reflecting all plans potentially eligible to elect the exemption), while a more likely figure is 1.1 million (reflecting the Mercer survey

cited above). Assuming each notice requires 2 minutes of labor at \$11 per hour, plus \$0.50 for postage and materials, total costs would amount to up to \$4.3 million or more probably \$931,000. (These assumptions reflect plans' ability to satisfy this notice requirement through the provisions of a separately required summary of material modifications, as well as availability of a model notice to the government, which together essentially eliminate separate preparation burdens under this requirement and help minimize ongoing burdens.)

With respect to requirement for group health plans to notify the federal government of use of the transition period, and to post these notices in the workplace, only those plans whose plan years begin during the first three months on 1998 and who are potentially eligible for the one percent cost exemption are potentially affected by this provision. These notices would be filed and posted within 30 days or less of the beginning of the plan year, so all would be filed in 1998. Based on annual reports filed with the Department of Labor, the Departments estimate that 60 percent of all eligible plans, accounting for 72 percent of participants in such plans, begin their plan years during these months. This amounts to 18,000 plans, representing the maximum number of notices that would be filed. Extrapolating from the Mercer survey cited above, about 4,000 of these plans might intend to pursue the exemption, representing a more probable number of notices to be filed. Applying the same per unit cost assumptions as above to the filing and posting of these notices, the cost of these notices would be no more than \$8,000 and more likely \$2,000. These assumptions reflect the availability of a model notice, the use of which eliminates preparation costs and helps minimize ongoing burdens.

With respect to the requirement for plans to disclose on request summary information documenting the plan's eligibility for the one percent increased cost exemption, the number of such disclosures will depend on the volume of requests. One might expect requests to arise most commonly when participants are at or near plans' dollar limits. Hay Huggins estimates for the Congressional Research Service (See Roland Sturm, "How Expensive is Unlimited Mental Health Care Coverage

Under Managed Care?" *JAMA*, Nov. 12, 1997—Vol. 278 No. 18) suggest that 0.73 percent of participants on average incur mental health claims of more than \$10,000—a typical annual limit—in a given year. The Departments adjusted this figure to reflect the estimated relationship between increased expenditures under the MHPA for plans eligible for the one percent increased cost exemption and increased expenditures under the MHPA for all affected plans, concluding that 3.74 percent of participants in plans eligible for the one percent increased cost exemption incur claims of more than \$10,000 in a given year. Assuming that this proportion of participants in plans electing the exemption request disclosures, the maximum number of such disclosure requests would be 186,000, while a more probable figure would be 40,000. Given the same per unit cost assumptions as above, the associated costs would be \$161,000 and \$35,000, respectively.

Finally, with respect to plan determinations of eligibility for the one percent increased cost exemption, the Departments expect that plans wishing to exercise the one percent increased cost exemption or their service providers will revise their automated claim record systems to facilitate calculation of the plans' increased costs attributable to the MHPA. The number of plans performing such functions in-house that might wish to exercise the exemption is estimated to be no than 5,346 and more probably 1,142. The number of service providers (including health insurance issuers and third party administrators) that will perform this function for plans that wish to exercise the exemption is estimated to be 1,770 (including 400 third party administrators, 650 health insurers, 645 HMOs, and 75 Blue Cross Blue Shield organizations). Assuming a start up cost of \$5,000 per affected entity, the total start-up cost associated with determining plans' eligibility to exercise the exemption amounts to \$14.6 million to \$35.6 million, to be amortized over 10 years beginning in 1998.

The estimates of the numbers and costs of notices, disclosures and calculations reported above, and below in connection with the Paperwork Reduction Act, may be high with respect to nonfederal governmental plans. An estimated 2,215 self-

insured nonfederal governmental plans might become eligible for the one percent cost exemption. These plans are separately permitted to opt out of the MHPA entirely, thereby exercising an alternative exemption with equivalent effect, and without becoming subject to the calculation, notice, and disclosure requirements. These plans cover 1.8 million individuals, or 16 percent of individuals in potentially eligible plans.

Weighted Average

The economic impact of the Departments' exercise of discretion in the weighted average rule is also expected to be modest.

First, separate limits for benefit categories other than mental health are not very common. For example, among full-time employees at establishments with 100 or more employees participating in non-HMO group health plans in 1993, only a fraction were subject to separate limits for many major benefit categories. For example, just 14 percent were subject to separate limits for inpatient surgery, just 13 percent were subject to such limits for outpatient surgery, and only about one in four were subject to separate limits for both inpatient and office physician visits (U.S. Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments*, 1993). "Separate limits" in this context include not only dollar limits, but also non-dollar limits, such as inpatient day or outpatient visit limits, as well as differential coinsurance rates, copayments, or deductibles. Therefore, the proportion with separate dollar limits that would permit imposition of a weighted average limit on mental health benefits would be even smaller. In addition, such separate limits are even less common in HMOs.

Second, discretion exercised in the weighted average rule affects plans' ability to impose weighted average limits on mental health benefits only at the margin. In other words, compared with the approach set forth in the rule, alternative approaches would have increased or decreased the proportion of plans that are able to impose weighted average limits and the dollar level of calculated averages by only a small amount.

Third, not all plans that are permitted to impose weighted average limits on mental health benefits will elect to do so.

Fourth, some plans that under the rule are not permitted to impose weighted average limits on mental health benefits, under an alternative approach, might have been permitted to impose only a relatively high limit. As such, their expenditure increases from the MHPA might have been nearly the same with a weighted average limit on mental health benefits as with no separate limit on such benefits. Consider a plan with a \$500,000 annual cap on all inpatient care and a \$250,000 annual cap on all outpatient care, and a \$25,000 annual cap on mental health benefits. Under the interim rules, such a plan could not impose a weighted average limit on mental health benefits. Any separate limit on mental health care would have to be at least \$750,000, or at least \$500,000 for inpatient care and at least \$250,000 for outpatient care. Had the plan been permitted to impose a weighted average cap, however, it still would have been required to increase its mental health cap from \$25,000 to some amount between \$250,000 and \$500,000, depending on the weights.

Finally, as with the one percent cost exemption and with the MHPA generally, the impact of regulatory discretion in the weighted average rule will be reduced because self-insured nonfederal governmental plans can opt out, the MHPA's added expenditure is modest, plans can be designed in ways that lessen the MHPA's added expenditure, and the estimates presented here are conservative.

F. Unfunded Mandates Reform Act of 1995

The Unfunded Mandates Reform Act of 1995 (P.L. 104-4) requires agencies to prepare several analytic statements before proposing any rules that may result in annual expenditures of \$100 million by state, local and tribal governments or the private sector. These rules are not subject to the Unfunded Mandates Reform Act because they are interim final rules. However, consistent with the policy embodied in the Unfunded Mandates Reform Act, the regulation has been designed to be the least burdensome alternative for

state, local and tribal governments, and the private sector, while achieving the objectives of the MHPA.

G. Small Business Regulatory Enforcement and Fairness Act of 1995.

The Administrator of the Office of Information and Regulatory Affairs of the Office of Management and Budget has determined that this is a major rule for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. Section 801 *et. seq.*)(SBREFA).

The Secretaries have determined that the effective date of these interim final rules is January 1, 1998. Pursuant to Section 808(2) of SBREFA, the Secretaries find, for good cause, that notice and public procedure thereon are impracticable, unnecessary and contrary to the public interest.

These rules are adopted on an interim final basis because the Secretaries have determined that without prompt guidance some members of the regulated community may have difficulty complying with the MHPA requirements, which may result in an adverse impact on participants and beneficiaries with regard to their mental health benefits under group health plans and the protections provided under MHPA. Moreover, MHPA's requirements will affect the regulated community in the immediate future.

MHPA's requirements are effective for all group health plans, and for health insurance issuers offering coverage in connection with such plans for plan years beginning on or after January 1, 1998. Plan administrators and sponsors, issuers and participants and beneficiaries will need guidance on the new statutory provisions before MHPA's effective date. As noted earlier, these interim rules take into account comments received by the Departments, in response to the request for public comments on MHPA published in the **Federal Register** on June 26, 1997 (62 FR 34604). For the foregoing reasons, the Departments find that notice and public comment would be impracticable, unnecessary and contrary to the public interest.

H. Paperwork Reduction Act—The Department of Labor and the Department of the Treasury

The Department of Labor and the Department of the Treasury have submitted

this emergency processing public information collection request (ICR), consisting of three distinct ICRs to the Office of Management and Budget (OMB) for review and clearance under the Paperwork Reduction Act of 1995 (Pub. L. 104-13, 44 U.S.C. Chapter 35). The Departments have asked for OMB clearance as soon as possible, and OMB approval is anticipated by the applicable effective date.

These regulations contain three distinct ICRs. The first ICR is a notice to participants and beneficiaries and to the federal government of the plan's election of the exemption from the MHPA's provisions due to an increase in cost under the plan of at least one percent attributable to compliance with these provisions. A plan may satisfy this requirement by providing participants and beneficiaries with a notice of material reductions in covered service or benefits, under the Department of Labor's regulations at 29 CFR section 2520.104b-3(d), that includes the information in paragraph (f)(3)(i) of this interim final rule regarding issuing a notice to participants and beneficiaries of the plan's exemption from these parity requirements. Before the one percent increased cost exemption is effective, the plan must also notify the federal government. For this purpose, the group health plan may either send the Department of Labor a copy of the summary of material reductions in covered services or benefits sent to participants and beneficiaries, containing the plan number and the plan sponsor's employer identification number, or the plan (or coverage) may use the Departments' model notice in this interim final rule which has been developed for this purpose.

The second ICR is a summary of the information used to calculate the plan's increased costs under the MHPA for purposes of electing the one percent increased cost exemption, which the plan must make available to participants and beneficiaries, on request at no charge.

The third ICR is a notice of a group health plan's use of the transition period. The rule requires plans exercising the one percent increased cost exemption during all or part of the first quarter of 1998 under the rule's transition provisions to notify the federal government, and to post a copy of this notice at the workplace.

1. Notice to Participants and Beneficiaries and the Federal Government of Electing One Percent Increased Cost Exemption

i. Department of Labor

The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden, conducts a preclearance consultation program to provide the general public and Federal agencies with an opportunity to comment on proposed and/or continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (Pub. L. 104-13, 44 U.S.C. Chapter 35) and 5 CFR 1320.11. This program helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed. Currently, the Pension and Welfare Benefits Administration is soliciting comments concerning the proposed collection of information, Notice to Participants and Beneficiaries and the Federal Government of Electing One Percent Increased Cost Exemption. A copy of the proposed ICR can be obtained by contacting the employee listed below in the contact section of the notice.

Information collection: affected parties are not required to comply with the ICRs in these rules until the Department of Labor publishes in the Federal Register the control numbers assigned to these ICRs by OMB. The publication of the control numbers notifies the public that OMB has approved these ICRs under the Paperwork Reduction Act of 1995. The Department has asked for OMB clearance as soon as possible, and OMB approval is anticipated by the applicable effective date.

Dates: Written comments must be submitted to the office listed in the addressee section below on or before February 20, 1998. The Department of Labor is particularly interested in comments which:

- evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

- evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- enhance the quality, utility, and clarity of the information to be collected; and
- minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submissions of responses.

Addressee: Gerald B. Lindrew, Office of Policy and Research, U.S. Department of Labor, Pension and Welfare Benefits Administration, 200 Constitution Avenue, Room N-5647, Washington, DC 20210. Telephone: 202-219-4782 (this is not a toll-free number). Fax: 202-219-4745.

ii. Department of the Treasury

The collection of information is in 54.9812-1T. This information is required by the interim final rules so that participants will be informed about their rights under MHPA, and so that participants and beneficiaries, and the federal government, will receive notice of a plan's election of the one percent increased cost exemption. The likely respondents are business or other for-profit institutions, non-profit institutions, small businesses or organizations, and Taft-Hartley trusts. Responses to this collection of information are required to obtain the benefit of the exemption.

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

Comments on the collection of information should be sent to the Office of

Management and Budget, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the Internal Revenue Service, Attn: IRS Reports Clearance Officer, T:FP, Washington, DC 20224. Comments on the collection of information should be received on or before February 20, 1998. In light of the request for OMB clearance by the effective date of the MHPA, submission of comments within the first 30 days is encouraged to ensure their consideration. Comments are specifically requested concerning:

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

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

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

How to minimize the burden of complying with the proposed collection of information, including the application of automated collection techniques or other forms of information technology; and

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

I. Background: MHPA generally requires that group health plans provide parity in the application of dollar limits to mental health and medical/surgical benefits. The statute exempts plans from this requirement if its application results in an increase in the cost under the plan or coverage of at least one percent. This regulation requires a plan electing this exemption to notify participants and beneficiaries and the federal government of the plan's election of the exemption. This ICR covers this notification requirement.

II. Current Actions: Under 29 CFR 2590.712 (f)(3)(i) and (ii), and 26 CFR

54.9812-1T a group health plan electing the one percent exemption is obligated to provide a written notice of that election to participants and beneficiaries and to the federal government of the plan's election of the exemption. A plan may satisfy this requirement by providing participants and beneficiaries with a notice of material reductions in covered service or benefits, under the Department of Labor's regulations at 29 CFR section 2520.104b-3(d), that includes the information in paragraph (f)(3)(i) of this interim final rule regarding issuing a notice to participants and beneficiaries of the plan's exemption from these parity requirements. To satisfy the requirement to notify the federal government, a group health plan may either send the Department a copy of the summary of material reductions in covered services or benefits sent to participants and beneficiaries, containing the plan number and the plan sponsor's employer identification number, or the plan may use the Department's model notice in this interim final rule which has been developed for this purpose. Based on past experience, the staff believes that most of the materials required to be issued under this notice procedure will be prepared by contract service providers such as insurance companies and third-party administrators.

Type of Review: New.

Agencies: U.S. Department of Labor, Pension and Welfare Benefits Administration; U.S. Department of the Treasury, Internal Revenue Service.

Title: Notice to Participants and Beneficiaries and the Federal Government of Electing One Percent Increased Cost Exemption

OMB Number: XXXXXXXX

Affected Public: Individuals or households; Business or other for-profit; Not-for-profit institutions; Group health plans.

Frequency: On occasion

Burden:

Year	Total Respondents (range)	Total Responses (range)	Average Time per Response (range)	Burden Hours (range)	Cost (range)
1998	-	-	-	-	-
1999	5,612 to 25,446	813,505 to 3.8MM	2 minutes	6,324 to 29,605	\$705,037 to \$3.3MM
2000	-	-	-	-	-
TOTALS	5,612 to 25,446	813,505 to 3.8MM	2 minutes	6,324 to 29,605	\$705,037 to \$3.3MM

Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval of the ICRs; they will also become a matter of public record.

2. Calculation and Disclosure of Documentation of Eligibility for Exemption

i. Department of Labor

The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden, conducts a preclearance consultation program to provide the general public and Federal agencies with an opportunity to comment on proposed and/or continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (Pub. L. 104-13, 44 U.S.C. Chapter 35) and 5 CFR 1320.11. This program helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed. Currently, the Pension and Welfare Benefits Administration is soliciting comments concerning the proposed collection of information, Disclosure of Documentation of Eligibility for Exemption. A copy of the proposed ICR can be obtained by contacting the employee listed below in the contact section of the notice.

Information collection: affected parties are not required to comply with the ICRs in these rules until the Department of Labor publishes in the Federal Register the control numbers assigned to these ICRs by OMB. The publication of the control numbers notifies the public that OMB has approved these ICRs under the Paperwork Reduction Act of 1995. The Department has asked for OMB clearance as soon as possible, and OMB approval is anticipated by the applicable effective date.

Dates: Written comments must be submitted to the office listed in the addressee section below on or before February 20, 1998. The Department of Labor is particularly interested in comments which:

- evaluate whether the proposed collection of information is necessary for the

proper performance of the functions of the agency, including whether the information will have practical utility;

- evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- enhance the quality, utility, and clarity of the information to be collected; and
- minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submissions of responses.

Addressee: Gerald B. Lindrew, Office of Policy and Research, U.S. Department of Labor, Pension and Welfare Benefits Administration, 200 Constitution Avenue, Room N-5647, Washington, DC 20210. Telephone: 202-219-4782 (this is not a toll-free number). Fax: 202-219-4745.

ii. Department of the Treasury

The collection of information is in Section 54.9812-1T. This information is required by the interim final rules so that participants will be informed about their rights under MHPA, and so that participants and beneficiaries may receive a summary of the information upon which the plan based its election of the one percent increased cost exemption. The likely respondents are business or other for-profit institutions, non-profit institutions, small businesses or organizations, and Taft-Hartley trusts. Responses to this collection of information are required to obtain the benefit of the exemption.

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

Comments on the collection of information should be sent to the Office of Management and Budget, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the Internal Revenue Service, Attn: IRS Reports Clearance Officer, T:FP, Wash-

ington, DC 20224. Comments on the collection of information should be received on or before February 20, 1998. In light of the request for OMB clearance by the effective date of the MHPA, submission of comments within the first 30 days is encouraged to ensure their consideration. Comments are specifically requested concerning:

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

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

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

How to minimize the burden of complying with the proposed collection of information, including the application of automated collection techniques or other forms of information technology; and

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

I. Background: MHPA generally requires that group health plans provide parity in the application of dollar limits to mental health and medical/surgical benefits. The statute exempts plans from this requirement if its application results in an increase in the cost under the plan or coverage of at least one percent. This regulation requires plans wishing to elect this exemption to calculate their increased costs according to certain rules. It further requires plans electing this exemption to disclose to participants and beneficiaries (or their representatives), on request, and at no charge, a summary of the information upon which the exemption was based. This ICR covers this disclosure requirement.

II. Current Actions: Under 29 CFR 2590.712(f)(2) and 26 CFR 54.9812-1T, a group health plan wishing to elect the one percent exemption must calculate their increased costs according to certain rules. Under 29 CFR 2590.712(f)(4) and 26 CFR 54.9812-1T, a group health plan electing the one percent exemption is obligated to disclose to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information on which the exemption was based.

Type of Review: New.

Agencies: U.S. Department of Labor, Pension and Welfare Benefits Administration; U.S. Department of the Treasury, Internal Revenue Service.

Title: Calculation and Disclosure of Documentation of Eligibility for Exemption

OMB Number: XXXXXXXX

Affected Public: Individuals or households; Business or other for-profit; Not-for-profit institutions; Group Health Plans.

Frequency: On occasion

Calculation burden: It is expected that

plans wishing to exercise the one percent increased cost exemption or their service providers will revise their automated claim record systems to facilitate calculation of the plans' increased costs attributable to the MHPA. The number of plans performing such functions in-house that might wish to exercise the exemption is estimated to be no than 4,489 and more probably 958. The number of service providers (including health insurance issuers and third party administrators) that will perform this function for plans using service providers that wish to exercise the exemption is estimated to be 1,770. As-

suming a cost of \$5,000 per affected entity, the total cost associated with determining plans' eligibility to exercise the exemption amounts to \$12.5 million to \$30.1 million, to be amortized over 10 years beginning in 1998.

Disclosure burden: In addition to the calculation burden, plans wishing to elect the one percent increased cost exemption will incur a burden in connection with disclosure requests from participants, as detailed below.

Year	Total Respondents (range)	Total Responses (range)	Average Time per Response	Burden Hours (range)	Cost (range)
1998	–	–	–	–	–
1999	5,612 to 25,466	30,188 to 140,412	2 minutes	235 to 1,101	\$26,163 to \$121,690
2000	5,612 to 25,466	30,188 to 140,412	2 minutes	235 to 1,101	\$26,163 to \$121,690
TOTALS	5,612 to 25,466	60,377 to 280,824	2 minutes	470 to 2,201	\$52,326 to \$243,381

Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval of the ICRs; they will also become a matter of public record.

3. Notice of Group Health Plan's Use of Transition Period, and Posting Thereof

i. Department of Labor

The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden, conducts a preclearance consultation program to provide the general public and Federal agencies with an opportunity to comment on proposed and/or continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (Pub. L. 104-13, 44 U.S.C. Chapter 35) and 5 CFR 1320.11. This program helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed. Currently, the Pension and Welfare Benefits Administration is soliciting comments concerning the proposed

collection of information, Notice of Group Health Plan's Use of Transition Period. A copy of the proposed ICR can be obtained by contacting the employee listed below in the contact section of the notice.

Information collection: affected parties are not required to comply with the ICRs in these rules until the Department of Labor publishes in the Federal Register the control numbers assigned to these ICRs by OMB. The publication of the control numbers notifies the public that OMB has approved these ICRs under the Paperwork Reduction Act of 1995. The Department has asked for OMB clearance as soon as possible, and OMB approval is anticipated by the applicable effective date.

Dates: Written comments must be submitted to the office listed in the addressee section below on or before February 20, 1998. The Department of Labor is particularly interested in comments which:

- evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- evaluate the accuracy of the agency's estimate of the burden of the proposed

collection of information, including the validity of the methodology and assumptions used;

- enhance the quality, utility, and clarity of the information to be collected; and
- minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submissions of responses.

Addressee: Gerald B. Lindrew, Office of Policy and Research, U.S. Department of Labor, Pension and Welfare Benefits Administration, 200 Constitution Avenue, Room N-5647, Washington, DC 20210. Telephone: 202-219-4782 (this is not a toll-free number). Fax: 202-219-4745.

ii. Department of the Treasury

The collection of information is in Section 54.9812-1T. This information is required by the interim final rules so that participants will be informed about their rights under MHPA, and so that plans electing the one percent increased cost exemption during all or part of the first quarter of 1998 under the rules' transition pro-

visions will notify the federal government and post the notice in the workplace. The likely respondents are business or other for-profit institutions, non-profit institutions, small businesses or organizations, and Taft-Hartley trusts. Responses to this collection of information are required to obtain the benefit of the exemption.

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

Comments on the collection of information should be sent to the Office of Management and Budget, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the Internal Revenue Service, Attn: IRS Reports Clearance Officer, T:FP, Washington, DC 20224. Comments on the collection of information should be received on or before February 20, 1998. In light of the request for OMB clearance by the effective date of the MHPA, submission of comments within the first 30 days is encouraged to ensure their consideration. Comments are specifically requested concerning:

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

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

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

How to minimize the burden of complying with the proposed collection of information, including the application of automated collection techniques or other forms of information technology; and

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

I. Background: MHPA generally requires that group health plans provide parity in the application of dollar limits to mental health and medical/surgical benefits. The statute exempts plans from this requirement if its application results in an increase in the cost under the plan or coverage of at least one percent. This regulation requires a notice of group health plan's use of transition period, under which plans electing the one percent increased cost exemption during all or part of the first quarter of 1998 under the

rule's transition provisions must notify the federal government and to post a copy of the notice in the workplace. This ICR covers this notification requirement.

II. Current Actions: Under 29 CFR 2590.712(h)(3)(ii) and 26 CFR 54.9812-1T, group health plans electing the one percent increased cost exemption during all or part of the first quarter of 1998 under the rule's transition provisions must notify the federal government. Based on past experience, the staff believes that most of the materials required to be issued under this notice procedure will be prepared by contract service providers such as insurance companies and third-party administrators.

Type of Review: New.

Agencies : U.S. Department of Labor, Pension and Welfare Benefits Administration; U.S. Department of the Treasury, Internal Revenue Service.

Title: Notice of Group Health Plan's Use of Transition Period

OMB Number: XXXXXXXX

Affected Public: Individuals or households; Business or other for-profit; Not-for-profit institutions; Group Health Plans.

Frequency: On occasion

Burden:

Year	Total Respondents (range)	Total Responses (range)	Average Time per Response	Burden Hours (range)	Cost (range)
1998	3,348 to 15,193	3,348 to 15,193	2 minutes	19 to 89	\$1,514 to \$6,910
1999	–	–	–	–	–
2000	–	–	–	–	–
TOTALS	3,348 to 15,193	3,348 to 15,193	2 minutes	19 to 89	\$1,514 to \$6,910

Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval of the ICRs; they will also become a matter of public record.

**I. Paperwork Reduction Act—
Department of Health and Human
Services**

Under the Paperwork Reduction Act of 1995 (PRA), agencies are required to provide a 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management

and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- Whether the information collection is necessary and useful to carry out the proper functions of the agency;
- The accuracy of the agency's estimate of the information collection burden;
- The quality, utility, and clarity of the information to be collected; and

- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Therefore, we are soliciting public comment on each of these issues for the information collection requirements discussed below.

Section 146.136 of this document contains three distinct information collection requirements, as summarized below:

Type of Information Request: New collection.

Title of Information Collection: Mental Health Parity Act of 1996; Information

Collection Requirements Contained in 45 CFR 146.136; HCFA-2891-IFC.

Form Number: HCFA-R-223 (OMB approval #: 0938-XXXX)

Use: The information collection requirements contained in this interim final rule will help ensure that sponsors and administrators of group health plans notify the required individuals/entities of a plan's exemption from the MHPA parity requirements and make the data used to calculate the exemption available to affected individuals and entities.

Frequency: On occasion.

Affected Public: States, businesses or other for profit, not-for-profit institutions, Federal Government, individuals or households.

Notification Requirements: Nonfederal governmental plans, not exempt from the

parity requirements by reason of an opt out under regulations at 45 CFR 146.180, must furnish participants and beneficiaries with a notice of the plan's exemption from the parity requirements based on increased costs. A plan may satisfy this requirement by providing participants and beneficiaries with a notice of material reductions in covered services or benefits, under 29 CFR 2520.104b-3(d), that includes the information in paragraph (f)(3)(i). Even though a plan generally is not required to furnish a material reduction in covered services or benefits for 60 days, in no case will the exemption be effective until 30 days after the notice is sent to participants and beneficiaries. For this purpose, a plan that does not furnish the summary of material reductions in covered services or benefits may satisfy

its notice requirements by using the model exemption notice described above in this preamble.

In addition, the nonfederal governmental plan (or issuer providing coverage to such a plan) must also furnish to the Department of Health and Human Services a notice similar to the notice sent to participants and beneficiaries before the exemption is effective. For this purpose, the plan may either send the Department the summary of material reductions in covered services or benefits sent to participants and beneficiaries, or the plan (or issuer) may use the model described above. In all cases, the exemption is not effective until 30 days after notice has been sent.

Burden:

Year	Total Respondents (range)	Total Responses (range)	Average Time per Response (range)	Burden Hours (range)	Cost (range)
1998	–	–	–	–	–
1999	890 to 4,092	261,000 to 1.2 MM	2 minutes	2,133 to 9,975	\$226,000 to \$1.1 MM
2000	–	–	–	–	–
TOTALS	890 to 4,092	261,000 to 1.2 MM	2 minutes	2,133 to 9,975	\$226,000 to \$1.1 MM

Availability of documentation: Nonfederal governmental plans that take the exemption, or issuers that provide coverage for such plans, must make available to participants and beneficiaries, on request and at no charge, a summary of the data used to calculate the exemption of this

section. The summary of data must include the incurred expenditures (including identification of the portion of the total representing claims and the portion of the total representing administrative expenses), the base period, the claims incurred during the base period that would

have been denied under the terms of the plan absent amendments required to comply with parity, and the administrative expenses attributable to complying with the parity requirements.

Burden:

Year	Total Respondents (range)	Total Responses (range)	Average Time per Response (range)	Burden Hours (range)	Cost (range)
1998	–	–	–	–	–
1999	890 to 4,092	9,700 to 45,300	2 minutes	79 to 372	\$8,400 to \$39,300
2000	890 to 4,092	9,700 to 45,300	2 minutes	79 to 372	\$8,400 to \$39,300
TOTALS	890 to 4,092	19,400 to 90,600	2 minutes	158 to 744	\$16,800 to \$78,600

Plans that take the exemption will incur start up costs for preparing to issue the information they must disclose. We estimate the start up costs for nonfederal governmental plans that take this exemption to range from \$2.1 million to \$5.5 million.

Notice of Use of Transition Period: With respect to the increased cost exemption, the interim rules provide in paragraph (g)(3) a transition period for compliance with the requirements of paragraph (f). Under paragraph (g)(3), no enforcement action shall be taken against a nonfederal governmental plan that is

subject to the MHPA requirements prior to April 1, 1998 solely because the plan claims the increased cost exemption under section 2705(c)(2) of the PHS Act based on assumptions inconsistent with the rules under paragraph (f), provided that the plan is amended to comply with the parity requirements no later than March 31, 1998 and the plan complies with the certain notice requirements. A nonfederal governmental plan satisfies the notice requirements only if such plan provides notice to the Department of Health and Human Services of the plan's

intent to use the transition period by 30 days after the first day of the plan year beginning on or after January 1, 1998, but in no event can the notice be provided later than March 31, 1998. Such notice shall include the name of the plan; the name, address, and telephone number of the plan sponsor or plan administrator; the employer identification number; and the plan number. In addition, such notice must be provided at no charge to participants within 30 days after receipt of a written request for such notification.

Burden:

Year	Total Respondents (range)	Total Responses (range)	Average Time per Response (range)	Burden Hours (range)	Cost (range)
1998	531 to 2,441	531 to 2,441	2 minutes	4 to 17	\$250 to \$1,151
1999	—	—	—	—	—
2000	—	—	—	—	—
TOTALS	531 to 2,441	531 to 2,441	2 minutes	4 to 17	\$250 to \$1,151

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirements in §146.136. These requirements are not effective until they have been approved by OMB.

If you comment on any of these information collection and recordkeeping requirements, please mail copies directly to the following:

Health Care Financing Administration,
Office of Information Services,
Information Technology Investment
Management Group,
Division of HCFA Enterprise
Standards,
Room C2-26-17, 7500 Security
Boulevard,
Baltimore, MD 21244-1850.

ATTN: John Burke HCFA-2891-IFC

We have submitted a copy of this rule to OMB for its review of these information collections. A notice will be published in the **Federal Register** when approval is obtained. Interested persons are invited to send comments regarding this burden or any other aspect of these collections of information. If you comment on these information collection and record-

keeping requirements, please mail copies directly to the following addresses:

Office of Information and Regulatory
Affairs

Office of Management and Budget
Room 10235

New Executive Office Building
Washington, DC 20530, Attn: Allison
Herron Eydt, HCFA Desk Officer.

DATED:

Gerald B. Lindrew
Deputy Director, Pension and Welfare
Benefits Administration,
Office of Policy and Research

Statutory Authority

The Department of the Treasury temporary rule is adopted pursuant to the authority contained in sections 7805 and 9833 of the Code (26 U.S.C. 7805, 9833), as amended by HIPAA (Pub. L. 104-191, 110 Stat. 1936) and the Taxpayer Relief Act of 1997 (Pub. L. 105-34, 111 Stat. 788).

The Department of Labor interim final rule is adopted pursuant to the authority contained in sections 107, 209, 505, 701-703, 711, 712, and 731-734 of ERISA (29 U.S.C. 1027, 1059, 1135, 1171-1173,

1181, 1182, and 1191-1194), as amended by HIPAA (Pub. L. 104-191, 110 Stat. 1936) and MHPA (Pub. L. 104-204, 110 Stat. 2944), and Secretary of Labor's Order No. 1-87, 52 FR 13139, April 21, 1987.

The Department of Health and Human Services interim final rule is adopted pursuant to the authority contained in sections 2701, 2702, 2705, 2711, 2712, 2713, 2721, 2722, 2723, and 2792 of the PHS Act (42 U.S.C. 300gg, 300gg-1, 300gg-5, 300gg-11, 300gg-12, 300gg-13, 300gg-21, 300gg-22, 300gg-23, and 300gg-92), as established by HIPAA (Pub. L. 104-191, 110 Stat. 1936) and MHPA (Pub. L. 104-204, 110 Stat. 2944).

* * * * *

Adoption of Amendments to the Regulations

Internal Revenue Service
26 CFR Chapter I

Accordingly, 26 CFR Part 54 is amended as follows:

PART 54—PENSION EXCISE TAXES

Paragraph 1. The authority citation for part 54 is amended by revising the entries

for §§54.9801-1T through 54.9801-6T and 54.9802-1T, by removing the entries for §§54.9804-1T and 54.9806-1T, and by adding entries for §§54.9812-1T, 54.9831-1T, and 54.9833-1T to read in part as follows:

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

Section 54.9801-1T also issued under 26 U.S.C. 9833.

Section 54.9801-2T also issued under 26 U.S.C. 9833.

Section 54.9801-3T also issued under 26 U.S.C. 9833.

Section 54.9801-4T also issued under 26 U.S.C. 9833.

Section 54.9801-5T also issued under 26 U.S.C. 9801(c)(4), 9801(e)(3), and 9833.

Section 54.9801-6T also issued under 26 U.S.C. 9833.

Section 54.9802-1T also issued under 26 U.S.C. 9833.

Section 54.9812-1T also issued under 26 U.S.C. 9833.

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

Section 54.9833-1T also issued under 26 U.S.C. 9833.

Par. 2. In §54.9801-1T, paragraph (a) is revised to read as follows:

§54.9801-1T Basis and scope (temporary).

(a) *Statutory basis.* Sections 54.9801-1T through 54.9801-6T, 54.9802-1T, 54.9812-1T, 54.9831-1T and 54.9833-1T (portability sections) implement Chapter 100 of Subtitle K of the Internal Revenue Code of 1986.

* * * * *

Par. 3. Section 54.9801-2T is amended by:

- 1. Revising the introductory text.
- 2. Revising the definition of *excepted benefits*.

3. Revising the definition of *health insurance coverage*.

The revisions read as follows:

§54.9801-2T Definitions (temporary).

Unless otherwise provided, the definitions in this section govern in applying the provisions of §§54.9801-1T through 54.9801-6T, 54.9802-1T, 54.9812-1T, 54.9831-1T, and 54.9833-1T.

* * * * *

Excepted benefits means the benefits described as excepted in §54.9831-1T(b).

* * * * *

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 service plan contract, or HMO contract offered by a health insurance issuer. However, benefits described in §54.9831-1T(b)(2) are not treated as benefits consisting of medical care.

* * * * *

Par. 4. In §54.9801-4T, paragraph (a)(2) is revised to read as follows:

§54.9801-4T Rules relating to creditable coverage (temporary).

(a) * * *

(2) *Excluded coverage.* Creditable coverage does not include coverage consisting solely of coverage of excepted benefits (described in §54.9831-1T).

* * * * *

Par. 5. In §54.9801-5T, the first sentence of paragraph (a)(3)(vi) is revised to read as follows:

§54.9801-5T Certification and disclosure of previous coverage (temporary).

(a) * * *

(3) * * *

(vi) *Excepted benefits; categories of benefits.* No certificate is required to be furnished with respect to excepted benefits described in §54.9831-1T. * * *

* * * * *

§54.9804-1T [Redesignated as §54.9831-1T]

Par. 6. Section 54.9804-1T is redesignated as §54.9831-1T and revised in paragraph (b)(1) to read as follows:

§54.9831-1T Special rules relating to group health plans (temporary).

* * * * *

(b) *Excepted benefits*—(1) *In general.* The requirements of §§54.9801-1T through 54.9801-6T, 54.9802-1T, and 54.9812-1T do not apply to any group health plan in relation to its provision of

the benefits described in paragraph (b)(2), (3), (4), or (5) of this section (or any combination of these benefits).

* * * * *

§54.9806-1T [Redesignated as §54.9833-1T]

Par. 7. Section 54.9806-1T is redesignated as §54.9833-1T and amended by:

1. Revising redesignated paragraph (a)(1).

2. Revising the first sentence of redesignated paragraph (a)(2).

The revisions read as follows:

§54.9833-1T Effective dates (temporary).

(a) *General effective dates*—(1) *Non-collectively-bargained plans.* Except as otherwise provided in this section, Chapter 100 of Subtitle K and §§54.9801-1T through 54.9806-1T, 54.9802-1T, and 54.9831-1T apply with respect to group health plans for plan years beginning after June 30, 1997.

(2) *Collectively bargained plans.* Except as otherwise provided in this section (other than paragraph (a)(1) of this section), in the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before August 21, 1996, Chapter 100 of Subtitle K and §§54.9801-1T through 54.9801-6T, 54.9802-1T, and 54.9831-1T do not apply to plan years beginning before the later of July 1, 1997, or 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 August 21, 1996). * * *

* * * * *

Par. 8. Section 54.9812-1T is added to read as follows:

§54.9812-1T Parity in the application of certain limits to mental health benefits (temporary).

(a) *Definitions.* For purposes of this section, except where the context clearly indicates otherwise, the following definitions apply:

Aggregate lifetime limit means a dollar limitation on the total amount of specified benefits that may be paid under a group

health plan for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

Annual limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a plan for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

Medical/surgical benefits means benefits for medical or surgical services, as defined under the terms of the plan, but does not include mental health benefits.

Mental health benefits means benefits for mental health services, as defined under the terms of the plan, but does not include benefits for treatment of substance abuse or chemical dependency.

(b) *Requirements regarding limits on benefits*—(1) *In general*—(i) *General parity requirement.* A group health plan that provides both medical/surgical benefits and mental health benefits must comply with paragraph (b)(2), (3), or (6) of this section.

(ii) *Exception.* The rule in paragraph (b)(1)(i) of this section does not apply if a plan satisfies the requirements of paragraph (e) or (f) of this section.

(2) *Plan with no limit or limits on less than one-third of all medical/surgical benefits.* If a plan does not include an aggregate lifetime or annual limit on any medical/surgical benefits or includes aggregate lifetime or annual limits that apply to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual limit, respectively, on mental health benefits.

(3) *Plan with a limit on at least two-thirds of all medical/surgical benefits.* If a plan includes an aggregate lifetime or annual limit on at least two-thirds of all medical/surgical benefits, it must either—

(i) Apply the aggregate lifetime or annual limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health benefits in a manner that does not distinguish between the medical/surgical and mental health benefits; or

(ii) Not include an aggregate lifetime or annual limit on mental health benefits that is less than the aggregate lifetime or annual limit, respectively, on the medical/surgical benefits.

(4) *Examples.* The rules of paragraphs (b)(2) and (3) of this section are illustrated by the following examples:

Example 1. (i) Prior to the effective date of the mental health parity provisions, a group health plan had no annual limit on medical/surgical benefits and had a \$10,000 annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Eliminating the plan's annual limit on mental health benefits;

(B) Replacing the plan's previous annual limit on mental health benefits with a \$500,000 annual limit on all benefits (including medical/surgical and mental health benefits); and

(C) Replacing the plan's previous annual limit on mental health benefits with a \$250,000 annual limit on medical/surgical benefits and a \$250,000 annual limit on mental health benefits.

(ii) In this *Example 1*, each of the three options being considered by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

Example 2. (i) Prior to the effective date of the mental health parity provisions, a group health plan had a \$100,000 annual limit on medical/surgical inpatient benefits, a \$50,000 annual limit on medical/surgical outpatient benefits, and a \$100,000 annual limit on all mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Replacing the plan's previous annual limit on mental health benefits with a \$150,000 annual limit on mental health benefits; and

(B) Replacing the plan's previous annual limit on mental health benefits with a \$100,000 annual limit on mental health inpatient benefits and a \$50,000 annual limit on mental health outpatient benefits.

(ii) In this *Example 2*, each option under consideration by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

Example 3. (i) A group health plan that is subject to the requirements of this section has no aggregate lifetime or annual limit for either medical/surgical benefits or mental health benefits. While the plan provides medical/surgical benefits with respect to both network and out-of-network providers, it does not provide mental health benefits with respect to out-of-network providers.

(ii) In this *Example 3*, the plan complies with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

Example 4. (i) Prior to the effective date of the mental health parity provisions, a group health plan had an annual limit on medical/surgical benefits and a separate but identical annual limit on mental health benefits. The plan included benefits for treatment of substance abuse and chemical dependency in its definition of mental health benefits. Accordingly, claims paid for treatment of substance abuse and chemical dependency were counted in applying the annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b),

the plan sponsor is considering each of the following options:

(A) Making no change in the plan so that claims paid for treatment of substance abuse and chemical dependency continue to count in applying the annual limit on mental health benefits;

(B) amending the plan to count claims paid for treatment of substance abuse and chemical dependency in applying the annual limit on medical/surgical benefits (rather than counting those claims in applying the annual limit on mental health benefits);

(C) amending the plan to provide a new category of benefits for treatment of chemical dependency and substance abuse that is subject to a separate, lower limit and under which claims paid for treatment of substance abuse and chemical dependency are counted only in applying the annual limit on this separate category; and

(D) amending the plan to eliminate distinctions between medical/surgical benefits and mental health benefits and establishing an overall limit on benefits offered under the plan under which claims paid for treatment of substance abuse and chemical dependency are counted with medical/surgical benefits and mental health benefits in applying the overall limit.

(ii) In this *Example 4*, the group health plan is described in paragraph (b)(3) of this section. Because mental health benefits are defined in paragraph (a) of this section as excluding benefits for treatment of substance abuse and chemical dependency, the inclusion of benefits for treatment of substance abuse and chemical dependency in applying an aggregate lifetime limit or annual limit on mental health benefits under option (A) of this *Example 4* would not comply with the requirements of paragraph (b)(3) of this section. However, options (B), (C), and (D) of this *Example 4* would comply with the requirements of paragraph (b)(3) of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

(5) *Determining one-third and two-thirds of all medical/surgical benefits.*

For purposes of this paragraph (b), the determination of whether the portion of medical/surgical benefits subject to a limit represents one-third or two-thirds of all medical/surgical benefits is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime or annual limits). Any reasonable method may be used to determine whether the dollar amounts expected to be paid under the plan will constitute one-third or two-thirds of the dollar amount of all plan payments for medical/surgical benefits.

(6) *Plan not described in paragraph (b)(2) or (3) of this section*—(i) *In general.* A group health plan that is not described in paragraph (b)(2) or (3) of this section, must either—

(A) Impose no aggregate lifetime or annual limit, as appropriate, on mental health benefits; or

(B) Impose an aggregate lifetime or annual limit on mental health benefits that is no less than an average limit for medical/surgical benefits calculated in the following manner. The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual limits, as appropriate, that are applicable to the categories of medical/surgical benefits. Limits based on delivery systems, such as inpatient/outpatient treatment or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories for purposes of this paragraph (b)(6)(i)(B). In addition, for purposes of determining weighted averages, any benefits that are not within a category that is subject to a separately-designated limit under the plan are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that a plan may reasonably be expected to incur with respect to such benefits, taking into account any other applicable restrictions under the plan.

(i) *Weighting.* For purposes of this paragraph (b)(6), the weighting applicable to any category of medical/surgical benefits is determined in the manner set forth in paragraph (b)(5) of this section for determining one-third or two-thirds of all medical/surgical benefits.

(ii) *Example.* The rules of this paragraph (b)(6) are illustrated by the following example:

Example. (i) A group health plan that is subject to the requirements of this section includes a \$100,000 annual limit on medical/surgical benefits related to cardio-pulmonary diseases. The plan does not include an annual limit on any other category of medical/surgical benefits. The plan determines that 40% of the dollar amount of plan payments for medical/surgical benefits are related to cardio-pulmonary diseases. The plan determines that \$1,000,000 is a reasonable estimate of the upper limit on the dollar amount that the plan may incur with respect to the other 60% of payments for medical/surgical benefits.

(ii) In this *Example*, the plan is not described in paragraph (b)(3) of this section because there is not one annual limit that applies to at least two-thirds of all medical/surgical benefits. Further, the plan is not described in paragraph (b)(2) of this section because more than one-third of all medical/surgical benefits are subject to an annual limit. Under this paragraph (b)(6), the plan sponsor can choose either to include no annual limit on mental health benefits, or to in-

clude an annual limit on mental health benefits that is not less than the weighted average of the annual limits applicable to each category of medical/surgical benefits. In this example, the minimum weighted average annual limit that can be applied to mental health benefits is \$640,000 ($40\% \times \$100,000 + 60\% \times \$1,000,000 = \$640,000$).

(c) *Rule in the case of separate benefit packages.* If a group health plan offers two or more benefit packages, the requirements of this section, including the exemption provisions in paragraph (f) of this section, apply separately to each benefit package. Examples of a group health plan that offers two or more benefit packages include a group health plan that offers employees a choice between indemnity coverage or HMO coverage, and a group health plan that provides one benefit package for retirees and a different benefit package for current employees.

(d) *Applicability—(1) Group health plans.* The requirements of this section apply to a group health plan offering both medical/surgical benefits and mental health benefits regardless of whether the mental health benefits are administered separately under the plan.

(2) *Health insurance issuers.* See 29 CFR 2590.712(d)(2) and 45 CFR 146.136(d)(2), which provide that health insurance issuers offering health insurance coverage for both medical/surgical benefits and mental health benefits in connection with a group health plan are subject to rules similar to those applicable to group health plans under this section.

(3) *Scope.* This section does not—

(i) Require a group health plan to provide any mental health benefits; or

(ii) Affect the terms and conditions (including cost sharing, limits on the number of visits or days of coverage, requirements relating to medical necessity, requiring prior authorization for treatment, or requiring primary care physicians' referrals for treatment) relating to the amount, duration, or scope of the mental health benefits under the plan except as specifically provided in paragraph (b) of this section.

(e) *Small employer exemption—(1) In general.* The requirements of this section do not apply to a group health plan for a plan year of a small employer. For purposes of this paragraph (e), the term *small employer* means, in connection with a group health plan with respect to a calen-

dar year and a plan year, an employer who employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. See section 9831(a) and §54.9831-1T(a), which provide that this section (and certain other sections) does not apply to any group health plan for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(2) *Rules in determining employer size.* For purposes of paragraph (e)(1) of this section—

(i) All persons treated as a single employer under subsections (b), (c), (m), and (o) of section 414 are treated as one employer;

(ii) If an employer was not in existence throughout the preceding calendar year, whether it is a small employer is determined based on the average number of employees the employer reasonably expects to employ on business days during the current calendar year; and

(iii) Any reference to an employer for purposes of the small employer exemption includes a reference to a predecessor of the employer.

(f) *Increased cost exemption—(1) In general.* A group health plan is not subject to the requirements of this section if the requirements of this paragraph (f) are satisfied. If a plan offers more than one benefit package, this paragraph (f) applies separately to each benefit package. Except as provided in paragraph (h) of this section, a plan must comply with the requirements of paragraph (b)(1)(i) of this section for the first plan year beginning on or after January 1, 1998, and must continue to comply with the requirements of paragraph (b)(1)(i) of this section until the plan satisfies the requirements in this paragraph (f). In no event is the exemption of this paragraph (f) effective until 30 days after the notice requirements in paragraph (f)(3) of this section are satisfied. If the requirements of this paragraph (f) are satisfied with respect to a plan, the exemption continues in effect (at the plan's discretion) until September 30, 2001, even if the plan subsequently purchases a different policy from the same or a different issuer and regardless of any other changes to the plan's benefit structure.

(2) *Calculation of the one-percent increase*—(i) *Ratio*. A group health plan satisfies the requirements of this paragraph (f)(2) if the application of paragraph (b)(1)(i) of this section to the plan results in an increase in the cost under the plan of at least one percent. The application of paragraph (b)(1)(i) of this section results in an increased cost of at least one percent under a group health plan only if the ratio below equals or exceeds 1.01000. The ratio is determined as follows:

(A) The incurred expenditures during the base period, divided by,

(B) The incurred expenditures during the base period, reduced by—

(I) The claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section; and

(2) Administrative expenses attributable to complying with the requirements of this section.

(ii) *Formula*. The ratio of paragraph (f)(2)(i) of this section is expressed mathematically as follows:

$$\frac{IE}{IE - (CE + AE)} \geq 1.01000$$

(A) *IE* means the incurred expenditures during the base period.

(B) *CE* means the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section

(C) *AE* means administrative costs related to claims in *CE* and other administrative costs attributable to complying with the requirements of this section.

(iii) *Incurred expenditures*. *Incurred expenditures means* actual claims incurred during the base period and reported within two months following the base period, and administrative costs for all benefits under the group health plan, including mental health benefits and medical/surgical benefits, during the base period. Incurred expenditures do not include premiums.

(iv) *Base period*. *Base period means* the period used to calculate whether the plan may claim the one-percent increased cost exemption in this paragraph (f). The base period must begin on the first day in any plan year that the plan complies with

the requirements of paragraph (b)(1)(i) of this section and must extend for a period of at least six consecutive calendar months. However, in no event may the base period begin prior to September 26, 1996 (the date of enactment of the Mental Health Parity Act (Pub. L. 104-204, 110 Stat. 2944)).

(v) *Rating pools*. For plans that are combined in a pool for rating purposes, the calculation under this paragraph (f)(2) for each plan in the pool for the base period is based on the incurred expenditures of the pool, whether or not all the plans in the pool have participated in the pool for the entire base period. (However, only the plans that have complied with paragraph (b)(1)(i) of this section for at least six months as a member of the pool satisfy the requirements of this paragraph (f)(2).) Otherwise, the calculation under this paragraph (f)(2) for each plan is calculated by the plan administrator based on the incurred expenditures of the plan.

(vi) *Examples*. The rules of this paragraph (f)(2) are illustrated by the following examples:

Example 1. (i) A group health plan has a plan year that is the calendar year. The plan satisfies the requirements of paragraph (b)(1)(i) of this section as of January 1, 1998. On September 15, 1998, the plan determines that \$1,000,000 in claims have been incurred during the period between January 1, 1998 and June 30, 1998 and reported by August 30, 1998. The plan also determines that \$100,000 in administrative costs have been incurred for all benefits under the group health plan, including mental health benefits. Thus, the plan determines that its incurred expenditures for the base period are \$1,100,000. The plan also determines that the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section are \$40,000 and that administrative expenses attributable to complying with the requirements of this section are \$10,000. Thus, the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are \$1,050,000 (\$1,100,000 – (\$40,000 + \$10,000) = \$1,050,000).

(ii) In this *Example 1*, the plan satisfies the requirements of this paragraph (f)(2) because the application of this section results in an increased cost of at least one percent under the terms of the plan (\$1,100,000/\$1,050,000 = 1.04762).

Example 2. (i) A health insurance issuer sells a group health insurance policy that is rated on a pooled basis and is sold to 30 group health plans. One of the group health plans inquires whether it qualifies for the one-percent increased cost exemption. The issuer performs the calculation for the pool as a whole and determines that the application of this section results in an increased cost of 0.500 percent (for a ratio under this paragraph (f)(2) of

1.00500) for the pool. The issuer informs the requesting plan and the other plans in the pool of the calculation.

(ii) In this *Example 2*, none of the plans satisfy the requirements of this paragraph (f)(2) and a plan that purchases a policy not complying with the requirements of paragraph (b)(1)(i) of this section violates the requirements of this section.

Example 3. (i) A partially insured plan is collecting the information to determine whether it qualifies for the exemption. The plan administrator determines the incurred expenses for the base period for the self-funded portion of the plan to be \$2,000,000 and the administrative expenses for the base period for the self-funded portion to be \$200,000. For the insured portion of the plan, the plan administrator requests data from the insurer. For the insured portion of the plan, the plan's own incurred expenses for the base period are \$1,000,000 and the administrative expenses for the base period are \$100,000. The plan administrator determines that under the self-funded portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are \$0 because the self-funded portion does not cover mental health benefits and the plan's administrative costs attributable to complying with the requirements of this section are \$1,000. The issuer determines that under the insured portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are \$25,000 and the administrative costs attributable to complying with the requirements of this section are \$1,000. Thus, the total incurred expenditures for the plan for the base period are \$3,300,000 (\$2,000,000 + \$200,000 + \$1,000,000 + \$100,000 = \$3,300,000) and the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are \$3,273,000 (\$3,300,000 – (\$0 + \$1,000 + \$25,000 + \$1,000) = \$3,273,000).

(ii) In this *Example 3*, the plan does not satisfy the requirements of this paragraph (f)(2) because the application of this section does not result in an increased cost of at least one percent under the terms of the plan (\$3,300,000/\$3,273,000 = 1.00825).

(3) *Notice of exemption*—(i) *Participants and beneficiaries*—(A) *In general*. A group health plan must notify participants and beneficiaries of the plan's decision to claim the one-percent increased cost exemption. The notice must include the following information:

(1) A statement that the plan is exempt from the requirements of this section and a description of the basis for the exemption;

(2) The name and telephone number of the individual to contact for further information;

(3) The plan name and plan number (PN);

(4) The plan administrator's name, address, and telephone number;

(5) For single-employer plans, the plan sponsor's name, address, and telephone number (if different from paragraph (f)(3)(i)(A)(3) of this section) and the plan sponsor's employer identification number (EIN);

(6) The effective date of the exemption;

(7) The ability of participants and beneficiaries to contact the plan administrator to see how benefits may be affected as a result of the plan's claim of the exemption; and

(8) The availability, upon request and free of charge, of a summary of the information required under paragraph (f)(4) of this section.

(B) *Use of summary of material reductions in covered services or benefits.* A plan may satisfy the requirements of paragraph (f)(3)(i)(A) of this section by providing participants and beneficiaries (in accordance with paragraph (f)(3)(i)(C) of this section) with a summary of material reductions in covered services or benefits required under 29 CFR 2520.104b-3(d) that also includes the information of this paragraph (f)(3)(i). However, in all cases, the exemption is not effective until 30 days after notice has been sent.

(C) *Delivery.* The notice described in this paragraph (f)(3)(i) is required to be provided to all participants and beneficiaries. The notice may be furnished by any method of delivery that satisfies the requirements of section 104(b)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1024(b)(1)) (e.g., first-class mail). If the notice is provided to the participant at the participant's last known address, then the requirements of this paragraph (f)(3)(i) are satisfied with respect to the participant and all beneficiaries residing at that address. If a beneficiary's last known address is different from the participant's last known address, a separate notice is required to be provided to the beneficiary at the beneficiary's last known address.

(D) *Example.* The rules of this paragraph (f)(3)(i) are illustrated by the following example:

Example. (i) A group health plan has a plan year that is the calendar year and has an open enrollment period every November 1 through November 30. The plan determines on September 15 that it satisfies the requirements of paragraph (f)(2) of this section. As part of its open enrollment materials, the plan mails, on October 15, to all participants and beneficiaries a notice satisfying the requirements of this paragraph (f)(3)(i).

(ii) In this *Example*, the plan has sent the notice in a manner that complies with this paragraph (f)(3)(i).

(ii) *Federal agencies.* A group health plan that is a church plan (as defined in section 414(e)) claiming the exemption of this paragraph (f) for any benefit package must provide notice in accordance with the requirement of this paragraph (f)(3)(ii). This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies. For any other group health plan, see 29 CFR 2590.712(f)(3)(ii)(B).

(4) *Availability of documentation.* The plan must make available to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information on which the exemption was based. An individual who is not a participant or beneficiary and who presents a notice described in paragraph (f)(3)(i) of this section is considered to be a representative. A representative may request the summary of information by providing the plan a copy of the notice provided to the participant under paragraph (f)(3)(i) of this section with any individually identifiable information redacted. The summary of information must include the incurred expenditures, the base period, the dollar amount of claims incurred during the base period that would have been denied under the terms of the plan absent amendments required to comply with paragraph (b)(1)(i) of this section, the administrative costs related to those claims, and other administrative costs attributable to complying with the requirements of this section. In no event should the summary of information include any individually identifiable information.

(g) *Special rules for group health insurance coverage—(1) Sale of nonparity policies.* See 29 CFR 2590.712(g)(1) and 45 CFR 146.136(g)(1) for rules limiting the right of an issuer to sell a policy without parity (as described in 29 CFR 2590.712(b) and 45 CFR 146.136(b)) to a plan that meets the requirements of 29 CFR 2590.712(e) or (f) and 45 CFR 146.136(e) or (f).

(2) *Duration of exemption.* After a plan meets the requirements of paragraph (f) of

this section, the plan may change issuers without having to meet the requirements of paragraph (f) of this section again before September 30, 2001.

(h) *Effective dates—(1) In general.* The requirements of this section are applicable for plan years beginning on or after January 1, 1998.

(2) *Limitation on actions* (i) Except as provided in paragraph (h)(3) of this section, no enforcement action is to be taken by the Secretary against a group health plan that has sought to comply in good faith with the requirements of section 9812, with respect to a violation that occurs before the earlier of—

(A) The first day of the first plan year beginning on or after April 1, 1998; or

(B) January 1, 1999.

(ii) Compliance with the requirements of this section is deemed to be good faith compliance with the requirements of section 9812.

(iii) The rules of this paragraph (h)(2) are illustrated by the following examples:

Example 1. (i) A group health plan has a plan year that is the calendar year. The plan complies with section 9812 in good faith using assumptions inconsistent with paragraph (b)(6) of this section relating to weighted averages for categories of benefits.

(ii) In this *Example 1*, no enforcement action may be taken against the plan with respect to a violation resulting solely from those assumptions and occurring before January 1, 1999.

Example 2. (i) A group health plan has a plan year that is the calendar year. For the entire 1998 plan year, the plan applies a \$1,000,000 annual limit on medical/surgical benefits and a \$100,000 annual limit on mental health benefits.

(ii) In this *Example 2*, the plan has not sought to comply with the requirements of section 9812 in good faith, and this paragraph (h)(2) does not apply.

(3) *Transition period for increased cost exemption—(i) In general.* No enforcement action will be taken against a group health plan that is subject to the requirements of this section based on a violation of this section that occurs before April 1, 1998 solely because the plan claims the increased cost exemption under section 9812(c)(2) based on assumptions inconsistent with the rules under paragraph (f) of this section, provided that a plan amendment that complies with the requirements of paragraph (b)(1)(i) of this section is adopted and effective no later than March 31, 1998 and the plan complies with the notice requirements in paragraph (h)(3)(ii) of this section.

(ii) *Notice of plan's use of transition period.* (A) A group health plan satisfies the requirements of this paragraph (h)(3)(ii) only if the plan provides notice to the applicable federal agency and posts the notice at the location(s) where documents must be made available for examination by participants and beneficiaries under section 104(b)(2) of the Employee Retirement Income Security Act of 1974, and the regulations thereunder (29 CFR 2520.104b-1(b)(3)). The notice must indicate the plan's decision to use the transition period in paragraph (h)(3)(i) of this section by 30 days after the first day of the plan year beginning on or after January 1, 1998, but in no event later than March 31, 1998. For a group health plan that is a church plan (as defined in section 414(e)), the applicable federal agency is the Department of the Treasury. For a group health plan that is not a church plan, see 29 CFR 2590.712(h)(3)(ii). The notice must include—

- (1) The name of the plan and the plan number (PN);
- (2) The name, address, and telephone number of the plan administrator;
- (3) For single-employer plans, the name, address, and telephone number of the plan sponsor (if different from the plan administrator) and the plan sponsor's employer identification number (EIN);
- (4) The name and telephone number of the individual to contact for further information; and
- (5) The signature of the plan administrator and the date of the signature.

(B) The notice must be provided at no charge to participants or their representative within 15 days after receipt of a written or oral request for such notification, but in no event before the notice has been sent to the applicable federal agency.

(i) *Sunset.* This section does not apply to benefits for services furnished on or after September 30, 2001.

*Deputy Commissioner of
Internal Revenue.*

*Acting Assistant Secretary of
the Treasury.*

Pension and Welfare Benefits Administration

29 CFR Chapter XXV

29 CFR Part 2590 is amended as follows:

PART 2590—RULES AND REGULATIONS FOR HEALTH INSURANCE PORTABILITY AND RENEWABILITY FOR GROUP HEALTH PLANS

1. The authority citation for Part 2590 is revised to read as follows:

Authority: Secs. 107, 209, 505, 701-703, 711, 712, and 731-734 of ERISA (29 U.S.C. 1027, 1059, 1135, 1171-1173, 1181, 1182, and 1191-1194), as amended by Pub. L. 104-191, 110 Stat. 1936 and Pub. L. 104-204, 110 Stat. 2944; and Secretary of Labor's Order No. 1-87, 52 FR 13139, April 21, 1987.

Subpart B—Other Requirements

2. Section 2590.712 is revised to read as follows:

§ 2590.712 *Parity in the application of certain limits to mental health benefits.*

(a) *Definitions.* For purposes of this section, except where the context clearly indicates otherwise, the following definitions apply:

Aggregate lifetime limit means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan (or group health insurance coverage offered in connection with such a plan) for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

Annual limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a plan (or group health insurance coverage offered in connection with such a plan) for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

Medical/surgical benefits means benefits for medical or surgical services, as de-

finied under the terms of the plan or group health insurance coverage, but does not include mental health benefits.

Mental health benefits means benefits for mental health services, as defined under the terms of the plan or group health insurance coverage, but does not include benefits for treatment of substance abuse or chemical dependency.

(b) *Requirements regarding limits on benefits—*(1) *In general—*(i) *General parity requirement.* A group health plan (or health insurance coverage offered by an issuer in connection with a group health plan) that provides both medical/surgical benefits and mental health benefits must comply with paragraph (b)(2), (3), or (6) of this section.

(ii) *Exception.* The rule in paragraph (b)(1)(i) of this section does not apply if a plan, or coverage, satisfies the requirements of paragraph (e) or (f) of this section.

(2) *Plan with no limit or limits on less than one-third of all medical/surgical benefits.* If a plan (or group health insurance coverage) does not include an aggregate lifetime or annual limit on any medical/surgical benefits or includes aggregate lifetime or annual limits that apply to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual limit, respectively, on mental health benefits.

(3) *Plan with a limit on at least two-thirds of all medical/surgical benefits.* If a plan (or group health insurance coverage) includes an aggregate lifetime or annual limit on at least two-thirds of all medical/surgical benefits, it must either—

(i) Apply the aggregate lifetime or annual limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health benefits in a manner that does not distinguish between the medical/surgical and mental health benefits; or

(ii) Not include an aggregate lifetime or annual limit on mental health benefits that is less than the aggregate lifetime or annual limit, respectively, on the medical/surgical benefits.

(4) *Examples.* The rules of paragraphs (b)(2) and (3) of this section are illustrated by the following examples:

Example 1. (i) Prior to the effective date of the mental health parity provisions, a group health plan had no annual limit on medical/surgical benefits and had a \$10,000 annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Eliminating the plan's annual limit on mental health benefits;

(B) Replacing the plan's previous annual limit on mental health benefits with a \$500,000 annual limit on all benefits (including medical/surgical and mental health benefits); and

(C) Replacing the plan's previous annual limit on medical/surgical benefits with a \$250,000 annual limit on medical/surgical benefits and a \$250,000 annual limit on mental health benefits.

(ii) In this *Example 1*, each of the three options being considered by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

Example 2. (i) Prior to the effective date of the mental health parity provisions, a group health plan had a \$100,000 annual limit on medical/surgical inpatient benefits, a \$50,000 annual limit on medical/surgical outpatient benefits, and a \$100,000 annual limit on all mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Replacing the plan's previous annual limit on mental health benefits with a \$150,000 annual limit on mental health benefits; and

(B) Replacing the plan's previous annual limit on mental health benefits with a \$100,000 annual limit on mental health inpatient benefits and a \$50,000 annual limit on mental health outpatient benefits.

(ii) In this *Example 2*, each option under consideration by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

Example 3. (i) A group health plan that is subject to the requirements of this section has no aggregate lifetime or annual limit for either medical/surgical benefits or mental health benefits. While the plan provides medical/surgical benefits with respect to both network and out-of-network providers, it does not provide mental health benefits with respect to out-of-network providers.

(ii) In this *Example 3*, the plan complies with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

Example 4. (i) Prior to the effective date of the mental health parity provisions, a group health plan had an annual limit on medical/surgical benefits and a separate but identical annual limit on mental health benefits. The plan included benefits for treatment of substance abuse and chemical dependency in its definition of mental health benefits. Accordingly, claims paid for treatment of substance abuse and chemical dependency were counted in applying the annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Making no change in the plan so that claims paid for treatment of substance abuse and chemical

dependency continue to count in applying the annual limit on mental health benefits;

(B) amending the plan to count claims paid for treatment of substance abuse and chemical dependency in applying the annual limit on medical/surgical benefits (rather than counting those claims in applying the annual limit on mental health benefits);

(C) amending the plan to provide a new category of benefits for treatment of chemical dependency and substance abuse that is subject to a separate, lower limit and under which claims paid for treatment of substance abuse and chemical dependency are counted only in applying the annual limit on this separate category; and

(D) amending the plan to eliminate distinctions between medical/surgical benefits and mental health benefits and establishing an overall limit on benefits offered under the plan under which claims paid for treatment of substance abuse and chemical dependency are counted with medical/surgical benefits and mental health benefits in applying the overall limit.

(ii) In this *Example 4*, the group health plan is described in paragraph (b)(3) of this section. Because mental health benefits are defined in paragraph (a) of this section as excluding benefits for treatment of substance abuse and chemical dependency, the inclusion of benefits for treatment of substance abuse and chemical dependency in applying an aggregate lifetime limit or annual limit on mental health benefits under option (A) of this *Example 4* would not comply with the requirements of paragraph (b)(3) of this section. However, options (B), (C), and (D) of this *Example 4* would comply with the requirements of paragraph (b)(3) of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

(5) *Determining one-third and two-thirds of all medical/surgical benefits.*

For purposes of this paragraph (b), the determination of whether the portion of medical/surgical benefits subject to a limit represents one-third or two-thirds of all medical/surgical benefits is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime or annual limits). Any reasonable method may be used to determine whether the dollar amounts expected to be paid under the plan will constitute one-third or two-thirds of the dollar amount of all plan payments for medical/surgical benefits.

(6) *Plan not described in paragraph (b)(2) or (3) of this section—(i) In general.* A group health plan (or group health insurance coverage) that is not described in paragraph (b)(2) or (3) of this section, must either—

(A) Impose no aggregate lifetime or annual limit, as appropriate, on mental health benefits; or

(B) Impose an aggregate lifetime or annual limit on mental health benefits that is no less than an average limit calculated for medical/surgical benefits in the following manner. The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual limits, as appropriate, that are applicable to the categories of medical/surgical benefits. Limits based on delivery systems, such as inpatient/outpatient treatment or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories for purposes of this paragraph (b)(6)(i)(B). In addition, for purposes of determining weighted averages, any benefits that are not within a category that is subject to a separately-designated limit under the plan are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that a plan may reasonably be expected to incur with respect to such benefits, taking into account any other applicable restrictions under the plan.

(ii) *Weighting.* For purposes of this paragraph (b)(6), the weighting applicable to any category of medical/surgical benefits is determined in the manner set forth in paragraph (b)(5) of this section for determining one-third or two-thirds of all medical/surgical benefits.

(iii) *Example.* The rules of this paragraph (b)(6) are illustrated by the following example:

Example. (i) A group health plan that is subject to the requirements of this section includes a \$100,000 annual limit on medical/surgical benefits related to cardio-pulmonary diseases. The plan does not include an annual limit on any other category of medical/surgical benefits. The plan determines that 40% of the dollar amount of plan payments for medical/surgical benefits are related to cardio-pulmonary diseases. The plan determines that \$1,000,000 is a reasonable estimate of the upper limit on the dollar amount that the plan may incur with respect to the other 60% of payments for medical/surgical benefits.

(ii) In this *Example*, the plan is not described in paragraph (b)(3) of this section because there is not one annual limit that applies to at least two-thirds of all medical/surgical benefits. Further, the plan is not described in paragraph (b)(2) of this section because more than one-third of all medical/surgical benefits are subject to an annual limit. Under this paragraph (b)(6), the plan sponsor can choose either to include no annual limit on mental health benefits, or to include an annual limit on mental health benefits that is not less than the weighted average of the annual limits applicable to each category of medical/surgical benefits. In this example, the minimum

weighted average annual limit that can be applied to mental health benefits is \$640,000 (40% x \$100,000 + 60% x \$1,000,000 = \$640,000).

(c) *Rule in the case of separate benefit packages.* If a group health plan offers two or more benefit packages, the requirements of this section, including the exemption provisions in paragraph (f) of this section, apply separately to each benefit package. Examples of a group health plan that offers two or more benefit packages include a group health plan that offers employees a choice between indemnity coverage or HMO coverage, and a group health plan that provides one benefit package for retirees and a different benefit package for current employees.

(d) *Applicability—(1) Group health plans.* The requirements of this section apply to a group health plan offering both medical/surgical benefits and mental health benefits regardless of whether the mental health benefits are administered separately under the plan.

(2) *Health insurance issuers.* The requirements of this section apply to a health insurance issuer offering health insurance coverage for both medical/surgical benefits and mental health benefits in connection with a group health plan.

(3) *Scope.* This section does not—

(i) Require a group health plan (or health insurance issuer offering coverage in connection with a group health plan) to provide any mental health benefits; or

(ii) Affect the terms and conditions (including cost sharing, limits on the number of visits or days of coverage, requirements relating to medical necessity, requiring prior authorization for treatment, or requiring primary care physicians' referrals for treatment) relating to the amount, duration, or scope of the mental health benefits under the plan (or coverage) except as specifically provided in paragraph (b) of this section.

(e) *Small employer exemption—(1) In general.* The requirements of this section do not apply to a group health plan (or health insurance issuer offering coverage in connection with a group health plan) for a plan year of a small employer. For purposes of this paragraph (e), the term *small employer* means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than 50 employees on busi-

ness days during the preceding calendar year and who employs at least two employees on the first day of the plan year. See section 732(a) of the Act and §2590.732(a), which provide that this section (and certain other sections) does not apply to any group health plan (and health insurance issuer offering coverage in connection with a group health plan) for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(2) *Rules in determining employer size.* For purposes of paragraph (e)(1) of this section—

(i) All persons treated as a single employer under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C. 414) are treated as one employer;

(ii) If an employer was not in existence throughout the preceding calendar year, whether it is a small employer is determined based on the average number of employees the employer reasonably expects to employ on business days during the current calendar year; and

(iii) Any reference to an employer for purposes of the small employer exemption includes a reference to a predecessor of the employer.

(f) *Increased cost exemption—(1) In general.* A group health plan (or health insurance coverage offered in connection with a group health plan) is not subject to the requirements of this section if the requirements of this paragraph (f) are satisfied. If a plan offers more than one benefit package, this paragraph (f) applies separately to each benefit package. Except as provided in paragraph (h) of this section, a plan must comply with the requirements of paragraph (b)(1)(i) of this section for the first plan year beginning on or after January 1, 1998, and must continue to comply with the requirements of paragraph (b)(1)(i) of this section until the plan satisfies the requirements in this paragraph (f). In no event is the exemption of this paragraph (f) effective until 30 days after the notice requirements in paragraph (f)(3) of this section are satisfied. If the requirements of this paragraph (f) are satisfied with respect to a plan, the exemption continues in effect (at the plan's discretion) until September 30, 2001, even if the plan subsequently purchases a different policy from the same or a differ-

ent issuer and regardless of any other changes to the plan's benefit structure.

(2) *Calculation of the one-percent increase—(i) Ratio.* A group health plan (or group health insurance coverage) satisfies the requirements of this paragraph (f)(2) if the application of paragraph (b)(1)(i) of this section to the plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least one percent. The application of paragraph (b)(1)(i) of this section results in an increased cost of at least one percent under a group health plan (or for such coverage) only if the ratio below equals or exceeds 1.01000. The ratio is determined as follows:

(A) The incurred expenditures during the base period, divided by,

(B) The incurred expenditures during the base period, reduced by —

(I) The claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section; and

(2) Administrative expenses attributable to complying with the requirements of this section.

(ii) *Formula.* The ratio of paragraph (f)(2)(i) of this section is expressed mathematically as follows:

$$\frac{IE}{IE - (CE + AE)} \geq 1.01000$$

(A) *IE* means the incurred expenditures during the base period.

(B) *CE* means the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section

(C) *AE* means administrative costs related to claims in *CE* and other administrative costs attributable to complying with the requirements of this section.

(iii) *Incurred expenditures.* *Incurred expenditures* means actual claims incurred during the base period and reported within two months following the base period, and administrative costs for all benefits under the group health plan, including mental health benefits and medical/surgical benefits, during the base period. Incurred expenditures do not include premiums.

(iv) *Base period.* *Base period* means the period used to calculate whether the

plan may claim the one-percent increased cost exemption in this paragraph (f). The base period must begin on the first day in any plan year that the plan complies with the requirements of paragraph (b)(1)(i) of this section and must extend for a period of at least six consecutive calendar months. However, in no event may the base period begin prior to September 26, 1996 (the date of enactment of the Mental Health Parity Act (Pub. L. 104-204, 110 Stat. 2944)).

(v) *Rating pools.* For plans that are combined in a pool for rating purposes, the calculation under this paragraph (f)(2) for each plan in the pool for the base period is based on the incurred expenditures of the pool, whether or not all the plans in the pool have participated in the pool for the entire base period. (However, only the plans that have complied with paragraph (b)(1)(i) of this section for at least six months as a member of the pool satisfy the requirements of this paragraph (f)(2).) Otherwise, the calculation under this paragraph (f)(2) for each plan is calculated by the plan administrator (or issuer) based on the incurred expenditures of the plan.

(vi) *Examples.* The rules of this paragraph (f)(2) are illustrated by the following examples:

Example 1. (i) A group health plan has a plan year that is the calendar year. The plan satisfies the requirements of paragraph (b)(1)(i) of this section as of January 1, 1998. On September 15, 1998, the plan determines that \$1,000,000 in claims have been incurred during the period between January 1, 1998 and June 30, 1998 and reported by August 30, 1998. The plan also determines that \$100,000 in administrative costs have been incurred for all benefits under the group health plan, including mental health benefits. Thus, the plan determines that its incurred expenditures for the base period are \$1,100,000. The plan also determines that the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section are \$40,000 and that administrative expenses attributable to complying with the requirements of this section are \$10,000. Thus, the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are \$1,050,000 (\$1,100,000 - (\$40,000 + \$10,000) = \$1,050,000).

(ii) In this *Example 1*, the plan satisfies the requirements of this paragraph (f)(2) because the application of this section results in an increased cost of at least one percent under the terms of the plan ($\$1,100,000/\$1,050,000 = 1.04762$).

Example 2. (i) A health insurance issuer sells a group health insurance policy that is rated on a pooled basis and is sold to 30 group health plans.

One of the group health plans inquires whether it qualifies for the one-percent increased cost exemption. The issuer performs the calculation for the pool as a whole and determines that the application of this section results in an increased cost of 0.500 percent (for a ratio under this paragraph (f)(2) of 1.00500) for the pool. The issuer informs the requesting plan and the other plans in the pool of the calculation.

(ii) In this *Example 2*, none of the plans satisfy the requirements of this paragraph (f)(2) and a plan that purchases a policy not complying with the requirements of paragraph (b)(1)(i) of this section violates the requirements of this section. In addition, an issuer that issues to any of the plans in the pool a policy not complying with the requirements of paragraph (b)(1)(i) of this section violates the requirements of this section.

Example 3. (i) A partially insured plan is collecting the information to determine whether it qualifies for the exemption. The plan administrator determines the incurred expenses for the base period for the self-funded portion of the plan to be \$2,000,000 and the administrative expenses for the base period for the self-funded portion to be \$200,000. For the insured portion of the plan, the plan administrator requests data from the insurer. For the insured portion of the plan, the plan's own incurred expenses for the base period are \$1,000,000 and the administrative expenses for the base period are \$100,000. The plan administrator determines that under the self-funded portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are \$0 because the self-funded portion does not cover mental health benefits and the plan's administrative costs attributable to complying with the requirements of this section are \$1,000. The issuer determines that under the insured portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are \$25,000 and the administrative costs attributable to complying with the requirements of this section are \$1,000. Thus, the total incurred expenditures for the plan for the base period are \$3,300,000 (\$2,000,000 + \$200,000 + \$1,000,000 + \$100,000 = \$3,300,000) and the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are \$3,273,000 (\$3,300,000 - (\$0 + \$1,000 + \$25,000 + \$1,000) = \$3,273,000).

(ii) In this *Example 3*, the plan does not satisfy the requirements of this paragraph (f)(2) because the application of this section does not result in an increased cost of at least one percent under the terms of the plan ($\$3,300,000/\$3,273,000 = 1.00825$).

(3) *Notice of exemption—(i) Participants and beneficiaries—(A) In general.* A group health plan must notify participants and beneficiaries of the plan's decision to claim the one-percent increased cost exemption. The notice must include the following information:

(I) A statement that the plan is exempt from the requirements of this section and a description of the basis for the exemption;

(2) The name and telephone number of the individual to contact for further information;

(3) The plan name and plan number (PN);

(4) The plan administrator's name, address, and telephone number;

(5) For single-employer plans, the plan sponsor's name, address, and telephone number (if different from paragraph (f)(3)(i)(A)(3) of this section) and the plan sponsor's employer identification number (EIN);

(6) The effective date of the exemption;

(7) The ability of participants and beneficiaries to contact the plan administrator to see how benefits may be affected as a result of the plan's claim of the exemption; and

(8) The availability, upon request and free of charge, of a summary of the information required under paragraph (f)(4) of this section.

(B) *Use of summary of material reductions in covered services or benefits.* A plan may satisfy the requirements of paragraph (f)(3)(i)(A) of this section by providing participants and beneficiaries (in accordance with paragraph (f)(3)(i)(C) of this section) with a summary of material reductions in covered services or benefits required under §2520.104b-3(d) that also includes the information of this paragraph (f)(3)(i). However, in all cases, the exemption is not effective until 30 days after notice has been sent.

(C) *Delivery.* The notice described in this paragraph (f)(3)(i) is required to be provided to all participants and beneficiaries. The notice may be furnished by any method of delivery that satisfies the requirements of section 104(b)(1) of ERISA (e.g., first-class mail). If the notice is provided to the participant at the participant's last known address, then the requirements of this paragraph (f)(3)(i) are satisfied with respect to the participant and all beneficiaries residing at that address. If a beneficiary's last known address is different from the participant's last known address, a separate notice is required to be provided to the beneficiary at the beneficiary's last known address.

(D) *Example.* The rules of this paragraph (f)(3)(i) are illustrated by the following example:

Example. (i) A group health plan has a plan year that is the calendar year and has an open enrollment

period every November 1 through November 30. The plan determines on September 15 that it satisfies the requirements of paragraph (f)(2) of this section. As part of its open enrollment materials, the plan mails, on October 15, to all participants and beneficiaries a notice satisfying the requirements of this paragraph (f)(3)(i).

(ii) In this *Example*, the plan has sent the notice in a manner that complies with this paragraph (f)(3)(i).

(ii) *Federal agencies—(A) Church plans.* A church plan (as defined in section 414(e) of the Internal Revenue Code) claiming the exemption of this paragraph (f) for any benefit package must provide notice to the Department of the Treasury. This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(B) *Group health plans subject to Part 7 of Subtitle B of Title I of ERISA.* A group health plan subject to Part 7 of Subtitle B of Title I of ERISA, and claiming the exemption of this paragraph (f) for any benefit package, must provide notice to the Department of Labor. This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(C) *Nonfederal governmental plans.* A group health plan that is a nonfederal governmental plan claiming the exemption of this paragraph (f) for any benefit package must provide notice to the Department of Health and Human Services (HHS). This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(4) *Availability of documentation.* The plan (or issuer) must make available to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information on which the exemption was based. An individual who is not a participant or beneficiary and who presents a notice described in paragraph (f)(3)(i) of this section is considered to be a representative. A rep-

resentative may request the summary of information by providing the plan a copy of the notice provided to the participant under paragraph (f)(3)(i) of this section with any individually identifiable information redacted. The summary of information must include the incurred expenditures, the base period, the dollar amount of claims incurred during the base period that would have been denied under the terms of the plan absent amendments required to comply with paragraph (b)(1)(i) of this section, the administrative costs related to those claims, and other administrative costs attributable to complying with the requirements of this section. In no event should the summary of information include any individually identifiable information.

(g) *Special rules for group health insurance coverage—(1) Sale of nonparity policies.* An issuer may sell a policy without parity (as described in paragraph (b) of this section) only to a plan that meets the requirements of paragraphs (e) or (f) of this section.

(2) *Duration of exemption.* After a plan meets the requirements of paragraph (f) of this section, the plan may change issuers without having to meet the requirements of paragraph (f) of this section again before September 30, 2001.

(h) *Effective dates—(1) In general.* The requirements of this section are applicable for plan years beginning on or after January 1, 1998.

(2) *Limitation on actions.* (i) Except as provided in paragraph (h)(3) of this section, no enforcement action is to be taken by the Secretary against a group health plan that has sought to comply in good faith with the requirements section 712 of the Act, with respect to a violation that occurs before the earlier of—

(A) The first day of the first plan year beginning on or after April 1, 1998; or

(B) January 1, 1999.

(ii) Compliance with the requirements of this section is deemed to be good faith compliance with the requirements of section 712 of Part 7 of Subtitle B of Title I of ERISA.

(iii) The rules of this paragraph (h)(2) are illustrated by the following examples:

Example 1. (i) A group health plan has a plan year that is the calendar year. The plan complies with section 712 of Part 7 of Subtitle B of Title I of ERISA in good faith using assumptions inconsistent

with paragraph (b)(6) of this section relating to weighted averages for categories of benefits.

(ii) In this *Example 1*, no enforcement action may be taken against the plan with respect to a violation resulting solely from those assumptions and occurring before January 1, 1999.

Example 2. (i) A group health plan has a plan year that is the calendar year. For the entire 1998 plan year, the plan applies a \$1,000,000 annual limit on medical/surgical benefits and a \$100,000 annual limit on mental health benefits.

(ii) In this *Example 2*, the plan has not sought to comply with the requirements of section 712 of the Act in good faith and this paragraph (h)(2) does not apply.

(3) *Transition period for increased cost exemption—(i) In general.* No enforcement action will be taken against a group health plan that is subject to the requirements of this section based on a violation of this section that occurs before April 1, 1998 solely because the plan claims the increased cost exemption under section 712(c)(2) of Part 7 of Subtitle B of Title I of ERISA based on assumptions inconsistent with the rules under paragraph (f) of this section, provided that a plan amendment that complies with the requirements of paragraph (b)(1)(i) of this section is adopted and effective no later than March 31, 1998 and the plan complies with the notice requirements in paragraph (h)(3)(ii) of this section.

(ii) *Notice of plan's use of transition period.* (A) A group health plan satisfies the requirements of this paragraph (h)(3)(ii) only if the plan provides notice to the applicable federal agency and posts such notice at the location(s) where documents must be made available for examination by participants and beneficiaries under section 104(b)(2) of ERISA and the regulations thereunder (29 CFR 2520.104b-1(b)(3)). The notice must indicate the plan's decision to use the transition period in paragraph (h)(3)(i) of this section by 30 days after the first day of the plan year beginning on or after January 1, 1998, but in no event later than March 31, 1998. For a group health plan that is a church plan, the applicable federal agency is the Department of the Treasury. For a group health plan that is subject to Part 7 of Subtitle B of Title I of ERISA, the applicable federal agency is the Department of Labor. For a group health plan that is a nonfederal governmental plan, the applicable federal agency is the Department of Health and Human Services. The notice must include —

(1) The name of the plan and the plan number (PN);

(2) The name, address, and telephone number of the plan administrator;

(3) For single-employer plans, the name, address, and telephone number of the plan sponsor (if different from the plan administrator) and the plan sponsor's employer identification number (EIN);

(4) The name and telephone number of the individual to contact for further information; and

(5) The signature of the plan administrator and the date of the signature.

(B) The notice must be provided at no charge to participants or their representative within 15 days after receipt of a written or oral request for such notification, but in no event before the notice has been sent to the applicable federal agency.

(i) *Sunset.* This section does not apply to benefits for services furnished on or after September 30, 2001.

Signed at Washington, DC, this day of December, 1997.

Olena Berg,

Assistant Secretary,

Pension Welfare Benefits Administration,

U.S. Department of Labor.

Health Care Financing Administration

45 CFR Subtitle A, Subchapter B

45 CFR Part 146 is amended as follows:

PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

1. The authority citation for Part 146 is revised to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92).

2. A new Subpart C is added to Part 146 to read as follows:

Subpart C—Requirements Related to Benefits

§ 146.136 Parity in the application of certain limits to mental health benefits.

(a) *Definitions.* For purposes of this section, except where the context clearly

indicates otherwise, the following definitions apply:

Aggregate lifetime limit means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan (or group health insurance coverage offered in connection with such plan) for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

Annual limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a plan (or group health insurance coverage offered in connection with such plan) for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

Medical/surgical benefits means benefits for medical or surgical services, as defined under the terms of the plan or group health insurance coverage, but does not include mental health benefits.

Mental health benefits means benefits for mental health services, as defined under the terms of the plan or group health insurance coverage, but does not include benefits for treatment of substance abuse or chemical dependency.

(b) *Requirements regarding limits on benefits—(1) In general—(i) General parity requirement.* A group health plan (or health insurance coverage offered by an issuer in connection with a group health plan) that provides both medical/surgical benefits and mental health benefits must comply with paragraph (b)(2), paragraph (b)(3), or paragraph (b)(6) of this section.

(ii) *Exception.* The rule in paragraph (b)(1)(i) of this section does not apply if a plan, or coverage, satisfies the requirements of paragraph (e) or paragraph (f) of this section.

(2) *Plan with no limit or limits on less than one-third of all medical/surgical benefits.* If a plan (or group health insurance coverage) does not include an aggregate lifetime or annual limit on any medical/surgical benefits or includes aggregate lifetime or annual limits that apply to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual limit, respectively, on mental health benefits.

(3) *Plan with a limit on at least two-thirds of all medical/surgical benefits.* If

a plan (or group health insurance coverage) includes an aggregate lifetime or annual limit on at least two-thirds of all medical/surgical benefits, it must either—

(i) Apply the aggregate lifetime or annual limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health benefits in a manner that does not distinguish between the medical/surgical and mental health benefits; or

(ii) Not include an aggregate lifetime or annual limit on mental health benefits that is less than the aggregate lifetime or annual limit, respectively, on the medical/surgical benefits.

(4) *Examples.* The rules of paragraphs (b)(2) and (3) of this section are illustrated by the following examples:

Example 1. (i) Prior to the effective date of the mental health parity provisions, a group health plan had no annual limit on medical/surgical benefits and had a \$10,000 annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Eliminating the plan's annual limit on mental health benefits;

(B) Replacing the plan's previous annual limit on mental health benefits with a \$500,000 annual limit on all benefits (including medical/surgical and mental health benefits); and

(C) Replacing the plan's previous annual limit on mental health benefits with a \$250,000 annual limit on medical/surgical benefits and a \$250,000 annual limit on mental health benefits.

(ii) In this *Example 1*, each of the three options being considered by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

Example 2. (i) Prior to the effective date of the mental health parity provisions, a group health plan had a \$100,000 annual limit on medical/surgical inpatient benefits, a \$50,000 annual limit on medical/surgical outpatient benefits, and a \$100,000 annual limit on all mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Replacing the plan's previous annual limit on mental health benefits with a \$150,000 annual limit on mental health benefits; and

(B) Replacing the plan's previous annual limit on mental health benefits with a \$100,000 annual limit on mental health inpatient benefits and a \$50,000 annual limit on mental health outpatient benefits.

(ii) In this *Example 2*, each option under consideration by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

Example 3. (i) A group health plan that is subject to the requirements of this section has no aggregate lifetime or annual limit for either medical/surgi-

cal benefits or mental health benefits. While the plan provides medical/surgical benefits with respect to both network and out-of-network providers, it does not provide mental health benefits with respect to out-of-network providers.

(ii) In this *Example 3*, the plan complies with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

Example 4. (i) Prior to the effective date of the mental health parity provisions, a group health plan had an annual limit on medical/surgical benefits and a separate but identical annual limit on mental health benefits. The plan included benefits for treatment of substance abuse and chemical dependency in its definition of mental health benefits. Accordingly, claims paid for treatment of substance abuse and chemical dependency were counted in applying the annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Making no change in the plan so that claims paid for treatment of substance abuse and chemical dependency continue to count in applying the annual limit on mental health benefits;

(B) Amending the plan to count claims paid for treatment of substance abuse and chemical dependency in applying the annual limit on medical/surgical benefits (rather than counting those claims in applying the annual limit on mental health benefits);

(C) Amending the plan to provide a new category of benefits for treatment of chemical dependency and substance abuse that is subject to a separate, lower limit and under which claims paid for treatment of substance abuse and chemical dependency are counted only in applying the annual limit on this separate category; and

(D) Amending the plan to eliminate distinctions between medical/surgical benefits and mental health benefits and establishing an overall limit on benefits offered under the plan under which claims paid for treatment of substance abuse and chemical dependency are counted with medical/surgical benefits and mental health benefits in applying the overall limit.

(ii) In this *Example 4*, the group health plan is described in paragraph (b)(3) of this section. Because mental health benefits are defined in paragraph (a) of this section as excluding benefits for treatment of substance abuse and chemical dependency, the inclusion of benefits for treatment of substance abuse and chemical dependency in applying an aggregate lifetime limit or annual limit on mental health benefits under option (A) of this *Example 4* would not comply with the requirements of paragraph (b)(3) of this section. However, options (B), (C), and (D) of this *Example 4* would comply with the requirements of paragraph (b)(3) of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

(5) *Determining one-third and two-thirds of all medical/surgical benefits.* For purposes of this paragraph (b), the determination of whether the portion of medical/surgical benefits subject to a limit represents one-third or two-thirds of all medical/surgical benefits is based on

the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime or annual limits). Any reasonable method may be used to determine whether the dollar amounts expected to be paid under the plan will constitute one-third or two-thirds of the dollar amount of all plan payments for medical/surgical benefits.

(6) *Plan not described in paragraph (b)(2) or paragraph (b)(3) of this section—* (i) *In general.* A group health plan (or group health insurance coverage) that is not described in paragraph (b)(2) or paragraph (b)(3) of this section, must either impose—

(A) No aggregate lifetime or annual limit, as appropriate, on mental health benefits; or

(B) An aggregate lifetime or annual limit on mental health benefits that is no less than an average limit for medical/surgical benefits calculated in the following manner. The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual limits, as appropriate, that are applicable to the categories of medical/surgical benefits. Limits based on delivery systems, such as inpatient/outpatient treatment, or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories for purposes of this paragraph (b)(6)(i)(B). In addition, for purposes of determining weighted averages, any benefits that are not within a category that is subject to a separately-designated limit under the plan are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that a plan may reasonably be expected to incur with respect to such benefits, taking into account any other applicable restrictions under the plan.

(ii) *Weighting.* For purposes of this paragraph (b)(6), the weighting applicable to any category of medical/surgical benefits is determined in the manner set forth in paragraph (b)(5) of this section for determining one-third or two-thirds of all medical/surgical benefits.

(iii) *Examples.* The rules of this paragraph (b)(6) are illustrated by the following example:

Example. (i) A group health plan that is subject to the requirements of this section includes a \$100,000 annual limit on medical/surgical benefits related to cardio-pulmonary diseases. The plan does not include an annual limit on any other category of medical/surgical benefits. The plan determines that 40% of the dollar amount of plan payments for medical/surgical benefits are related to cardio-pulmonary diseases. The plan determines that \$1,000,000 is a reasonable estimate of the upper limit on the dollar amount that the plan may incur with respect to the other 60% of payments for medical/surgical benefits.

(ii) In this *Example*, the plan is not described in paragraph (b)(3) of this section because there is not one annual limit that applies to at least two-thirds of all medical/surgical benefits. Further, the plan is not described in paragraph (b)(2) of this section because more than one-third of all medical/surgical benefits are subject to an annual limit. Under this paragraph (b)(6), the plan sponsor can choose either to include no annual limit on mental health benefits, or to include an annual limit on mental health benefits that is not less than the weighted average of the annual limits applicable to each category of medical/surgical benefits. In this example, the minimum weighted average annual limit that can be applied to mental health benefits is $\$640,000$ ($40\% \times \$100,000 + 60\% \times \$1,000,000 = \$640,000$).

(c) *Rule in the case of separate benefit packages.* If a group health plan offers two or more benefit packages, the requirements of this section, including the exemption provisions in paragraph (f) of this section, apply separately to each benefit package. Examples of a group health plan that offers two or more benefit packages include a group health plan that offers employees a choice between indemnity coverage or HMO coverage, and a group health plan that provides one benefit package for retirees and a different benefit package for current employees.

(d) *Applicability—*(1) *Group health plans.* The requirements of this section apply to a group health plan offering both medical/surgical benefits and mental health benefits regardless of whether the mental health benefits are administered separately under the plan.

(2) *Health insurance issuers.* The requirements of this section apply to a health insurance issuer offering health insurance coverage for both medical/surgical benefits and mental health benefits in connection with a group health plan.

(3) *Scope.* This section does not—

(i) Require a group health plan (or health insurance issuer offering coverage in connection with a group health plan) to provide any mental health benefits; or

(ii) Affect the terms and conditions (including cost sharing, limits on the number

of visits or days of coverage, requirements relating to medical necessity, requiring prior authorization for treatment, or requiring primary care physicians' referrals for treatment) relating to the amount, duration, or scope of the mental health benefits under the plan (or coverage) except as specifically provided in paragraph (b) of this section.

(e) *Small employer exemption*—(1) *In general.* The requirements of this section do not apply to a group health plan (or health insurance issuer offering coverage in connection with a group health plan) for a plan year of a small employer. For purposes of this paragraph (e), the term *small employer* means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. See regulations at § 146.145(a), which provide that this section (and certain other sections) does not apply to any group health plan (and health insurance issuer offering coverage in connection with a group health plan) for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(2) *Rules in determining employer size.* For purposes of paragraph (e)(1) of this section—

(i) All persons treated as a single employer under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C. 414) are treated as one employer;

(ii) If an employer was not in existence throughout the preceding calendar year, whether it is a small employer is determined based on the average number of employees the employer reasonably expects to employ on business days during the current calendar year; and

(iii) Any reference to an employer for purposes of the small employer exemption includes a reference to a predecessor of the employer.

(f) *Increased cost exemption*—(1) *In general.* A group health plan (or health insurance coverage offered in connection with a group health plan) is not subject to the requirements of this section if the requirements of this paragraph (f) are satisfied.

If a plan offers more than one benefit package, this paragraph (f) applies separately to each benefit package. Except as provided in paragraph (h) of this section, a plan must comply with the requirements of paragraph (b)(1)(i) of this section for the first plan year beginning on or after January 1, 1998, and must continue to comply with the requirements of paragraph (b)(1)(i) of this section until the plan satisfies the requirements in this paragraph (f). In no event is the exemption of this paragraph (f) effective until 30 days after the notice requirements in paragraph (f)(3) of this section are satisfied. If the requirements of this paragraph (f) are satisfied with respect to a plan, the exemption continues in effect (at the plan's discretion) until September 30, 2001, even if the plan subsequently purchases a different policy from the same or a different issuer and regardless of any other changes to the plan's benefit structure.

(2) *Calculation of the one-percent increase*—(i) *Ratio.* A group health plan (or group health insurance coverage) satisfies the requirements of this paragraph (f)(2) if the application of paragraph (b)(1)(i) of this section to the plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least one percent. The application of paragraph (b)(1)(i) of this section results in an increased cost of at least one percent under a group health plan (or for such coverage) only if the ratio below equals or exceeds 1.01000. The ratio is determined as follows:

(A) The incurred expenditures during the base period, divided by,

(B) The incurred expenditures during the base period, reduced by —

(1) The claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section, and

(2) Administrative expenses attributable to complying with the requirements of this section.

(ii) *Formula.* The ratio of paragraph (f)(2)(i) is expressed mathematically as follows:

$$\frac{IE}{IE - (CE + AE)} \geq 1.01000$$

(A) *IE* means the incurred expenditures during the base period.

(B) *CE* means the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section.

(C) *AE* means administrative costs related to claims in *CE* and other administrative costs attributable to complying with the requirements of this section.

(iii) *Incurred expenditures.* *Incurred expenditures* means actual claims incurred during the base period and reported within two months following the base period, and administrative costs for all benefits under the group health plan, including mental health benefits and medical/surgical benefits, during the base period. Incurred expenditures do not include premiums.

(iv) *Base period.* *Base period* means the period used to calculate whether the plan may claim the one-percent increased cost exemption in this paragraph (f). The base period must begin on the first day in any plan year that the plan complies with the requirements of paragraph (b)(1)(i) of this section and must extend for a period of at least six consecutive calendar months. However, in no event may the base period begin prior to September 26, 1996 (the date of enactment of the Mental Health Parity Act (Pub. L. 104–204, 110 Stat. 2944)).

(v) *Rating pools.* For plans that are combined in a pool for rating purposes, the calculation under this paragraph (f)(2) for each plan in the pool for the base period is based on the incurred expenditures of the pool, whether or not all the plans in the pool have participated in the pool for the entire base period. (However, only the plans that have complied with paragraph (b)(1)(i) of this section for at least six months as a member of the pool satisfy the requirements of this paragraph (f)(2).) Otherwise, the calculation under this paragraph (f)(2) for each plan is calculated by the plan administrator (or issuer) based on the incurred expenditures of the plan.

(vi) *Examples.* The rules of this paragraph (f)(2) are illustrated by the following examples:

Example 1. (i) A group health plan has a plan year that is the calendar year. The plan satisfies the requirements of paragraph (b)(1)(i) of this section as of January 1, 1998. On September 15, 1998, the plan determines that \$1,000,000 in claims have been

incurred during the period between January 1, 1998 and June 30, 1998 and reported by August 30, 1998. The plan also determines that \$100,000 in administrative costs have been incurred for all benefits under the group health plan, including mental health benefits. Thus, the plan determines that its incurred expenditures for the base period are \$1,100,000. The plan also determines that the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section are \$40,000 and that administrative expenses attributable to complying with the requirements of this section are \$10,000. Thus, the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are \$1,050,000 (\$1,100,000 - (\$40,000 + \$10,000) = \$1,050,000).

(ii) In this *Example 1*, the plan satisfies the requirements of this paragraph (f)(2) because the application of this section results in an increased cost of at least one percent under the terms of the plan ($\$1,100,000/\$1,050,000 = 1.04762$).

Example 2. (i) A health insurance issuer sells a group health insurance policy that is rated on a pooled-basis and is sold to 30 group health plans. One of the group health plans inquires whether it qualifies for the one percent increased cost exemption. The issuer performs the calculation for the pool as a whole and determines that the application of this section results in an increased cost of 0.500 percent (for a ratio under this paragraph (f)(2) of 1.00500) for the pool. The issuer informs the requesting plan and the other plans in the pool of the calculation.

(ii) In this *Example 2*, none of the plans satisfy the requirements of this paragraph (f)(2) and a plan that purchases a policy not complying with the requirements of paragraph (b)(1)(i) of this section violates the requirements of this section. In addition, an issuer that issues to any of the plans in the pool a policy not complying with the requirements of paragraph (b)(1)(i) of this section violates the requirements of this section.

Example 3. (i) A partially-insured plan is collecting the information to determine whether it qualifies for the exemption. The plan administrator determines the incurred expenses for the base period for the self-funded portion of the plan to be \$2,000,000 and the administrative expenses for the base period for the self-funded portion to be \$200,000. For the insured portion of the plan, the plan administrator requests data from the insurer. For the insured portion of the plan, the plan's own incurred expenses for the base period are \$1,000,000 and the administrative expenses for the base period are \$100,000. The plan administrator determines that under the self-funded portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are \$0 because the self-funded portion does not cover mental health benefits and the plan's administrative costs attributable to complying with the requirements of this section are \$1,000. The issuer determines that under the insured portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are \$25,000 and the administrative costs attributable to complying with the requirements of this section are \$1,000. Thus, the

total incurred expenditures for the plan for the base period are \$3,300,000 (\$2,000,000 + \$200,000 + \$1,000,000 + \$100,000 = \$3,300,000) and the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are \$3,273,000 (\$3,300,000 - (\$0 + \$1,000 + \$25,000 + \$1,000) = \$3,273,000).

(ii) In this *Example 3*, the plan does not satisfy the requirements of this paragraph (f)(2) because the application of this section does not result in an increased cost of at least one percent under the terms of the plan ($\$3,300,000/\$3,273,000 = 1.00825$).

(3) *Notice of exemption—(i) Participants and beneficiaries—(A) In general.* A group health plan must notify participants and beneficiaries of the plan's decision to claim the one percent increased cost exemption. The notice must include the following information:

(1) A statement that the plan is exempt from the requirements of this section and a description of the basis for the exemption.

(2) The name and telephone number of the individual to contact for further information.

(3) The plan name and plan number (PN).

(4) The plan administrator's name, address, and telephone number.

(5) For single-employer plans, the plan sponsor's name, address, and telephone number (if different from paragraph (f)(3)(i)(A)(3) of this section) and the plan sponsor's employer identification number (EIN).

(6) The effective date of such exemption.

(7) The ability of participants and beneficiaries to contact the plan administrator to see how benefits may be affected as a result of the plan's election of the exemption.

(8) The availability, upon request and free of charge, of a summary of the information required under paragraph (f)(4) of this section.

(B) *Use of summary of material reductions in covered services or benefits.* A plan may satisfy the requirements of paragraph (f)(3)(i)(A) by providing participants and beneficiaries (in accordance with paragraph (f)(3)(i)(C)) with a summary of material reductions in covered services or benefits consistent with Department of Labor regulations at 29 CFR 2520.104b-3(d) that also includes the information of this paragraph (f)(3)(i). However, in all cases, the exemption is

not effective until 30 days after notice has been sent.

(C) *Delivery.* The notice described in this paragraph (f)(3)(i) is required to be provided to all participants and beneficiaries. The notice may be furnished by any method of delivery that satisfies the requirements of section 104(b)(1) of ERISA (29 U.S.C. 1024(b)(1)) (e.g., first-class mail). If the notice is provided to the participant at the participant's last known address, then the requirements of this paragraph (f)(3)(i) are satisfied with respect to the participant and all beneficiaries residing at that address. If a beneficiary's last known address is different from the participant's last known address, a separate notice is required to be provided to the beneficiary at the beneficiary's last known address.

(D) *Example.* The rules of this paragraph (f)(3)(i) are illustrated by the following example:

Example. (i) A group health plan has a plan year that is the calendar year and has an open enrollment period every November 1 through November 30. The plan determines on September 15 that it satisfies the requirements of paragraph (f)(2) of this section. As part of its open enrollment materials, the plan mails, on October 15, to all participants and beneficiaries a notice satisfying the requirements of this paragraph (f)(3)(i).

(ii) In this *Example*, the plan has sent the notice in a manner that complies with this paragraph (f)(3)(i).

(ii) *Federal agencies—(A) Church plans.* A church plan (as defined in section 414(e) of the Internal Revenue Code) claiming the exemption of this paragraph (f) for any benefit package must provide notice to the Department of the Treasury. This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(B) *Group health plans subject to Part 7 of Subtitle B of Title I of ERISA.* A group health plan subject to Part 7 of Subtitle B of Title I of ERISA, and claiming the exemption of this paragraph (f) for any benefit package, must provide notice to the Department of Labor. This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this

section identifying the benefit package to which the exemption applies.

(C) *Non-Federal governmental plans.* A group health plan that is a non-Federal governmental plan claiming the exemption of this paragraph (f) for any benefit package must provide notice to the Department of Health and Human Services (HHS). This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(4) *Availability of documentation.* The plan (or issuer) must make available to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information on which the exemption was based. An individual who is not a participant or beneficiary and who presents a notice described in paragraph (f)(3)(i) of this section is considered to be a representative. A representative may request the summary of information by providing the plan a copy of the notice provided to the participant under paragraph (f)(3)(i) of this section with any individually identifiable information redacted. The summary of information must include the incurred expenditures, the base period, the dollar amount of claims incurred during the base period that would have been denied under the terms of the plan absent amendments required to comply with paragraph (b)(1)(i) of this section, the administrative costs related to those claims, and other administrative costs attributable to complying with the requirements for the exemption. In no event should the summary of information include any individually identifiable information.

(g) *Special rules for group health insurance coverage—(1) Sale of nonparity policies.* An issuer may sell a policy without parity (as described in paragraph (b) of this section) only to a plan that meets the requirements of paragraph (e) or paragraph (f) of this section.

(2) *Duration of exemption.* After a plan meets the requirements of paragraph (f) of this section, the plan may change issuers without having to meet the requirements of paragraph (f) of this section again before September 30, 2001.

(h) *Effective dates—(1) In general.* The requirements of this section are ap-

plicable for plan years beginning on or after January 1, 1998.

(2) *Limitation on actions.* (i) Except as provided in paragraph (h)(3) of this section, no enforcement action is to be taken by the Secretary against a group health plan that has sought to comply in good faith with the requirements of section 2705 of the PHS Act, with respect to a violation that occurs before the earlier of —

(A) The first day of the first plan year beginning on or after April 1, 1998; or

(B) January 1, 1999.

(ii) Compliance with the requirements of this section is deemed to be good faith compliance with the requirements of section 2705 of the PHS Act.

(iii) The rules of this paragraph (h)(2) are illustrated by the following examples:

Example 1. (i) A group health plan has a plan year that is the calendar year. The plan complies with section 2705 of the PHS Act in good faith using assumptions inconsistent with paragraph (b)(6) of this section relating to weighted averages for categories of benefits.

(ii) In this *Example 1*, no enforcement action may be taken against the plan with respect to a violation resulting solely from those assumptions and occurring before January 1, 1999.

Example 2. (i) A group health plan has a plan year that is the calendar year. For the entire 1998 plan year, the plan applies a \$1,000,000 annual limit on medical/surgical benefits and a \$100,000 annual limit on mental health benefits.

(ii) In this *Example 2*, the plan has not sought to comply with the requirements of section 2705 of the PHS Act in good faith and this paragraph (h)(2) does not apply.

(3) *Transition period for increased cost exemption—(i) In general.* No enforcement action will be taken against a group health plan that is subject to the requirements of this section based on a violation of this section that occurs before April 1, 1998 solely because the plan claims the increased cost exemption under section 2705(c)(2) of the PHS Act based on assumptions inconsistent with the rules under paragraph (f) of this section, provided that a plan amendment that complies with the requirements of paragraph (b)(1)(i) of this section is adopted and effective no later than March 31, 1998 and the plan complies with the notice requirements in paragraph (h)(3)(ii) of this section.

(ii) *Notice of plan's use of transition period.* (A) A group health plan satisfies the requirements of this paragraph (h)(3)(ii) only if the plan provides notice to the applicable federal agency and posts

the notice at the location(s) where documents must be made available for examination by participants and beneficiaries under section 104(b)(2) of ERISA and the regulations thereunder (29 CFR 2520.104b-1(b)(3)). The notice must indicate the plan's decision to use the transition period in paragraph (h)(3)(i) of this section by 30 days after the first day of the plan year beginning on or after January 1, 1998, but in no event later than March 31, 1998. For a group health plan that is a church plan, the applicable federal agency is the Department of the Treasury. For a group health plan that is subject to Part 7 of Subtitle B of Title I of ERISA, the applicable federal agency is the Department of Labor. For a group health plan that is a nonfederal governmental plan, the applicable federal agency is the Department of Health and Human Services. The notice must include —

(1) The name of the plan and the plan number (PN);

(2) The name, address, and telephone number of the plan administrator;

(3) For single-employer plans, the name, address, and telephone number of the plan sponsor (if different from the plan administrator) and the plan sponsor's employer identification number (EIN);

(4) The name and telephone number of the individual to contact for further information; and

(5) The signature of the plan administrator and the date of the signature.

(B) The notice must be provided at no charge to participants or their representative within 15 days after receipt of a written or oral request for such notification, but in no event before the notice has been sent to the applicable federal agency.

(i) *Sunset.* This section does not apply to benefits for services furnished on or after September 30, 2001.

Authority: Secs. 2741 through 2763, 2791, and 2792 of the PHS Act, 42 U.S.C. 300gg-41 through 300gg-63, 300gg-91, and 300gg-92.

Nancy-Ann Min DeParle,
Administrator, Health Care Financing Administration.

Donna E. Shalala,
Secretary.

(Filed by the Office of the Federal Register on December 19, 1997, 8:45 a.m., and published in the issue of the Federal Register for December 22, 1997, 62 F.R. 66932)

Part III. Administrative, Procedural, and Miscellaneous

Cash or Deferred Arrangements; Nondiscrimination

Notice 98-1

I. PURPOSE

This notice provides guidance and transition relief relating to recent statutory amendments to the nondiscrimination rules under § 401(k) and § 401(m) of the Internal Revenue Code. The rules applicable to qualified cash or deferred arrangements under § 401(k) and matching and employee contributions under § 401(m) were amended by the Small Business Job Protection Act of 1996 (SBJPA), Pub. L. 104-188.

Specifically, this notice provides guidance on

- The election to use the current year testing method.
- The use of qualified nonelective contributions (QNCs) and qualified matching contributions (QMACs) under the prior year testing method.
- The application of the first plan year rule under the prior year testing method.
- The impact of certain plan population changes under the prior year testing method.
- A change from the current year testing method to the prior year testing method, including related transition relief.
- Plan amendments needed to reflect the testing method of a plan, including the application of the remedial amendment period under § 401(b).

II. BACKGROUND

A. SBJPA Amendments to § 401(k) and § 401(m)

Under § 401(k) and § 401(m), the actual deferral percentage (ADP) and the actual contribution percentage (ACP) of highly compensated employees (HCEs) are compared with those of nonhighly compensated employees (NHCEs). Section 1433(c) of SBJPA amended § 401(k)(3)(A) and § 401(m)(2)(A), effective for plan years beginning after De-

cember 31, 1996, to provide for the use of prior year data in determining the ADP and ACP for NHCEs, while continuing to provide for the use of current year data for HCEs. Alternatively, an employer may elect to use current year data for determining the ADP and ACP for both HCEs and NHCEs, but the statute provides that this election may be changed only as provided by the Secretary. Section 1433(d) of SBJPA amended § 401(k)(3) and § 401(m)(3) to provide a special rule for determining the ADP and ACP for NHCEs for the first plan year of a plan (other than a successor plan) where the prior year testing method is used.

B. Guidance on the SBJPA Amendments

Notice 97-2, 1997-2 I.R.B. 22, provides guidance on determining the individuals who are taken into account in computing the ADP or ACP for NHCEs for the prior year under the prior year testing method. The guidance provides transition relief to allow plans using the current year testing method for the 1997 testing year to change to the prior year testing method for the 1998 testing year without obtaining approval from the Internal Revenue Service. The notice also provides rules for distributions of excess contributions and excess aggregate contributions.

Notice 97-2 states that Treasury and the Service will issue guidance regarding the conditions under which employers that elect to use current year data for the 1998 or a later plan year may change that election and use prior year testing for subsequent plan years. Notice 97-2 also requested comments concerning (i) the use of QNCs and QMACs in computing the prior year's ADP for NHCEs, including methods of preventing inappropriate double counting; and (ii) the appropriate determination of the prior year's ADP for NHCEs when the group of employees tested is significantly different in the current year than in the prior year. After consideration of the comments received, this notice provides guidance on these issues.

Rev. Proc. 97-41, 1997-33 I.R.B. 51, provides guidance to sponsors of plans that are qualified under § 401(a) with re-

spect to the date by which they must adopt amendments to comply with changes in the law, including a remedial amendment period for amendments to reflect changes to the qualification requirements made by SBJPA.

C. Definitions

If a term that is used in this notice is defined in the regulations under § 401(k) or § 401(m), then the definition under these regulations applies for purposes of this notice. For example, "plan" as used in this notice means plan as defined in § 1.401(k)-1(g)(11) of the Income Tax Regulations.

In addition, for purposes of this notice, the "testing year" is the plan year for which the ADP or ACP for HCEs is being tested; the "prior year" is the plan year immediately preceding the testing year. If the plan uses data from the testing year in determining the ADP or ACP for NHCEs, it is using the "current year testing method;" if the plan uses data from the prior year in determining the ADP or ACP for NHCEs, it is using the "prior year testing method."

Sections V and VI of this notice provide additional definitions used in applying the first plan year rule and definitions used in the rules relating to changes in the group of eligible employees when a plan uses the prior year testing method.

D. Effect of Statutory Changes on Regulations

Because of the amendments made to § 401(k) and § 401(m), certain portions of § 1.401(k)-1 and §§ 1.401(m)-1 and 1.401(m)-2 no longer reflect current law. This notice provides guidance on a limited number of issues relating to the use of the prior year testing method and relating to a change in testing method. The regulations shall continue in force to the extent that they are not inconsistent with the Code, as amended, and subsequent guidance, including Notice 97-2 and this notice.

III. USE OF CURRENT YEAR TESTING METHOD

As provided under § 401(k)(3)(A) and § 401(m)(2)(A), an employer may elect to

use the current year testing method for a plan in lieu of the prior year testing method. A plan using the prior year testing method may adopt the current year testing method for any subsequent testing year. Notification to or filing with the Service of an election to use the current year testing method is not required in order for the election to be valid. However, as provided in section IX of this notice, the plan document governing the plan must reflect whether the plan uses the current year testing method or the prior year testing method for a testing year.

A plan that uses the current year testing method for a testing year may not be permissively aggregated under § 1.410(b)-7(d) with a plan that uses the prior year testing method for that testing year.

IV. USE OF QNCs AND QMACs UNDER PRIOR YEAR TESTING METHOD

Section 401(k)(3)(D) and § 401(m)(3) provide that an employer may take into account QNCs and QMACs in calculating the ADP, and QNCs in calculating the ACP, as provided by the Secretary. A plan may continue to take QNCs and QMACs into account under the prior year testing method, subject to the limitations set forth in section VII.B. of this notice.

A. Timing of Contribution of QNCs and QMACs

In order to be taken into account in the calculation of the ADP or ACP for a year under the prior year testing method, a QNC or QMAC must be allocated as of a date within the year and must actually be paid to the trust no later than the end of the 12-month period following the end of the year to which the contribution relates. See §§ 1.401(k)-1(b)(4)(i)(A) and (b)(5)(v) and §§ 1.401(m)-1(b)(4)(ii) and (b)(5)(iv). Consequently, under the prior year testing method, in order to be taken into account in calculating the ADP or ACP for NHCEs for the prior year, a QNC or QMAC must be contributed by the end of the testing year. Thus, for example, if the prior year testing method is used for the 1998 testing year, QNCs that are allocated to the accounts of NHCEs for the 1997 plan year (i.e., the prior year) must be contributed to the plan by the end of

the 1998 plan year in order to be treated as elective contributions for purposes of the ADP test for the 1998 testing year. By contrast, in order to be taken into account in calculating the ADP or ACP for HCEs for the 1998 testing year, a QNC or QMAC must be contributed by the end of the 1999 plan year.

It should be noted that § 1.415-6(b)-(7)(ii) provides that, for purposes of satisfying § 415, employer contributions shall not be deemed credited to a participant's account for a particular limitation year unless the contributions are actually made to the plan no later than 30 days after the end of the period described in § 404(a)(6) applicable to the taxable year with or within which the particular limitation year ends. Thus, contributions made after the date described in § 1.415-6(b)(7)(ii) are treated as annual additions for the next § 415 limitation year. Accordingly, under either the prior year testing method or the current year testing method, a violation of § 415(c) might occur if QNCs or QMACs are contributed after the date described in § 1.415-6(b)(7)(ii).

B. Nondiscrimination Testing of QNCs under the Prior Year Testing Method

Section 1.401(k)-1(b)(5) provides that (i) the amount of nonelective contributions, including those QNCs treated as elective contributions for purposes of the ADP test, and (ii) the amount of nonelective contributions, excluding those QNCs treated as elective contributions for purposes of the ADP test, must each satisfy the requirements of § 401(a)(4). Under § 1.401(m)-1(b)(5), a similar rule applies to QNCs treated as matching contributions for purposes of the ACP test.

These nondiscrimination requirements continue to apply to plans that use the prior year testing method. This is true even though the QNCs allocated to the HCEs and NHCEs in a single plan year are taken into account for ADP and ACP testing in different testing years. Accordingly, QNCs allocated to the accounts of NHCEs and HCEs for the same plan year will be subject to the requirements of § 401(a)(4) for that plan year; however, QNCs allocated to the accounts of HCEs will be taken into account for ADP or ACP testing in the plan year for which

they are allocated, while QNCs allocated to the accounts of NHCEs will not be taken into account in determining the permitted ADP or ACP for HCEs until the following plan year.

V. FIRST PLAN YEAR RULE UNDER PRIOR YEAR TESTING METHOD

Section 401(k)(3)(E) provides that, for the first plan year of any plan (other than a successor plan) that uses the prior year testing method, the ADP for NHCEs for the prior year is 3%, or, if the employer elects, is the ADP for NHCEs for that first plan year. For this purpose, the "first plan year" of any plan is the first year in which the plan, within the meaning of § 414(l), is or includes a section 401(k) plan (i.e., the first year a plan provides for elective contributions described in § 1.401(k)-1(g)-(3)). However, a plan does not have a first plan year if for such plan year the plan is aggregated under § 1.401(k)-1(g)(11) with any other plan that was or that included a section 401(k) plan in the prior year.

Section 401(m)(3) provides that rules similar to the rules of § 401(k)(3)(E) shall apply for purposes of the ACP test. For purposes of the ACP test, the "first plan year" of any plan is the first year in which a plan, within the meaning of § 414(l), is or includes a section 401(m) plan (i.e., the first year a plan provides for employee contributions described in § 1.401(m)-1(f)(6) or matching contributions described in § 1.401(m)-1(f)(12), or both). However, a plan does not have a first plan year if for such plan year the plan is aggregated for purposes of § 1.401(m)-1(g)(14) with any other plan that was or that included a section 401(m) plan in the prior year.

For purposes of this notice, a plan is a "successor plan" if 50% or more of the eligible employees for the first plan year were eligible employees under another section 401(k) plan (or section 401(m) plan, as applicable) maintained by the employer in the prior year. For example, in 1998, Employer H sponsors Plan T, a section 401(k) plan. In 1999, Employer H establishes Plan U, also a section 401(k) plan, which had 200 eligible employees, including 100 employees who were eligible employees under Plan T in 1998. Plan U is a successor plan.

If a plan (other than a successor plan) uses the prior year testing method and for its first plan year the plan determines the ADP or ACP for NHCEs for the prior plan year using the ADP or ACP for NHCEs for that first plan year (in lieu of 3%), then the use of the prior year testing method in the next testing year is not treated as a change in testing method. Such a plan would not be subject to the limitations on double counting described in section VII.B. for that next testing year. If a successor plan uses the prior year testing method for its first plan year, the ADP and ACP for NHCEs for the prior year are determined under the rules in section V of this notice.

VI. CHANGES IN THE GROUP OF ELIGIBLE NHCEs WHERE PLAN USES PRIOR YEAR TESTING METHOD

A. General Rule: Disregard Changes in the Group of NHCEs

Except as provided in section VI.B. and C., below, under the prior year testing method, the ADP or ACP for NHCEs for the prior year under a plan is determined without regard to changes in the group of NHCEs who are eligible employees under the plan in the testing year. Thus, under the prior year testing method, the prior year ADP or ACP for NHCEs is used even though some NHCEs may have first become eligible employees under the plan in the testing year because they meet existing plan eligibility requirements, and even though individuals who were eligible employees under the plan and NHCEs in the prior year are no longer employed by the employer or have become HCEs in the testing year.

B. Exception for Plan Coverage Changes

If a plan results from, or is otherwise affected by, a plan coverage change that becomes effective during the testing year, then the ADP and ACP for NHCEs for the prior year under the plan is the weighted average of the ADPs for the prior year subgroups and the weighted average of the ACPs for the prior year subgroups, respectively.

C. Optional Rule for Minor Plan Coverage Changes

If a plan results from, or is otherwise affected by, a plan coverage change, and 90% or more of the total number of NHCEs from all prior year subgroups are from a single prior year subgroup, then in determining the ADP or ACP for NHCEs for the prior year under the plan, an employer may elect to use the ADP and ACP for NHCEs for the prior year of the plan under which that single prior year subgroup was eligible, in lieu of using the weighted averages described in section VI.B., above.

D. Definitions

For purposes of this notice:

1. "Plan coverage change" means a change in the group or groups of eligible employees under a plan on account of (a) the establishment or amendment of a plan, (b) a plan merger, consolidation, or spinoff under § 414(l), (c) a change in the way plans within the meaning of § 414(l) are combined or separated for purposes of § 1.401(k)-1(g)(11) (e.g., permissively aggregating plans not previously aggregated under § 1.410(b)-7(d), or ceasing to permissively aggregate plans under § 1.410(b)-7(d)), or (d) a combination of any of the foregoing.

2. "Prior year subgroup" means all NHCEs for the prior year who, in the prior year, were eligible employees under a specific section 401(k) plan (or, in the case of the ACP test, a specific section 401(m) plan) maintained by the employer and who would have been eligible employees in the prior year under the plan being tested if the plan coverage change had first been effective as of the first day of the prior year instead of first being effective during the testing year.

3. "Weighted average of the ADPs for the prior year subgroups" and "weighted average of the ACPs for the prior year subgroups" mean the sum, for all prior year subgroups, of the adjusted ADPs and adjusted ACPs, respectively.

4. "Adjusted ADP" and "adjusted ACP" with respect to a prior year subgroup mean the respective ADP and ACP for NHCEs for the prior year of the spe-

cific plan under which the members of the prior year subgroup were eligible employees, multiplied by a fraction, the numerator of which is the number of NHCEs in the prior year subgroup and the denominator of which is the total number of NHCEs in all prior year subgroups.

E. Examples

The requirements of this section VI are illustrated by the following examples:

Example 1:

(i) Employer B maintains two plans, Plan N and Plan P, each of which includes a section 401(k) plan. The plans were not permissively aggregated under § 1.410(b)-7(d) for the 1998 testing year. Both plans use the prior year testing method. Plan N had 300 eligible employees who were NHCEs for 1998, and their ADP for that year was 6%. Plan P had 100 eligible employees who were NHCEs for 1998, and the ADP for those NHCEs for that plan was 4%. Plan N and Plan P are permissively aggregated under § 1.410(b)-7(d) for the 1999 plan year.

(ii) The permissive aggregation of Plan N and Plan P for the 1999 testing year under § 1.410(b)-7(d) is a plan coverage change that results in treating the plans as one plan (Plan NP) for purposes of § 1.401(k)-1(g)(11). Therefore, the prior year ADP for NHCEs under Plan NP for the 1999 testing year is the weighted average of the ADPs for the prior year subgroups.

(iii) The first step in determining the weighted average of the ADPs for the prior year subgroups is to identify the prior year subgroups. With respect to the 1999 testing year, an employee is a member of a prior year subgroup if the employee (A) was an NHCE of Employer B for the 1998 plan year, (B) was an eligible employee for the 1998 plan year under any section 401(k) plan maintained by Employer B, and (C) would have been an eligible employee in the 1998 plan year under Plan NP if Plan N and Plan P had been permissively aggregated under § 1.410(b)-7(d) for that plan year. The NHCEs who were eligible employees under separate section 401(k) plans for the 1998 plan year comprise separate

prior year subgroups. Thus, there are two prior year subgroups under Plan NP for the 1999 testing year: the 300 NHCEs who were eligible employees under Plan N for the 1998 plan year and the 100 NHCEs who were eligible employees under Plan P for the 1998 plan year.

(iv) The weighted average of the ADPs for the prior year subgroups is the sum of: (A) the adjusted ADP with respect to the prior year subgroup that consists of the NHCEs who were eligible employees under Plan N, and (B) the adjusted ADP with respect to the prior year subgroup that consists of the NHCEs who were eligible employees under Plan P. The adjusted ADP for the prior year subgroup that consists of the NHCEs who were eligible employees under Plan N is 4.5%, calculated as follows: 6% (the ADP for the NHCEs under Plan N for the prior year) \times 300/400 (the number of NHCEs in that prior year subgroup divided by the total number of NHCEs in all prior year subgroups), which equals 4.5%. The adjusted ADP for the prior year subgroup that consists of the NHCEs who were eligible employees under Plan P is 1%, calculated as follows: 4% (the ADP for the NHCEs under Plan P for the prior year) \times 100/400 (the number of NHCEs in that prior year subgroup divided by the total number of NHCEs in all prior year subgroups), which equals 1%. Thus, the prior year ADP for NHCEs under Plan NP for the 1999 testing year is 5.5% (the sum of adjusted ADPs for the prior year subgroups, 4.5% plus 1%).

Example 2:

(i) Employer C maintains a plan, Plan Q, which includes a section 401(k) plan and which uses the prior year testing method. Plan Q covers employees of Division A and Division B. In 1998, Plan Q had 500 eligible employees who were NHCEs, and the ADP for those NHCEs for 1998 was 5%. Effective January 1, 1999, Employer C spins off a portion of Plan Q under § 414(l), creating a new Plan R which includes a section 401(k) plan in which the 100 employees of Division B are eligible employees.

(ii) The spin-off of Plan R is a plan coverage change that affects Plan Q. Accordingly, for purposes of the 1999 testing year under Plan Q, the prior year ADP

for NHCEs under Plan Q is the weighted average of the ADPs for the prior year subgroups. Plan Q has only one prior year subgroup (because the only NHCEs who would have been eligible employees under Plan Q for the 1998 plan year if the spin-off had occurred as of the first day of that plan year were eligible employees under Plan Q). Therefore, for purposes of the 1999 testing year under Plan Q, the ADP for NHCEs for the prior year is the weighted average of the ADPs for the prior year subgroups, or 5%, the same as if the plan spin-off had not occurred.

Example 3:

(i) The facts are the same as in Example 2, except that instead of spinning off Plan R from Plan Q, Employer C amends the eligibility provisions under Plan Q to exclude employees of Division B effective January 1, 1999. In addition, effective on that same date, Employer C establishes a new plan, Plan R, which includes a section 401(k) plan that uses the prior year testing method. The only eligible employees under Plan R are the 100 employees of Division B who were eligible employees under Plan Q.

(ii) Plan R is a successor plan, within the meaning of section V of this notice (because all of the employees were eligible employees under Plan Q in the prior year), and, therefore, the first plan year rule of that section does not apply.

(iii) The amendment to the eligibility provisions of Plan Q and the establishment of Plan R are plan coverage changes that affect Plan Q and result in Plan R. Accordingly, the prior year ADP for NHCEs under Plan Q is the weighted average of the ADPs for the prior year subgroups. Plan Q has only one prior year subgroup (because the only NHCEs who would have been eligible employees under Plan Q for the 1998 plan year if the amendment to the Plan Q eligibility provisions had occurred as of the first day of that plan year were eligible employees under Plan Q). Therefore, for purposes of the 1999 testing year under Plan Q, the ADP for NHCEs for the prior year is the weighted average of the ADPs for the prior year subgroups, or 5%, the same as if the plan amendment had not occurred.

(iv) Similarly, Plan R has only one prior year subgroup (because the only

NHCEs who would have been eligible employees under Plan R for the 1998 plan year if the plan were established as of the first day of that plan year were eligible employees under Plan Q). Therefore, for purposes of the 1999 testing year under Plan R, the ADP for NHCEs for the prior year is the weighted average of the ADPs for the prior year subgroups, or 5%, the same as that of Plan Q.

Example 4:

(i) The facts are the same as in Example 3, except that the provisions of Plan R extend eligibility to 50 hourly employees who previously were not eligible employees under any section 401(k) plan maintained by Employer C.

(ii) Plan R is a successor plan, within the meaning of section V of this notice (because 100 of Plan R's 150 eligible employees were eligible employees under another section 401(k) plan maintained by Employer C in the prior year), and, therefore, the first plan year rule of that section does not apply.

(iii) The establishment of Plan R is a plan coverage change that affects Plan R. Because the 50 hourly employees were not eligible employees under any section 401(k) plan of Employer C for the prior year, they do not comprise a prior year subgroup. Accordingly, Plan R still has only one prior year subgroup. Therefore, for purposes of the 1999 testing year under Plan R, the ADP for NHCEs for the prior year is the weighted average of the ADPs for the prior year subgroups, or 5%, the same as that of Plan Q.

VII. CHANGE FROM CURRENT YEAR TO PRIOR YEAR TESTING METHOD

A. General Rule

Section 401(k)(3)(A) provides that if an employer elects to use the current year testing method for purposes of the ADP test, that method may not be changed except as provided by the Secretary. A similar rule applies under § 401(m)(2)(A) in the case of the ACP test. Thus, the statute indicates that once an employer elects to use the current year testing method, the ability to change that election will be limited.

In general, it is expected that plans will select a testing method and retain it.

Treasury and the Service recognize, however, that there may be legitimate reasons for occasionally reevaluating and changing the testing method under a plan. In addition, certain business transactions may result in a diversity of testing methods among plans of an employer, and the employer may wish to use consistent testing methods. Finally, Treasury and the Service believe that employers with existing plans should be given a period of time to decide whether to change from the current year testing method (which was the required testing method prior to the SBJPA changes) to the prior year testing method.

Accordingly, a plan is permitted to change from the current year testing method to the prior year testing method in any of the following situations:

1. The plan is not the result of the aggregation of two or more plans, and the current year testing method was used under the plan for each of the 5 plan years preceding the plan year of the change (or if lesser, the number of plan years the plan has been in existence, including years in which the plan was a portion of another plan).

2. The plan is the result of the aggregation of two or more plans, and for each of the plans that are being aggregated (the aggregating plans), the current year testing method was used for each of the 5 plan years preceding the plan year of the change (or if lesser, the number of plan years since that aggregating plan has been in existence, including years in which the aggregating plan was a portion of another plan).

3. A transaction occurs that is described in § 410(b)(6)(C)(i) and § 1.410(b)-2(f); as a result of the transaction, the employer maintains both a plan using the prior year testing method and a plan using the current year testing method; and the change from the current year testing method to the prior year testing year method occurs within the transition period described in § 410(b)(6)(C)(ii).

4. The change occurs during the plan's remedial amendment period for the SBJPA changes (see Rev. Proc. 97-41). Notification to or filing with the Service of a change from the current year to the prior year testing method is not required in order for the change to be valid. However, as provided in section IX of this no-

tice, the plan document governing the plan must reflect such a change.

B. Limitations on Double Counting of Certain Contributions

If a plan changes from the current year testing method to the prior year testing method, then, for purposes of the first testing year for which the change is effective, the ADP and ACP for NHCEs for the prior year is determined in the following manner:

1. The ADP for NHCEs for the prior year is determined taking into account only (a) elective contributions for those NHCEs that were taken into account for purposes of the ADP test (and not the ACP test) under the current year testing method for the prior year and (b) QNCs that were allocated to the accounts of those NHCEs for the prior year but that were not used to satisfy the ADP test or the ACP test under the current year testing method for the prior year.

2. The ACP for NHCEs for the prior year is determined taking into account only (a) employee contributions for those NHCEs for the prior year, (b) matching contributions for those NHCEs that were taken into account for purposes of the ACP test (and not the ADP test) under the current year testing method for the prior year, and (c) QNCs that were allocated to the accounts of those NHCEs for the prior year but that were not used to satisfy the ACP test or the ADP test under the current year testing method for the prior year.

Thus, in determining the ADP for NHCEs for the prior year, the following contributions made for the prior testing year are disregarded: QNCs used to satisfy either the ADP or ACP test under the current year testing method for the prior testing year, elective contributions taken into account for purposes of the ACP test, and all QMACs. Similarly, in determining the ACP for NHCEs for the prior year, the following contributions made for the prior testing year are disregarded: QNCs used to satisfy either the ADP or ACP test under the current year testing method for the prior testing year, QMACs taken into account for purposes of the ADP test, and all elective contributions.

The limitations on double counting under this section VII.B. do not apply for testing years beginning before January 1, 1999. Accordingly, in the case of a plan

that changes from the current year to the prior year testing method for the first time for either the 1997 or 1998 testing year, the ADP and ACP for NHCEs used for that testing year are the same as the ADP and ACP, respectively, for NHCEs used for the prior testing year.

3. Examples

The limitations on double counting are illustrated by the following examples:

Example 1:

(i) Employer A established Plan M, a calendar year section 401(k) plan, in 1993 and, through the 2000 testing year, has always used the current year testing method under Plan M. The ADP for the HCEs under Plan M is 7% for the 2000 testing year. Based solely on elective contributions by NHCEs under Plan M for the 2000 testing year, the ADP for NHCEs for the 2000 testing year is 4%. In order to satisfy the ADP test, Employer A provides a QNC to each NHCE for the 2000 testing year equal to 1% of compensation. No other contributions under Plan M are taken into account in determining the ADP for NHCEs. Thus, the ADP for NHCEs for the 2000 testing year is 5%. Plan M is amended to use the prior year testing method instead of the current year testing method for purposes of the ADP test for the 2001 testing year.

(ii) In determining the ADP for NHCEs under Plan M for the 2001 testing year in accordance with the prior year testing method, the elective contributions made by NHCEs under Plan M for the 2000 plan year are taken into account. However, the QNCs equal to 1% of compensation made under Plan M on behalf of NHCEs for the 2000 plan year are disregarded because they were used to satisfy the ADP test for the 2000 testing year. Thus, for purposes of the 2001 testing year, the ADP for NHCEs for the prior year is 4% (unless additional QNCs for NHCEs are timely contributed and allocated for the 2000 plan year).

Example 2:

(i) The facts are the same as in Example 1, except that the testing years are 1997 and 1998, instead of 2000 and 2001.

(ii) For purposes of the 1998 testing year, the ADP for NHCEs for the prior

year is 5%. The QNCs equal to 1% of compensation made under Plan M on behalf of NHCEs that were used to satisfy the ADP test for the 1997 testing year are not disregarded because the limitation on double counting applies only for testing years beginning on or after January 1, 1999.

VIII. ANTI-ABUSE PROVISION

This guidance is designed to provide simple, practical rules that accommodate legitimate plan changes. At the same time, the rules are intended to be applied by employers in a manner that does not make use of changes in plan testing procedures or other plan provisions to inflate inappropriately the prior year ADP and ACP for NHCEs (which are used as benchmarks for testing the ADP and ACP for HCEs). Further, the ADP and ACP tests are part of the overall requirement that benefits or contributions not discriminate in favor of HCEs. Therefore, a plan will not be treated as satisfying the ADP or ACP test if there are repeated changes in plan testing procedures or plan provisions that have the effect of distorting the ADP or ACP test so as to increase significantly the permitted ADP or ACP for HCEs and if a principal purpose of the changes was to achieve such a result.

IX. PLAN PROVISIONS REGARDING TESTING METHOD

Sections 1.401(k)-1(b)(2)(iii) and 1.401(m)-1(b)(2) require that a plan to which § 401(k) or § 401(m) applies must provide that the ADP or ACP test will be met. Because a plan may now use either the current year testing method or the prior year testing method, a plan must specify which of these two testing methods it is using. If the employer changes the testing method under a plan, the plan must be amended to reflect the change. Further, if the first plan year rule described in § 401(k)(3)(E) and § 401(m)(3) and section V of this notice applies, a plan that incorporates these provisions by reference must specify whether the ADP and ACP for NHCEs for the prior plan year is 3% or the current year's ADP and ACP for the NHCEs.

The regulations under § 401(k) and § 401(m) permit a plan to incorporate by reference § 401(k)(3) and § 401(m)(2)

(and, if applicable, § 401(m)(9)) and the specific underlying regulations. A plan that incorporates these provisions by reference must continue to refer to the applicable Code sections and the specific underlying regulations, must specify which of the two testing methods (prior year or current year) it is using, and must now provide that it is incorporating by reference subsequent Internal Revenue Service guidance issued under the applicable Code provisions. Further, for purposes of the first plan year rule described in § 401(k)(3)(E) and § 401(m)(3) and section V of this notice, a plan that incorporates these provisions by reference must specify whether the ADP and ACP for NHCEs for the prior plan year is 3% or the current year's ADP and ACP for the NHCEs.

Rev. Proc. 97-41 provides that qualified retirement plans have a remedial amendment period under § 401(b) so that certain plan amendments for SBJPA generally are not required to be adopted before the last day of the first plan year beginning on or after January 1, 1999. Pursuant to Rev. Proc. 97-41, a plan provision reflecting the ADP or ACP testing method is a disqualifying provision, and thus any plan amendments to reflect a choice in testing method are not required to be adopted until the end of this remedial amendment period. However, plans must be operated in accordance with the SBJPA changes to § 401(k)(3)(A) and § 401(m)(2)(A) as of the statutory effective date. In addition, under Rev. Proc. 97-41, any retroactive amendments must reflect the choices made in the operation of the plan for each testing year, including the choice of testing method (and any changes to that election), and must reflect the date on which the plan began to operate in accordance with those choices (and any such changes).

X. PAPERWORK REDUCTION ACT

The collection of information contained in this notice has been reviewed and approved by the Office of Management and Budget (OMB) in accordance with the Paperwork Reduction Act (44 U.S.C. 3507) under control number 1545-1579.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the col-

lection of information displays a valid OMB control number.

The collection of information in this notice is in section IX. This requirement to amend plan documents is necessary to reflect the new nondiscrimination test under § 401(k)(3) and § 401(m)(2) as amended by SBJPA. The pre-SBJPA method of nondiscrimination testing is still available under these Code sections and a plan amendment may not be required to reflect the choice of the pre-SBJPA testing method. The information will be used to determine whether the ADP and ACP of HCEs exceeds the ADP and ACP of NHCEs by more than the statutory limits. The collection of information is required to obtain a benefit. The likely respondents are businesses or other for-profit institutions, and nonprofit institutions.

The estimated total annual recordkeeping burden is 49,000 hours. The estimated annual burden per recordkeeper is 20 minutes. The estimate number of recordkeepers is 147,000.

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

XI. COMMENTS

Treasury and the Service invite comments regarding the matters discussed in this notice. Comments may be submitted to the Service at CC:DOM:CORP:R (Notice 98-1), Room 5226, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044. Alternatively, taxpayers may hand-deliver comments between the hours of 8 a.m. and 5 p.m. to CC:DOM:CORP:R (Notice 97-XX), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington, DC, or may submit comments electronically via the Service's Internet site at http://www.irs.ustreas.gov/prod/tax_regs/comments.html.

Drafting Information

The principal authors of this notice are Susan Lennon of the Office of the Associate Chief Counsel (Employee Benefits and Exempt Organizations) and Roger Kuehne of the Employee Plans Division.

For further information regarding this notice, contact the Employee Plans Division's telephone assistance service between 1:30 and 4:00 p.m., Eastern Time, Monday through Thursday at (202) 622-6074/75. (These telephone numbers are not toll-free.)

Publicly Traded Partnerships

Notice 98-3

This notice provides the method for grandfathered publicly traded partnerships to elect to remain exempt from § 7704 of the Internal Revenue Code pursuant to § 7704(g). This notice also provides the procedures for revoking the election. In addition, this notice informs grandfathered publicly traded partnerships that do not elect the application of § 7704(g) that the rules contained in proposed regulation § 1.743-2 regarding special § 743(b) basis accounts may be followed for purposes of a conversion from a partnership to a corporation. The references in this notice to § 7704(g) reflect the amendments made by the Taxpayer Relief Act of 1997 (1997 TRA), Pub. L. No. 105-34, 111 Stat. 788 (1997).

BACKGROUND

Section 7704(a) provides that a publicly traded partnership is treated as a corporation.

Section 7704(b) defines a partnership as a "publicly traded partnership" if interests in the partnership are traded on an established securities market or are readily tradable on a secondary market (or the substantial equivalent thereof).

Section 7704(c) provides that a publicly traded partnership will not be treated as a corporation if, for the current taxable year and each preceding taxable year beginning after December 31, 1987 during which the partnership (or any predecessor) was in existence, (1) at least 90 percent of the gross income of the partnership consisted of certain "qualifying income" (as defined in § 7704(d)), and (2) the partnership would not be described in § 851(a) if the partnership were a domestic corporation.

Section 7704 applies to taxable years beginning after December 31, 1987. However, for any existing partnership (as

defined in § 10211(c)(2) of the Revenue Reconciliation Act of 1987 (1987 Act), 1987-3 C.B. 125), § 7704 applies to taxable years beginning after December 31, 1997. The term "existing partnership" means any partnership that was a publicly traded partnership on December 17, 1987. If a substantial new line of business is added with respect to an existing partnership anytime after December 17, 1987, the grandfather status of the partnership terminates.

Section 7704(g) was enacted as part of the 1997 TRA. Under § 7704(g), an existing 1987 partnership may elect to remain exempt from § 7704(a) by agreeing to pay each taxable year a 3.5 percent tax on gross income from the active conduct of all trades and businesses of the partnership. A publicly traded partnership may make the election under § 7704(g) if: (1) the partnership is an existing partnership (as defined in § 10211(c)(2) of the 1987 Act), (2) § 7704(a) has not applied (and without regard to § 7704(c)(1) would not have applied) to the partnership for all taxable years beginning after December 31, 1987, and before January 1, 1998, and (3) the partnership elects the application of § 7704(g) for its first taxable year beginning after December 31, 1997, and consents to the application of the 3.5 percent tax imposed for each taxable year on gross income from the active conduct of all trades or businesses of the partnership.

PROCEDURAL REQUIREMENTS

To make an election under § 7704(g), a partnership must file with the Memphis Service Center a statement that provides the following: (1) a notification at the top of the statement that an election is being made (that is, "ELECTION UNDER SECTION 7704(g) FILED PURSUANT TO NOTICE 98-3"); (2) the name of the partnership; (3) the federal tax identification number of the partnership; (4) the mailing address of the partnership; (5) the taxable year of the partnership; and (6) a declaration that, pursuant to § 7704(g), the partnership consents to the imposition of a 3.5 percent tax on gross income from the active conduct of all trades and businesses by the partnership.

The statement must be signed by the tax matters partner of the partnership (as defined under § 6231(a)(7)) and must be filed at any time on or before the 75th day

of the first taxable year of the partnership beginning after December 31, 1997. The mailing address for the Memphis Service Center is Internal Revenue Service, Stop 1, 5333 Getwell Road, Memphis, TN 38118.

TAX ON GROSS INCOME

An electing partnership must pay each taxable year a tax of 3.5 percent of the gross income from all active trades and businesses conducted by the partnership. The tax is not deductible by the partnership. Pursuant to § 705(a)(2)(B), a partner of an electing partnership must reduce the adjusted basis of the partner's partnership interest by a proportionate share of the 3.5 percent tax paid by the partnership.

TERMINATION OF ELECTION

If a partnership that elects special treatment under § 7704(g) adds a substantial new line of business after December 31, 1997, the election under § 7704(g) will terminate. The rules concerning a new line of business and the timing of a resulting termination that are set forth in § 1.7704-2 of the regulations will be applied to electing partnerships.

In addition, a partnership may voluntarily terminate its election at any time by filing a notice of revocation. The revocation will be effective as of the date designated in the notice, but not earlier than the date that the notice is filed with the Internal Revenue Service. Once a partnership revokes or otherwise terminates its election under § 7704(g), the election may not be reinstated. If the partnership remains a publicly traded partnership on the date of the termination and does not meet the exception for partnerships with passive-type income contained in § 7704(c), then absent an actual transaction that eliminates the partnership, the conversion from a partnership to a corporation will be determined under § 7704(f).

PROCEDURAL REQUIREMENTS FOR REVOCATION

To make a revocation under § 7704(g), a partnership must file with the Memphis Service Center a statement that provides the following: (1) a notification at the top of the statement that a revocation is being made (that is, "REVOCATION UNDER

SECTION 7704(g) FILED PURSUANT TO NOTICE 98-3"; (2) the name of the partnership; (3) the federal tax identification number of the partnership; (4) the mailing address of the partnership; (5) the taxable year of the partnership; (6) a declaration that, pursuant to § 7704(g), the partnership revokes its election to pay a 3.5 percent tax on gross income from the active conduct of all trades and businesses by the partnership; and (7) the effective date of the revocation. The statement must be signed by the tax matters partner of the partnership (as defined under § 6231(a)(7)).

PARTNERSHIPS THAT DO NOT ELECT

If an existing partnership does not elect the special treatment of § 7704(g), then the partnership will become taxable as a corporation if it (1) remains a publicly traded partnership on the first day of its first taxable year beginning after December 31, 1997, and (2) does not meet the exception for partnerships with passive-type income contained in § 7704(c). Absent an actual transaction that eliminates the partnership, the conversion from a partnership to a corporation will be treated under § 7704(f) as an asset transfer from the partnership to the corporation followed by a liquidation of the partnership.

On October 28, 1997, proposed regulations under § 743 were issued that provide that upon the contribution of assets by a partnership to a corporation, the special § 743 basis accounts are reflected in the basis of the assets in the hands of the corporation. 62 Fed. Reg. 55768, 1997-48 I.R.B. 13. Although these rules are in proposed form, the Service will not challenge a taxpayer's § 7704(f) conversion, or any actual transaction applying the conversion method of § 7704(f) that follows the rules in proposed regulation § 1.743-2, so long as the conversion or transaction occurs prior to the issuance of further guidance on this issue.

DRAFTING INFORMATION

The principal author of this notice is Christopher Kelley of the Office of the Assistant Chief Counsel (Passthroughs and Special Industries). For further information regarding this notice, contact

Christopher Kelley at (202) 622-3080 (not a toll-free number).

Foreign Tax Credit Abuse

Notice 98-5

Treasury and the Internal Revenue Service understand that certain U.S. taxpayers (primarily multinational corporations) have entered into or may be considering a variety of abusive tax-motivated transactions with a purpose of acquiring or generating foreign tax credits that can be used to shelter low-taxed foreign-source income from residual U.S. tax. These transactions generally are structured to yield little or no economic profit relative to the expected U.S. tax benefits, and typically involve either: (1) the acquisition of an asset that generates an income stream subject to foreign withholding tax, or (2) effective duplication of tax benefits through the use of certain structures designed to exploit inconsistencies between U.S. and foreign tax laws. This notice announces that Treasury and the Service will address these transactions through the issuance of regulations as well as by application of other principles of existing law, and requests public comment with respect to these and related foreign tax credit issues.

I. BACKGROUND

United States persons are subject to U.S. income tax on foreign-source as well as U.S.-source income. Subject to applicable limitations, U.S. persons with foreign-source income may credit income taxes imposed by foreign jurisdictions against their U.S. income tax liability on foreign-source income.

Worldwide taxation of U.S. persons coupled with the allowance of a foreign tax credit establishes general tax neutrality between foreign and domestic investment by U.S. taxpayers. A tax system that simply exempts foreign-source income from taxation creates an incentive for citizens and residents to invest overseas in low-taxed jurisdictions. On the other hand, worldwide taxation without a foreign tax credit creates double taxation that distorts investment decisions by inhibiting foreign investment or business activities. The foreign tax credit provisions of

the Code, principally sections 901 through 907 and 960, effectuate Congress's intent to provide relief from double taxation and alleviate these distortions. *American Chicle Co. v. United States*, 316 U.S. 450 (1942); *Burnet v. Chicago Portrait Co.*, 285 U.S. 1 (1932).

In contrast to certain tax credits that are intended to create an incentive for taxpayers to invest in certain activities, such as the research credit under section 41 or the low-income housing credit under section 42, the foreign tax credit is designed to reduce the disincentive for taxpayers to invest abroad that would be caused by double taxation. In other words, the foreign tax credit is intended to preserve neutrality between U.S. and foreign investment and to minimize the effect of tax consequences on taxpayers' decisions about where to invest and conduct business.

Relief from double taxation generally is not calculated separately with respect to each dollar of foreign-source income and tax. The foreign tax credit limitation or "basket" regime of section 904(d) permits, to a limited extent, a credit for foreign tax imposed with respect to income taxed at a rate in excess of the applicable U.S. rate to shelter from U.S. tax income from other, similar investments and activities that are subject to a relatively low rate of tax (the "cross-crediting regime"). Accordingly, the foreign tax credit provisions do not limit credits on an item-by-item basis. Rather, subject to certain restrictions, the provisions permit cross-crediting of foreign taxes imposed with respect to specified groups or types of income as consistent with the interrelated quality of multinational operations of U.S. persons.

Multinational corporations that are subject to relatively low rates of tax on their foreign-source income may be in an excess limitation position. Generally, such taxpayers may properly use credits for foreign taxes imposed on high-taxed foreign income to offset residual U.S. tax on their low-taxed foreign income. Treasury and the Service are concerned, however, that such taxpayers may enter into foreign tax credit-generating schemes designed to abuse the cross-crediting regime and effectively transform the U.S. worldwide system of taxation into a system exempting foreign-source income from residual U.S. tax.

This result is clearly incompatible with the existence of the detailed foreign tax credit provisions and cross-crediting limitations enacted by Congress. No statutory purpose is served by permitting credits for taxes generated in abusive transactions designed to reduce residual U.S. tax on low-taxed foreign-source income. The foreign tax credit benefits derived from such transactions represent subsidies from the U.S. Treasury to taxpayers that operate and earn income in low-tax or zero-tax jurisdictions. The effect is economically equivalent to the tax sparing benefits for U.S. taxpayers that Congress and the Treasury have consistently opposed in the tax treaty context because such benefits are inconsistent with U.S. tax principles and sound tax policy.

II. ABUSIVE ARRANGEMENTS

Treasury and the Service have identified two classes of transactions that create potential for foreign tax credit abuse. The first class consists of transactions involving transfers of tax liability through the acquisition of an asset that generates an income stream subject to foreign gross basis taxes such as withholding taxes. Transactions described in this class may include acquisitions of income streams through securities loans and similar arrangements and acquisitions in combination with total return swaps. In abusive arrangements involving such transactions, foreign tax credits are effectively purchased by a U.S. taxpayer in an arrangement where the expected economic profit from the arrangement is insubstantial compared to the foreign tax credits generated.

The second class of transactions consists of cross-border tax arbitrage transactions that permit effective duplication of tax benefits. Duplicate benefits result when the U.S. grants benefits and, in addition, a foreign country grants benefits (including benefits from a full or partial imputation or exemption system, or a preferential rate for certain income) to separate persons with respect to the same taxes or income. These duplicate benefits generally can result where the U.S. and a foreign country treat all or part of a transaction or amount differently under their respective tax systems. In abusive arrangements involving such transactions, the U.S. taxpayer exploits these inconsistencies where the expected economic

profit is insubstantial compared to the foreign tax credits generated.

The following are examples of abusive arrangements within the scope of this notice.

Example 1

On June 29, 1998, *US*, a domestic corporation, purchases all rights to a copyright for \$75.00. The copyright will expire shortly and the only income expected to be received with respect to the copyright is a royalty payable June 30, 1998. The gross amount of the royalty is expected to be \$100.00. The royalty payment is subject to a 30-percent Country X withholding tax. On June 30, 1998, *US* receives the \$100.00 royalty payment, less the \$30.00 withholding tax. *US* reasonably expects to incur a \$5.00 economic loss (having paid \$75.00 for the right to receive a \$70.00 net royalty payment), but expects to acquire a \$30.00 foreign tax liability. In this example, *US* has effectively purchased foreign tax credits in a transaction that was reasonably expected to result in an economic loss.

Example 2

On June 29, 1998, *US*, a domestic corporation, purchases a foreign bond for \$1096.00 (including accrued interest). The foreign bond provides for annual interest payments of \$100.00 payable June 30 of each year. The interest payments are subject to a 4.9-percent Country X withholding tax. On June 30, 1998, *US* receives a \$95.10 interest payment on the bond (net of a \$4.90 Country X withholding tax). On July 4, 1998, *US* sells the bond for \$1001.05. Because the value of the bond is not reasonably expected to appreciate due to market factors, *US* reasonably can expect only a \$0.15 economic profit (the \$1001.05 sales price and the \$95.10 net interest coupon, less the \$1096.00 purchase price) and expects to acquire a \$4.90 foreign tax liability. In this example, *US* has effectively purchased foreign tax credits in a transaction with respect to which the reasonably expected economic profit is insubstantial in relation to expected U.S. foreign tax credits. No implication is intended as to whether the interest described in this example will constitute high withholding tax interest under section 904(d)(2)(B).

Example 3

F, an entity that does not receive a tax benefit from foreign tax credits, wishes to acquire a foreign bond with a value of \$1000.00 that provides for annual interest payments of \$100.00. The interest payments are subject to a 4.9-percent Country X withholding tax. Instead of purchasing the bond, *F* invests its \$1000.00 elsewhere and enters into a three-year notional principal contract (NPC) with *US*, an unrelated domestic corporation. Under the terms of the NPC, *US* agrees to make an annual payment to *F* equal to \$96.00 and *F* agrees to make an annual payment to *US* equal to the product of \$1000.00 and a rate calculated based on LIBOR. In addition, the parties agree that, upon termination of the NPC, *US* will make a payment to *F* based on the appreciation, if any, in the value of the foreign bond, and *F* will make a payment to *US* based on the depreciation, if any, in the value of the foreign bond.

In order to hedge its obligations under the NPC, *US* purchases the bond for \$1000.00. Assume that, in connection with the purchase of the foreign bond, *US* incurs or maintains an additional \$1000.00 of borrowing at an interest rate equal to the LIBOR-based rate provided for in the NPC.

At the time *US* enters into this arrangement, *US* reasonably expects to incur an annual \$0.90 economic loss each year under the arrangement (the \$95.10 net interest payment on the bond plus the LIBOR-based amount received from *F* under the NPC, less the sum of the \$96.00 payment to *F* under the NPC and the LIBOR-based amount associated with the \$1000.00 borrowing incurred or maintained in order to acquire the foreign bond). In this example, *US* has effectively purchased foreign tax credits in a transaction that was reasonably expected to result in an economic loss.

Example 4

US, a domestic corporation, forms *N*, a Country X corporation, by contributing \$10.00 to the capital of *N* in exchange for the only share of *N* common stock. *N* borrows \$90.00 from *F*, a Country X individual unrelated to *US*, at an annual interest rate of 7.5 percent, and *N* purchases preferred stock of an unrelated party with a par value of \$100.00 or a bond with a face amount of \$100.00. *US* reasonably expects the preferred stock or bond to pay dividends or interest at an annual rate of 10 percent. Alternatively, rather than purchasing preferred stock or the bond, *N* lends \$100.00 to *US* at an annual interest rate of 10 percent.

Country X treats the *F* loan as an equity investment and does not allow a deduction for *N*'s interest expense. Country X imposes an individual income tax and a corporate income tax of 30 percent. Country X thus is expected to impose a \$3.00 corporate income tax each year on *N*. Country X has an imputation system, under which dividends from Country X corporations are excluded from the gross income of Country X individuals. (A similar result could be achieved if the dividends are wholly or partially exempt from Country X tax due to a consolidated return or group relief regime, a dividend-received deduction, or an imputation credit.)

At the time *US* enters into this arrangement, *US* reasonably expects that *N* will have annual earnings and profits of \$0.25 (\$10.00 dividend or interest income from the preferred stock or bond (or \$10.00 interest income from the loan to *US*), less \$6.75 interest expense and \$3.00 foreign tax liability). *US* expects that each year *N* will pay a \$0.25 dividend to *US* and *US* will claim a \$3.00 foreign tax credit for taxes deemed paid under section 902. In this example, *US* has entered into an arrangement to exploit the inconsistency between U.S. and Country X tax laws in order to generate foreign tax credits in a transaction with respect to which the reasonably expected economic profit is insubstantial in relation to expected U.S. foreign tax credits.

Example 5

US, a domestic corporation, forms *N*, a Country X entity. *US* contributes \$100.00 to the capital of *N* in exchange for a 100-percent ownership interest. *N* borrows \$900.00 from *F*, an unrelated Country X corporation, at an annual interest rate of 8 percent, and *N* purchases preferred stock of an unrelated

party with a par value of \$1000.00 that *US* reasonably expects to pay dividends at an annual rate of 10 percent. The dividends are subject to a Country Y 25-percent withholding tax.

Country X treats the *F* loan as an equity investment in *N* and treats *N* as a partnership. Consequently, *F* claims a foreign tax credit in Country X for 90 percent of the withholding tax paid by *N*. Under U.S. law, the *F* loan is respected as debt, and *N* is disregarded as a separate entity (a partnership with only one partner). See Reg. § 301.7701-3(a) and § 301.7701-3(b)(2)(C). Thus, *US* claims a U.S. foreign tax credit for the taxes paid by *N* and the tax benefit of the foreign taxes paid by *N* are effectively duplicated.

At the time *US* enters into this arrangement, *US* reasonably expects an annual profit of \$3.00 (\$100.00 dividend income, less \$72.00 interest expense and \$25.00 foreign tax liability) and an annual foreign tax credit of \$25. In this example, *US* has entered into an arrangement to exploit the inconsistency between U.S. and Country X tax laws in order to generate foreign tax credits in a transaction with respect to which the reasonably expected economic profit is insubstantial in relation to expected U.S. foreign tax credits.

III. REGULATIONS TO BE ISSUED PURSUANT TO THIS NOTICE

Regulations will be issued to disallow foreign tax credits for taxes generated in abusive arrangements such as those described in Part II above. These regulations will be issued under the authority of some or all of the following sections of the Internal Revenue Code of 1986: section 901, section 901(k)(4), section 904, section 864(e)(7), section 7701(l), and section 7805(a).

In general, these regulations will disallow foreign tax credits in an arrangement such as those described in Part II above from which the reasonably expected economic profit is insubstantial compared to the value of the foreign tax credits expected to be obtained as a result of the arrangement. The regulations will emphasize an objective approach to calculating expected economic profit and credits, and will require that the determination of expected economic profit reflect the likelihood of realizing both potential gain and potential loss (including loss in excess of the taxpayer's investment). Thus, under the regulations, expected economic profit will be determined without regard to executory financial contracts (*e.g.*, a notional principal contract, forward contract, or similar instrument) that do not represent a real economic investment or potential for profit or that are not properly treated as part of the arrangement. Fur-

ther, the regulations will require that expected economic profit be determined over the term of the arrangement, properly discounted to present value.

It is expected that the regulations in general and any test relying on a comparison of economic profit and credits in particular would be applied to discrete arrangements. The utility of a test comparing profits and credits depends upon the proper delineation of the arrangement to be tested. If necessary to effectuate the purposes of the regulations, a series of related transactions or investments may be treated as a single arrangement or portions of a single transaction or investment may be treated as separate arrangements. The proper grouping of transactions and investments into arrangements will depend on all relevant facts and circumstances.

For example, a series of transactions involving a purchase and resale might be treated as a single arrangement. Similarly, an investment together with related hedging and financing transactions, *e.g.*, a borrowing, an investment, and an asset swap designed to limit the taxpayer's economic exposure with respect to the investment, might be treated as a single arrangement. In addition, if a controlled foreign corporation, as part of its business, enters into a buy-sell transaction involving a debt instrument, that buy-sell transaction could be treated as a separate arrangement.

In general, reasonably expected economic profit will be determined by taking into account foreign tax consequences (but not U.S. tax consequences). However, it is inappropriate in the context of the U.S. foreign tax credit system to allow foreign tax credits with respect to abusive arrangements simply because the arrangements generate substantial foreign tax savings. Accordingly, the regulations will provide that the calculation of expected economic profit will not include expected foreign tax savings attributable to a tax credit or similar benefit allowed by a foreign country with respect to a tax paid to another foreign country.

In general, expected economic profit will be determined by taking into account expenses associated with an arrangement, without regard to whether such expenses are deductible in determining taxable income. For example, in determining eco-

nomical profit, foreign taxes will be treated as an expense. In addition, interest expense (and similar amounts, including borrowing fees, "in lieu of" payments, forward contract payments, and notional principal contract payments) generally will be taken into account in determining expected economic profit only to the extent that the indebtedness or contract giving rise to the expense is part of the arrangement.

In addition, the regulations will provide special rules that will operate to deny credits for foreign taxes generated in abusive arrangements involving asset swaps or other hedging devices (including rules that allocate interest expense to an arrangement in certain cases other than pursuant to a tracing approach). For example, an arrangement involving a purchase of a foreign security coupled with an asset swap that is designed to hedge substantially all of the taxpayer's risk of loss with respect to the security for the duration of the arrangement generally will constitute an abusive foreign tax credit arrangement even if the taxpayer has not incurred indebtedness for the specific purpose of acquiring the asset. However, the regulations will not treat arrangements involving debt instruments as abusive solely because the taxpayer diminishes its risk of interest rate or currency fluctuations, unless the taxpayer also diminishes its risk of loss with respect to other risks (*e.g.*, creditor risk) for a significant portion of the taxpayer's holding period. See Part VI of this notice for additional rules for portfolio hedging strategies and partial hedges.

Under the foregoing principles, the regulations will not disallow foreign tax credits merely because income from the arrangement is subject to a high foreign tax rate. Treasury and the Service anticipate that credits for taxes paid to a high-tax jurisdiction will not be subject to disallowance under the regulations absent other indicia of abuse.

The regulations generally will not disallow a credit for withholding taxes on dividends if the holding period requirement of section 901(k) is satisfied. However, the regulations will operate to determine whether foreign tax credits with respect to cross-border tax arbitrage arrangements (as described in Part II, above) will be disallowed, even if such

credits arise with respect to withholding taxes on dividends and the section 901(k) holding period is satisfied. In addition, the regulations generally will apply to determine whether credits should be disallowed with respect to qualified taxes (as defined in section 901(k)(4)(B)) that are not subject to the general section 901(k) holding period rule. For example, the regulations may disallow credits with respect to gross basis taxes paid or accrued with respect to certain arrangements involving equity swaps and equity buy-sell transactions entered into by securities dealers even if such credits would not have been disallowed under section 901(k) pursuant to section 901(k)(4). See section 901(k)(4)(C).

IV. EFFECTIVE DATE OF REGULATIONS ISSUED PURSUANT TO THIS NOTICE

The regulations to be issued with respect to arrangements of the kind described in Part II above generally will be effective with respect to taxes paid or accrued on or after December 23, 1997, the date this notice was issued to the public. The effective date of the regulations issued pursuant to this notice, however, will not limit the application of other principles of existing law to determine the proper tax consequences of the structures or transactions addressed in the regulations.

V. IRS COORDINATION PROCEDURES

The Service intends to carefully examine foreign tax credits claimed in arrangements of the type described in Part II to determine whether such credits should be disallowed under existing law even without application of the regulations to be issued pursuant to this notice. The Service plans to establish early coordination procedures utilizing foreign tax credit experts in the National Office and the International Field Assistance Specialization Program to assist examining agents in analyzing these transactions. These coordination procedures will continue in effect following issuance of the regulations to ensure uniform and appropriate application of the regulations by examining agents.

VI. OTHER FOREIGN TAX CREDIT GUIDANCE

Treasury and the Service are considering issuing other guidance to ensure that foreign tax credits are allowed to U.S. taxpayers in a manner consistent with the overall structure of the Code and the intent of Congress in enacting the credit. For example, Treasury and the Service are considering issuing additional regulations under section 904(d)(2)(B)(iii) to address abusive transactions involving high withholding taxes. Treasury and the Service are also considering whether additional approaches may be necessary to identify abuses in the case of foreign gross basis taxes generally.

In addition, Treasury and the Service are considering various approaches to address structures (including hybrid entity structures) and transactions intended to create a significant mismatch between the time foreign taxes are paid or accrued and the time the foreign-source income giving rise to the relevant foreign tax liability is recognized for U.S. tax purposes. For such structures and transactions, Treasury and the Service are considering either deferring the tax credits until the taxpayer recognizes the income, or accelerating the income recognition to the time at which the credits are allowed (*e.g.*, by allocating the credits or the income under section 482).

Finally, Treasury and the Service are concerned about credits claimed in transactions described in Part II above, with respect to assets or income streams that are hedged pursuant to portfolio hedging strategies and with respect to hedges entered into with respect to assets or income streams that the taxpayer holds without diminished risk of loss for a significant period of time.

In general, regulations addressing these other foreign tax credit issues will be effective no earlier than the date on which proposed regulations (or other guidance such as a notice) describing the tax consequences of the arrangements are issued to the public. The effective date of any such regulations will not, however, affect the application of other principles of existing law to determine the proper tax consequences of the structures or transactions addressed in the regulations.

VII. COMMENTS

Comments are requested on the matters discussed in this notice. Written comments may be submitted to the Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Attention: CC:DOM:CORP:R (Notice 98-5), Room 5226, Washington DC 20044. Submissions may be hand delivered between the hours of 8 a.m. and 5 p.m. to CC:DOM:CORP:R (Notice 98-5), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue NW, Washington DC. Alternatively, taxpayers may submit comments directly to the IRS Internet site at http://www.irs.ustreas.gov/prod/tax_regs/comments.html. Comments will be available for public inspection and copying.

For further information regarding this notice, contact Seth Goldstein or Rebecca Rosenberg of the Office of Associate Chief Counsel (International) at 202-622-3850 (not a toll-free call).

Qualified Funeral Trusts

Notice 98-6

PURPOSE

Section 1309 of the Taxpayer Relief Act of 1997, Pub. L. No. 105-34, 111 Stat. 788 (the Act) added § 685 of the Internal Revenue Code to permit certain trusts to elect Qualified Funeral Trust (QFT) status. This notice provides guidance on QFT eligibility requirements, election procedures, and simplified reporting requirements.

BACKGROUND

A pre-need funeral trust arises from an arrangement where funeral merchandise or services are purchased from a seller to benefit a specified beneficiary before the beneficiary's death. A pre-need cemetery merchandise trust arises from an arrangement where cemetery merchandise or services are purchased from a seller to benefit a specified beneficiary before the beneficiary's death. The purchaser enters into a contract with the seller of the funeral or cemetery merchandise or services whereby the purchaser selects the merchandise and services to be provided upon the death of the beneficiary, and agrees to

pay for them before the beneficiary's death. Under state law, such amounts (or a portion thereof) are required to be held in trust during the beneficiary's lifetime and are paid to the seller upon the beneficiary's death.

Rev. Rul. 87-127, 1987-2 C.B. 156, addresses the taxation of pre-need funeral trusts. The ruling provides four situations under which funeral trusts are formed and concludes that in all four situations the trust is a grantor trust and the purchaser is treated for federal tax purposes as the owner of the trust. Any amount that a seller receives from the trust (as payment for services or merchandise) is includible in the gross income of the seller.

Section 685 permits the trustees of certain pre-need trusts to elect QFT status on behalf of the trusts. If the election is made, a trust is not treated as a grantor trust and the purchaser would not be subject to tax on trust income. The trustee is liable for the tax on the taxable income of the trust as determined in accordance with the income tax rate schedule generally applicable to estates and trusts. However, the personal exemption deduction under § 642(b) is unavailable.

QFT ELIGIBILITY REQUIREMENTS

Section 685(b) defines a QFT as any trust (other than a foreign trust) if—(1) the trust arises as a result of a contract with a person engaged in the trade or business of providing funeral or burial services or property necessary to provide such services, (2) the sole purpose of the trust is to hold, invest and reinvest funds in the trust and to use the funds solely to make payments for those services or property for the benefit of the beneficiaries of the trust, (3) the only beneficiaries of the trust are individuals with respect to whom those services or property are to be provided at their death under contracts described in item (1), (4) the only contributions to the trust are contributions by or for the benefit of those beneficiaries, (5) the trustee elects the application of this subsection, and (6) the trust would, but for this election, be treated as owned under subpart E (the grantor trust provisions) by the purchasers of the contracts.

Pre-need cemetery merchandise trusts are substantially similar to pre-need funeral trusts and therefore the analysis in

Rev. Rul. 87-127 applies to them. Pre-need funeral trusts and pre-need cemetery merchandise trusts that meet one of the situations under Rev. Rul. 87-127 are grantor trusts and the purchasers of the contracts giving rise to the trusts are the owners of the trusts. Accordingly, these trusts may elect to be treated as QFTs if they meet the other QFT requirements under § 685.

A QFT cannot accept aggregate contributions by or for the benefit of an individual in excess of \$7,000 (contribution limit). Section 685(c)(1). Section 685(c)(2) provides that for purposes of § 685(c)(1), all trusts having trustees that are related persons shall be treated as 1 trust. Persons are related if (A) the relationship between the persons is described in §§ 267 or 707(b), (B) the persons are treated as a single employer under subsection (a) or (b) of § 52, or (C) the Secretary determines that treating the persons as related is necessary to prevent avoidance of the purposes of this section. The \$7,000 contribution limit is adjusted annually for inflation for any contracts entered into after calendar year 1998. Section 685(c)(3).

A trust is deemed to exceed the contribution limit under § 685(c) if the trust is determined, over the anticipated life of the trust, to receive projected contributions (based upon existing contributions, the applicable state law trust contribution requirements, and any expected contributions in excess of the state law requirements) that exceed the contribution limit. The determination is made at the inception of the trust and is made again when the amount of the projected contributions used in the previous determination changes. For example, a trust that is determined at its inception to exceed the contribution limit during the life of the trust will be deemed to exceed the contribution limit at inception. However, a trust that is determined at its inception not to exceed the contribution limit but exceeds the contribution limit in a future year, due to a change in projected contributions, will be deemed to exceed the contribution limit at the time of the change in projected contributions. A trust loses its QFT status at the time that it is deemed to exceed the contribution limit.

If a QFT has multiple beneficiaries, the contribution limit will apply separately to each beneficiary. A QFT that has multiple

beneficiaries will be taxed as if each beneficiary's interest in the QFT is a separate trust. Each beneficiary's share of the total contributions to a trust and share of the trust's income is determined in accordance with the beneficiary's interest in the trust; a beneficiary's interest in a trust may be determined under any reasonable method.

QFT ELECTION PROCEDURES

A trustee may elect QFT status for trusts that meet the requirements of QFTs under § 685 for taxable years ending after August 5, 1997. Therefore, trusts existing prior to August 5, 1997, and trusts created after August 4, 1997, may elect QFT status. The filing of Form 1041-QFT is treated as the election. The election must be filed no later than the due date, with extensions, for filing the trust income tax return for the year of election. The election applies to each trust reported in the QFT return.

A trustee need not elect QFT status for the trust's first eligible year; even if no election is made for the first eligible year, a QFT election may be made for subsequent tax years. A QFT election, once made, cannot be revoked without the consent of the Commissioner.

Under both § 685 and Rev. Rul. 87-127, amounts received by the seller from a trust are treated as payments for services and merchandise and are includible in the gross income of the seller in the taxable year received or properly accrued under the seller's method of accounting. In the case where a seller was not reporting income in accordance with Rev. Rul. 87-127, for example, where a seller improperly reported investment income in the taxable year it was earned by the trust rather than the purchaser reporting such income, a duplication of income may result from an election under § 685. The Service is continuing to study this issue.

SIMPLIFIED QFT REPORTING REQUIREMENTS

A trustee of a QFT is required to file a trust return on behalf of the QFT. The proper form to file is Form 1041-QFT. A trustee may file one aggregate Form 1041-QFT for all of its QFTs and should follow the instructions associated with that form.

REQUESTS FOR COMMENTS

The Treasury and the Service invite comments from the public on issues that may arise in implementing § 685. Send written comments to the following address:

Internal Revenue Service
CC:DOM:CORP (NT 98-6;
CC:DOM:P&SI:1)
P.O. Box 7604, Ben Franklin Station
Washington, DC 20044

Alternatively, send written comments electronically via the Internet to the IRS Internet site at http://www.irs.ustreas.gov/prod/tax_regs/comments.html. Please identify the comments as relating to this Notice.

DRAFTING INFORMATION

The principal author of this notice is Daniel J. Coburn of the Office of Assistant Chief Counsel (Passthroughs and Special Industries). For further information regarding this notice contact Mr. Coburn at (202) 622-3050 (not a toll-free call).

Returns Relating to Interest on Education Loans

Notice 98-7

PURPOSE

This notice describes the information reporting requirements for 1998 under § 6050S of the Internal Revenue Code (as enacted by the Taxpayer Relief Act of 1997, Pub. L. No. 105-34, § 202(c), 111 Stat. 804 (the Act)) that apply to certain persons who receive payments of interest that may be deductible as qualified education loan ("student loan") interest. The Treasury Department intends to issue regulations on the information reporting required under § 6050S. Pending the issuance of those regulations, this notice describes who must report information with respect to payments of student loan interest, and the nature of the information that will be required under § 6050S for 1998.

For 1998, payees are required to report interest received only with respect to student loans that have a "covered period" (described below) ending during or after 1998. Comments are requested regarding

the student loan interest reporting requirements that should apply for future years. The Internal Revenue Service will issue additional guidance on the student loan interest that a taxpayer may deduct, including further guidance for determining whether a taxpayer has made a payment of interest on a student loan during the first 60 months in which interest payments are required.

BACKGROUND

A. The Student Loan Interest Deduction.

Section 202(a) of the Act added § 221 to the Code. Section 221 allows certain taxpayers who pay interest on qualified education loans to claim a federal income tax deduction for their interest payments, regardless of whether they itemize other deductions.

A qualified education loan is a loan used to pay the costs of attendance at an eligible educational institution for a student enrolled at least half-time in a program leading to a degree, certificate, or other recognized educational credential. The student must be the taxpayer, the taxpayer's spouse, or the taxpayer's dependent at the time the loan was taken. A loan made by an individual who is related to the borrower, within the meaning of § 267(b) or § 707(b)(1), is not a qualified education loan.

An eligible educational institution is any college, university, vocational school, or other postsecondary educational institution that is described in § 481 of the Higher Education Act of 1965 (20 U.S.C. 1088) and, therefore, is eligible to participate in the student aid programs administered by the Department of Education. This category includes virtually all accredited public, nonprofit, and proprietary postsecondary institutions. For purposes of the student loan interest deduction, eligible educational institutions also include institutions that conduct an internship or residency program leading to a degree or certificate awarded by an institution of higher education, a hospital, or a health care facility that offers postgraduate training.

Costs of attendance are generally the same as those described in § 472 of the Higher Education Act for purposes of calculating a student's financial need (*e.g.*,

tuition, fees, room, board, books, equipment, and other necessary expenses, such as transportation). However, for purposes of the student loan interest deduction, costs of attendance are reduced by educational assistance that the student receives and excludes from gross income under § 127, 135, 530, or as a scholarship.

The student loan interest deduction is available only for interest payments made during the first 60 months, whether or not consecutive, in which interest payments are required on the loan. Notice 97-60, 1997-46 I.R.B. 8, provides additional information about the student loan interest deduction.

B. Information Reporting Relating to Student Loan Interest.

Section 6050S(a) requires information reporting by any person engaged in a trade or business who, in the course of that trade or business, receives from any individual interest aggregating \$600 or more for any calendar year on 1 or more qualified education loans.

Section 6050S(b) provides that the return of information must be in the form prescribed by the Secretary and contain:

(1) the name, address, and taxpayer identification number (TIN) of the individual with respect to whom interest was received,

(2) the name, address, and TIN of any individual certified by the individual named in the first item as the taxpayer who will claim that individual as a dependent for purposes of the deduction under § 151 for any taxable year ending with or within the year for which the information return is filed,

(3) the aggregate amount of interest received for the calendar year with respect to the individual named in the first item, and

(4) such other information as the Secretary may prescribe.

Section 6050S(c) states that information reporting is required by governmental units or any agency or instrumentality thereof. The return required by the governmental entity must be made by the officer or employee appropriately designated for the purpose of making the return.

Section 6050S(d) provides that every person required to make an information return under § 6050S(a) must also furnish to each individual whose name is required

to be included in the return a written statement showing the name, address, and phone number of the reporting person's information contact, and the aggregate amounts required to be included in the return.

Section 6050S(f) provides that, in the case of any amount received on behalf of another person, only the person first receiving the amount is required to make the return under § 6050S. Thus, where more than one person has a connection with a qualified education loan, the person first receiving the payment of interest, such as a loan servicer or collection agent receiving payments on behalf of the lender, is required to file an information return regarding the interest received on the loan.

DISCUSSION

A. Definitions.

The following definitions apply to these terms for purposes of this notice:

(1) *Payee*. A payee is the person first receiving one or more interest payments on a student loan.

(2) *Payor*. A payor is the individual with respect to whom interest payments are received on a particular student loan.

(3) *Consolidated Loan*. A consolidated loan is a single loan refinancing more than one student loan.

(4) *Collapsed Loan*. A collapsed loan is a set of loans of a single payor treated as a single loan for loan servicing purposes.

(5) *Defaulted Loan*. A defaulted loan is a loan with respect to which required payments of interest and principal have not been made when due over a period of time such that the holder has declared the loan in default based on its terms and conditions, and, if applicable, sought recourse against the ultimate guarantor of the loan.

(6) *Covered Period*. For loans other than consolidated loans, collapsed loans, and defaulted loans, the covered period begins on:

(a) the date on which the loan went into repayment status if the payee knows or has reason to know that date; or

(b) January 1, 1998, if the payee does not know and does not have reason to know that date.

For consolidated loans and collapsed loans, the covered period begins on:

(a) the most recent date on which any of the loans subject to consolidation or collapse went into repayment status, if the payee knows or has reason to know that date; or

(b) January 1, 1998, if the payee does not know and does not have reason to know that date.

For defaulted loans, the covered period begins on:

(a) the date the loan went into repayment status if the payee knows or has reason to know that date;

(b) the date the loan went into default, if the payee knows or has reason to know that date and does not know or have reason to know the date the loan went into repayment status; or

(c) January 1, 1998, if the payee does not know and does not have reason to know the dates the loan went into repayment status or default.

The covered period ends on the date that is 60 months after the date on which the period starts or, if later, the last day of the month in which that 60-month date occurs. However, if the payee knows or has reason to know of any periods of grace, deferment, or forbearance during the covered period, the covered period is extended by the number of months the loan was subject to grace, deferment, or forbearance.

(7) *Covered Student Loan*. A covered student loan is a loan with a covered period ending during or after 1998 that is either:

(a) subsidized, guaranteed, financed, or otherwise treated as a student loan under a program of the federal, state, or local government or an institution of postsecondary education, or

(b) certified by the payor as a student loan.

B. Who Must File for 1998.

Payees who receive interest aggregating \$600 or more during 1998 with respect to a single payor on one or more covered student loans must file an information return with respect to that interest.

C. Information Required for 1998.

Payees required under this notice to file information returns for 1998 must properly complete Form 1098-E, Student Loan Interest Statement, for all student loan accounts that contain one or more

covered student loans ("student loan account"). A payee may file a separate Form 1098-E for each student loan account of the payor, or a single Form 1098-E for all student loan accounts of the payor.

For 1998, a properly completed Form 1098-E filed with the Service must include:

(1) the name, address, and TIN of the payee;

(2) the name, address, and TIN of the payor; and

(3) the aggregate amount of interest received during 1998 with respect to the student loans in the account or accounts included on the return.

D. Mixed Use Loans and Revolving Accounts.

Payments of interest made on or after January 1, 1998, on mixed use loans or revolving accounts, such as credit card accounts, are treated as interest paid with respect to a student loan (and must be reported as such) only if the mixed use loan or revolving account is certified to be, in part, a student loan, and the payee has a reasonable method for allocating the interest payments to the part of loan that is certified to be a student loan.

E. Coordination with Reporting on Payments of Mortgage Interest.

If, for a year before 1998, a payee treated a loan as a mortgage within the definition of § 6050H(e) for purposes of the information reporting required under § 6050H, the payee must continue to treat the loan as a mortgage for information reporting purposes, even if all or part of the loan is used to pay costs of attendance.

For loans made on or after January 1, 1998, the payee must treat loans secured by real property and not made exclusively to acquire or improve real property as either mortgages or student loans in accordance with the certification provided by the payor. Thus, if a payor certifies all of a loan secured by real property and made on or after January 1, 1998, as a student loan, the payee must treat the entire loan as a student loan and not as a mortgage for purposes of information reporting. If the payor certifies part of a loan as a student loan, only the certified portion of the loan may be treated as a student loan for purposes of information reporting. For

loans made on or after January 1, 1998, the payee must treat a loan secured by real property and made exclusively to acquire or improve real property as a mortgage and provide information returns as required by § 6050H. The regulations under § 6050H will be amended to be consistent with this rule.

F. *When To File.*

The information returns required under § 6050S for 1998 must be sent to the Service by March 1, 1999.

G. *Manner of Filing.*

The regulations under § 6011 will be amended to require any person required to file 250 or more Forms 1098-E for 1998 to file those returns by magnetic media or electronically. Additional guidance will be provided on how to file by magnetic media or electronically.

H. *Statements To Be Provided to Payors.*

The payee must provide each payor a statement containing the same information that is provided to the Service on the information return required by § 6050S. In addition, the statement provided to the payor must contain a phone number for the individual serving as information contact of the payee. The statement must also notify the payor that the amount of interest reported as paid may differ from the amount of interest that the payor may be able to claim as a deduction. The statement must be provided to the payor by February 1, 1999. The statement may be a copy of Form 1098-E (or an acceptable substitute statement).

I. *Collecting Information.*

The Service is developing an optional Form W-9S for use in collecting information for the purpose of complying with § 6050S. The payee will be able to use the form to collect the information necessary to meet the information reporting requirements of § 6050S. The information can be collected on paper or on an electronic version of Form W-9S (or an acceptable substitute). The payee also may collect the necessary information by using its own forms and procedures.

J. *Waiver of Penalties.*

The Treasury Department intends to issue regulations under § 6050S, and modify the regulations under § 6050H, to provide guidance on how payees are to comply with the requirements of the statute. Until the regulations are adopted, no penalties will be imposed under §§ 6721 and 6722 for failure to file correct information returns with the Service or to furnish correct statements to the payors with respect to whom information reporting is required under § 6050S (or § 6050H for those loans secured by real property the proceeds from which are used to pay the costs of postsecondary education). Furthermore, even after the regulations are adopted, no penalties will be imposed under §§ 6721 and 6722 for failure to file correct information returns or furnish correct statements for 1998 as required by § 6050S or § 6050H if the payee made a good faith effort to file information returns and furnish statements in accordance with this notice.

K. *Request for Comments.*

The Conference Report accompanying the Act states the following, "The conferees expect that the Secretary of Treasury will issue regulations setting forth reporting procedures that will facilitate the administration of this provision. Specifically, such regulations should require lenders separately to report to borrowers the amount of interest that constitutes deductible student loan interest (*i.e.*, interest on a student loan during the first 60 months in which interest payments are required). In this regard, the regulations should include a method for borrower certification to a lender that the loan proceeds are being used to pay for qualified higher education expenses." H.R. Conf. Rep. No. 220, 105 Cong., 1st Sess. at 368 (1997). Treasury and the Service invite taxpayers to submit comments on how regulations could be drafted in accordance with the legislative history. In particular, comments are requested on how parties receiving interest are to determine whether a payment of interest on a student loan has been made during the first 60 months in which interest payments are required and on how much of a payment should be treated as interest, especially

where interest has been capitalized. Comments are requested by April 30, 1998. An original and eight copies of written comments should be sent to:

Internal Revenue Service
Attn: CC:DOM:CORP:R
Room 5228 (IT&A:Br1)
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044,

or hand delivered between the hours of 8:00 a.m. and 5:00 p.m. to:

Courier's Desk
Internal Revenue Service
Attn: CC:DOM:CORP:R
Room 5228 (IT&A:Br1)
1111 Constitution Ave., NW
Washington, DC

Alternatively, taxpayers may submit comments electronically via the Internet by selecting the "Tax Regs" option on the IRS Home Page, or by submitting comments directly to http://www.irs.ustreas.gov/prod/tax_regs/comments.html (the IRS Internet site). All comments will be available for public inspection and copying in their entirety.

DRAFTING INFORMATION

The principal author of this notice is John McGreevy of the Office of the Assistant Chief Counsel (Income Tax and Accounting). For further information regarding information reporting, contact Mr. McGreevy on (202) 622-4910 (not a toll-free call) or, regarding the deduction, call John Moriarty on (202) 622-4950 (not a toll-free call).

26 CFR 601.601: Rules and regulations.
(Also Part I, § 1397E)

Rev. Proc. 98-9

SECTION 1. PURPOSE

This revenue procedure sets forth the maximum face amount of Qualified Zone Academy Bonds ("Bond" or "Bonds") that may be issued for each State during 1998. For this purpose "State" includes the District of Columbia and the possessions of the United States.

SECTION 2. BACKGROUND

Section 226 of the Tax Relief Act of 1997, Pub. L. 105-34, 111 Stat. 788

(1997), added § 1397E to the Internal Revenue Code to provide a credit to holders of Bonds under certain circumstances so that the Bonds generally can be issued without discount or interest. Ninety-five percent of Bond proceeds are to be used for qualified purposes, as defined by § 1397E(d)(5), with respect to a qualified zone academy, as defined by § 1397E(d)(4).

The aggregate amount of Bonds that may be issued for the States is limited to \$400 million for 1998 and \$400 million for 1999 (the “national limitation”). This amount is to be allocated among the

States by the Secretary on the basis of their respective populations below the poverty level (as defined by the Office of Management and Budget). This amount is further allocated by the State to qualified zone academies within the State or possession. A State may carry forward to the next calendar year any amount of an allocation of the national limitation for a calendar year that is in excess of the amount of Bonds issued during that calendar year that are designated with respect to qualified academies within the State.

SECTION 3. SCOPE

This revenue procedure applies to Bonds issued under § 1397E during 1998.

SECTION 4. NATIONAL QUALIFIED ZONE ACADEMY BOND LIMITATION FOR 1998

The total face amount of Bonds that may be issued in 1998 is \$400 million. This amount is allocated among the States as follows:

STATE	MAXIMUM FACE AMOUNT OF BONDS THAT MAY BE ISSUED DURING 1998 (thousands of dollars)
ALABAMA	\$6,128
ALASKA	556
ARIZONA	10,094
ARKANSAS	4,625
CALIFORNIA	56,360
COLORADO	4,243
CONNECTICUT	4,037
DELAWARE	649
DISTRICT OF COLUMBIA	1,339
FLORIDA	20,981
GEORGIA	11,299
HAWAII	1,463
IDAHO	1,442
ILLINOIS	14,718
INDIANA	4,408
IOWA	2,874
KANSAS	2,956
KENTUCKY	6,777
LOUISIANA	8,992
MAINE	1,390
MARYLAND	5,376
MASSACHUSETTS	6,406
MICHIGAN	11,000
MINNESOTA	4,717
MISSISSIPPI	5,922
MISSOURI	5,150
MONTANA	1,596
NEBRASKA	1,741

STATE	MAXIMUM FACE AMOUNT OF BONDS THAT MAY BE ISSUED DURING 1998 (thousands of dollars)
NEVADA	1,370
NEW HAMPSHIRE	752
NEW JERSEY	7,478
NEW MEXICO	4,861
NEW YORK	31,497
NORTH CAROLINA	9,115
NORTH DAKOTA	711
OHIO	14,667
OKLAHOMA	5,727
OREGON	3,934
PENNSYLVANIA	14,152
RHODE ISLAND	1,071
SOUTH CAROLINA	4,964
SOUTH DAKOTA	845
TENNESSEE	9,043
TEXAS	32,753
UTAH	1,576
VERMONT	762
VIRGINIA	8,188
WASHINGTON	6,860
WEST VIRGINIA	3,327
WISCONSIN	4,738
WYOMING	597
AMERICAN SAMOA	350
GUAM	227
NORTHERN MARIANAS	268
PUERTO RICO	22,659
VIRGIN ISLANDS	268

SECTION 6. EFFECTIVE DATE

This revenue procedure applies to Bonds issued after December 31, 1997.

DRAFTING INFORMATION

The principal author of this revenue procedure is Timothy L. Jones of the Office of Assistant Chief Counsel (Financial

Institutions & Products). For further information regarding this revenue procedure contact Mr. Jones on (202) 622-3980 (not a toll free call).

Part IV. Items of General Interest

Notice of Proposed Rulemaking

Deposits of Excise Taxes

REG-102894-97

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking by cross-reference to temporary regulations.

SUMMARY: In T.D. 8740, page 4, the IRS is issuing temporary regulations relating to deposits of excise taxes. The temporary regulations contain rules relating to the availability of the safe harbor deposit rule based on look-back quarter liability and to floor stocks taxes. The text of those temporary regulations also serves as the text of these proposed regulations.

DATES: Written comments and requests for a public hearing must be received by March 30, 1998.

ADDRESSES: Send submissions to: CC:DOM:CORP:R (REG-102894-97), room 5226, Internal Revenue Service, POB 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand delivered between the hours of 8 a.m. and 5 p.m. to: CC:DOM:CORP:R (REG-102894-97), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue NW, Washington, DC. Alternatively, taxpayers may submit comments electronically via the Internet by selecting the "Tax Regs" option on the IRS Home Page, or by submitting comments directly to the IRS Internet site at http://www.irs.ustreas.gov/prod/tax_regs/comments.html.

FOR FURTHER INFORMATION CONTACT: Concerning submissions, the Regulations Unit, (202) 622-7180; concerning the regulations, Ruth Hoffman, (202) 622-3130 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Background

T.D. 8740 amends the Excise Tax Procedural Regulations (26 CFR part 40). The temporary regulations contain rules

relating to the availability of the safe harbor deposit rule based on look-back quarter liability and to floor stocks taxes.

The text of those temporary regulations also serves as the text of these proposed regulations. The preamble to the temporary regulations explains the temporary regulations.

Special Analyses

It has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in EO 12866. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations and, because these regulations do not impose on small entities a collection of information requirement, the Regulatory Flexibility Act (5 U.S.C. chapter 6) does not apply. Therefore, a Regulatory Flexibility Analysis is not required. Pursuant to section 7805(f) of the Internal Revenue Code, this notice of proposed rulemaking will be submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Comments and Requests for a Public Hearing

Before these proposed regulations are adopted as final regulations, consideration will be given to any written comments (a signed original and eight (8) copies) that are submitted timely to the IRS. All comments will be available for public inspection and copying. A public hearing may be scheduled if requested in writing by any person that timely submits written comments. If a public hearing is scheduled, notice of the date, time, and place for the hearing will be published in the **Federal Register**.

Drafting Information

The principal author of these regulations is Ruth Hoffman, Office of Assistant Chief Counsel (Passthroughs and Special Industries). However, other personnel from the IRS and Treasury Department participated in their development.

* * * * *

Proposed Amendments to the Regulations

Accordingly, 26 CFR part 40 is proposed to be amended as follows:

PART 40—EXCISE TAX PROCEDURAL REGULATIONS

Paragraph 1. The authority citation for part 40 continues to read in part as follows:

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

Par. 2. In §40.0-1, paragraph (a) is amended by revising the second sentence to read as follows:

§40.0-1 Introduction.

(a) * * * The regulations set forth administrative provisions relating to the excise taxes imposed by chapters 31, 32, 33, 34, 36, 38, and 39 (except for the chapter 32 tax imposed by section 4181 (firearms tax) and the chapter 36 taxes imposed by sections 4461 (harbor maintenance tax) and 4481 (heavy vehicle use tax)), and to floor stocks taxes imposed on articles subject to any of these taxes. * * *

* * * * *

Par. 3. In §40.6011(a)-1, add paragraph (a)(2)(iii) to read as follows:

§40.6011(a)-1 Returns.

- (a) * * *
- (2) * * *
- (iii) *Floor stocks tax return.*

[The text of this proposed paragraph is the same as the text of §40.6011(a)-1T(a)(2)(iii) published in T.D. 8740.]

Par. 4. Section 40.6302(c)-1 is amended as follows:

- 1. Paragraph (c)(2)(iv) is added.
- 2. Paragraph (f)(1) is amended by adding a sentence to the end of the paragraph.

The additions read as follows:

§40.6302(c)-1 Use of Government depositaries.

* * * * *

- (c) * * *
- (2) * * *
- (iv) *Modification for new or reinstated taxes.*

[The text of this proposed paragraph is the same as the text of §40.6302(c)-1T(c)(2)(iv) published in T.D. 8740.]

* * * * *

(f) * * * (1) * * * Also, no deposit is required in the case of any floor stocks tax described in §40.0-1(a).

* * * * *

Par. 5. In §40.6302(c)-2, add paragraph (b)(2)(iii) to read as follows:

§40.6302(c)-2 *Special rules for use of Government depositaries under section 4681.*

* * * * *

(b) * * *

(2) * * *

(iii) *Modification for new chemicals.*

[The text of this proposed paragraph is the same as the text of §40.6302(c)-2T(b)(2)(iii) published in T.D. 8740.]

* * * * *

Michael P. Dolan,
Acting Commissioner of Internal Revenue.

(Filed by the Office of the Federal Register on December 24, 1997, 8:45 a.m., and published in the issue of the Federal Register for December 29, 1997, 62 F.R. 67589)

Notice of Proposed Rulemaking HIPAA Mental Health Parity Act REG-109704-97

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking by cross-reference to temporary regulations.

SUMMARY: In T.D. 8741, page 6, the IRS is issuing temporary regulations relating to mental health parity requirements imposed on group health plans. These requirements were added to the Internal Revenue Code by section 1532 of the Taxpayer Relief Act of 1997. The IRS is issuing the temporary regulations at the same time that the Pension and Welfare Benefits Administration of the U.S. Department of Labor and the Health Care Financing Administration of the U.S. Department of Health and Human Services

are issuing substantially similar interim final regulations relating to mental health parity requirements added by the Mental Health Parity Act of 1996 to the Employee Retirement Income Security Act of 1974 and the Public Health Service Act. The temporary regulations provide guidance to employers and group health plans relating to the new mental health parity requirements. The text of those temporary regulations also serves as the text of these proposed regulations.

DATES: Written comments and requests for a public hearing must be received by March 23, 1998.

ADDRESSES: Send submissions to: CC:DOM:CORP:R (REG-109704-97), room 5226, Internal Revenue Service, POB 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand-delivered between the hours of 8 a.m. and 5 p.m. to: CC:DOM:CORP:R (REG-109704-97), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington, DC.

Alternatively, taxpayers may submit comments electronically via the Internet by selecting the "Tax Regs" option on the IRS Home Page, or by submitting comments directly to the IRS Internet site at: http://www.irs.ustreas.gov/prod/tax_regs/comments.html

FOR FURTHER INFORMATION CONTACT: Concerning the regulations, Russ Weinheimer, (202) 622-4695; concerning submissions or to request a hearing, Mike Slaughter, 202-622-7180. These are not toll-free numbers.

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

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

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

The collection of information is in §54.9812-1T (see T.D. 8741). The collection of information is required if a plan

wishes to avail itself of an exemption provided under the statute. The likely respondents are business or other for-profit institutions, nonprofit institutions, small businesses or organizations, and Taft-Hartley trusts. Responses to this collection of information are required in order to obtain the benefit of being exempt from the mental health parity requirement.

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

Comments on the collection of information should be sent to the **Office of Management and Budget**, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the **Internal Revenue Service**, Attn: IRS Reports Clearance Officer, T:FP, Washington, DC 20224. Comments on the collection of information should be received by February 20, 1998. Comments are specifically requested concerning:

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

— The accuracy of the estimated burden associated with the proposed collection of information (see the preamble to the temporary regulations published in T.D. 8741);

— How to enhance the quality, utility, and clarity of the information to be collected;

— How to minimize the burden of complying with the proposed collection of information, including the application of automated collection techniques or other forms of information technology; and

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

Background

The temporary regulations published in T.D. 8741 add §54.9812-1T to the Miscellaneous Excise Tax Regulations. These regulations are being published as part of a joint rulemaking with the Department of Labor and the Department of Health and

Human Services (the joint rulemaking).

The text of those temporary regulations also serves as the text of these proposed regulations. The preamble to the temporary regulations explains the temporary regulations.

Special Analyses

Pursuant to sections 603(a) and 605(b) of the Regulatory Flexibility Act, it is hereby certified that the collection of information referenced in this notice of proposed rulemaking (see §54.9812-1T of the temporary regulations published in T.D. 8741) will not have a significant economic impact on a substantial number of small entities. Employers with 50 or fewer employees are not subject to the law. Moreover, even for employers that are subject to the mental health parity requirements, no collection of information is required unless they qualify for and claim the 1% increased cost exemption. Even for employers subject to the law who claim the exemption, the estimated time for each response is 2 minutes. Thus, for example, an employer with 100 employees in its group health plan that claimed the 1% increased cost exemption, that took advantage of the three-month transitional period provided in the temporary regulations and that received 10 requests to examine the assumptions used in claiming the exemption would incur a total one-time burden of less than 4 hours. At an estimated cost of \$11 per hour, this would result in a one-time cost of less

than \$44. This is not a significant economic impact.

This regulation is not subject to the Unfunded Mandates Reform Act of 1995 because the regulation is an interpretive regulation. For further information and for analyses relating to the joint rulemaking, see the preamble to the joint rulemaking. Pursuant to section 7805(f) of the Internal Revenue Code, this notice of proposed rulemaking will be submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Comments and Requests for a Public Hearing

Before these proposed regulations are adopted as final regulations, consideration will be given to any written comments (a signed original and eight (8) copies) that are submitted timely to the IRS. All comments will be available for public inspection and copying. A public hearing may be scheduled if requested in writing by a person that timely submits written comments. If a public hearing is scheduled, notice of the date, time, and place for the hearing will be published in the **Federal Register**.

Drafting Information

The principal author of these proposed regulations is Russ Weinheimer, Office of the Chief Counsel, Employee Benefits and Exempt Organizations. However, other personnel from the IRS and Treas-

ury Department participated in their development. The proposed regulations, as well as the temporary regulations, have been developed in coordination with personnel from the U.S. Department of Labor and U.S. Department of Health and Human Services.

* * * * *

Proposed Amendments to the Regulations

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

PART 54—PENSION EXCISE TAXES

Paragraph 1. The authority citation for part 54 is amended by adding an entry in numerical order to read as follows:

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

Section 54.9812-1 is also issued under 26 U.S.C. 9833. * * *

Par. 2. Section 54.9812-1 is added to read as follows:

§54.9812-1 Parity in the application of certain limits to mental health benefits.

[The text of this proposed section is the same as the text of §54.9812 1T published in T.D. 8741.]

Deputy Commissioner of Internal Revenue.

(Filed by the Office of the Federal Register on December 19, 1997, 8:45 a.m., and published in the issue of the Federal Register for December 22, 1997, 62 F.R. 66967)

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 ap-

plies 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. Proc.—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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¹ A cumulative list of all revenue rulings, revenue procedures, Treasury decisions, etc., published in Internal Revenue Bulletins 1997-27 through 1997-52 will be found in Internal Revenue Bulletin 1998-1, dated January 5, 1998.

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